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2019

Providing counseling in a rural setting : a new multicultural perspective

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ABSTRACT

PROVIDING COUNSELING IN A RURAL SETTING:
A NEW MULTICULTURAL PERSPECTIVE

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Northern Illinois University, 2019
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Counseling research shows a lack of information regarding training counselors to work in rural communities. However, more than 80% of the United States land is considered rural. This appears to be an extremely desperate combination of lack of information and training for a large portion of the country's population. An additional complication to this dynamic is that neither CACREP standards nor the ACA *Code of Ethics* mandate any specific trainings or address any specific needs of rural communities.

To improve the understanding of rural community dynamics, this qualitative study explored the phenomenological experiences of counselors working in rural communities. This research was conducted with the purpose of better understanding how rural clinicians name their personal experiences and how they identify the benefits and limitations of working in rural environments. This was done through both individual qualitative interviews and through conducting a focus group of counselor educators.

The goal of this research was to not only better understand the experiences of clinicians in rural communities and how they are trained but also to develop policy changes to repair potential deficits and better prepare clinicians to work in rural environments. This study also identified implications for counselor education.

Key words: counselor education, rural, rural communities, rural counseling

NORTHERN ILLINOIS UNIVERSITY

DEKALB, ILLINOIS

MAY 2O19

PROVIDING COUNSELING IN A RURAL SETTING:

A NEW MULTICULTURAL PERSPECTIVE

BY

DANESSA CARTER

A DISSERTATION SUBMITTED TO THE GRADUATE SCHOOL

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE

DOCTOR OF PHILOSOPHY

DEPARTMENT OF COUNSELING, ADULT AND HIGHER EDUCATION

Doctoral Co-Directors:
Jane Rheineck and Melissa Fickling

ACKNOWLEDGEMENTS

I could not possibly have gotten to this point without the support and encouragement from my friends and family. Specifically, I would like to thank my parents, Dane and Teressa, and my husband, Chris, for going above and beyond to allow me the time, space, and words of wisdom to keep me moving along in this process. To my parents, you have always been encouraging of my dreams and you created a safe space for me to want to follow them. To my husband, thank you for standing by my side through all of my education and doing anything I needed to help ease the journey. This has been a long journey and I do not believe I would have made it without you.

To my dissertation committee, Dr. Jane Rheineck and Dr. Melissa Fickling, Dr. Laura Johnson, and Dr. Scott Wickman, thank you for all that you have done throughout my doctoral career. Dr. Rheineck, I am forever impacted by my time spent with you at NIU. You have helped me learn and grow and provided much-needed debriefing throughout this process. Dr. Fickling, I do not believe you will ever truly know how important you have been in my dissertation process. Thank you for being a counselor, mentor, and motivator. Dr. Johnson, this dissertation would not be what it is without you. Thank you for encouraging me to go the extra mile. Dr. Wickman, you have influenced me as a supervisor. Thank you for being so willing to share and teach.

Thank you to my friends and co-workers, Breanna Yantis, Jessica Taylor, Chelsea Butler, Melissa Parker, and Terri Johnson. You have been a shoulder to cry on, a sounding board, and the strongest support system ever. There is no way I could have completed this journey without

you all. Your late-night texts, mid-week check-ins, and prayers helped every step of the way.

You are all beautiful, strong women and I am blessed to know you.

To Angela Yoder, you are an amazing woman. Thank you so much for guiding me through my master's and continuing to be an important part of my life to this day. You kept me grounded through this writing process and offered words of wisdom that kept me moving forward no matter what.

DEDICATION

This dissertation is dedicated to those providing counseling services in rural communities. I know the work that you do. Thank you for giving your time, energy, and compassion to the underserved despite all the limitations and barriers you encounter every day.

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CHAPTER 1

RURAL COMMUNITIES INTRODUCTION

According to the U.S. Census Bureau, rural areas are defined as what urban areas are not. A city or town with a population of over 50,000 people would be defined as an urban community. A rural community would therefore require a population of less than 50,000 people in a given town (U.S. Census Bureau, n.d.). Additionally, nearly 60 million people live in what is defined as a rural community (Coduti & Manninen Luse, 2015). Although the main defining aspect of rural communities is the population size, there are other characteristics which are unique to rural communities. These unique characteristics were defined by those interviewed for the research. These communities are often underserved with resources. The lack of resources include lack of medical practitioners, lack of mental health counselors, and lack of career and education opportunities.

Rural Communities Description

An understanding of the concept of *community* is essential to understanding the rural environment. Oncescu and Giles (2014) named five aspects to defining a community: (a) membership, which refers to feelings of association to part of a community; (b) influence, which represents opportunities for individuals to contribute to community life; (c) integration and fulfillment of needs, which describes the benefits individuals receive from being a part of a community; (d) shared emotional connection, which highlights a shared history and social bond that develops over time with other community members; and (e) community identity, which

refers to the extent an individual identifies with their community. The same researchers reported that a sense of community is not guaranteed by all community members. Not feeling a sense of community while being a community member can generate or increase feelings of exclusion, oppression, and alienation (Oncescu & Giles, 2014). For this research study, counselors in rural areas were defined as having been trained at CACREP-accredited counseling programs who provided counseling services (individual, couples, group, and family) in a community mental health setting in areas of population of less than 50,000 people. These providers were licensed through the state of Illinois as a Licensed Professional Counselor or a Licensed Clinical Professional Counselor. No limits were set as to the clinician's previous experiences, but the clinician had to be currently practicing in a rural counseling setting. Community mental health settings include offices which treat mental health conditions, take a variety of payor sources, and potentially operate through state and federal grant programs. Urban practitioners provide the same group, individual, couples, and family services as rural counselors. However, urban counselors provide these services in cities and towns with populations of 50,000 or more. Rural counselors have unique difficulties and abilities based on the setting in which the clinician operates.

Rural Community Values

Rural communities come with a specific set of values that go beyond population density. These values help to shape rural communities and guide rural community member behavior. Some examples of rural community values include a reduction in access to services, resources, and vocational opportunities (Coduti & Manninen Luse, 2015). These negative qualities lead to increased health complications and strain on the available resources in these communities.

Careers in rural communities are most frequently focused on small businesses and self-employment. This leads to increased poverty rates, limited access to health care and insurance, and complex boundary issues between clients and providers.

Barriers to acceptance in rural communities focus around insider and outsider status. Rural community members show a mistrust of those not from the community and rely heavily on participation in community organizations to form a sense of belonging to the community (Oncescu & Giles, 2014). These rural community organizations allow for comfort and trust to develop among rural community members. Without participation in these organizations, rural community members often feel disconnected from their communities and rely even more on themselves (Oncescu & Giles, 2014).

Advocacy Needs

Advocacy in rural communities becomes additionally complicated due to the limited resources and complex values discussed previously. For instance, Shirley (2010) reported on segregation and discrimination both between and within races and ethnicities in rural communities. These multiple facets of discrimination also included discrimination based on other demographic factors including but not limited to: gender, socioeconomic status, and religion (Shirley, 2010). Coduti and Manninen Luse (2015) reported on how the stigma associated with mental health services and the lack of access of services combine to reduce the utilization of mental health services in rural communities. Therefore, it takes additional advocacy work to not only promote the use of mental health services but to do this advocacy while tackling the barriers inherent in rural communities.

Training

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) was founded in 1981 and the current mission statement attests that the organization's mission is the development of preparation standards, the encouragement of excellence in program development, and the accreditation of professional preparation programs (CACREP, n.d.). Part of this accreditation process involves the development of practices, standards, and education about multicultural populations. It must be noted here that multicultural competencies cover more than simply race and ethnicity.

A counselor educator's ultimate goal is to help train future counselors to work with a variety of populations that may require specialized training, techniques, or understanding. One of these multicultural populations which requires specialized training and education is the rural population. Rural communities come with their own set of unique characteristics and differences that can create challenging presenting client issues and complex environments in which to work. Each rural population can vary based on geographic region, racial composition, and additional factors. Counselor educators utilize scholarly research to inform and prepare future counselors to work in the field; however, there is a lack of investigative research about how rural populations can impact the job of a counselor. Therefore, it is difficult, if not impossible, to completely prepare counselors to work in these specific areas. This is a form of that looks at specific counseling programs at colleges and universities and holds them to a set of standards. For a program to be CACREP-accredited, the university or college as a whole must have accreditation by a different accrediting body. This accreditation provides students and employers with understanding of the quality and content of the courses being offered in the program. CACREP

accreditation defines standards used for clinical counseling, career counseling, college student affairs, school counseling, addictions counseling, and marriage, couples, and family counseling. CACREP also sets standards for the requirements for doctoral-level degrees in Counselor Education and Supervision (CACREP, 2016). These standards define diversity as one of the core content areas that CACREP programs should educate their students on (CACREP 2016 Standards, p. 43).

Counselor education standards established by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) establishes defined guidelines for multicultural training for graduates of CACREP-accredited programs. These guidelines include directions for addressing each individual student's attitudes and beliefs associated with multiculturalism (CACREP, 2009). These standards also discuss developing a level of understanding of the need for multicultural awareness and acceptance to help increase advocacy for diverse populations and reduce discrimination and oppression (CACREP, 2009).

While the standards specifically discuss multicultural education in one particular section, the need for multicultural competencies is woven throughout the other CACREP standards and is therefore reinforced as an extremely important aspect of counselor education and training. Due to this, it is crucial that counseling students are exposed to different cultures and explore their biases as related to the diverse populations. Working in a rural environment gives students an opportunity to examine a specific set of beliefs, ideals and norms which is the basis for defining a specific culture (CACREP, 2009).

However, counselors' perspectives on working in rural populations is missing from the literature. There is information about operating in a rural environment in other professions (e.g.,

physician, psychiatrist), and there is information about the basic elements that define certain rural environments (e.g., poverty, limited resources; Kenny et al., 2013). But there is no information on how counselors operate in these conditions or how counselors define the barriers and benefits of working in a rural environment. Therefore, we have a significant amount to learn about the process of counseling in a rural environment, that can assist counselors in preparing for work in a rural environment and can assist counselor educators in training and educating future counselors about working with rural populations and about the specific issues surrounding them.

<div align="center">Relational Cultural Theory</div>

One theory that specifically addresses power and multicultural dynamics is Relational Cultural Theory (Walker, 2008a). This theory is instrumental in that it views the therapist as someone who holds multiple cultural identities, some of which have power and some of which do not (Walker, 2008a). Walker (2008b) also discussed an important aspect of this theory which states that when a group of people is in a position of power, they begin to treat those with less power negatively by not incorporating their views or ideas, and by not allowing those in non-power positions to make important community decisions. The first use of Relational Cultural Theory was to help women become more understood in the therapeutic setting and focus on culture as a whole, rather than only examining and valuing the voices of those in power in a specific culture (Walker, 2008a).

This theory worked to integrate the experiences and identities of those not in positions of power into their own stories. For instance, the founders believed that women's identities were being described, labeled, and assigned value by white, middle-class men, rather than the women themselves (Walker, 2008b). Beyond this being a social justice concern, Relational Cultural

Theory creators believed that this was skewing perspectives and understanding of the marginalized individuals' actual experiences (Walker, 2008a).

According to Walker (2008a), this theory helps to understand how power dynamics within communities influence the messages received by individual community members. These power dynamics and overt and covert dialogue between sections of a community can be examined to better understand the overall experiences of individual community members. Without understanding such intricacies, parts of the phenomenological experiences are lost (Walker, 2008a).

<div align="center">Research Significance</div>

Skubby, Bonfine, Novisky, Munetz, and Ritter (2013) stated that rural populations and partnerships to rural populations, such as community organizations, law enforcement, and other specialized services, face specific systemic and environmental factors including limited resources, unique environmental factors, and unique experiences. This process can make collaboration and progress more difficult in rural communities (Skubby et al., 2013). Often, models and processes that are well developed and utilized in urban environments may need to be adapted and changed to fit these unique rural environments (Skubby et al., 2013). This research study could inform the counseling community about the specific benefits and limitations to working in a rural community. Counselor educators could use information discovered in this study to better inform, adapt, and expand the training they provide for master's-level counselors. This could in turn potentially increase rural counselor job preparedness and satisfaction.

By increasing job preparedness and satisfaction, it is possible that rural counselors would then be more likely to better serve the communities they work in, increase client satisfaction, and

even increase the number of community members who are comfortable with and interested in the counseling process. The purpose of this phenomenological study was thus to discover experiences of counselors providing services in rural communities to better inform counselor educators about appropriate training procedures for master's students.

Rationale

Because research in this area is lacking or not specific to the counseling profession, it is difficult to know how to properly prepare counselors-in-training for the experiences, limitations, and benefits of working in the counseling field in a rural setting. It is important that rural communities have counselors who have been adequately trained and prepared to work with rural populations and live in rural communities. To better train, prepare, and understand counseling in rural communities, qualitative research in this area is essential. It is hoped that the findings from this study will help counselors and counselor educators begin to understand the unique qualities that exist in providing counseling services in a rural counseling setting.

Statement of the Problem

The job of a counselor educator is to prepare future counselors to work in a multitude of different situations and settings with numerous types of populations. To do this properly, it is important that counselor educators understand what features and qualities can impact the work of counselors working in different settings with different populations (Locke, Myers, & Herr, 2001; Oncescu & Giles, 2014). The lack of research on rural communities impacts counselors' ability to be prepared for future work settings and for counselor educators to gear their education and guidance towards helping these underserved communities.

Research Questions

The following three research questions guided this study:

1) How do counselors in rural settings describe their experiences practicing in rural communities?

2) What benefits and limitations do rural counselors see in practicing in rural communities?

3) How do counselors name and conceptualize characteristics of counseling in a rural setting?

Through the use of qualitative individual interviews, a focus group, field notes, and web search, data was gathered to examine these questions. This research utilized phenomenology to examine the unique experiences of rural counselors.

Differences in Rural Communities

While this study was based in central Illinois, this is not the only area with rural populations and thus this particular setting creates a limitation of the research. There are rural populations nationwide, and there could be a varying range of what "rural" means in different parts of the country. Kenny et al. (2013) stated that there is a growing awareness that some common features are experienced across rural communities; however, other aspects of rural communities vary widely from one rural community to another. There could be different unique characteristics which define rural communities in other parts of the nation which might not be present in the central Illinois location in question. Therefore, assumptions about the findings of this research study should not necessarily be generalized across the nation to every rural community.

One specific stereotypical characteristic of rural communities is the lack of trust and acceptance of outsiders (Friedman, Bergeron, Foster, Tanner, & Kim, 2013). Feelings associated with the research experience in rural communities are often experienced as mistrust and fear of being treated like an experiment (Friedman et al., 2013). There is also a lack of understanding about the scope of research—of how it could be used to benefit rural participants specifically, for example— and concerns about the cost or negative effects that may be experienced (Friedman et al., 2013). This overall lack of trust and acceptance of research could greatly cloud the information collected if collected directly from rural community members. Therefore, collecting information from rural counselors could potentially reduce bias because such participants in the counseling profession are more likely to have been exposed to the research process and familiar with the benefits and limitations of participating in research.

Based on this, collaboration as a researcher or outside member may be too large of a barrier to overcome for the purposes of qualitative research. However, this collaboration is incredibly important not only in research, but also progress in continued community development. Shoffner and Briggs (2001) defined the benefits of collaboration as knowledge and information gained, learning skills, identifying information needed, and attitude changes with regard to other professions. It is clear that active and open collaboration help to develop extensive gains for all parties involved.

Personal Background

Growing up in a rural community, the daughter of two mental health professionals, I have always understood and respected the need for mental health services. My small town of 800 offered very few services (i.e., medical offices and mental health services) in general. The

neighboring town, where my parents worked, provided minimal individual mental health counseling services and a comprehensive substance abuse treatment program. I learned early that community members were leery and cautious of mental health services. There was often a distrust, perceived or real, that these services were not accepted as an option for assistance. Problems should be handled internally by an individual or a family system and not discussed with outside parties. It was common for my parents to encounter their clients in public and as a result, I learned to detect quickly who they were without asking. As I have continued my education, becoming a clinical counselor and now pursuing my doctorate in Counselor Education and Supervision, it has become increasingly important for me to assist those who practice in rural communities. I have seen the positive changes that people are able to make through the assistance of mental health services. Those participating in these services have improved overall functioning, learned new skills for healthy living and communication, and reduced or eliminated mental health symptomology.

I have also seen the high turnover in of clinicians in mental health settings. Counselors move from position to position and change agencies regularly. While it is unclear why this regular turnover is associated with mental health counseling, it is clear that this has an impact both on counselors and clients. I am passionate about finding out how to fill the gaps in these areas so the people of rural communities can benefit from mental health services and the counselors practicing in these areas can feel supported and remain practicing in these settings. All these personal characteristics were important for me to acknowledge and be aware of throughout my research into this topic.

To summarize, my primary experience in counseling and living are both based out of rural settings. In addition, I also desire to continue to practice and live in a rural setting. While I am aware of the disadvantages of this environment, it is the environment in which I am most comfortable. My extended family lives in rural communities and being close to them is something I value. Because of this, I am aware that I may be more likely to acknowledge the positives of these areas rather than admit any faults. In Chapter 3, I will discuss ways in which I was intentional in limiting the effect of this bias in my research.

Assumptions

The assumptions for this study come from the foundational research and from my personal experience with rural community living. The first primary assumption is that this is a unique experience that rural counselors have in participating in rural counseling roles. This experience is different from counseling in an urban or suburban environment. Based on studies of other professions operating in rural communities, the research indicates that unique differences exist in rural communities. Oncescu and Giles (2014) reported some of these unique perspectives as decline in resource production, high unemployment rates, and limited services and amenities. Their research further discussed the difficulties that rural community members experience in identifying and utilizing social, health, and educational services (Oncescu & Giles, 2014). These resources are more difficult to obtain due to the distance that rural community members must traverse to obtain these resources and a lack of education and exposure to the availability of these resources (Oncescu & Giles, 2014).

Another assumption is that beginning to understand these unique experiences can help those entering the counseling profession prepare for the positives and negatives that come from

working in this unique environment. Schwitzer, Gonzalez, and Gurl (2001) reported on the need for classroom experiences to be as close to real-life counseling experiences as possible. Their research reported that these realistic classroom experiences have a more lasting impression on students partaking in the experiences and thus are more likely to accurately prepare students for the real-life situations the classroom activity is attempting to replicate (Schwitzer et al., 2001).

This research found that these topics can elicit negative feelings in students receiving the training, such as defensiveness, shame, guilt, and anger. These negative feelings must be handled and addressed in the training forum to increase the effectiveness and the acceptance of the diversity training. It is the role of the counselor educator to create a safe space for students to address these feelings, experience the learning environment, and express biases and opinions openly (Steele, 2008).

A final assumption is that those practicing in rural environments have the ability and desire to name the specific differences in providing mental health counseling services in a rural community. This assumption is based on the foundation for qualitative research and the idea that those who experience something are able to name and identify their own personal experiences. Other research indicates that people in other professions (i.e., teachers, psychiatrists, general practitioners) were able to name the experiences of providing services in rural communities to researchers.

These assumptions are based on the research discussed throughout Chapter 2 and introduced in this chapter. Assumptions must be acknowledged so they can be addressed throughout the research process. These assumptions will be further addressed in Chapter 5.

Chapter 1 Summary

A range of unique qualities distinguishes rural populations and areas from others. It is essential that counselor educators, supervisors, non-rural counselors, and lawmakers understand these differences so they can better inform their teaching and supervision practices to enable counselors to thrive in these settings. This can only be done by furthering the research on counselors' experience in rural settings. Further information presented in Chapter 2 will discuss the pertinent literature available in the areas of rural counseling and CACREP diversity training and education.

CHAPTER 2

RURAL COMMUNITIES

The standard definition of "rural" is typically based on population density; Harowski, Turner, LeVine, Shank, and Leichter (2006) use an updated U.S. Census Bureau definition where rural communities are less than 1,000 people per square mile per town and less than 500 people per square mile near the town's limits. Based on this definition, more than 80% of U.S. land would be characterized as rural (U.S. Census Bureua, n.d.).

Throughout the United States, there is a lack of mental health services available. Murray and Keller (1991) found that population strongly correlates with the number of registered psychologists in a given area, stating, "77.5% of the counties with fewer than 100 persons per square mile lacked a single registered psychologist, whereas only 2% of counties with a density greater than 400 persons per square mile were in a similar situation" (p. 225). This lack of service area and vast percentage of land means that the average mental health service range is one provider for every 5,000 miles (Murray & Keller, 1991). Oncescu and Giles (2014) identified rural schools as a major contributor to mental health services for rural communities. Although it is expected that school settings assist minors with mental health services, the authors also found that these rural schools also provide psychoeducation, referral services, and family counseling for the adult guardians and families of the minors. Baker et al. (2009) reported that additional professions—including teaching—face underfunding and high turnover rates.

Haroswki et al. (2006) reported that over 60% of mental healthcare in rural communities is performed and provided by a general medical practitioner. The authors discussed that mental health care such as diagnosis, prescribing, and basic listening skills are frequently administered by general medical practitioners rather than trained mental health professionals. This is a concern due to the lack of mental health specific training that these doctors are given (Haroswki et al., 2006).

<div align="center">Characteristics</div>

The definition of rural communities often centers on population totals. However, this definition can marginalize rural communities by not considering all the values, morals, traits, and special issues that actually define a rural community. This definition by numbers also removes the understanding that rural communities vary from place to place across the nation (DeMarco & DeMarco, 2009; Murray & Keller, 1991).

