Summer 8-1-2021

EXAMINING SELF-CARE PRACTICES FROM A SYTEMIC PERSPECTIVE: UNDERSTANDING THE LIVED EXPERIENCES OF HISPANIC FEMALE COUNSELORS IN RURAL NEW MEXICO

Melissa C. Henry

Melissa C Henry

Candidate

Individual, Family, & Community Education (IFCE)

Department

This dissertation is approved, and it is acceptable in quality and form for publication:

Approved by the Dissertation Committee:

Dr. Thomas A. Chavez, Co-Chairperson

Dr. Kristopher M. Goodrich, Co-Chairperson

Dr. David T. Lardier

Dr. Carlos Lopez Leiva

EXAMINING SELF-CARE PRACTICES FROM A SYTEMIC PERSPECTIVE: UNDERSTANDING THE LIVED EXPERIENCES OF HISPANIC FEMALE COUNSELORS IN RURAL NEW MEXICO

by

Melissa C. Henry

B.A., Psychology, California State University, Fresno, 2013

M.S., Marriage, Family, and Child Counseling, California State University, Fresno, 2016

DISSERTATION

Submitted in Partial Fulfillment of the
Requirements for the Degree of

Doctor of Philosophy
Counselor Education

The University of New Mexico
Albuquerque, New Mexico

July 2021

DEDICATION

This project is dedicated to the participants of this study and the women that continue to serve rural communities in New Mexico. Thank you for your time and sharing your narratives. You are the everyday hero's that make the lives of others more bearable.

And to my parents, Carol Mills-Henry and Gary Henry, who continued to encourage me to pursue higher education and to attain college degrees. Without their persistent and consistent support and encouragement I would not have been able to understand how education can free you.

ACKNOWLEDGEMENTS

Thank you to my committee co-chairs, Dr. Kristopher Goodrich and Dr. Thomas Chavez, for the countless hours spent writing, proofreading, and pondering ideas. My experience working with the two of you, no doubt, will influence my professional career as a Counselor Educator for the rest of my life. A special thanks to Dr. David Lardier and Dr. Carlos Lopez Leiva for serving on my committee. I am very fortunate to have been privileged to your talents and expertise and worked from you. Thank you for pushing me forward, influencing my research, and guiding me towards impactful scholarship.

EXAMINING SELF-CARE PRACTICES FROM A SYTEMIC PERSPECTIVE: UNDERSTANDING THE LIVED EXPERIENCES OF HISPANIC FEMALE COUNSELORS IN RURAL NEW MEXICO

by

Melissa C. Henry

B.A., Psychology, California State University, Fresno, 2013
M.S., Marriage, Family, and Child Counseling, California State University, Fresno, 2016
Ph.D., Counselor Education, University of New Mexico, 2021

ABSTRACT

This interpretative phenomenological analysis (IPA) explored the experiences of Hispanic female counselors in rural New Mexico conceptualization and practice of self-care and wellness. The aim of the study was to understand the systemic, environmental, and cultural factors that reinforce and prevent resilience and wellness. Data consisted of two interviews: one structured hour-long demographic interview and one semi-structured hour-long interview related to the participant's experience of identity, professional counseling, and self-care. Participants included 9 Hispanic women practicing professional counseling and living in various rural communities in New Mexico. Six main themes identified systemic, environmental, and cultural strengths and barriers for participants to practice self-care, resiliency, and wellness: (1) maintaining a sense of purpose, (2) managing poor work conditions, (3) the use of relationships as a resource, (4) navigating social and cultural expectations, (5) connectedness to social and community care, and (6) systemic oppression. Implications for this study include the counseling field rethinking and reconsidering how it conceptualizes and assesses self-care, wellness, and resilience.

Keywords: self-care, wellness, vicarious trauma, Hispanic

Table of Context

Chapter 1: Introduction

Counseling is a helping profession, wherein practitioners work with clients to heal them and guide them towards growth and development. However, during the counseling process, the client and counselor change, like a symbiotic relationship. Kottler (2003) described how, "physicians take careful steps to protect themselves from the infection, disease, and suffering of their patients. Rubber gloves, surgical masks, and probing stainless steel instruments keep germs from arm's length..." (p.17). Kottler further explained how counselors wear nothing to protect themselves emotionally from their clients. In this way counselors can't entirely protect themselves from the pain, suffering, happiness, and joy that the client experiences. Hansen (2014) echoed Kottler's sentiments when he reminded readers that practitioners often sit across from very hopeless and traumatized clients, who are regularly discharged and freshly replaced with new clients, contributing to a vicious cycle of re-exposure. These descriptions from leaders in the field of counseling are not unusual or exacerbated. Many clinicians often feel influenced and affected by the work that they do with clients.

Corey, Muratori, Austin II, and Austin's (2018) book *Counselor Self-Care,* Mark A. Stebnicki described the cost of being a healer:

> "In traditional Native American philosophy, it is believed that each time you heal someone you give away a piece of yourself. The journey to become a medicine man or woman requires an understanding that the healer at some point in time may become a wounded healer. This experience occurs naturally when you enter into your client's sacred space" (p. 14).

This is further acknowledgement of the exposure and the inherent risk counselors are subject to, Kottler (2003) described this similarly:

> "We sit in a sacred vault, completely isolated from the rest of the world and all other intrusions, accompanied only by those who have lost hope, who live with excruciating agony, and who sometimes try to make other's lives as miserable as their own. Even with the best defenses and clinical detachment, we are still sometimes polluted by this pain" (p. 2).

These vivid descriptions are duplicated throughout counseling literature when practitioners describe the very important work they do. Unfortunately, this is not an uncommon experience and leads many counselors to report feeling the negative effects of working with clients. Kottler, Hansen, and Stebnicki's description of how mental health professionals are penetrated emotionally by their clients in session is one side of the issue that I aimed to investigate. The purpose of this study was to understand the environmental, cultural, and systematic factors that influence and contribute to counselor's emotional absorption and perception of the meaning of their work with clients. Specifically, I sought to understand the systemic, environmental, and cultural factors that reinforce and prevent resilience, wellness, and self-care in Hispanic women practicing professional counseling in rural New Mexico. Because no previous research has examined Hispanic women's experiences with self-care, even further none have sought to understand their experiences of wellness in rural communities. Minority stress theory positions these women as the most vulnerable to the development of vicarious symptoms because of chronically high levels of stress associated with interpersonal prejudice and discrimination related to their various identities (Prowell, 2019). However, initial research on Latinx providers have shown that this population tends to have better health outcomes, despite facing exaggerated stress related to social structures and conditions (Ruiz et al., 2016; Arredondo et al., 2014). The following introduction will outline the importance of calling to attention the difficult work these

counselors do, how social structures, norms and institutions specifically impacts these women and their work, and how this study further contributed to exploring and honoring their unique experiences.

This chapter will provide a background and context for this study within the field of counseling. The chapter will begin with the historical foundations of counseling, with a focus on the field's value and promotion of wellness and resiliency in clinical mental health counseling. Next I will identify why the field's value of placing personal responsibility on the individual counselor to maintain wellness and resilience ignores the power of oppression and environmental stressors and overestimates counselor's control of circumstances. This section will serve as a thorough description of the problem the research is trying to solve by clearly identifying the gaps in the field. Next, this chapter will provide a rationale and significance for this research. This will be followed by the research questions and the research assumptions this study was grounded in. Lastly, immediately following this information, this chapter will provide definitions of key terminology that I will reference throughout the document.

History and Values in the Counseling Field

Counseling as a distinct field and profession has differentiated itself from the medical model by rooting itself in the humanistic values of wellness and holism (Atieno Okech & Rubel, 2019). Counseling evolved from other helping fields such as psychology, social work, and psychiatry, who are grounded in diagnosing and evaluating mental illness to develop an effective treatment to "cure" patients (Hansen, 2017). However, the field of counseling distinguished itself with a specific focus on the wellness and health of clients with a unique emphasis on system and environmental context of mental health (Stebnicki, 2008). This further differentiated counseling from other fields of study within the realm of mental health and wellness.

Additionally, the counseling profession values diversity, inclusion, and social justice within the field of the mental health and therapeutic practice. According to the American Counseling Association (ACA) Encyclopedia of Counseling (2009) the purpose of ACA is to enhance professional identity and counselors' practice in areas that satisfy the diverse needs of the counseling community (ACA, 2009). ACA promotes and values counselor's effort to become culturally competent counselors and social justice advocates (ACA, 2009). These values of inclusion and understanding are vital to person-centered models that counselors frequently utilize. Carl Rogers, being the most famous, developed his philosophy off the notion that a counselor must respect, value, and care for clients unconditionally. Humanistic values in the counseling field therefore depend on the "working alliance" (Rogers, 1957). Rogers (1957) emphasized a foundational relationship with clients that centered on concepts of empathy, unconditional positive regard, and authenticity in the counseling relationship (Kottler & Balkin, 2017). These conditions that Roger's introduced into the field of mental health at the time, were revolutionary, because they began a shift away from the medical model and developed the beginning of understanding clients in their specific context. This shift moved the counseling profession into focusing and aspiring to helping people move towards wellness and holism and not simply diagnosis and treating illness and disease.

Wellness

The counseling field distinguished itself by recognizing that mental health should come from a wellness pedagogy and this value uniquely situated it away from other perspectives and disciplines. For the purpose of this dissertation, wellness is the optimal health of cognitive, emotional, physical, and spiritual dimensions and is the cornerstone of the counseling field (Meany-Walen, Davis-Gage, & Lindo, 2016). Myers et al. (2000) defined wellness as, "…a way

of life oriented toward optimal health and well-being in which body, mind, and spirit are integrated by the individual to live more fully within the human and natural community" (p.234). The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) defines wellness as a "culturally defined state of being in which mind, body, and spirit are integrated in a way that enables a person to live a fulfilled life" (p.91). Often summarized as the overall health and wellbeing of an individual (Sweeney & Witmer, 1991) or a positive state of wellbeing (Myers & Sweeney, 2008). Theoretically, the counseling field has valued wellness and contributed to its development in multiple arena's. Further, Myers and Sweeney (2005) wrote about the wellness paradigm that exist and includes holistic and positive approaches to growth. Sweeney and Witmer (1991) and Witmer and Sweeney (1992) developed the first model of wellness in counseling, the Wheel of Wellness (WEL). The original goal of this model was to identify empirical correlations to health, quality of life, and longevity (Myers & Sweeney, 2007). However, the WEL was later revised and expanded by Myers, Sweeney, and Witmer (2000). The WEL acknowledged a dynamic interaction between individual, family, community, and multiple systems (Witmer, Sweeney, & Myers, 1998). This model of well-being started to acknowledge the exacerbated circumstances that contribute to any individual's ability to be "well." The holistic model includes environmental and individual aspects of health; additionally, it crosses along the lifespan, is interconnected, and is inclusive of the mind, body, and spirit (Myers et al., 2000). The WEL model emphasizes five life task: spirituality, self-direction, work/leisure, love, and friendship. Within these task there are 12 subtasks which consist of: problem solving and creativity, emotional awareness and coping, sense of worth, sense of control, realistic beliefs, sense of humor, nutrition, exercise, self-care, stress management, gender identity, and cultural identity. Lastly, barriers to wellness include, but are not limited to, people, activities, habits, or

things that discourage or enable individuals from wellness (Myers & Sweeney, 2008). This wellness model is the only empirically validated model of wellness in the field of counseling and is focused entirely on holism (Myers & Sweeney, 2008). Counseling has pioneered a pathway for clinicians to conceptualize and explain the complicated relationship that subsist among the various components of well-being in human development. In conclusion, CACREP (2016) encourages wellness discussions and practices be infused throughout training in master-level counseling programs to educate future counselors about this aspect of the field.

Resilience

Resilience, which is the ability of the counselor or individual to recover or adjust after change or tragedy, is a core concept that wellness-based counseling research investigates (Myers, 2018). Resilience is a concept that is centered within the counseling field as a positive aspect that buffers the effects of trauma (Myers, 2018). In a meta-analysis Lee and colleagues (2013) found the largest effect on resilience was related to protective factors which included life satisfaction, optimism, positive affect, self-efficacy, self-esteem, and social support. These factors were found to increase counselor's ability to be resilient and manage vicarious trauma symptoms. Additionally, psychological resilience is predicted by the influence of cultural moderators that affect the meaning and purpose of a counselor's well-being (Lightsey, 2006). Culture moderators, environmental factors, and protective factors all influence a counselor's ability to be resilient. Furthermore, Skovhold, Grier, and Hansen (2001) stressed the importance of prevention strategies for counselors by actively building resilience, such as caring for yourself professionally and personally. They further added that personal and work-life balance throughout one's career are important components to resilience (Skovhold et al., 2001). However, it is not usual for resilience to be challenged during difficult times. For instance, when a counselor is

dealing with increased pressure related to dealing with difficult client loads and cases. Every counselor at some point during their professional career will report periods of distress related to one's decreased resilience and inability to mitigate stress.

Kottler and Balkin (2017) wrote about the normalcy of professional counselors feeling an amount of doubt, confusion, insecurity, or even incompetency at times while working with clients. These types of feelings are normal and can be managed depending on the counselor's resilience and ability to care for oneself. And an example of resilience is having and maintaining healthy thinking about oneself and career. Eddington and Shuman (2011) recognized the importance for practitioners to know the prevalence of mistakes that professionals make, so they collected prominent practitioner's disclosures of therapeutic failures. Urging counselors to examine their own mistakes and ability to learn from them is a way for counselors in-training to cultivate healthy thinking about themselves and their career in the field. Resilience is an enduring long-term character trait that is not challenged or dismissed during errors in the counseling room or just during difficult times; it prevails across time and space. However, this perspective neglects to acknowledge how individuals from stigmatized social categories are exposed to exaggerated stress as a result of their social, often an underrepresented, position (Meyer, 2003).

Problem Statement

There is a risk involved with the work of counselors, a possibility that they will be harmed, because of the necessary condition to bear witness to pain and suffering during their work as counselor. Kottler (2003) stated it best when he said there is a "… tremendous risks for counselors living with the anguish of others, in being so close to other's torments" (p.18). He warned that counselors must protect themselves, they must engage in self-care, and need to

constantly re-evaluate and reflect on their experience to be sure to protect themselves. Lawson and Cook (2017) explained some of the hazards of our profession which include: empathy, sensitivity, caring, emotional stress, professional loss and elusive success, cognitive deprivation, legal and ethical anxiety, and physical and emotional trauma. Many authors and counselors have admitted to the peril of the practice of psychotherapy. However, the current literature provides minimal solutions to this issue, often stating self-care is our foremost option to build immunity and buffering any danger or risk.

An eternal metaphor that narrates our ethical duty to care for ourselves is the metaphorical oxygen mask, such as, when we are on an airplane we are briefed to put on our mask before we can care for others (Corey et al., 2018). This metaphor sustains the self-enforced stance to put ourselves before our clients and ultimately it continues to dismiss the cultural and environmental factors that proffer us to take on individual responsibility. Putting ourselves before our clients is problematic in the absence of supportive resources (which many counselors do not have) and are even less available in poor rural communities and may be even more limited for marginalized counselors. For instance, Corey et al. (2018) further acknowledged that it may be difficult for some to find the time to care for themselves, but it is not optional to be able to live and work effectively as a counselor by ignoring self-care. The common theme of personal responsibility in the discipline underestimates the power of oppression, systematic factors, and environmental stressors and overestimates counselor's control of circumstances. It is simplistic to believe that being overwhelmed with stressors, which may be financial, relational, or environmental, and not choosing to first take care of yourself is failing to practice self-care. Especially, when many counselors from historically and culturally marginalized groups often report feeling helpless and out of control in situations related to changing their wellness and

station (APA, 2017; Smith, Allen, & Danley, 2007). When the profession of counseling tells practicing counselors that when they experience burnout it is only because they are not caring for themselves or practicing self-care, it perpetuates the belief of individual blame.

Gaps in the Field

Several terms have been identified to qualify the negative change in an individual counselor's cognitions, beliefs, and feelings after engaging in psychotherapy with clients. Some of the terms used to describe negative changes are vicarious trauma, secondary traumatic stress, compassion fatigue, empathy fatigue, and burnout. To make matters worse, current literature lacks consistency in terminology when theorizing or investigating these terms and frequently uses them interchangeably (Prikhidko & Swank, 2018; Lawson & Cook, 2017; O'Halloran & Linton, 2000). For example, when authors in the literature attempt to define some of these terms they use the same definition or similar definitions for different terms. For instance, Lawson and Cook (2017) described symptoms of burnout as exhaustion, negative work environment, and deterioration in personal life. Yet, these symptoms have also been described as vicarious trauma and secondary traumatic stress by other authors (e.g., Figley, 1995, Edelkott et al., 2016; Hernandez et al., 2007). Despite shifts in the literature that define and describe these conditions, one apparent symptom aligns them- impairment.

Impairment is defined as "…chronic illness or severe psychological depletion that can prevent a professional from being able to deliver effective services" (Corey et al., 2018, p.45). Counselor ethics state that counselors are responsible for monitoring their effectiveness and wellness, as well as mental health (O'Halloran & Linton, 2000). Counselors not only have a responsibility to monitor their own mental health, but also their colleague's mental health. Furthermore, counselors are asked to intervene whenever they are impaired or when their

(un)wellness interferes with their work with clients. The American Counseling Association (2014) Code of Ethics states in C.2.g. impairment is when:

> Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients (p.9).

The counseling field has an explicit value connected to their Code of Ethics (2014) when they state specifically, "…counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems (p.9)." This exact sentiment clearly places the burden and the obligation of the counselor's own health and wellness on the individual counselor, neglecting external threats to the counselor's health. This type of statement also does not account for noxious environments that maintain ambient stressors associated with a counselor's position in society (Myer, 2003). Additionally, this philosophy is frequently enforced in the field, with the prevailing belief being, counselors who experience symptoms of impairment do so because of their own lack of personal responsibility of managing their cognitions, behaviors, and emotions (Corey et al., 2018). This type of thinking places the onus of responsibility of resulting impairment on the counselor themselves. However, this value and belief that the helping field

perpetuates lacks the understanding of how systems outside of the individual can contribute to the development of secondary or harmful symptoms from working with clients.

Professional counseling organizations value and place importance on wellness, resiliency, and self-care; however, the discussion of barriers or variations of these practices in the field are limited. Counseling literature has fallen short of recognizing how resilience and wellness can be impaired or inhibited by social determinants and intersectional epistemology. Examples of this limitation include marginalized counselor's experiences in the profession and how systemic injustices can act as barriers or even hinder their professional career in counseling. Having multiple identities does not automatically increase counselor's risk of experiencing VT and burnout, but sociocultural factors within systems can weaken the support and resources counselors have access to. For example, Social Determinants of Health (SDOH) have a major impact on marginalized women's health and contribute to wide health disparities and inequalities (Healthy People 2030, 2020). Women experience more emotional exhaustion than men (Maslach et al., 2001; Emery et al., 2009). For instance, Purvanova and Muros (2010) conducted a metanalysis of literature on burnout and found that women are more prone to burnout than men. Additionally, younger mental health providers experience more burnout than their older peers (Ackerley et al., 1988, D'Souza et al., 2011, Rupert & Morgan, 2005). And LGBT mental health practitioners report higher rates of burnout than their heterosexual peers (Viehl & Dispenza, 2015; Viehl et al., 2017). Because of SDOH, inequities, and injustices, having at least one minority identity is correlated with lowered rates of resilience. Research has not yet identified the variables that contribute to this relationship. However, it has been found that two-way interactions of intersectional identities, such as gender, age, and years of experience, place a counselor at higher risk for burnout than any other counselor with a single marginalized identity

(Lent & Schwartz, 2012). This research demonstrates the added difficulties that marginalized counselors face in the counseling profession.

Minority stress theory, referring to the additional stressors that members of marginalized groups experience because of prejudice and discrimination, this theory begins to offer some understanding to what contributes to increased risk of VT and burnout (Myer, 2016; Testa et al., 2015). Counselors that hold multiple oppressed or marginalized intersectional identities are more likely to be subjected to conflicts in the dominant culture, social structures, and norms that may be incongruent with or not reflect their experience or understanding of the world (Meyers, 2003). The aim of this study was to begin to fill some of the gaps in the field related to understanding how this conflict within the dominant culture is resolved. It has been proposed that the disharmony between an individual and the dominant culture is onerous and results in significant strain (Meyers, 2003). However, the Hispanic paradox or Latino paradox, says that Hispanic and Latino Americans have better health outcomes paradoxically compared to others, such as non-Hispanic Whites (Ruiz et al., 2016; Arredondo et al., 2014). Therefore, this study sought to explore the narratives of Hispanic women practicing in rural New Mexico, by doing so more knowledge was gained in understanding how these women conceptualize and understand wellness, resilience, and self-care.

Despite inequities many Hispanic counselors' report that their identities and culture backgrounds act as a source of strength. For example, Ruiz, Campos, and Garcia (2016) reported the biggest moderator of resilience in Hispanic's was sociocultural factors, such as cultural values, social and community ties, and close social support. Some of these values include simpatia (value of social harmony), familsmo (valuing of the family), and respect (respect and investment in care of older network members) (Ruiz et al., 2016). Additionally, culture values of

personalism and collectivismo inspire connection and pride, this encourages individuals to serve as mental health professionals within their communities (Teran, Fuentes, Atallah, & Yang, 2017). For instance, Flores (2009) demonstrated these values in her experience as a Hispanic therapist, she narrated a finding of the self and healing, connecting resilience to challenges and barriers overcome. She stated that this is a common narrative for Latinas in the profession who demonstrate and cultivate resilience (Flores, 2009). Numerous authors have also suggested that through representation and visibility, marginalized groups develop resilience (Guzman, 2012; Williams & Pomales, 1989; Teran, Fuentes, Attallah, & Yang, 2017). Representation and visibility are important because they give validation to marginalized groups who are largely ignored in prominently White dominated societies. For most individuals that hold oppressed identities they are rendered unseen and invisible in society and this decreases broader social consciousness. Social consciousness is linked to the collective self-awareness and consciousness that we collectively share as a society (Grollman, 2017). Grollman (2017) stated that it is imperative for individuals that hold oppressed identities to feel represented, because doing so affirms their identity, increases feelings of self-worth, and a provides society a broader perspective of visibility and range of stories that can be told. Resilience is the ability for counselors to develop and maintain protective factors that buffer the effects of working with clients and give them strength to manage difficult feelings and situations. Counselors who hold intersecting identities develop adaptive coping mechanisms and resilience that provides this protection; however, this has not yet been recognized in the existing counseling literature.

