

Integrating Social Justice Advocacy Into Mental Health Counseling in Rural, Impoverished American Communities



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This phenomenological study explored the experiences of 15 professional counselors who work with clients living in impoverished communities in rural America. Researchers used individual semi-structured interviews to gather data and identified four themes that represented the counselors' experiences using the Multicultural and Social Justice Counseling Competencies as the conceptual framework to identify the incorporation of social justice and advocacy-oriented counseling practices. The themes representing the counselors' experiences were: (1) appreciating clients' worldviews and life experiences, (2) counseling relationships influencing service delivery, (3) engaging in individual and systems advocacy, and (4) utilizing professional support. The counselors' experiences convey the need to alter traditional counseling session delivery formats, practices, and roles to account for clients' life experiences and contextual factors that influence mental health care in rural, impoverished communities. Approaches that counselors use to engage in social justice advocacy with and on behalf of rural, impoverished clients are discussed.

Keywords: rural, impoverished communities, advocacy, social justice, multicultural

Approximately 41.3 million Americans live in poverty (Semega, Fontenot, & Kollar, 2017) and consistently face multiple chronic stressors (e.g., food and housing insecurities, social isolation, inability to access adequate physical and mental health care) that impact their quality of life (Fifield & Oliver, 2016; Hill, Cantrell, Edwards, & Dalton, 2016). Nevertheless, the scope of mental health concerns of individuals and families residing in persistently poor, rural communities remains under-researched and overlooked by the public, scholars, and policymakers (Tickamyer, Sherman, & Warlick, 2017). Furthermore, advocacy efforts that foster social and economic justice and support the mental health of persons living in rural poverty warrant further advancement.

Scarce availability of mental health care services, ineffective modes of treatment and interventions, and mistrust of mental health care professionals contribute to the low utilization of mental health care services among persons living in rural poverty (Fifield & Oliver, 2016; Imig, 2014). Consequently, there are few evidence-supported culturally relevant mental health interventions tailored to address the specific needs of people living in rural poverty, particularly with a focus on social justice advocacy (Bradley, Werth, Hastings, & Pierce, 2012; Imig, 2014). Counselors practicing in rural, impoverished areas must be prepared to address systems of oppression, discrimination, marginalized statuses, and the impact these factors have on counseling services and clients' well-being (Grimes, Haskins, & Paisley, 2013; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). Moreover, according to the 2016 *Code of Ethics* from the National Board for Certified Counselors (NBCC) and the 2014 *ACA Code of Ethics* from the American Counseling Association, counselors are expected to take actions to prevent harm and help eradicate the social structures and processes that reproduce mental health disparities in vulnerable communities (ACA, 2014; NBCC, 2016). In recognition of this expectation, the Multicultural and Social Justice Counseling Competencies (MSJCCs) were developed to guide mental health counselors toward

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practicing culturally responsive counseling and incorporating social justice advocacy initiatives into the process (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015). Thus, the MSJCCs' framework undergirds our examination of counselors' experiences and clinical practices that support the mental health and well-being of clients living in poverty in rural America.

Understanding Rural Poverty and Mental Health Care

When discussing literature pertaining to rural poverty, it is important to first define relevant terms. The U.S. Department of Agriculture's Economic Research Service (USDA; 2017) defines poverty as having an income below the federally determined poverty threshold. For example, the 2017 poverty threshold for an individual under 65 years of age was \$12,752, and the poverty threshold was \$16,895 for a household with two adults under age 65, with one child under 18 years of age (USDA, 2017). Persistently poor areas are defined as communities in which 20% or more of the population has lived below the poverty threshold over the last 30 years with low populations (fewer than 2,500 people; USDA, 2017). The majority of persistently poor communities are located in rural Southern regions of the United States (USDA, 2017). Rural communities that experience persistent poverty have had little diversification of employment, are underserved by mental health care providers, and lack affordable housing and economic development (Tickamyer et al., 2017). For the purposes of this study, the definitions described above were used to define and understand rurality and poverty.

Mental Health Care in Rural, Impoverished America

An abundance of literature exists that identifies concerns related to mental health care for people who live in rural poverty (Reed & Smith, 2014; Tickamyer et al., 2017). For example, Snell-Rood and colleagues (2017) conducted a qualitative study that explored the sociocultural factors that influence treatment-seeking behavior among rural, low-income women. Participants reported that the quality of counseling in their rural settings was unsatisfactory because of counselors recommending coping strategies that were "inconsistent" with daily routines and beliefs (Snell-Rood et al., 2017). Alang (2015) conducted a quantitative study that investigated the sociodemographic disparities of unmet health care needs and found that men in rural areas were more likely to forgo mental health treatment because of gender stereotypes. Specifically, Alang found that men were encouraged to ignore mental health concerns and avoid help-seeking behaviors. Furthermore, children living in rural poverty have fewer protective resources and less access to services that can address their needs and are subsequently exposed to increased violence, hunger, and poor health (Curtin, Schweitzer, Tuxbury, & D'Aoust, 2016).