An additional and potentially more accurate way to define rural communities may be to identify qualities of the populations rather than the numbers that quantify it. Campbell and Gordon (2003) examined several of these qualities, including the fact that residents are known in social, family, and historical contexts. Campbell and Gordon also stated that rural residents choose the amount of social interaction they participate in and whom this social interaction is with. Change and diversity are well controlled and monitored by rural residents, as rural residents are sensitive to any changes in demographics and town makeup (Campbell & Gordon, 2003). Additional characteristics that were described are: rural relationships span generations rather than years, mental health issues are expected to be dealt with in the family or individual rather than seeking help outside, people from outside of the community are often distrusted, and

multiple relationships are seen as normal, necessary, and accepted. Schank, Helbok, Haldeman, and Gallardo (2010) gave further insight to these characteristics and helped broaden understanding of rural communities by identifying the link from rural communities to that of small communities, which can include such networks as military, campus life, communities of color, corrections, suburban, chemical dependency, and school districts, among others. These small communities act similarly to rural communities and can have many of the same characteristics attributed to rural communities.

Media and outside perception often label rural communities as idyllic living situations that have a strong moral compass (Edwards, Torgerson, & Sattem, 2009). However, research indicates that issues such as prostitution, drug and alcohol use, poverty, racial hatred, and gun violence are often found at increased rates in rural communities across the nation (Edwards et al., 2009). These statistics greatly contradict the idea that rural communities are environments whose members are happier and healthier than those in urban environments. For instance, according to statistics obtained in the late 1990s, rural 8th graders were twice as likely as their urban counterparts to have tried amphetamines, including methamphetamine, while just over 6 percent of rural 12th graders had used meth in the previous year (Edwards et al., 2009). This shows the rapidly changing climate in rural communities. A study completed in 2011 found that rural adolescents had a higher rate of using illicit substances and were 26% more likely to use prescription medication without a valid prescription than adolescents in suburban and urban areas (Young, Glover, & Havens, 2012).

Poverty is often a characteristic that has been attributed to and widely studied in the rural population (Grinstein-Weiss, Curley, & Charles, 2007). This characteristic of poverty is defined

by the overall lower income rates and higher poverty rates of rural communities. Reasons that poverty is found at a higher rate in rural communities are attributed to additional characteristics of rural communities such as (1) fewer economic opportunities, (2) lower earnings, (3) fewer high-quality jobs, and (4) fewer educational and training opportunities. Poverty is disproportionate when compared to urban areas. For instance, Grinstein-Weiss et al. stated that the 2003 poverty rate was 14.2 percent for rural residents compared to 12.1 percent for urban residents. Poverty has an even stronger impact on rural children: in the same 2003 data collection, 20.8% of children in rural environments were below the poverty line as compared to 16.9% of children in urban environments. In addition, single-parent families with women as the head of household were more likely to be impoverished, 34.1% as compared to 26.8%, in rural communities. Oncescu and Giles (2014) identified agriculture as the primary career and work opportunity for rural community members.

However, these agricultural work opportunities were often family owned and employed few outside members. Being a racial minority in a rural community shows an increasingly high poverty rate as compared to Caucasian rural community members. In 2003, it was found that the African American rural community poverty rate was 30.2% and the Hispanic rural community poverty rate was 25.4%, whereas the Caucasian rural community poverty rate was only 12.5% (Grinstein-Weiss et al., 2007). However, while many rural community members qualify for public assistance, the distances that they live from resources such as welfare offices, hospitals, mental health care offices, and other valuable resources decrease the likelihood that they will utilize them. Oncescu and Giles (2014) found that rural communities rely heavily on community

organizations such as youth and senior clubs, city hall organizations, and recreation clubs that assist in providing needed resources, including funding for community projects to rural locations.

Advocacy

Due to the lack of resources available to those in rural communities, including mental health resources, advocacy is essential to both make resources available to clients and educate clients on mental health services. An essential characteristic of a counselor is the ability to advocate for clients (Cohen, Lee, & McIlwraith, 2012). Advocacy and social justice are both key components to social change and assisting the populations with which counselors work. These definitions of advocacy as well as the process of advocacy in rural communities are discussed as follows.

Cohen et al. (2012) and Locke et al. (2001) depicted the traditional counseling definition of advocacy as helping individuals, clients, or groups in underrepresented populations. However, for the purposes of this study, advocacy focuses on promoting and supporting the counseling profession as a whole in a specific realm. According to the aforementioned authors, this concept has not been as developed as advocating for clients and other neglected populations. Counselors often define themselves as altruistic, and using advocacy as a form of self-promotion can feel unnatural and counterintuitive (Cohen et al., 2012). However, promoting the counseling profession may transcend self-interests when counselors work to increase services to underrepresented populations.

Advocating for the counseling profession can take place in many arenas. For instance, counselor advocacy can begin in counseling organizations where members can work to identify roles, define aspects of the profession, and develop universal standards for its members (Locke et

al., 2001). The simple definition of counseling could stand some advocacy to help define what counseling means and decrease stigma in receiving services. For instance, different counselor education programs refer to counselors using different terms (e.g., therapist, counselor, professional counselor) and counseling licensure is attainable for those receiving degrees and holding titles in professions other than counseling. One important counseling advocacy initiative was the American Counseling Association 20/20 Vision. According to Kaplan, Tarvydas, and Gladding (2014), the purpose of this initiative was not to critique previous definitions of counseling but rather align these definitions of counseling and create a uniform description of counseling to provide one consistent definition of counseling for both counseling professionals and those outside the counseling profession. This final definition became, "Counseling involves professional relationships designed to assist individuals, families, and groups toward mental health, wellness, educational, and career goals" (p. 368). By unifying a definition of counseling, both professional counselors and those outside the counseling profession can have a clear definition and understanding of the holistic view of the responsibilities and roles counselors fulfill.

As noted in Cohen et al. (2012), the Canadian Psychological Association has taken an active role in advocating for the profession of psychology in Canada. Advocacy in this realm has been in the form of developing government and media relations kits, TV commercials, media training, and leadership conferences at both the provincial and territorial levels. This advocacy has led to an increase in enrollment in undergraduate and graduate higher education for psychology. Another arena that advocacy should impact is public policy. Counselors

participating in public policy making can not only help improve the legitimacy of the profession but can also improve standards of the profession and normalize the profession.

<p align="center">Advocacy in Rural Communities</p>

One opportunity for advocacy in rural communities is the concept of asset building. While the majority of government assistance programming focuses on financial compensation and assistance, Grinstein-Weiss et al. encouraged assisting those in rural communities through building resources, businesses, and projects in each community member rather than providing financial assistance. The authors cited that education is a far more influential factor in reducing poverty rates than providing financial assistance. In rural communities in 2003, rural community members with a bachelor's degree or more experience poverty at a rate of 3.5%, whereas those rural community members with less than a high school degree experience poverty at a rate of 22.2%.

A common use of advocacy in the realm of social justice is to advocate for rights of minority community members. However, Shirley (2010) found that rural communities have shown discrimination and segregation among Caucasian members from other Caucasian members. These Caucasian groups are not homogeneous groups. Instead, these groups are self-categorized by region, gender, and class to form a sort of ranking system among Caucasian members that is also often associated with different levels of privilege based on identities and experiences (Shirley, 2010). Due to the identifiers by which rankings are made (i.e., identity and experience) the rankings can change based on individual regions and can also change as time progresses. For example, a valued gender or class may be different from one region to another and a community member may gain experiences or change socio-economic status and therefore

change his or her value amongst other Caucasian rural community members. This poses an additional need for advocacy among intra-racial systems in rural communities.

Substance use can also look markedly different in rural communities versus urban communities. Heil, Sigmon, Jones, and Wagner (2008) conducted a study profiling differences between urban and rural female opiate users. The researchers found that rural women were often significantly younger, more likely to identify as Caucasian, and more likely to use while pregnant than their urban counterparts. An additional complication to this issue is that these rural women lived significantly further away from any form of treatment clinic than those suffering with substance addiction in an urban environment. Rural women were also three times more likely to present for and require treatment compared to urban women (Heil et al., 2008).

Based on the above-stated characteristics and statistics, it is clear that living in a rural community provides unique and diverse issues for both counselors and clients. It is essential that counselors understand these unique issues in order to better assist clients and for clients to understand these unique issues in order to be more open to the treatment process. The following identifies some of the unique issues for clients and counselors as identified in previously conducted research.

Rural Values

Research has found that rural values center on several concepts, including: importance of self-reliance, emphasis on conservatism, a lack of trust in outsiders, religion transcendence, strong work orientation and ethic, and emphasis on family, individualism, and fatalism (Harowski et al., 2006). These characteristics impact the utilization of mental health services in a negative way (Harowski et al., 2006). Based on some of these biases in the rural community,

general medical doctors are often the professionals who provide mental health assistance in rural

communities. In research by Harowski et al. (2006), these professionals have reported a lack of

desire to refer mental health issues out because of the already established trusting

patient/professional relationship and lack of knowledge of policies and procedures for referral

and transfer of information to a mental health professional. For instance, Oncescu and Giles

(2014) observed that rural community members rely on rural community organizations or

organizations founded and conducted within the rural community to create interpersonal

relationships, establish community connections, and provide resources. Therefore, when these

community organizations do not include mental health services, rural community members are

less likely to access these services (Oncescu & Giles, 2014).

The belief that rural communities are idyllic and lack issues still exists; however, these

settings are actually more likely to experience lower income, more poverty, less healthcare, less

education, lower employment rates, and greater lack of public transportation (Murray & Keller,

1991). These issues contradict the notion that rural communities lack issues that would

necessitate mental health services. As further evidence, Harowski et al. (2006) noted during a

single-study design:

> Although rates of depression in rural areas were comparable with rates in urban areas,
> outcomes of treatment for depression were not. Detection rates by rural physicians were
> only half of those from urban practice sites, and rural patients were less likely to receive
> guideline dosage levels of antidepressants or a referral to concurrent psychotherapy or
> counseling, even when mental health providers were present in their local communities.
> Rural residents were also four times more likely to experience a serious mental health
> relapse or second episode within the year following treatment, and they were four times
> more likely to attempt suicide than their urban resident comparators. When combined
> with the increased utilization of emergency or hospital care, these poorer outcomes also
> have serious economic implications for rural communities and hospitals and for rural
> patients and families, many of whom are uninsured. (p. 161)

Mental health stigma in both rural and urban areas is at least reported to be equal (Harowski et al., 2006). However, members of rural communities experience stigma and a lack of anonymity that occurs in urban areas; rural community members receiving mental health treatments are more easily identified and ostracized due to obtaining services (Murray & Keller, 1991). Additional research conducted by Coduti and Manninen Luse (2015) discussed similar findings which limited access for mental health services in rural communities due to the stigma associated with utilizing these resources. This stigma is compounded by the need for self-sufficiency and independence among rural community members (Coduti & Manninen Luse, 2015).

Additional complications arise when considering the difficulty in implementing physical healthcare in rural communities. De Marco and De Marco (2010) found that the increase in poverty rate associated with rural communities also showed a decrease in healthcare access and utilization in rural communities. Some of the factors that contributed to the poor physical healthcare in addition to poverty were: unemployment, female heads of households, and public assistance use. These factors decreased the likelihood that members of rural communities would access healthcare in times of physical illness and also decreased the likelihood for accessing and utilizing preventative healthcare (De Marco & De Marco, 2010). Instead of using traditional forms of physical healthcare, the researchers found that rural community members who identified as having more positive physical health also identified as having a high-quality social network. Therefore, it may be important for rural community members to access social support systems in times of physical health limitations.

Parenting in rural communities can look much different than parenting in an urban community. For instance, a study by Bender, Fedor, and Carlson (2011) found that parents in

urban communities have greater access to social resources, including a wider availability of

education and access to those parenting similarly aged children. The same study also found that

maternal monitoring and stricter parenting are both qualities of urban parenting. To combat this

difference, parents in rural communities develop stronger community relationships with friends

and neighbors and spend an increased amount of time in these relationships (Bender et al., 2011).

Career development also varies widely from rural to urban communities. Many of the job

opportunities present in rural communities are found to be traditionally male jobs, and there is

increased segregation between male and female gender roles (Bender et al., 2011). However, due

to the increased poverty rate, more females seek employment in rural communities than in urban

communities. The increased stigma and increased desire for females to work outside of the home

complicate career development and job search for female populations in rural communities.

For Counselors

Providing counseling services in rural communities involves a unique set of issues for

mental health providers. Murray and Keller (1991) found that no differences existed between

doctoral and master's-level psychologists in services provided or the clients served. This would

lead a professional to believe that an advanced degree would not be valued or justified in a rural

setting. The same researchers also found more supportive evidence for this idea; rural

community mental health is more often funded at the state and federal level rather than private

pay, which can have a great impact on income level for the mental healthcare provider. Due to

the issues of lack of staff and referral sources, clinicians can feel a sense of isolation and be

forced to provide a wider umbrella of care to clients (Murray & Keller, 1991). This larger range

of care can raise issues of competency and training for counselors, both of which can have an

impact on self-efficacy (Bradley, Werth, & Hastings, 2011). An additional study conducted by Benavides-Vaello, Strode, and Sheeran (2013) found that retaining qualified counselors in rural communities proved to be additionally difficult due to poverty issues in these rural communities. Skubby et al. (2013) actually found that law enforcement personnel were more likely to be first responders and referral sources for mental health issues in rural communities than a crisis or mental health worker. These police officers often have little to no training on how to de-escalate mental health crises and provide mental health triage. This leads to inappropriate care and treatment of mental health conditions.

Yet another issue in providing mental health services in rural communities is the lack of anonymity for the healthcare provider. It is understood that there is a high potential for community members to know what car a provider drives, where a provider lives, and for counselors to be overall more well-known in the community, whereas this is less likely the case in an urban setting where anonymity is more likely to be understood (Bradley, Werth, Hastings, & Pierce, 2012; Helbok, Marinelli, & Walls, 2006). It is also the case that practitioners in rural settings often play numerous roles in the community setting and are more visible to other community members. This concept can make avoiding dual roles nearly impossible (Bradley et al., 2012).

Rural communities often have difficulty retaining providers for a variety of special populations. While no research has specifically indicated issues in retaining mental health care professionals, research has been conducted in examining teacher retention in rural communities. Monk (2007) discussed the lower financial compensation reported in those teaching in rural communities. However, this same research identified that those teaching in rural communities

reported lower class sizes, lower discipline issues, and higher job satisfaction overall. These facts, combined with the high turnover rate, help to disentangle the complicated issues in providing specialized work in rural communities.

<u>Advocacy Strategies</u>

By combining the characteristics and statistics of rural communities with the unique issues presented to counselors and clients, some important strategies for success can be identified. These tactics can assist counselors and clients in making significant progress and increasing the positive effects of the counseling process. The following are some ideas for implementation for both clients and counselors.

A lack of education on mental health issues is one of the reasons for increased stigma surrounding mental health diagnoses in rural communities, and this stigma combined with lack of resources can often push those dealing with mental health issues in rural communities to more urban areas to achieve appropriate care and anonymity (Robinson et al., 2012). Based on this issue, it could be said that if the role of advocate was taken on by not only the mental health professionals but also clients and families of those experiencing mental health issues, the stigma could be reduced and the need for appropriate resources established and potentially fulfilled.

Another important dimension of education for rural mental health clients would be to understand the nature of the counseling process. Research conducted by Sherman, Barnum, Nyberg, and Buhman-Wiggs (2008) uncovered potential barriers to a client even entering the front door of a community mental health agency. These barriers were strongly correlated with potential wait time for appointments and constraints of those who had to pay for services out of pocket. Potential clients must be aware of the strains and limitations of local mental health

professionals. The potential for having to wait for an intake session is ever present. Clients must be prepared to remain self-motivated for treatment even if there is a lengthy wait time between initial call and the first session. Payment options, requirements, and health insurance benefits must be provided and explained to the client in a direct way so that the client has a firm understanding of rights and responsibilities (Sherman et al., 2008).

Navigating dual relationships and examining boundary issues appears to be the most salient issue for counselors to maintain ethical and legal best practices (Bradley et al., 2012; Helbok et al., 2006; Murry & Keller, 1991; Schank & Skovholt, 1997). Campbell and Gordon (2003) indicate the risk for practitioners based on rural setting qualities (i.e., limited shopping areas, few banking centers, few school systems) that increase the number of dual relationships and the prevalence of boundary violations. These characteristics include: being comfortable with the rural lifestyle and therefore accepting dual relationships without much consideration, allowing and believing in the necessity for multiple facets of community involvement, and maintaining a general practitioner service. All these qualities can help a rural mental health professional be accepted in a rural community while simultaneously facing an increasing prevalence of boundary issues.

Schank and Skovholt (1997) emphasized counselor networking to develop strong consultation and supervision networks. This consultation and supervision process can help a counselor maintain objectivity and better navigate through the complicated ethical situations present in rural communities (Campbell & Gordon, 2003). However, it is essential that rural practitioners maintain these network contacts throughout their careers to ensure that support is in place when an ethical dilemma arises. Also important is that a rural practitioner be aware of the

federal and state programs or initiatives available to help increase rural mental health availability (Human & Wasem, 1991). The funding for services in rural communities is frequently obtained only from federal or state grants (Campbell & Gordon, 2003). For a mental health practitioner to be effective and financially stable, it is crucial that counselors working with this population do everything possible to stay in-the-know about financial opportunities to provide mental health care to those who otherwise would not have access.

Counselor Training

Counselor training and the educational background that a counselor may obtain before entering the field looks different across the United States. One uniform credentialing body which accredits and standardizes counselor training programs is known as the Council for Accreditation of Counseling and Related Educational Programs (CACREP). This section will discuss the purpose and foundation of CACREP as well as the standards created by this credentialing body to guide the work of counselors. These standards will be discussed in relation to the impact on working within rural communities.

Schwitzer et al. (2001) reported on the theoretical importance of appropriate training in counselor development. These researchers indicated that training should focus on role playing, watching demos, and practicing foundational skills (Schwitzer et al., 2001). The more a classroom situation can replicate and expose students to real-life issues with the populations in which they are preparing to work, the more likely the classroom experience will be meaningful and increase preparedness for working with specific populations and in specific settings (Schwitzer et al., 2001). These specific and intentional training practices allow for growth and

development of the student. This process is crucial when working on multicultural competency training and education about multiculturalism.

Steele (2008) discussed the importance of addressing social justice and multiculturalism issues throughout the curriculum of counselor education programs through the use of constructivism. This pedagogy allows for development of multiculturally competent counselors by allowing for open and safe dialogue discussing multicultural competencies, theories, and norms throughout a counseling training program rather than simply in one specific class. Steele notes that discussing bias, supremacy, and privilege can evoke feelings of shame, guilt, and anger in those participating in the training. These are complex reactions which must be addressed and discussed in a safe way which allows for the trainee to grow and develop the ability to have similarly difficult discussions in his or her counseling practice.

<u>CACREP</u>

CACREP was founded in 1981. The purpose of this organization is to provide accreditation and standardization of education to counselor education training programs. Currently, there are more than 600 programs accredited by CACREP at more than 260 different higher education institutions (Urofsky, 2013). While all 50 states require a specific license for practicing as a counselor within the state, states rarely mandate graduation from a CACREP-accredited institution. However, CACREP accreditation often accelerates the licensure process and allows the student to complete all required coursework for licensure in the state in which he or she wishes to become licensed.

Through use of a set of standards, CACREP mandates the topics of a CACREP-accredited counselor education program. There are more than 200 standards and substandards as

well as an additional 60 standards and substandards per specialty area (Urofsky, 2013). These standards were recently updated in 2016 and there were no additions made to providing counseling or training counselors to working in rural settings (CACREP, 2016). In addition to discussing the objectives and requirements of each CACREP-accredited program, these standards also discuss the nature, purpose, and regulations behind clinical supervision, training facilities, and faculty support. CACREP identifies requirements for both master's- and doctoral-level training as well as specializations in addiction counseling, career counseling, clinical mental health counseling, marriage, couples, clinical rehabilitation counseling, family counseling, school counseling, and student affairs and college counseling.

CACREP accreditation focuses heavily on multicultural development, education, and counseling practice. The movement toward multicultural counseling began in the 1950s, and research conducted in the 1970s indicated that counselors were not meeting the needs of multicultural clients (Robinson & Morris, 2000). Based on this information, multicultural competencies were added to CACREP accreditation standards and are a core component of the educational training of both master's and doctoral students obtaining a degree in counseling from a CACREP-accredited institution.

ACA *Code of Ethics*

In addition to CACREP standards that graduates of CACREP programs are exposed to in training, these counselors are also mandated to adhere to the American Counseling Association's (ACA) *Code of Ethics*. These codes were last updated in 2014 (ACA, 2014). According to the *Code of Ethics*,

The mission of the American Counseling Association is to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity. (p. 2)

This code includes 9 sections discussing: (section a) the counseling relationship; (section b) confidentiality and privacy; (section c) professional responsibility; (section d) relationships with other professionals; (section e) evaluation, assessment, and interpretation; (section f) supervision, training, and teaching; (section g) research and publication; (section h) distance counseling, technology, and social media; and (section i) resolving ethical issues. This Code is meant to guide and direct counselors in any given situation (ACA, 2014). Not only is the Code meant to direct and define counseling, but it also provides a guide for how to resolve ethical issues and dilemmas as they may arise.

While the *Code of Ethics* is used to guide and direct counselors working in rural communities, many of the codes may have an increased rate of frequency in use in this setting based on the aforementioned unique qualities and characteristics that are attributed to rural communities. There is a wealth of standards that speak to meeting the needs of diverse clients. Some of these include: A.4.b. Personal Values, A.7.a. Advocacy, A.10.e. Bartering, and B.1.a. Multicultural/Diversity Considerations (ACA, 2014). These specific standards speak to the needs of and accommodations that may be necessary to assist in counseling diverse individuals.

