Social Justice Advocacy in Rural Communities: Practical Issues and Implications

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Abstract

The professional literature related to social justice has increased, but there has been little discussion of the practical issues and implications associated with social advocacy. However, adding new roles will result in new considerations for counseling psychologists. The need to be attuned to how the practical aspects of advocacy intersect with the context of psychological work may be especially present in rural areas where practitioners may be more involved in the community and thus their actions highly visible. Because the data indicate that rural communities may have few resources, a limited number of mental health professionals, and higher rates of mental illness, psychologists practicing in these areas may feel compelled to engage in advocacy. Yet there is little practical guidance for these psychologists. Therefore, the authors present considerations for social justice advocacy in rural areas, using the American Counseling Association advocacy competencies as an organizing framework.

Keywords

social justice, advocacy, rural, small communities, counseling psychology

Moral conduct and justice are issues that have been debated and discussed for thousands of years by philosophers dating back to the ancient Greeks.

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(e.g., Aristotle and Socrates) as well as more contemporary activists such as Paulo Friere and Simone de Beauvoir. Although differences exist between and within cultures, the discussion of what is right or just in any given society has endured.

Similarly, the field of counseling psychology has been examining the issue of social justice for decades (Fouad, Gerstein, & Toporek, 2006; Fouad et al., 2004). However, whereas earlier literature in the field appeared to focus on defining social justice, the current emphasis appears to be shifting to taking action in order to promote social justice (e.g., Blustein, 2006; Blustein, McWhirter, & Perry, 2005; Goodman et al., 2004; Ivey & Collins, 2003; Palmer, 2004; Pieterse, Evans, Risner-Butner, Collins, & Mason, 2009; Singh et al., 2010; Speight & Vera, 2004; Toporek, Gerstein, Fouad, Roysircar, & Israel, 2006; Vera & Speight, 2003; Watts, 2004; Werth, Borges, McNally, Maguire, & Britton, 2008).

Yet it will be important for counseling psychologists to consider the context in which they practice prior to taking action. For example, in urban areas a psychologist might not think twice about having a bumper sticker addressing a social issue on her car or posting a sign in his yard promoting a political figure. However, in rural areas, current and potential future clients may see the psychologist driving around town or go by the professional’s home on a regular basis and, knowing who drives the car or lives in the house, may not distinguish between the psychologist’s personal social/political beliefs and professional practice considerations. This could have a significant impact on the therapist’s client base, depending on whether the psychologist’s choices are similar to the majority of community members.

Thus, although we have appreciated the increased attention to social justice in the counseling psychology literature, we want to continue to move the field forward from global perspectives to more focused discussion of issues and implications practitioners may need to consider when taking social justice advocacy action. Because context matters (Verges, 2010), instead of discussing social justice in a vacuum, we focus on a particular kind of setting in order to illustrate some of the overarching considerations. Specifically, we discuss the practical implications that psychologists and other mental health professionals may need to take into account when considering engaging in social justice advocacy in rural communities. Although our focus is on rural areas, the literature is clear that there are other types of small communities that share some similar characteristics (see, e.g., Schank & Skovholt, 2006). Therefore, the general issues we raise may be relevant to psychologists who work with specific groups or in special settings (e.g., the military; lesbian, gay, bisexual, and transgender communities; and ethnic groups residing in a particular region; Schank, Helbok, Haldeman, & Gallardo, 2010).
Because readers may not be familiar with some of the characteristics of rural communities that make practicing in these areas different from urban work, we begin with a brief review of special considerations in rural practice. As rural residents ourselves, we highlight some of the struggles and difficulties faced by people in rural areas to emphasize the point we are making about the need for advocacy, not because we wish to pathologize members of rural communities. We then introduce the American Counseling Association (ACA; Lewis, Arnold, House, & Toporek, 2003) Advocacy Competencies as a framework for organizing the types of practical issues that counseling psychologists may want to consider. Next, we bring together these two areas and discuss several matters that mental health professionals may want to reflect on when considering engaging in social justice work in rural communities. We incorporate aspects of the American Psychological Association (APA, 2010) ethics code into this discussion. We conclude by proposing directions for research to provide an empirical examination of our hypothetical and anecdotal perspectives.

