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Exploring the Experiences of Counselors Responding to Crisis in Rural Communities

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Responding to clients/students who are threatening harm to self or others is often perceived as a demanding and challenging job for any clinician, especially for those working with limited resources in rural communities. This research explored the experiences of clinical mental health and school counselors who respond to those types of crises within four different states in communities of 9,000 or fewer residents. Using face-to-face and synchronous online interviews, five themes were identified through phenomenological analysis, including collaboration, training, staffing, distance, and time. Though each clinician identified ample opportunities for crisis response improvement within their communities, there was a sense of pride working in small communities where the residents are familiar with one another and offer individualized support not often found in larger cities. Overall, what emerged from this study is the importance of highlighting clinicians' needs in smaller communities as their stories and experiences are often lost to the trauma and crises happening in metropolises.

Public Health Significance Statement

Through this study, a voice was given to counselors in rural communities regarding their experiences in crisis response. We wanted to highlight the shortcomings of rural crisis response and increase awareness within the healthcare system about these small communities' plight. Five themes that were discovered include collaboration, training, staffing, distance, and time, which demonstrated that smaller communities tend to benefit when collaboration and communication occur.

Keywords: crisis, clinical mental health counselor, school counselor, rural community, phenomenological analysis

Suicidal ideation, self-harm, and the desire to harm others are all forms of crisis that mental health workers encounter frequently. In a recent study by The Center for Discovery (2018), 15% of adolescents and between 17% and 35% of college students engaged in some form of self-harm behavior, an increase in over 5%–10% in the last 5 years. Klonsky et al. (2013) found that almost half of people who self-harm reported at least one suicide attempt. Schweitzer et al. (2011) addressed similar concerns by disclosing that those in rural agricultural settings, wherein fewer mental health services are accessed, were more susceptible to depression and male suicide.

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This research was previously discussed in two presentations, the first was in October 2019, presenters Suzanne L. Scott, A. Petty, and R. A. Edelman titled *School Counselor's Role Supporting Students Living With Trauma*. The second presentation was in February 2020, presenters Suzanne L. Scott and R. A. Edelman titled *Self Compassion and the Power of Play*.

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Even more profound is that suicide rates are generally higher in rural areas where access to resources is limited (Hirsch, 2006). From 2015 to 2018, rural suicide completion rates averaged approximately 19 for every 100,000 residents versus about 13 for every 100,000 residents in urban areas (Centers for Disease Control and Prevention, 2020). Fontanella et al. (2015) asserted that this gap between urban and rural suicides had continued widening over the past 15 years. With rural suicide rates surpassing urban rates over the past decade and a half, there is significant concern that social isolation and loneliness stemming from 2020s Coronavirus will further increase rural suicide completions (Monteith et al., 2021).

Less research has examined the prevalence of homicide/homicidal ideation within rural communities, though existing statistics are still concerning. According to the Centers for Disease Control and Prevention (2020), between 2015 and 2018, there were approximately five homicides per 100,000 residents in rural communities compared to approximately six homicides per every 100,000 residents in urban communities. Furthermore, Gillespie and Reckdenwald (2017) found that living in a rural community was associated with a higher likelihood of intimate partner violence and sexual assault. The U.S. Department of Justice (2009) noted that about half of female homicide victims were killed by a current or previous partner, and approximately 20% of child homicide victims died from intimate-partner violence (Adhia et al., 2019). These statistics demonstrate a reason to be aware of and concerned with homicidal ideation within rural communities.

Research on suicides and homicides within rural communities illustrates that smaller populations are not immune to mental health challenges. Yet, these communities, and mental health crisis responders, often lack the resources to address those needs. Robinson et al. (2012) posited that this lack of resources is a blight on rural communities in need of appropriate treatment for mental health concerns. Bushy and Carty (1994) stressed that a sparse population limits the quantity and variety of health and human service offerings. Having only a few people in an area makes the acquisition of these essential services cost-prohibitive. Essentially, sparse population density dissuades financial investment in mental health resources for these local communities. Peters' recent, 2020 study on COVID's impact in rural communities showed they are more vulnerable because of fewer doctors, fewer mental health services, and poor internet access that prohibits many residents from obtaining critical telemental health care. A gap in receiving mental health care can lead to acute crises.