Adults and children living in rural poverty often have lower mental health literacy (i.e., the ability to recognize a mental health concern when it arises and how to cope with one when it occurs; Rural Health Information Hub, 2017). For example, researchers (Pillay, Gibson, Lu, & Fulton, 2018) examined the experiences of the rural Appalachian clients who utilized mental health services and found that clients were ambivalent about diagnoses and suspicious when providers suggested psychotropic medications to support treatment. Likewise, Haynes et al. (2017) conducted focus group interviews that included persons living with a mental illness, health care providers, and clergy living in rural, impoverished communities in the Southern United States, and reported a general lack of awareness about mental illness. The researchers suggested that individuals have less knowledge of what mental illness looks like, how to recognize it, and how to identify warning signs of crises in Southern rural, impoverished communities (Haynes et al., 2017). As a result of less mental health literacy, people in rural low-income communities may delay seeking counseling treatment until symptoms have intensified and face a greater likelihood of hospitalization related to mental health challenges (Neese, Abraham, & Buckwalter, 1999; Stewart, Jameson, & Curtin, 2015).

Counselor Competence and Poverty Beliefs

Researchers have indicated that mental health professionals practicing in rural, economically deprived areas are not properly trained to address the multiple needs of this population (Bradley et al., 2012; Fifield & Oliver, 2016; Grimes, Haskins, Bergin, & Tribble, 2015). Fifield and Oliver (2016) surveyed 107 rural clinicians, exploring their perceived training-related needs and the pros and cons of rural counseling practice. The researchers found that many counselors did not receive adequate training to work with the population they served, and the counselors did not feel properly prepared to address the host of issues that may arise in their rural practice.

Moreover, mental health professionals continue to hold negative poverty beliefs and social class biases (Bray & Schommer-Aikins, 2015; Grimes et al., 2015; Smith, Li, Dykema, Hamlet, & Shellman, 2013) that negatively impact the quality of services provided. Researchers have shown that some counselors are less willing to work with clients of lower socioeconomic statuses because of communication barriers, having less knowledge of and exposure to the poverty culture, and possessing negative stereotypes about poor, rural populations (e.g., uneducated, dirty, violent, lazy; Bray & Schommer-Aikins, 2015; Smith et al., 2013). Consequently, clients from lower socioeconomic statuses receive more serious mental health diagnoses or are often misdiagnosed, which may be attributed to the professional's negative biases, as well as lack of adequate multicultural training (Clark, Moe, & Hays, 2017).

Multicultural Counseling Competence

Increased training in multicultural counseling competence has a significant impact on counselors' poverty beliefs (Clark et al., 2017; Toporek & Pope-Davis, 2005). In a quantitative study examining the relationship between multicultural counseling competence and poverty beliefs using a sample of 251 counselors, Clark et al. (2017) identified that higher levels of multicultural competence and training decreased poverty biases and helped counselors to understand the structural causes of poverty. Similarly, Bray and Schommer-Aikins' (2015) survey of 513 school counselors found that counselors with training through multicultural courses recognized the external factors that contribute to poverty; however, the study did not focus on effective interventions that counselors utilized with this population.

Although these studies identified that multicultural knowledge and awareness increased counselors' understanding of the culture of poverty, more research is necessary to explore how this information is applied to provide counseling professionals with evidence-based illustrations of social justice advocacy in practice (Ratts & Greenleaf, 2018). Accordingly, the purpose of this study was to (1) develop an understanding of the experiences of mental health counselors who work in rural, persistently poor communities and (2) identify ways that counselors incorporate social justice advocacy into counseling using the lens of the MSJCCs. The research question guiding this study was: What are the lived experiences of mental health counselors working in rural, persistently poor communities?

Conceptual Framework

The MSJCCs, a revision of the Multicultural Counseling Competencies (Sue, Arredondo, & McDavis, 1992), offer a framework to incorporate culturally responsive counseling and social justice advocacy initiatives into counseling practices, research, and curricula (Ratts et al., 2015). Established in a socioecological framework, the MSJCCs help counselors examine personal biases, skills, and the dynamics of marginalized and privileged identities in relation to multiculturalism and social justice counseling competence and advocacy. Additionally, the MSJCCs assist counselors in acknowledging clients' intersecting identities, which bestow various aspects of power, privilege, and oppression that may impact their growth and development.

The developmental domains of the MSJCCs—(a) counselor self-awareness, (b) client worldview, (c) counseling relationship, and (d) counseling and advocacy interventions—help counselors understand social inequalities that are perpetuated by institutional oppression in order to better serve historically marginalized clients (Ratts et al., 2015). Likewise, aspirational competencies espoused in the MSJCCs—namely (a) attitudes and beliefs, (b) knowledge, (c) skills, and (d) action—serve as objectives for multicultural, social justice competence and advocacy interventions (Ratts et al., 2015, 2016). Although the MSJCCs have been identified as goals for all counselors, limited research exists that illuminates the MSJCCs as a framework for understanding social justice applications within rural, high-poverty areas. Therefore, in considering the four distinct developmental domains and aspirational competencies, the authors utilized the MSJCCs as a basis to understand counselors' experiences in rural, high-poverty communities. For the purposes of this study, social justice advocacy is understood as interventions and skills that counselors utilize to address inequitable social, political, or economic conditions that impede the personal and social development of individuals, families, and communities (Lewis, Ratts, Paladino, & Toporek, 2011).

