Chi Sigma Iota
Chi Omega Chapter
Quincy University

The Insight

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The Rural Counseling Issue

Special Issue Introduction

By: Dr. Andrea Fifield

The inspiration for this issue sprang from a class project way back in the fall semester of 2011. During a class presentation, a group of students commented on some of the unique ethical issues that come from practicing counseling in a rural community. They also commented on the fact that the ACA Code of Ethics does not always provide clear guidance on how to resolve some of these ethical issues. The discussion then grew into general observations regarding the challenges associated with rural or small community counseling. Eventually, in expressing their desire for more guidance and resources for rural practitioners, our students hatched an idea: What if there was a dedicated division of the Illinois Counseling Association, or better yet, an ACA division, specifically for rural and small community counselors?

This question led to a number of special projects within our Chi Omega chapter of Chi Sigma Iota. The first such project was a poster presentation at the annual ICA Southern Conference in March of 2012. This poster highlighted the unique challenges associated with counseling in rural and small communities, and offered suggestions for enhancing rural practice. From there, we created a survey for rural and small community counselors, which we distributed to counselors practicing in Illinois. We presented the results of this survey at the annual ICA Conference in November of 2012. We have now been granted approval to distribute our rural and small community counseling needs assessment nationwide, and we will be presenting those results in a poster session at the annual ACA Conference in March of 2014.

In the meantime, the membership of Chi Omega wanted to shed light on some of the local challenges that our students have experienced firsthand. That is the purpose of this special issue of *The Insight*. In the following pages, you will read about some of the challenges associated with counseling in and around Quincy, IL. It should be noted, however, that this is not an indictment of our local counseling agencies. It is simply an effort to raise awareness of the realities faced each day by counselors in our local schools and agencies. Counseling in a rural or small community comes with unique challenges related to boundary issues, availability of resources, access to resources, or the acceptability of seeking help. Some of our students have personally experienced or witnessed these harsh realities, and have graciously agreed to share their stories for this special issue. Enjoy.

The Insight

The Criminalization of Mental Illness

By: Stacey Soliman

Punishment is worse than no treatment - this is the best way to describe the shame of having law enforcement be called for a person who needs mental health assessment instead. It has been a common practice of people, here in Quincy at least, to call the police when they witness someone violating the social norms. Even in places where a person is primarily housed for a mental health concern, police are still being called instead of a referral for psychiatric treatment. Although this is considered a practice to ensure safety for everyone, this puts a lot of stigma on people with mental health problems.

The huge cut made by Illinois for mental health treatment has affected the profession in many ways. One of the major effects is that mentally ill people are being thrown to places that are non-beneficial or damaging to them. These cuts on the state mental health budget translate to a larger prison and jail population. The last thing we want to see is for jails to be a substitute for mental health facilities because of lack of money for treatment. In line with this, a lot of psychiatric hospitals in the tri-state area have been shut down due to budget constraints. This also increases the problems faced by people with mental health problems. One of the biggest factors that contributed to this decline in inpatient treatment is the reimbursement issue with insurance companies. These companies usually limit the number of hospitalization days even though there is need for longer treatment. In response to scarcity in psychiatric treatment, funding was increased for community mental health, but it was not enough. One study found that this has also resulted in an unintended effect known as trans-institutionalization, where the mentally ill who are discharged from, or no longer admitted to, mental hospitals are frequently found in prisons or jails (Ringhoff, Rapp, & Robst, 2012).

In this area, if I am to guess, I believe that individuals with mental illness make up a disproportionate percentage of the jail population. In my position in a local hospital, I have had several instances where I get calls from the state's attorney for a referral for an inmate who was thrown in jail but is clearly mentally ill. The question, in this case, is whether or not the jail environment exacerbated his or her mental illness to the point that the legal staff is now looking at mental health treatment options. This is the danger of not properly assessing a person after a witnessed or suspected violent or criminal act. So many people assume that all criminals should be punished no matter what, but what the society doesn't know is that people with mental illness typically do not do well when they are involved in the criminal justice system (Ringhoff et al., 2012). I have heard from some of the patients I have talked to that they are often traumatized due to the embarrassment of being arrested. Also, when these people end up in jail cells, they may present with their symptoms for a mental health diagnosis, such as being verbally or physically aggressive. But since jail guards are not trained to deal with these certain behaviors, these people are often ignored, or in worse cases, condemned (Schmitt, 1999). This just shows that going untreated and being on one's own is better than being locked up and punished.

> "This increases the problems faced by people with mental health issues."

Since it has already been a practice to call law enforcement in cases of people being verbally or physically aggressive, police should be trained on how to respond to mental health emergencies. There should be a clear distinction between the responses to a criminal versus a mentally ill person. As front-line responders to mental health crisis, law enforcement should adhere to all ethical guidelines in handling mentally ill people. The good practice that I have observed here in Quincy is that although the police are called for people deemed to be violating social norm, they have a good instinct on whether the person actually

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needs to go to a psychiatric facility or jail. I have seen them use their own judgment regarding if the person belongs in the hospital or not. This, I salute to, because this not only shows that our law enforcement in this area seem to be trained to deal with mental health crises, but also, that they don't put the stigma on these mentally ill people. Being in a small rural community, the only problem that I have seen is that there are those certain people who, when police are called, end up not sending that person to the hospital because they think the person is being facetious. This does not exclude youths with mental health problems. Families sometimes lose hope of obtaining mental health treatment for their children, and when these families believe they are left with no options for appropriate mental health care, they turn to juvenile detention centers, which then cause more harm to these adolescents.