Another important consideration in dealing with clients from rural populations is the need for confidentiality and the overlap of roles in small communities. Some codes that address these issues are: A.2.a. Informed Consent, A.5.e. Personal Virtual Relationships with Current Clients, A.6.a. Previous Relationships, A.6.c. Documenting Boundary Extensions, A.6.d. Role Changes in the Professional Relationship, and A.8. Multiple Clients (ACA, 2014). These standards

discuss the need for clear informed consent about the rules and roles of a counselor/client relationship. These standards also dictate the ability or lack thereof for a counselor and client to be engaged in a relationship of any kind outside of the therapeutic relationship. They discuss the importance of documenting any boundary extension which may occur while in a client/counselor relationship.

In addition, counselors are guided through the Code to have clear expectations of themselves regarding competence. Section C.2. discusses the need for counselors to operate their counseling services within the realm of competence based on education, training, supervised experience, state and national professional credentials, and appropriate professional experience (ACA, 2014). While counselors in rural communities are often required to be generalists due to the lack of local, accessible specialists, it is important that counselors discuss this limitation as necessary with clients and seek appropriate supervision and consultation to assure that the ethical codes are followed. As the modality for counseling advances with technology, the code mandates rules for distance counseling, indicating that strict regulations on confidentiality and privileged communication continue to be upheld despite changes in setting for the counseling relationship.

<center>Relational Cultural Theory</center>

While many key aspects of Relational Cultural Theory involve power dynamics, another key component of the theory is the overall importance of culture itself. The founders of this theory believe that an individual's culture, both inherited and currently lived, have a strong impact on individuals' day-to-day experiences (Walker, 2008a). Culture impacts a person's view of self, defines important concepts such as achievement and value, and shapes how they view others (Walker, 2008b). Based on the inherent power dynamics, the outlook experienced by an

individual can be positive or negative (Walker, 2008b). In other words, someone may have inflated views of self and one's capabilities based on coming from a position of power, while another individual may have stunted beliefs in their own capabilities from being outside a position of power.

Another important dynamic that this theory explores is how a therapist exists and navigates roles in the community. Walker (2008a) stated that therapists have multiple identities in a culture and may have power in some of those identities while lacking power in others. These power differences can have a strong impact on the therapeutic relationship. Walker (2008a) believed that the therapeutic process hinged on being able to remove any power differences and truly empathize with the client. This research went on to provide examples of times that a power differential, with either the therapist having more power than the client or the client having more power than the therapist, has had a negative impact on the therapeutic relationship to the point where therapy potentially provided more harm than good (Walker, 2008a). However, this theory also includes the concept that the power differences can be talked about, reduced, and processed in healthy ways that positively impact all parties involved (Walker, 2008b).

This theory challenges the idea that the voices from those in power must outweigh and out-value those not in positions of power. The founders of the theory instead work to integrate all voices and use the knowledge of which characteristics or categories of individuals hold power as more data to better understand dynamics between community members (Walker, 2008b). Additionally, the founders of the theory emphasized the extreme importance and social justice calling to focus more on the voices of those without positions of power to better understand whole cultures (Walker, 2008b).

Chapter 2 Summary

Rural communities cannot simply be defined by population marker. Instead, the many characteristics which make up a rural community must be understood to distinguish a rural community from an urban community. Rural communities possess unique issues for both counselors and clients which may require advocacy on an individual and systemic level. Through advocacy and other means, clients and counselors can develop strategies for success which will assist in conceptualization of the client/counselor relationship. By counselor training programs adhering to the CACREP accreditation standards and counselors following the ACA *Code of Ethics*, counselors have a necessary foundational knowledge and guiding source for future counseling relationships.

CHAPTER 3

METHODOLOGY

The purpose of this research study was to explore the phenomenon of being a counselor in a rural community. This research will allow for a further and more complex understanding of the experience of providing counseling services in a rural community. The following research questions were explored through this study:

(1) How do counselors in rural settings describe their experiences practicing in rural communities?

(2) What benefits and limitations do rural counselors see in practicing in rural communities?

(3) How do counselors name characteristics of counseling in a rural setting?

A description of the study's theoretical orientation and research design, participant selection, and the structure of the research protocol follows.

Theoretical Orientation

The basis for this study is rooted in concepts outlined by Relational-Cultural Theory (Comstock et al., 2008). While other counseling theories discuss culture but focus on individualism/individuation, Relational-Cultural Theory emphasizes the importance of how culture and relationships not only influence but also assist in the development of all people (Comstock et al., 2008). Relational-Cultural Theory was created based on women and other marginalized populations to gain a fuller understanding and interpretation of community and individual development. This basis of research allowed for theoretical development on how

specific populations interact with the environment in which the population exists and with one another (Comstock et al., 2008). These interactions help create unique experiences and influence the individual's whole cultural identity (Walker, 2008a). These experiences can be defined based on marginalized population, region, and other demographic factors (Walker, 2008b).

Currently, Relational-Cultural Theory is utilized with a multitude of multicultural populations, including majority and minority cultural members (Comstock et al., 2008). Additionally, Walker (2008) stated that open dialogue between cultures belonging to a particular community is essential to further development. In other words, to have a strong identity and deep understanding of one's surroundings, one must be willing to engage in both overt and covert dialogue with other members of the community in which one is operating. The covert and overt dialogue contains the formal and informal rules and regulations which a community member learns to follow to successfully operate within a cultural system.

Walker (2008) also stated that power dynamics play a significant role in the understanding and navigation of interpersonal relationships. These power dynamics change based on community and cultural norms, and therefore a member must be aware of these rules to successfully interact in an environment (Walker, 2008b). According to Walker, power influences the way community members interact and communicate with one another; it influences the roles community members are allowed to fill and limits potential for both minority and majority individuals. Understanding a culture hierarchy is essential in the conceptualization of the unique culture. These power dynamics change from culture to culture and help to shape each individual culture as well has interactions of different cultures. These power dynamics must be fully conceptualized to understand the how and why of communication and roles in communities.

This theoretical orientation was used in this research study due to the understanding that rural communities operate as unique and individual cultures. The tenets of this theory allowed for a framework of understanding how overt and covert conversations as well as power dynamics assist in forming the basis for the rural cultural experience. This rural cultural experience is unique based on the diverse individual characteristics of both the community members and the environment in which these members operate.

Phenomenological Design

This study's design utilized qualitative research techniques. These techniques allowed the researcher to fully conceptualize and gather data on the research participants (Bogdan & Biklen, 2011). It allowed for a deeper understanding of the descriptive data which was attributed to the subjects. Qualitative data differs from statistical data in that it involves the use of quotations from participants, field notes, transcripts, photographs, and numerous other sources of data which cannot be summarized into numerical form (Bogdan & Biklen, 2011).

One specific research design in the realm of qualitative research is phenomenology. This research method is used to describe "both the depth and breadth of participants' lived experiences" (Hays & Wood, 2011, p. 291). This understanding of depth and breadth allows for a full and rich understanding of the experience of the participants. By examining experience through the lens of phenomenology, researchers can look at how the participant interacts with his or her specific environment. Understanding this back-and-forth relationship between participant and environment allows for a greater understanding of the participant experience. This experience can then be compared and contrasted to other participants experiences (Hays & Wood, 2011). Understanding these specific participant experiences helps us better conceptualize

the specific experiences of each individual, which can aid in training and preparation as well as development of resources and supports for these individuals.

Phenomenological research is used to gain a comprehensive understanding of the world in which a participant exists by analyzing research data, including transcripts of phenomenological interviewing. This process allows the researcher to examine the experience of the participant as he or she interacts with the world. This analysis process allows for the synthesis of shared experiences among separate research participants as well as the acknowledgement of divergent experiences among participants.

Sousa (2014) discussed how phenomenology examines how general notions about human beings connect human beings with the rest of the world. This connection is made through linking each human to the world through their individual experiences. These connections allow for the participant experiences to be broken down into judgements, concepts, and theories which name their specific and unique experiences. In addition to examining the subject's current experience, phenomenological research, pioneered by Husserl (2011), also incorporates previous experiences of each subject and their own personal history which is ever evolving (Sousa, 2014). Husserl (2011) discussed the importance of phenomenology in allowing things that are not seen in real space but are expressed in logic to be defined. Researchers can utilize this logical expression to help define and name experiences and abstract concepts (Husserl, 2011). Phenomenology also addresses the idea that these experiences may be uniquely experienced and interpreted by each person. This process allows for unconscious ideas and concepts to be expressed and explored (Husserl, 2011). Giorgi (2012) further described Husserl's phenomenology method as looking to understand phenomena in the world of the subject rather than dictate the phenomena through

description of experience. This technique focuses on description rather than interpretation. It allows for a true analysis of the phenomena while acknowledging researcher bias (Giorgi, 2012).

Recruitment and Demographics of Participants

The first form of data collected was through individual interviews. These interviews were semi-structured and took place at the agency where the interview participant was employed. The interview guide is listed in Appendix A. The purpose of this data collection method was to gather phenomenological narratives of the personal experiences of rural clinicians to directly address the research questions. Participants were selected from three separate community mental health agencies located in three separate counties in central Illinois. These agencies accept a range of payment methods, including private insurance, Medicaid/Medicare, and self-payment on a sliding scale. The agencies employ Licensed Social Workers, Licensed Clinical Professional Counselors and Licensed Professional Counselors as well as interns and practicum students who have yet to complete a counseling degree and become licensed. Two participants were selected at each of the participating agencies, for a total of six participants.

For the focus group, participants were selected who are teaching for CACREP-accredited master's or doctoral programs in the state of Illinois. These participants all worked for public universities in Illinois. They all have taught students who work in rural communities. However, not all their students work in rural communities and they were not required to live in rural communities.

Recruitment of Interview Participants

Initial contact of the agency was conducted through the head of the agency. This initial contact included emailing the recruitment message to the person listed as the director of the agency according to the counseling center's website. The recruitment email explained the nature and purpose of the research. The requirements of the research participants were described as well as the time requirements made of each participant.

After the initial contact with the director, I worked with individual participants to create a schedule for data collection. The directors forwarded this email to eligible participants and then participants responded to my email. The participants reported that they did not receive any benefit or pressure to participate in the interviews from their agencies. At the interview, I introduced the study to each participant and provided the informed consent form to obtain the appropriate signatures.

Based on the data gathered from both the individual interviews and the field notes of counselor agencies and offices, I wanted to look at the experiences of counselors in rural communities from a more meta level. Therefore, my research process evolved to include a focus group of counselor educators from CACREP-accredited schools. The goal of this focus group was to better understand the training and preparation that counselors in rural communities experienced before entering the field. With the focus group, I also sought to examine the intentionality of counselor educators in preparing future clinicians to work in rural communities and serve the needs of rural community members.

Recruitment of Focus Group Participants

For the focus group, the CACREP website was utilized to identify CACREP-accredited master's programs in the state of Illinois. An email was then sent to all listed faculty for CACREP-accredited master's programs in the state of Illinois. The email requested participation in a focus group to gain further understanding of the issues facing clinicians in rural communities.

Demographics of Interview Participants

Six counselors were interviewed. Five of these counselors had completed a master's degree in counseling and were Licensed Clinical Professional Counselors. One of the clinicians completed a master's degree in social work and was a Licensed Clinical Social Worker. Each of the clinicians are female and Caucasian. Four out of six of the clinicians have lived in a rural community for their whole lives. Two of the clinicians grew up in urban environments but currently live in rural locations. The clinicians have provided counseling services in rural settings for between eight and 40 years.

Five out of the six counselors were Licensed Clinical Professional Counselors and one was a Licensed Clinical Social Worker in the state of Illinois. The agency that included a Licensed Clinical Social Worker only employed three clinicians; one was a Licensed Clinical Professional counselor, who was also interviewed, the second was the Licensed Clinical Social Worker, and the third was a student who had not completed her master's and was not licensed in any way. Five out of six participants work full-time and one is contracted part-time to the agency.

The first community mental health agency provides individual, group, family, parenting, and senior counseling services in an outpatient setting. This agency is a charitable, not-for-profit agency. The town has a 2013 population of 4,469 and a median household income of $34,737. The county has a 2014 population estimate of 14,837 and consists of 335.94 square miles with a population density of 44.2 people per square mile.

The second community mental health organization provides outpatient counseling for adult and adolescent populations and specialized substance use disorder treatment. The town has a 2014 population of 2,821 and a median household income of $41,870. The county has a 2016 population estimate of 9,554 and consists of 494 square miles with a population density of 19.0 people per square mile.

The final community mental health agency provides outpatient counseling. The town has a 2014 population of 10,971 and a median household income of $44,057. The county has a 2016 population estimate of 33,755 and consists of 709 square miles with a population density of 48.0 people per square mile.

<u>Demographics of Focus Group Participants</u>

Based on responses from the initial request for participation, a focus group was selected from one university located in a rural Illinois community. The university has existed for more than 120 years. It currently has more than 7,000 students enrolled in its undergraduate and graduate programs combined. The counseling program employees six full-time faculty who teach in both school and clinical counseling tracks. The counseling program has been CACREP-accredited since 1997. This university just happened to be near the community mental health agencies which were utilized in the individual interviews. All three participants of the focus

following professional websites: CACREP, American Counseling Association, Illinois Counseling Association, National Board for Certified Counselors, American Mental Health Counseling Association, Association for Multicultural Counseling and Development, and National Association for Alcoholism and Drug Abuse Counselors. I also searched state-level governmental websites and the Centers for Disease Control website to find information regarding trainings, education, and information for clinicians working in rural communities.

<u>Interviews</u>

Each of the six interviews was conducted at the agency site at the convenience of the participant. Conducting the interviews on site assisted in aligning with the phenomenological paradigm by more naturally observing the interaction between the participant and the world in which the participant exists. Interviews were conducted in a one-on-one setting with as few distractions as possible. The audio recordings, approximately an hour long, were transcribed and the transcriptions were used for the analysis process.

These interviews were designed to ascertain the specific experiences of counselors in rural communities. Other interview questions were created to examine and explore the barriers, benefits, limitations, and assets associated with providing services in rural communities. Additionally, the interviews explored how participants defined the rural communities in which they provide services and/or live. Criteria for participation dictated that interview participants must practice in rural communities but did not state that they must live in rural communities. Participants were encouraged to discuss any ethical considerations they face to provide services in these communities and the populations that they work with in this setting.

Agency One

This agency describes their mission as having the purpose to provide professional mental health services to improve the quality of life of the people they serve. This agency is located on a quaint downtown square. Parking spaces are available for clients in the front, and the back of the agency has a hitching post for Amish clients who use horses and buggies for transportation. Once I entered the agency, I was greeted by a secretary behind a glass partition. She asked whom I was there to meet with and then directed me to the waiting room. This space had white walls and was decorated with motivational phrases. There was child-sized furniture, toys, and books in an area in this room for kids to use. There were resources such as pamphlets and advertisements for groups and services at this location. The waiting room was quiet. My appointments with the clinicians were after the agency's normal operating hours. Some counselors were finishing up their final sessions of the day. However, the waiting room was empty, quiet, and calm. When my first interviewee came to take me to her office, she introduced me to the director and showed me around the office. The director made sure to mention the hitching post in the back of the agency. This was clearly an important part of the agency and a way that their staff members could feel inclusive and meet the needs of the local community. The office was comfortable and each person I met greeted me warmly.

The first office I went to had a significant amount of toys and play therapy equipment. The office was lit by lamps and had cozy furniture. Throughout the interview, the participant was turned away from her desk, facing me. She appeared slightly nervous at the beginning but continued to get more comfortable and open throughout our discussion. The second office I went to was also was equipped with comfortable furniture and lit by lamps. There was a painting on

the wall that the counselor discussed using as a visualization for her clients. When this therapist began her interview, she took a call from her child and immediately spoke openly about her experiences.

<u>Agency Two</u>

The second agency where I conducted interviews was located right next to the local high school. Their mission includes providing developmental disability services and employment services in addition to mental health and substance abuse treatment. This agency had ample parking in the front of their building and their agency was clearly labeled. I was also greeted by a secretary at this agency from behind a glass partition. I was directed to a waiting room that also had a special area for children with toys and books. Magazines were available on coffee tables for reading while waiting for sessions. This waiting room was also void of any other person waiting for services. The waiting room was bright with natural light from the windows and it was completely quiet.

The first office that I went to for my interview was bright with overhead lighting and filled with file cabinets. The seating area was tight, with therapist and client chairs located close together. My first interviewee at this location presented as excited to talk about not only her agency and work, but also how the field of counseling has evolved over the past 40 years. After our interview, she walked me to the office of the next participant. This office was bright and open and covered in children's drawings. She discussed these drawings frequently in relation to answers of the interview questions. She was able to identify the differences between her work in this community mental health setting and the private practice she operates in the same rural town.

Agency Three

The third agency at which I conducted interviews was located directly behind the county health department right off a main road in town. I parked and entered the building, where I was again greeted by secretarial staff from behind a glass partition and directed to the waiting room. This waiting room had a lot of seating. There was a small table for children with toys and books. There was a television with daytime programming showing while I waited. There was a large bulletin board on one side of the wall covered with information for clients. Signs for groups and specialty programming for the agency were present. There was also information about other local services such as transportation and food banks.

My first interviewee at this location walked me back to her office. This office was decorated with personal items, including decorative pillows on the client chairs. She started the interview in her chair next to her desk and then moved to a chair paired in a seating area separate from her computer. She excitedly discussed her experiences at her current agency and was also able to talk about working at two other rural agencies. When our interview concluded, she walked me to her coworker's office, which was decorated with personal pictures of her family. She was seated in a chair away from her desk throughout the interview, where she discussed her goal of working at this agency from the moment she went back to school to get a degree in counseling.

Office Descriptions

I created field notes based on Bogdan and Biklen's (2011) recommendations for discussing each site location. These field notes described the physical structure of the agency,

including each participant's office. I documented thoughts, sights, and sounds which I experienced at the site (Bogdan & Biklen, 2011). These field notes were used to provide additional information about the world in which each individual participant operated. Due to the sensitive nature of counseling, no field notes were taken that identified any protected populations, including those receiving counseling services. Furthermore, no field notes were taken which described protected health information.

<div align="center">Focus Group</div>

The focus group was conducted in person at the university where the participants worked. This group interview lasted an hour and fifteen minutes and was audio recorded. After the interview was complete, it was transcribed. The transcription was utilized for the analysis process. The purpose of the focus group was to gain additional data to better understand the training and preparation of counselors in rural communities. Through the focus group, I also sought to better understand how counselor educators were prepared to train rural counselors and how their personal experiences in rural communities shaped the way they teach future clinicians.

<div align="center">Website Information</div>

As noted earlier in this chapter, I conducted an initial search of professional association websites. These websites were all then individually examined to see if there were any references, trainings, supports, or information regarding the provision of services for rural communities or for counselors working in rural communities. Additionally, I examined governmental websites to look for the same types of information to support and educate rural counselors.

Data Analysis

The analysis procedure for both the individual interviews and the focus group utilized the same four-step process discussed in Wertz (2005). The first step involves an initial interview read-through to understand the whole interview and the second step requires the researcher to read back through the interview and identify different items of meaning within the framework of the interview. The third step involves the researcher's reflection on the items of meaning and connecting them to phenomena about the research questions, and the fourth step combines these separate meanings through synthesis about the participant's experience.

I began the analysis procedure by transcribing all interviews. I then reviewed the transcriptions, completely identifying themes and counterevidence to themes, as follows: After conducting the interviews, I transcribed the data and read through the transcripts while completing memos and beginning the coding process. The memo-writing process allowed me to identify potentially emerging themes (Bogdan & Biklen, 2011). These memos were written after each transcription process and were included in the analysis of the findings. The initial transcription process was conducted after all the individual interviews were completed and again after the focus group was completed; then the full coding process began. The coding was completed through an open coding process where the full text was examined and broken down into smaller parts which were linked, labeled, and defined in the context of the interview transcript. Individual codes were used to identify themes and phenomena, also known as assertions, described in the interviews (Bogdan & Biklen, 2011). I identified assertions made about the experiences of rural counselors based on recurrent themes in the interviews (Bogdan &

Biklen, 2011). Information was used from all sources of data, including interviews and field notes about the site locations.

Once coding was completed on each individual interview, the interviews were cross-analyzed to identify common themes across interviews and agencies. This second round of coding was utilized to connect the multiple codes from the first round of coding into similar and broader categories to synthesize the data. For this process, I utilized focus coding to take general codes from the first round of coding to find central themes and analyze their connections to one another, including their relationship between participants (Saldana, 2013). The final write-up of findings identified these themes and organized them in groupings rather than in separate interviews. Themes were identified based on interview question and found commonalties in interviewee responses. These themes were used to capture the phenomenological nature of rural counselor experiences, characteristics, benefits, and limitations (Saldana, 2013). This process allowed participants to name their own experiences and create their own themes rather than have their experiences put in pre-determined categories (Saldana, 2013, p. 140). The theming process allowed for discovery of both commonalities and discrepancies between participants and for both kinds of information to be captured and portrayed (Saldana, 2013).

I conducted a search to identify websites that counselors in training would be encouraged to utilize as part of their training and preparation for direct service. These websites included both professional associations and governmental websites which discussed counseling, mental health, and substance abuse issues. Once the websites were identified, a search of the website was conducted to identify any resources or information directed toward rural populations. These searches were then synthesized to identify themes and resources for counselors in training.

Researcher Role and Bias

Because of the inherently subjective nature of qualitative and specifically phenomenological research, it is essential that the researcher acknowledge and put aside personal bias and assumptions about the research subject or environment (Hays & Wood, 2011). As discussed in Chapter 1, I have significant personal involvement with this research subject. I personally provide substance abuse counseling services in a rural community. I was also raised in a rural community, in a household where both of my parents provided substance abuse counseling services in a rural community. I am the same race as all the participants of the study and the same gender as all but one of the participants of the study. All the participants of the study had a minimum of a master's degree, which is the same degree that I have. I was similarly aged to two participants. However, the majority of the participants were older than I am. The vast majority of my characteristics made me an insider in both the individual interviews and the focus groups.