Rationale and Significance of the Study

The purpose of this research was to influence the self-care philosophy that exist in the counseling field and reduce the blame that is attributed to individual counselors that experience

burnout symptoms. Specifically, this research aimed to do so by investigating and reporting the lived experiences and narratives of Hispanic female counselors in rural New Mexico communities. I sought to explore how they managed the personal and environmental systems that protect and influence their ability to develop VT in their professional work with clients. Policy, ethics, and mandates that postulate impairment as an individual problem need to change. The phenomenon being studied emphasized how these women's cultural identities, family systems, environmental systems, and workplaces contributed to or influenced their ability to build resilience or avoid burnout symptoms. Counselors cannot deny the impact of our work on our lives. It is also unrealistic for us to take on the sole responsibility of that infection as our own responsibility (Corey, Muratori, Austin, & Austin, 2018). Collectively, counselors in training, practice, and academia must protect each other and recognize systematic factors that influence our work. By acknowledging the multiple systems of oppression and environmental stressors that influences individual counselors we will excel at promoting wellness and success for all students and counselors. This will serve to further support and encourage marginalized counselors conceptualize of wellness and also encourage their entrance into the field as a career option that respects and acknowledges their cultural background.

Research Questions

With little research on how marginalized counselors with intersecting identities practice and model self-care and wellness, this study focused on exploring Hispanic women's experiences practicing professional counseling in rural communities in New Mexico. The research questions and sub-questions for this study were as follows:

1. How do female Hispanic counselors in rural New Mexico experience professional counseling, make meaning of their intersecting identities, and navigate their systemic environments while maintaining health and wellness?
    a. What are the systemic, environmental, and cultural factors that reinforce and strengthen resilience in female Hispanic counselors working and living in rural communities?
    a. What are the systemic, environmental, and cultural factors that prevent and act as barriers to rural female Hispanic counselors from maintaining wellness and practicing self-care?

Assumptions

One of the major assumptions of the researcher is that the counseling field fundamentally neglects to acknowledge how systemic factors influence impairment in practicing counselors. Specifically, in the self-care literature in the counseling field there is no acknowledgement addressing how individual responsibility of maintaining wellness and self-care is a uniquely Western and an American ideal that doesn't fit into all culture groups and represent all professional counselors. Additionally, the counseling literature does not address how inequities and Social Determinants of Health (SDOH) can reduce an individual counselor's ability to maintain a Western view of what self-care includes. Examples this research sought to address include: (1) do the systemic and environmental factors that rural counselors face in their practice contribute or prevent symptoms of burnout, (2) do women perceive themselves as having more or less professional support than their male peers, and (3) do racial/ethnic marginalized counselors believe they have more or less opportunities for growth and development in the field of counseling compared to their White peers.

Another assumption this research makes is that organizations and institutions want to embrace diversity and social justice, but fail to provide adequate resources and interventions to do so. For example, academic institutions embrace the vocabulary of social justice, but also shield themselves from responsibility that could include potential discrimination litigation and public scrutiny that could come with its pronunciation (Pan, 2020). The field of counseling prescribes to the philosophy that individuals need to change, rather than the system or the nature of working conditions. This individualistic notion frames the situation of impairment as simply strategy based (e.g., taking bubble baths, setting boundaries, and practicing yoga) and focuses on better self-management (Gill, 2018). By collecting the narratives of Latina clinical counselors, living and practicing in rural New Mexico I sought to explore impairment risk and protective factors specifically influenced by systems. I particularly explored the socioecological protective factors and impairment risk that Latina counselors in rural New Mexico identified as contributing to their wellness and resilience.

The third major assumption of this research is that marginalized groups and individuals with intersecting oppressed identities face increased discrimination and injustices that influence their work with clients. SDOH and Racial Battle Fatigue (RBF) are examples of how this sample faced additionally domains of oppression. RBF is an interdisciplinary theoretical framework that states racially marginalized and stigmatized groups face additional strain, that leads to "…increased levels of psychosocial stressors, psychological and physiological, and behavioral responses of fighting racial microaggressions" (Smith et al., 2011, p. 68). This is further described as the mundane, extreme, and environmental stress (MEES) that can produce symptoms that include: frustration, shock, anger, disappointment, resentment, anxiety, helplessness, hopelessness, and fear (Smith, Allen, & Danley, 2007). Smith et al. (2011) found

that racial minorities and marginalized groups that have higher educational attainment and college completion rates have an increased amount of racial microaggressions and societal problems that contribute to RBF symptomology. Professional counselors are required to earn a master's-level degree to practice professional clinical counseling and access to this education is not always a source of resilience. Additionally, the long-term and short-term effects of resisting and fighting against racialized stressors often lead to physical and emotional drain on the individual (Franklin, Smith, & Hung, 2014). RBF symptoms are an example of how the specific rippling effects of racism and microaggressions can be observed in the environmental cultural context of an individual. This makes it especially important for educators, supervisors, clinical directors, policy makers, and leaders to legitimize the diverse experiences of marginalized counselors and the impact of discrimination and oppression.

Furthermore, SDOH are the conditions of the physical environment where people, live, learn, work, and play that affect the range of health and quality-of life-risks and outcomes of individuals. SDOH include five key areas of determinants: economic stability, education, social and community context, health and health care, and neighborhood and built environment (Healthy People 2020, 2020). Economic stability is related to employment, food insecurity, housing instability, and poverty (Healthy People 2020, 2020). Rural counselors face these issues when seeking employment that covers health insurance, provides benefits, and offers a competitive salary, is stable, and provides adequate training and supervision. Education refers to early childhood education and development, enrollment in higher education, high school graduation, and language and literacy (Healthy People 2020, 2020). For rural counselors this includes the cost and access to higher education and availability and location of childcare, such as early childhood education for their children. Social and community context includes civic

participation, discrimination, incarceration, and social cohesion (Healthy People 2020, 2020). Counselor's relationships and interactions with family, friends, providers, and community members impact their well-being and clinical treatment. SDOH determinant health and health care is related to access to health care and primary care, health literacy, and quality of treatment. Finally, the domain of neighborhood and built environment refer to access to foods that support healthy eating patterns, crime and violence, environmental conditions, and quality of housing (Healthy People 2020, 2020). Adverse health consequences: such as social, environmental, and economic factors, increase risk for impairment for counselors, who as individuals do not have access to conditions that support positive health. Additionally, individuals from marginalized and oppressed groups experience a disproportionately high level of factors that contribute to health disparities (Galea & Vlahov, 2020). Because of the above outlined disparities related to health and wellness, I held the assumption that participants did not have equal access to services and products. In conclusion, Latina counselors' unique experiences might not fit into the presumption and cultural norms related to the counseling experience, but this does not downplay the importance of their work or quality of it. It is imperative that the counseling field starts to address and acknowledge the many systemic factors that can contribute to their work and development as professional counselors.

Definition of Key Terminology Used in this Study

Terms Associated with Negative Effects of Clinical Work

1. Vicarious traumatization (VT) is defined as

> harmful changes that occur in professionals' views of themselves, others, and the world as a result of exposure to graphic and/or traumatic material. VT can be seen as a normal response to ongoing challenges to a helper's beliefs and values but

can result in decreased motivation, efficacy, and empathy (McCann & Pearlman, 1990).

2. Secondary traumatic Stress (STS) is defined as

   a syndrome among professional helpers that mimics post-traumatic stress disorder and occurs as a result of exposure to the traumatic experiences of others (Figley, 1995; Stamm, 1999).

3. Compassion Fatigue is defined as

   a state of tension and preoccupation with traumatized clients in which the counselor reexperiences traumatic events disclosed by the clients, avoids reminders of client material, and experiences persistent anxiety associated with a client (Figley, 1995; Merriman, 2015).

4. Empathy Fatigue is defined as

   the stress generated by listening to the multiple stories of trauma that clients bring to therapy (Stebnicki, 2008).

5. Burnout is defined as

   a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce expected reward (Freudenberg & Richelson, 1980) and is a syndrome distinguished by emotional exhaustion, depersonalization, or cynicism, and a lack of personal accomplishment (Maslach, Schaufeli, & Leiter, 2001; Lawson & Cook, 2017).

Terms Associated with Positive Effect of Clinical Work

1. Posttraumatic Growth is defined as

positive changes in self after working with a traumatized client, which can include: changes in self-perception, interpersonal relationships, and philosophy of life (Arnold, Calhoun, Tedescki, and Cann, 2005).

2. Vicarious Resilience is defined as

   the positive impact on and personal growth of therapist resulting from exposure to client's resilience. This is a pattern of behavior, not a personality trait, and involves is based on past or current adversity and a pattern of positive adaption to challenges (Edeklkott et al., 2016; Hernandez et al., 2007).

3. Empathy Balance is defined as

   being able to enter the client's world without getting lost in their world (Skovholt & Trotter-Mathison, 2016).

4. Compassion Satisfaction is defined as

   the pleasure defined from being able to do one's work well, this is developed when counselors acknowledge and are aware of how their work brings them satisfaction (Alkema et al., 2008).

5. Resilience is defined as

   an ability to recover from or adjust easily to misfortune or change (Myers, 2018).

6. Wellness is defined as

   a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving (Myers, Sweeney, & Witmer, 2000b, p.252).

Other Important Terminology:

1. Hispanic defined as:

   individuals who identify themselves as being of Spanish-speaking background and trace their origin or descent from Mexico, Puerto Rico, Cuba, Central and South America, and other Spanish-speaking countries (US Census, 1976). This describes the majority of Mexican Americans, who lived in what is today New Mexico (Gomez, 2008, p.13).

2. Rural defined as:

   less dense, sparsely populated, not built up, and distanced from urban close together communities/geographies (Ratcliffe, Burd, Holder, & Fields, 2016).

3. Self-care is defined as

   an individual's intentional care of themselves to restore their wellbeing and is the individual's ability to engage in behaviors that restore themselves (Gentry, 2002).

Chapter 2: Literature Review

The following chapter will provide an overview of the relevant literature this research utilized. Topics that will be covered include: self-care, wellness, and resiliency philosophy in counseling, clinical exhaustion and professional deterioration, and the conceptual framework used for this study applied to the population of focus. The first topic that will be discussed is the problematic nature of the counseling field to put emphasis on the individual counselor to take responsibility for their mental wellbeing and resilience. Because the helping field in the literature emphasizes the primary prevention of impairment symptoms is to engage in self-care practices, this section of this review will include information on what the field says is acceptable and necessary: which is self-care strategies (Corey, Muratori, Austin, & Austin, 2018; Myers, Sweeney, & Witmer, 2000; Merriman, 2015). Within the section of self-care, I will provide an examination of the Western American ideal of individual rights and responsibility to self-improvement and self-examination. I will argue that the fields emphasis on the individual to mitigate trauma symptoms is severely lacking because it desists to recognize the systemic determinants that can contribute to this outcome. The next topic that will be covered in-depth is clinical exhaustion and professional deterioration that may occur when working with clients, which may include vicarious trauma, burnout, and impairment like symptoms; these impairment symptoms are exactly what self-care practices are supposed to prevent. Numerous authors have described each of these terms and differentiated them (Edlkott, Engstrom, Hernandez-Wolfe, & Gangsei, 2016; Lawson & Cook, 2017; O'Halloran & Linton, 2000); however, in this study these terms are referred to collectively as impairment like symptoms or clinical impairment. Lastly, the conceptual framework used for this study will highlight how systems interfere with individual's environments and functioning by applying Intersectionality (Collins, 2000; Hancock, 2016) and

Bronfenbrenner Bioecological Human Development theory. When discussing intersectionality, I will highlight the many intersecting identities that participants held. I will then explain how Bronfenbrenner's Ecological Systems Theory can be used to understand the context of a system of relationships that form the environment of the professional development of counselors. These topics assemble the researcher's argument that there are currently limitations in the field that ignore important systemic factors that contribute to impairment in counselor's clinical work with clients.

Preponderance of Self-Care

Self-care is a vague and ambiguous term that many researchers have described as: coping strategies, career sustaining behaviors, or burnout prevention (Brownlee, 2016). Self-care has been defined as "the process of recognizing one's physical, emotional and spiritual needs and finding personal and flexible ways of meeting these needs" (Brownlee, 2016, p.3). Myers et al. (2000) stated that self-care includes multiple dimensions, "safety habits that we learn to protect ourselves from injury or death, periodic physical, medical, and dental check-ups, and avoiding harmful substances, both those that we might ingest and toxic substances in the environment" (p. 252). It is important for counselors to incorporate self-care practices into their daily life, but within the counseling room they are needed to assist counselors with the ability to emotionally regulate during sessions by maintaining these proper self-care practices (Prikhidko & Swank, 2018).

Additionally, many authors have stated self-care is imperative because it builds resistance and immunity to the development of negative symptoms related to clinical work (Beauchemin, 2018; Prikhidko & Swank, 2018; O'Halloran & Linton, 2000; Myers et al., 2000; Merriman, 2015; Lawson & Cook, 2017). For instance, Merriman (2015) asserted self-care is the "most

essential" protective factor and Lawson and Cook (2017) maintained that "… those counselors who do not enact healthy self-care behaviors are at serious risk for feeling the negative effects of compassion fatigue" (pp. 323). Despite the fields prevalence of guidance that postulates that clinician self-care is necessary, there is very little empirical support for this endorsement. Moffatt (2018) demonstrated this in his attempt to encourage the field to engage in more self-care, he stated, "there is no shortage of books and articles on self-care for therapists. A quick search in an academic database yielded almost 1,000 articles on the topic" (p.54). Although there is a multitude of literature on the "importance" of self-care practices, there is no empirical evidence to this author's knowledge, that supports the fields inherent belief that personal self-care is effective when done individually to prevent impairment symptoms. Kaplan (2015) recognized that the literature has identified self-care as the primary factor that mitigates vicarious trauma, but "the efficacy of these interventions remains unclear" (p. 137). O'Halloran and Linton (2000) also acknowledged the problems associated with focusing on coping strategies because they limit the scope of our understanding of impairment symptoms.

Many authors have found that there is no relationship to self-care practices and engagement and the development and severity of impairment symptoms (Bober & Regehr, 2006). For example, Kaplan (2015) noted how strange it is that self-care strategies are endorsed in the literature without any substantial empirical support for them. It is no coincidence that advertisements in the media promotes that there is only one way for individuals to take care of themselves and this often includes things like taking baths, drinking wine, alone-time, and the use of coloring books, which is a Westernized perspective that is situated in the dominant culture. "Domination operates by seducing, pressuring, or forcing…members of subordinated groups to replace individual and cultural ways of knowing with the dominate group's specialized

thought" (Collins, 1990, 156). This Westernized notion of doing these specific activities, are catered for a specific audience, the dominant group, and it plays into Western superiority (Farooqi, 2018). Farooqi (2018) further explained that specific self-care activities were invented to be a validated tool for healing, but they fail to recognize and support multiple methods of self-care that marginalized groups use in the West. This reinforces specific groups and establishments as being viewed as more credible in producing knowledge and understanding reality then others (Collins, 1990). Self-care was originally a concept stemming from queer feminist theory. Audre Lorde wrote, "caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare." However, since Lorde wrote about this concept it has been stripped of its original intent to allow the mass market of people to avoid social care, it has become more of a branding opportunity for private companies, and is even further rooted in individualism (Spicer, 2019).

Some of the ways that counseling programs limit the production of knowledge is through, "…professional gatekeeping, including shaping initial and continued education, steering the production of knowledge, and informing state regulatory practices" (McDowell & Hernandez, 2010). It may be unethical for counselor educators and supervisors to continue to demand and require supervisees and students to verbalize self-care strategies when there is no evidence to support their utility. Especially, when self-care is clearly a concept from the American lexicon that stems from Puritanical values of individuals always striving to self-improve, forced examination of the self (Kisner, 2017), and ignoring how individuals can heal within their communities and systems.

Moreover, another inconsistency to the self-care culture of the field of counseling includes training self-care in counseling programs to counselors in training. Corey et al (2018)

voiced his concern when he stated "… we hope your program emphasis the value of self-care" referring to counseling programs, but there is no obligation in CACREPs standards to connect to this value (Corey et al., 2018, p. 24). Meany-Walen, Davis-Gage, and Lindo (2015) reflected on this when they noted that the 2016 CACREP Standards (CACREP, 2015) have stated that wellness discussion and practices be infused throughout training experiences, although I could not find this section in a cursory review. From every level of authority and privilege we advance the self-care culture through our literature and training programs.

Nevertheless, there is no shortage of advice in literature telling us how we should be taking care of ourselves, many professionals have weighted in this issue (Neace & Kottler, 2017). Nelson, Hall, Anderson, Birtles, and Hemming (2018) spoke about compassion and the development of self-care plans and practices that incorporate self-compassion as a skill that can prevent contamination from clients. Corey et al. (2018) made recommendations like gratitude journals and positive mindsets as self-care strategies that help counselors treat themselves with kindness and compassion. Christopher and Maris (2010) recommended mindfulness as a strategy for self-care that prevents impairment symptoms. Prikhidko and Swank's (2018) call for counselors to regulate their emotions during or after sessions is based on their ability to practice and maintain "proper self-care" practices. Many of the described authors do not cite research that supports their claims and none of the above recommendations are based off of empirical-based research. One empirically based study, wherein graduate students were trained to use mindfulness-based stress reduction (MBSR), found that students were less stressed with its continued use after four years of practice (Schure, Christopher, & Christopher, 2008). However, this study is just one example of how the responsibility was on the student to mitigate stress and regulate their emotions individually. Furthermore, the researchers in their study did not test their

hypothesis on clinical counselors who might be more likely to encounter difficult situations that could contribute to impairment.

Excluding the current literatures lack of empirical support for self-care practices and the inconsistency of what those practices look like, several authors have acknowledged the difficulty for counselors to practice self-care strategies (e.g., Carroll et al., 2003; Neace & Kottler, 2017; Brownlee, 2016; O'Halloran & Linton, 2000). Self-care is challenging for counselors to embrace because they often feel guilt, selfishness, and self-indulgence when they take the time to practice these strategies (Brownlee, 2016). Sometimes taking care of ourselves is viewed as self-indulgent, and because of that we usually continue to see clients even when we feel ourselves being impaired (Neace & Kottler, 2017). The British Association for Counselling and Psychotherapy (BACP) Ethical Framework for the Counselling Professionals (2018) addressed this issue with their counselors when they stated self-care, "… is neither a luxury nor an indulgence" (BACP, 2018, p.8). ACES Best Practices in Clinical Supervision says supervisors must maintain self-care (Borders et al., 2011) section 7.b.vi. mentions "the supervisor appropriately engages in and models self-care" (p.10) and section 11.d. xiii. says "the supervisor engages in critical self-reflection and self-care and avoids professional stagnation and burnout" (p.15). Besides counselor's defiant beliefs around self-care, one study even found that counselors would hide their negative symptoms from colleagues because they feared what those colleagues would think of them (Carroll et al., 2003). Further studying how respondents would discuss seeking help, they found that counselors who did know something was wrong with their colleague, would rather that person tried anti-depressants before trying alternative strategies and this was perceived as the more professionally competent behavior (Carroll et al., 2003).

Community Care Vs Self-Care

Not yet written about in academic circles, literature, or journals; community care is a new concept that criticizes the popular culture notion of self-care and was first spoken about in social justice and non-profit organizations. Nakita Valerio, a Canadian academic and community organizer was the first to coin the word community care (Dockray, 2019). She argued that unlike self-care, community care does not place the responsibility for compassion on a single individual and it also ask people to commitment and leverage their privilege to be there for one another in various ways (Dockray, 2019). Community care encompasses people's feelings about their bodies, their relationships with others, the meaning of home, the roots of identity, the struggle for status and regard, and the fight to maintain independence (Twigg, 2000). Community care principles are grounded in more collectivist culture values that serve marginalized communities (Dockray, 2019). Community care is taking care of collectively the most basic and everyday needs of a community of people (Twigg, 2000).

The World Health Organization (2020) defines self-care as what people do for themselves to control and maintain mental health and prevent illness (Dainkeh, 2019). Community care does not eliminate the importance of practicing good self-care, and this is especially important for practicing counselors. However, community care asks us to not just care for ourselves individually but our community as well. Dainkeh (2019) tells us that individuals with socially marginalized identities deal with various forms of discrimination and this is a systemic issue; if the problem is systemic, then there also needs to be collective social responsibility to care for one another. And "…self-care does not address the systemic issue that people who face compounded discrimination have to deal with" (Valerio, 2019). Self-care is a Westernized individualistic Puritanical belief that individual consumption in a capitalistic manner is best for healing. Whereas community care is a way for individuals to heal within their

community by leaning on each other and opening up a dialogue that enables each other (Leach, 2019). The next sections will provide information on clinical exhaustion and professional deterioration and the many terms we use to describe impairment in the helping profession.