On the other hand, there are also those people who actually need to be in jail for a period of time. However, I believe that inmates who show behavioral problems should be assessed by mental health professionals to determine further action upon release from jail. It is then essential to have a plan for them to either be just sent home or be recommended and referred for mental health treatment. People with mental illness who were put in jails should not have to suffer. They should be given an equal opportunity to get the treatment that they actually need.

Although this has been a longstanding problem in our society, there is still hope to eliminate this criminalization of mental illness. Awareness of the fact that jails and prisons are not the right place to treat people with behavioral and mental health problems is the first step. If the people in society are aware of this and ultimately believe in this, then little by little, we will be able to eliminate the criminalization of mental illness and the stigma put upon the mentally ill.

Although there is very little that we can do about the budget for mental health, other mental health systems can make a difference by putting their best into trying to actually help the mentally ill, and not be one of the contributing factors to the criminalization of mental illness. The use of jails and prisons as a replacement for mental health hospitals is dangerous and diabolical, and it will only put the mentally ill in a state of aversion and terror.

References:

Ringhoff, D., Rapp, L., & Robst, J. (2012). The criminalization hypothesis: Practice and policy implications for persons with serious mental illness in the criminal justice system. *Best Practice in Mental Health, 8*(2) 1-19.

Schmitt, S. M. (1999). Criminalizing the mentally ill. *Counseling Today*, *42*(4), 1-5.

About the Author:

Stacey Soliman will be entering into her 5th semester of the counseling program at Quincy University this spring. Currently, Stacey works as a Clinical Intake Coordinator at Blessing Hospital. She chose to look at this topic because she sees a lot of law enforcement involvement with the psychiatric patients that she deals with through her current job. Stacey is a member of the Social Committee for Chi Omega and is in the Clinical Mental Health Counseling Track.

Addressing Domestic Violence and Sexual Assault in a Rural Community

By: Samantha Houghton

There is no doubt that domestic violence and sexual assault is a worldwide issue that really has no limits as to socioeconomic class, gender, race, or culture. According to the National Network to End Domestic Violence, in 2012, 64,324 survivors across the US were served in a 24-hour period during their annual census (National Network to End Domestic Violence, 2013). I worked in this field for several years as a legal advocate with Quanada, and I believe that survivors living in rural communities like ours have a very different set of barriers that they must deal with when trying to break free from the abuse. Just as the survivors have barriers, so do those trying to provide assistance. A lot of the barriers are the same, just applied differently. Lack of resources, supports, and training are the main themes to the obstacles that face both survivors and advocates.

Lack of resources is a major concern when looking at the domestic and sexual violence field as most programs are non-profit. For those who work in the field, this means that you never know how much longer your shelter or program is going to be operating because most programs are grant and government funded. If grants end and you cannot find another one to replace that funding, or if the government makes budget cuts, then chances are that something has to give. Most of the time this means making cuts to personnel, which in turn affects the number of survivors served on a daily basis.

This is where the support piece becomes an issue a lot of the time. There is not enough support from law makers to keep domestic violence and sexual assault at the forefront of their platforms. And it isn't just DV and SA, it is really any social service/mental health area. People cannot continue to do valuable work if there is no support, and the government keeps thinking they can make cuts to such vital programs.

Another way lack of resources affects the work is that, in a rural community, there might not be as many options for the DV and SA programs to reach out to in order to provide other support for the survivors. Your shelter might be the only one in 150-200 miles, so if the shelter is full, where do you send overflow? At one point my agency had a waiting list of at least 20 women and children who needed shelter. We had cut the number of people we would accept because personnel cuts had to be made. The agency I worked for was lucky enough to have pretty good relationships with the churches and other social service agencies, so we kind of all helped each other out, which is how it has to be in a rural community to fully serve the client to your best ability. But even then, sometimes it is not enough and clients fall through the cracks.

> "Law enforcement in rural communities is a very funny beast, and another resource issue."

To go along with the idea of being the only program in quite some distance, the program I worked for served five surrounding rural counties. If someone from the furthest county needed shelter, we had to work very hard at finding a way to get them there safely. There were cases of staff going along with officers to the home to pick up the client, but that was always dangerous because you might not know where the abuser had gone. If it was in the middle of the night, we had to rely on finding a motel room in the town in order to put the client up for the night and then work on transportation the next morning. At those times you prayed you had a decent cop who responded to the call, and who would take your work seriously enough to believe that there was an actual threat of harm to the client which warranted help.