Several other crisis response challenges have been presented in previous research. Poor interagency communication has resulted in a disparity of access to adequate mental health services for those in crisis (Turpin et al., 2007). Furthermore, Ryan-Nicholls and Haggarty (2007) found that mental health provider shortages, distances to access services, and community stigma were also significant factors in fostering less than favorable attitudes about psychological distress in rural communities. Specific to transportation concerns, Varia et al. (2014) affirmed that individuals in rural communities often had to travel long distances to access mental health services. Bischoff et al. (2004) added that distances to access traditional mental health services impacted work and wages as some participants reported having traveled 2–3 hr to the nearest therapeutic services, which can quickly dissuade residents of these small communities from seeking the crisis care they need.

External issues in crisis response like scarcity of resources, poor interagency communication, and lengthy travel to receive services are just one piece of what rural crisis responders struggle with daily. Preventive measures for addressing mental health crises, such as clinician preparedness, are equally crucial to the country's rural areas. In a study of school counselors, Allen et al. (2002) found that only 18% of a total sample of school counselors ($n = 236$) reported feeling "well prepared" or "very well prepared" to deal with crises and only 10.6% had taken a course in graduate school, specific to school crisis intervention. Morris and Minton (2012) reported that most new professional counselors participating in the study of crisis preparedness had received little or no instruction in crisis-related scenarios during their master's coursework. Still, over 80% had worked with suicidal clients, thus doing so without adequate preparation. Omary (2020) noted that rural areas lack mental health resources, but also struggle with a "lack of experienced health professionals" (p. 2), which can be problematic for persons with pervasive mental illness in crisis.

Due to this limited research, the purpose of this research study was to examine the collaboration

among mental health professionals; the types of crisis training offered; and how staffing, distance, and time affect the quality of care provided to those in crisis in rural communities. Our research question was as follows: What is the experience of the mental health crisis responders in rural communities? Based on the previous research, we hypothesized that training, access to services, transportation, and stigma would be some of the significant hurdles that rural crisis counselors experience daily. We hoped our research would illustrate specific difficulties faced by rural crisis clinicians that could be used to improve mental health education and promote awareness of the needs of rural mental health crisis responders.

Methodology

Sample

This study utilized qualitative phenomenology, which was introduced in *The Crisis of European Sciences and Transcendental Phenomenology: An Introduction to Phenomenology* by Edmund Husserl, published in German in 1970. Though he is often considered the father of phenomenology, many researchers have modified his work in the modern-day. This specific study followed Moustakas (1994) interpretation of transcendental phenomenology. Moustakas modified theory aims to uncover the common meaning of the lived experiences of several individuals. (Husserl, 1970; Moustakas, 1994) further reported that saturation is considered between 5 and 25 interviews, so in the interest of time and availability, we decided as a team to interview two people within each state. We chose Colorado, Oklahoma, Texas, and Wyoming because they are the states in which each researcher resides, yielding important information that we could use to make essential changes in rural crisis response.

Participants were professional counselors who worked as clinical mental health counselors and certified school counselors in what they consider rural communities. The U.S. Census Bureau delineates rural from urban communities by defining urban as populations of 50,000 or more and urban clusters as populations of at least 2,500 but less than 50,000 (United States Census Bureau, 2020). Rural would therefore be considered communities with populations of 2,499 and less. Our participants live in cities with populations of 9,000 or less but consider themselves rural because of isolation from urban areas and vast country/farmland.