**Rural Communities**

There are many definitions of rural, and various governmental agencies, researchers, and policy makers will choose different definitions depending on their needs (United States Department of Agriculture, 2008). For example, definitions may be used to target resources and for health-related research purposes (Hart, Larson, & Lishner, 2005). Various experts have examined the characteristics of rural communities and the values of people who live in these areas (Campbell, Richie, & Hargrove, 2003; DeLeon, Wakefield, Schultz, Williams, & VandenBos, 1989; Hargrove, 1986; Schank, 1994; Schank & Skovholt, 2006; Slama, 2004; Wagenfield, 2003). Residents of rural communities may have strong kinship ties and often have multiple family members who reside in the same community. A strong sense of self-reliance among rural individuals may be a barrier that prevents outsiders from gaining the trust of community members. Relationships are often interdependent and may have strong political, familial, social, or historical roots (Hargrove, 1986; Helbok, 2003; Schank, 1994).

The research also indicates that residents of rural communities may have scarce resources, high rates of poverty, less formal education, higher illiteracy rates, limited insurance coverage, higher rates of disabilities, fewer mental health resources, and less access to employment than people living in urban or suburban areas (Campbell et al., 2003; Wagenfield, 2003). In addition, rural persons may have less access to governmental, community, and private resources because public transportation is often unavailable and maintaining
personal transportation may be impossible for those who are impoverished. These factors can lead to difficulties accessing health care, rehabilitation, educational, and/or employment services.

Because there is significant stigma in rural areas associated with having mental health issues or needing to see a mental health professional (Larson & Corrigan, 2010; Pullman, VanHooser, Hoffman, & Heflinger, 2010; Schank & Skovholt, 2006; Stamm et al., 2003), rural community members may be less likely to seek out the services of a counseling psychologist than urban or suburban residents. This is cause for concern given the significant need for mental health services in rural communities. Rates of mood and anxiety disorders, trauma, and developmental and psychotic disorders are at least as high as the rates in urban areas, where professionals and transportation to services may be more readily available, thus inhibiting opportunities for adequate care in rural areas as opposed to urban communities (Roberts, Battaglia, & Epstein, 1999). There are some mental health problems that are more frequent in rural areas than in other communities, including suicide (Roberts et al., 1999), alcohol abuse, and chronic illness (Wagenfield, 2003). However, there may be few providers of mental health services in rural areas because of difficulties recruiting and retaining personnel (Schank & Skovholt, 2006). These types of issues must be taken into account by advocacy-minded practitioners because the combination of high rates of mental illness; low rates of protective supports such as insurance, literacy, education, and employment; and limited access to and presence of resources can place rural residents in a position where social justice advocacy may be especially needed.

Challenges for Mental Health Practitioners in Rural Areas

The practice of psychology in rural communities can be rife with challenges that will require diligence on behalf of the mental health professional, especially those unfamiliar with the dynamics of rural areas (Helbok, 2003; Roberts et al., 1999; Schank, 1994; Schank & Skovholt, 2006; Turchik, Karpenko, Hammers, & McNamara, 2007; Werth, Hastings, & Riding-Malon, 2010). In this section, we provide a brief overview of these practical considerations because this material provides the context for a general understanding of challenges that are present for rural mental health professionals that will be helpful to have in place before incorporating the additional considerations that social justice advocacy may involve.

Many rural areas have few, if any, mental health service providers (Helbok, Marinelli, & Walls, 2006; Schank & Skovholt, 2006). Thus, Keller, Murray, Hargrove, and Dengerink (1983) stated that the:
single most accepted element for rural mental health training is that such persons must be generalists. … [T]he same individual may be required to provide services to children; senior citizens; marital couples; deinstitutionalized, chronically mentally ill; persons in crisis; and alcoholics. (p. 14)

As a result, mental health professionals in these areas may encounter issues related to competence. Often the question becomes how far one can stretch one’s expertise in working with clients (Helbok et al., 2006).