Due to my background, I have assumptions about the benefits and limitations associated with working and living in a rural community. I believe that serving rural communities is beneficial and rewarding. I currently provide counseling services as an outpatient coordinator for rural populations. I believe that this population operates differently and has unique experiences than individuals from other geographical locations. As a counseling professional, I also believe in the importance of counseling and have bias that participating in counseling is beneficial to clients and counselors. It is essential that I as the researcher and instrument in this qualitative study acknowledge these biases and work to limit the influence of my bias in the gathering and analysis of the data.

To reduce the influence these biases may have on the research, I intentionally chose not to not work with agencies that I have personally worked at or been employed through. I also did not utilize agencies located in the county where I currently live and work. However, the focus group was conducted at a university where I am teaching classes in an adjunct position. I have also had a significant amount of personal experience working with the individuals who participated in the focus group. These connections have the potential to influence the way I interpret the data. However, this dual role is also reflective of the rural environment in which I have conducted this research.

Chapter 3 Summary

Phenomenological qualitative research allows for full, rich understanding of how the participants interact with each other and the world. Utilizing a Relational-Cultural theoretical lens, I worked to understand how interacting together between participant and world, a culture can form unique ideas, rules, and roles. These concepts helped conceptualize the experiences of counselors working in rural communities, which are described in the next chapter.

CHAPTER 4

RESULTS

In this chapter, I will discuss findings from qualitative interviews conducted with six

clinicians at three different agencies, and field notes made based on the experiences I had at each

of the offices. The results also incorporate findings from the focus group and website analysis.

These findings are connected to clinician needs, unique characteristics of rural communities, and

backgrounds/experiences of clinicians. Themes were determined through the analysis process to

capture participant lived experience. These themes were found both through commonality among

participants and differences between participants' described experiences. In this chapter I will

also examine the connections and disparities between the individual interviews and the focus

group data to deepen the descriptions and understanding of counselor experiences in rural

communities. I will also identify any resources available for counselors on the following

websites: CACREP, American Counseling Association, Illinois Counseling Association,

National Board for Certified Counselors, American Mental Health Counseling Association,

Association for Multicultural Counseling and Development, and National Association for

Alcoholism and Drug Abuse Counselors. The following research questions were addressed

though this study:

   (1) How do counselors in rural settings describe their experiences practicing in rural

   communities?

(2) What benefits and limitations do rural counselors see in practicing in rural communities?

(3) How do counselors name characteristics of counseling in a rural setting?

Themes found in the research were identified both by frequency that interviewees (both individual and focus group) discussed certain topics as well as the level of emotion and conviction with which the participants discussed these issues. Table 1 shows the themes and sub-themes that were identified in this study.

Table 1

Themes and Sub-themes

Theme	Sub-Themes
	Training for Real Life
Preparing to Counsel	Professional Growth and Support
	Integration
	Consultation
	Personal Life
Merging and Separating Work and Personal Life	Proximity to Workplace
	Insider Status
	Confidentiality
	Spaces Which Prepare Clients for Services
s	Not Enough Time and Not Enough Staff
Rural Counseling Dynamic	Alternative Services
	Lack of Resources
`	Being a Generalist
	Specialized Treatment with Impoverished Clients
	Cultural Changes

Preparing to Counsel

The first major theme identified during data collection was the importance of counselor training and preparation. Not only was counselor preparation important in the classroom, but it was also crucial that the training continued throughout the counselors' careers. Based on the information from the individual interviews and the focus group participants, the training happened both formally and informally as well as in the classroom and on the job.

Training for Real Life

It was very clear during the focus group that the participants put heavy importance in making assignments and classroom activities tied to real-life issues in rural communities. One such assignment included doing a case study involving problem-solving on how to get a client services and complete paperwork when the client is struggling to travel to services. As previously discussed, clients in rural communities struggle with travel, and this assignment's purpose is to prompt students to begin to think outside of the box and utilize problem-solving techniques to address these rural issues.

Another way that they prepared students to work in rural communities is to prepare them to work in diverse environments. A participant discussed that they work to educate students that the expectations in one work environment may be completely different in another work environment. This leads to an increased need for advocacy. Students must learn to be good advocates for their own skills, for appropriate ethical boundaries, and for asking for what the counselors need. One participant discussed training clinicians to walk the line in advocacy and being respectful of their supervisor, stating, "You know you're a student, so how do you work

with the family to get the services they need and not step on your supervisors' toes?" While the individual interviewees had significant commonalities between workplaces, they had all been prompted to branch out based on the needs of the local agency. Some of them have begun working with children even though that was not one of their passions or interests. Others have done more work outside of the agency through doing counseling at the school, home visits, and nursing home counseling sessions.

Sometimes the rural counseling dynamics had people struggle to feel open and connected to others. One focus group participant stated: "It can be very lonely and isolating because I have to be careful of the friends I make, not as much now in administration, but if you're practicing you have to think of it." This isolation has been a challenge for new clinicians and something that they need to be prepared to manage. This sentiment was echoed by many of the individual interview participants, who discussed struggling to set and maintain boundaries due to overlap in their personal and work lives.

All these training needs are made easier to complete because of the fact that the members of the focus group have significant experiences providing services in rural communities. One reported:

> I think this is important, too. It's one of the things that makes me proud to serve with the people I serve with. People here have experience. There isn't a lot of ivory tower thinking. There is understanding of theory and optimal ways of things working and also just having that experience in the very communities which we are training students to go into we ourselves have had that experience so that we can have some sense of what their struggles are to help prepare them.

Another stated:

> We had a former student that graduated from our program maybe 10 years ago and went to Chicago and worked in an urban clinic and there were a number of new graduates and

they were comparing notes as they do and she realized she was so much better trained from these others who I won't say from what school and now she is in San Francisco with low-end, diverse populations so I think we do, you guys do a good job of getting them ready.

Students benefitted from the experiences of the faculty and learned from the real-life situations their professors have lived through. They used these real-life experiences that normalized the students' future experiences and promoted counselor growth before they have even entered the field.

One of the benefits of working in a rural community is that students who graduated and continued to practice in a rural setting are eligible for student loan assistance if they work in a rural setting for a significant time. Several of the students graduating from the program run by the focus group participants took advantage of this student loan forgiveness program. Another focus group participant explained that one of her class projects involves helping students learn to write grants. While she got a lot of resistance about this project from students, one went on to apply for the grant once she was at her permanent place of work and actually received the grant. This has increased the amount of funding she has to provide services in her rural community.

<u>Professional Growth and Support</u>

Each of the clinicians reported on how their small offices with few professional staff helped increase the bonds they formed with their co-workers and facilitated more purposeful professional growth than they might have in more urban, larger offices. I interviewed at one office on Halloween and the two clinicians I interviewed at this location were wearing coordinating angel and devil outfits. These two clinicians repeatedly discussed their relationship in working together and being supportive of one another and how crucial this was to remain in

the field and provide direct services. They were the only two clinicians at this agency that provide mental health services. Their clients were often related and connected to one another. It was clear that their personal relationship with one another allowed them to feel supported and have someone to process the daily difficulties of being a counselor. They both mentioned each other by name throughout the interview and laughed and smiled while telling stories about the other. This support helped them continue to stay grounded in their jobs.

They were the two members of the clinical team that rotated crisis on-call services and reported on how important their relationship was to support this additional duty of their job. They worked with each other if one of them had a schedule conflict or needed a break. They shared goals, discussed concerns, and freely asked for help from the other clinician. Based on their responses to questions, it was clear that their relationship with one another was one of their most important relationships both in and out of the work environment. One of these clinicians had just been in the hospital and the other of the pair had taken her there. She had checked in on her while she was at the hospital and had been a big support for their medical condition, not just their work concerns. They also had only worked together for three years. Based on their individual interviews, it was clear that this relationship developed quickly and was difficult for them to quantify how important it was in their lives.

Another clinician discussed the connection of their clinical team. She said:

> We lean on each other. If one of us needs to take a long lunch it isn't a big deal. I had a weird crisis call. It crossed a lot of boundaries. I just didn't feel like I could do the crisis line for a while after that. I talked to the other girls that work it and they totally understood and gave me a break from it.

This individual interviewee indicated that she felt comfortable enough with her fellow clinicians to express that she needed a break from crisis work and how this experience had impacted her personally enough to make her uncomfortable continuing this service. Her relationship was strong enough with her coworkers   that she could be emotionally vulnerable with them and know that they would work to assist in her whatever way they could.

An additional clinician discussed the support she feels from her agency and her coworkers:

> Working at a non-profit we don't make a ton of money, but we do have a significant amount of time off that we can take. If I am, like, my dad fell and I have to go, then the world isn't going to end. My peers are supportive. I think so, … that's one of the reasons that I have stayed here so long. It's very, sort of like our own family. So, … super support[ive] and even with things that can be kind of chaotic, this is stable.

They also discussed sharing information and resources amongst each other. One of the offices included two clinicians who were related to each other. These cousins, both of whom I interviewed, discussed being raised in the same area and how entering the same profession continued to help their relationship grow and evolve. They have a shared background and lived experiences which has helped them have a strong base of communication to utilize in their clinical work. They also often work with the same families in complicated arrangements. Their ability to communicate with one another helped to smooth out this process.

Another office discussed their use of team meetings where they case-reviewed clients and shared perspectives on client cases and identified who this client would best work with on the clinical team. These team meetings were held over lunch where clinicians got to eat and chat with one another casually while also dealing with pertinent work issues. One clinician discussed how this scheduled meeting with other clinicians at the agency helps protect from burnout and

feeling stuck. She knew that she got to spend time with her peers and discuss any client concerns she had once a week. She seemed relieved when discussing this process and felt comfortable in letting things go between meetings because she knew that she would have the next scheduled meeting to address any issues that had arisen, with excellent support from her coworkers.

All the clinicians discussed sharing information and resources amongst each other. Several of the clinicians reported on sharing training information with the clinical team after they had gone to a training or conference. They discussed this mutual giving as being extremely beneficial for each other in helping to expand the resources available and support clinicians who are forced to be generalists due to a lack of local specialists. By doing this, clinicians felt less pressure to attend trainings for every possible diagnosis and treatment issue and could instead seek out someone on their clinical team who had been to a training or had experience with this client concern.

Another prevalent theme to support work relationships and the sharing of resources was the longevity of the careers at each agency. Five out of six of the clinicians had worked at the agency they are currently employed by for more than five years. One of these clinicians had worked there for more than 40 years. All the clinicians noted that employees stayed at these agencies for extended periods of time and this included support staff such as secretaries and billing assistants as well as clinicians. The only real turnover at these agencies appeared to be from temporary hires such as graduate assistants and interns.

Additionally, three of the clinicians I interviewed had interned at the agency where they are currently working. One of these clinicians had been hired by a different agency but then applied to their current workplace when an opening became available. It was clear from the

interviews that these clinicians were incredibly satisfied with their place of employment and none discussed plans to change locations or even retire anytime soon. This team support helped the clinicians feel connected and committed to the agency and the community it serves. Several of the clinicians also discussed how important the support staff was to their jobs. One clinician identified how the support staff helped to make her feel extremely welcome and "learn the ropes" of the agency. Another participant discussed how each of the roles at the agency relied on each other and each of the jobs were crucial to the agency's overall. The majority of the support staff had worked at the agency for longer than the clinicians I interviewed. One clinician reported that the secretary and billing specialist at her facility helped her to get to know her clients and prepare to work with the population when she first started. She also indicated that these members of the support staff had lived locally and had knowledge of the clients' families—sometimes multiple generations of the client families.

The offices themselves also helped form connections with other resources. Two of the offices offered services other than mental health counseling in the physical building. One provided services for clients with developmental disabilities and employment assistance services. The other included part of the county's health department services. This allowed for clinicians to have exposure to other direct services and build connections with additional resources. One clinician described these multiple services as "two different worlds" but enjoyed having access to even more resources for her clients. These connections allowed clinicians to have interactions with other community resources and helped problem-solve specific concerns about clients with professionals outside of the mental health facility.

Even though the university exists in a small community, there was a range of options for practicum and internship placement in the area. One professor reported that they have placed students at hospitals, rural private practices, community mental health/substance abuse facilities, and small and large university counseling centers. This range of services and agency sizes allowed students to have a diverse range of experiences. The structure of the program also encouraged all classmates to share their experiences and learn and grow from what each of their classmates are going through at their practicum and internship sites.

Although the students' college is housed in a rural community, they had enough agencies around the area that the professors help to consciously pair the students with whatever populations and settings they hope to work at in the future. This allowed students to gain real-life experience in the areas where they wanted to work. The applicable placement also helped to dispel myths the training clinician may have about a particular environment. For example, the interviewees commented that they have one practicum and three internship semesters. Therefore, a student may do one section of internship at one location, determine that this placement is not a good fit and/or not something they are interested in pursuing as a career, and then be placed at a different location for future internship semesters.

<u>Integration</u>

When the focus group participants discussed how they train students to work in rural communities, they stressed the importance of integrating these concepts into their courses. They reported that it was important for them to give students an education on what their textbooks say about counseling but also for them to teach how to apply it to the real world in rural situations. They also utilized the same practices in their personal lives and gave back through service work

in the rural communities in which they lived and did not simply limit their preparation and

training to in the classroom.

One struggle of integration of rural training in the classroom comes from CACREP,

according to the focus group participants. One said:

> I am always complaining about CACREP lives in DC and their reality is in DC, but they never seem to get what we are all about. There is a disconnect even with the people who are telling us how to train that they aren't really addressing these issues.

The focus group members reported that it was difficult to ensure that they integrated rural

training into the classroom when the guidelines that inform and shape the services they provided

do not discuss the importance of training in rural communities, nor did they have standards

related to this specific population.

Consultation

Focus group participants regularly discussed students struggling with having limited

supervisory resources once they leave the program. They reported that these students contacted

the professors and discussed supervision issues and received consultation from their former

university supervisors. The main reason that these consultations continued is the lack of

supervision in the field and the high rate of inexperienced supervisors. Also, counselors were

frequently the only clinical person or one of very few clinical personnel in the building. This

meant that they had to rely on former university supervisors rather than an agency assigned

supervisor. The individual interview participants did not discuss any supervision they received.

The only indication of support came from consultation with peers employed at the same agency.

Focus group participants also consult with other professionals to continue to grow their practices and engage in resources sharing. One participant reported, "When I go to conferences one of the ideas of going is to connect with other educators and what are you doing with this and how do you handle this and what are your problems and our problems." This consultation process helped to support the professors, which in turn helps to support the students being trained in the program. The consultations focused on specific rural issues such as limited resources and dual-role issues.

<div align="center">Merging and Separating Work and Personal Life</div>

Another central idea found during the research was the complicated dynamics that happen in the lives of rural counselors who live and work in rural communities. This overlap led to blurred boundaries and an increased need to acknowledge and manage dual relationships. Both the counselor and counselor educators interviewed identified ways they have learned from these experiences.

<div align="center">Personal Life</div>

Because each of the clinicians lived and worked in rural environments, interviewees discussed the pros and cons of having their work lives bleed over into their personal lives. These experiences that participants have had in rural communities in their personal lives influenced and shaped the way they interact in the rural communities in which they work. These personal life interactions were even more important for the counselors who lived and worked in the same community.

The counselors mentioned several surprises they have noticed in living in rural communities. One reported that in her small town there was a strong agricultural basis and several individuals had been grandfathered in to raising goats in their backyard. She discussed having to learn to expect the unexpected, as rules from her more urban upbringing did not necessarily apply in her new rural community. Her husband inherited a farm in a small town where she was now living. This farm had its own name and had been in the family for generations and was known by local residents. Becoming a part of a network with so much local connection was initially overwhelming and was something she continues to adjust. As the farm was inherited from her husband's family, his family had been extremely involved with any updates that she had done in her home. She discussed the shock her mother-in-law expressed when they were fixing their dining room floor due to her husband falling through it. She reported that her mother-in-law stated that she would have just put a rug over the hole rather than repairing it. This vividly expressed the attitude that she believed is the core of rural communities. She said: "You make do with what you have. It's a Great Depression mentality. You fix things on your own and unless it is absolutely horrible, it doesn't need fixed." Another clinician discussed her rural community's relationship with the police:

> The police are not the governing body. It doesn't work that way. They tolerate the police, but they are going to handle themselves until it becomes a punching match at the town meeting but the thing that really holds water is seniority.

While this relationship seemed different from how other communities view the police, it seemed to be commonplace in small towns. Other clinicians stated that the community members themselves are the ones who organize, fix, and police services in their areas. This self-policing policy was viewed as an extreme complication for the clinicians who addressed this in their

interviews. It seemed that this mentality made it less likely for clients to seek services in general, not just mental health treatment. One clinician reported that she knew someone who recently passed away due to complications from diabetes. While the person knew they were diabetic, they refused to seek treatment for this condition. The town members did not want to violate this norm of the person taking care of himself and not asking for outside assistance. The person passed away of complications that could have easily been treated had the individual chosen to seek medical care. The participant who told this story looked upset and frustrated with this. They expressed sadness at someone losing their life because of resistance to outside assistance, even if it was from a medical professional.

Several of the clinicians discussed their own families struggling to ask for assistance or even accept the job of counselor as a valid field. Another clinician mentioned a similar theme of self-policing by discussing how she felt as a child growing up in a small community. She stated: "I did not like that everyone knew what I was doing. As a child it was a real pain in the butt but then I raised my kids in this environment and I loved it." They were able to identify both pros and cons associated with the town handling its own issues. It appeared that their perspectives on these town norms changed with their own personal experiences and life status as well as the individual situation. While it was discussed positively that community members rally around each other and help out with supporting children's programs such as band and football, it was frustrating for the clinicians that clients are afraid to talk to someone about their medical or mental health needs.

Proximity to Workplace

All the clinicians interviewed live and work in rural communities. The proximity to the workplace was found to have an impact on their experiences in a multitude of ways. This proximity impacted topics of dual relationships, confidentiality, personal life, and their feelings of connection to their agency and community. Four out of the six counselors were raised in the rural communities where they are now working. All these clinicians spent a significant amount of time in the interviews discussing this as a positive process for their counseling. One clinician specifically expressed sincere love for her home town/the town in which she works. She had many fond memories of growing up in this small community and feeling especially connected to the location because of the amount of family that she had all around her at any given moment. She also said: "I planned on escaping it and never did it. Everyone wants to leave in the beginning and then you realize these are your people." They reported on the issues regarding insider versus outsider status of small towns. These four clinicians also currently lived in the rural communities where they worked.

One of these clinicians lived extremely close to where she works. She stated: "I lived about a block and a half away. Then six years ago I got divorced and now I live across the street. I am here almost every day off. Write that under *stupidity*." She laughed after this statement but made it clear that the proximity of her home made it easier to blur the boundaries of her work hours and spend a lot of time at her job. She reported that she went to the office to work every day despite not being scheduled to work and that the office was not even open two days a week. She discussed the struggle to adequately set boundaries and reduce her number of hours spent at the job when she can see her office window from her home. However, even though she identified

that this was "stupidity," she looked happy and pleased with the fact that she can spend so much time at her job. She enjoyed her work and made it her goal to work at this facility from the moment she decided to become a counselor. She discussed the extensive amount of paperwork required for her job, commented that she often struggles to leave on time and she spends her days off in the office catching up on paperwork such as case notes from the prior week. Even though she did not talk about this paperwork fondly, she noted it was a very necessary part of her job and did not overshadow the time she gets to spend with clients.

Another clinician discussed her struggles with living in the same town she works. She reported that she moved away for a brief period to work on her master's degree and when she moved back to her hometown and the town she works in she found it difficult to assimilate. This discomfort prompted her to isolate in her home and she dreaded going out to the grocery store due to concerns of running into clients, former classmates, and having all her business known by all her neighbors. This constant visibility was still a struggle for her, but she discussed becoming more desensitized to it. She was more likely to go out and about now, and participated in community activities in which the agency is involved. She stated: "I feel like I kept to myself a lot, so it was um, … I feel like it was. I didn't know any different." When she discussed the extreme overlap between her work and her home life, it was clear that this was not a pleasant topic for her. She is working to have her own life separate from the work she does. However, the small nature of the town and limited options for activities, shopping, and errands mean that the chances of her encountering clients while participating in a local leisure activity are quite high. This was something she considered before moving back to this area to live. The pros of being

close to family and her job outweighed the additional scrutiny she received from community members.

Two counselors who worked at the same office have lived in their hometowns for their whole lives. They worked in the same towns. They had extremely positive views of these experiences. They both discussed feeling nurtured by the small towns that helped raise them and the support they felt with this when raising their own children. They both had extended family systems that also lived in the same towns and their families had been established in that area for generations. These extended family systems both owned small businesses in the area, which allowed the two clinicians to feel even more connected to their town and community members. While neither of these businesses exist any longer, the participants shared many fond memories of growing up with these connections and how this helped them form a love for spending time with people and developing relationships. They both told stories in which they fondly recalled learning how to interact with the community around them, respect people who seemed different than them, and treat people with kindness. Growing up in rural communities helped provide real-life experiences that shaped the way the clinicians understand and operate in rural areas. One clinician reported that her upbringing helped prepare her for working in this small community by saying, "So before I went to school it was an easy transcendence for this kind of job. It doesn't matter what people look like or how they live, and I just did my job."