Clinical Exhaustion and Professional Deterioration

In this section, literature will be examined that describes clinical exhaustion, impairment, and professional deterioration prevalence, outcomes, and prevention. There are many terms to describe the experience of counselors and the consequences of working with clients who are severely injured and suffering. Some of these terms include vicarious trauma, compassion fatigue, secondary trauma, empathy fatigue, and burnout. Essentially, these terms encompass the phenomenon described as *psychic spillage*, which can be defined as "…a type of past wound irritation that arises when our interaction with clients triggers some inner dynamic feelings stemming from a similarity in our own relational and attachment histories" (Beauchemin, 2018, p.56). It could also be described as the rippling effect of engaging in clinical work for an extended time or clinical work that that is profound and fervent. One thing that the field does agree on, is that we cannot help others if we need help ourselves, we too are human and can experience burnout, spiritual despair, or personal neglect (Roysircar, 2009).

Despite knowing that we are not immune to the same issues that are clients face, we are often less likely to follow our own advice. Kottler (2003) questioned this habit when he stated, "what sort of hypocrite have we become when we ask people to do things that we are unwilling or unable to do ourselves?" (Kottler, 2003, p. 30). The following section will provide a brief description of what impairment in the counseling profession is portrayed as and describe the known risk and protective factors to diminish this potential harm.

Deterioration in the Helping Profession

"If something burns your soul with purpose and desire, it is your duty to be reduced to ashes by it. Any other form of existence will be yet another dull book in the library of life" (Bukowski, 1947, p.112). This quote by the famous poet Charles Bukowski is a habituated disposition of the field of counseling and the tendency for helpers to invoke a spirit of giving themselves to their work with dangerous consequences. Moffatt (2018) cautioned counselors about the pain of being in personal crisis and the importance of strong self-care habits; originally, he blamed his pain to lack of practice of self-care habits. However, later he went on to disclose, "one of my strengths in life is that I have never once done anything simply for money. Money doesn't own me, so nobody else does either" (p.55). Unfortunately, many counselors are dependent on their work and are more willing to take on more clients and provide increased services to make a livable wage. This personal narrative lacks the ability to see that individual accountability can be polluted by oppression and marginalization. Factors such as class, gender, age, ability, and social status can interfere with a counselor's ability to practice self-care, make time to engage in protective practices, or afford to pause from obligations and responsibilities in their daily life.

Figley (1995) was the first to describe *vicarious trauma* (VT), defining it as a negative change in a counselor that happens after empathetic engagement with a client who discloses instances of trauma. This is vastly different than compassion fatigue, which happens when a counselor becomes burnout by their client's trauma by becoming desensitized and lacks the ability to connect and empathize (Figley, 1995). Compassion fatigue is a state of exhaustion and happens when a counselor feels depleted due to working with clients over time (Lawson & Cook, 2017). Lawson and Cook (2017) stated VT is different from other impairment-like terms because it is when counselors are working specifically with clients with trauma and it can happen in a

single-episode or within a short period of time. Clarifying that the term *burnout* better describes something that happens over time (Lawson & Cook, 2017). Furthermore, counselors who experience VT will be able to pinpoint a specific case and client that triggered burnout symptoms. Burnout symptoms include, "exhaustion, perceived incompetence, negative work environment, devaluing clients, and deterioration interpersonal life" and it causes psychological and emotional strain (Lawson & Cook, 2017, p. 318). Lastly, *secondary traumatic stress* is the direct result of listening to traumatic stories, which is different than burnout because it can happen no matter the content or population of clients (O'Halloran & Linton, 2000). Fundamentally, all the above terms describe a counselor's cognitive and emotional change when practicing clinical work. That change involves working with clients and the change in them is comparable to the way that client's change after they are impacted by a traumatic event or life-changing situation (Edelkott et al., 2016).

In the literature, many of these terms have been used interchangeably to describe any trauma or impairment symptom related to counselors work with clients. However, no matter the term, the symptoms experienced by counselors seem to be similar to those experienced by patients with Post-traumatic Stress Disorder (PTSD) (Figley, 1999). They include: intrusive thoughts, avoidance, somatic symptoms, depression, and the feeling of being numb (McCann & Pearlman, 1990). Essentially, these terms describe an occupational risk, such as: development of symptoms of impairment, premature exit of the field, client boundary violations, and professional ethical violations (Merriman, 2015).

Researchers have noted the significant effects of VT in clinicians (e.g., Adams & Riggs, 2008; Jordan, 2016; Harrison & Westwood, 2009; Sabin-Farrell & Turpin, 2003; Sommer, 2008; Saakvitne, 2002). For instance, Rasmussen and Bliss (2014) explained the neurobiological

alternations in clinicians who are exposed to clients repeated disclosure of trauma. They explained when counselors use empathy, they use the mirror neuron system to stimulate understanding, and this in turn this triggers the activation of the autonomic, sympathetic, and parasympathetic nervous systems (Rasmussen & Bliss, 2014). Some factors that have been noted that increase the likelihood of counselors to develop VT include client and therapist shared trauma (Saakvitine, 2002), interpersonal trauma histories (Jenkins & Baird, 2002; Sabin-Farrell & Turpin, 2013), and self-sacrificing defense styles (Adams & Riggs, 2008). Saakvitine (2002) described her personal experience with 9/11, and how her vulnerability to clients who also were touched by this event challenged her empathetic engagement. She too stressed the importance of awareness of a clinician shared trauma history with clients. Clinicians that have a personal history of trauma are more vulnerable to VT. This is further demonstrated by Jenkins and Baird (2002) who observed that when volunteers and domestic violence workers disclosed instances of past trauma, they also presented with higher burnout rate. Adam and Riggs (2008) found that such symptomatology characterized by self-sacrificing defense styles have been associated with significantly higher levels of trauma symptomology. This is characterized by reaction formation and pseudoaltristic responses, these individuals tend to distance themselves from emotions, and thus lose the ability to express empathy (Adams & Riggs, 2008). There is surmountable evidence of the negative effects of client trauma on counselors. Bercier and Maynard (2015) completed a comprehensive meta-analysis of over 4,000 citations that researched VT in mental health workers. Their study confirmed that clinicians are affected by working with trauma victims; however, they were unable to find evidence of effective interventions to reverse its effects (Bercier & Maynard, 2015).

Jordan (2010) found that VT symptoms was most severe when therapists worked specifically with the military population. Symptoms increased when the following factors were involved: the number of combat veterans the therapist served, the severity of combat trauma of each client, and the therapist's perception of adequate training for working with combat veterans with trauma. Jordan (2010) further stated that military therapists have a unique susceptibility to developing VT because many of them have been deployed themselves, some experiencing war associated traumas. Because of this they could develop trauma symptoms from being triggered by their clients. He suggested that military therapists seek their own counseling from a civilian therapist rather than through the military to combat this (Jordan, 2010).

Impairment and Gatekeeping

Gatekeeping is a unique concept grounded in helping professions, that recognizes the position these types of programs are situated in health care, unlike traditional careers that are not concerned with professional dispositions. Hard science, such as physics, engineering, and mathematics do not require faculty, mentors, or advisors to evaluate their students "fit" for entering their chosen field. Often the only form of gatekeeping in these fields includes academic pursuits, such as meeting graduation requirements and making grades. Most other science fields do not require students to "bracket" their potentially conflicting political, religious, or personal ethics and beliefs to become proficient at their chosen career. Perry (1970) found that students in clinical training held high levels of dualist and dichotomous thinking in their learning process (Homrich, 2018). This introduced the concept of gatekeeping, which is the process of a counseling program or faculty member intervening when a student does not meet the standards of requisite knowledge, skills, or values for professional clinical practice (Ziomek-Daigle & Bailey, 2009). Because of the fields' potential position to train students that do not "fit" into the

standard of the profession, there are risks associated with their development. Falvey (2002) spoke to the ethical and legal risk associated with those that do not maintain a standard of care or practice. A standard of care/practice; is considered to be a practice that is consistent with what other similarly trained professionals would do under similar circumstances (Falvey, 2002).

Gatekeeping includes recruiting and promoting students into the professional field that demonstrate personal dispositions (Homrich, 2018), such as commitments, characteristics, values, beliefs, interpersonal functioning, and behaviors that influence the counselor's professional growth and interactions with clients and colleagues (CACREP, 2016). This is different from "gate-slipping," which is when a student successfully completes a counseling program and enters the professional field with deficient professional competence (Gaubatz & Vera, 2002). Active gatekeeping and monitoring of supervisees and students is an important task counselor educators and supervisors need to pursue to prevent gate-slipping. ACA (2014) Code of Ethics F.6.b. describes this responsibility, saying that supervisors and Counselor Education faculty are required to participant in related gatekeeping and the remediation processes:

> "Through initial and ongoing evaluation, supervisors, are aware of supervisee limitations that might impede performance. Supervisors assist supervisees in securing remedial assistance when needed. They recommend dismissal from training programs, applied counseling settings, and state or voluntary professional credentialing processes when those supervisees are unable to demonstrate that they can provide competent professional services to a range of diverse clients. Supervisors seek consultation and document their decisions to dismiss or refer supervisees for assistance. They ensure that supervisees are aware of options available to them to address such decisions (p.13)."

The career trajectory of how counseling trainees develop is dependent on multiple levels (professional and personal) and this is influenced by their family and cultural background (Fitzpatrick, Kovalak, & Weaver, 2010). Students may need extra guidance, monitoring, supervision, or advisement depending on what intellectual, emotional, or cognitive factors they bring into a counseling program. Additionally, supervision is another important tool to gatekeeping and the goal of supervision is to produce more competent counselors (Bernard, 1979). Of course, supervision and gatekeeping is highly shaped by the powerful intricacies of culture that happen in the supervisor- supervisee relationship (Hardy & Bobes, 2016). Hardy and Bobes (2016) encourage supervisors and faculty to develop a "Multicultural Relational Perspective" (MRP) that includes a worldview that considers our positionality in the world.

When considering if a student needs to enter a remediation process because of gatekeeping, impairment is key in determining their competence. ACA (2014) Code of Ethics C.2.g. differentiates impairment as:

> "Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients" (p.9).

Impairment should be what supervisors and counselor educators evaluate when deciding when would be an appropriate time to speak to a student about a concern. However, even a professional counselor in the field can develop signs and symptoms of being impaired. Witmer and Young (1996) explain that impairment is the individual's inability to make good decisions and diminished capacity to perform clinical counseling. Furthermore, Witmer and Young (1996) acknowledge that ACA code of ethics ask counselors to monitor themselves and places responsibility for preventing impairment on those in the counseling community. Examples of monitoring in the counseling community could occur from a college, supervisor, director, or even client. Sheffield (1998) draws on physician literature when she describes examples of impairment as physical, mental, chemical dependent, incompetent, or improperly trained counselors. Very little research has done on impaired counselors, but Lawson (2011) found that counselors rate their own wellness high and impairment low. However, counselors usually rate their colleague's wellness lower and impairment higher (Lawson, 2011). This is problematic in that ACA Code of Ethics currently ask clinicians to monitor their own impairment, but on average they underestimate their own impairment and overestimate their colleague's impairment. Currently, the recommendation for an impaired counselor, includes halting counseling services when they are facing some type of impairment that negatively affects their clients, such as burnout, stress, or dealing with personal issues (Enochs & Etzbach, 2004). Consequently, if professional counselors in the field struggle to monitor themselves effectively and accurately, it is unrealistic for counselors to also be able to understand where the line is to cease services with clients.

Protection and Prevention Factors

The previous findings have cited pre-disposition to VT (Jenkins & Baird, 2002; Saakvitine, 2002; Sabin-Farrell & Turpn, 2013) and the development of symptoms (Rasmussen & Bliss, 2014). These findings on VT have inspired researchers to expand understanding of the phenomenon to include protective and preventive factors for clinicians. Harrison and Westwood (2009), in a qualitative study, explored how mental health counselors maintained their well-being. Consistent with other research (Clark, 2009; Beaumont, Durkin, Martin, & Carson, 2016), they found nine protective factors: countering isolation, mindful self-awareness, expanding perspectives to embrace complexity, optimism, self-care, empathy, professional satisfaction, and creating meaning. These factors promoted resiliency in clinicians and were recommendations for prevention behaviors. Other protective factors that should be instilled and nurtured in counselor trainees, include emotional attachment, personal growth, career development, having a calling, and ability to work in a flexible environment (Clark, 2009). Beaumont, Durkin, Martin, and Carson's (2016) findings further support the effects of these protective factors among psychotherapist and counselors. They further added that practicing self-compassion and well-being reduce chances of helpers developing fatigue or trauma symptoms.

Based on the previous findings, counselors need to take on an active role in protecting their mental health and wellness. Trippany, Kress, and Wilcoxon (2004) described ways counselors can do this through self-care, such as caseload management, supervision, education, coping mechanisms development, and spirituality. Counselors should be cognizant of work-related factors that are mentioned in the literature that increase VT. For example, Sabin-Farrell and Turpin (2003) found that it is important clinicians manage their caseloads so that they do not have a large number of clients presenting as trauma survivors. Other work-related issues such as being new to the profession, experience working with clients with trauma, and work-related

stressors best predict a clinician's resiliency (Devilly, Wright, & Varker, 2009). In addition, Buchanan, Anderson, Uhlemann, and Horwitz (2006) found that in work related factors such as working with adults, working at community agency, and working at multiply settings increases the development of VT, because of the increased exposure to clients with trauma. Sommer (2008) advocated for trauma-sensitive supervision, increased provisions in CACREP standards related to trauma training, and ACA code of ethics that require counselors to be more aware of VT protective and preventive factors, starting at the master-level training. Teaching these counselor trainees stress management behaviors will lead to lower levels of distress as trauma counselors (Bober, Regehr, & Zhou, 2016).

Posttraumatic Growth

In addition to the various terms to report a negative change in clinical work, many authors have developed terms that refer to a positive change in clinical work; some of these terms include posttraumatic growth, vicarious resilience, empathy balance, and compassion satisfaction. Posttraumatic growth (PTG), which has been described as a positive change in clients and counselors after experiencing a trauma or hearing about a trauma second hand, has a similar definition of the above terms. Samios, Rodzik, and Abel (2012) found that PTG moderated the symptoms related to secondary traumatic stress in therapist that worked with sexual assault survivors. This is consistent with other research findings (e.g., Schauben & Frazier, 1995) that found that working with clients who are seeking services primarily for trauma, increases the counselor's risk of developing counter symptoms. PTG is an opportunity for the individual counselor to make meaning from their experiences with clients.

Vicarious resilience is another term that is similar to PTG in that it describes the ability to "bounce back" from our work with clients. Emerging from the responses of participants from

their study, Edelkott et al. (2016) found that there are four major themes that are characteristic of vicarious resilience: the therapist worldview is altered, their spirituality has changed, perceptions of self-care changed, and lastly, they have a new perception of trauma and work and relationship with their clients. Many researchers (e.g., Edelkott et al., 2016; Samios, Rodzik, & Abel, 2012; Schauben & Frazier, 1995) have developed counternarratives to describe the positive impact and change that occurs in clinical counseling work to give significant attention to this ideology.

Splevins, Cohen, Bowley, and Joseph (2010) introduced and then compared the comprehensive theories behind PTG, the functional descriptive model of PTG and the OVP theory of growth. They stated that both theories assume that trauma can change a counselor's ideas about the world, creating a dissonance between their ideas of the world before the trauma and after. When counselors try to confront this dissonance, they rebuild their idea of the world in a meaningful way (Spelvins, Cohen, Bowley, & Joseph, 2010). Brockhouse, Msetfi, Cohen, and Joseph (2011) found that the factors that contribute to the development of PTG include: empathy, sense of coherence, and perceived organizational support. Additionally, Vishnevsky, Cann, Calhoun, Tedeschi, and Demakis (2010) established that women reported more PTG than men, with women more likely to be able to make positive meaning of their world after being exposed to trauma. Because women are more likely to develop PTG symptoms, this study will focus on the importance of understanding women in professional counseling.

Conceptual Framework

The conceptual framework that I used for this research includes Intersectionality and Bronfenbrenner's Bioecological Systems Theory. These theories have been used fairly sparsely in the counseling research and literature. Haskins and Singh (2015) addressed the hegemonic instructor-student interactions in Counselor Education and the role of and impact of color

blindness in pedagogy. For example, how embedded Whiteness in the curriculum benefits select populations, how to integrate nontraditional perspectives to ensure cultural sensitivity and inclusivity, and implementation and evaluation of postmodern pedagogy (Haskins & Singh, 2015). Counselor Education programs continue to perpetuate hegemonic systems of oppression by utilizing traditional models and do not allow marginalized and underserved students the ability to move from the margins into the position of equitable learners (Haskins & Singh, 2015). Dinsmore and England (1996) found that most Counselor Education program faculty are White male professors and many lack integration of multicultural context throughout coursework and courses. I will utilize Intersectionality as a conceptual framework to provide a thorough examination of current training and education in counselor education. This will aid future counselors in training with the ability to engage in a system that acknowledges the systems of oppression that contribute to impairment symptoms. This is extremely important because the multicultural counseling competences state that,

> "…all counseling is multicultural in nature; sociopolitical and historical forces influence the culture of counseling beliefs, values, and practices and the worldview of clients and counselors; and ethnicity, culture, race, language, and other dimensions of diversity need to be factored into counselor preparation and practice" (p. 265).

At the heart of the counseling field is a dedication and commitment to these values and this research utilized those beliefs. The social justice counseling and advocacy competencies encourage counseling researchers to understand participant's problems from a contextual perspective and aim to use advocacy to remove oppressive environmental barriers (Lewis et al., 2011).

Intersectionality

Intersectionality is a part of second wave feminism, beginning approximately 30-years ago, it origins were African-American Feminist (Hobbs & Rice, 2018). Many women of color related to this framework because it addressed their unique experiences that did not parallel White women's experiences at the time (Collins, 1990). Because African American women in particular were excluded from political representation and participation in feminist movements this approach was created (Collins, 1990). The Combahee River Collective, named in 1970 after a raid led by Harriet Tubman, the manifesto addressed oppression within the women's movement (Collins, 2000). In "A Black Feminist Statement" the group reported their experiences and growing marginalization because they identified as women of color and members of the LGBT community (Collins et al., 2016). The term intersectionality was later introduced by Kimberly Crenshaw, a law professor who spoke about the unique experiences of Black women in the legal system (Crenshaw, 1989). Crenshaw (1989) aimed to decolonize the legal system and write about how there was no previous writings and theory that described the unique experiences of Black women as an oppressed group. Intersectionality is defined as,

> "…the study of how race, gender, disability, sexuality, class, and other social categories are mutually shaped and interrelated with broader historical and global forces such as colonialism, neoliberalism, geopolitics, and culture configurations to produce shifting relations of power and oppression" (Crenshaw, 1991, p. 72).

Intersectionality is not just an approach to talk about the various identities that an individual can hold, but a framework for critiquing systemic, interacting forms of oppression and privilege (Grzanka, Santos, & Moradi, 2017). Intersectionality is a theoretical framework for understanding how people can hold disadvantage (oppression) and advantage (privilege) based on their multiple sources of identity (Collins & Bilge, 2016). Collins (1990) used

intersectionality as a paradigmatic shift to understand interlocking systems of oppression and privilege that can be simultaneous occupied. Collins further argued that individuals can occupy multiple levels of oppression and privilege, thus various socio-cultural identities and positions can occur simultaneously. Intersectionality addresses the broad agenda and combinations of injustice that a person can hold, by belonging to multiple dimensions of identity in a combination of two or more unique ways (Hancock, 2016). Intersectionality dives into the reality that there are multiple social systems that intersect, produce, and regulate inequalities that promotes systemic injustices (Grzanka et al., 2017). The framework also avoids generalizing the complex realities of belonging to multiple identities and groups, and is usually adapted to specific context (Osborne, 2015). Social groups are not homogenous or static, and intersectionality recognizes the complexity of this by considering historical, social, cultural, and political context into account (Crenshaw, 1989). Most importantly to this study, it also can help us understand the differentiated nature of vulnerability and resilience. Intersectionality highlights the social root causes of vulnerability, risks, and barriers (Crenshaw, 1989). Therefore, Intersectionality uncovers the dynamics that shapes vulnerability and resilience in an individual and community (Crenshaw, 1989).

Intersectionality has already been applied to the counseling field in multiple domains, it has been used to criticize research, teaching, and training. Intersectionality has been used in counseling and psychology research (McDowell & Hernandez, 2010; Band, 2015) and as a way for counselors to better understand the oppression and discrimination marginalized students and clients face (LaMantia, Wagner, & Bohecker, 2015; Aleman, 2018). Despite this, Shin et al. (2017) found that counseling and psychology researchers are lagging in publishing in peer-review journals using intersectionality framework in their research and clinical work.

Additionally, Nunez (2014) critiqued how intersectional framework is used in social sciences, stating this research usually explores how multiple social identities and relationship interlock systems of power and equity. However, it rarely provides direction on how these diverse dimensions' shape individual's life opportunities (Nunez, 2014). Further, McDowell and Hernandez (2010) criticized the training of mental health professionals, stating that it is usually very colonializing. They argued that counseling education and training should seek to critically examine how knowledge is disseminated in a social constructionist and critical perspective and how doing this might be contradictory to existing academic institutional power structures (McDowell & Hernandez, 2010).