We used criterion sampling to conduct this study. According to Creswell and Poth (2018), criterion sampling involves researchers seeking cases that meet specified criteria and "works well when all individuals studied represent people who have experienced the phenomenon" (p. 157). Participants resided in rural communities in Colorado, Wyoming, Texas, and Oklahoma. A script was used to inform participants of this study and to determine if the participants satisfied inclusion criteria of being a professional counselor with experience in crisis response, which included either training or appropriate education in crisis response and at least 6 months employed in their current role. Table 1 includes a more thorough description of participant demographics.

Procedure

Each of the researchers has worked in rural communities; three have encountered crises in their professional work, and one worked as an actual rural crisis clinician. Because most of us have been involved in work closely related to the research topic, we bracketed our own experiences. Bracketing consists of setting aside our previous experiences, as much as possible, to help us take a "fresh perspective" toward rural crisis response (Creswell & Poth, 2018, p. 78). The researcher who worked as a rural crisis clinician also used journaling to identify her own biases before, during, and after interviews because her previous work closely mirrored the research. The remaining researchers did not journal, but the whole team met to discuss our personal experiences and biases before conducting interviews. Such brainstorming activities allowed us to set aside preconceived ideas or beliefs as much as possible. Other colleagues reviewed the final article but did not participate in data review because we felt confident in our ability to remain neutral after lengthy discussions about biases.

To ensure trustworthiness and credibility, we used interrater reliability through intercoder agreement (Creswell & Poth, 2018). We also demonstrated investigator triangulation (Hussein, 2009) through the process of corroborating each other's significant statements, meanings, and emerging themes from the transcripts. Using direct quotations from the participants, we ensured an accurate representation of their reality (McGregor, 2018).

Table 1
Participant Demographics

Demographic	Number
Gender	Female: 7 Male: 1
Race	Caucasian: 7 Other: 1
Age	25–34: 3 35–44: 3 45–54: 1 55–64: 1
Education	Master's degree: 8
Clinical identification	Clinical mental health counselor: 4 School counselor: 4
Licensure	No license or certificate: 1 Professional clinical license: 3 Professional school counselor license: 2 Licensed Clinical Social Worker (LCSW) license: 1 Other license or certificate: 1
Experience in counseling	At least 4 years: 5 At least 11 years: 3
Experience in crisis	At least 4 years: 8

Using fellow counselor education colleagues from our university, we submitted our study for peer review and received expert consultation from others experienced in qualitative research.

The Institutional Review Board of Adams State University reviewed and approved our research design. For participants who qualified for this study, the informed consent and demographic survey were sent by email to each participant before the interview to maximize the discussion time. After participants agreed to the informed consent, each researcher conducted one interview with a school counselor and one with a clinical mental health counselor using preagreed upon questions that can be found in the Appendix. Due to the geographical distance of some rural counselors, synchronous online interviews were conducted with seven participants, and one interview was conducted face-to-face. The video conferencing allowed us to record the video and audio of each interview. Other audio recording and transcription programs were also utilized. Both modes of audio and video recording were password protected and encrypted for the privacy of the participants.

Research Design

During the first stage of analysis, we transcribed our interviews and then provided each participant with a pseudonym. School counselors were labeled SC1, SC2, SC3, and SC4. The mental health counselors were labeled MH1, MH2, MH3, and MH4. The next step in the analysis was to read each transcript and use memoing to collect ideas. Per Creswell and Poth's (2018) study, memoing is the recording of ideas as data are collected during the study. We then utilized Colaizzi's phenomenological method to analyze the data (Colaizzi, 1978). Throughout this procedure, we used open coding, axial coding, and selective coding. The first part of this process included drawing out 437 significant statements from the transcripts (discerning conversational items from content related to the interview questions). Next, we drew out commonalities from meaningful statements, and themes were coded and identified. This first set of themes was specific to the significant statements. Specific themes from all transcripts totaled 120. We then examined the frequency at which each theme was identified by participants and narrowed these specific themes into five clusters that expressed the essence of the participants' experience. These theme clusters included training, collaboration, staffing, distance, and time.