Another clinician made comments about how her youth in rural community prepared her, "We had quite a few people in our community who had intellectual limitations and [were] mentality ill. I was taught not to make fun of them. We were taught to treat them with courtesy and respect." She discussed how salient the message was from her family not to judge or

stigmatize these members of the community who might be different than others. Instead, she had models in her personal life which helped her to learn acceptance of those different than her from a very young age. These life lessons became invaluable in the counseling field. It made it easier for them to work with challenging clients and those with different backgrounds than they had. It also made them more comfortable meeting new people and allowed them to feel safe and connected to their work environment even before they took positions in mental health.

Another clinician discussed living in a rural environment, but being exposed to different cultures stating, "We made regular trips into the city. I went to a school where my graduating class was 40 but we were close enough to things where I got exposure." She appreciated this balance in her upbringing. She felt that it taught her how to interact in both worlds.

While two of the clinicians were not raised in rural communities, they both have since moved to rural communities. However, they did not move to the communities in which they work. They instead moved to neighboring rural communities. One of these clinicians commuted almost an hour to work. The other commuted approximately a half hour. Neither seemed bothered by this commute. They both enjoyed the buffer this gave them from overlapping by both living and working in the same environment. The clinician with the longest distance from work used her travel time to prepare for and unwind from the day. She planned her day ahead on the way to work and felt prepared to enter the work setting by the time she arrived and used her drive home to mentally debrief from work. The process of providing mental health counseling services, according to this clinician, could be "taxing". This drive time allowed her to arrive home with her children without still being in the midst of the chaos and difficulties of the day.

One clinician was raised in an urban environment. This clinician discussed the extreme difficulty she felt in moving to a rural community:, "It was a huge change. My children and I are here and all of my family is back home. It was a struggle trying to find resources for even stuff needed at home." She had a lot of issues with feeling like she was providing her children with the same experiences that she was given while being a child in an urban environment. She contrasted this with her positive feelings about the safety of her children and feeling less worried that they might be exposed to violence. She had lived in her new, rural community for approximately five years. She reported still feeling like an outsider because her thinking, processing, and interacting with the world around her in her small town seems different than that of most of her neighbors and connections she has made since moving to this community. This outsider status felt more intense because she did not have any family who lives in this area. All of her family lived in the urban environment that she was from. While she misses them, she had no plans of moving back. She enjoyed her job, felt connected to her coworkers, and had begun to "put down roots" in the local area which helped her to feel more connected and more supported by the world around her.

The other clinician discussed spending her childhood going to large cities and being exposed to different cultures and ideas through these experiences. This clinician mentioned it took her three weeks to find an internet provider for her new farm house residence. She expressed shock and frustration by this process. What other people may consider as common and expected in urban areas were actually rare and riddled with difficulty in rural communities. She also discussed the process of remodeling her home to have an area for visitors who just stop by. She identified that the uninvited neighborhood visitor was a frequent guest in her small town.

She reported, "They don't stay long. They are there for 10-15 minutes and they go. It's like they are just checking in." It was clear that this was an adjustment for her and one that she had to work to accept and understand. While she had become accustomed to this periodic visitation, she still felt the need to create a special area for this in her home as a designated location to entertain and provide for these visitors who do not schedule their visits.

One of the most distinct characteristics that the focus group participants discussed was the fact that most of their graduates both lived and worked in the small town which they are from. This added an extra complicated dynamic because these rural counselors then had built-in dual relationship issues and complicated relationships in the rural communities in which they live and now work.

All the focus group participants also lived and worked in the same rural community and have done so for more than 10 years. One stated: "So yeah, it's something that we do all the time and maybe we don't really think of that as managing a rural situation." She identified that because this piece is so woven into their lives, they don't always notice when something is a specific rural issue and when they are addressing a rural issue. Another reinforced this concept by stating: "It's all around us. This is where we are." The focus group members also gave numerous examples of dual relationships that they had encountered both as faculty and clinicians. They discussed how these dual relationships were intensified because this small community is where they have done their grocery shopping, banking, and where their children have gone to school. All these community interactions complicated the boundaries they had set between their work and personal lives.

<u>Insider Status</u>

Most of the clinicians identified concerns with insider versus outsider status. These labels of either being a part of or excluded from the community impacted their ability to not only participate in the community but also to perform counseling services. A major characteristic of citizens in rural communities appeared to be the fear of outside intervention and denial of new information and ideas. One clinician stated: "You do without, you work harder, so they don't trust outside resources coming in as much as they do their own ability to plow through something and keep it under wraps and fight harder." Another reported, "You have people here who still don't believe that cigarettes are going to hurt you," when discussing how clients were hesitant to believe that talk therapy would be a benefit to them. This resistance to new information, outside intervention, and unfamiliar treatment was a large frustration for the clinicians interviewed.

Participants expressed frustration in having to spend a significant amount of time explaining counseling and "selling" therapy to new clients and community members who were asking them questions about their careers. The clinicians reported that they seemed to have some clients who were more willing to come to services because they knew the clinician personally. Even if the client did not see the clinician they knew in a professional setting, the client felt as if they could ask questions to get more comfortable with the counseling process before even walking in the clinic doors. The clinicians all discussed the fact that they liked to help their communities become more comfortable with the idea of attending counseling, but this also created a heavy burden for them. Even when they were not at work, they may be doing work to advocate and educate for counseling services. This education and advocacy still hold true at community events as well as in their personal lives at family functions and gathering with

friends. Focus group participants discussed the same concepts. They believed they have been able to increase the number of practicum and internship placements for their students based on having strong ties to the community. They also addressed the fact that they are always discussing what counseling is and what counselor training looks like for community members. This means that counselor educators were also spending their non-working hours reducing stigma and educating the general public regarding the nature and purpose of counseling. This was another example of a blurred boundary, which increased the difficulty for both clinicians and counselor educators to take off their work hats and simply *be* in the rural community.

Confidentiality

Issues surrounding confidentiality filled the interviews. Each clinician had extensive concerns about explaining confidentiality to clients, knowing people who come to the agency to seek treatment, and treating multiple members of the same family at their agencies. Individual interview participants and focus group participants had a lot to say about the difficulty of maintaining confidentiality in small towns. They all discussed having conversations with clients about the limits of confidentiality and how they worked to respect client confidentiality.

These discussions included preparing clients to see them out in the community, reminding them that they would not address them if they see them out, and that what they say in the counseling office remains in the counseling office. They also discussed running into clients in public and their reactions to this. A clinician reported, "I explain confidentiality and that when I leave here that goes on lockdown. I am just myself wherever I am. But people get pretty panicked about seeing me in public." Another stated: "So if we are out in public people

announce they have an appointment or try to reschedule appointments when I see them out.

Pretty much everywhere we go we know somebody."

Both having the conversation with clients and adhering to the rules of confidentiality was

of extreme importance to all the individual interview participants. They all reported on how they

had worked to develop their own scripts and ways of communicating how they would protect

clients' confidentiality. Having a script not only to originally discuss confidentiality but also to

address it in the midst of a confidentiality conflict, such as seeing a client at the bank, allows the

clinicians to feel more comfortable in maintaining healthy boundaries and respecting clients'

right to have privacy about their counseling relationship. One participant discussed the duality of

responses to confidentiality:

> I explain the whole confidentiality thing with the kiddos. I explain that I'm not going to
> be like, oh, hey, how is it going? I will see you at your appointment Monday. So most are
> fine with that. It's half and half. Sometimes kids are super excited and want to talk and
> other times they just smile and don't want to interact with me.

She identified that half of her clients are very excited to talk to her if they see her in public and

immediately acknowledge her, while the other half become visibly uncomfortable and avoid her

in these situations. She reported being able to accept and respect both responses. She was okay

with clients wanting their distance or being comfortable talking to her. However, she did make it

clear that she had to set limits about having a discussion about their clinical needs while in

public.

A second complication in confidentiality was clinicians and support staff struggling with

knowing individuals whom they worked with as clients. A clinician reported on the way she

handles this overlap:

> Another thing is having people come in here that know me and explaining that I'm, especially if I know them really well, that I may have already had that conversation that I won't have any part of their therapy, I would excuse myself from staff meetings they were brought up in. Sometimes if they forget I'm here or don't know I'm here I might actually bring them here and explain everything stays here and that's something we take seriously. I feel like it works out most of the time.

This process helped her not only be able to advocate for counseling for people she personally knows, but also keep a distance from their actual counseling services so that the client would be more likely to participate in services.

Another clinician mentioned that the secretaries at her agency know all the clients personally and professionally. Several of the clinicians believed that the overlap of knowing members of the community helped to increase clients coming to the agency. One even mentioned that she believed people are more likely to come see her and request her counseling services because they know who she is and what she does. She believed that her visibility in the community and the fact that she has lived in the town she works in for her whole life allows for potential clients to feel more comfortable coming to counseling services when they may have never done so before.

Another reported the near impossibility of attempting to eliminate dual relationships by saying: "There are 3,000 people in your town, and I have lived here for 50 years. If I took people off my list that I knew I would only have half a list." She was clearly comfortable with having clinical relationships that qualify as potentially dual relationships. These dual relationships were prevalent throughout her 40-year career. She discussed having worked with multiple generations of family members and how knowing whole family histories because she had counseled multiple family members improved the treatment she was able to do.

Yet another clinician discussed her experience of having people from her personal life ask her about counseling services and then make the decision to seek services at her agency because she works there. She said: "I know there are people that have contacted me that want to ask some questions about things but choose to go elsewhere because it feels weird to them and that's okay too." She was clear that she was supportive of any decision that they made to seek services at her office or another location. She respected the decision that they made regarding their own treatment and she could identify that even though they might seek treatment elsewhere, they also may not have gone to treatment at all if they had not known her and been able to ask her questions about the counseling process.

The messages given regarding dual relationships were quite conflicting. Clinicians were able to discuss the positives and negatives of these interactions. Some clinicians were more hesitant regarding having overlap while others seemed to think it assisted in the process of building rapport and connecting to clients. Some clinicians seemed overwhelmed by the idea of knowing their clients and interacting with clients outside of the clinical setting. Other clinicians discussed their firm belief that participating in dual relationships promoted counseling services in these rural communities and allowed for people to feel more comfortable potentially seeking out mental health services.

One clinician discussed joining a local book club that a client began also attending. This client suffered from extreme anxiety and when she saw her clinician in the book club she never came back. The clinician offered to no longer attend the book club and reiterated the aspects of confidentiality that protected the client from being known in this public setting as a client. However, the client refused any potential alternatives and never returned to this community

gathering. Another clinician discussed clients being happy to see them at the local high school football game or bingo because it reminded them that their clinician was just like them and was connected to their same community. Not only were the clinicians conflicted about the nature of dual relationships but also the clients had varying views on whether dual relationships were a positive or a negative. This conflicted nature of beliefs about dual relationships was prevalent throughout the interviews.

All the interviewees also reported that treating whole family unit at the counseling centers was common and potentially problematic. Several clinicians stated that they try to have different clinicians on the team see each individual family member to attempt to reduce the enmeshment and overlap in these dual relationships. However, limitations on clinical availabilities could impact the ability to have family members seen by different clinicians. They also discussed the difficulty of being able to put family members with different clinicians.

One agency where I conducted interviews only employs two mental health counselors. It would be impossible to have a four-member family seen by different clinicians at this agency. Several participants also reported that clients frequently discontinued and then restarted treatment. This also happens with multiple members of a family unit. In the beginning of treatment, there may only be one member of the family using services. This may change to having all the family members using services and drop right back down to having only one of the family members using services. This makes scheduling and keeping differing counseling relationships even more difficult. It also becomes difficult for all family members to have a positive therapeutic relationship with a counselor at each agency. If a clinician has begun seeing the mother of a family who struggles in her relationship with her daughter, the daughter may not

feel comfortable coming to services if the only option is for her to see her mother's counselor.

The participants discussed how this specific issue had unfortunately increased the likelihood that

some family members have dropped out of treatment. This means that clinicians have to have

increased skill to maintain healthy boundaries between family members to maintain the ability to

serve all members of a family system.

Similar to the individual interview participants, the focus group participants discussed

significant concerns with dual relationships. They focused heavily on helping students learn how

to navigate dual relationships in the real world. One participant stated:

> I have a student who was saying, "I know the parents because I went to high school with
> [their child]." So, a discussion ensues about how to breach that and there is nobody else
> for them to go to. So, you know, she said, "They won't call me back because they didn't
> like me in high school and it's real."

They have to train students how to navigate dual relationships in these rural communities with

complicated dynamics, which affect the student's ability to provide services. The same

participant discussed a real-life example that she uses in class to prepare students for these

interactions. The story she told involved running into a client and his parents with her husband at

a local department store. During the interaction, the client's family wanted to meet her husband

and asked her to handle behavioral issues with her client in the public department store. Another

participant discussed how a client in a rural school told his friend that she was his cousin rather

than his therapist due to concerns with stigma. The third participant recalled a time when he was

taking a ballroom dance class with his wife and a client was taking the same class. He

remembered counting the lines to make sure he was not going to be partnered up with his client

for part of the dancing. He also had a client who was an OB-GYN and was going to deliver his

friend's child. He stated:

> It was hard to have all of that knowledge. She was struggling with some serious anxiety
> and a lot of things. It was hard to know all of that and also be excited for my friend that
> she was going to deliver his baby.

They all had multiple examples of living through dual relationship issues in rural

communities that they use as examples in the classroom to give students real-life scenarios of

these dual-relationship issues and help them think about how they can navigate these issues in

the future. One participant said: "I think that the real-life experiences we bring to the classroom

helps students understand what they are getting into. They know that we have gone through it

and we have dealt with it too." Another participant noted that he has had to work on this in his

personal life because he set such rigid boundaries that they carried over into his personal

relationships. He discussed this being a maladaptive coping skill that he had to learn to loosen in

his personal life but keep in his professional life.

Rural Counseling Dynamics

Counselors in rural communities can set the stage for counseling services by discussing

what services look like with local community members and their families. However, these

counseling services looked different than counseling in other rural settings. These client issues

and unique rural characteristics impacted the way clinicians perform services in rural

communities.

<u>Spaces That Prepare Clients for Services</u>

Each clinician had designed office spaces that met the needs of their daily activities. This ranged from calm and centering offices for a clinician who provides long-term mental health counseling for clients diagnosed with personality disorders to offices filled with toys and interactive materials for a clinician whose primary clientele were children. All the clinicians had spaces unique to their personalities. All six of the clinicians' offices that I conducted interviews in were individualized and they each illustrated how the setup of their offices served a purpose specific to their personality and diverse daily lives. The first office that I entered included half of the office dedicated to toys. This counselor reported that most of her clients were children and she did play therapy. While she saw adult clients, she no longer puts the toys away when they adults come for session. She reported that she believed "everyone needs to play". She encouraged all her clients to utilize the things in her office to connect to themselves and aid in the therapeutic process. There was no overhead lighting on in her office; it was instead lit with several lamps. There were comfortable chairs for clients to sit in. The office felt extremely comfortable, warm, and inviting. The second office that I interviewed in had the same lamplit aura. This office, however, had no children's items. The therapist reported that her caseload was primarily adults. This office also felt welcoming and nicely designed to facilitate therapeutic discussion. Neither of these offices at this agency had any personal pictures visible. They were filled with personality even though they did not show any intimate family connections such as having pictures of children or partners.

The next agency where I conducted interviews used overhead lighting in both individual counselors' offices. One of the offices was heavily administrative. It was filled with file cabinets.

This clinician reported that she not only sees clients but is also the clinical manager for the agency. Her office was minimally decorated but did include a few pictures of her family. The setup of client and clinician chairs felt extremely close in the narrow office. The second individual clinician office at this agency was covered in children's drawings. There were crayon scrawled pictures covering one entire wall, above her desk, and covering the upper portion of her desk. Some of the pictures were bright and happy, covered in pinks and greens, depicting flowers and smiling faces. Other pictures were negative and dark with blacks and reds and separated family members. She reported that these drawings were all completed by her clients and that she primarily works with children or whole family systems. She told several stories about the different drawings and discussed how these detailed, expressive images accurately depicted the issues that these children had come to her office to work on. She kept them as memories of progress and struggles.

The third office also used overhead lighting. Not only did these offices have individualized artwork, but they also had throw pillows which were unique to the person who worked in the office. Each office had lots of natural lighting. The florescent lighting did not seem harsh because of how much natural light each office had. They felt comfortable and unique. Upon walking to the office, I seemed to feel like I understood the personal style that each clinician was working to portray. They both included personal pictures of friends and family. Both clinicians mentioned these pictures during the interviews and reported that these reminders of their family helped them stay more positive throughout the day and reminded them of the connections they have outside of the agency.

<u>Not Enough Time and Not Enough Staff</u>

The participants all reported on daily activities that challenged and exhausted them. These difficulties touch each of their days at work and continue to challenge them even after years in the field. The most central theme of the clinicians' daily schedule was how unpredictable it can be. One clinician described this by saying, "Before I get down the hall there are one or two problems and how do you want me to fix this" and "You are still working with people, but you don't really know what your day is going to bring." This unpredictable nature added an additional layer of stress to their jobs. One clinician expressed this frustration by saying that it made it difficult to complete her daily sessions and paperwork associated with these sessions. She spoke specifically about complications with clients who are running out of their medication and call with only a day of medication left. This meant that she had to act immediately or have a client run out of medications that are potentially helping to decrease or completely eliminate psychosis and suicidal/homicidal concerns. She then contacted the psychiatrist, the pharmacy, and the nurse to appropriately advocate for the client. This drastically increased her paperwork, stress level, and frustration with clinical issues.

There was also a distinct shrinking of mental health services in this area. The participant who reported working at the same agency for more than 40 years discussed the change in employment at this agency:

> Ten years ago we had a staff of 20-23 people and now we are down to nine staff. We are humping and bumping, and they expect us to do the same work that 20 some people used to do. And clients keep increasing.

They were now treating more clients with a staff of nine than they had done with a staff of 20-23. This meant that most of her days were chaotic. She discussed dealing with a significant amount

of crisis each day and that supervision and support were limited because each hour of the day was booked with clients.

The clinicians reported on how they manage this unpredictability by asking for assistance from colleagues and preparing clients that crisis must come first. Therefore, if a client comes in in crisis, the normally scheduled client may have to have their session cut short or rescheduled. None of the clinicians seemed pleased with this solution. It seemed like a struggle for them to manage validating the client who is in front of them for an appointment while still addressing a potentially volatile and dangerous situation outside of their scheduled appointment. It was clearly difficult for them to manage all the help that everyone needs at any given minute. They discussed this being true throughout their careers. The compounding nature of this stress is massive for them to process and continue to provide excellent services for the people that they serve. This stress led to burnout and frustration that the clinicians were responsible for identifying and coping with before it affects their work.

Another difficulty the clinicians faced was finding a way to fit in everything that they needed to do in a day and adjust to constantly increasing caseloads. A clinician identified that she often had to adjust her appointment times to half-hour sessions instead of hour sessions to accommodate her clients. This was irritating for her because she felt her clients would benefit from a full hour of counseling services per week. However, there was already a significant waitlist to begin services at this agency, so shortening sessions to a half hour allow for more clients to be served. Additionally, a clinician discussed not being able to fit in all the after-school appointments that she needed for child clients. She stated:

> During the school year my days are disproportionately stacked. Not a lot of clients in the morning or my few adults come in in the morning or if I can capture a kiddo at school then I can travel out, but I have a lot of families that want after-school appointments.

These appointment times became a premium during the school year, but during the summer she had much more flexibility in her schedule. She also reported that she would meet with clients every other week or once a month to assist in serving more clients who need these after-school appointments. Several of the clinicians discussed missing lunches and sacrificing paperwork time to accommodate clients and serve as many people in need as possible.

All the clinicians mentioned paperwork with significant disdain and disgust. Finding time to complete case notes, admission paperwork, and treatment planning documentation proved to be a constant struggle in chaotic clinical schedules. One clinician discussed the paperwork required at her agency, stating: "Our intake assessment is 29 pages long. It is insane. Every question you could think of." Another clinician discussed the length of their assessment and paperwork process, stating: "Any down time I have is catching up on notes and paperwork because the assessment process takes 2 or 3 appointments."

Billing insurance was reported as a copious and complicated process. It also was very clear that the clinicians found this to be one of the most difficult pieces of their job, as it not only had to meet insurance billing standards, but it also cut into the time they got to spend completing face-to-face services. The clinicians described this as a necessary evil. They were aware that paperwork was necessary for billing and therefore essential to the continued work of the agency. They also knew that paperwork allowed the clinical work to be documented so that if a client should leave and return, they or a new clinician would be able to understand the previous work

the client had completed. However, this understanding was a cold comfort for them when they were facing difficulty to fit all the clients asking for services into their schedules.

Because of the limited staff and limited time issues related to rural clinical work, counselors in training programs were trying to prepare themselves by diversifying their experiences, expanding their education, and being intentional with their assignments. Participants in the focus group also discussed how students are becoming more strategic with the coursework they are participating in and elective classes to which they have access. One participant stated that a school counseling student was angry that a school counseling required course was booked at the same time as the addictions class. She needed the addictions course information to better work in her school setting and meet the needs of the students/families. The students had to be prepared to immediately get to work in their practicum and internship settings. Instead of observing and standing outside of the clinical environment, students were immediately "in the trenches," to borrow the words of one of the participants. They were encouraged to provide much-needed potentially billable services as soon as they got to the site. Furthermore, one participant discussed the ability of a new student to navigate a duty to warn situation:

> I'm just thinking about a duty to warn situation in a small town and the student doing the right thing and I still remember vividly her handling this so well because it was very clear imminent risk. She is working with this woman and she says this must be really scary for you, so I want to make sure we have a specialist who can come and work with you and manage this situation; is it okay if I go and get her? And so, the client says yes, and she goes out and gets her supervisor and of course the tape is still rolling and the client sighs; she was really relieved, and this woman comes in who [was] small town, but she had actually dealt with it before and worked with law enforcement and got the other person safe.