Intersectionality has also been applied to counselor education and supervision and the practice of clinical supervision (Peters, 2017). Chan, Cor, and Band (2018) urged counselor educators who are committed to culturally competent practice to use intersectionality framework; stating that it may address gaps in multicultural training and education in the field. Intersectionality has been used to investigate and explore specific identities and the personal experiences of individuals that hold those identities. For instance, LaMantia, Wagner, and Bohecker (2015) addressed the importance of investigating societal attitudes toward each independent identity a person may hold; their study focused on LGBT ally development using a feminist pedagogy. Most importantly, Aleman (2018) found that Hispanic students have been found to negotiate their intersectional identities to navigate experiences of privilege and disenfranchisement. Because of this, intersectionality was used as one of the lens of analysis to analyze the qualitative data provided by the participants in this study. The following sections will provide the rational for why this theory is applicable to Latina counselor's and provide further information on each identity that this study aimed to further investigate.

Latinx and Intersectionality

Latinx refers to an ethnic identity that is associated with a frequently brown racial identity, but can also be White, Black, or Indigenous. This term inherently describes an interlocking category, related to coloniality, ethnicity, gender, race, and sexuality (Soto Vega & Chavez, 2018). However, intersectionality has been traditionally rooted in the work of Black feminist scholars and social activist (Crenshaw 1989, 1991). Despite this, intersectionality as a theoretical lens seeks to understand the experiences of individuals from traditionally marginalized groups, and this includes Latina's (Torres et al., 2018). Similar to the *Combahee River Collective*, Moraga and Anzaldua (1981) were the first Latina scholars to argue that feminism should shift away from hierarchical thinking that critically examines only gender differences. They postulated that facets of culture differences are interrelated, interdependent, and integral to women of color's lives (Moraga & Anzaldua, 1981). Using intersectionality with Latinx groups helps focus on areas of disadvantage and privilege, within a particular setting and time, and allows researcher to better identify risk factors and protective mechanisms (Torres et al., 2018). Intersectionality research assesses the individual- and structural- or group-level factors to understand how identities and social processes impact individuals and groups within Latinx communities (Torres et al., 2018). The current sociopolitical climate has ripened increased hostility directed toward Latinx, immigrants, and Hispanic women; intersectionality honors their lives and intersectional identities (Cerezo, 2020). Intersectionality as a framework and approach allows for a deeper understanding of how these women's interlocking identities and group memberships contribute to their lived experience.

Women in Counseling

More women than men enter the field of counseling, practice professional clinical counseling, and retire from the field; 73.3% of the workforce in the US is female (US Census Bureau, 2019). Women who are professional counselors deal with similar issues in professional spaces that other women in other professional field's face. Balancing work and school with a family life, responsibilities, community involvement, and practicing self-care is a common struggle. Many studies have examined the experience of women in the counseling field: pastoral counseling (Jangha et al., 2017), counselor education (Alexander-Albritton & Hill, 2015; Shillingford, Trice-Black, & Butler, 2013; Hill et al., 2005), mental health counselors (Eckart & Ziomek, 2019; Rehfuss & Gambrell, 2014) and counselors in training (Storlie et al., 2015). Despite the counseling's field's divorce from more medical-based models in earlier history, until the 1970's mental health counseling still perpetuated a gender bias. For example, in the 1970s the counseling field was still using predominately male developmental models and functioning as the bases of normal human development (Choate, 2008). Therefore, not only do women face destructive obstacles in entering and remaining in the profession, but they also face difficulty in providing services that are culturally appropriate to female clients (Choate, 2008).

Numerous studies have examined the effects of work-related stressors and environmental factors that influence women in the field of counseling. For instance, Eckart and Ziomek (2019), in their latest study, examined the relationship between female counselor's work-family conflict and their demographic, occupational, and family characteristics. They found that when women's employment impacted their family then they usually also did not have individual autonomy and spent more hours at work. Additionally, most commonly their family interfered with their work when they did not have autonomy; this was depended on what age their youngest child was and if they were caring for the elderly, ill, or a special needs family member (Eckart & Ziomek,

2019). Managing a balance between work and home is a uniquely female issue in all careers, even in counseling. Rehfuss and Gambrell (2014) found that women adapted to managing their family and career by utilizing mentorship. Mentorship empowered female counselors to develop careers in diverse specialty areas and overcome the reality of significant career obstacles (Rehfuss & Gambrell, 2014). Overall, women are more likely to experience burnout when they experience work-family conflict (Eckart & Ziomek, 2019). The obstacles that woman face in the workforce are not non-existent in the field of counseling; even when woman gain experience, additionally credentials, or with advanced education become counselor educators or clinical supervisors.

Ethnic minority female counselors face further obstacles and challenges than their White non-Hispanic peers. For example, ethnic minority female counselor educators report increased challenges with students, feeling frequently overwhelmed with their workload, experiencing higher expectations placed on them by administrators and other faculty, and report feelings of alienation at their University (Shillingford, Trice-Black, & Butler, 2013). Jangha et al. (2017) specifically examined the experiences of African American women pastoral counselors and reported powerlessness as a main theme. Their participants said they faced academic challenges, had a lack of support, and experienced microaggressions from their peers and faculty that acted as significant stressors (Jangha et al., 2017). Despite these challenges, female ethnic minority counselor educators have been found to develop wellness and maintain a holistic balance when they had a self-care plan, motivation to excel, were able to set boundaries, developed a strong professional identity, and maintained a positive support system (Shillingford, Trice-Black, & Butler, 2013). Storlie et al. (2015) supported these results when they found that African American female counseling students attending a preeminently White institution were found to

show resilience through adversity; these students were found to thrive regardless of the obstacles they encountered, and this further motivated them toward future success.

Finally, even women who have taken the extra step in the field to further their education and become counselor educators, have also reported discouraging situations and experiences related to being a woman in the field. Usually, the most discouraging factors in the lives of these women that impacted their life satisfaction were related to relationships and lack of support (Hill et al., 2005). Similar to women in the field of counseling (who most likely have only earned a master's degree), but this research shows that obtaining further education does not change women's experience of obstacles. This can be resolved if women in counselor education have autonomy, which has been found to increase their job satisfaction levels (Alexander-Albritton & Hill, 2015). Additionally, job satisfaction is often impacted by parental status, access to resources, and partnership status **(**Alexander-Albritton & Hill, 2015). Female counseling students, professional clinical counselors, counselor educators, and ethnic minority counselors share a diverse range of protective factors and barriers in the field that are unique to them based on their gender.

Motherhood

An identity that is frequently, but not always related to a female gender identify is the role of being a mother. For many participants in this study motherhood was a central role and identity that they held. Most women at some point in their lives are mothers, and the according to the U.S. Census Bureau (2003) many of them will also be employed. Despite many mothers working full-time jobs, it is still difficult to manage the role of motherhood and a career. Gendered systems of parenting still place the primary responsibility of most planning, scheduling, emotional support, family management, and behind-the-scenes actives associated

with raising children on women (Medina & Magnuson, 2009). Furthermore, Hispanic families have well-defined gender roles and expectations that are based on a system of hierarchical organization; because of this, women are often instructed to assume household responsibilities and care for family members and children (Arredondo et al., 2014). Even though it is common for Hispanic mothers to work outside of the home, they will also still subscribe to the belief that family comes first (Arredondo et al., 2014). Raffaelli et al., (2012) examined the experiences of immigrant Latina mothers living in rural communities and found direct associations between community context variables, capital assets, and indicators of well-being. Ultimately their results show that higher levels of contextual risk (such as, challenge accessing resources, negotiating life in the community, and experiences of discrimination) were associated with lower levels of individual and family well-being in immigrant Latina mothers (Raffaelli et al., 2013). Hispanic women have competing resource demands, such as their multiple family roles, cultural beliefs, and lack of access to adequate health care services (Lieberman et al., 1997) in rural communities that further adds to the contextual influences in their lives. Additionally, Long et al. (2019) found that single mothers that lived in poverty experienced various barriers to wellness and self-care, such as emotional barriers, balancing roles and responsibilities, lack of self-care strategies, lack of support, lack of resources, and systemic oppression. Long et al. (2019) attributed these themes to the view that participants managed a lot of responsibilities and viewed self-care as a privilege and not necessarily something that was accessible in their daily lives. For women that manage motherhood and a career they experience various forms of culture expectations, socioecological risk factors, and seldomly get to practice individual self-care strategies.

Many researchers have investigated the experiences of doctoral students and faculty in the counseling field. Trepel and Stinchfield (2012) found that Counselor Education mothers

experienced various forms of discrimination and support in their work environments. Examples of discrimination in the work environment were usually related to changing of parental status by those in power and in administration (Trepel & Stinchfield, 2012). Additionally, they found that female Counselor Educators who were mothers valued setting clear boundaries between work and family ties to balance barriers and discrimination (Trepel & Stinchfield, 2012). Hermann et al., (2014) also discussed the institutional and cultural barriers in Counselor Education that effect mothers. They cited increased societal expectations related to motherhood and gender discrimination as barriers to participant's ability to practice self-care and wellness (Hermann et al., 2014). Doctoral students in Counselor Education that were mothers have also been investigated, they too also reported issues related to effectiveness of wellness being emphasized in their programs, they cited inconsistent or conditional faculty support based on their ability to manage multiple-roles as mothers and students (Pierce and Herlihy, 2013). However, Kent et al., (2020) found that effective faculty and peer mentors served as a protective factor in navigating barriers for doctoral mothers in Counselor Education. The intersectional experiences of how social class, race, sexual orientation, and disability influence mother's experiences and ability to care for the needs and desires of themselves and their families has not been fully investigated.

Hispanic Women

In the United States 70.6% of counselors are White (non-Hispanic), with Black being the second most common race/ethnicity (19.8%) (US Census Bureau, 2019). Lerma et al. (2015) further reported that 5.26% and 4.72% of their sample of enrolled doctoral students and full-time faculty were Hispanic, respectively (CACREP, 2014). This leaves little room to understand the experiences of Hispanic counseling students, Hispanic professional counselors and Hispanic counselor educator's identity and professional development in the field of counseling. Further,

the literature has reported specific barriers for Hispanic counseling students to enter the profession, such as reconciling their cultural identity with their professional identity (Lerma et al., 2015; Nelson & Jackson, 2003; Olive, 2008). Some of the barriers include Hispanic helpers struggling with the identity they have to evolve into as a counselor with their cultural, which has values and beliefs that sometimes conflict with the dominant cultures (Nelson & Jackson, 2003). For instances, Flores (2009) described her personal experience of becoming a psychologist and the many barriers she encountered that she would eventually have to challenge and conquer to be a resilient professional. Hispanic bilingual counselors in particular have been shown to face additional barriers, such as: having to provide colleagues with information about culture issues, they typically have larger caseloads because of the need for their bilingual skills, and they feel compelled to advocate for culture and linguistics needs of those in their community (Teran et al., 2017). Lastly, Teran, Fuentes, Atallah, and Yang (2017) found that 75% of their sample of Latina clinicians experienced moderate to high levels of emotional fatigue, but they also found meaning and personal satisfaction within their career despite levels of distress and emotional fatigue.

Entering the counseling field requires receiving and earning a bachelors and master's degree. For many first-generation Hispanic counseling college students, the desire to complete many years of academic work are related to a desire for improved socioeconomic status, a need to contribute to the wellbeing of others, purposefully breaking with tradition, and the influence of respected role models (Olive, 2008). Female students in particular face upward mobility issues, such as explaining to family their desire to leave home, coping with internal social mobility issues, and a desire to change when attending college (Olive, 2008). Lerma et al. (2015) found these women often feel like an outsider and this contributes to their experience of reporting

feelings of vulnerability in college settings. Despite all this, resilience theory explains how Hispanic students overcome barriers related to educational attainment by having various bioecological systemic protections. Nelson and Jackson (2003) assessed Hispanic student counseling interns and found that extensive family encouragement and support to help with finances, childcare, and family obligations, including making personal sacrifices in order to establish a professional identity served as a buffer to systemic strains. Additional stressors that Hispanics face include discrimination and prejudice. For instance, an annual survey, titled *Stress in America,* that the American Psychological Association (APA; 2017) conducts, found that Hispanic adults often report lying awake at night, thinking about the future of our nation and hate crimes, as a significant source of stress. Despite systemic issues that impact female Hispanic students, Nelson and Jackson (2003) made recommendations for counselor educators to promote Hispanic students' success, which include developing meaningful relationships, having sensitivity to student needs, acknowledging the sacrifices that students make, and adapting to the needs to students when feasible.

Rural Counseling

More than sixty million people in the United States live in rural areas (United States Department of Agriculture Economic Research; USDA, 2013). The US Census Bureau (2013) classifies rural as all populations, housing and territory, not included within an urban area. An urban area is defined of communities of 50,000 people or more (US Census Bureau, 2013). Rurality can be defined as the population ratios and the remoteness from urban communities (Pelling & Butler, 2015). However, ruralness can also refer to descriptive terms, such as socio-spatial characteristics, socio-cultural beliefs or actives, locality characteristics, and the social representation of generally understood perceptions (Martens, 2002). The range of characteristics

that describe ruralness are complex and dynamic and include: geographic location, diversity of inhabitants, social and economic factors, as well as problems and resources available (Imig, 2014).

There are many rural areas in the state of New Mexico. Rural New Mexico consists of 121,593 square miles of geographic landmass and 12 counties are considered rural or mostly rural out of the 33 in NM (Johnson et al., 2006; NM Bureau of Business & Economic Research, 2020). Johnson et al., (2006) specifically looked at health care disparities in New Mexico and found that rural residents in NM face numerous disparities in obtaining health care, have limited access to care providers, and strained ability to be provided with mental health care. Most prominently in rural communities, there is increased stigmatization towards psychotherapy and stereotypes related to mental illness and disorders. Erickson (2001) reported that in small rural communities, cultural norms encourage residents to only get support and help from people that they know and trust. Rates of mental health are no different in rural communities versus urban ones (Cohn & Hastings, 2013), but there is a distinct lack of behavioral health and mental health providers and disparities in terms of services that are culturally responsive.

Providing services as a counselor in rural areas have been studied extensively in many different disciplines of counseling such as school counseling (Worzbyt & Zook,1992; Morrissette, 2000; Monteiro-Leitner et al., 2006; Hann-Morrison, 2011), family counselors (Weigel & Baker, 2002), rehabilitation counselors (Coduti & Luse, 2015), and drug and alcohol counselors (Oser et al., 2013). Practicing behavioral and mental health counseling in rural areas provides, however, unique challenges for practitioners and the community they serve. For instance, Morrissette (2000) reported isolation as being a common experience of rural counselors, due to limited access to social activities and fewer social supports. Other research has

further identified that counselors tend to lack privacy and anonymity due to heightened visibility and professional reputations, attitudinal differences, and obstacles to community networking (Morrissette, 2000; Cohn & Hastings, 2013; Weigel & Baker, 2002). Another common barrier is multiple relationships (Hargrove, 1986; Erickson, 200; Weigel & Baker, 2002). Counselors in rural communities residing in low population density areas are more likely to have relationships or be connected in some way to their clients or their clients' children, family, or spouses (Oser et al., 2013; Sexton et al., 2008).

Additionally, the sociocultural environment of living in a rural area provides a unique lifestyle and family life that is different from urban areas (Morrison-Hann, 2011). Morrison-Hann (2011) argued that these societal norms render rural communities their own distinctive cultural entities. Rural cultures are characteristic of interdependent people that have their own values (Breen & Drew, 2012). Some of those distinct values include family coming first and having a strong influence and expectation on their children (Breen & Drew, 2012). Each rural community has its own cultural variables; consequently, they can have a diverse perspective of what attributes to illness and what is the cultural norm, acceptable response, or behavior to wellness (Coduti & Luse, 2015). It is imperative that culture is considered as an important factor for researchers and counselors to consider when serving these diverse rural communities.
New Mexico, the location of this study, is in a majority minority state with the major economic resources in the state coming from agriculture, mining, oil and gas, and tourism. Additionally, NM has the second highest poverty rate in the nation, with many children living below the poverty line (Lopez, et al., 2018). Rural low-income areas such as those in New Mexico, usually have fewer resources, including mental health services, which places a larger strain on health providers. Cacari Stone et al., (2017) found specifically in NM, race and place of birth play a

role in socially economic status for the state's women, with foreign-born Hispanic women having the lowest income and highest unemployment rates. Elsewhere, Payne (2017) reported among rural pastoral counselors in low-income communities their environment impacted their perceived ability to affect change and feel a purpose in their communities. Low-income rural areas which struggle with poverty are another socioeconomical factor that can influence the burnout rates of health providers in rural NM.

A special consideration related to this research is the higher rates of burnout among rural treatment providers. Rural mental health counselors deal with increased bioecological factors that contribute to their ability to cope with stress and build resilience. Rural counselors have reported increased work-related stressors, such as increased workloads, lower salaries, few resources, and shortage of help (Cole, 1988). These increased bioecological factors and work-related stressors contribute to increased burnout in rural counselors. Adding to an already difficult situation, rural counselors are usually the only provider in their area, so when they experience burnout symptoms they usually have few people to turn to and no providers that specialize in helping them (Cohn & Hastings, 2013).

Burnout is higher when counselors are isolated, lack resource, and are overwhelmed with their caseloads. Oser et al. (2013) found that rural substance abuse treatment counselors reported higher levels of burnout than their urban counterparts. These authors further cited issues exclusive to rural counselors related to their geographical location, such as office politics and low occupational prestige (Oser et al., 2013). Thomas, Kohli, and Choi (2014) also found that rural human service workers experienced moderate to high levels of burnout rates compared to their urban peers. A contributing factor for burnout in their study was emotional exhaustion, defined as, "...emotional overload that reduces vital emotional resources needed to effectively

perform job-related task" (Thomas, et al., p. 84). Despite the added challenges of working in rural areas, research is beginning to understand how to help rural counselors.

An example of how rural counselors can cope with these challenges and adversity is by practicing mindfulness, which increases compassion satisfaction, decreases depression, and increases positive indicators of adjustment, such as positive affect and life satisfaction (Samios, 2018). It has also been found that having a historical legacy or connection to the community, tolerating commuting, buying into the communities' way of life, and practicing intentional ethics increases long-term retention of rural mental health counselors (Wilson, Knezevic, Kibugi, Peterson, & Polacek, 2018). In conclusion, there is minimal existing literature seeking to understand the protective and mitigating factors that contribute to the growth and development of rural counselors.

Hispanic+Woman+Counselor+Rurality

Currently, there is no literature that examines the intersectional identities of individuals who identify as Hispanic+Woman+Counselor+Rural or Hispanic women that live and practice professional counseling in rural communities. There is also no current research exploring the lived experiences and identities of New Mexico counselors that are women and Hispanic. Intersectionality recognizes and acknowledges that when counselor belong to multiple disadvantaged or marginalized groups or identities it convolutes experiences of oppression in various context (Grzanka, 2014). The purpose of this study was to shift away from an individualist to a systemic lens of understand the systemic, environmental, and cultural factors that influence and contribute to these women's wellness, self-care, and resilience. An emphasis was placed on Latina counselors practicing counseling in rural New Mexico because (1) no previous research has examined their experiences and (2) current research hypothesizes that the

intersection of their multiple marginalized identities puts them at more risk to develop negative symptoms. Current research positions these women as having to cope and adapt to a "triple lens of oppression" as a threat to their wellness and resilience. The "triple lens of oppression," refers to Hispanic women, because they experience increased instances of prejudice and discrimination because of the intersecting social location they inhibit related to race and ethnicity, class, and gender (Pesquera & Segura, 1996). Utilizing intersectional approaches allowed me to reject the idea that research subjects exist with stable essential identities and instead identities are mostly relational, fluid, multiple, and always being renewed and revived (Gruenfelder & Schurr, 2015). By not focusing on any one identity, I was able to examine how participants varying interconnected identities of social categorization created overlapping and interdependent systems that influenced their wellness, conceptualization of self-care, and development of resilience.

Systematic Levels of Knowledge

The last section will provide another theoretical foundation for understanding impairment and protective factors in clinicians from a systems-based perspective. Using a systems perspective to understand impairment will support the notion that complex personal and environmental interactions (such as, demographic characteristics, organizational discrimination, protective factors, coping, supervision, and community support) are responsible for burnout among professional counselors (Lent & Schwartz, 2012). Systemic and organizational components have been acknowledged in counseling research to utilize a holistic view of clinical cases. For instance, Roysircar (2009) stated that the difference between psychology and counseling, is that counseling is supposed to focus on etiologically symptoms, like the context and social inequities of client's lives. This is supported in ACA's Multicultural and Social Justice Counseling Competencies which states that "… privileged and marginalized counselors

intervene with, and on behalf, of clients at the intrapersonal, interpersonal, institutional, community, public policy, and international/global levels" (Ratts et. al., 2015, p.5). Therefore, it is imperative for counselor educators and supervisors to consider the multiple levels of a counselor's identity, cultural, and personal experience to frame any negative or positive symptoms they develop as an outcome of working with clients.

Community Models of Impairment and Stress

Within the counseling field the understanding of the development of impairment symptoms is predominately based on factors that the individual counselor can control for as an individual. Examples of this include: the theoretical orientation they subscribe to, the coping skills they engage or don't engage in, the practice of self-care actives, and their personal resilience. However, human development shows us that counselors work involves multiple evolving interactions between individuals and interconnected environments (Campbell, Dworkin, & Cabral, 2009). Myer and Moore (2006) reminded us that no single system can be the sole cause of a reaction, however, it is important to consider the gestalt of the whole. Considering the current philosophy of the field of counseling, Bronfenbrenner's Bioecology theory is an excellent model for describing the interactions involved in a counselor's environment that contribute to trauma symptoms (Bronfenbrenner, 1975). Especially when their work, providing treatment to clients, is a prerequisite for the development of trauma. Various authors have applied crisis counseling and crisis interventions to Bronfenbrenner's Bioecology model, addressing rape (Neville & Heppner, 1999), sexual assault victims (Campbell, Dworkin, & Cabral, 2009), crisis intervention (Myer & Moore, 2006), and trauma recovery (Harvey, 1996). Many of these authors have pointed to the complex understanding of the socioecological of individuals, which includes examining the influence of family, nation, community, subcultural,

and cultural related to psychology and interpersonal relationships in relation to trauma (Harney, 2007). For instance, Myer and Moore (2006) developed the Crisis in Context Theory, that takes into consideration ecology perspectives, which are a vital part of individual crisis responses. Bronfenbrenner's Bioecology model is a human development model that I will use to further explain systemic models of stress and impairment. This model can help account for factors that the previous models of stress and impairment do not address.