In addition, practitioners are often highly visible in rural communities and may be unable to maintain anonymity. Schank and Skovholt (2006) highlighted the importance of considering all community members as potential clients: “Even if each person in a small community is not a prospective client, it is likely that clients or prospective clients are connected to others through business, social, or familial relationships” (p. 37). In fact, it may be detrimental to the rural mental health professional to not become involved in the community because he or she may be judged more on the basis of personal image than professional abilities (Schank & Skovholt, 2006). Consequently, rural mental health professionals “need to function in a variety of community-oriented roles” (Murray & Keller, 1991, p. 227), such as member of a religious group, youth sports coach, board of directors member, or educational consultant. Being involved in the community will assist in developing trust and acceptance from rural residents. The consequence of such involvement, however, is that engaging in multiple relationships with clients or potential clients often becomes unavoidable for rural practitioners (Helbok, 2003; Schank & Skovholt, 2006). Business, professional, and personal relationships need to be developed with a limited number of people (Schank, 1994; Schank & Skovholt, 2006). Therefore, rural mental health professionals often encounter dilemmas related to multiple relationships (Helbok et al., 2006).

On a related note, rural communities have been compared to fishbowls (Roberts et al., 1999), which leads to difficulties for mental health practitioners, who must maintain confidentiality. Informal information sharing and gathering networks often exist and make privacy difficult for community members. For example, clients may be seen entering or exiting the practitioner’s office by other community members. Additionally, clients who have referred other community members for treatment may inquire about their progress (Helbok et al., 2006). It may also be difficult to discern between information provided by the client versus information attained in the community. Therefore, rural practitioners must be diligent in maintaining client confidentiality.

The issues of competence, multiple relationships, and confidentiality can be difficult for the typical rural mental health practitioner and more has been
written about each of these topics in an effort to help rural providers manage the dynamics of living and practicing in a rural area (e.g., Helbok, 2003; Schank & Skovholt, 2006; Werth et al., 2010). The addition of social justice advocacy presents another layer of considerations for the rural practitioner. Before detailing the resultant challenges, we provide a framework for discussing advocacy interventions.

Social Justice Advocacy Competencies

There are many ways that a mental health practitioner might advocate for clients. The APA has not established competencies or identified skills that are needed in order to advocate for clients or client groups. However, the American Counseling Association (ACA) has developed advocacy competencies (Lewis et al., 2003) that provide a good framework for discussing roles and responsibilities of mental health professionals who want to engage in social justice work.

The ACA identified six advocacy competency domains, which are organized along two axes. Charted vertically, the first axis, “Extent of Client/Student Involvement,” consists of two levels: (1) Acting With Clients/Students and (2) Acting on Behalf of Clients (Lewis et al., 2003; see Table 1). Acting With Clients entails equipping people with knowledge and skills enabling them to view their lives in context and to act on their own behalf. A counseling psychologist Acting With Clients would likely limit his or her social justice involvement to the therapeutic setting, introducing clients to available resources and helping them understand and negotiate social, political, or economic barriers. Equipped with this knowledge and the new skills, clients would then be empowered to advocate for themselves. When Acting on Behalf of Clients, a counseling psychologist may access resources for the client directly or coordinate with other helpers to intervene for the client’s well-being. Acting on Behalf of Clients may be deemed necessary when the psychologist is working with underserved or vulnerable populations.

The horizontally oriented axis, “Level of Intervention,” is divided into three categories: Microlevel, Mesolevel, and Macrolevel. When operating in the microlevel, the psychologist’s involvement is primarily with the client. In the mesolevel, the psychologist moves beyond the client to include the client’s support system or immediate community, while in the third level, the psychologist operates in more expansive social, cultural, or political terrain.

The resulting 2 × 3 model features six cells: (a) client/student empowerment, (b) client/student advocacy, (c) community collaboration, (d) systems advocacy, (e) public information, and (f) social/political advocacy. Each domain entails a number of skills required of the counselor, resulting in a total
of 43 specific competencies that assist in explaining what social justice advocacy might look like as well as highlight the various levels of involvement for a mental health professional. Because it would be unwieldy to include all of the specific competencies here, below we outline each of the six large “Advocacy Competency Domains” and provide examples of the specific competencies. In the next major section, we explore how each of these domains might look in a rural setting.

**Client/Student Empowerment**

Empowerment of clients/students is considered a microlevel intervention that allows the client/student to act on her or his own behalf (Lewis et al., 2003). A counseling psychologist can help a client/student advocate for herself or himself by assisting the client with “identifying the external barriers that affect his or her development” and “training students and clients for themselves.