This focus group participant noted that a clinician in training was faced with information from a client which required her to break confidentiality and warn someone who was potentially at risk

for harm. This is a foundational ethical code in counseling. However, it could be a complicated and challenging process for clinicians to handle, explaining this limitation to confidentiality to clients and also appropriately complete the process to warn a potential victim of violence. The students they are training have become increasingly more capable and prepared to handle difficult counseling situations earlier in their training.

<div align="center">Alternative Services</div>

Each of the agencies provided services to community members out of the traditional office setting. The most common message of these external counseling opportunities was positive. Several of the clinicians interviewed identified that part of their individual jobs is providing services in the community. Most centrally, this happened when clinicians went into the schools to work with children who had been referred to their services. One clinician stated: "With the SASS program I do travel out. I go to schools and I do go to clients' homes during the summer in particular because you can't catch them anywhere else." These home and school visits allowed her to see clients who otherwise might not actually engage in treatment. She also mentioned, "During the school year that picks up a lot …. Maybe even 3 or 4 times a week out and not just at one place." When she traveled out of the office for appointments, she would go to four different schools in four different local towns based on the service area her agency provided for children's crisis services. Another clinician discussed spending time in the schools:

> I go out to the schools, middle and high school about one day a week. Right now, I have more high school than middle. So, I see them at the schools and it is [a] great help for the parents. Sometimes they are easier to talk to because they want to get out of math class.

Her work outside of the office, again, allowed for clients to receive counseling who might not be able to come to treatment to receive services. Several of the agencies also reported that clinicians went to local nursing homes to provide services to clients as well.

> A common theme that the professors discussed was the limited resources that their students experienced. However, rather than focusing on the lack of resources during the group, they instead spent their time acknowledging the strengths of the training program and of the students to make the most of these limited resources, think outside of the box, and come up with creative solutions to complex problems. One participant discussed preparing students to deal with the limits of career options in small rural communities, stating: I help them think of ways to use the internet and other resources to expand what we call contextual affordances, giving them more options to think about life other than just "I live in a small town and there is nothing to do."

This helped to show these professors' ability to encourage students to utilize alternative methods to expand options and abilities of rural counseling participants. They also discussed the ways that students and themselves in their own rural practices have changed the idea of a traditional session to meet clients' needs. For example, they discussed numerous concerns with transportation. This has prompted longer, less frequent sessions to accommodate travel concerns. One participant even stated that in previous rural work he had completed groups with clients who traveled to session together for the convenience of the clients. Another session alteration which frequently happened in this rural community was to conduct counseling in the home. These home visits helped to reduce concerns of clients traveling to sessions. According to focus group participants, these also helped to build rapport between client and counselor and gave the counselors key insights into issues going on in the home, like issues with food insecurity.

One of the focus group participants reported that he has been contacted by several local superintendents to hire their school counseling students, sometimes before they have even been accepted into the program. These school officials have had increased difficulty in obtaining

school counselors in their rural communities and have now looked at hiring interns for full-time

positions to meet the school's needs. However, this has created a new set of problems with

insuring that these hired students have appropriate supervision and support. There was a high

likelihood that these students, who have not finished their master's program, may be the only

school counselor in the building. Therefore, it became increasingly important that they had

access to good supervision. Furthermore, another participant discussed supervisors sometimes

having limited experiences themselves and difficulty handling situations. She stated:

> I had a student who was seeing two kids: One who was traumatized from seeing their dad
> attempt suicide—he tried to hang himself—and another that was being sexually abused
> and the school counselor didn't know what to do so her supervisor was like, "I don't
> know, can you ask your university professor?"

This complicated the supervisor-supervisory relationship which, in turn, often prompted interns

and practicum students to look towards these university professors for guidance more than their

onsite supervisor and also to reach out to their professors even after completing their master's

program.

Another participant also reported on research she has done to train paraprofessionals to

provide play therapy in schools. When she had presented this research at conferences, she had

received a lot of pushback from people who work in more populous areas and were concerned

with training paraprofessionals; they instead suggested referring the students to licensed

professionals, saying that training paraprofessionals may impact the ability for licensed

practitioners to maintain their jobs. She reported on having to work hard to explain and truly

have attendees understand that there is not an option of sending clients to a licensed professional

in this area. Another participant furthered this issue and reported that she had to consult with a

professional in Chicago to provide appropriate services for the client she was seeing in her

private practice. There was no option of referring this client to a different therapist. She instead

utilized published works and distance supervision to help treat the client.

<div align="center">Lack of Resources</div>

Another characteristic was the severe lack of resources available to individuals in rural

communities. While all counselors struggle with needing more to serve their clients, these rural

clinicians identified unique and challenging issues that a lack of overall resources brings to their

clinical responsibilities. Clinicians reported transportation, poverty, unemployment,

homelessness (with lack of shelter opportunities) to be common issues that their clients face.

They discussed the struggle of working with a client on their underlying trauma issues when they

can't pay for their electricity. One clinician discussed the use of foodbanks and severe poverty,

stating: "They are full and there will be a line of people waiting but my concern is the ratio of

unemployment and a lack of opportunity and people are at the point they don't want it anymore."

Another discussed the frustration with not being able to connect people to needed

resources, stating:

> You get chased by this never-ending system where no one answers the phone and you
> don't get called back. And we go to their building and say we need to get this guy, we
> need to find out if he gets food stamps. He hasn't eaten in 3 days.

She believed that the extreme generational poverty has negatively impacted people's desire to

attempt to get out of poverty, creating a sense of hopelessness. She believed that it has become

far more common for clients to continue to remain unemployed and on public assistance. She

stated: "Their family has done this for generations, and this has become normal and comfortable

rather than working." She indicated that this cycle of poverty impacts clients generationally.

While all the towns that I interviewed in had a strong agricultural history and economy, they also

had a lot of blue-collar work, focusing on factories and industrial work. However, these local

factories in all three areas are closing, which creates an additional lack of income and job

opportunity for the members of the community. One participant stated: "So the community, there

is a loyalty factor here that is foreign to me although I respect it. They are much more prone to

attempt to find jobs in the area and be close to family." These jobs were once highly sought after

and created a potential career ladder for the community members. However, it has been

increasingly difficult for clients to find employment which supports family systems. The focus

group participants discussed increased mental health concerns in rural communities and limited

resources to treat these mental health issues. One participant stated: "School counselors are

trapped in this 1960s way of doing school counseling and they are the ones that the teacher, the

school counselor, they are seeing the kid every day and there is nowhere else to go." This has

meant that there has been an increase of mental health training for rural school counselors and

other employees of the school. She continued:

> And trying to get creative about how do we help people in this community in maybe unique ways, and the former faculty member and I are working right now because we are really concerned about the kindergarten. They are inundated with numbers of kids and with kids that need help, you know, there is no money to … pay another staff. But yeah, working with teachers and maybe teaching them some of what we know to implement in their classrooms, … just some ideas that we can throw their way because they are really hurting. There just aren't easy solutions available.

This helps to show how the focus group participants are assisting the community and helping to

solve problems which are gravely affecting rural community members.

All the office waiting rooms were painted white with standard waiting room furniture.

They contained minimal decorations and all displayed advertisements for services that the

agency offered such as groups. These areas also displayed local resources available, including:

food banks, transportation services, and services to help apply for insurance. Each of the clinicians discussed the importance of connecting clients to these resources and of this being a large part of the therapeutic work that they do with their clients. The focus group participants also discussed the resources available in the small towns that are helping clients on a daily basis. She mentioned disability services, specialized women's substance abuse treatment services where their kids are treated with them, sexual assault counseling services, and domestic violence counseling services, all located in this same small town. She also reported that she believed these services all worked well together and helped provide multidisciplinary treatment to clients with complex issues. One participant also was able to identify that she feels students who complete their training program are more prepared than some other programs because of the fact that they work in rural communities and have a wider range of experiences in their early training.

All the clinicians were struggling with providing crisis intervention services. Several clinicians reported on the closing of local psychiatric units that were used to hospitalize clients in times of crisis, psychosis, suicide potential, and homicide risk. Each member discussed staffing crisis lines which were available twenty-four hours a day, seven days a week, three hundred and sixty-five days a year with a maximum of 3 clinicians. If the agency had three clinicians available to work the crisis line, this means that they each would work more than 121 days on the crisis line per year or approximately 10 days out of each month. If there are only 2 people available to work the crisis line, then each clinician would work 182 days per year and approximately 15 days per month. This would be an incredibly exhausting pace. One clinician stated: "I have had 3-4 or a couple in a night. That's the thing. If I have a 9 o'clock client I have to haul my rear in here even if I had to deal with someone at 2 am."

When they had a psychiatric emergency, they were struggling to get someone

hospitalized and when they finally found an available psychiatric bed, it was frequently hours

away from the client's home. One clinician discussed how this negatively impacted the client:

> It is poor client care. Their families can't visit. It's just putting a band-aid on it. You are
> setting them up to fail before they are even discharged. We have to hold people overnight
> in the ER until we can find a place for them.

She discussed her feelings of defeat with this process and her concerns with the negative impact

this has on her clients' recovery and transition back into their home communities.

The clinicians also identified that finding psychiatric services was difficult. Each office

that participated in interviews offered psychiatric services. However, waitlists to begin

psychiatric care were often a month or more out and they all identified that the occurrence of

psychiatrist visits were not frequent enough, mentioning both that the clients were not able to see

the psychiatrist as frequently as they would like and that the psychiatrist is not in the office

enough, as none of their psychiatrists are employed at that agency full-time. There was also a

high likelihood that there was only one psychiatrist in the entire county. This ratio was vastly

different in more urban areas. This created a horrible circular problem that continued to

negatively impact the work that mental health counselors were able to do with their clients

suffering from mental illness who would benefit from psychiatric care. The focus group also

discussed this major concern with the distinct lack of psychiatrists in these areas. One stated that

when a position is posted for a psychiatrist there are frequently no applicants, and local agencies

have gone to telepsychiatry in order to meet the needs of local communities. Another focus

group participant expanded on the idea of limited resources by discussing that the local

university also struggled with access to resources and that this smaller university did not have the

access or quantity of resources that some larger universities do. This lack of resources affected

all levels of the university, with a trickle-down effect to the students learning to provide

counseling services.

Both the individual interviewees and the focus group participants discussed the use of

electronic, web-based resources to assist clients. The focus group members also reported

encouraging students to become members of state- and national-level associations in order to

build connections and resources for their future clinical practice. The individual interviewees

also noted being a part of these organizations but did not discuss how they utilized them or even

if they did utilize them.

Of the seven professional websites surveyed, only five websites had any information

regarding providing counseling services in rural communities. The CACREP and Association for

Mental Health Counseling websites did not contain any information when searching about rural

communities. This means that these websites did not appear to have any resources, trainings, or

educational opportunities for counselors working in rural communities wanting to improve their

ability to work with this specific population. The National Association for Drug and Alcohol

Abuse Counselors contains a manual about implementing a specific treatment modality in rural

communities. This manual provided instructions on how to begin using a screening, brief

intervention, and referral system in rural communities and is a free resource for anyone who

chooses to access it. All other items regarding rural communities on this website were simply

citing this same manual in the references portion of the article. The National Board for Certified

Counselors did not contain any resources for counselors providing counseling in rural

communities. This site only had links to profiles of two registered members who listed rural clinics or specialties.

The Illinois Counseling Association website included past conference listings which had presentations regarding rural counseling. These conference listings had conference descriptions but no additional information or resources from the actual conference presentations. This website only had one article about rural counseling. This site had resource categories of Post-Traumatic Stress Disorder, Grad Students, and Addiction listed as resources for anyone who accessed the site. The American Mental Health Counseling association had twelve search items regarding rural counseling. However, most of these discussed rural communities outside of the United States of America. All twelve of the items were articles discussing specific aspects of communities, with a large portion of these communities being in rural Africa.

The American Counseling Association website included four videos regarding providing services in rural communities. These videos were trainings and informational presentations regarding specific aspects of providing rural mental health services. These videos were free to view for anyone accessing the website. This website also included an extensive amount of blog posts or anecdotal discussion of providing counseling in rural communities. These blogs are non-peer reviewed and appear both in print in the Counseling Today magazine and on the website. They also did not have an interface for comments or information sharing between readers or the readers and the author.

The Centers for Disease Control website has extensive information on the health issues facing rural Americans. These health issues are primarily physical health concerns such as heart disease and cancer. However, two sections on the website address issues in rural communities

related to substance use and suicide rates. Both of these areas mentioned mental health concerns, but did not discuss treatment options or ways to support these mental health issues. Instead, the website focused on data related to overdoses and suicide rates rather than ways to combat these issues and does not include any supports, trainings, or resources to address these issues for counselors. There was no information found on the website regarding rural community mental health issues on state-level government websites.

Overall, the websites had a distinct lack of information regarding provision of counseling services in rural communities. They also lacked ways for rural counselors and providers to connect and share information with each other. The only website that contained any specific amount of data regarding rural communities, the Centers for Disease Control website, neglected to have any ideas to solve any of the concerns they defined nor does the website discuss any research being conducted to find ways to improve these issues. The lack of resources on these websites reflected the information found in both the individual interviews and focus groups by showing an overall lack of support and education for rural clinicians.

<u>Being a Generalist</u>

Any diagnosis found in providing mental health counseling could be found in the clinicians' caseloads. While other agencies or clinicians in more urban areas may provide specialized services, this was not a luxury provided to these rural counselors. Problem areas and diagnosis focused on issues with substance abuse, chronic and pervasive mental illness, and sexual abuse. All six clinicians discussed the significant amount of work they do with clients who are survivors of sexual abuse and that this sexual abuse is primarily molestation. This was another characteristic that appeared to have an extreme generational trend. Most of the clinicians

identified that the clients they have served who have experienced sexual abuse also reported that their parents and grandparents and other family members have had similar experiences. The clinicians discussed the difficult nature of both having to address sexual abuse and having clients identify that it is sexual abuse. The interviewees discussed clients' significant resistance to identifying that anything in their lives was abnormal due to the prevalence of these issues. It seemed absurd to connect your experiences as problematic when most of the people that you know or were in your family have been through the same or similar experiences. Educating clients about these issues is a complex and complicated process that increased the likelihood of clinician burnout. This seems to be counter evidence to national statistics, which show that in 2014 only 10% of overall rapes and sexual assaults are reported from rural locations (The National Center for Victims of Crime, 2017).

A clinician reported on her perceived struggle to get clients with chronic mental health diagnosis to be medication compliant when imbedded in the severe poverty of the region, stating: "Telling someone with schizophrenia that they have a $6 copay for meds. Well that's a pack of cigarettes, then they are going to pick that." Her experience was that clients struggled to choose paying for their medication over other things. Another clinician discussed the difficulty of engaging clients in talk therapy due to the reliance on medication alone: "A lot of the clients up here think that by taking medication they are cured. They don't understand the process of medication works best with counseling involved." These clinicians believed that mistrust and lack of medication compliance continued to create treatment issues in clients, which complicates the jobs of the clinicians I interviewed.

As previously discussed, they all reported on having significant waitlists at their agencies to see a psychiatrist. This also created complications for clients who need medication changes and updates. Clinicians described their frustrations with not being able to assist clients in this process due to a lack of availability. Therefore, it is not only difficult for the clients to be compliant with medications based on costs but also to obtain the appropriate medications as their needs change and evolve. One clinician discussed the pace of their psychiatrist and difficulty getting clients in for appointments by saying,

> We have him like, every 15 minutes seeing clients. Our kids come every 2 months at max and the adults every 3 but sometimes they need to come in sooner so that's a struggle. That's something I feel like, that's, a lot of people are in that boat.

The participants discussed several ways that medication resistance and lack of compliance created a more complicated treatment environment.

Maintaining relationships with community organizations was identified as a crucial theme to successfully working successfully in a rural community. A clinician reported:

> Knowing a lot of people in the community is a crucial thing. This isn't downtown Chicago. People need services and you get those by knowing who to call, when to call, so knowing the community and the providers here is really important to get people what they need.

She identified how she has worked to build relationships with community organizations and this has benefited not only her clients but also the support and comfort she feels in working her job. The clinicians discussed the importance of having reliable relationships with community partners as well as being someone that outside agencies can rely on. These community partnerships ranged from traditional connections, such as police, probation, domestic violence shelters, to more unique groups such as community service groups, churches, and local business owners.

This variety of community connections helped the clinicians have access to resources that they might not be able to get any other way.

One participant discussed working with a client who was in psychosis. She instructed a new secretary to call an ambulance while she met with the client because she was aware that the client need to be transported to the hospital. She discussed this recommendation with the client and the client was willing to be transported to the hospital. When the clinician left the room, the hall was filled with police and emergency workers. The clinician was extremely surprised because she had meant for the new secretary to call a non-emergency line and request transportation. Even though this was not what she had intended, she reported feeling so grateful and comforted by the fact that when the secretary had called and reported she had an issue, there was a fast and large response from the police and first responders. This let the clinician know that they respected and cared for her.

She also discussed this reciprocal relationship and that these same people personally have requested her assistance to assess people and help de-escalate situations. This connection was clearly rewarding and fulfilling for this participant and it is a priority for her to maintain it. Another clinician also discussed interacting with other community resources. She said: "Well, I have always had really good working relationships with people like DCFS or probation so that you always get phone calls back and they can count on you. It's more personal." It was clear that this mutual relationship was incredibly important for her to do her job. Another clinician discussed these relationships being crucial due to the complex nature of clients in rural communities. She stated: "It's not just coming in and working on anxiety. You're anxious because now you don't have housing." She identified that it is difficult to work with clients on

dealing with mental health concerns if they cannot connect the client to resources to reduce the external stresses to make changes in the client's mental health condition.

This same mutual relationship was discussed by the focus group. They identified connections to the community which have been established for years. They also discussed being well known enough for people to reach out to them when they have concerns or needs that the counselor educators can assist in addressing. For instance, one clinician said:

> Right now, I am working with the kindergarten classes to give them some extra assistance. They are just swamped right now with a lot of kids with serious issues. They asked for some help, so I am trying to find a way to help them.

This back-and-forth communication helps to improve the community and improve the training of future counselors and improve the community as a whole.

Specialized Treatment with Impoverished Clients

Each of the clinicians identified specific needs that their agencies or communities were not currently able to fulfill. These needs challenged the way they all perform their jobs and continued to make providing services difficult. There was a diverse list of specialty counseling treatment services reported as needs. The clinicians discussed that they have had to be generalists and while they may have specific interests in the field of counseling, they must treat everything, every diagnosis and unique client issue. One interviewee who primarily works with children stated: "Being that person that treats them differently is super important. A lot of my kids, even if they haven't come in to deal with trauma, have trauma in their background." She discussed the lack of trauma specialists in the area. So even if clinicians were able to identify a trauma background that would benefit from a specific specialist or specialized treatment modality, she was unable to connect her clients to these resources.

Clinicians reported that their clients would benefit from eating disorder services, autism resources, and wellness programs. However, none of these services were available in the rural community locations. One of the agencies did not provide primary substance abuse services either. They discussed that clients did not have the resources to drive to these specialized services, which may or may not be available in the nearest large communities. This created a great deal of frustration and discomfort for clinicians, knowing there was specialized care that would benefit the client's recovery, but this care was out of reach. It also put an excessive amount of pressure on the clinicians to treat issues that they may not feel confident treating and creates an environment where these participants must learn as they go and constantly grow and adapt to changing client concerns.

A main difficulty these clinicians have appeared to be the lack of funding for their own services as well as local resources to support client needs. As mentioned previously, several of the agencies have shrunk in size over the years, but they were still being asked to provide the same amount of services, if not more. This shrinking of available clinicians was representative of the overall poverty level of the region. When discussing the severe increase of poverty in her rural community, one participant stated: "Seven years ago those statistics were like we were in the 30th percentile range for kids using free lunch at school. That's around 45-47% percent now, which is a massive jump in a small period of time." Clinicians all reported that the majority of their caseloads are clients on Medicaid and they see very few private insurance clients. One of the primary qualifiers to obtain Medicaid insurance is low income level. The clinicians struggled to engage clients in talk therapy and had clients prioritize this service when they have so many needs and are working to survive in their day to day lives. One of the agencies hosted an annual

gala to help to fund the services that they provide. This required assistance from the entire agency to host a plated dinner where a former client comes and describes the benefits that they have seen from engaging in mental health treatment at that agency. Both the clinicians that I interviewed from this agency discussed the importance of this function. Not only did it help to fund services for the organization, but it also allowed for their work to become more known to the local community, thus reducing stigma associated with receiving mental health services.

<u>Cultural Changes</u>

Another characteristic that the clinicians discussed was the changing landscape of rural communities, including treating diverse populations. A clinician reported on how she had seen discrimination change in her rural setting. She mentioned that there was a growing Latinx population in the community who have moved to this area to complete agricultural field work and have opened a local Mexican restaurant. She said: "People love that restaurant. They go in and treat those workers like family." She believed that this restaurant has allowed for the community to become more understanding and inclusive of people different than historical community members. Another clinician discussed working at a different rural counseling office: "We had a lot of the Amish community and so we had different rules we had to adhere to or it was overstepping boundaries. They also had a higher Latino population, so it was about making those connections multiculturally." One of the locations had a hitching post in the back of the building. When I was introduced to the director of the facility, he specifically drew my attention to this feature and reported that this was for the significant population of Amish clients that the agency served.