Method

University institutional review board approval was granted for this study. We used a descriptive phenomenological qualitative research design, which is suitable for scholars to examine the lived experiences of individuals within their sociocultural context (Creswell & Creswell, 2018; Giorgi, 2009). In descriptive phenomenological studies, researchers use participants' responses to describe common experiences that capture the "intentionality" (perception, thought, memory, imagination, and emotion) related to the phenomenon under study (Giorgi, 2009). Furthermore, using qualitative research methods allows researchers to provide an in-depth exploration of lived experiences and helps multiculturally competent counselor–researchers highlight gaps in counseling literature and inequities in counseling practices in order to advocate for systemic changes in the counseling profession (Hays & Singh, 2012; Ratts et al., 2015).

Role of the Researchers

We recognize the possibility of bias in empirical research and acknowledge our social locations, identities, and professional experiences in relation to the current research study. All three authors identify as African American women from low socioeconomic backgrounds. We identify as counselor–advocate–scholars (Ratts & Greenleaf, 2018) and incorporate advocacy for underserved populations into our counseling practices, research, supervision, and teaching (Ratts et al., 2015). We bracketed personal thoughts and feelings and discussed biases that may possibly influence the data throughout the study. For example, the frequent criminalization of poverty was a difficult finding to discuss with the participants and we met to express our thoughts regarding this finding. A graduate research assistant (middle class, European American female) was selected to assist in data collection and analysis to increase objectivity in the research process, as she was less familiar with underserved populations, but trained extensively in qualitative research techniques. We acknowledge that we used the developmental domains and aspirational competencies espoused in the MSJCCs to conceptualize this research study, analyze the data, and present the findings and implications to foster positive changes in mental health care for people living in rural, poor communities. Furthermore, it is our view that the data did not emerge independently, but that as researchers we used a rigorous process such as the use of thick descriptions to analyze and identify nuances and commonalities in the data while also accounting for our assumptions and biases (Hays & Singh, 2012; Lincoln & Guba, 1986).

Our position as counselor–advocate–scholars helps to bring expertise to our scholarship and practices (Hays & Singh, 2012; Ratts & Greenleaf, 2018).

Participants

Fifteen participants ($N = 15$; 13 women, two men) were selected for the study using purposeful criterion sampling (Patton, 2014). Participants' ages ranged from 28 to 67 years ($M = 40$). Twelve participants identified as European American and three as African American. Twelve participants were licensed professional counselors and three were licensed professional counselor associates. Two participants had doctoral degrees in counseling. Participants practiced counseling in various settings such as private practices, colleges, secondary schools, and community counseling centers. Participants also had additional credentials: three were licensed professional counselor supervisors, seven were licensed clinical addiction specialists, one was a certified clinical trauma professional, and one was a registered play therapist. Years of work experience as a professional counselor ranged from 2 to 20 ($M = 6.7$).

Data Collection and Analysis

Recruitment solicitation flyers were distributed to various mental health agencies located in rural counties designated as persistently poor (USDA, 2017) in one state in the Southeastern United States. The mental health agencies were identified by searching public information websites for counseling and psychological support resources within these counties. Potential participants completed a telephone eligibility screening and a demographic questionnaire. The demographic questionnaire included questions asking potential participants to identify a pseudonym, their age, ethnicity, employment status and location, and professional credentials. Participants who met inclusion criteria (i.e., licensed mental health clinicians currently employed in persistently poor rural locales) were selected to participate in the study. There is no required sample size for phenomenological studies; rather, authors (Creswell & Creswell, 2018; Hays & Singh, 2012) recommended researchers consider the purpose of the research and depth of the data. We continued to recruit participants until saturation was achieved by seeing a recurrence in the data (Creswell & Creswell, 2018; Hays & Singh, 2012). After completing Interview 15, we did not identify novel data and agreed that a sufficient amount of data was collected to provide a comprehensive understanding of the phenomenon under investigation.

The researcher is the key instrument for data collection in qualitative research (Creswell & Creswell, 2018). A graduate assistant and the first author collected all study data by the use of qualitative interviews using an open-ended, semi-structured interview protocol (Hays & Singh, 2012). Each participant completed individual, one-phase, open-ended, semi-structured, face-to-face or live video interviews, lasting approximately 60–90 minutes. We audio-recorded all interviews, and they were transcribed by a professional transcription service.