Law enforcement in rural communities is a very funny beast, and another resource issue. Most of the officers in the communities I saw were a part of that "good ol' boy club." Most of the abusers or other male family members were often in this same club, so they looked out for one another. It was easy for some of them to just see a disagreement between a man and a woman, and they usually took the male's side. It was very hard to get buy in from the law enforcement agencies on what our organization was trying to do for our clients, and that there was actually a need in their community for us.

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Cont.: Addressing Domestic Violence

For a survivor, the lack of resources could be any number of things. They could need the most basic things such as help with food and shelter, or they may need more in depth help such as legal representation for orders of protection or immigration issues and everything in between. When I was doing legal advocacy, we were lucky enough to have a system called Land of Lincoln where there was free or reduced legal representation available if the client's income met certain requirements. One year we had to go about three months without that resource because it had used all of its funding for the year. It was terrible to have to tell clients that they had to go through the process alone because I had no legal training and there were a lack of funds for the only agency we had that could help them.

Also for the client, a lack of resources is largely about not knowing what is out there to help them. A big part of perpetuating the cycle of violence is isolation. Abusers generally like to keep a tight rein on their partner, so getting information about who can help is really hard. A lot of them would finally know about us because of the placards that are placed in the bathroom stalls. Others would see our displays in October during Domestic Violence awareness month. But even if they had knowledge of the agency, they still needed help reaching out. If they had a cell phone, some of them wouldn't call because they would be scared the abuser would walk in or see the number on their phone later. A lot of the clients didn't have much in the way of a support system, so getting that encouraging voice to tell them that they were doing the right thing by reaching out was very uncommon. Rural communities are often very small, so a lot of times everyone knows everyone. It would quickly get back to the abuser if the survivor was doing something he/she was not supposed to be doing.

Even though there are a lot of challenges and barriers when working with domestic violence and sexual assault victims in rural communities, it doesn't negate the very valuable work that is being done with this population. It takes a lot of persistence, but the hard work does pay off, and it can be seen in the families… Not always in huge ways, but it is there. You just have to trust that you are doing your best to help.

References:

National Network to End Domestic Violence. (2013, March 25). *Domestic violence counts 2012*. Retrieved from http://nnedv.org/downloads/Census/DVCounts2012/DVCounts12_NatlReport_Color.pdf

About the Author:

Sam Houghton has completed five semesters of the counseling program at Quincy University. She plans to complete both the clinical mental health counseling track and the professional school counseling track. She currently works at Knapheide Manufacturing but previously worked at QUANADA as a crisis intervention worker, legal advocate, and victim advocate. She worked with both adults and children who were domestic violence and sexual assault survivors. Currently, Sam is the Chi Omega chapter Member-at-Large for School Counseling.

Resource Issues in Serving Rural Families

By: Shandi Joubert-Kanz

In my time in the Northeast Missouri community, I have come across many issues when serving women and children. Before deciding to become a counselor, I worked for the Children's Division in a rural community. I went into houses and explained to parents that they needed help providing for their children. I told them that they needed services that would improve the lives of their children. An issue that I commonly encountered was that these parents did not have access to the services that they needed. I could tell them that they needed counseling, but there was no way to pay for it. However, the children were, in some cases, able to receive counseling through state medical insurance. But any other service that was needed was either not available or not in the area, and there was no way to get to where the services were located. Years later I am a forensic interviewer, and I come across these same issues. At my agency we provide counseling referrals and free counseling to children, but we have no funding for parents. The children that I see have been abused, and in a lot of cases the parents are just as much a victim but cannot receive services due to lack of insurance or lack of needed services.

I recently met with a counselor, Pam Lightle, in Hannibal, Missouri. She told me that the hardest part about serving children and families in her rural community is the lack of healthy activities that are free or offered at a reduced rate. Schools don't have afterschool programs, and there is no outreach outside of the counselors that are readily available. Not only that, but there is a real issue with psychiatric services in the area. The waiting list to see a psychiatrist is at least a two month wait, and children who need medication immediately have to see a general practitioner or pediatrician.

> "The children that I see have been abused, and in a lot of cases the parents are just as much a victim but cannot receive services due to lack of insurance or lack of needed services."

We also spoke about the issues that adults have getting services. There is frequently an issue with finances preventing adults from being able to seek out services. Many adults in our rural community don't have jobs. They are out of work because of lay-offs, lack of available jobs, or lack of appropriate child care. If they are able to get an appointment with a psychiatrist, there is no way to pay for the medications.

Pam and I also spoke about what it would look like if she woke up tomorrow and it were a perfect world. She explained to me that in her perfect world as a counselor, there would be local access to a child psychologist where children could receive psychological assessments. There would be fast and available psychiatric services, as well as funding for those without money to receive the medication that they need to function better. Something that Pam (who works mainly with children) really highlighted in our conversation was that her perfect world would also have low or no cost healthy activities (after school programs, health and wellness activities, sports, etc.) and support groups.