<table>
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<tr>
<th>Acting With</th>
<th>Client/Student Empowerment</th>
<th>Community Collaboration</th>
<th>Public Information</th>
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<tr>
<td>Helping people name external barriers, equipping them with skills, and helping them advocate for themselves.</td>
<td>Equipping community organizations to act on behalf of their constituents. Identifying both the environmental barriers and the group’s strengths which can be applied to implement change.</td>
<td>Sharing information with the general public to help others decide whether to make changes.</td>
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<th>Acting on Behalf</th>
<th>Client/Student Advocacy</th>
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<th>Social/Political Advocacy</th>
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<td>Assisting people in accessing allies to overcome barriers.</td>
<td>Assisting people in accessing allies to overcome barriers.</td>
<td>Providing leadership to illuminate problems, collaborating with others to envision and work toward change.</td>
<td>Partnering with allies to promote dialogue and lobby leaders for change.</td>
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*Source: Adapted from Lewis et al. (2003). Reprinted with permission. No further reproduction authorized without written permission from the American Counseling Association.*
The mental health professional may go so far as to “assist students and clients in carrying out action plans” (p. 1).

**Client/Student Advocacy**

A client/student advocacy role is still a microlevel intervention but entails a greater degree of acting on behalf of the client or student, and this may be particularly relevant when working with members of underserved groups (Lewis et al., 2003). Counseling psychologists acting on behalf of clients/students can help them “gain access to needed resources” and “identify potential allies for confronting the barriers” experienced by the clients/students as well as “carry[ing] out the plan of action” (Lewis et al., 2003, p. 2).

**Community Collaboration**

Moving into a community collaborator role shifts to the mesolevel and has the counseling psychologist helping community organizations to act on behalf of their constituents (Lewis et al., 2003). In this role, counseling psychologists could “identify environmental factors that impinge upon students’ and clients’ development,” “identify the strengths and resources that the group members bring to the process of systemic change,” and “assess the effect of the counselor’s interaction with the community” (Lewis et al., 2003, p. 2), among other activities.

**Systems Advocacy**

In systems advocacy, the counseling psychologist is operating at the mesolevel but is taking a leadership position in making change happen (Lewis et al., 2003). In other words, instead of helping others to effect system-level changes, here the counseling psychologist would be publicly identified as a force for change. Some activities include “provide and interpret data to show the urgency for change”; “in collaboration with other stakeholders, develop a vision for change”; “develop a step-by-step plan for implementing the change process”; and “recognize and deal with resistance” (Lewis et al., 2003, p. 2).

**Public Information**

The public information approach is a macrolevel intervention where the counseling psychologist would share information with others and let the general public decide whether to make changes (Lewis et al., 2003). The psychologist could “recognize the impact of oppression and other barriers to health...”
development,” “identify environmental factors that are protective of health development,” and “disseminate information through a variety of media” (Lewis et al., 2003, p. 3).

**Social/Political Advocacy**

Finally, with social or political advocacy, the counseling psychologist would take an active, macrolevel approach and attempt to be a change agent around an issue that impacts a significant number of people (Lewis et al., 2003). Among the actions in this domain are “with allies, prepare convincing data and rationale for change”; “with allies, lobby legislators and other policy makers”; and “maintain open dialogue with communities and clients to ensure that the social/political advocacy is consistent with the initial goals” (Lewis et al., 2003, p. 3).

**Summary**

The ACA competencies offer specific ways that mental health professionals can engage in social justice advocacy. These competencies allow practitioners to delineate the different forms of advocacy and identify those in which they might be proficient as well as those that they may need to develop further in order to advocate effectively within a specific arena. A given problem could be addressed through a single approach or a combination, and different professionals may use different mechanisms to respond to a similar problem. Our focus here is not on which approach is best but rather on the fact that there are practical issues and implications associated with each of the advocacy domains.

Although ethical considerations are not mentioned within the ACA competency standards (Lewis et al., 2003), the importance of considering the ethical implications of one’s actions and the need to identify the ethical issues that may arise when advocating should be clear. Furthermore, because contextual issues may alter the available methods for advocacy, mental health professionals will have to adapt their advocacy efforts and take into account the ethical issues that arise in their specific environment.

**Practical Issues and Implications Associated With Social Justice Advocacy in Rural Areas**

When counseling psychologists decide to advocate for clients or participate in social justice activities, there are a variety of issues and implications that must be considered. For example, at a fundamental level, should one work to
empower a client to act for himself or herself or be an active advocate on behalf of the client, or is either of these a step beyond what is acceptable? A variety of factors associated with the client, the psychologist, the therapeutic alliance, and the context will affect the decision regarding in which direction one will go.