The 12 interview questions that guided the study were framed by the MSJCCs' constructs in extant literature related to the experiences of mental health counselors and clients in rural, poor communities (Bradley et al., 2012; Clark et al., 2017; Grimes et al., 2015; Grimes et al., 2013; Kim & Cardemil, 2012) and specific multicultural and social justice counseling constructs espoused in the MSJCCs (Ratts et al., 2015; Ratts et al., 2016). Six questions focused on understanding the participants' knowledge of rural, poor communities and their experiences. Examples of these questions were: "Can you tell me the influence that persistent poverty has on the services you provide in a rural setting? What personal and client factors or experiences are influential to your work?" and "What is needed for you to competently provide counseling services to this population, if anything?" An additional six questions, also informed by the MSJCCs, sought to further explore the participant's beliefs, skills, and actions related to multicultural competence, social justice advocacy, and counseling, such as

“Can you share with me your definition and understanding of social justice advocacy in counseling? Can you share ways (if any) you incorporate social justice advocacy into your work as a counselor in a rural, economically deprived area?” and “Please share any perceived barriers to engaging in social justice advocacy and counseling in rural, economically deprived areas.”

Analysis of the data was informed by Giorgi’s (2009) and Giorgi, Giorgi, and Morley’s (2017) process for descriptive phenomenological data analysis. Specifically, we adhered to five steps in the data analysis process. First, we assumed a phenomenological attitude, in which we bracketed suppositions that could potentially influence the data and research process, such as our frustrations with perpetual deficit ideology in research related to marginalized populations. Second, after each interview was completed, we individually read each transcript to get a sense of the whole experience (i.e., native descriptions) and wrote brief notes in the margins to pinpoint any significant descriptive statements and expressions (Hays & Singh, 2012). For instance, we notated participants describing specific counseling practices that they believed were related to social justice advocacy as significant descriptive statements. We sent participants a copy of their transcript for member checking. Third, we re-read transcripts to demarcate data into multiple meaning units by clustering the invariant descriptions of participants’ experiences.

Initially, we also used *a priori* codes based on the MSJCCs to begin to identify units of meaning. For example, codes such as *systems*, *advocacy*, *self-awareness*, *community*, and *collaboration* helped us to infuse the MSJCCs’ framework and focus the findings toward understanding social justice experiences. As an example, the recognition and appreciation of a client’s ability to ascertain needed resources despite having less access and the participants’ willingness to assist in resource allocation were two invariant descriptions of experiences. The analysis process yielded 46 initial units of meaning. Participants’ quotes and definitions related to meaning units were contained in a research notebook to manage data and establish consensus coding (Hays & Singh, 2012). We held multiple meetings to discuss if and how these meaning units related to the developmental domains of the MSJCCs. For example, we discussed how one meaning unit, *idiosyncrasies in the support system*, closely related to the MSJCCs’ client worldview domain and reached a consensus in understanding that the participants’ ability to recognize that their clients had often strained their natural support systems exemplified that the counselor possessed knowledge of how their clients’ economic status and limited support systems shaped their attitudes and engagement in mental health treatment. In our fourth step, we reviewed the data to transform the meaning units into sensitive descriptive expressions that highlighted the psychological meaning of participants’ descriptions. We used free imaginative variation to determine the essence of the phenomenal structures of the participants’ experiences (Giorgi, 2009; Giorgi et al., 2017). We discussed any differences in understanding participants’ invariant experiences. For example, we discussed if the participants’ recognition of their need for a professional consultation to address underdeveloped counseling skills and biases related to the MSJCCs’ counselor self-awareness domain. Finally, we negotiated the interconnections and essential meanings of the meaning units, coalesced the data, and identified four essential structures that represented the descriptions of participants’ experiences and assigned them a descriptive thematic label.

Strategies for Trustworthiness

It is vital that researchers establish criteria for trustworthiness in qualitative research studies (Morrow, 2005). We demonstrated credibility through the use of bracketing, triangulation of the data sources, member checking, and peer debriefing (Morrow, 2005). Participants were provided with a copy of their transcriptions and case displays to review for member checking. We employed triangulation of data by crosschecking data (Hays & Singh, 2012) with the existing empirical studies related to rural poverty and mental health counseling. Data collection and analysis occurred concurrently in order to triangulate findings (Hays & Singh, 2012).

Findings

Using an MSJCCs lens, we identified four themes that represented the experiences of counselors who work with clients in rural poverty: (1) appreciating clients' worldviews and life experiences, (2) counseling relationships influencing service delivery, (3) engaging in individual and systems advocacy, and (4) utilizing professional support. The findings are explicated using participants' quotes to illustrate the meaning of each theme.

Appreciating Clients' Worldviews and Life Experiences

Participants in the study described how they developed an appreciation for their clients' worldviews and life experiences, even if they were different from their own. For example, Jade shared how she gained insight into and showed an appreciation for her clients' worldviews by "showing empathy, being curious, and asking questions about what it was like for them in certain situations." Jade expressed that seeking to understand clients' worldviews was vital when working with African Americans living in rural poverty because she did not have the same experiences. Shelly also conveyed an appreciation for her clients' worldviews and experiences and the impact on her clinical skills, sharing that she acquired a "different perspective" in her approach by gaining knowledge of her clients' family structures and listening to their history.