Bronfenbrenner's Bioecology Theory

The Bioecological model has a long history. First Bronfenbrenner developed the ecological systems theory (1979), that later was updated in 1994 by Bronfenbrenner and Ceci, and once again was further developed in 1986 by Bronfenbrenner and Morris to become the Bioecological model of development. The original Ecological Systems Theory was a way to understand individuals' development within their environments and included five ecological systems (microsystem, mesosystem, exosystem, macrosystem, and chronosystem) (Bronfenbrenner, 1975). In comparison to the original theory, Bioecological systems theory added more to the person as the context to the development and introduced the new idea of Process-Person-Context-Time Model (PPCT) (Bronfenbrenner, 2001).

The Bioecological model evolved and adapted over time by Bronfenbrenner and changed constantly throughout his lifetime. He added the Process-Person-Context-Time Model (PPCT) which is the role of processes on the role of the individual and how individuals and environments change over time (Rosa & Tudge, 2013). Bronfenbrenner and Evans (2000) said process was related to proximal process and is the transfer of energy between the developing individual and the persons, objects, and symbols in the immediate environment. The transfer of energies can be either direct or indirect, from the individual to the environment. Proximal process develops two

different outcomes; competence (referring to the development of knowledge, skill, and ability of behavior across situations and domains) and dysfunction (refers to the difficulty of maintaining behavior across situations and domains; Bronfenbrenner & Evans, 2000). Person in the PPCT model is relate to the personal characteristics of individuals and how that affects social interactions (Bronfenbrenner, 1986). Bronfenbrenner (1986) categorized personal characteristics in three categories, they were demand characteristics (e.g., age, gender, or physical appearance), resource characteristics (e.g., mental and emotional, intelligence, and skills), and force characteristics (e.g., motivation, persistence, and temperament; Tudge et al., 2016). The "C" in the PPCT model is context and this refers to Bronfenbrenner's original five interconnected systems that he describes. The "T" in the PPCT model is time and is highlighted in the micro, meso, and macro-level of the model, together this accounts for functions that occur within and across generations across the lifespan (Tudge et al., 2009).

The following subsections will account for the various environments that interact with the individual counselor in relation to the development of VT using Bronfenbrenner's Bioecological human development model to conceptualize stress in environmental systems. All of Bronfenbrenner's levels that affect the individual will be covered in a context related to counselors work and how their cultural identities can contribute or mitigate the development of trauma.

The Individual- "The Counselor"

Bronfenbrenner (1976) labeled the individual as the character traits, demographics, and wellbeing of the person central to the environment of systems. Previous findings have clearly stated that the individual level is the only level where counselors develop and prevent VT. Harrison and Westwood (2009) questioned mental health counselors concerning how they

maintained their wellbeing. Consistent with other research, they found nine protective factors of VT that included: countering isolation, mindful self-awareness, expanding perspectives to embrace complexity, optimism, self-care, empathy, professional satisfaction, and creating meaning. These factors promoted resiliency in counselors and emphasized the counselor as the primary source of preventing the development of VT. Additionally, Harney (2007) stated counselor's theoretical framework, formulations, and treatment goals comprise this system. Other protective factors that the individual can control for include emotional attachment, personal growth, career development, having a calling, and ability to work in a flexible environment (Clark, 2009). Beaumont, Durkin, Martin, and Carson (2016) supported the above protective factors and added, based on their results of a study done on psychotherapist, that self-compassion and wellbeing reduced the chances of helpers developing fatigue or trauma symptoms. Similarly, Trippany, Kress, and Wilcoxon (2004) echoed the fields consensus that self-care, coping mechanism development, and spirituality can resolve VT in practitioners. These authors provide a simplistic view of VT by stating that if counselors take an active role in protecting their mental health and wellness, they can control for the epistemology of VT.

The counselor as the individual is responsible for their own mental health and wellness and the lack of individual self-care and wellbeing is blamed on that very individual. Frustration and alienation are developed when rage cannot be expressed, showed to others, or admitted by the individual within a racial context (Bell, 1992). And placing the responsibility on the individual to maintain their emotional wellbeing in a toxic environment ignores the very environment that is contributing to the individual's distress. This was echoed when King (1999) said that it is "…actually pathological for a person to become well-adjusted to a world of injustice, violence, war, or exploration" (Roysircar, 2009). Self-care is something that is required

to happen outside of the work environment where the professional counselor conducts their clinical work. This means that counselors must develop resilience and practice self-care on their own time (unpaid) to be able to continue to maintain optimum work productivity. It is something they are responsible to do on their own, with their own resources, and outside of the professional work environment (Brownlee, 2016).

This does not take into consideration psycho-pollutants in the social environment, such as racism and racial microaggressions, that can spill into the individual's ability to care for themselves (Smith, Hung, & Franklin, 2011). Chan et al. (2019) recognized that individuality is not mutually exclusive to identity development and identity development is dependent on the social context and structures that surround the individual. Social structures and racism that are impossible to ignore for marginalized and underprivileged counselors can act as barriers to practicing adequate self-care as an individual. Collins' (1990) Matrix of Domination outlines how oppression can occur on a social paradigm, this social paradigm contributes to issues of oppression that impair individuals' social classifications. For example, Collins (1990) postulated that at the individual level personal biography, the interpersonal domain of power, is impacted by concrete experiences, values, motivations, and emotions that can impact how a person can function in a social context. Individual experiences of oppression vary by race and other key identities that can contribute to an individual's experience of oppression that the individual can not alter. Some of these inherent factors are race and ethnicity, gender, age, disability, sexual orientation (Collins, 1990). Because of these inherent factors, marginalized counselors have differing individual experiences compared to Whites. For instance, racial and ethnic minorities experience significant disparities, such as: income, education, employment opportunities, discrimination, and access to health care (Ruiz et al., 2016). Therefore, although there are factors

that the professional counselor can control for within the environmental context of the individual, such as their ability to practice self-care, monitor themselves, and develop resilience, there are also factors that cannot be controlled for by the individual. In summary, there are characteristics that the individual does not have within their power to change, such as their ability to experience oppression and discrimination based on inherent individual characteristics. Systems that the individual usually does not have power to change include all other levels of the bioecological model, these are the environments that impact the individual living and surviving in them.

Microsystem

The microsystem is the immediate setting, period of time, and elements of a setting that surround the individual, Bronfenbrenner (1976) gave examples in this system, which include family, peers, school, church, or health services. The immediate environment that effects the development of a counselor's microsystem include the counselor's peers/colleagues, friends and family of the counselor, and the administration, supervisor, or center director at the agency that the counselor is employed at. Those social supports and immediate environmental factors impact the individual counselor's development and career trajectory.

Counselors should be cognizant of work-related factors that are mentioned in the literature that increase VT. For example, Sabin-Farrell and Turpin (2003) found that it is important counselors manage their caseloads so that they do not have many clients presenting as trauma survivors. Counselors can sometimes manage their caseload, but the agency they work for can also put them at risk. Agencies that focus on specific populations and require specialized training put counselors at increased risk. For instance, Kaplan (2015) found that trauma workers often feel a lack of control that is characterized in high-demand and low-resource environments and this can impact their day-to-day wellbeing more than their work with clients. Other work-

related issues such as being new to the profession, experience working with clients with trauma, and work-related stressors best predict a clinician's resiliency (Devilly, Wright, & Varker, 2009). For example, Lawson and Cook (2017) encouraged supervisors to build a positive environment for counselors by recommending that "no shop" talk is discussed outside of an official individual or group supervision session. Not discussing cases during lunch breaks and guarding what counselors do outside of counseling sessions breaks are suggested (Lawson & Cook, 2017). The organizational environment is one of the greatest predictors of distress and impairment; this includes things such as, paperwork, polices, and relationships with co-workers (Kaplan, 2015). In addition, Buchanan, Anderson, Uhlemann, and Horwitz (2006) found that work related factors such as working with adults, working at community agency, and working at multiply settings increases the development of VT, because of the increased exposure to clients with trauma. Administrators, supervisors, and clinic directors play a large part of counselor's microsystem constraints as they often make decisions that impact the work environment, such as caseload management, availability of quality supervision, and leave for continued education (Trippany, Kress, and Wilcoxon, 2004). Lawson and Cook (2017) stated addressing the symptoms of VT include working in an accommodating environment where counselor's feel supported, as well as having a supportive supervisor and supervision. In their study, they found that counselors that work at private practices report having more meaningful work and this is hypothesized due to the greater control over size and make-up of caseloads (Lawson & Cook, 2017).

Collins (1990) also addressed how organizations and institutional arrangements can interfere with the individual's cultural context. In the Matrix of domination, the social institutional level includes schools, churches, the media, and other formal organizations that individuals are exposed to through the dominate cultures thinking (Collins, 1990). Examples of

this include Western colonial perspectives such as, academy, professional organizations, the health care industry, and the state (McDowell & Hernandez, 2010). Racial battle fatigue (RBF) which is the "physiological, psychological, and behavioral strain exacted upon racially marginalized and stigmatized groups" (p.66) is an example of potential mundane, extreme environmental stressors (MEES; Smith et al., 2011). It is also an interdisciplinary theoretical framework that acknowledges increased levels of psychosocial stressors, psychological, and physiological, and behavioral response occur while individuals must fight off racial microaggressions in MEES (Smith et al., 2011). Symptoms of this include frustration, shock, anger, disappointment, resentment, anxiety, helplessness, hopelessness, and fear; these symptoms are similar to Combat Stress Syndrome which is produced in hostile environments that produce distress (Smith, Allen, & Danley, 2007). While an individual can interact with their immediate settings, such as attaining an education and completing college at a University, racial microaggressions and societal problems can contribute to increased symptomology (Smith et al., 2011). These long-term and short-term effects of resisting and fighting against racialized stressors are often physically and emotionally draining for people of color (Franklin, Smith, and Hung, 2014) and contribute to environmental impacts on the individual.

Mesosystem

The mesosystem is the interconnection of the relationship in the microsystem with each other and the relationships of those factors to the individual (Bronfenbrenner, 1976). Factors contributing to the individual counselor that are related to the counselor's mesosystem include: the alumni program they received their training, the organization/agency they are employed and the connections and of the attitudes and beliefs of both environments. Environments can influence individual counselors in differently ways, at various amounts, such as the relative size

of the system, amount of interaction, and degree of importance of that environmental setting (Campbell, Dworkin, & Cabral, 2009). One example of this would include questions such as, did the counselors alumna University provide any formal training and education related to VT, secondary traumatic stress, or burnout?

Lau and Ng (2014) proposed an ecology model for counselor educators that develops a more holistic and comprehensive view of counselor's environments and how educators and administrators create this. The authors pose questions such as: does the clinic they are employed through provide continuing education; how does the culture of the clinic frame trauma symptoms in clinicians; and does the agency provide any recommendations or proscribed procedures for handling a clinician that is obviously impaired because of their secondary trauma reactions (Lau & Ng, 2014). Counselors in training are impacted by their counseling program policies and the Universities that they attend. Hence, Guzman (2012) reported while attending a Hispanic Serving Institution (HSI) she was still the only Latina student in her graduate classes. She also stated that women of color often do not have enough representation and their experiences often remain invisible in a still predominately White profession in the counseling field (Guzman, 2012). Indeed, there has been mixed results related to Hispanic clinician's experiences of burnout and emotional fatigue. Teran et al., (2017) found that Hispanic counselors had lower degrees of burnout, but also found that 75% of their participants experienced moderate to high levels of emotional fatigue. Despite distress and emotional fatigue many found meaning in their work and 75% also reported high personal satisfaction in their career (Teran et al., 2017). This shows that Hispanic counselors may have a higher tolerance to emotional fatigue because they report higher levels, but also mitigate the distress more than others. From the beginning of their education Hispanic students are more likely to seek out counseling services based on their level of

acculturation and their perception of a counselor's trustworthiness and understanding (Williams & Pomales, 1989). So, recommending that these students seek out individual counseling to cope with these feelings may not be helpful. Specific cultural factors that influence emotional fatigue for Hispanic clinicians include, "…having to provide staff with information about culture issues, encountering increased workloads based on bilingual skills, needing to secure independent learning of cultural and clinical issues related to Hispanic, and advocating for change at their clinical setting to meet the cultural and linguistic needs of Hispanic" (Teran et al., 2017, p. 28). In conclusion, the individual relationships that marginalized and oppressed counselors have to their environment impacts their ability to thrive or be impaired in the professional environment.

Exosystem

The exosystem is the indirect environment of the individual, the link between the micro-and-macrosystem that the individual is not actively involved with (Bronfenbrenner & Morris, 2006). Examples of the exosystem of counselors include the counselor's local counseling association and state licensure and regulation boards because they link the counselor's immediate environmental relationships with a larger system of support. The counselor's individual involvement with associations at the local, state, or regional level contribution to the counselor's development of resilience outside of their immediate environment and they link them with the larger field. Questions to ask to understand the level of support the individual received in these environments include: does the state the counselor resides in have a licensure and regulation board that places emphasis on counselors continued education and development? Further, how does the state licensure board investigate letters of compliant related to counselor impairment, competency, and misconduct? Do counselors sit on their state's licensure and regulatory board and contribute to the development of policies, ethics, and laws that oversee them? These are just

some examples of questions that should be asked when understanding this level of the counselor's systemic development.

Macrosystem

The macrosystem is the social and cultural values related to the individual, values related to greater society can be proscribed by the individual's industry neighbors, leaders, and mass media (Bronfenbrenner, 1976). Major contributors to a counselor's identity and professional values and ethics are provided by American Counseling Association (ACA), Council for Accreditation of Counseling and Related Educational Programs (CACREP, which is the accrediting body for masters-and doctoral-level counseling programs), Chi Sigma Iota (CSI, international counseling honor society) and National Board for Certified Counselors (NBCC). These organizations monopolize the industry of counselor training programs, counselor professional identity, and counselor legitimacy. Moreover, publications, professional journals, newsletters, and books published through ACA have tremendous power over the values of the field of counseling during the current time. Ways that VT can be prevented at the macrosystem level include Sommer's (2008) who advocated for trauma-sensitive supervision, increased provisions in CACREP standards related to trauma training, and ACA code of ethics that require counselors to be more aware of VT protective and preventive factors, starting at master-level students/trainees. Teaching counselor trainees stress management behaviors will lead to lower levels of distress as trauma counselors (Bober, Regehr, & Zhou, 2016). It is obvious that leaders, counselor educators, and change-makers in the field of counseling have a colossal amount of clout associated with VT.

Chronosystem

Last, the chronosystem which are the changes that occur over time that effect the individual's development (Bronfenbrenner, 1976); or the climate of the field of counseling that can change the potency of a counselor's trauma symptoms while working with clients. Examples of changes over time include the fact that we are, "…living in an age of globalization and social media, we cannot escape the constant bombardment of stressful news about local, national, and international events" (Corey et al., 2018, p.54). APA (2017) annual survey "Stress in America" revealed that Americans are more likely now to report symptoms of stress; including anxiety, anger, and fatigue based on the current political climate. Additionally, women are more likely than men to experience stress and have stress-related symptomology (APA, 2017). Ahmed (2014) introduced the idea of "collective suffering" and how it can encourage individuals to attribute meaning through painful experiences. She stated that pain may be solitary, but it is never private; and that often individuals take on the collective pain as their own. Sometimes this can account to "wound fetishism" which is when an injury becomes an entitlement to a specific group of people (Ahmed, 2014, p. 32). Relationships of time and environmental events that influence the development of Hispanic's include historical events, such as changes in immigration policy and changes in the number of Hispanic's attending institutions of higher education (Arredondo, 2014).

Furthermore, Shannon and Pyle (1993) as cited in Myers, Sweeney, and Witmer (2000), found that "...more than half and as many as two thirds of all premature deaths in the U.S. are due to lifestyle factors that can be modified." There is growing literature that recognizes that individual self-care strategies are not the only solution to reduce the burden of individual providers, systems, and organizations (Kaplan, 2015). To make change we must cross through all levels of systems and take paths of least resistance by developing comprehensive relationships

that reinforce collaborations throughout all systems (Ferber et al., 2007). Hegemonic cultural norms that govern and control most of the world, how people understand, classify, understand, and improve need to be modified (McDowell & Hernandez, 2010). For instance, "…overriding cultural assumptions that situate individual success and wellness at an oppositional pole to community success" (Way, Ali, Gilligan, & Noguera, 2018). Way et al. (2018) stated that the dangerous cultural beliefs that thrive at the expensive of the collective prevent individuals from fostering positive change. The solution is to allow relationships to develop that allow for mobility, collaboration, and alliances in all levels of systems (McDowell & Hernandez, 2010). Having a professional community, such as friends and loved ones, and maintaining intimate connections can help professional counselors develop shared meaning as a community throughout all of their environments.

Conclusion

This chapter provided an in-depth literature review of the topics that this study used to ground and guide the date collection and analysis. Starting with the preponderance of self-care practices that place the responsibility of impairment symptoms on the individual counselor and abides to a hegemonic dominant culture's positionality of knowing was presented. Next, counselor impairment and deterioration, which includes vicarious trauma, empathy fatigue, and burnout symptoms, definitions, and risk factors was covered. Lastly, models of how organizations and systems can manipulate and penetrate individuals was provided in the context of how counselors can develop impairment symptoms, no matter the frequency and intensity of practicing self-care practices. As an analytical framework, I utilized a systemic theoretical perspective and intersectionality to explore the lived experiences of Hispanic female counselors living and working in rural New Mexico.

Chapter 3: Methodology

The purpose of this study was to investigate the organizational and systemic factors that served as strengths and barriers to Hispanic female counselors in rural New Mexico practicing wellness and self-care. This chapter will provide the methods and description of the research study that was conducted. To accomplish this goal, the methodology used was Smith, Flowers, and Larkin's (2009) Interpretative Phenomenological Analysis (IPA) qualitative method. McLeod (2001) stated that IPA is about understanding people's everyday experiences in their own version of reality to understand a specific phenomenon. IPA research is aimed at capturing the experiences of a uniquely specific sample. The sample collected for this study included Hispanic women that were professional counselors in rural areas of New Mexico, which is a very specific population and the specific phenomenon of practicing wellness and self-care. Participants were encouraged to participate through a recruitment letter that was distributed through a convenience sample methodology. Participants were invited to be interviewed by the researcher in English, after agreeing to the informed consent, then they participated in a brief structured demographic interview, and a longer follow-up semi-structured interview.

Data was collected using recorded audio Zoom interviews among Hispanic women working as professional counselors in rural areas of New Mexico to understand the experiential contexts and bioecological environmental factors that contributed to and protected these women from developing burnout and impairment symptoms. Following data collection, the interviews were transcribed verbatim by the researcher and analyzed to extract themes. Using IPA to collect and analyze the data in this study honored and gave voice to the stories of these women in a way that highlighted their personal lived experiences by looking for patterns of convergence and divergence across cases (Eatough & Smith, 2017).

Introduction and Overview

This chapter is organized by providing the research design used, description of the sample, the role of the researcher, data collection methods, and how the data was analyzed. The research questions that were explored include:

1. How do female Hispanic counselors in rural New Mexico experience professional counseling, make meaning of their intersecting identities, and navigate their systemic environments while maintaining health and wellness?
    a. What are the systemic, environmental, and cultural factors that reinforce and strengthen resilience in female Hispanic counselors working and living in rural communities?
    b. What are the systemic, environmental, and cultural factors that prevent and act as barriers to rural female Hispanic counselors from maintaining wellness and practicing self-care?

To understand the lived experiences of the participants, IPA was most appropriate to use. Chan et al. (2019) further stated that this research method allows for a deeper understanding of the complex systems of inequality to emerge that effect professional counselor's mental wellness and counseling relationships. Pietkiewicz and Smith (2014) recommend when formulating research questions for IPA studies, questions should generate rich and detailed descriptions that explore the lived experience of participants. IPA allowed me to uniquely qualify and deepen the understanding of the phenomenon of wellness and self-care by creating new knowledge through the development of my central research questions (Creswell, 2013).

It was my intent to understand the many levels of systems, organizations, culture, and identities that contribute to counselors developing protective factors and wellness while

practicing counseling. Very few counseling researchers have investigated, explored, or written about Hispanic women's experiences as professional helpers, including their personal experience working in rural areas or within their own communities.

Research Design

Traditionally, researchers have relied on quantitative methods of inquiry to investigate phenomenon. This requires the researchers to build a hypothesis, a predetermined understanding, and then attempt to approve or disapprove it. This type of method does not allow for the researcher to fully understand the lived experiences of the participants by more deeply investigating the meaning attached to specific topics and phenomena. Therefore, I chose to utilize qualitative methods of inquiry. Depending on what the researcher attempts to understand and the population of interest, the design of a study can be one of five main qualitative methods: case study, grounded theory, ethnography, narrative, or phenomenological (Creswell, 2017). I used a phenomenological approach for this study.