We contend that there are factors in rural areas and other forms of small communities that counseling psychologists need to take into account regarding social justice advocacy work above and beyond the basic issues that are present in any counseling situation. As we noted earlier, the primary issues that are discussed in the rural practice literature are competence, multiple relationships, and confidentiality. These underlying issues lead to additional considerations of practical issues for the psychologist because rural psychologists not only serve a small community but are often part of the same community. Thus, the rural practitioner is faced with the complications associated with being a professional and person within a rural community, as opposed to being seen by clients only in a professional role, as is the case in larger areas.

In addition to the shortage of practitioners in rural communities and associated ethical issues such as multiple relationships are several practical considerations that must be part of a psychologist’s analysis of whether to engage in social advocacy action. Here, we focus on limited time, role identification issues, and values conflicts as notable issues that may be present for rural practitioners who want to do social justice advocacy work. Although similar matters may be present with urban/suburban psychologists, below we expand on why these areas need special consideration by the rural therapist who is considering involvement in social justice advocacy.

Within each of the three areas, we include two case examples highlighting how a psychologist wishing to incorporate the ACA advocacy competency domains (Lewis et al., 2003) may need to take into account contextual considerations in rural communities. We then provide optional courses of action. However, these are merely suggestions and any changes in context could influence the decision-making process. It is important to note that these are only examples of potential advocacy opportunities that could exist in most communities and are not meant to reflect negatively on rural communities or representative of rural problems. There are many differences in the issues that rural communities may face. The ideas reviewed subsequently are limited to the information found within the literature, our own professional experience, and consultation with other professionals. Hence, the information awaits empirical confirmation—a point to which we return in the concluding section of the article.
Before moving to these three examples of practical considerations, we first need to discuss the overarching issue of possible damage to the community. In other words, because of the nature of rural areas, it would be easier for the psychologist’s actions to disrupt the functioning of the community, whereas it is unlikely that a psychologist (who is not a politician) would have enough power to cause significant disruption in a suburban or urban area. Thus, when one is considering whether to take actions that might affect a rural community, it would be important to consider the variety of possible effects and repercussions that may occur and the many and varied types of implications for large numbers of people. This may be difficult for the psychologist to do. Individual treatment usually allows for relatively easy identification of the parties of interest; however, when doing social advocacy, the entire town and perhaps others outside the area may be affected by one’s actions. Thus, if a professional takes action with the intention of benefiting the community, the practitioner would be required to take “reasonable steps” to avoid harm, which may require different considerations from the standard process used in therapeutic situations (Toporek & Williams, 2006).

Recognizing the difficulty associated with this issue, Pope (1990) recommended a “human impact report” (p. 54) that would examine the short- and long-term effects of the intervention on all aspects of community life. Pope noted that small communities may be relatively stable and develop an informal structure of leadership. If the practitioner engages in social justice advocacy, then these actions have the potential to disrupt natural leadership, decrease community cohesion, and/or produce a sense of dependency. If this could occur, then working with community members will be an important aspect in maintaining community involvement and support and therefore minimizing harm. Pope offered several questions, which are paraphrased here, to assist in considering the impact on a community:

- What are the possibilities of direct harm to the people being treated and to those directly affected (e.g., families, communities)?
- If a particular community is the focus of an intervention, in what way could the community itself suffer harm through the intervention?
- To what degree can we anticipate damage that might have a delayed onset?
- What effects that might be considered harmful could occur in the context of the community’s relationship with the larger society?

Although Pope was focused on prevention-related interventions, the considerations he presented are directly relevant because they present many of the
same dilemmas that may be involved in social justice advocacy efforts. In addition, prevention may be a form of social justice advocacy. Obviously, this type of effort could be very time-consuming and labor-intensive, which leads to the first major practical consideration.