Nine participants described that working in rural, impoverished communities entailed understanding the impact that limited resources have on providing adequate mental health services and recognizing the idiosyncrasies in clients' support systems. Three participants described how their clients had often "burned" or "exhausted" their natural support system (i.e., personal relationships with other people that enhance the quality of one's life), which made it difficult for participants to identify persons who would be supportive of their clients in the mental health treatment process. Addie described her counseling experiences in rural, poor communities, stating, "People have so little to fall back on, if they're chronically mentally ill or they have a family member who is, they're just out of resources, and they've maybe even burned their natural supports." Addie further elaborated on her experiences, explaining that family members would often not return her phone calls after a client was admitted for inpatient mental health treatment.

Five participants expressed the importance of considering how low mental health literacy and mental illness stigma influenced clients' knowledge, attitudes, and beliefs toward mental health treatment. Lola explained that she observed low mental health literacy in rural, poor communities: "There is a very low level of understanding with regard to symptoms associated with mental illness." Lola discussed the prevalence of stigma toward clients with diagnosed mental health disorders as well as toward clients that had not been formally diagnosed because of the limited understanding of mental illness. Likewise Julian, a school-based counselor, expressed the impact of low mental health literacy in rural, high-poverty communities. Julian shared that the majority of her youth clientele were being raised by their grandparents, who had less knowledge of mental health symptoms and treatment; therefore, grandparents were often hesitant to seek mental health treatment services for their grandchildren.

Many ($n = 11$) of the participants indicated that in understanding the clients' experiences and worldviews they were able to see how clients managed to be resourceful and resilient when faced with hardships. In illustration, Lola stated, "They are some of the most resourceful and resilient people that I've ever met; they have a knack for finding ways to achieve what needs to happen despite not having the typical resources . . . that's very admirable." Sue and Brenda expressed similar sentiments, also describing their clients as "resourceful." In essence, participants explicated their attitudes

and dispositions (e.g., recognizing and appreciating clients' resourcefulness, possessing curiosity, learning about family structure and support systems) in working with clients in rural, impoverished communities. In accordance with the MSJCCs, participants expressed the importance of recognizing how the worldviews and life experiences of their marginalized clients are influenced by the context of rural poverty, such as how low mental health literacy and stigma impact the utilization of mental health treatment for this population.

Counseling Relationships Influencing Service Delivery

Participants ($n = 10$) described the importance of having a strong counseling relationship when working with marginalized individuals and families living in rural poverty. This solid relationship motivated participants to alter the mode of service delivery or intentionally focus more on client-centered services. Reflecting on her experiences providing home-based counseling services, Sue expressed the importance of building trust and empowerment in counseling relationships, especially when clients were involved with professionals from other agencies (e.g., probation officers) who also visited their homes. Sue described how she reinforced trust and empowerment by telling her clients, "This is about you and I'm walking alongside this path with you, I'm not going to make decisions for you." Sue expressed that reinforcing empowerment was an essential part of counseling in rural, poor communities because clients often felt as if their power has been taken away.

Other participants shared that many of their clients came to counseling sessions without their basic needs met (e.g., food, housing, and safety) and that a solid counseling relationship allowed for more trust and openness. In return, participants expressed that clients were more willing to express their need for basic necessities without feeling ashamed, and that they often altered their services to assist clients in ascertaining immediate resources. For example, Heather noted that the poverty level was so low in her community that many of her youth clients' basic needs were not being met and they would ask her to stop and purchase them meals. Heather disclosed that she often responded by stating, "Okay, we're going to have to change where we're providing therapy today, or maybe how therapy's going to look today" to accommodate their needs. Similarly, Sadie shared, "It's hard to see your clients going without things that you would consider basic." Sadie described circumstances in which she arranged for food to be dropped off to the school and picked up by her clients.

Che and eight other participants acknowledged that having strong counseling relationships with clients living in rural poverty increased their willingness to extend their services beyond traditional counseling roles and settings. The participants described various cases in which they assisted clients in securing food or housing, or navigating Medicaid and other entities. For example, Che shared that she attended a mental health disability hearing with her client in which she was allowed to speak on the behalf of a client who experienced severe social anxiety. Additional participants described ways they broadened their roles to include consulting and case management and provided examples of ways they altered counseling sessions (e.g., including children because clients had no childcare) or offered incentives for attendance (e.g., bus passes and toiletries) to support clients' continuity in treatment as well as using these as a means to help meet clients' imminent needs. Overall, participants conveyed that their counseling relationships allowed for trust and flexibility that enabled them to use ancillary skills and knowledge when working in rural, persistently poor communities, such as skills in crisis management or intentionally building resource networks with medical professionals, churches, social service providers, law enforcement, and community organizations to help meet clients' basic needs.