These cultural changes were diverse and looked differently from one community to another. All three offices had different cultural changes happening at each location. These changes were a struggle for clinicians to adapt to and to receive appropriate training on. Several of the interviewees discussed learning about these multicultural populations from the multicultural community members themselves rather than receiving any formal training on these populations. This education came from getting to know multicultural populations in the counseling setting rather than out in the community. A clinician said: "What a counselor does is put themselves in your shoes and you can't do that unless you understand the subculture you are working with." It was crucial for the clinicians to be open about what they did and did not know about the specific multicultural demographic when beginning the counseling relationship. This allows for a stronger therapeutic relationship that allows for growth and understanding.

While rural areas are frequently characterized as homogenous groups, the participants had a lot to say about the diversity in the rural environments in which they train students. One focus group participant discussed the complexity of working with Amish populations, stating:

> This may be more of a religious component but it's also poverty. Talking about the Amish population and that's, I mean, they may not consider themselves living in poverty but when we look at financials, that kind of thing. They may have different resources that aren't monetary. Twenty people show up when you want to build a house for free, but … those kinds of things.

The same participant also discussed helping an intern find residential placement for an Amish woman to treat her depression. This referral required the support of all the male authorities in her Amish community. Once they obtained this approval, the woman had to go to a treatment center in Pennsylvania for services.

Another focus group participant discussed utilizing research and books to help treat diverse clients because of the limited specialists in the area. An additional concern discussed was the high likelihood of having English as a second language students and clients. One participant discussed training students to work with these populations: "We talk in foundations [classes] about not making children work as interpreters and services that you can call that are free that someone will serve as an interpreter and how to do that." In rural settings, there was limited ability to refer a client to a specialist; therefore, the local clinician was frequently the only person who can treat the client. It was important for clinicians to learn to provide the most appropriate and comprehensive services possible even when there is a diverse range of clients.

Chapter 4 Summary

The three research questions posed in this study found significant themes in the lives of clinicians in rural communities which were reinforced by the information received from the focus group participants. The first research question found that rural clinician experiences are influenced by the proximity of their workplace, professional growth and support, spaces which prepare clients for counseling services, and not enough time and not enough staff. The second research question identified confidentiality, personal life, services out of the office, and specialized treatment with impoverished clients are all crucial benefits and challenges to providing services in rural communities. The third research question discovered that insider status, lack of resources, being a generalist, and cultural changes are how these rural clinicians name the characteristics of providing services in rural communities.

The information found during the website search indicated that professional and government websites have minimal information to provide support and training to counselors in

rural communities. These findings help to define specific implications for future development of counselor education, accreditation, and training. Future research should continue to explore the dynamics of rural counselors working in rural communities and provide additional support to counselors in rural communities to further their training and development.

CHAPTER 5

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

This research study was conducted to investigate a multicultural area that is often neglected in research: rural communities. Rural areas account for more than 80% of U.S. land (U.S. Census Bureau, n.d.). However, most counseling research focuses on urban populations and communities. This leaves a large gap in training for counselors to be prepared to work in the rural areas and treat clients from rural communities. The following research questions guided this study:

   (1) How do counselors in rural settings describe their experiences practicing in rural communities?

   (2) What benefits and limitations do rural counselors see in practicing in rural communities?

   (3) How do counselors name characteristics of counseling in a rural setting?

Qualitative interviews and field notes were used to address these research questions and gather data from counselors practicing counseling in rural settings.

This study found that the clinicians were likely to live and work in the same community. It also found that the counselor educators were also likely to live and work in the same community. They also frequently reported on issues with dual relationships and struggling to maintain boundaries both while at work and while living in their rural communities. This seemed to make the importance of discussing confidentiality with clients even more crucial both initially and throughout the counseling relationship. The counselor educators used real life examples

from their own personal experiences counseling in rural communities to help prepare clinicians

to work with these complicated dual relationships. While at work, these clinicians focus on their

work relationships to get support, supervision, and share information with their peers. The

difficulty of completing paperwork with the level of unpredictability in their daily jobs also

appeared to be a central theme.

These clinicians work with a range of diagnoses and multicultural populations while

dealing with insider-outsider-status and limited resources. The counselor educators utilized

similar insider status benefits to help make connections to place students and do their own work

to support the rural community in which they live and work. Working with other community

agencies is absolutely essential to provide treatment in these areas, especially when providing

crisis intervention services. Walker (2008a) identified that the connection of different specialty

populations within a community (such as individual multicultural populations or those specific

people requiring crisis intervention services) help to shape the culture of the larger community

and their individual identities help to grow and mold the system in which they operate.

Discussion

This qualitative research was used to answer the three aforementioned research questions.

Specific themes were found regarding clinician experiences, benefits and challenges, and

characteristics of rural communities. It is important to note that some of the things discussed are

common to all counseling settings. Some of these findings include: not having enough time or

staff and dealing with extensive paperwork. The results of this study are not meant to indicate

what only happens in rural settings, but rather the whole experience of rural clinicians, including

what is common for all clinicians. These findings have been summarized below.

Experiences

There was a vast amount of experiences while practicing in rural communities that each clinician discussed throughout the interviews and the counselor educators discussed in the focus group. Some of the most passionately discussed experiences were those felt outside of their counseling positions and in the communities that they live in. All six of the individual interview participants live and work in rural communities. Four of the six live in the rural community in which they work. All of the focus group participants live and work in the same rural community and they also had previously worked in direct service and dealt with the same complicated dynamics of encountering clients in their hometowns. According to participants this created a plethora of boundary issues. The clinicians discussed overlap in clients, having friends and family attend the agency where they work, encountering clients in the community, participating in community events while representing the agency, and forming relationships with community members.

According to participants, all of these experiences seemed to have both positive and negative connotations with the research participants. While it is difficult to run into your client at the grocery store, you are also able to see them operate in an environment that the traditional counseling session does not allow. While it might be complicated to have your childhood friend be a local police officer, your previous relationship can potentially allow for a more effective and mutually beneficial partnership in your new roles. In the focus group of counselor educators, they did not appear to assign positive or negative labels to this rural dynamic. Instead, participants treated these dynamics as simply matter-of-fact and focused on preparing clinicians for work within these systems.

Learning to expect the unexpected and "roll with the punches" was reported to be a key quality of the counselors in these rural communities. Several of the interviewees discussed the need to be flexible in their schedules, skillsets, and expectations. This flexibility has allowed them to manage crisis that come up throughout the day. It has also enabled them to deal with changing financial status of the mental health field and encouraged them to build funding sources in other, non-traditional ways. These adaptations have allowed for fewer clinicians to serve more clients with fewer resources. This has allowed these small community treatment centers to survive and even thrive. The focus group echoed these same concepts including adjusting to the new need of local schools trying to hire students before they have even been admitted to the school counseling program. As a program, they are working to adapt to this change in need from the local community and work to meet the needs of both their students and the surrounding client populations.

<div align="center">Benefits and Challenges</div>

One of the most interesting things about benefits and challenges in these rural communities is how much participants reported they overlap. For instance, counselors in this study described the limited resources of these small communities as both a benefit and a limitation. While it is challenging to work without the resources of a large area, they are also able to work with a population that they feel like excels in working with one another and showing internal motivation to change. Dual relationships cause complications with maintaining boundaries of confidentiality. However, nearly all the clinicians mentioned that they are known as the counselor in their family and in their neighborhood. This helps to reduce the stigma of attending counseling and allows for people who may be nervous or unsure of what counseling

looks like to ask questions of these counselors because they feel attainable and open to discussing the field. This insider status allows for clinicians to become trusted members of the community and potentially reach people in need who may have never went to services without knowing someone who provided them and becoming more comfortable with the idea of going to counseling based on this process. Moreover, counselor educators who participated in this study recognized that while their small community may lack a diverse range of resources to meet specific client needs. However, they reported on how well the specialized services work together to assist clients in the community.

Lack of resources paired with the range of diagnostic issues was reported to be an extreme limitation of providing services in rural communities. Individual interview participants often looked stressed and overwhelmed when discussing the variety of treatment, they are asked to offer. If a client presents with a diagnosis that would benefit from specialized care, such as an eating disorder or autism, the chances of finding a specialist in the area that the client can go see are slim to none. Focus group participants also discussed struggling to help train clinicians to work with a variety of clients. They also gave some of their own personal examples in how they have struggled with working with their own clients who had diagnosis that may be better served by being treated by a specialist. However, there were no specialists in the area within which they worked in do not exist, which means that rural community counselors were often asked to be generalists and specialists. This makes supervision even more essential to providing quality counseling services. According to the participants, it also prompted the clinicians to rely on each other, share information from trainings, and always be willing to grow and learn. It also seems to explain why graduates of the counseling program continue to reach out to members of the faculty

for assistance and guidance with continued supervision from their former practicum and internship supervisors.

Individuality was reported to be promoted by each of the counselors' agencies. Their offices were all uniquely decorated and filled with counseling tools that fit the expertise and personality of the clinician. Several of the clinicians also discussed how they have been able to venture into specific areas of counseling that they enjoy and how this has been encouraged by their bosses. For instance, two of the clinicians began groups for certain diagnoses or issues that they wished to work more with. Other interviewees have been able to change their client populations to work predominantly with the specific demographics they enjoy. The focus group participants also work to match future clinician goals and interests with the appropriate practicum and internship sites. Instead of making the students fit into a small number of placements, they have worked to make connections with a variety of local agencies and the agencies in surrounding communities to help meet the needs and interests of students.

A significant challenge reported during the interviews was related to psychiatry and psychiatric care. Each of the agencies ran a 24/7 crisis line with a maximum of three clinicians assisting in providing these services. It is impressive and overwhelming to think about potentially only having two staff exclusive rotate the responsibility of on-call including suicide/homicide/psychosis risk assessment. Five out of six of the clinicians that I interviewed were either currently a part of the on-call team or had been a part of the on-call team. The focus group participants also discussed the lack of local psychiatric resources. They reported frustration in working to train students to work with limited access and referral opportunities for

psychiatric care. They also emphasized training clients in suicide and homicide assessment for appropriate placement to higher levels of care to support client needs.

These clinicians also discussed the frustration of obtaining hospitalization for clients in need of involuntary commitment. Several psychiatric centers have recently closed. This means that clients are being sent sometimes three hours away from their home for inpatient treatment. This makes it all but impossible for effective aftercare planning and family involvement in the inpatient treatment. Each agency that participated in the study offered psychiatry services. These services all had extensive waitlists, potentially three months, before a client could begin care with a psychiatrist. Asking a client who is experiencing symptoms of schizophrenia or severe depression to wait three months before receiving necessary medication therapy is unfair for the clients and extremely frustrating for the clinicians providing their counseling services. This also continues to be a problem once the client begins treatment with a psychiatrist due to continued difficulty in obtaining appointments for medication checks and/or adjustments. Clinicians often struggle with feeling ineffective and like they are "putting band-aids" on large problems when clients cannot get appropriate appointments with their psychiatrist.

<u>Characteristics</u>

A major characteristic of the client attending services in rural communities is the likelihood that they have experienced trauma. This trauma could be severe poverty, joblessness, domestic violence, or sexual assault/molestation. The clinicians interviewed reported that all of these issues were extremely common in their clients to the point that clients rarely identified these as traumas. Not only are the clients likely to have experienced these issues, but they are even more likely to be generational issues. Therefore, clients are less likely to interpret these

issues as traumas when generations before them have experienced the same things. This creates an additional challenge for clinicians to address when trauma becomes normalized.

These clinicians must become experts in taking care of themselves. Providing services in rural communities paired with living in rural communities was reported by participants to mean you are a constant representative of your agency and the counseling field in general. This is a heavy cross to bear and increases the likelihood of burnout. The interviewees reported on ways that they have managed these concerns such as stepping back from management positions within the agency, asking for help from peers, and taking actual breaks from work (i.e. leaving the office for lunch, not coming in on days off, using vacation/benefit time). However, some of the clinicians discussed potentially unhealthy coping skills for this constant perceived pedestal such as isolating and avoiding areas that they feel clients might frequent even if that means banking or getting groceries in a different town. Focus group participants also discussed training students to work on self-care, reaching out to others when they need assistance and support, and continuing to further their education. The counselor educators also discussed how they have had to work on finding balance themselves both in their current faculty positions and in direct services positions. All of these training focuses encourage clinicians to take care of themselves and then provide the best care possible for their clients.

Another characteristic of rural community members was reported by participants to be the need to take care of themselves and manage issues independently. This can make encouraging counseling extremely difficult. There still appears to be significant shame and stigma associated with asking for help in rural communities. Families are taught to take care of things themselves rather than ask for help. This asking for help is extremely frowned upon when

the help comes from outside of the family. This prompts clinicians in these areas to always be working to destigmatize counseling, make themselves familiar to community members, and always be selling counseling services.

These issues can be intensified when you add the layer of working with multicultural and minority populations within the rural communities. Individual interviewees reported on these dynamics being even more difficult to break through when providing services to Amish and Hispanic populations in rural areas. The focus group participants also discussed these complicated multicultural issues. They also discussed clinicians dealing with differences in Amish populations and training students to work with clients who have a primary language as something other than English. Each clinician I interviewed was a Caucasian female and the focus group participants were all Caucasian and included two females and one male. Racial, ethnic, and gender diversity in these rural clinics is extremely limited. Therefore, clinicians are attempting to encourage clients to come to treatment and destigmatize services when they may look, sound, and act different than the clinicians who need their assistance the most.

<div align="center">Web Search</div>

A search of seven major professional counseling association websites indicates that there is a distinct lack of training, support, and resources for clinicians providing services in rural communities. Of all seven websites, only one provided actual training information for rural settings. Based on the search, it was evident that from the past session listings of conferences hosted by these associations that there are frequently sessions and seminars regarding rural communities. However, these trainings may be incredibly difficult for rural counselors to attend.

They are state or even national conferences which come with significant travel time, expense, and a need to be gone from work for several days.

All of the websites contained resource information for many other topics such as post-traumatic stress disorder, substance use disorders, and other mental health diagnosis. They also had databases for registered members including their credentials and current employment. These databases could be used to connect people with similar work in rural communities to assist in sharing resources and providing support. Additionally, these websites are easily accessible and user friendly. They are also highly promoted, as are the associations in general, for clinicians to join while training to become a counselor. Therefore, a significant number of counselors, providing services in rural settings, are members of organizations who do not have information to support the clinicians that belong to them.

It was also very telling that the Association for Multicultural Counseling and Development did not have any information or resources available to help support counselors in rural communities. This organization is specifically created to support the understanding of multicultural services and the improvement of providing multicultural services for all populations and there was not any information about rural communities. This site did not have any connections to other rural community counselors, nor did it have any training or additional information to help clinicians provide services to rural community members.

The lack of rural counseling support, training, or information on state level government websites is concerning. This not only shows a lack of resources for clinicians but also indicates that potential clients have the same limited access to information regarding the availability of counseling services and limited educational information about what counseling is in these rural

communities. The Center for Disease Control website has a significant amount of information about physical health issues in rural communities. However, they have limited information about mental health issues and also no information regarding treatment for these concerns. This could be extremely difficult for both counselors and potential clients. The website discusses extremely high suicide and overdose rates in rural communities but does not report on any ways to reduce these issues or provide support for these persons.

Connection to Research

This research project first examined the literature regarding rural communities, advocacy, training, and ethics. This previous literature was gathered and reviewed in order to have a better understanding and framework for the research which was completed. How the research supports and contradicts the findings of this research are detailed below.

Rural Communities and Values

Two definitions of rural are created through the literature. These are size of the geographic region versus population and characteristics. The U.S. Census Bureau definition, which describes rural communities as less than 1,000 people per square mile per town and less than 500 people per square mile near the town's limits, was used to determine inclusion criteria for the agencies that participated in the study (Census Urban and Rural Classification, n.d.). However, the individual interview participants of the study did not mention the population density during their interviews. When discussing the difference of urban versus rule and examining their own personal experience, participants never mentioned the amount of people in the community.

Instead, they discussed specific characteristics which they believed typified the towns in which they live and work. The same was true for focus group participants. They discussed the availability or lack of availability of resources. They also discussed the complicated dynamics of dual relationships and confidentiality issues. Campbell and Gordon (2003) stated that change and diversity were both characteristics that define rural communities. They found that these issues are both controlled and monitored by rural community members (Campbell & Gordon, 2003). This characteristic was supported by my research. Many of the individual interview participants discussed how rural community members self-police their communities and have struggled to adjust to change such as cultural changes. Focus group participants also work on prepare students to work with the changing multicultural issues in the communities in which they work. Another characteristic that Campbell and Gordon (2003) identified is the distrust of outside individuals and difficulty seeking help from those outside of the individual's family. This information was also supported by the research. Individual interview participants discussed insider versus outsider status in their rural communities. Many participants reported that they believed they were more trusted and accepted by community members due to the fact that they live and work in the same community and are known in the community. They also reported that an important piece of their daily lives is educating family, friends, and community members about counseling services in general. Being from the community also appears to be beneficial for the counselor educators. They are able to make connections easier with local community agencies in order to place clinicians at meaningful training sites. This helps these counselor educators have a better understanding of the needs of the local community. Therefore, they have

become insiders in the community and then can train clinicians to do the same in order to reduce

barriers to clients obtaining appropriate counseling services.

Another key piece of research about rural communities found that prostitution, drug and

alcohol use, poverty, racial hatred, and gun violence are also often qualities of rural communities

(Edwards, Torgerson, & Sattem, 2009). This information was partially supported by my

research. Participants discussed substance use and poverty both as difficult and prevalent

characteristics in their rural locations. However, none of them mentioned any concerns with

racial hatred or gun violence. These characteristics did not appear to be something that the six

counselors who participated in this study experienced in the clinical work they do or in their

personal lives.

Grinstein-Weiss et al. (2007) broke down the characteristic of poverty even further and

described it as: (a) fewer economic opportunities, (b) lower earnings, (c) fewer high-quality jobs,

and (d) fewer educational and training opportunities. Participants supported these specific

aspects of poverty by discussing concerns regarding closing of factories, losing jobs, and lack of

education in the clients they served. The researchers discussed the disproportionate rate of racial

minorities being more likely to experience poverty (Grinstein-Weiss et al., 2007). Their findings

were supported by the individual interview participants of this study reporting on the increasing

racial diversity of the areas they serve paired with increasing poverty rates. The focus group

members also discussed the changing landscape and racial makeup of the surrounding rural

communities.

A challenging characteristic of rural communities defined through the research was the

stigma in seeking out mental health services and the lack of prominence of mental health

services (Coduti & Manninen Luse, 2015). Coduti & Manninen Luse (2015) found that rural

community members we less likely to have access to counseling and psychiatric services and

were less likely to utilize these services when they did have access to them.

Again, the evidence found in my research was mixed on this topic. It was clear that all

participants identified stigma in their communities regarding receiving mental health treatment.

They discussed the desire for rural community members to be self-reliant and not to fear

attending counseling services. The individual interview participants also discussed that "no-

show" rates for assessments are around 50 percent for each of the agencies. However, all of the

clinicians had completely full caseloads and the agencies frequently had waitlists for different

programs, especially psychiatry. This would both contradict and support the previous

information that rural community members failed to utilize mental health services when

available. The focus group participants also discussed how clinicians must be prepared to

immediately jump into work in their practicum and internship sites rather than spend a

significant amount of time observing and receiving on-site training. According to rural

community members in the areas that participated in this research, clients are likely to fail to

attend initial sessions but engage in services up to and beyond the capacity of the local agency.

<u>Advocacy</u>

While completing research to understand the role of counselors and advocacy, Cohen et

al. (2012) found that counselors were often uncomfortable and felt un-natural advocating for

themselves and for clinical services. The authors reported that these feelings of discomfort can

prevent counselors from advocating for their profession to clients and members of the

communities in which they work. The focus group and individual interview participants in my

study challenged this finding. All the participants reported that they regularly talk to family, friends, and community members about the counseling profession and see this process as a part of their job. However, none of the participants specifically mentioned being comfortable or uncomfortable with this process. Rather, the participants reported it was a necessary and expected aspect of their job. Focus group participants also identified explaining the counseling process—including confidentiality issues—to clients and to friends and family, many of whom end up participating in services.

Another advocacy concern related to previous research which reported that minority groups are often discriminated against in rural communities and Caucasian groups are even discriminated against and separated in rural communities by region, gender, and class (Shirley, 2010). The research I conducted did not specifically discuss racial discrimination, nor did any issues regarding racial discrimination arise during any of the interviews. However, the individual interview participants did discuss conflict within specific groups of Caucasian community members including discrimination of clients with criminal backgrounds and lower socioeconomic status. According to participating counselors, these challenges have affected their clients in finding jobs and feeling respected by those of higher socioeconomic statuses.

According to research, counselors in rural communities do not have advanced degrees, such as master's and doctoral degrees, and have minimal time in each position due to dealing with additional challenges such as poverty (Benavides-Vaello et al., 2013). The participants in my study partially contrasted this research. Everyone I interviewed individually had a master's degree, but none held a doctorate. All the clinicians had worked in rural communities for more than 5 years and only one had worked at her specific agency for less than five years. One of the

participants had worked at her current agency for more than 40 years. Because they were professors, the focus group participants all held doctoral degrees. However, they discussed the difficulty of attracting counselor educators to the rural community in which their program exists. This difficulty impacts the hiring process and obtaining qualified counselor educators to an area with limited resources, perceived benefits, or attraction points.

Individual interviewees all talked about the steady careers of their coworkers. They had very little turnover at any of the three agencies where I interviewed. The same was true for focus group participants. They have all worked for the program for a minimum of 20 years and were clearly devoted to the university and their profession. Additional concerns are maintaining clinicians and serving clients when providers are well known in rural communities and rural communities are struggling to keep specialized providers (Bradley et al., 2012). This statement was strongly confirmed by my research. Several of the clinicians discussed concerns with being well known in the community and having to constantly educate about the counseling process to family, friends, and community members. They also all struggled with the lack of specialty providers and services in their areas. They believed this has a negative impact on clients and increases the stress levels of their job. The counselor educators worked to prepare clients for these complicated counseling dynamics. They strived to prepare clinicians to work with limited resources and make connections with other counselors to share resources and learn from each other.