**Time Management**

Although the issue of limited time is not unique to rural practitioners (e.g., providers working in any overburdened system, such as university counseling centers or community mental health centers have to make decisions about how to spend their time), it may be especially pressing because of the small number of professionals combined with multiple needs. Because it is likely that there are few other mental health practitioners in rural communities, it may be difficult to take on time-consuming advocacy work. Urban and suburban psychologists often have several referral sources if their own waiting list becomes too long or if a client presents with an issue outside of the therapist’s comfort zone. Potential clients can go elsewhere and self-pay or be referred to another provider through their insurance carrier. Thus, compared to the rural practitioner, the urban/suburban therapist may not feel the same pull to add a client, including one presenting with an unfamiliar issue, to an already full schedule—especially if some of the time had been blocked off for advocacy work instead of already being filled with clients. The rural practitioner knows that if she does not add the person to her current caseload (e.g., because she is going to be using time that would usually be assigned to clients to spend on advocacy efforts), the client will not receive services for what may be a substantial period of time, if the client is even willing to return at a later date. Given the well-documented stigma associated with receiving mental health care in rural areas (Larson & Corrigan, 2010; Pullman et al., 2010; Schank & Skovholt, 2006; Stamm et al., 2003), not accepting a client immediately may mean that the psychologist has lost the window of opportunity with this person. Thus, because rural practitioners are expected to be ready and able to see any client presenting with any issue at any point in time, the therapist may find it difficult to justify to clients or herself that time is better spent in advocacy efforts than in sessions with clients.

Yet although still time-consuming, when there are other practitioners who are interested in advocacy, collaboration may be possible. Collaboration has been identified as a competency area for social justice advocacy (Dean, 2009; Lewis et al., 2003). Multidisciplinary expertise and support are important aspects of professional collaboration, but the most practical advantage may be the dispersion of duties and time invested in social advocacy. Advocacy efforts could become much more realistic if the professional could share the
load with others. Addressing global advocacy issues, rather than those specific to one’s own area, may make finding common ground with practitioners located in other communities easier. In addition, technology could make communication much easier for the practitioner and could be a way to bridge the distance gap between rural community practitioners and colleagues. However, face-to-face interaction and common community connections may be important motivational factors.

**Client Advocacy Example**

A client is involved in a custody dispute and the practitioner believes that the client is not being treated fairly because of a lack of resources and lack of knowledge about how to navigate the process. The practitioner decides to develop a plan to maximize the likelihood of the client receiving fair treatment and decides to assist the client in taking action. In an urban setting, this might simply require a referral to services that are readily available. However, the rural practitioner may have to actually do much of the work, such as assisting the client with finding affordable legal counsel or providing the client with education related to the steps necessary to navigate the court process and perhaps even accompanying the client to appointments or the hearing itself. These services would not be reimbursable and could quickly become time consuming (thereby taking time away from seeing other clients) if the provider is acting alone.

One of the most obvious options is to try and work within the existing system to garner support for the client and not overburden the practitioner. This would largely depend on whether there are existing services available in the community, the practitioner’s awareness of those services, and the relationships between the practitioner and vital persons in the existing system.

On the other hand, the practitioner may decide not to become involved because of the consequences (e.g., the amount of time this effort will take). If this were the case, the practitioner could become involved in advocating for resources for persons in the client’s situation. This could potentially be a less time-consuming form of advocacy with a longer lasting impact.

**Systems Advocacy Example**

Through her work with clients, a psychologist identifies a significant problem with opiate abuse in her community. Around 25% of her cases are individuals who have a diagnosis of opiate abuse or dependence. Additionally, the practitioner attends church with several community members who have been directly or indirectly affected by the problem. She is aware of grants available to
assist with funding to expand services for individuals with acute substance abuse problems. She is the only mental health practitioner in the area and maintains a full caseload. However, she does have some grant writing experience and feels compelled to take action.

She decides to talk to the community physician and to an informal community leader. Both individuals agree that there is a significant problem and something needs to be done but the physician is already working 50 hours a week. The informal leader works a full-time job and volunteers in the community several hours a week. They are motivated to help but believe that taking time away from their jobs to write the proposal would be problematic. The psychologist offers to write the grant with an agreement that the proposal will involve a commitment from the others to participate, if the grant is funded.

In this example, the practitioner was able to utilize a systems approach within her community to make advocacy possible. If systems advocacy had not worked or had not been an option, then the practitioner could have taken a client empowerment approach and provided support to clients while they sought funding. Alternatively, she could have made the grant information known to community leaders and served in a more limited role as a consultant, taking an approach more akin to community collaboration.