Engaging in Individual and Systems Advocacy

All participants reported engaging in various individual and systems advocacy interventions when

working in rural, impoverished communities. Participants shared that engaging in advocacy was necessary, ranging from their initial sessions with their clients until termination and follow-up. George shared that he started advocacy initiatives in the initial assessment by “not jumping to assumptions” and spending more time observing clients and exploring their history. He stated that he acknowledged if clients were already taking steps toward positive change to encourage self-advocacy. George explained, “I think the most direct thing that I can do is to empower people to recognize their strengths and their rights.” Similarly, Jade shared, “I use motivational interviewing with clients to help them become better advocates for themselves.” Other participants expressed that promoting self-advocacy was vital for this specific population because of the high probability that a client would not return to counseling because of barriers related to transportation, finances, and stigma. Seven participants shared that it is important to have personal knowledge of systems that affect the client in order to inform advocacy interventions. Renee mentioned, “With all the Medicaid changes . . . I’ve got to take every client into a financial conversation. . . . So keeping myself educated . . . I can be a voice of support to them and have an understanding if they come to me.”

Additionally, participants reported various situations in which they engaged in advocacy interventions outside of the office setting. Two participants shared that they engaged in advocacy with and on behalf of clients to help them navigate the criminal justice system. For example, Jade advocated on behalf of a teenage client to law enforcement officials to request the removal of her client’s ankle monitor, which she believed was not necessary. Heather shared that she wrote letters to the courts on behalf of her clients.

Participants also discussed their involvement with helping clients sustain housing. Che shared, “I’ve spoken up for my clients against landlords who were trying to railroad several of my clients with their rent, and one in particular was trying to charge my client double the rent.” Similarly, Jade shared, “I was able to advocate to my supervisors to get funds to help pay the past bills so [clients] could move into a new location and not lose housing.”

Four participants conducted trainings in schools and within the community to inform others of culturally responsive practices with people living in rural poverty. Sadie shared that she provided educational workshops to school counselors, administrators, and teachers to help them understand the life experiences of individuals and families living in rural poverty. Sadie explained that she educated her colleagues on the effects of generational poverty and helped them to explore ways they could use various educational strategies for clients in these circumstances. Overall, counselors recognized clients’ needs and engaged in an array of advocacy interventions individually with clients, as well as in the community to support clients’ continuation in treatment, link clients to services, or help clients allocate resources in rural, poor communities.

Utilizing Professional Support

Some participants ($n = 6$) were the only mental health providers in the communities in which they worked. Thus, they spoke of instances of feeling frustrated because of the lack of resources for clients, role overload, and inability to connect with other counselors. Participants expressed that support from other professionals in the behavioral health field was helpful to alleviate frustrations. With this awareness, participants shared that conversations, consultations, and formalized supervision sessions were useful to explore their biases and feelings of hopelessness, to address compassion fatigue, and to learn new clinical interventions. For example, Blaze shared that formalized supervision was beneficial to increase his knowledge and improve his attitude about working in rural, impoverished communities. He stated, “The people who have supervised me understand that I’m coming from a

different area and this is all kind of a learning curve. They've been good about helping me acclimate to the area." Similarly, eight participants shared that ongoing supervision was helpful to abate adopting negative stereotypes and to address de-sensitization to clients' needs, particularly when seeing clients who perpetually faced hardships. Lola discussed the benefits of having a professional support system among her colleagues to manage the demands of counseling in rural poverty. She stated, "We support each other personally when professional issues begin to impact our personal lives." Furthermore, Lola described that ongoing supervision was "very helpful and necessary" as it provided her the opportunity to "check in" with herself and assess how she was managing the demands of her work.

Seven participants shared that receiving professional support reinforced ongoing self-awareness. For example, Sadie stated, "I think [it's important] being willing to recognize that I'm not perfect . . . being willing to say here's a place where I need to improve." Sadie also expressed that it was important for her to seek supervision or personal mental health services to not allow her personal frustrations to "bleed over" into her client sessions. Likewise, Jade explained that supervision and taking continuing education credits regarding cultural differences were optimal to her success. In alignment with the constructs in the MSJCCs, the participants acknowledged the importance of engaging in critical self-reflection to take an inventory of their skills, beliefs, and attitudes (Ratts et al., 2016) that impact the services they provided to marginalized clients living in rural poverty. Overall, seeking ongoing supervision and engaging in professional development activities were necessary to prevent adopting stereotypes and to continue advocacy efforts.

Using participants' voices and the lens of the MSJCCs, we illuminated the essence of providing mental health counseling in rural, persistently poor communities. The participants described the importance of showing an appreciation for clients' worldviews and life experiences and how their counseling services encompassed varied approaches to service delivery and non-traditional counseling methods to engage rural, impoverished clients in the treatment process. Participants frequently engaged in individual and systems advocacy with and on behalf of their clients and described how having professional support was necessary to provide culturally responsive mental health counseling in rural, persistently poor communities. The findings serve as the basis for the following discussion.