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I do have to say that with the work that I currently do, I was not surprised that these were some of the things that concern Pam in our rural community. I found a study that supports the issues that we are seeing. A study by Pullman, VanHooser, Hoffman, and Hefflinger (2009) addresses some of these same issues, including lack of resources and transportation, and goes on to talk about the stigma that is placed on clients that receive care. I have seen how these issues affect the families that I work with. For some of my clients, their biggest concern is that community members will know that they are receiving services, and this is humiliating to them. For the most part, it has not stopped the families that I work with from getting needed counseling services for their children. However, it has had an impact on them seeking out services for themselves.

I would say that there are ways for counselors in rural areas to help clients find outside resources. In many communities there is more availability than we think. I have found that having a resource guide to all of the area services has been helpful when talking to families who feel that there is nothing for them. When presenting the options for services, I make sure that they fit that family's needs and follow up with them to make sure that they don't have trouble accessing said services. The counselors that I work with are also doing this, and even with what little we have available, we are making it work the best we can.

References:

Pullmann, M. D., VanHooser, S., Hoffman, C., & Hefflinger, C. A. (2009). Barriers to and supports of family participation in rural system of care for children with serious emotional problems. *Community Mental Health, 46*(3), 211-220. doi:10.1007/s10597-009-9208-5

About the Author:

Shandi Joubert-Kanz is getting ready to start her sixth semester in the Clinical Mental Health Counseling Track at Quincy University. Shandi currently works as a Forensic Interviewer for The Child Advocacy Center of Northeast Missouri. She is interested in this topic because through her position she works closely with women and children in crisis who have no access to services. Shandi is currently the President of Chi Omega, the Quincy University chapter of Chi Sigma Iota.

The Insight

Mental Health Service Availability for Rural Children and Families

By: Paige Nottingham

Formal mental health services are scarce in rural areas. Twenty percent of the U.S. population, however, currently lives in rural areas (Heflinger & Christens, 2006). The proportion of psychologists, physicians, and other mental health professionals to individuals in distress is far lower for individuals residing in rural communities (Heflinger & Christens, 2006). Over the years, I have seen children and adults suffer from mental health problems and never seek help due to cost, accessibility, and lack of understanding by professionals of rural community issues. Reputable service providers are usually located in urban areas, meaning that rural residents have to travel further, pay more, and do not get the luxury of feeling comfortable in relating with their clinician.

It has been my experience that children and families living in rural communities suffer from a variety of social and economic factors that have contributed to their needs for mental health services. Rural families are often more susceptible to the effects of stress and depression due to their isolated living conditions (Heflinger & Christens, 2006). They experience higher levels of poverty, economic struggle, transportation limitations, stigma associated with seeking services, higher numbers of reported child abuse, and limited access to appropriate services (Heflinger & Christens, 2006). Society has come to believe that rural living is simplistic and idealized, when in fact some of the theorized benefits of rural living directly contribute to the increased need of mental health services in rural areas.

One in three rural citizens make up the nation's poor (Heflinger & Christens, 2006). These individuals too often struggle from anxiety, psychological dysfunction, cognitive impairment, physical aggressiveness, withdrawal, depression, loss of temper, marriage problems, behavioral problems, and substance abuse (Heflinger & Christens, 2006). Regardless of the wide range of reported symptoms, mental health services are still limited and insufficient in rural areas due to the lack of incentive to make changes by policy makers. Some typical assumptions of policy makers about behavioral health in rural areas are: rural communities are too tight knit, rural services can be effectively delivered through urban hubs, and rural dwellers are a low-risk population (Heflinger & Christens, 2006).

Due to the lack of evidence supporting the need for sufficient mental health care in rural areas, individuals advocating for this cause are often confronted with mental health resource allocation issues. Being able to document rural versus non-rural differences in the need for mental health services is crucial for informing policy and resource allocation. Walrath, Miech, Holden, Manteuffel, Santiago, & Leaf (2003) attempted to justify service eligibility and resource allocation for rural individuals by looking at the degree of functional impairment in rural versus non-rural communities.

Walrath et al. (2003) wanted to examine if there was a difference in overall functioning of youth based on their geographic location: rural versus non-rural. Results indicated that on a functional impairment assessment, of the 31% rural communities studied, rural participants scored on average 10 points under the participants living in urban areas (Walrath et al., 2003). In other words, rural residents had lower functioning levels as compared to urban residents. Researchers also found that after they accounted for demographic differences between rural and non-rural participants, there was no difference in the prevalence of mental health issues recorded. Both rural and non-rural individuals were found to be at risk for experiencing mental health problems and to be in need of mental health services (Walrath et al., 2003).

The lack of evidence differentiating rural and non-rural children should show policymakers and funding agents that in a time of increasing demand for resources, individuals in rural areas are not immune to the same types of mental health challenges faced in urban areas. In short, the rationalization that mental health issues are less prevalent in rural areas is a falsely popularized belief. Rural and non-rural areas deserve comparable fiscal attention when it comes to determining appropriate services needed and accessibility to those services.