Once these overarching themes emerged, we used member checking as another form of validation. Member checking is the process of reviewing uncovered themes through feedback from participants (Creswell & Poth, 2018). We presented the themes to the participants who answered the following three questions: Do you think the key themes in this study are an accurate representation of your experiences? Do you feel any key themes were left out of this summary? After reviewing these key themes and summaries, is there anything else you would like the researchers to know? SC1, SC3, and MH3 responded to the member checking questions before the publishing of this article and agreed that the main themes accurately depicted their experiences.

Results

From the 120 specific themes derived from all 8 verbatim transcripts, 5 theme clusters emerged. These themes each contribute to the essence of the experiences of counselors in rural areas. Table 2 provides theme clusters and some select significant statements.

Table 2
Theme Clusters and Significant Statements

Theme	Significant statement
Training	" . . . in our area, no one does suicide training, and when we do it's sporadic. Nothing consistent."
Collaboration	"I've actually had a couple of times lately where the police were not able to respond in any way."
Staffing	"There's just not enough of us to go around with a crisis."
Distance	"There's not any facility here that can quickly move in and support our clients."
Time	"So, if you're looking for further testing with a psychologist, the ones here are usually booked out a few months."

Theme 1: Training

Participants in this study all held master's degrees, yet the lack of specific crisis training courses in their master's program was a common thread throughout each interview. Other concerns included the lack of training opportunities in rural areas and how they "never really feel trained" (SC4). On the job training and experience were often seen as more beneficial than professional development or continued education. As SC1 reported, "I think that actual work experience that I just happened to be doing while I was in grad school prepared me more than anything." Another aspect of training included school counselors and mental health clinicians responsible for training others in their buildings. SC4 expressed concern regarding handling crisis response, and the training received, "I'm just a trained school counselor. I really do get very nervous when dealing with it [crisis]." Also, the lack of retention of crisis content taught during one's master's program created some uncertainty for some participants. MH3 admitted, "I remember very little of what I was taught." This participant attributed this ambiguity in crisis to the amount of time since completing their master's education.

With many barriers to beneficial, ongoing crisis training, some participants identified experience as their mode of training. MH4 stated, "A lot of it was in the moment on the job experience and training and what you've been doing long enough." Often when the school counselor or mental health clinician is the only provider in the area, they are responsible for training other school personnel or staff in crisis response. SC4 expressed her feelings regarding having to juggle her other duties and the expectation to teach others, "'can't *you* train us? Can't *you* do these things, can't *you*' and it's like, but I have a full-time job too! And I have other responsibilities being a school counselor."

Theme 2: Collaboration

Collaboration is both a benefit and a barrier to counselor response to crisis in rural areas. All participants spoke of the positive aspects of collaboration in their small communities. These benefits included knowing others in the community, connecting with other resources, utilizing statewide resources, having a working relationship between schools and mental health facilities, and working well as a team. SC1 stated, "Everyone knows one another in town and looks out for one another." MH4 spoke of the positive connection with others, "I think that happens in rural areas, you really have to have a good support network, with other providers and you have to be able to figure it out together." Negative aspects of collaboration also spoken of by all participants included the lack of outside resources, lack of parental collaboration, contractual obligations belonging to a different mental health provider, and lack of reentry procedures. Speaking about another mental health provider holding the state's crisis contract, MH1 stated as follows:

> We do not have any availability to a hospital situation here because the hospital has a contract with [other mental health facility]. So, if we have a client who is suicidal, we have two options. The first is to get them to their local hospital where they call [contracted mental health facility], and their emergency crisis people come in. The second option we have is to contact a family member or a parent or roommate or someone who can come in and transport them to [hospital out of town].