Discussion

This study explored the experiences of mental health counselors working in rural, impoverished communities and identified ways counselors incorporated social justice advocacy using the lens of the MSJCCs to identify advocacy skills and interventions. We found that counselors who work with clients in rural poverty appreciate their clients' worldviews and life experiences, value their counseling relationships, alter service delivery formats, engage in advocacy, and seek ongoing professional support and development opportunities. Specifically, the first theme captured how counselors in the study expressed an appreciation for their clients' worldviews and life experiences, as described in the MSJCCs' client worldview domain. Counselors recognized that various contextual factors, such as family structure, nuances in the natural support systems, less access to resources, as well as how race and social class status shaped their clients' worldviews, influenced their utilization of mental health treatment. This finding lends support to previous literature associated with examining how economic disadvantages and rurality influence mental health care services and literacy (Deen & Bridges, 2011; Kim & Cardemil, 2012). Consistent with the MSJCCs' (Ratts et al., 2015) client worldview domain, the counselors explored and appreciated clients' history and life experiences, and acknowledged the clients' "resourcefulness" as a strength.

Furthermore, counselors in the study expressed a willingness to engage in their clients' personal communities, which aligns with the suggestion in the client worldview domain that counselors should immerse themselves in the communities in which they work to learn from and about their clients (Ratts et al., 2015). The findings from the study correspond to previous research that examines how counselors with increased exposure to individuals living in poverty have enhanced multicultural competence and are able to critically examine systemic or structural factors that contribute to the underutilization of mental health services in high-poverty communities (Clark et al., 2017).

The second theme, counseling relationships influencing service delivery, reflected the MSJCCs' counseling relationship domain. Participants recognized that their clients' ability to engage in the traditional therapeutic process was often thwarted because many of their clients' basic needs were not met. As implied in the counseling relationship domain, counselors are advised to utilize culturally competent assessment and analytical and cross-cultural communication skills that allow them to effectively determine clients' needs and employ collaborative, action-oriented strategies to strengthen the counseling relationship (Ratts et al., 2015).

Reflective of this domain, counselors in the study often altered service delivery formats and assumed alternative roles to meet clients' needs. The current findings offer support for research that advances increasing flexibility in counseling roles and culturally competent assessments when working in marginalized communities (Fifield & Oliver, 2016).

Another distinctive finding of this study was encompassed in the third theme, which captured the MSJCCs' counseling and advocacy interventions domain, and illuminated the participants' use of strategies to promote continuation of services (e.g., home-based counseling, group formats with the inclusion of childcare, and distributing incentives) as well as advocacy interventions to address clients' imminent needs. Expanding previous research that illuminated the role of self-advocacy (Singh, Meng, & Hansen, 2013), the participants expressed the importance of engaging in intrapersonal, interpersonal, and institutional advocacy interventions with and on behalf of clients, such as assisting clients in securing or maintaining housing, acquiring supportive educational resources in school settings, rebuilding familial relationships, and preventing the criminalization of poverty. Although these findings are similar to previous researchers' perspectives that suggest that counseling in rural poverty requires counselors to engage in various advocacy roles (Kim & Cardemil, 2012; Reed & Smith, 2014), this study answers the call to provide practical examples of incorporating social justice advocacy into counseling with historically marginalized populations (Ratts & Greenleaf, 2018).

The final theme identified in our study involved the participants' use of professional support networks and seeking professional development opportunities to address areas of professional incompetence. Accordingly, this theme aligns with aspects in the MSJCCs' self-awareness domain. As articulated in this domain, multiculturally competent counselors are expected to have an awareness of their social group statuses, power, privilege, and oppression, as well as acknowledge how their biases, attitudes, strengths, and limitations may influence clients' well-being (Ratts et al., 2015). The counselors in our study engaged in both informal and formal action-oriented strategies, such as consultations and ongoing supervision with other mental health professionals, that helped them examine prejudicial beliefs, prevent the development of additional biases, and explore other areas of vulnerability and skills deficiencies as designated in the MSJCCs' counselor self-awareness domain. This finding supports past research (Bowen & Caron, 2016; Reed & Smith, 2014) that indicated that because of the limited resources and remoteness in rural, impoverished areas, professional support is vital to assuage frustrations because of consistently seeing poor, rural clients navigate difficult life

circumstances. However, this finding expands current understanding by focusing on the counselors' ability to identify their own limitations and readily seek out additional supports.

Implications for Counseling Practice, Advocacy, and Training

Foremost, in order to offer culturally competent mental health counseling, it is important for counselors to appreciate their clients' worldviews and life experiences and understand the unique oppressions that clients from rural, impoverished communities experience. For example, participants acknowledged that various contextual factors, such as family structure, mental illness stigma, and nuances in the natural support systems, shaped their clients' worldviews and influenced their utilization of mental health treatment. Viewing clients' concerns from a socioecological lens may strengthen the counselor–client relationship (Ratts et al., 2016) and decrease stigma related to mental health treatment (Stewart et al., 2015).