Traditionally, rural community members have dealt with mental health concerns through informal services such as a pastor, bartender, teacher, or neighbor (Heflinger & Christens, 2006). This option was the only alternative as opposed to other "formal" and insufficient options available (Heflinger & Christens, 2006). I do believe that appropriate services are critical in rural areas, but I do want to note that there are many difficulties that come with attempting to create mental health services in rural communities. First, it is difficult to recruit sufficient practitioners to live in rural areas. Many clinicians do not want to pick up and move to an isolated, small town (Rollins, 2010). Second, the professional is introduced to a different style of living than in urban settings. Rural living does not come with the same accommodations and amenities that urban living offers. Third, ethical codes are harder to uphold. The practitioner has to be careful of dual relationships and confidentiality. Both are harder to maintain in small rural areas (Schank, Haldeman, Helbok, & Gallardo, 2010). Lastly, mental health is an extremely stigmatized form of health care in rural communities (National Institute of Mental Health, 2000). Rural residents do not want to be viewed as deviant by neighbors and community members.

When it comes to the accessibility and appropriate services provided to rural residents, the topic of Medicaid needs to be discussed. Medicaid

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Cont.: Mental Health Service Availability

is a controversial topic currently being debated among policymakers. Rural children are at equal or greater risk of being uninsured or on public insurance as urban individuals (Heflinger & Christens, 2006). Medicaid plays an important part in access to mental and behavioral health services in rural areas. Several of the children that I worked with have been on some form of assisted living. The services that they receive, via Medicaid, would otherwise not be an option due to high costs. Medicaid is a program that is responsible for large numbers of rural children not only being able to see a health care provider, but a qualified professional. When working with rural residents, affordability of services is a necessary conversation. With the future of Medicaid in crisis, professionals working with rural clients need to contemplate the potential issue of rural residents not being able to obtain coverage for services.

Rural mental health is a field that has been historically neglected by both researchers and policymakers, causing rural residents with mental health problems to be underserved by relevant professionals (Walrath et al., 2003). Popular belief would have you think that behavioral health issues in rural areas are not as problematic as in urban areas, when in fact they are of equal or higher concern and prevalence. Heflinger & Christens (2006) suggest some basic principles to consider when working with the rural population:

1. Recognize the unique situations of rural communities and use local knowledge and ideas. A plan that is perfect from a practitioner's perspective can fail easily if it does not address local beliefs and does not fit well within local preferences and existing systems. Sometimes, the best ideas for solutions to local problems can be found by simply asking local residents about their needs.

2. Incorporate the efforts of the providers of the informal care sectors such as family, church, and other local resources. Build alliances with local systems instead of competing with them or overlooking their importance.

3. Identify and work toward addressing the underlying rural health and health care problems. Community psychologists have long been encouraged to take active roles in community organizing, policy making, and public interest litigation.

It is clear that adolescents and families in rural and non-rural systems are more similar than different when it comes to the occurrences and severity of mental health concerns (Walrath et al., 2003). However, rural families have less access to mental health clinicians than non-rural individuals, even though there is evidence to show both have comparable challenges when it comes to dealing with emotional, physical, or psychological distress. Youth and families in rural communities need equal access to mental health resources, and there also needs to be greater attention given to ensure that rural residents are receiving continued funding for appropriate care. Along with the suggestions above, rural mental health practitioners must encourage rural residents to advocate for themselves and make their needs known so that they can receive effective mental health care.

References:

Heflinger, C., & Christens, B. (2006). Rural behavioral health service for children and adolescents: An ecological and community psychology analysis. *Journal of Community Psychology, 34*(4), 379-400.

National Institute of Mental Health (2000, September). Rural Mental Health Research at the National Institute of Mental Health. Retrieved from http://www.nimh.nih.gov/publicat/ruralresfact.htm

Rollins, J. (2010, April). Learning the ropes of rural counseling. *Counseling Today online.* Retrieved from http://ct.counseling.org/2010/04/learning-the-ropes-of-rural-counseling/

Schank, J. A., Haldeman, D. C., Helbok, C. M., & Gallardo, M. E. (2010). Challengesand Benefits of Ethical Small Community Practice. *Professional Psychology Research and Practice* , 502-505.

Walrath, C., Miech, R., Holden, E., Manteuffel, B., Santiago, R., & Leaf, P. (2003). Childfunctioning in rural and nonrural areas: How does it compare when using the service program site as the level analysis? *The Journal of Behavioral Health Service & Research, 30*(4), 452-461.

About the Author:

Paige Nottingham is entering into her last semester in the Clinical Mental Health track at QU. She is currently completing interning as a Substance Abuse Counselor at Hopewell Clinic in Quincy. She really wanted to go into this field because she is interested in serious mental health disorders. Paige currently serves as Secretary for Chi Omega. She also received the Outstanding Graduate Student Award—Clinical Mental Health track—in 2013.

The Struggle:
The Search for a Clinical Mental Health Practicum and Internship

By: Belinda Cullo

The Dream

In the final year of the masters in counseling program, the students are required to secure a practicum/internship site where they can practice their skills, and obtain real world experience working with clients. It's important to note that the responsibility for finding an internship belongs to the student. The University has no hand in this. In the interest of getting on top of things, I started this process in March knowing that my practicum would be beginning in the fall semester. I was sure this would not be an arduous task for me as I felt I had something interesting to offer. Not only did I believe that my particular interest in financial therapy and family systems would be eagerly received, but I am also well spoken, well dressed, and a great student. I was sure that I would be able to find that "just right" internship that would benefit not only the site, but myself as well.