Another concern was the counselor's burden in assessing a student/client alone and not having someone with whom to collaborate. One school counselor had great concern with the quality of mental health resources in her area. SC4 reported, "I can tell you horror stories where it has not been good, and the treatment has not been good. And I've been very concerned." SC4 expressed a lack of collaborative communication when crises

happen. SC4 stated, "There's nothing worse than not knowing when you come into a school that something bad has happened." Although several participants spoke of positive collaboration during the assessment process, participants also desired a more transparent reentry collaboration after students and clients return from a treatment facility. Per SC1, "I think a big piece of crisis is also the follow-up; not only being able to put the fire out but also have reintegration meetings and meet with families and call parents."

Theme 3: Staffing

Another theme throughout all interviews was barriers relating to staffing. Many participants felt supported by others in their small community or surrounding area. However, due to their rural location, the participants were often the only mental health/school counselor provider in the area, a sense of "there's only one of me" (SC4). This created the feeling that the participants must take care of everything themselves. Several participants reported not having enough staff members available to help during times of crisis, or that other staff members were busy or unavailable. When speaking of the crisis staff who are contracted to respond in her town, MH1 stated, "[Involuntary commitment] people from [contracted mental health facility] may be on another crisis, they could be 2–3 hr to get help." SC4 stated, "I always feel inadequate dealing with it because I do very much feel alone." When SC4 was asked if she had unlimited resources what would crisis response look like, she responded with " ... the unlimited resources—I'd have more mental health counselors that I could use that I could bring in and work with and partnership at the school with more." Due to participants wearing multiple hats and juggling various roles, they were often more reactive instead of proactive, as SC1 suggested when she stated, "The most frustrating part of this work is that you feel like you're just going from one crisis to the other instead of feeling like you're able to prevent."

Theme 4: Distance

In rural areas, distance to the nearest mental health facility plays a critical role in providing services for clients in crisis. This lack of local facilities was heard throughout all eight interviews. MH4 reiterated the difficulty with distance as follows:

> If someone needs to go to a hospital, there's not a lot of options. There is nowhere locally right here that we could have somebody go to. It's trying to co-ordinate and get them over 100 miles to the closest hospital where they could stay.

Participants echoed the concern that hospitals and treatment facilities are hundreds of miles away. MH1 responded with a similar statement, "We don't have a facility here if we [involuntarily commit] them" and "We have to transport them out to another facility, usually by ambulance." This distance barrier then creates transportation issues. Finding someone available to transport the client can be difficult. Often, the responsibility falls to a family member or parent of the clients/students, creating a more significant burden on the family if they miss work, losing needed income. It can also cause stress on loved ones who must travel to unfamiliar territory. When asked what her ideal crisis response would include, SC1 stated, "I think saving families and people that drive down the canyon to somewhere super uncertain would be a huge strength."

In addition, some facilities may be inappropriate for certain clients/students. When speaking of clients in crisis who also abuse substances, MH4 explained, "nobody will take them, and somebody sits in the jail. And that's not a good option." Similarly, MH1 reflected on clients who are under the influence by saying she would like "somewhere for a quick placement for someone that's having a drug and alcohol crisis that would include mental health, long term, kind of rehab." MH4 also reflected on younger clients in crisis, "I think it brings a whole another set of barriers with children and adolescents. We have fewer places and options for them to go. And so that is always a challenge to it."

Theme 5: Time

Along with distance, time can become an issue when it takes someone a long time to travel to the hospital or treatment facility. Likewise, it can take several hours for another health care provider to travel to where the student/client is so that an additional assessment can be conducted. Time may be spent waiting for a bed in a crisis facility, as MH1 suggested when she discussed clients waiting several hours for an evaluation, stating,

"it may be 2–3 hr to get help while the client sits at the hospital and continues to have suicidal thoughts." If the student/client enters a treatment facility, the time spent away from home or the family's time with the student/client can be costly.