Counselors also must be flexible and recognize that altering the format of session delivery is often necessary to engage with clients in rural poverty. Individuals living in rural poverty face immense financial barriers that impede the utilization of mental health treatment (e.g., transportation issues), and there is a general lack of awareness about mental illness in rural, poor communities (Haynes et al., 2017). Thus, counseling in rural poverty should extend beyond office-bound interventions to include community-based interventions (Ratts & Greenleaf, 2018) and account for barriers that influence treatment utilization. For instance, the findings indicated that participants had a greater appreciation for clients' worldviews and expanded their roles to include consulting, advocacy, and case management when they became more engaged in their clients' personal environment and community.

Furthermore, counselors in this study collaborated with and on behalf of clients in advocacy efforts in various areas such as housing, criminal justice, social services, and school systems. Engaging in individual- and systems-level advocacy interventions (Ratts et al., 2016) when working in rural, impoverished communities is vital to promote equity and positive systemic changes (Reed & Smith, 2014). Given these findings, counselors should become comfortable with professionals in these areas as well as going into the respective environments. Thus, it warrants counselors to network with community partners, schools, faith communities, and law enforcement entities to establish relationships to enhance support networks. In addition, writing letters to federal and state legislators regarding national issues such as Medicaid funding is critical to address policies that benefit rural, impoverished communities.

Finally, multicultural and social justice competence is a developmental process, and professional counselors as well as counselors-in-training need opportunities for ongoing self-reflection to examine their personal assumptions and biases and enhance their skills when working with rural, impoverished communities. Clinical supervision grounded in a social justice framework can help counselors and supervisors process their biases and assumptions, develop a social justice lens of understanding clients from rural poverty, and cultivate advocacy skills (Smith et al., 2013). The MSJCCs should be facilitated throughout counseling program curricula versus one foundation course in multicultural counseling and development. Some possibilities for incorporating the MSJCCs into student learning across all courses include experiential activities, group work, and role-plays that cover topics such as worldviews, intersecting identities, power, privilege, and social class. For example, audiovisual materials found on the Rural Health Information Hub website (www.ruralhealthinfo.org) can help students visualize the experiences of rural and impoverished communities. Additionally, encouraging or requiring counselors-in-training to engage in rural, economically disadvantaged communities for their practicum and internship experiences can be incorporated into the clinical sequence in counselor preparation programs

Recommendations for Future Research

There are several pathways to advance research pertaining to mental health counseling and social justice advocacy in rural poverty. Rural, impoverished areas continue to experience low mental health literacy, which perpetuates stigma. Thus, investigations about stigma in rural poverty can provide insights into the underutilization of mental health treatment in rural communities. Research of various designs regarding the lived experiences of poor women, men, and children in rural communities can inform culturally responsive counseling practices. For example, empirical studies about the experiences of grandparents raising grandchildren in rural poverty can offer unique perspectives for ways to enhance mental health literacy and increase utilization of mental health services. Additional studies are also needed to explore social justice advocacy interventions that are necessary to test the efficacy of the MSJCCs.

Finally, a primary limitation of this study was that the participants had varied professional license levels, areas of specialization, years of professional experience, and provided counseling services to diverse clientele in various settings. The data in the current study did not allow us to assess if variances in the noted areas had a differential impact on the participants' counseling experiences in rural poverty. Consequently, additional qualitative studies that allow researchers to examine these differences more pointedly are needed to fully understand the experiences of counselors from varied backgrounds and experience levels. Furthermore, readers should exercise caution when generalizing the experiences of the 15 participants in this sample to other counselors working in rural, impoverished communities. The experiences of participants in this sample may not capture the experiences of all counselors working in these communities; however, readers can make decisions regarding the degree to which the findings of the study are applicable to the settings in which they live and work (Hays & Singh, 2012).

Conclusion

Poverty significantly impacts the mental health of children and adults living in rural communities, resulting in having limited access to resources and services that can promote healthy development and well-being. Therefore, mental health counselors working in rural, poor communities must often incorporate social justice advocacy within the context of clients' experiences of oppression in their counseling practices to provide culturally responsive services. The MSJCCs provided a lens to explore the knowledge, skills, beliefs, and overall practices of 15 professional counselors working in rural, impoverished communities. By examining the experiences of these counselors, we identified how counseling professionals working in rural, impoverished communities acknowledged and appreciated their clients' worldviews and life experiences, created strong therapeutic alliances, altered counseling service delivery, engaged in advocacy, and sought professional support to sustain their ability to provide culturally responsive counseling services. Multiculturally competent counselors should continually explore ways to amend their current practices to address the various sociocultural barriers that impede the mental health and well-being of rural, poor children and adults. It is our hope that counselors will utilize the findings from this study to further the discourse on rural poverty and create positive change in these communities.

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