The Reality

The search resulted in a humbling experience to say the least. I contacted no less than 15 places in Quincy, ranging from higher learning institutions, to nursing homes, medical facilities, counseling agencies, as well as private practitioners. The irony is that I did not contact the more sure fire facilities, specifically Recovery Resources, Chaddock, and the Hopewell House. Honestly if I did, I probably wouldn't be writing this article, but frankly, I really didn't want to work with the very specific clientele that all of those places serve. I wanted more of a Full Monty experience. Well guess what? My inquiries were met with everything from suspicion to "Huh?" to "What do you have to do?" to my personal favorite, "We don't do counseling here". You know the saying "When God closes a door he opens a window"? Well, my experience in all of this was more "When God closes a door, another one slams behind it." I was like, "I'm willing to work for free! You have got to be kidding me!" My prospects were getting slimmer.

The Issues

In all fairness, my inability to secure an internship wasn't about me. No one said, "Gee, I'm sorry, but you smell." No one said I was too ugly, too unqualified, too boorish, or anything else of the sort. The real reasons were numerous, and disheartening. In only one situation was it clear that the person really did not want to take on an intern to supervise. She could have, but she just didn't want to, and she framed it in a way that put the onus on me. She basically said I wouldn't be happy because I wouldn't be able to utilize my theoretical orientation, as their center was solution-focused. Whatever! As I previously mentioned, the nursing homes and Veteran's home don't do counseling, so they got knocked out of the running. Our junior college doesn't actually have any professional counselors on staff, although they do have a counseling department. It just so happens that not one of them is able to supervise me, as they are not actually licensed. The private practitioners were probably the most understanding of the bunch, but they had never actually supervised anyone at a master's level before and frankly just didn't have the excess of clients to throw my way. Which brings me to a basic tenet of supervision. Some of the real issue is that the site needs to have the ability to garner clients, often pro-bono, or at a severely discounted rate, to ensure that the intern gets enough direct hours, and the hours are extensive. A couple of places were shocked when I told them I had 700 hours to complete, and they really had no idea how to utilize me for that long.

There were other issues as well. One place couldn't take me on for a practical reason. The supervisor was pregnant, and would be on maternity leave during my practicum, which seemed quite reasonable. Another large agency in town mentioned something about a stipend, and state funding, and that generally they weren't taking on any interns. Fine, but the reason that surprised me the most was a catch-22 dilemma. Here's where the rural counseling issue rears its head. At the two medical facilities in town, both of which were incredibly receptive and wanted to help me out, had their hands tied. The facilities are designated as rural health clinics, and therefore abide by very specific rules. Although they have counselors on staff, neither place is able to take on an intern and be able to meet our criteria stated in our graduation requirements. The interns would not be able to see clients or have their own caseload, and we could only get very minimal hours by maybe offering a parent group. We could sit in on their counseling sessions if the client is amenable to that, but sitting in is not

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considered direct client contact. What made it all worse is that even at the end of internship, hopefully ending in a degree and a license; neither facility will hire an LPC. They only hire LCPC's, which means they require their clinicians to have two years post-graduate supervision. However, neither facility can supervise LPC's since they can't get insurance reimbursement for them. So ultimately, you have to get your post-graduate training somewhere else! Oh, the irony!

Suggestions

I'd like to say that starting early is the answer, but in reality, no one started looking earlier than me. None of the issues I faced had anything to do with a delayed timetable. I do think it helps enormously to be already working in the mental health field, or have some experience in the field. Let's face it. It also doesn't hurt to know someone. Quincy is a small town, and plays by small town rules, and nepotism is one of them. I also think that there might be more possibility at one of the substance abuse clinics in town, as the criteria to be able to counsel is different at such agencies. Let it be known that I cannot speak to the experience that might be had by those on the professional school counseling track. Interning in the schools is a completely different experience, although the hour requirements remain the same. In the end, I never think it hurts to volunteer. It's a great way to meet people, and perhaps get your foot in the door, or alternately, you can do what I did, and get out of dodge. As a last resort, I crossed the river, as well as state lines. I'm doing my internship in Hannibal, Missouri, and although I am gaining great experience and really like where I am, I still intend to practice in Illinois. It would be more beneficial for me to have an internship experience where I can practice within the parameters of Illinois laws and regulations as they apply to the counseling profession.

A Profession Hanging in the Balance

I'd like to say that my experience was unusual, and possibly related to the fact that I am in a rural area, but that's not the case at all. As a member of the American Counseling Association, I receive daily emails from the ACA Forum. Graduate students around the country almost daily are putting out feelers hoping to obtain an internship to fulfill their graduation requirements. I have a friend in a St. Louis graduate program that also struggled with finding a site, even though she already works at a mental health facility.