Role Identification

With calls to social action becoming more pronounced in counseling psychology, there is an accompanying need to clarify the role of the practitioner. Although the psychologist may want to believe the role of community member is distinct from the professional role, this will likely not be the case among rural community members (Schank & Skovholt, 2006). Pipes, Holstein, and Aguirre (2005) pointed out the importance of context when identifying roles: “What might constitute personal behavior in a large urban setting might constitute professional behavior in a small community” (p. 332). Because of the overlapping roles, multiple relationships, and close connections among residents that are present in rural areas, it may be important to consider that any social action that is taken will reflect on the therapist as both a practitioner and a community member. In other words, in a fellow resident’s eyes, the behavior is what is important, not the role the psychologist asserts he or she was in while acting in this way (Schank, 1994).

Under the current APA (2010) ethics code, once behavior is defined as personal, the enforceable standards present in the ethics code become moot (Pipes et al., 2005). However, there are obvious implications related to role identification when one engages in social action. The APA (2010) ethical requirement
to minimize harm (Aspirational Goal A; Enforceable Standard 3.04) must be considered, because social action may have the potential to cause harm to clients. Furthermore, if a practitioner chooses to act within his or her professional role, all aspects of the ethics code would presumably apply. When action is taken in a personal role, the practitioner may have more flexibility as far as the APA ethics code is concerned but will likely be held accountable by the community in various informal ways. Depending on how controversial the action taken by the psychologist is, some negative repercussions could include (but not be limited to) a decrease in personal interactions, refusal to utilize professional services provided by the practitioner, or talking about the practitioner in a negative way. On the other hand, there could be positive effects, such as increased professional referrals and improved personal standing in the community. Therefore, because the line between professional and personal roles is unclear when considering social action in rural areas, the safest approach might be to consider personal and professional actions as indistinguishable to community members.

**Client Empowerment Example**

As noted earlier, one of the major issues in rural areas is confidentiality. Combine this with the fact that many community members will know the psychologist’s job and therefore be curious and make assumptions about who is on the therapist’s caseload and it becomes clear that many clients will be more interested in empowerment than advocacy because they can do things on their own without being identified as a client of the psychologist.

A young adult gay man who was concerned about how he had been bullied and physically assaulted while growing up wanted to do something to help current children and adolescents grow up in a more accepting environment. After much discussion with his therapist, who was well-known in the community, the client decided that he wanted help dealing with social anxiety and in finding resources for opportunities to help youth rather than have the psychologist find or develop contacts and options for him. In this way, the client felt empowered without being outed, as he feared would happen if the therapist took on an advocacy role.

If the client had decided that he did want the therapist to advocate on his behalf, then the original informed consent material would need to be revisited along with additional considerations. Considerations would need to include the limits of confidentiality given the communication occurring in a small community. It would also be prudent for the psychologist to thoroughly discuss the limits of advocacy and not create unrealistic expectations that may not be realized and could potentially be disempowering.
Advocating at a systemic level for youth would also be an option for the psychologist. This might involve working within the community, state, or federal level to address bullying in rural areas. Providing education and information to the local schools and community about the issue of bullying would be another option. This could be done by presenting information to school personnel, students, or parents in the community.

**Public Information Example**

The local school principal is concerned with corporal punishment toward children in the community. The principal is aware that the mental health practitioner completed research on the topic and asks the practitioner to put together a packet of information for parents. Eager to share her knowledge and because of her own growing concern, she readily agrees. When some of the parents ask the principal where the information came from, the principal informs them that the practitioner put together the information in hopes that this would make it more reliable. Within a few days, most parents are aware of the practitioner’s involvement. Many of the community members decide that they would rather go without mental health treatment because of fear of judgment by the practitioner, so the therapist sees her referrals decline. Additionally, the practitioner notices that community members are less likely to be candid with her in public and rarely discuss issues related to raising their children.

The practitioner could have taken a more collaborative approach and worked with school counselors to develop the information, which could have led to shared responsibility for the information. If the practitioner could have foreseen the possible consequences, then she could have talked to the principal ahead of time to ensure the fact that she was the source of the information would be confidential. The psychologist could have offered her time to answer questions related to parenting practices at a parent-teacher meeting. At the meeting, she could have made it more explicit that she was providing information from the professional research available on the topic. This could have limited the assumptions made by community members and possibly led to a more defined role regarding her perspective.