Sherman et al. (2008) found that clients had a difficult time utilizing services in rural communities due to concerns about paying for said services, wait times for appointments, and because of the lack of anonymity in the area. Research confirmed these findings. The counselors

who participated in this study discussed poverty rates in their towns and clients' fears about coming to the agency and seeing someone they know. They also addressed difficulties with having waitlists and being unable to fit everyone requesting services into their caseloads; this was especially difficult for clients seeking psychiatric services at their agencies. Counselor educators also reported on training clinicians to be prepared to navigate these dynamics when they are out in the field.

Bradley et al. (2012) found issues with dual relationships to be at increasingly high levels with medical personnel in rural communities due to limited resources such as grocery stores, banks, and school systems. My research found the same concerns with counselors in rural communities. Each of the individual interviewees discussed issues they have had throughout their career with dual relationships in their current work environment. These relationships were viewed as both positive and negative depending on the reporter and the specific incident. Focus group participants gave personal examples of dual relationship issues they faced in their own clinical work. They use these dual relationship examples in the classroom to both normalize and prepare clinicians to work in these environments.

<u>Training</u>

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) discusses the importance of multicultural competency for training and education with clinicians graduating from their programs. However, these multicultural competencies do not specifically mention urban versus rural environments as a part of the education process. Five out of six of the clinicians in this study graduated from CACREP-accredited programs. None of them had specific education regarding providing counseling services in rural communities. They

all discussed their internship and specific job training as being their main education in how to

provide treatment in their rural settings. Focus group participants discussed their frustration with

the lack of specific guidance from CACREP in addressing the dynamics of rural communities

and concerns that their own governing body does not specifically outline how to prepare students

to work in a rural environment. They also reported concerns about not seeing how CACREP

administrators truly understood the potential issues and dynamics experienced working in rural

communities. This lack of understanding has a strong negative impact on this accreditation

body's ability to create appropriate standards to address rural issues.

Ethics

The American Counseling Association *Code of Ethics* heavily addresses concerns that the

participants of this research faced daily in their jobs. Some of these codes include dual

relationships, confidentiality, multiple clients, and multicultural concerns (ACA, 2014). Research

participants in this study addressed these issues readily throughout their interviews and the focus

group. They reported on issues with dual relationships and maintaining confidentiality for

clients. They also discussed issues with having multiple members of the same family system on

their caseload and how to address these difficulties. Multicultural issues were discovered not

only with the specific dynamics in rural communities but also the increase of minority

populations, such as Amish and Latinx, increasing in these rural areas.

Theoretical Orientation

The theoretical orientation utilized for this research was Relational-Cultural Theory. This

theory focuses on culture and relationships and how they impact people's development

(Comstock et al., 2008). It examines how specific populations interact within the system in which they live and how these interactions and experiences change dynamics in the individual and therefore the whole culture (Comstock et al., 2008). This theory dictates that to have a strong individual identity, one must be able to have an open dialogue with the culture around them, including both overt and covert messages from this community (Comstock et al., 2008). These complex interactions also help to explain power dynamics and cultural hierarchy (Comstock et al., 2008).

This theoretical orientation was used because the nature of this research was to examine the individual experiences of clinicians in a specific culture. According to participants, this theory captured the specific intricacies of rural communities. The individual interview participants identified that rural communities express their own hierarchy which does not follow the same power dynamics of other communities. According to these participants, rural community members are self-containing and do not utilize outside authorities such as police. This research specifically looked at the interactions between rural counselors and the surrounding rural community. These interactions were intensified for the four clinicians who both lived and worked in the same rural area. The identity development of these rural counselors was strongly shaped by the surrounding community members. The focus group participants also helped conceptualize the structure of rural communities. They all live and work in the same community and are improving their ability to navigate the specific intricacies of their unique rural environment.

Implications

Based on the findings of this study, there are new implications for changes in practice in the counseling field. This research specifically addresses counselor education, clinicians, accreditation and training, and the theoretical orientation on which my methodology was based. These implications should shape the way counselor educators look at, work with, and train practitioners in rural communities.

Counselor Education

Information from the literature combined with themes found in this research offer implications for the future of counselor education. There is no formal education through the CACREP process about providing treatment in rural settings. However, 80% of this country is considered rural territory (U.S. Census Bureau, n.d.). This seems like an extreme discrepancy. Counselor education should be changed to provide necessary diversity training so clinicians are prepared to work with this diverse population. The focus group participants echoed this concern. They discussed their frustrations with having a lack of focused training and guidelines for use in their program. The counselor educators also stated that they do not believe they specifically conduct trainings about working in rural communities. They do not have PowerPoint presentations, handouts, or specific lectures about working in rural communities. Rather, they reported that just being in the rural community attests to their work as counselor educators. Because they live, work, and teach in the same rural community, they noted that they believe all their work is focused on training for rural communities.

This type of counselor education needs to be implemented in direct, specific classroom training, much like how other forms of cross-cultural training happen. Education should include additional research in providing counseling in rural communities as well as techniques, challenges, and strategies to accommodate rural populations. This requirement would be especially important for counselor training programs located in rural environments and which therefore have a high likelihood of current students in the field performing internship and practicum experiences in a rural counseling environment. This training would require specific standards added to the CACREP accreditation requirements.

Additionally, this education requirement would mean that educators would potentially need additional training and education themselves. It is highly possible, based on the literature and this research, that educators have not had any formal training on providing counseling services in rural communities. For instance, during the focus group recruitment process, several counselor educators responded that they could not participate in the focus group because they do not work in rural communities. Counselor educators self-excluded themselves due to their perceived inexperience with rural communities. While lived experience was reported by participants to have a significant impact on how counselors work in rural communities, this alone is not enough. It is also interesting to hear that counselor educators did not feel comfortable participating in a focus group about rural counseling. I am not sure they would have had the same response to a request for participation for other multicultural issues such as race or sexual orientation despite potential lack of exposure or experience in treating or training these specific minority populations. The individual interview participants all reported that they felt that their education was crucial to learning how to deliver counseling services. However, none of them had

any specific education on doing counseling in rural communities. This was a similar issue for educators. They may have had lived experiences in rural communities, both in and out of a counseling environment, but that does not constitute enough knowledge to provide formal education services regarding providing treatment in rural community settings.

<u>Clinicians</u>

This study has significant implications for clinicians both in counselor training programs and working in the field. It is important for clinicians to be aware of the massive amount of land which is considered rural in this country. This increases the likelihood that clinicians will provide counseling services in rural communities or minimally provide services to rural community members who travel to a more urban environment to receive services. It also increases the likelihood that clinicians will live in rural communities. Both living and working in rural communities comes with specific advocacy needs for clinicians.

The individual interview and focus group participants of this study found that they spent a significant amount of time talking about, educating, and debunking myths about participating in counseling. While this is a common experience of counselors in the counseling environment, these interviewees discussed the high prevalence of these educational opportunities in their daily lives outside of the counseling environment with friends, family, and general community members. Someone living and/or working in an urban environment may not have the same concerns about being a constant representative of counseling services. This can be an exhausting process. The literature also specifically addresses concerns with being at this level of visibility in a community. Clinicians in rural communities must think about their actions in the context of representing counseling services everywhere they go and in whatever they do. This level of

constant contact with your profession adds an extreme amount of pressure and is a high requirement of this career.

It is important for clinicians to be aware of these issues that are specific to rural counseling services. It requires an extra commitment to the profession on the part of the clinician and is not something that has been discussed in their education. Therefore, clinicians begin providing services in rural communities without necessarily being prepared for or educated in how to handle these difficult dynamics. Because of this lack of preparation and education, it then becomes the personal responsibility of the clinician to seek appropriate supervision to learn to navigate the difficulties associated with being extremely connected to the local environment. He or she also has to utilize the supervision process to address issues such as dual relationships, confidentiality, and lack of resources, which arise in all counseling environments but emerge at exceedingly high levels in rural communities.

<div align="center">Accreditation and Training</div>

Not only must counselor training program educators include information regarding providing counseling in rural environments, but CACREP accreditation programs also need to be updated to include specific multicultural standards regarding this specific population. This could be a complicated process to not only adjust the CACREP standards but then also have each CACREP-accredited counselor training program change its programming to accommodate the new standards.

This change in standards and accreditation requirements is essential to appropriately advocate for rural counseling services and prepare clinicians to work in rural counseling settings. Without a formal standard change, it is highly possible that counselors will continue to lack

education in the complex dynamics of rural treatment and therefore continue to be ill-prepared to work in these communities. In other words, clinicians will continue to miss valuable classroom training to work with these populations and instead continue to rely on on-site training to learn to navigate rural community issues.

To make up for the significant number of clinicians who currently work in rural communities, there should be trainings for clinicians on how to best provide services regarding rural treatment. These trainings can help to merge gaps between old accreditation standards which do not include rural counseling treatment knowledge and new accreditation standards which account for this multicultural population. These trainings could be created in multimedia options such as online, web-based trainings to best reach all the rural areas and rural service providers. These trainings would need to include information from future research to more fully capture information specific to different regional rural areas if these results differ from area to area.

<div align="center">Theoretical Orientation</div>

Relational-Cultural Theory (Walker, 2008a) was reported by participants to be strongly supported by this research. It is recommended that this theory be utilized as a framework for future research on rural communities to further explore dynamics between rural community members and clinicians and their rural culture. Relational-Cultural Theory promotes a better understanding of how the interactions between culture and individuals help to create the individual's identity. This theory was reinforced by this specific research. Information found from the interviews—both focus group and individual interviews—helped demonstrate that specific power structures are different in rural communities. Members of the rural communities

examined discussed self-policing. They also identified how the introduction of minority cultures influenced the overall culture as a whole. As these minority cultures have changed, the interviewees identified that the rural communities have been able to change with them.

All the participants in this study were able to identify how the rural community around them has influenced their own development and current identity. The clinicians discussed numerous ways that how they were raised impacted the experiences they have had in their clinical world and how they blend into the rural community. The counselor educators discussed a similar perspective: that their experience of living in the communities in which they have previously counseled and currently teach shape the way they provide instruction to training clinicians. It is also a symbiotic relationship because the rural communities around the interview participants continue to influence them in their active positions while also benefiting from having mental health services. While the clinicians and counselor educators discussed many ways they achieved insider status in the local community, they also discussed several ways in which they felt "other" or outside such as their profession, education level, and discussion of feelings. These issues speak to Relational Cultural Theory's premise that parts of a culture in positions of power can have a higher influence on parts of a culture not in positions of power. This study looks at this complicated overt and covert communication because the counselors and counselor educators fit into both positions of power and positions without power. This theoretical orientation could be used in trainings and education regarding rural communities to help future clinicians better prepare to work in rural settings. This orientation helps to explain the dynamics in rural communities and how counselors come to be influenced by the world around them, both at work and in the general community.

Challenges

With any research, there are certain potential challenges which may impact the research process and interpretation. This research is no exception. This specific research brings up potential bias in myself and potentially eliminated participants who may have had valuable information regarding the research questions.

Scope of Limitations

Current research on this topic is limited. The research that does exist about rural communities and counseling focuses on the field of psychology and the realm of ethical issues centering on dual relationships. While this information can help inform counselor education and future counselors, it is not specifically directed toward our profession or the training of our professionals. Therefore, there is a large segment of the client population with a lengthy amount of defining variables with whom our graduating counselors are not necessarily trained or prepared to work.

Such research indicates how rural communities have had an impact on other professions. For instance, Baker et al. (2009) reported on the difficulties that teachers face in working in rural communities. Baker et al. discussed limitations, including underfunding and lack of ability to meet the comprehensive needs of the students participating in the school system. This study identifies some basic limitations of working in rural environments. However, it is clear that working as a teacher is a much different experience than working as a counselor.

Due to this limited knowledge base, it is important to conduct a qualitative research study to gather themes present in the experiences of rural counselors. However, this research angle has its own set of limitations. One major limitation is the small sample size to represent such a large

segment of the counseling population. There is also a range in the literature of what "rural" means. This would indicate that the population in question and the audience reading the research would have a wide understanding and interpretation of what a rural community is.

While there is a lack of research about the counseling experience in rural communities, a larger body of research discusses the unique characteristics of rural communities. Henderson, Crotty, Fuller, and Martinez (2014) discussed the barriers to rural individuals seeking mental health assistance through the use of psychiatry. They discussed the propensity for rural community members to rely on general medical practitioners to provide psychiatric prescriptions and assistance due to the lack of psychiatric care available in rural communities. Along with this tendency, the researchers found that rural community members are, overall, less likely to utilize specialists and general medical practitioner services than those in more populated areas (Henderson et al., 2014). However, the same researchers reported that rural community members utilize other protective factors to support mental health. One of the factors listed was social support. Social support and engagement, including feelings of being a part of a rural community, showed a decrease of mental health symptomology and increase in mental health resilience (Henderson et al., 2014).

Much of the research on rural communities focuses on the barriers within these communities; however, some research discusses positive aspects of rural communities. Such positive aspects include survival, resilience, sustainability, and fiscal responsibility (Kenny et al., 2013). These positive aspects are often overlooked and instead research focuses more heavily on the difficulties experienced in living and working in rural communities. It is my hope that in this

research study I have been able to look more holistically at the experiences of rural counselors and examine both the positives and the negatives in working with these communities.

<u>Researcher Bias</u>

I have lived and worked in rural communities for the clear majority of my life, only living in an urban environment for two years of my life. My parents have also worked in this field for more than 30 years each. My father has lived in a rural environment for his entire life and my mother has lived in a rural environment for more than 35 years. I have a degree in Clinical Mental Health Counseling and I am a Licensed Clinical Professional Counselor who is currently an Outpatient Coordinator in a rural substance abuse treatment facility. While I am not a mental health counselor in a rural community, I have the qualifications to work in a mental health setting and if I were working in a mental health setting, I could have been a participant in this study. I have a passion for rural communities and believe that there are unique variables to these areas that deserve to be examined, studied, and taught to future counselors.

A potential complication of this bias is also the possibility that data could have been missed or not analyzed because what may potentially be a unique experience or characteristic of counseling in rural communities felt commonplace or easily understood by me and therefore was not summarized in my findings. My immersion in rural communities and experiences providing counseling in rural communities not only has the potential to make me advocate for uniqueness and importance in the experiences of rural clinicians, but also might make me more likely to miss aspects that are unique to this environment because they are also my lived experiences. Both ends of this spectrum are a potential challenge to this research.

<u>Limited Diversity of Participants</u>

Another potential limitation is the lack of diversity in the participants. While this appears to be a representative sample of the people providing counseling services, all of the clinicians who worked at each of the three agencies I interviewed were Caucasian and female, and the focus group participants were also Caucasian and included one male and two females; it is definitely possible that someone providing these services with different demographics, such as race, ethnicity, and gender, may have had different interpretations and experiences when working in these rural communities. However, these demographics appear to be representative of the communities in which the research was conducted.

Another concern regarding limited diversity of individual interview participants is that the inclusion criteria limited the ability to capture experiences from other persons providing counseling services at these agencies. All three of the agencies employed interns. These interns had not completed a master's degree in counseling or a related field. They also had not obtained any kind of licensure. The criteria also excluded individuals who were Certified Alcohol and Other Drug Abuse counselors. Both these demographic areas made up a significant number of counselors in the rural agencies that participated in this study. However, due to the criteria for participation, none of these individuals were interviewed despite the fact that they are providing extremely similar or the exact same services as the individuals who were included in the study.

Recommendations for Future Research

This research revealed that there is a unique set of experiences for those providing counseling services in these rural settings and training counselors to work in rural settings. It can

be expected that other rural counseling settings may have similar or different experiences, characteristics, benefits, and limitations. These findings indicate that providing services in this setting comes with its own benefits and challenges which directly impacts the work that counseling professionals do.

More research is needed to better understand providing counseling in rural settings. It is crucial to examine other rural settings and populations to more fully understand the dynamics of these rural communities. Once these areas are better understood, potential policy changes are needed to improve the training provided to counselors so they are more fully prepared to provide counseling in rural settings. This population should be added to multicultural classes and trainings to shed more light on this underserved and under-researched population. For instance, more research should be conducted to make recommendations for formal CACREP multicultural standards to train and prepare future counselors. These multicultural standards would help to train counselors to better deal with the unique dynamics in rural communities. These standards would then be implemented in all CACREP-accredited training programs. The ACA *Code of Ethics* would also be updated to account for unique ethical challenges in rural communities, including being more specific about dual boundary issues, limited resources, and limited supervisor options.

Future research could also encourage change of funding for future counseling services to better serve rural populations and better train rural clinicians. Technology is advancing in the field of counseling. By noting the underserved specialty needs of rural populations, it would be beneficial to explore tele-counseling services for certain diagnoses. For instance, a client in a rural community may be able to access specialized eating disorder treatment by connecting to an

eating disorder treatment specialist in another part of the country by using some type of web-based video chat. This could help ease the need for rural clinicians to be masters of all diagnosis and treatment issues, encourage a larger sharing of knowledge, and provide more directed and impactful treatment to clients in need. It would also be important to explore how clients are responding to the currently available internet-based counseling and psychiatric services before expanding to additional services. However, I think there is a high likelihood that some amount of access to specialty services would be better than none.

Another important perspective would be to discuss counseling with rural clients themselves. Due to the structure of this study, the experiences of clients themselves were not directly examined. It is possible that the clients may have completely different perspectives than counselors or counselor educators. The research would need to include rural clients with a range of diagnoses and functionality. By doing this, there would be a better understanding of the specific issues that rural clients face. These perspectives would be important to consider when deciding on counselor training policies and ethical code changes.

One theme found in this study was that both rural communities and clinicians reported that they were adapting to changes in cultural dynamics and that diversity was prevalent in rural communities. This was contradicted in the literature review findings. It would be important to explore this difference to identify if this is a change that is happening in numerous rural communities or if this was unique to the communities that participated in the study.

These research expansions could also be replicated in numerous other rural areas around the United States of America and the world. It is unknown whether the results would be similar or different in other rural communities. Finally, it would also be important to look at other types

of specialty agencies that may exist in the area, such as substance abuse agencies and domestic violence agencies. These agencies also employ master's-level clinicians and were not included in this study. It would be interesting to see if they encounter the same or different experiences when providing rural counseling services in their specialized fields. These combined results would be used to better shape training programs and allow clinicians to be better prepared for the environment and clients with whom they will work in rural settings.

Chapter 5 Summary

Rural communities provide a unique set of experiences for rural counselors. Providing treatment in rural communities with rural populations comes with both benefits and limitations for these clinicians. However, both counselors in rural communities and rural community members show great strength and adaptability to overcome potential barriers. These unique experiences should be shared and further examined to help us better understand providing services in rural communities and the rural community members themselves.

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APPENDIX A

INTERVIEW GUIDE

Demographic Data (Ask directly if answers are not found through interview):

Gender

Age

Ethnicity/Race

Licenses/Certifications

Years of experience (general)

Years of experience (at this specific office)

Probes:

Tell me more about that.

What do you mean by (interviewee's term)?

What did/does that mean to you?

How has that impacted you?

1.) What was your training and/or education process in becoming a counselor?

2.) What is your life experience with rural communities?

3.) What are your areas of specialty in counseling?

4.) What are your previous experiences working in a rural counseling setting?

5.) What are your previous experiences living in a rural setting?

6.) What is a day like for you at this office?

7.) What was your last day at this office?

8.) What characteristics do you notice in this rural setting? (Follow up: Clients? Office?

Community?)

9.) What are your needs practicing in this community?

10.) What are client needs in this community?

11.) Tell me about a time when you succeeded/had a breakthrough with a client?

12.) Tell me about a mistake you made in working with a client?

13.) How did you learn to work in this setting?

14.) Is there anything about working in this setting that you have not been able to talk about?

APPENDIX B

FOCUS GROUP QUESTIONS

"Thank you so much for taking time out of your busy schedules to meet with me and participate

in this focus group. I have a consent for taping for you to sign (hand out consent). I will be audio

recording this session and identifying information will be removed from the transcripts. I will

keep the audio recordings for 3 years in a secure, password-protected location. There are no

foreseeable risks with participating in this focus group and you can withdraw at any time."

Have participants sign and turn in consents and then do introduction to research and findings –

Tell the focus group the following:

Research Questions

    (1) How do counselors in rural settings describe their experiences practicing in rural

    communities?

    (2) What benefits and limitations do rural counselors see in practicing in rural communities?

    (3) How do counselors name characteristics of counseling in a rural setting?

Findings:

    1.) Interviewees discussed frequently living near where they work.

    2.) Identified minimal time and staffing to assist clients.

3.) Discussed concerns with confidentiality. including having clients feel unsafe sharing information due to knowing the clinicians.

4.) Increased needs for clients living below the poverty line.

5.) Pros and cons to dual relationships–some believed it improved things and others believed it strained their jobs.

6.) Counselors have a lack of resources in general, and also feel that they have to be generalists and specialists in all areas.

Given these findings, what thoughts or ideas do you have regarding your program's preparation of students to serve clients in rural communities? (Other program's preparation that you have seen or worked for?)

Considering the importance of training counselors to work with diverse clients, how do you think about clients from rural communities in terms of multiculturalism and social justice? (How have you seen students advocate for these populations? What struggles have you seen students go through in providing services to these populations? How do you assist students in dealing with these issues?)

Based on the research questions and findings, do you have any personal experiences in providing counseling in rural communities that have influenced how you view and provide services to these populations? (How has this influenced how you train clinicians to work with these populations?)