The real issues speak to why we are having a mental health crisis in this country. Our contribution as a viable profession depends upon graduating counselors. Programs require audio and/or videotaping. Not every place allows videotaping, and not every client does either. HIPPA laws have changed the landscape. The hour requirements are quite different than they used to be as well. Not only are mental health programs more credit hours than ever, but also the internship hour requirements are more extensive. Some people were shocked that I had 700 clock hours to complete. Basically, it's working full time for four months for free. More power to you if you can get paid for your internship, but it's rare. It's even more arduous to attain if you also work full time, as many graduate students do. It's a juggling act trying to get your hours done while working full time, and requires flexibility not only in your own schedule, but also on the part of your practicum site, and your employer as well.

The continuation and growth of our profession hinges upon supervision. Not only to complete graduation requirements and obtain licensure, but also post-graduation. In Illinois, particularly in rural areas, many places will not hire you unless you have completed your two years post licensure supervision and sit for an additional test resulting in your LCPC. The sticking point is that many counselors working in the profession came up at a time when the requirements were not as stringent and therefore don't want to commit to supervision. And frankly, who can blame them? The more difficult it becomes to obtain good supervision and viable employment post-graduation, the more we will lose prospective students to other mental health programs. Unless we as counselors can lobby for Medicare reimbursement, and the same insurance reimbursement that other mental health professionals have, we will continue to be looked at as less qualified by employers.

Professional Responsibility

My experience was very much like the stages of grief described by Elisabeth Kubler-Ross in her groundbreaking book, On Death and Dying (1969). At first I was in denial. I mean, I couldn't believe this was happening to me. Then I was angry, almost belligerent in fact. Shortly thereafter, the bargaining started. I started

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lowering my expectations, and I prayed. When I finally hit depression, I just stopped trying, and almost quit the program. I really couldn't see the point of it all. When I finally reached acceptance, two things happened. The first was that I broadened my scope, and went outside of Illinois and into Missouri. At the recommendation of a dear friend whom I am forever grateful to, I obtained an internship at a Hannibal agency. The second thing that happened was an increase in my level of advocacy and responsibility, not only to my profession, but also to those students who are brave enough and willing to become counselors. It's made me realize the importance of supervising graduate school interns when I become licensed. In fact, it will help to ensure that upcoming counselors are well trained, which will only strengthen our profession as a whole.

Looking ahead, I believe it will also become the responsibility of universities with graduate counseling programs to help to ensure viable internships for their students. As I mentioned earlier, my experience is similar to other graduate students around the country. Frankly, it doesn't seem fair for programs to take students' money, require an internship, and then wish them luck without offering assistance in securing an internship site. Let me be clear that the onus rests on the university, and not the teachers. The teachers have enough to do. There needs to be a relationship between university counseling programs and area community agencies and schools. The profession needs to be continually kept abreast of the changing requirements of upcoming counselors. After all, graduate counselor preparation programs depend upon a viable profession in order to continue to offer the program.

And so, I leave my reader with this: Advocate. Supervise. Fight for your profession and your graduate program. It's in your best interest that we, as licensed professional counselors, can be reimbursed by all insurance companies as well as Medicare. If you are called upon to supervise a student needing to fulfill their program requirements, just say yes. The benefit to you will be the ability to give back, the benefit to your profession will be ensuring the output of competent counselors, and the benefit to your society will be more mental health professionals, and the hope to reach those in need. Help your university make the local connections they need to by starting a list of local schools and agencies that students can intern at, or holding an informational open house. These are but a few ideas, and so I ask you, "How important is your profession to you, and what are you willing to do about it?"

About the Author:

Belinda Cullo is currently in her final year of the counseling program. She recently started her internship at Advance Counseling Services in Hannibal, MO. She is in the Clinical Mental Health track of the MEC program at Quincy University. Belinda is also the Past-President of Chi Omega.

From Rural Student to Rural School Counselor

By: Denise Drebes

When I tell people I graduated high school with 21 students, I always have to add in that I went to public school. Even when I explain I went to a very rural high school, people are still surprised. Currently, I am completing my school counseling internship in a small, rural school. The average class size of this school is around 40 students, which is slightly larger than the school I attended as a student, but still very small. It has been very interesting to transition from a student in a rural school to a school counselor in a rural school. As a student, I saw everything from a student perspective, but now I see everything from the professional point of view.

Dynamics

The dynamics in a small school are much different than the dynamics in a larger school. In small schools, individuals know everything about everyone. During high school, I could tell you where everyone in my class lived, who their parents were, where their parents worked, who their cousins were, and tell you about any legal trouble their family had been in. Of course, having this intimate knowledge of each other and each other's lives is challenging at times. This causes a plethora of rumors to flow, and for many students, this causes ongoing conflicts. When transitioning to a counselor in a rural school, those dynamics make things even more interesting.

There have been many times where students have come into the counseling office and told me about a situation that has occurred. At times up to five students have come in telling me about the same incident. Making sure I don't bring up details that another student has told me is important. I must keep things confidential. Saying something as simple as, "I actually thought Suzy was the one who said that" then shows the student in my office that someone else has talked to me about the incident. Due to the small town atmosphere, the student can probably figure out who has been in to talk to me. The job as the counselor is to be a counselor, not an individual to stir more drama or accidentally expose that another student has reached out to discuss a situation that has been troubling them.