**Values Conflicts**

Practitioners may have different values from members of the community in which they practice (Knapp & VandeCreek, 2007; Schank, 1994; Schank & Skovholt, 2006). Social advocacy actions taken by rural mental health professionals probably will be noticed and discussed by community members given
the high visibility of the practitioner. The type of social advocacy as well as the degree of controversy (and therefore the potential for divisiveness) of the issue will invariably influence community conversation. Because of the role identification issues just mentioned, if the advocacy position taken by the professional conflicts with the perspective held by a large number of community members, this could be detrimental to the practitioner both professionally and personally. In addition, family members of the practitioner may also be negatively affected by the counselor’s advocacy efforts (Schank, 1994; Schank & Skovholt, 2006), with partners/spouses and children being ostracized, criticized, and targeted as extensions of the psychologist.

The fundamental question of whether a mental health provider should see clients with differing values is an important one. Some may believe that it would be best to have a mental health provider with similar values to the client, but this may not be possible in rural areas because of the limited number of therapists. Thus, it would seem inevitable that differences in values will arise. The next consideration would then be whether the therapist should reveal this to the client. We do not believe we can make an unequivocal statement in this regard; however, in rural areas, the beliefs of the counselor may be known or assumed by clients because of the visibility of the therapist. Thus, it may be worthwhile for the therapist to discuss the similarities or differences in values and process the impact this may have on the ability to work together. In this last set of examples, we provide two approaches to the same issue in order to highlight the different outcomes from two different approaches to social justice advocacy.

**Political/Social Advocacy Example**

A psychologist in central Appalachia is concerned with surface mining (aka, “mountain top removal coal mining”). The practitioner may value environmental protection and believe that there are multiple negative consequences associated with surface mining for the community members. However, he has many clients who are employed directly or indirectly through surface mining while other clients are strongly in favor of eliminating surface mining. The practitioner decides to collaborate with a local advocacy group with the goal of ensuring that relevant Environmental Protection Agency standards are followed. However, many residents value the practice because it provides jobs, and therefore, they may be more accepting of the detrimental effects of the practice than the psychologist is. Since he became involved in advocating against this form of mining, he notices that his client base has dropped dramatically, his children have been complaining of being picked on at school, and some of his friends
no longer speak to him. Additionally, he had a few clients become very angry with him and told him that they would not support someone’s income at the same time that he that was trying to take their jobs away.

**Community Collaboration Example**

Consider the same situation as above, but instead of the psychologist taking the lead in fighting surface mining (perhaps in opposition to the views of many community members), the psychologist responds to requests from a local organization to design a study to determine the level of community support for the practice. Here, the psychologist would be acting as a scientist instead of an advocate. The decision about what to do with the data would be left to the organization that commissioned the research. This role might be much more palatable to the practitioner who is concerned that taking one side or the other might cost him clients.

The practitioner could take a client empowerment approach with one of his clients who was already involved in advocacy related to the issue. However, there are numerous considerations to empowering the client to become more involved or effective in advocacy as this might increase the chances of negative consequences to the client. Alternatively, the practitioner could take a less visible political advocacy approach that involved advocacy efforts more removed from the local community. This might include presenting information related to surface mining at professional conferences or donating money to organizations that are supportive of his position on the issue.

**Conclusion**

The process of social justice advocacy can vary greatly depending on many factors, including the size of the community in which professionals live and work. Rural areas can be unique and rewarding places to practice (Schank & Skovholt, 2006) but might require consideration of special issues when a counseling psychologist is debating about whether to engage in advocacy.

Thus, we believe much more discussion needs to occur regarding what rural practitioners think about and actually do when it comes to social justice advocacy work in rural communities. We hope that research will help us better understand the types of social justice advocacy activities practitioners in rural communities are performing and the practical issues they face. It would be helpful to understand more about the decision-making processes that rural practitioners make when faced with dilemmas associated with social justice advocacy efforts, what they feared would happen, what steps they took
to reduce the likelihood of negative consequences for them and their clients and communities, and what lessons and wisdom they can share with others who want to take action. Furthermore, a better understanding of how other small communities may differ and how the considerations addressed in this article interact with those communities would help expand our understanding of social justice advocacy in small communities.

Although we have focused on rural communities, we believe that the considerations discussed have relevance to other small communities. Given that opportunities for social justice advocacy are abundant and likely exist in most communities, it will be important for practitioners to engage in considerable reflection before taking action. We hope that the issues raised in this article will lead to more social justice advocacy by counseling psychologists.

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