At the root of traditional phenomenology research is the researchers attempt to uncover what the participants who experience a phenomenon have in common with each other (Creswell, 2007). Phenomenologists do not examine specific individual experience (Savin-Baden & Major, 2013). Instead, phenomenologists examine how a common group experience a phenomenon (Savin-Baden & Major, 2013). Phenomenology also respects the meaning of the phenomenon as the participant's experience and reality (Savin-Baden & Major, 2013). Moving away from the traditional phenomenological methods developed by Husserl (1938), IPA specifically examines the lived experiences and significance of these experiences in the lives of participants as interpreted by the researcher (Smith, Flowers, & Larkin, 2018). IPA methods situate participants in their particular context, explore their personal experiences, and look at each detailed case

before generalizing to the entire group (Smith, Flowers, & Larkin, 2018). IPA was specifically chosen for this research study because it was important for the researcher to focus on the personal meaning-making in a particular context for people who share a particular experience. The researcher focused on examining the personal meaning-making of rural Hispanic female counselors in New Mexico and their experience of how they practice wellness and self-care in the profession of counseling. Specific objectives this research aimed to do included the following: (1) identify specific systemic factors that contribute to protective factors in Female Hispanic counselors in New Mexico, (2) understand the environmental and cultural factors that influence the stress response in marginalized practicing clinical counselors, (3) uncover solutions to improve minority women's counselor's professional and career development, and (4) understand how rural Hispanic women manage, mitigate, and conquer the stress and emotional toll of working as a professional counselor.

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) was utilized as the framework for data collection and analysis. Smith (1996) created the distinctive research method that he said drew on theoretical ideas from phenomenology, hermeneutics, and symbolic interactionism. Husserl (1931) developed phenomenology, the foundation of IPA, to understand and ground qualitative knowledge in experience. IPA contends Husserl's original approach by adding to the systematically and attentively reflection of lived experiences by understanding existential perspectives (Shinebourne, 2011). Husserl's phenomenology was a form of philosophy that,

> "…empathizes the attempt to get to the truth of matters, to describe phenomena, in the broadest sense as whatever appears in the manner in which it appears, that is as it

manifests itself to consciousness and to the experience" (Larkin, Eatough, & Osborn, 2011, p.332).

In recognizing the dynamic nature of IPA, it is defined as a phenomenological approach that, "…is concerned with an individual's personal perception or account of, so that the researcher can get close to the participant's personal world" (Smith, Jarman, & Osborn, 1999, p.218). IPA further seeks to explore more than just context. IPA is grounded in the personhood, related, perspectival, and meaningful nature of the lived and social world of the participant's positionality (Larkin, Eatough, & Osborn, 2010; Biggerstaff & Thompson, 2008). IPA also has strengths in cultural and cross-cultural context and requires a small sample size, which is homogenous (Pietkiewicz & Smith, 2014).

The researcher's job in phenomenology requires the observer to bracket their preexisting assumptions, understanding, and world view regarding the phenomena prior to observation. Shinebourne (2011) reports that IPA positions the researcher as trying to make sense of the participant's own social world. IPA assumes both the participant and researcher are immersed in a linguistic, relational, cultural, and physical world that does not allow either from escaping interpretation (Larkin & Thompson, 2012). The researcher grounds their interpretation in theory, which allows them to see a phenomenon from a richer, more insightful, and more psychological account (Larkin & Thompson, 2012). This study utilized Intersectionality as a framework and Bronfenbrenner's Bioecological theory to ground and interpret the participant's unique perspectives and worldviews while conducting an IPA analysis of the qualitative data.

Research Sample

This section will describe the study context, sample from which the population was drawn, discuss the sampling strategy used, and the researcher's inclusion and exclusion criteria

for the sample selection. The population this research attempted to address included licensed professional counselors who are Hispanic women and working in rural communities in the state of New Mexico. Before any contact with potential participants, I obtained UNM Institutional Review Board (IRB) approval (#1632046-1).

Study Context

The state of New Mexico is the fifth largest state in the US by land mass and is one of the most rural states, with 2,103,586 people living in 121,298 square miles (New Mexico Department of Health, 2018). Forty percent of the population follows within the U.S. Department of Health and Human Services Primary Care Professional shortage. More than half of adults with mental illness in NM do not receive treatment, and many cite limitations for receiving for services, such as: transportation and lack of access to internet/telehealth services (Bryan, 2019). Furthermore, the U.S. Health and Human Services Department reported that less than one-third of licensed providers are located in rural areas but nearly half of Medicaid enrollees in NM live outside of urban areas (Bryan, 2019). Additionally, NM has an unmet behavioral and mental health service need for individuals with mental illness of 21.6% (LFC Hearing Brief, 2019). And in the past 30 days by household income, adults that expressed mental distress in New Mexico (2016) showed that income of less than $15,000 had a higher prevalence of mental distress (30%) compared to higher incomes (11.9%) (New Mexico Department of Health, 2018). The highest requested behavioral health services in New Mexico's Medicaid patients are substance use/addiction treatment and suicidal ideation/counseling. For example, NM suicide rates are disproportionate, at least 50% higher, than U.S. rates for the past 20 years (New Mexico Department of Health, 2018). New Mexico is a primarily rural state with a large

unmet mental and behavioral health provider shortage, and it has an even larger demand for services in rural communities that go unmet.

Political injustices are one of the driving forces in the state of New Mexico that have further exacerbated the provider shortage. In 2013, then New Mexico Governor, Susana Martinez, began a criminal investigation of 15 of the largest mental health providers in the state. These agencies were accused of Medicaid fraud consisting of $36 million over three years (Frosch, 2013). According to Frosh (2013) state auditors found systemic billing problems that included widespread overpayment for services never provided, claims processed with mistakes, and overbilling. Because states under the Affordable Care Act have the power to suspend payments when evidence is shown that Medicaid dollars are being misused, thousands of New Mexican's behavioral health services were paused (Frosch, 2013). The NM Human Services Department vowed there would be no disruption of services to Medicaid clients by bring in Arizona providers as replacements (Horwath & Terrell, 2016), leading to further service confusion and disruption. However, three years later New Mexico's Attorney, General Hector Balderas, cleared 13 of the 15 providers after investigators found no pattern of fraud (Reichbach, 2016). This investigation not only left patients without valuable services they rely on, but it also caused hundreds of New Mexican behavioral health providers to lose their jobs (Horwath & Terrell, 2016). Because of these events New Mexico has not yet recovered and every year the provider shortage grows larger while the behavioral and mental health service needs also remain unmet in many communities. Because of the environmental and political context that this study took place, sampling had to be purposive and was difficult.

Sampling Strategy

I collected a sample of nine individual participants that met the study inclusion criteria from rural New Mexico via distance recruitment methods. Smith et al. (2009) suggested saturation levels would be met with eight to ten individuals. Therefore, sampling continued until saturation was met and no information was collected from participants, this occurred at approximately nine participants. The sample participants each engaged in two interviews for this process to make sure that no new information was gained (Guest, Bunce, & Johnson, 2006; Lester, 1999; Marshall, Cardon, Poddar, & Fontenot, 2013). It is noted by Pietkiewicz and Smith (2014) that, sampling in IPA is usually small and focuses on a case-by-case analysis; there is usually no ruling on how many participants should be included. Sampling in IPA depends entirely on the depth of each case, the richness of the case, how the cases compare, and pragmatic restrictions the research is working under (Pietkiewicz & Smith, 2014).

A purposeful sampling technique was used to recruit participants from rural New Mexico that fit the sample inclusion criteria. This sampling included contacting and recruiting agencies, non-profits, private practices, NM Universities, and behavioral health centers in rural New Mexico. Rurality depended on Census Bureau (2019) reporting of rural counties in New Mexico. Many participants reported providing services in more than one rural county and some reported at least half of their clients were from urban or semi-rural counties. All participants self-reported providing behavioral and mental health services to primarily rural clients for the majority of their time. Eligible participants also self-identified as Hispanic, as a woman, and as providing services to clients or clients living in rural communities in New Mexico. More information on participant inclusion and exclusion criteria can be found below.

Inclusion and Exclusion Criteria

The following section will outline the inclusion and exclusion criteria for this study. Inclusion criteria included: (1) identify as a women, (2) identify race/ethnically as Hispanic, Latinx, Mexican-American, or Chicana, (3) hold a license in counseling in New Mexico, either as a Licensed Mental Health Counselor (LMHC) or a Licensed Professional Counselor (LPC), (4) providing clinical counseling services (for example, career counseling, addiction counseling, marriage counseling, child counseling, school counselors, career counseling, or supervision and training), (5) practicing counseling in a rural county of New Mexico (there are 13 out of 33 rural counties in NM). The five most rural counties in New Mexico are Catron, De Baca, Harding, Hidalgo, Mora, and Union County (US Census Bureau, 2020). Participants had to identify as a woman when asked their gender. Participants either identified as either a race/ethnicity as Hispanic, Latina, Mexican, or Chicana because race and ethnicity are often combined or misunderstood. Additionally, participants that were identified as mixed race or multi-racial were included in the study. This study targeted licensed counselors that have received their master's degree and only accepted licensed professionals that have a bachelors and master's degree. The master's degree had to be in counseling but could be from various sub-specialties/tracks and could have been earned from an accredited or unaccredited University from anywhere (including outside of New Mexico). Counselors did not need to identify their specialty, but any clinical counseling specialty was considered. This inclusion criterion was established because of the many types of licenses in the state of NM that allow an individual to identify as a "counselor." For example, a Licensed Alcohol and Drug Addiction Counselor (LADAC) sometimes will identify as a "counselor;" however this type of license only requires Associates-level training and education specifically for drug and alcohol treatment and support. Many potential participants contacted the researcher to be apart for the study that held only the LADAC license

or identified as a “counselor” but were licensed as a psychologist or Licensed Clinical Social Workers (LCSW). Some of the participants in this study held multiple licenses in NM, the most common being the LADAC and LMHC. Lastly, participants self-identified they practiced primarily (at least more than half of their caseload) in a rural communities or area’s in New Mexico. Lastly, participants were not required to also live in the same county they practiced in or provided service for.

Exclusion characteristics for this study included the following. Firstly, participants had to agree to the informed consent by email before being enrolled in the study. Participants also had to be able to have the ability to agree and had to be over the age of 18. The informed consent was not only reviewed by them by email before agreeing to the interview and consent, but participants also gave a verbal confirmation at the beginning of each interview. Next, participants needed a stable internet connection and electronic device to conduct the interviews with the researcher through virtual means. This provided to be difficult for a few participants that were working from home with others in the home using internet data, such as children and spouses. All participants began interviews via Zoom, but if connection was not able to be maintained or there was not clear connection, the interviews moved to phone. Additionally, participants were asked to commit and had to agree to two virtual interviews. After both interviews the participants were briefed on the study and asked to further complete “member checks” if able through email. Third, participants had to meet all the inclusion criteria listed above. And lastly participants had to be able to communicate, speak, and write in English fluently.

Recruitment

Participants were recruited from agencies, non-profits, hospitals, and private practices in rural New Mexico. A list of these places was originally developed from the newmexico.networkofcare.org, which provides a list of all behavioral health service providers in the state of New Mexico to the public. The New Mexico Department of Human Services created the Behavioral Health Collaborative in 2004 with the purpose to unite multiple state agencies across the state government involved in behavioral health prevention, treatment, and recovery. The purpose of this was for all agencies to work together to improve mental health and substance abuse services in the state of New Mexico. New Mexico Network of Care allows users to search to find services in their area by providing a comprehensive directory related to behavioral health, crisis services, and substance use programs and facilitates. The researcher initially utilized this internet directory for rural communities in New Mexico to develop a list of recruitment locations. Most of these recruitment locations included hospitals, medical clinics, and integrated service businesses. These recruitment locations were contacted by the researcher to solicit supervisors, directors, and owners of practices by email and phone to solicit interest in receiving a recruitment email (Appendix A) with the study information. Locations that agreed to provide the study information to their employees or volunteers also received a recruitment flyer to distribute (Appendix B). Interested participants who contacted me then reviewed the informed consent (Appendix C) through email and were scheduled for the first structured interview through email and phone.

After initial recruitment, an IRB modification was completed to allow for open recruitment and allowed for the recruitment flyer to be more widely distributed. The researcher found that the state of New Mexico had not updated the Network of Care website in many years; it included agencies that no longer existed and was not a comprehensive list of resources for any

county in the state. Open recruitment then allowed the researcher to contact private practices, agencies, Universities, and services that could be found utilizing an internet search by city. This search allowed me to develop a list of recruitment sites by location that was up-to-date and current. Sample saturation was met by following this new targeted method.

Demographics

The following section outlines the demographics that were collected for this study. Demographic information was collected during the first interview and was based on Arredondo and Glauner's (1992) Dimensions of Personal Identity Model. This model provides a template for fixed and developmental dimensions that make us unique individuals (Arredondo & Glauner, 1992).

Related to Dimension A, which includes visible identities that most influence an individuals' ability to experience discrimination and oppression (Arredondo & Glauner, 1992). The mean age of participants (N=9) was 42.7 years old with a range of 30-73. All participants reported being racially Hispanic/Latinx and being female. All participants reported speaking English, but three participants reported also speaking Spanish fluently. Participants reported combined household income ranging from $28,000 to more than $100,000 a year. See Table 1 for Dimension A participant characteristic's.

Related to Dimension B, which includes less visible identities that are more of a choice (Arredondo & Glauner, 1992). All participants reported earning a high school diploma/GED, bachelor's degree, and master's degree in a topic related to Counseling/Human Services. One participant reported having a Ph.D. No participants reported any military experience or Veteran status. Most of the participants (44%) reported being married, with 1 participant reporting being single, 1 participant reporting being in a long-term relationship, and 3 participants reported being

divorced. Additionally, (33%) reported being Catholic, (33%) reported no religion, being Atheist, or Agnostic, (22%) reported being Protestant Christian, and (11%) reported being not involved with organized religion but practicing spirituality. See Table 2 for Dimension A participant characteristic's.

Related to Professional Identity and work experience participants reported the following. Two participants reported being part-time or seasonal workers and seven reported working full-time (more than 35 hours). Three participants were independently licensed in the state of NM having earned a Licensed Professional Clinical Mental Health Counselor (LPCC) credential. A LPCC in NM requires an educational requirement of holding a master's or doctoral degree in counseling or counseling-related field, two years of postgraduate professional clinical counseling experience, and evidence of 3,000 hours of postgraduate clinical client contact (NM Regulation & Licensing Department, 2021). Six participants were Licensed Mental Health Counselors (LMHC)'s; LMHC's require supervision under a licensed mental health or behavioral health provider and is a transitional entry level license. LMHC's hold a master's or doctoral degree in counseling or counseling related field and must receive one hour of face-to-face supervision for every ten hours of client contact (NM Regulation & Licensing Department, 2021). Additionally, three participants also reported holding a Licensed Alcohol and Drug Addiction Counselor (LADAC) credential. LADAC's are required to have either an associates, bachelors, or graduate level degree and demonstrate 90 clock hours of alcohol and drug training (NM Regulation & Licensing Department, 2021). Participants reported working a variety of settings, such as: private practices, behavioral health clinics, methadone clinics, outpatient and inpatient hospitals, and community-based services. Lastly, participants reported specializing in a number of topics (alcohol and drug addiction, play therapy, family therapy, and clinical supervision).

Table 1. Participant Characteristics Dimension A (N=9)

Demographics	**N**	**%**
Age		
18-29	0	0
30-39	5	56%
40-49	2	22%
50-59	1	11%
60-69	0	0
70-79	1	11%
Gender		
Female	9	100%
Male	0	0%
Language		
English Only	6	67%
English/Spanish	3	33%
Race		
Hispanic/Latina	9	100%
Sexual Orientation		
Heterosexual	9	100%
Household Income (per year)		
$20,000-29,999	1	11%
$30,000-39,999	0	0

$40,000-49,000	2	22%
$50,000-59,000	1	11%
$60,000-69,000	0	0
Over $70,000	5	56%

Table 2. Participant Characteristics Dimension B (N=9)

Demographics	**N**	**%**
Education		
High school, Bachelors, and Masters	8	89%
Ph.D.	1	11%
Military Experience		
No	9	100%
Yes	0	0%
Religion		
Christian, Catholic	3	33%
Christian, Protestant	2	22%
Reported none, Atheist, or Agnostic	3	33%
Other, Spiritual	1	11%
Relationship Status		
Single	1	11%
In-relationship	1	11%

Married	4	44%
Divorced	3	33%

The Researcher

The researcher is a vital part of the research process because they collect the data firsthand and this in turn creates a two-way relationship. IPA calls this the "double-hermeneutic process" which explains that the data collection and data analysis has two levels; the participant's narrative and the researcher's interpretation of that narrative (Smith et al., 2009). Therefore, it is important as a researcher that I attempt to reduce bias and build understanding related to my positionality as a researcher, the following section will provide an overview of my cultural background and theoretical orientation that I subscribe to in my own clinical work. Ferber et al. (2007) highlights that researchers need to acknowledge their positionality (or social location) on the Matrix of Domination to demonstrate social responsibility. Therefore, I, the primary researcher of this study, am a young White heterosexual woman from California. I have lived as a resident and practiced professional counseling in the state of New Mexico in an urban area for the last few years while I completed my doctoral education. I have experienced both privilege and oppression based on my intersecting identities. Identifying my unique location on the matrix allows me to reflect and be aware of how being part of the dominant ethnic and cultural group can perpetuate hegemonic values systems that can impact my analysis and interpretations (Chan et al, 2019). In Counselor Education, White men and women represents the dominant racial, ethnic, and cultural group of the United States. Because I explored counselor's narratives that are different from my own and I attempted to actively understand their experiences, I had to remain mindful of my lens of reference. Inhibiting the racial body of being

White, a dominate group within the U.S. and in the counseling field, I knew that I had to remain vigilant of my privilege by attempting not to further perpetuate a legacy of colonizing research practices. Being an active participate in this research required me to leave space for the voice of participants who may have experienced varying levels of oppression and injustices related to their culture and identities, that were uniquely different from my own. I primarily did this by employing decolonizing ideologies and research practices that allowed me the opportunity to challenge the status quo and Western ideologies by focusing my research agenda on honoring my participants and their local knowledge and experiences (Bermudez et al., 2016).

I grew up in a large urban city in California within a family of low socio-economic status. Neither of my parents went to college, making me a first-generation graduate. These early experiences of living in poverty, attending low-income and urban schools with students of color, and living in neighborhoods with other struggling families helped facilitate my understanding of systemic factors that challenge an individual's ability to be successful. I was not completely shielded from these burdens, but the close relationships I had with my family and extended community protected me from being lost within this environment. I was given opportunities to thrive because of the relationships that I had, which ultimately built security and safety for me in troubling times. I was also able to empathize and engage with a community that I did not inheritably belong to but was able to enter at multiple levels through understanding and shared environment.

My interest in studying psychology and counseling began early, when I started to realize that despite living in similar conditions as my peers, I had certain privileges that granted me opportunities to be successful despite my social territories. This fostered a curiosity in me to study the concept of psychological resilience. Specifically, I was curious about what are

individual differences that contributed to a person's growth and development in poor and difficult conditions. Even now, as a counselor I value relationships and I am primarily interested in the mitigating factors that promote life and the ability to thrive in harsh conditions. My training and experience in counseling drew me primarily into the theoretical orientation of Humanism or Rogerian Client-Centered counseling philosophy. Rogers too was interested in human growth and potential when he described his early experiences in his career. Rogers stated (1949):

> "The actualizing tendency can, of course, be thwarted or warped, but it cannot be destroyed without destroying the organism. I remember that in my boyhood, the bin in which we stored our winter's supply of potatoes was in the basement, several feet below a small window. The conditions were unfavorable, but the potatoes would begin to sprout- pale white sprouts, so unlike the healthy green shoots they sent up when planted in the soil in the spring. But these sad, spindly sprouts would grow 2 or 3 feet in length as they reached toward the distant light of the window. The sprouts were, in their bizarre, futile growth, a sort of desperate expression of the directional tendency I have been describing. They would never become plants, never mature, never fulfill their potential. But under the most adverse circumstances, they were striving to become. Life would not give up, even if it could not flourish. In dealing with clients whose lives have been terribly warped, in working with men and women on the back wards of state hospitals, I often think of those potato sprouts. So unfavorable have been the conditions in which these people have developed that their lives often seem abnormal, twisted, scarcely human. Yet, the directional tendency in them can be trusted. The clue to understanding their behavior is that they are striving, in the only ways that they perceive as available to

them, to move toward growth, toward becoming. To healthy persons, the results may seem bizarre and futile, but they are life's desperate attempt to become itself" (p. 78).

Rogers had a unique theoretical orientation that valued the individual experience foremost in the counseling relationship (Rogers, 1945). Roger's (1952) emphasized the therapeutic relationship as the primarily driving factor for change, stating that the relationship is a model for the clients to explore, freely, without defense, and difficulties that is ultimately needed for attaining to self-realization and self-transcendence. Roger's (1964) said this professional relationship was unique because of "necessary and sufficient" conditions in the therapeutic process, these factors include: empathy, genuineness, and unconditional positive regard. He advanced the design that

> "…individuals have within themselves vast resources for self-understanding, for altering the self-concept, basic attitudes, and their self-directed behavior- and that these resources can be tapped if only a definable climate of facilitative psychological attitude can be provided" (Roger, 1959).