Resources

During high school it wasn't on my radar that there was a lack of resources in our area. I just took things for granted. I did know, of course, that families struggled and there were a lot of really tough situations families were in. Yet I never realized the lack of resources that there truly is in rural areas until becoming a school counselor. I think back to a time in high school where a student needed mental health services and didn't receive them. With the knowledge I have today, I would have referred this student for an evaluation due to some of his behaviors. However, I am certain that did not happen. Looking back, I realize there was no counselor or any mental health services available in my town. An individual had to drive 20 miles to receive mental health services. For this student, he lived with his disabled grandparents. There was no transportation available for him to see the professionals he needed to see.

Most recently at my internship site, we had a student who needed to be referred to see a counselor outside of our school building. However, she has no insurance, Medicare, or money. She does not live with a parent, and where she does live, no one has a car to get her to an appointment. As a counselor, I felt extremely stuck. In the town, there is only one community counselor who actually works out of the doctor's office. She is only in town one day a week and payment is due at the time of the appointment. Due to the influx of people, there are rarely openings. Another issue is that in rural America there is no public transportation. Though the town is small, it is quite a hike to get to the counselor's office. In a more urban area there would have been other options like taxi cabs or city buses. More populated areas also have counselors available who are funded through other means besides insurance, Medicare, or private pay. However, in small towns these types of counselors are not available. Therefore, for this student, seeing a counselor was almost impossible.

Relationships

When I was in high school, my high school guidance counselor also served as my principal as well as a special topics teacher. If you know the role of a guidance counselor, then you know he should have never dueled as both the counselor and the principal. When looking back at his role as a school counselor, his hands were tied and he simply couldn't be the administrator and the counselor. Though he did take care of scholarships and assisted some students with career planning, there were never any counseling groups or any classroom guidance lessons administered. I of course don't know if he met with students individually and did counseling, but to my knowledge he didn't.

Dual roles are interesting and extremely common in small schools as a school

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counselor. Currently, my site supervisor at my internship has dual roles that she deals with daily. Her aunt is the elementary music teacher in the school, several of her cousins go to the school, and she has multiple friends that are parents of students as well as fellow teachers. Luckily for myself, I drive 20 miles to get to my internship. However, even with this bit of separation, there have been multiple times when I have been out with friends in Quincy eating dinner and enjoying an adult beverage and have seen a student from my internship site.

Seclusion

When I was in high school, one of my best friends was gay. He wasn't openly gay; however, he had come out to me. My friend didn't feel comfortable being openly gay in this rural area. Unfortunately some individuals in rural areas are biased when it comes to issues of sexual orientation, race, and gender. Those individuals do not hold back their biases and are openly bigoted. For him, being openly gay wasn't an option. He was secluded. Upon our high school graduation, he started to attend a local community college but didn't end up staying there. At this college he was still secluded. He ended up isolating himself in his home and only maintaining a life online with other individuals who are openly gay. As a person who grew up with him, it has been extremely sad to watch. He feels as if he can't have any life where he lives because of the worldview of individuals in that area. However, it isn't only gay people who are secluded in rural areas. During my internship I have worked with students interested in the Arts, those who like different music, those who are of a different cultural heritage, and students who are of a non-Christian religion. All of those students are secluded and don't feel comfortable in their rural environment. In rural areas there is a strong, dominant culture. Anything that does not go along with this culture is considered "not normal", and at times "wrong", by some individuals. It is hard to see students struggle with not being comfortable just being who they are. Yet it happens daily. As a school counseling intern, I must advocate for these students and ensure that they are not victims of bullying or discrimination.

Conclusion

Needless to say, the issues that affect rural school counselors and individuals living in rural areas are real. Every individual who is a counselor in a rural school has their own stories and their own examples of how these issues have personally affected their career. Ethical codes have holes in them that do not take into account the unique circumstances in which rural counselors find themselves. Individuals who plan to become counselors in rural areas need to be aware of these issues and be ready to deal with them when starting their practice. Though there is a high risk of burnout with being a rural school counselor, I have also found the reward to be high. Being able to show students daily that they have potential to become someone is great. Helping these students through their struggles and being someone a student can depend on is extremely fulfilling. Along with this, simply meeting and establishing relationships with so many great students is extremely rewarding. I hope that individuals can strive in this profession as school counselors in rural areas.

About the Author:

Denise Drebes is in the final stages of completing her Master's Degree in School Counseling from Quincy University. While completing her coursework, Denise worked as a Graduate Assistant of Events in the Office of Student Affairs at QU. She is a past-treasurer of Chi Omega. She was also part of the team who presented about rural issues at both the ICA Southern Conference as well as the ICA State conference. Denise and Dr. Andrea Fifield will be traveling in March for a poster presentation in Honolulu, Hawaii at the American Counseling Association Annual Conference. Denise recently accepted a position as the District Manager for Junior Achievement in the Hannibal and Quincy area.