Another area of concern was the lack of time the counselors have. Several participants wished they could have more time so they could see everyone that needed assistance. MH4 reported, "And time. It's always hard to squeeze people in, to get all the appointments seen, and make sure you see somebody as often as you need to. More time would be good." SC1 said it succinctly when she said, "there's just not enough hours in the day." Some participants expressed their busyness and how they often need to stop serving in other areas to handle a crisis.

Discussion

Participants were supportive and enthusiastic in sharing their insights about crisis response in their respective communities. Though located in different parts of the United States, this study identified several common themes in our data analysis that conveyed important implications for the entire counseling field. Though not shared by every participant, we believe other significant findings warrant further examination (e.g., competing mental health facilities, state contractual problems, lack of dual diagnosis training, and facilities). Our identified themes supported the themes elucidated in the limited research available. For example, Imig (2014) addressed similar themes such as resource availability, geographical isolation, and the need for flexibility.

Implications for Individuals in the Mental Health Profession

As crises continue to plague the United States, professional stakeholders, clinical counselors, school counselors, and other mental health professionals may consider advocacy work that encourages mental health professionals' staffing in primary and secondary schools across the nation. Rural schools, which already lack adequate resources, are at an even higher risk of these great tragedies without sufficiently trained mental health professionals.

Rural communities are not immune to crises inclusive of self-harm or threats to others. As a result, mental health professionals bear responsibility in making crisis response a priority in their schools and communities. Because of the scarcity of resources, such as inpatient facilities to serve those in crisis, smaller communities tend to benefit when collaboration and communication occur among mental health professionals. Developing alliances among these professionals creates an opportunity to share resources and experiences in crisis and generate referrals to address crisis concerns readily.

This investigation revealed a lack of uniformity in assessments utilized and procedures employed in crisis scenarios in school and clinical settings. Assessments discussed by the participants ranged from general questions rendered in a clinical interview format to actual hard copies of an empirically tested tool. Continuing education would address gaps in uniformity and skills related to crisis response. Specifically, continuing education, inclusive of lessons learned by those that frequently work in crisis, would be ideal.

Mental health professionals in rural communities would do well to train school or other agency staff on precautionary measures related to crisis (i.e., reading body language, building rapport, collaboration with parents, etc.). MHC2 explained about an agency within which the clinician works, "I cannot rely on them to provide the type of help that I need because they have not been trained to provide that assistance." Mental health professionals might also consider community education to address safety planning, procedures for securing resources, and stigma related to mental health treatment.

Implications for Counselor Education and Supervision

Despite the Council for Accreditation of Counseling and Related Educational Programs requirement for students to be familiar with their responsibilities related to crisis response (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2015), our participants felt crisis response lacks prevalence in counselor/mental health education curriculum. Morris and Minton (2012) noted the apparent lack of school counselor preparedness and the absence of literature related to other counselor training in

crisis intervention and suggested how such shortfalls may negatively impact the field. In a study examining counselor educator hesitancy in teaching crisis-based curricula, Van Asselt et al. (2016) shared that some participants were ill-prepared to train others on crisis due to having received their doctoral degrees many years prior and feeling that much of their education was outdated in light of new CACREP standards at the time. Essentially, incongruence exists between accreditation standards and actual practice in counselor/mental health education programs, which warrants more attention.

In addition, clinical supervision creates an environment that potentially renders a clinician competent in responding to crises in the counseling setting. Abassary and Goodrich (2014) suggested the use of the Context, Action, Response, and Activity (CARE) Model of Supervision to improve response outcomes with clients in crisis and render more self-efficacy for counselors in dealing with crisis scenarios. Addressing counselors-in-training and their ability to respond in crisis is efficacious to practice and core to supervisory ethics. The CARE Model was explicitly developed for counselors working in crisis, disaster, and trauma and allowed supervisors to pay specific attention to each aspect of their supervisee's work. The "C" in CARE is for context, discussing the "time, the place, and the logistical components that impact the crisis situation and intervention" (Abassary & Goodrich, 2014, p. 10). "A" is for action, addressing all the needs of a supervisee and their client(s), including how they may respond to a client crisis. "R" is for response, review of the crisis, treatment, and follow-up care. "E" is for empathy; the "compassionate and caring response that is initiated by the supervisor and emulated by the counselor" (Abassary & Goodrich, 2014, p. 11).