As a counselor and someone that is educated, I hold a social location status that demonstrates privilege. In order not to reinforce hegemony through the gaze of a dominant group, of White counselor educators (Chan et al., 2019), as a researcher I used critical reflexivity and cultural humility throughout this research project. I did this by continually reflecting on my own perspective and assumptions about identity and how those beliefs, judgements, and practices may interfere with the research. Because of my personal history and Roger's influence I have a fundamental belief that "... if people can be harmed by relationships, they can be healed by relationships" (Cottone, 2017). Finally, I ascribe to the understanding that race is a socially constructed category and notions of race are human creations not eternal or essential categories (Bonilla-Silva, 2018). Techniques I implemented in this research included *broaching*, which is

the stance of "…inviting [participants] to have explicit dialogues about race, ethnicity, and culture" (King & Borders, 2019, p. 346). The broaching process includes understanding the research participant in a cultural context and demonstrating a commitment to eliminating oppression and promote social justice and equality as a researcher (Day-Vines, 2007). King and Borders (2019) highlight that cultural responsiveness happens when researchers are direct with mentioning how cultural differences can influence the dynamics of interviews when relational contexts of identity and power are discussed. Chavez-Duenas et al., (2019) echoed this when they investigated systems of oppression, ethno-racial trauma, and interlocking systems of oppression and they advocate for researchers to use trauma informed care, liberation psychology concepts, and sanctuary spaces for Hispanic communities. It was important for me as White woman to be culturally responsive and demonstrate cultural humility throughout the research process to be able to study the lived experiences and narratives of women who have vastly different intersectional identities as me.

Being aware of my own biases, worldview, stigmatization, and environment was important to inform my research. I continuously worked from an understanding of social justice while respecting the autonomy and worldview of my participants (MacLeod, 2013). One way that I addressed the needs of my participants from culturally diverse communities is following Ratts et al. (2016) Multicultural and Social Justice Competencies, by remaining conscious of marginalized and privileged positions throughout the research project and later the methods of interpretation I used for the data. Lastly, by keeping in mind my purpose as a researcher to advocate for counseling, social justice, and social action to increase my participant's sense of personal power and foster sociopolitical change (Kiselica, 2001) helped me remain grounded in my work.

Data Collection Methods

The following section will provide an outline of the data collection methods and will include the steps that were taken to carry out each method. Participants were initially recruited by using purposive sampling techniques and snowball sampling was also utilized when appropriate. The rationalization for using these methods of sampling includes the ability of the research to target specific agencies and groups that might meet the inclusion criteria. It was anticipated, and later shown, that finding participants who met the inclusion criteria would be difficult and having this sampling technique would improve ability to meet saturation. It was vital for me to be able to target individuals that meet the inclusion criteria by sampling locations that met criteria, such as located in rural communities in New Mexico. Participants who contacted me were emailed an electronic consent form to review and asked if they met inclusion criteria listed. The informed consent outlined the procedures and risks associated with the study, participants were also made aware of their right to stop participation at any time, and if there were any clear reservations, it was reiterated to participants that they did not need to participate and could stop at any time. Additionally, the participants were able to review the informed consent through email and ask questions through email or during the interview, this allowed them to read through the consent and allow for comprehension. If there were no further questions, consent was obtained by the researcher verbally at the beginning of each interview. A waiver of documentation for consent was granted by the IRB for this study because no identifying information was collected, a pseudo-name was linked to each person, and it was determined there was no more than minimal risk to participate in this study. Because a waiver of consent documentation (not collecting a signature from each participant) it was especially

important for the researcher to make sure that the participant agreed to the study and understand everything related to the research.

Ethical Considerations

There were several ethical considerations for this study, such as the possibility that the researcher could have experienced and heard from participants who were professional counselors and were currently experiencing impairment symptoms. ACA Code of Ethics (2014) require in C.2.g. Impairment, "… colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients" (p.9). As a licensed counselor, I was aware of this ethical code, if a participant disclosed potential for past, current, or future harm to a client. However, no participant disclosed any information related to personal impairment. I mitigated this risk by reminding the participants of this ethical obligation in the informed consent and again before beginning an interview with them. This alone reduced the risk to the participant. This was because as a licensed counselor the participant was aware of this ethical obligation and was less likely to disclose something that they would have preferred me not to know or disclose by mistake. As a student researcher, I was also supervised by a committee of faculty members that had professional licenses in counseling and had advanced training and education in counseling supervision. I frequently relied on supervision and oversight by committee members to make any decisions related to ethical dilemmas. During the course of the study, no mandated reports were made. Furthermore, I provided referrals to participants that requested them, appeared distressed, or had difficulty emotionally regulating during the interview.

The study posed minimal risks including the possibility of unwanted disclosure of information, psychological distress, and unwanted intrusion of privacy. To counter these risks, risk and benefits were included in the informed consent agreement. I also reminded participants

during interviews of the limits of confidentiality including if they disclose abuse or neglect of a vulnerable person and that I would have to report this, as a mandated reported. I reminded participants that they could decline to participate or withdraw at any time without any adverse consequence and did not have to share anything with me that they did not feel comfortable sharing.

Instruments

Participant demographic information and contextual information related to their work and practice was collected. Demographic information that was collected included age, race, gender, and race/ethnicity. Contextual information that was collected included licensure of the participant, how long they have had their license, what kind of setting they currently practice in, history of employment, specializations in the field, and what kind of services they usually provide to clients. Perceptual information, which is defined as the participant's perceptions related to the research inquiry (Bloomberg & Volpe, 2016), was collected during the interviews with each participant. Participant interviews primarily focused on the participant's perception of protective factors and barriers to self-care that have been present in their environmental and organizational settings.

Videoconferencing

During the time of this study, in person research was severely limited, because of COVID-19. In March 2019 the novel human coronavirus disease COVID-19 (SARS-CoV-2) a severe acute respiratory syndrome originally from Wuhan, China spread to the United States (Liu et al., 2020). Specific antiviral treatment and vaccines were still under development and many people in the U.S., especially in NM, remained under quarantine, social distanced from one another, and wore mask (Liu et al., 2020). This severely limited behavioral and mental health

treatment and services for adults, children, and families across NM (Liu et al., 2020). The pandemic has had profound effects on all aspects of society, but especially on the psychological and social mental health of the public and its mental health and behavioral health treatment providers (Li et al., 2021). During this time, many counselors in NM began providing telehealth services, although in-person services were allowed to resume at the discretion of the counseling agency or in some cases individual counselor's preference. Many behavioral and mental health providers utilized telehealth services for the first time in their career and had to adjust their professional practice to cater to this type of treatment method (Liu et al., 2020).

Audiovisual and internet technologies are becoming more accessible and widely used by practicing counselors and researchers for data collection purposes. It has also been found that in cases where research participants are geographically dispersed using the internet as a data collection medium is appropriate for conducting in-depth qualitative interviews (Seqwick & Spiers, 2009). Seqwick and Spiers (2009) cited using technology as a medium to conduct qualitative interviews as a benefit to the researcher because it reduces cost and produces similar results to face-to-face in-person interviews. Because of the above reasons, the researcher recruited for the study, contacted participants, interviewed, and communicated with the participants completely through online and phone means for the entirety of the study. This was especially helpful to keep the participants and myself safe and in-compliance with NM health orders.

First Interview

After agreeing to the informed consent, Zoom video conferencing meeting was set-up with each participant. Zoom Pro, a HIPPA compliant software for healthcare providers; was utilized, this required participants to have access to an electronic device and reliable internet.

Additionally, each participant was given a private password to access this meeting that was unique to them. As mentioned early, during the course of the study, the UNM Office for Vice President for Research restricted all face-to-face human subject research activities because of COVID-19. Therefore, all research interactions with participants associated with this study (both interviews) was performed remotely. Interviews occurred over video and audio teleconferencing, with only me, as the researcher, and the participant present. The first interview usually lasted 30 minutes to an hour and included a structured interview that collected primarily demographic information (see Appendix D).

The demographic interview questions were developed from Arredondo and Glauner's (1992) Dimensions of Personal Identity Model, which presents the multiply dimensions that interconnect an individual holistically and between their various identity statuses. Arredondo (1999) stated that the Dimensions of Personal Identity Model shows how multiple fixed and flexible factors that develop a person's identity and worldview can influence one's cultural and individual differences. The model includes three different dimensions. Dimension A includes visible identities that most influence an individual's ability to experience discrimination and oppression such as age, culture, ethnicity, gender, race, language, physical disability, social class, and sexual orientation. Dimension B includes less visible identities that are more of a choice, such as participants educational background, income, geographic location, marital status, religion, work history, military experience, citizenship status, and hobbies/recreational interest. Last, dimension C includes historical moments or eras that have influenced how the individual's identity is lived (Arredondo & Glauner, 1992). Dimension C examples included the impact of COVID-19 and increased racial tension in the United States. Questions related to the professional status of the participant was also asked, including: what type of licensure they held,

how long they had this license, what their work status was, and what kind of facility they work at?

During this interview, rapport was established with the participant, so the participant felt more comfortable scheduling and answering questions for the second semi-structured interview. Biggerstaff and Thompson (2008) reported IPA is usually done in very loosely semi-structed interviews with the researcher using a few main themes to focus on with the participant. Therefore, the researcher focused on the protocol during the interview and steered participants in the direction and focus of the interview. The second interview was loosely semi-structured and primarily asked questions that addressed the research questions.

Second Interview

After the participant had completed the informed consent and the first interview, the researcher then scheduled a second interview with each participant. The second interview was 60-90 minutes long and included a semi-structured interview, also conducted through Zoom Video Conferencing. Interviews for phenomenological studies are typically unstructured with unforced questions using a collaborative approach that intends to produce a detailed description of the phenomenon (Savin-Baden & Major, 2013). The semi-structured interview requires the researcher to rely on an interview protocol, asking questions related to the study in a particular order, and the researcher is able to stray from the guide as appropriate (Savin-Baden & Major, 2013). For this study, questions were mostly open-ended and allowed for a limited time for the interaction to remain focused and related to the phenomena being studied. The researcher asked guided questions that focused on the participant's professional experience as a counselor, relationship to personal identities, and systemic and environmental conditions that facilitated and prevented them from maintaining wellness and self-care practices. Interview questions were

asked to invoke in-depth exploration including: descriptive, narrative, structural, and comparative questions (Smith, 2008) (see Appendix E). Examples of questions being asked in this interview included:

(1) What does it mean to maintain wellness and what are some barriers to wellness as a professional counselor?

(2) What are some environmental, community, or professional resources, events, or people that have contributed negatively or positively to your professional satisfaction?

(3) Describe your experience of developing self-care strategies throughout your growth as a professional from graduate school to working as a professional counselor?

These semi-structured interview questions allowed me to understand the lived experiences of rural Hispanic women who practice professional counseling and how they conceptualized wellness, impairment, and cultural factors that serve as barriers or protective factors in the prevention of negative symptoms related to working with clients. The semi-structured interview protocol also allowed for an open dialogue in real time and for flexibility for unexpected delays and issues. For example, many of the participants were managing dual responsibilities while completing the interview and had interruptions during the video because of internet connection issues, children at home, or even animals demanding attention. During the interview, I monitored the participants for fatigue, awkwardness, or discomfort. When I noticed any issues, I would stop and address them with the participant, particularly if the participant displayed emotional distress related to communicating a tragic, traumatic, or graphic memory or experience with a client. Participants were able to choose to stop the interview at any time, however, this only happened on a few occasions related to either the researcher or the participant experiencing internet instability. In almost all cases, the interviewer asked the participant to continue the interview by

phone connection, either by calling into the Zoom meeting or using cellular networks. All interviews were recorded and later transcribed verbatim without any identifying information related to the participant. I did not take notes during the interview process, as to remain attentive to the participant throughout the interview, but I did utilize a reflexive journal before and after each interview.

I transcribed the interviews without the help of a hired transcriptionist, to fully immerse myself in the richness of the raw data. Furthermore, I sought to immediately transcribe each interview before conducting the final second interview with each participant. However, I waited to send a copy of each participants transcribed interviews until they completed the study to allow for member checking. This process allowed for participants to follow-up with me between interviews or during another interview to make changes to their transcript or narrative, this included requests to omit any potentially recognizable information, personal data, or names/characteristics. Participants were also encouraged to contact me with any follow-up questions or concerns at any time before, during, or after they had completed the interviews.

Member Checking

Member checking, also known as member validation, member reflection, participant feedback/review, and stakeholder involvement; is the purpose of checking the accuracy of the participants account that was taken by the research (Thomas, 2017). Member checking involves asking each participant to voluntarily review the verbatim transcription of their interview to enhance accuracy in the data (Birt et al., 2016; Lincoln & Guba, 1985; Patton, 20002). Through this process, participants felt more validated and respected while reviewing verbatim-transcribed data, which may have elicited feelings of distress, such as embarrassment or anger. It was especially important for me, as a White woman, to use this method because interview-based

research is a representation of participants' experiences and perspectives and may be vastly different from the researcher, such as my own. Member checking requires the researcher to engage in extensive ethical attention because member checking can be distressing or a therapeutic process for participants (Birt et al., 2016). While Thomas et al. (2017) criticized member checks and said there is little evidence that member checks improve research findings, they did indicate that member checks are useful for obtaining participant approval of data. Also, adding that representation is useful because it adequately represents the realities and ensures that the participants agree with the findings constructed by the researcher (Thomas et al., 2017). Some other benefits of conducting member checks is that they further offer the researcher a chance to detect personal biases by soliciting alternative viewpoints about the interpretation of the data (Kornbluh, 2015). Below is an outline of how I approached and requested member checking. Additionally, this section will show how I eliminated and managed subjectivity and increased trustworthiness during the study.

Member checking required me to verify with each participant to ensure that they concurred that I obtained the most accurate information, clearly interpreted what they were saying, and gave them the opportunity to provide additional information (Creswell, 2017). For this particular study, participants were sent an email for review, comment, or correct related to (1) a verbatim transcription of both of their interviews in English and (2) a copy of emerging findings related to their individual case (Lincoln & Guba, 1985). Each participant was given this opportunity and any discussion and feedback that was received from participants was incorporated. Participants who engaged in this process were also reminded that as a research participant they had the right to withdraw from the study at any time, however none did. They were also heavily encouraged to participate in member checking from the researcher to increase

trustworthiness and credibility. Minimal requests were made, but these requests were mostly related to ensuring confidentiality. Many participants later voiced concerns to me about feeling overly comfortable during the interview and providing information about clients or personal friends or family members. For example, a participant was fearful that she overly disclosed information about a client that was causing her distress, citing concerns of breaking confidentiality. Every concern was followed-up by phone or email to ensure trustworthiness and credibility by each participant. Confidentiality was further ensured by not using any of the participants identifying information, such as their name, location, or workplace. When this information was provided during the interview it was removed from the transcripts.

Reflexive Journal

The researcher developed a reflexive journal throughout the research process, as suggested by Lincoln & Guba (1985) to meet the qualitative rigor and trustworthiness. The use of a reflexive journal allowed the researcher to record and reflect before and after interviews and during interactions with participants. Using a reflexive journal provided a means for me to use bracketing methods and support the intersubjective meaning-making and understanding within the process of the study (Lincoln & Gaba, 1985). For instance, I recognized that although I was a woman practicing clinical counseling in New Mexico, my own experiences were very different from those of my participants because I never had to contend with issues of race and rurality. However, having some similar attributes as my participants (being a woman and a counselor), helped the participants and myself further connect to their narratives and stories. For example, I noted in my reflexive journal when participants personally connected with me and how it enriched the interviews. Oftentimes this connection was related to a shared understanding and experience of sexism or gender roles/expectations. Another common connection was when

participants were curious about my own family and if I was or wasn't a mother. In summary, during this process I recorded my thoughts and feelings regarding the content and process of the interviews and the overall research process (Smith et al., 2009). My recording of reflection further connected me to my participants and reinforced the purpose of the study.

Data Analysis and Synthesis

This section describes the protocol for how I managed, organized, and analyzed the data. To begin, I temporarily kept the audio recordings of the interviews with the participants on my personal computer that is password protected and encrypted. After an interview was transcribed the original recording of the interview was destroyed. I kept these written de-identified transcriptions on my personal computer that was password protected.

Smith, Flowers, and Larkin (2018) method for analyzing IPA studies was used. First, I read and reread the original data, immersing myself in the data so that the participants became the focus of analysis. For example, beginning with the first interview transcript, I listened to the audio recordings of the interview while reading through the transcript; immersing myself and double-checking the transcript for consistency. When reading and rereading through the transcripts, I took my time and did not simply try to quickly summarize the experiences as related by the interviewee. Second, I started an initial level of analysis by exploring initial noting and comments to the transcriptions each individually and by written hand. By doing this, I was able to develop a comprehensive and detailed set of notes and comments on the data using pen and paper. This initial process started to yield a descriptive core of comments that have a phenomenological focus and followed the participants explicit meaning. The initial noting strategy was the most detailed and time-consuming stage of the analysis because of the importance of paying close attention to each line of the text. Focus remained on describing the

things that mattered to each participant and the meaning of those things for the participants, as described in their interviews. In step three, I developed emergent themes that attempted to produce a concise set of statements of what was important in the various parts of each participant's transcripts. Emergent themes were examined using an intersectional lens, paying particular focus to systemic factors in relation to power and privilege that were previously discussed. At this point in the data analysis process, I reduced the data of the text to chronologically ordered emergent themes. Next, I searched for connections across the emergent themes. Smith et al. (2009) suggested searching for connections by manually organizing how the researcher understood the themes fitting together. Emergent themes that were related to the specific research questions were prioritized during this stage. Step five included moving to the next participant interview transcriptions and repeating the first four steps that were previously described. The order in which the transcripts were analyzed was determined by the date in which data collection for each interview occurred and participant's interviews were combined to one transcription/case. Lastly, when I had completed all the steps of analysis for each individual participant, I looked for patterns across cases. This was completed by developing a table of all the themes with each individual participant and looking for themes that emerged collectively across all participants (Smith, Flowers, & Larkin, 2018). Through the interpretive process, I worked in a dynamic, iterative and non-linear manner, examining the whole within the individual and across cases (Eatough & Smith, 2017). Smith et al., (2009) provided direction for doing this by having the researcher simultaneously display all tables of themes for each case and then examining connections, patterns, and themes that emerged from the group-level or cross-case analysis. For me this process involved note cards laid out on a large table with each individual participant's themes on separate color coded cards. This allowed me to manually remove and

place individual participant themes in an organized manner to comply the collective experience together to describe the communal narrative of all participants. Lastly, although researcher interpretation influenced all stages of the research design, I maintained the lens and principles of intersectionality and bioecology to understand the specific phenomenon of the participant's unique experience throughout the process.

Intersectionality Framework

This research study used Intersectionality framework to inform the development of the study and to analyze the data that was collected. Using intersectionality in research, includes using six core ideas that are used as analytic tools, which are: inequality, relationality, power, social context, complexity, and social justice (Collins & Bilge, 2016). These six core analytic tools that are used in intersectional approaches were used throughout the course of this study. For instance, I infused intersectionality into the development of the study by being self-reflexive (Duran & Jones, 2019; Lopez et al., 2018), by using qualitative methods (Bauer, 2014; Syed, 2010), and focusing on representation of identities that are relational (Windsong, 2018; Duran & Jones, 2019).

Windsong (2018) stated that in intersectional data collection methods, a researcher needs to move away from additive analysis, by including relationality and the idea of social construction of race and gender. Moving away from an additive analysis means not ranking or using dichotomous thinking when evaluating oppression and privilege (Toro & Yoshikawa, 2016). The non-additive approach allows the researcher to explore intersecting patterns between different structures of powers and how different social categories mutually constitute each other (Christensen & Jensen, 2012). This non-additive approach, also known as identity development scholarship, illuminates the connection between overlapping axes of power and identity (Duran

& Jones, 2019). This study followed Christensen and Jensen (2012) recommendations during the analysis of the data for qualitative research to use anti-categorical approach, intra-categorical approach, and the inter-categorical approach. Taking a relational approach means shifting the focus away from just oppression and also examine its relation to privilege. The findings of this study were carefully examined by utilizing this perspective. This research study was built on these concepts and held the key assumption that categories are not static, absolute, or essentialist when critically examining conceptions of race, gender, class, or sexuality (Windsong, 2018).

Typically, creating a study with intersectional concepts includes how the researcher positions themselves in the research, how they formed the study, and what questions are asked during the interview. For example, intersectional analysis involves deeper more specific research questions that are focused on theoretical foundations that highlight positions and identities of participants (Bauer, 2014). Data collection methods related to interviews include asking questions that get at within-group differences and questions that get at interlocking systems of power (such as questions that are structural, representational, and political) (Duran & Jones, 2019). This study specifically used Arredondo and Glauner's (1992) Dimensions of Personal Identity Model to form the questions for the first interview this provided me with the multiple dimensions of participant's identity. Arredondo and Glauner's (1992) model has previously been used in various studies with Hispanic/Latinx populations (Arredondo, 2002). This aligns with Windsong (2018) recommendation that interview questions should ask participants to describe their identity instead of just checking boxes. The second interview utilized a collaborative approach that sought to understand the phenomenon of the participants lived experiences practicing counseling in rural New Mexico. This second interview sought to provide representation of identities, by providing a framework that focused explicitly on giving attention

to differences that exist across and within groups (Duran & Jones, 2019). This was especially important because intersectionality rejects the idea that research subjects exist with stable essential identities and instead identities are mostly relational, fluid, multiple, and always being renewed and revived (Gruenfelder & Schurr, 2015).

When the data was being analyzed, life-story narratives were sought. Life story narratives specifically tell us how participants draw on different categories in the construction of their own narratives. Life-stories as an intersectional analysis of methodological lets the research understand the complex process of identification and positioning (Christensen & Jensen, 2012). During the interview process I sought to understand participants understanding of their life-story narrative to better understand their conceptualization and utilization of self-care and wellness.