Suggestions for Future Research

Our participants identified a few other key concerns that did not present as themes, but could warrant further research. A qualitative study exploring the internal reactions of counselors responding to mental health crises would be beneficial. About half of the participants noted some anxiety about "missing" individuals in crisis due to a threat's often vagueness and subjectivity. SC3 exclaimed, "I'm the only mental health professional for 744 kids. So, who am I missing? If a teacher doesn't notice it, and I don't notice it and the principal doesn't notice it, who is falling through the cracks?" In addition, SC4 expressed

> . . . it's so scary. It is so scary. Because again, you really feel underresourced, and you feel overwhelmed. That really is like a lot of pressure for, I think, a school counselor. I always feel inadequate dealing with it [crisis response] because I do, I do very much feel alone.

Another qualitative study on counselor attitudes regarding crisis response in communities with historical trauma would be beneficial. SC1 acknowledged a geological crisis that happened approximately 6 years prior to when the study was conducted and how it continues to affect her community. She stated, "The community has a traumatic history and gets very scared when threat levels are high, or anything goes wrong." A possible qualitative exploration of counselor attitudes in communities similar to Santa Fe, Texas, Newtown, Connecticut, or larger cities that have experienced attacks on public locations may add to the literature surrounding this subject.

We also strongly suggest more qualitative, quantitative, or mixed-methods research on crisis response in communities with a higher prevalence of substance use disorders. A portion of our participants noted difficulties in addressing clients in crisis who are simultaneously under the influence of alcohol or other substances. MH1 shared, " . . . we don't have a really solid firm foundation of people, or facilities here for like, if they've overdosed on drugs, or, you know, something like that, where we need to put them in a safe place . . . ."

Limitations

Limitations of this study include threats to external validity in that the sample size is limited. Participants were selected from four different states, with only two communities from each state. Considering there were only eight participants, the results may not be exhaustive; however, we identified several common themes. In addition, it is unknown if our findings can be transferable to other geographical areas. A final limitation is the possibility that participants' self-reported data are prone to bias, though, as previously stated, we completed member checking to ensure the accuracy of participant narratives in hopes of minimizing biases.

Conclusion

Working with clients/students in the midst of a crisis involving threats to harm self or others is a daunting task for any mental health counselor or school counselor. It is a challenge that can be made even more complicated when dealing with counselors' various hurdles in rural communities. Through heartfelt words painting vivid pictures of eight professionals' experiences in four different states, it has become clear that more attention needs to be given to these communities so that counselors can solve issues related to collaboration, training, staffing, distance, and time. Although barriers are significant, the participants portrayed considerable pride in living within small communities, which often come together when the need arises. Additional dialogue and research are needed to offer a more robust look at the strengths and weaknesses of crisis response in these small towns/cities, especially regarding internal counselor reactions to crises, financial concerns, and crises involving substance use and abuse. Understanding crisis response in rural communities is vital for furthering counseling, counselor education, and supervision.

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Appendix

Interview Questions

1. Without giving specific client/student details, describe from start to finish what a crisis response looks like for you when working with a client/student who is threatening harm to self or others?

The next questions are asked with the participant's understanding that we are researching crisis response in the context of responding to a person threatening to harm themselves or others:

2. How were you prepared in your education/training for crisis response?
3. What are the barriers you face when working with clients/students in crisis?
4. What strengths have you experienced in your community for assisting clients/students in crisis response?
5. What are the challenges you face in crisis response?
6. If you had unlimited resources what would crisis response look like for you?

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