Triangulation

Triangulation is the process of reviewing the data collection through multiple methods in order to achieve a more accurate and valid estimate of the qualitative results (Oliver-Hoyo & Allen, 2006). Triangulation requires that the researcher take different perspectives under study and this allows for knowledge production to occur at different levels that go beyond any one approach (Flick, 2014). Oliver-Hoyo and Allen (2006) said that triangulation's main task is to cross-validate by comparing information to determine corroboration. This study used data triangulation to further validate the results of the IPA qualitative process. Data source triangulation is the process of collecting data from different types of people (e.g., individuals, groups, families, and communities) to gain different perspectives and validate the date (Carter et al., 2014). One way that this study used data source triangulation is through member checking. Member checking is a validation technique in qualitative research that increasing trustworthiness, authenticity, and credibility in results (Birt et al., 2016). Additionally, to validate

qualitative research in IPA studies, Smith et al., (2009) also recommends using Yardley's (2000) four principles for testing validity (sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance). Both of these methods were used to triangulate and validate this study. The following section will describe the above triangulation techniques that were employed throughout the course of this study.

Yardley (2000) Validity Testing

IPA qualitative research can be validated by assessing the quality of data using Yardley (2000) four broad principles (Smith et al., 2009). Yardley's (2000) four broad principles are: (1) sensitivity to context, (2) commitment and rigor, (3) transparency and coherence, and (4) impact and importance. The following will discuss each concept and how it was applied and used in this research study.

Sensitivity to context includes the socio-cultural factors in which the study examines, literature on the topic, and the data collected from the participants (Yardley, 2000). Sensitivity was managed by using Intersectionality and bioecological framework as a research lens and by using purposive sampling. I also demonstrated sensitivity to context when I wrote this final report by using a considerable number of verbatim quotes from my participants to demonstrate my findings. Sensitivity was also achieved by using member checks, this required each participant to check the data and interpretation being made. Many of which did provide feedback related to their transcripts, most notably concerns about confidentiality were discussed and addressed.

Secondly, commitment and rigor, which is the attentiveness to the participants during data collection and the care of carrying out the analysis (Yardley, 2000), was also used. I demonstrated commitment to my participants by making sure they were comfortable, informed,

and I also carefully listened to during the interview process. I also completed member checks to ensure participants that I had a personal commitment and investment in this research and that I am was careful to attend to their voices and lived experiences.

Third, transparency is providing clear instructions to the participants about the research process and how the study is conducted. Coherence refers to the fit between the research and the underlying theoretical assumptions being implemented (Yardley, 2000). Transparency was accounted for in the informed consent and in the initial conversations and communication when being informed about the study goals, aims, and purpose. It was accounted for in the research proposal and final draft, where I clearly communicated how my participants were selected, how the interviews were conducted, and how the analysis was conducted. Furthermore, coherence was used by adhering closely to the underlying principles of IPA, which are grounded in phenomenological and hermeneutic sensibilities (Smith et al., 2009). Lastly related to transparency and coherence, for the entire study I was aware of my positionality and understood that I was making sense of the participants lived experiences and narratives when demonstrating coherence.

The last concept in Yardley's (2000) model is impact and importance, which refers to the research being able to tell the reader something interesting, important, or useful (Yardley, 2000). I was easily able to evoke impact and importance by shedding light on an area of research that is not well researched with a population that is usually silenced and ignored. As an aspiring IPA researcher my aim was to make an impact in the field of counseling by providing important and significant findings related to a population that is not well researched or listened to. All four of Yardley's (2000) model of qualitative validity for IPA (sensitivity to context, commitment and

rigor, transparency and coherence, and impact and importance) was applied and examined in relation to this study.

Summary of Methods

The purpose of this study was to explore how Hispanic women in rural New Mexico make sense of wellness and self-care practices by investigating the barriers and protective factors in their bioecological environment. Chapter three aimed to introduce the research methodology of this IPA study, it provided information about the research design, research sample, the role of the researcher, data collection methods, and the data analysis. Specifically, I recruited Hispanic women that were licensed professional counselors and working with clients in rural communities in New Mexico. This qualitative research design included one short, structured interview that was primarily demographic in nature and one longer semi-structured interview that asked the participant about their experience in their community, conceptualization of wellness, and practice of self-care. Interpretative Phenomenological Analysis (Smith et al., 2008) was used to analyze the data, this chapter discussed the distinctive methodological features of IPA along with the appropriateness of this approach for this study. Bioecology theory and intersectionality framework was used as a lens for interpretation of participant narratives. This chapter also discussed how I, as the researcher, remained critically reflexive to my racial and cultural identities, and how this was different from the participants. Chapter four will include a discussion of the findings of this exploratory study. It will focus on the narratives and experiences of the participant's perceptions of self-care and wellness and the protective factors and barriers that promoted or inhibited their practice.

Chapter 4: Presentation of Findings

In this chapter, the findings are reported, and the results of the study are presented. The interviews from this study were assessed using Interpretative Phenomenological Analysis (IPA), an approach that focuses on providing insights into how a particular person gives context to a specific phenomenon (Smith et al., 2009). The purpose of this study was to investigate the lived experiences and narratives of Hispanic female counselors in rural New Mexico. In this study, I paid particular attention to how they managed the personal and environmental systems that contributed to their ability to maintain wellness and resilience. Additionally, I sought to understand how bioecological systems, such as cultural, family systems, environmental systems, and workplaces impacted their clinical practice of counseling, conceptualization of self-care, and barriers to practicing self-care. The research questions that guided this study are as follows:

1. How do female Hispanic counselors in rural New Mexico experience professional counseling, make meaning of their intersecting identities, and navigate their systemic environments while maintaining health and wellness?
    a. What are the systemic, environmental, and cultural factors that reinforce and strengthen resilience in female Hispanic counselors working and living in rural communities?
    b. What are the systemic, environmental, and cultural factors that prevent and act as barriers to rural female Hispanic counselors from maintaining wellness and practicing self-care?

Little research exists exploring how Hispanic women practicing rural counseling experience self-care and wellness. This present study addressed the lived experiences of wellness and self-care for Hispanic women practicing rural counseling in New Mexico.

Findings

The researcher engaged in the initial five steps of the IPA analytical process (Smith et al., 2009) for all nine participants' transcripts before developing superordinate themes across all interviews. This chapter describes the six major themes and twelve subthemes using examples from the participant's interviews. Each of these themes is described in depth using excerpts of participants accounts and the interpretative lens of the researcher. The double hermeneutic process is characteristics of IPA by presenting a narrative account of participants' interpretations identified through the interpretative process of the researcher (Smith et al., 2009). The following provides a summary of the themes and subthemes. Theme one was maintaining a sense of purpose and included the subtheme: (1) having a helper's mindset. Theme two included participants managing poor work conditions and included the subthemes: (1) lack of support and services and (2) being underpaid and overworked. Theme three was the use of relationships as a resource and included the subthemes: (1) family systems and (2) community and social networks. Theme four included navigating social and cultural expectations. Theme five was connectedness to social and community care. Lastly, theme' six described the systemic oppression that participants faced.

Examples from participants are provided below in the themes in which I used verbatim quotes or summaries to describe their experiences with that topic. Quotes and themes were used to support the findings presented to answer the research questions. Direct quotations from the participants are written throughout this section in "double quotation marks;" however, some of the quotes have been edited or modified to shorten the participant's response or to maintain confidentiality. I favored extensive quotes and detailed responses to ensure the authenticity of the participant's voice and experience to demonstrate each theme. I followed the experiences of

participants to gain understanding from their stories. Furthermore, to indicate when modifications have been made, square brackets within the "double [quotation] marks" are used to demonstrate when I have changed any participant response. Lastly, three periods within the double quotation…marks" are used to inform when parts of the quotation were omitted, changed, or altered. The most common instance of this was when there was words or phrases that sound or mark a pause or hesitation in speak, such as filler words.

Theme 1: Maintaining a lifelong sense of Purpose

Participants described personal traits that helped them overcome difficult situations and disadvantage. These traits included personal motivation to be successful, having a distinct sense of purpose, and holding a positive and helping mindset. When describing what helped them be resilient in the face of adversity, participants gave examples of character traits that were pervasive and consistent overtime to help them cope. Participants described personal motivation to be successful in their career, serve their communities, and contribute to their families. They did this by setting distinct goals to follow, being motivated by guiding principles, and carrying distinct mindsets and characteristics of positive thinking to reinforce their sense of purpose.

One of the ways that participants understood their sense of purpose and meaning of life was by pursuing their goals. Participants demonstrated goal directedness and motivation to succeed by focusing on obtainable realistic goals to further their career and wellness. Embracing goal-oriented mindsets allowed participants to adapt to difficult situations by remaining optimistic. But it also allowed them to be successful and achieve their dreams, whether it was to become a counselor, attending graduate school, or becoming an expert in their specialization.

Beginning with the motivation for them to enter the field, one participant said, "…I was encouraged by a high school counselor. She was a role-model for me. She told me about her

experience in college and how she became a counselor" (P4). This participant also shared how beginning in high school she had a strong desire to serve.

> "I was in a peer counseling program in high school…we learned basic skills and were given referrals of other students that might need someone to talk to. I understood from this experience the pain and suffering that some of my peers experienced… that I could not yet understand" (P4).

Participants were drawn into the field for noble reason, a strong desire to help others, and they continued to do this within their counseling role and outside of their professional life. They reported various reasons for entering the field, such as: "I wanted to help people" (P8), "…seemed like a good way not waste my life" (P5), and "…my dad was a psychologist, he was a role model of sorts" (P3). Participants were motivated to enter the field because they had a strong desire and goal to help others.

Many participants also reported working to improve their training and skills by becoming experts in their specializations (i.e., substance use counseling, trauma counselor, or family counseling). One participant described her motivation for doing this when I asked her why, she said, "…you need that extra training to market yourself, but you also need it to stand out…having some type of credentials behind your name gives you authority" (P7). They also received specialized training working with specific populations and using various forms of service (i.e., rural clients, telehealth services, and inpatient services). For example, the participant with the most years of experience and training said, "…over the years I have gone to hundreds of conferences and trainings…you have to stay current with what's happening…change happens fast" (P7). Besides their desire to attend college, enter and complete graduate school, and remain experts; they also shared stories that demonstrated deeper desires for

their lives. For instance, P5 who was a licensed counselor and licensed drug and alcohol counselor she shared personal reasons for connecting to the field of counseling.

> "Counseling changed my life; I was in a bad place growing up. I never got to go to school, and I was around the wrong kind of people. When I first started getting help, I became a Certified Peer Support Specialist and I realized how rewarding it is to help others…working with them kept me sober, I was a role-model" (P5).

Certified Peer Support Specialist in NM have to self-identify as a current or former consumer of mental health and/or substance abuse services (NM Human Services Department, 2021). For this participant obtaining this certification was a steppingstone to a career in mental health. "…I set small goals. I didn't know what you needed to do to become a counselor, all I knew is that I wanted to…" (P5). Her story illustrated a strong commitment to becoming a helper, working towards her goals, and achieving her career aspiration of becoming a counselor. P5 also shared that she doesn't believe she has achieved all her goals, she said she is also considering a doctoral program and other pursuits. As a cohort, all the participants used internal motivation and goals to improve their career outlook, help others, and maintain a strong sense of purpose.

Subtheme 1A: Helper's Mindset

Another way that participants maintained a sense of purpose was through the positive mindset that they carried, this mindset was related to their identity as a helper. For example, P7, when I asked her what it meant to her to be a counselor, supervisor, and trainer during her many decades serving in the field, she responded "…it's not just a job, it's a way of living." Many other participants also embodied this mindset when describing their clinical work and reasons for entering the field of counseling. They echoed the importance's of service to others over prestige, money, and reputation. This helped participants develop strong associations with the counseling

field, their culture, and their personal lives to manage the stress and barriers of finances, difficulty clients/cases, and barriers to wellness. Culture values such as having pride and connection with the community, served as a buffer against burnout because participants had an awareness of helping to meet the mental health needs within their community.

When asking participants to describe their counseling identity and how they conceptualize their professional career many described a deep appreciation for their service and community. But they also mentioned how they were not just counselors in the clinical realm, but in many contexts. For example, another participant said when conceptualizing her identity,

> "…I am my family's counselor. I am my neighbor's counselor, even my husband's officemates designated counselor…the person in line next to me at the store. Usually when I tell someone what I do for work, they immediately disclose some issue they or someone they know is dealing with…most commonly they ask for advice" (P6).

This participant shared how her identity as a counselor wasn't isolated to one context of her life but impacted many. This was similar to when another participant shared how her other identities make her a counselor. She said,

> "…being a counselor is just one part of my life…I am also a wife, daughter, sister…being with clients is sitting with them with all parts of myself…using that, thinking about how the person in front of me is loved by others provides compassion" (P2).

Participants had a strong identity as a helper but didn't always contribute that to their counseling training or career. Participants cited many different parts of themselves and their identities that contributed to their orientation as a helper. Participants also developed a mindset related to helping and serving that was related to many different contexts of their lives. They used their

training, skills, and personal characteristics to help others inside and outside of the counseling realm. For example, this participant said, "I am an advocate for people at my church…a mediator for families and couples…I would say it is a part of my sense of meaning and service…" (P9). This participant in particular gave examples of volunteering at church and with other formal organizations with children and youth. Similar to previously reported when (P3) said that she frequently provided pro-bono and sliding scale services when she could. Many participants gave examples of how they have helped others, such as their families and communities using their counseling skills and training. Having a helping-oriented mindset restored participants sense of purpose and provided them a sense of meaning while serving in various context of their lives.

Theme 2: Managing Poor Work Conditions

All of the participants highlighted the challenges they experienced living, working, and coping under severely poor working conditions in their clinical practice, especially during the COVID-19 pandemic. Additionally, because participants were located in rural communities, they worked, lived, and played under difficult situations. Rural communities are characterized as producing inherent stressors, such as having limited economic resources, limited availability of and accessibility of healthcare services, overlapping professional-client relationships and care-giver stress (Nelson et al., 2007). This was apparent for many participants that spoke of the lack of support and services in their rural communities in NM.

Participants described managing poor work conditions as counselors in rural NM as a barrier to practicing self-care and wellness. Some of the conditions that they described as being toxic and harmful included: sexism, inconsistent and irregular work schedules, and stressful situations. This was summarized by P9 who said being a counselor is accepting that as a career it is, "…a high stress job" (P9). Providing clinical services in underserved communities with little

support and career advancement is already a stressful work environment, but this is compounded by other factors that participants faced. For example, P3 gave examples of sexism in the workplace, saying "…being a man would be easier. I could get that raise…". Counselors also regularly work unusual or abnormal hours, P1 described this by stating, "…evening hours and weekends…yeah, it is hard. I can't go out with friends on the weekend. It's difficult to go out of town for a trip or visit anyone" (P1). In summary, participants also talked about how working at agencies or in-patient hospitals with colleagues close-by can increase vicarious trauma and be even more stressful. For instance, this was described by one participant who said,

> "COVID has made it less stressful because I'm not going to the office…it's toxic. Everyone brags about how stressed they are in-between sessions, like it's a positive thing…Oh, yeah my coworkers also like to word vomit the most stressful thing that happened at the end of the day when we close…I just zone-out and put away my files at the end of the day." (P5).

Participants described various conditions that contributed to increased stress and burnout related directly to their work environment.

Additionally, participants showed resilience when adapting their work schedules, family life, and managing the effects of living through a global pandemic. They had mixed experiences with the world switching to a mostly at-home online work environment. For example, P1 said, "The virus hasn't really changed much for my work with clients. Like I said I was already doing things mostly online. It has been a problem in different ways, like trying to find toilet paper or beans." P1 had pre-COVID mostly served clients through Talkspace, a technology assisted app that is a platform for virtual counseling and telehealth services. But for others, that did not already have the resources to move to an online format, they were perseverant in their ability to

manage fatigue and frustration. Such as, P4, who said,

> "With no childcare and schools closed, working from home is not working…I am so angry that I have to maintain my hours at home…my kids are understandably, frustrated and anxious, but I can't always be super mom when I have to be a super professional."

Although she voiced frustration with her situation, P4 persisted by continuing to work a full-time work schedule as a counselor while also being a full-time stay-at-home mom. She was also proud of her ability to maintain the two jobs simultaneously. The pandemic seemed to effect working mothers and parents more than single counselors practicing rural counseling. For example, one young-single participant spoke of the freedom the pandemic had given her, specifically related to her ability to manage her day-to-day life and how it improved her wellness and professional efficacy. She said,

> "Now that I am online, I have more freedom to speak to clients while also completing other task…I have switched to writing my notes while we meet. I have also gone on walks and painted while I talked on the phone with clients" (P2).

For her, unlike other participants that were also mothers, working from home during the pandemic afforded her the ability to rethink how she practiced wellness and self-care. And it allowed her the flexibility to make sure that she was regularly practicing it, when she wanted. Participants working conditions were severely affected by the COVID-19 pandemic. This global event amplified already difficult working conditions that participants were facing while practicing and living in rural communities. Participants kept working at improving their professional skills, connecting underserved clients to providers, and maintaining their wellness, work, and family lives during the pandemic. Even when they ran into roadblocks or challenges they stuck to their goals and demonstrated perseverance under difficult circumstances. However,

no matter how much they took care of themselves by practicing self-care, preserved through the pandemic, or worked at their jobs, they could not escape the often difficult working conditions they faced. Participants spoke of poor working conditions related to (1) working with a lack of support and services and (2) being underpaid and overworked. The following examples will provide further description and illustration of how participants worked under very poor working conditions at their professional jobs and in their communities.

Subtheme 2A: Lack of Support and Services

Participants expressed a lack of professional support and recognition in their clinical work as an example of managing poor and stressful work conditions in their rural communities. Participants rarely felt valued and supported at their workplace and cited this as a source of stress in their lives. Participants provided examples of being constrained in their capacity to provide services, what kind of services they could provide, and the type of career mobility and trajectory they had. One of the biggest stressors for participants was the lack of health insurance available for themselves or clients and lack of access to services (mostly behavioral or mental health care). Additionally, participants reported limitations related to their ability to be clinically supervised, gain additional training and credentials, and provide additional services. Many participants reported difficulty attaining clinical supervision and peers to consult with about their clinical practice. Participant's inability to receive supervision and career opportunities limited their career trajectory. For example, five of the participants remained under a license known for being a training and temporary professional license in NM, known as a Licensed Mental Health Counselor (LMHC). Participants held this training license, despite all of them having completed their counseling related graduate education more than two years ago and practicing clinical counseling for many years at the time of interviews. Typically, this level of post-graduate

experience and years of service equates to an independent permit license in the state, a Licensed Professional Clinical Counselor (LPCC). One participant illustrated the barriers to obtaining an independent counseling license and what has kept her from applying for one in NM,

> "… I have been licensed for seven years, but I don't get… receive regular supervision. The clinic that I work at provides [continuing education] opportunities, like we have people come and present and lately because of COVID we even get a paid hour to participate in trainings online. But it doesn't help because there is no one to sign-off saying that I get four hours of supervision a week. It makes me so angry because I have no idea how I will ever be able to apply for the LPCC…but really it doesn't matter because there is no pay difference if I did this, and I think it cost more to apply for a new license anyway" (P5).

This participant's story illuminated her desire to become independently licensed but also showed she wasn't supported by her workplace to pursue this for her career. A similar situation was described by another participant who said that the only qualifying supervisor (an independently licensed provider) was managing seven other associate-level full-time licensed providers and was mostly doing administrative work. Only LPCC's can provide clinical supervision to LMHC's that NM considers as an official supervision hour. She communicated the following,

> "Oh yeah, I have a supervisor. She reviews my case files and notes. I haven't seen her in a month…I don't blame her; she has kids at home too and could hardly provide us the time that we need for the state to recognize our work…I try to help the newer social worker we hired last year with questions and new patients…" (P8).

This participant shared the sentiment of many others when she expressed frustration at the system that she and her colleagues worked under. Participants not only voiced concerns for

supervision, but also had concerns about training and other opportunities for career advancement. P7 who was a Licensed Professional Clinical Counselor (LPCC), the NM independent license, shared how primarily in her retirement she provides clinical supervision and training to counselors and other mental health professionals. Her feelings about supervision included the following:

> "I feel confident in the supervision I provide. I love to work with new professionals, the progression of their development and confidence is a gift, like being a parent, I am so proud of them…I never received any formal supervision training…" (P7).

Primarily providing supervision for the last three years part-time she followed up with why she is still providing this service,

> "…well, I too thought that I would retire, but life had other plans. [My supervisees] need me for more than just my experience. I am now friends with many of [the supervisees] that I started-off with, I want them to be successful" (P7).

For this participant she clearly voiced concern for the lack of support that other helpers in her community worked under. She also did her best to try to eliminate as many barriers as possible to supervision and training for them to provide the support she knew they were lacking at their workplace.

Many participants also voiced concerns for lack of mental health and behavioral health services in their immediate area, providers with specific experience and training (specialist), and provider's long waitlist for clients. This lack of mental health and behavioral health support and care impacted the participants, their clients, and their communities. One participant captured the spirit of this perspective when she said her community was a "therapy desert" (P3) describing

how there was a lack of providers to transfer clients to and lack of service options. She gave an example of a particular upsetting situation with a client,

> "…three years ago, I was doing an intake session and a male client reported worries and anxiety related to disturbing and intrusive thoughts about young children…he had never acted on his thoughts, but I didn't know how to help him, my supervisor didn't know how to help, none of my colleagues would take him, and there was no one to refer him to…" (P1).

She reported feeling hopeless and stuck in responding to this situation, latter stating, "…it kept me up all night for days, I still think about it, and it's been years…what if it happens again?" (P1). Describing her community and surrounding communities as a "therapy desert" was a metaphor to demonstrate her frustration for the overall lack of healthcare available for her community and clients. This lack of support for mental health was felt throughout the community and impacted everyone in the system of care.

Furthermore, even a participant that was a bilingual counselor, who is a highly sought-after professional skill and ability in NM for Spanish speaking clients, families, and children, reported professional frustration related to her language skills. She shared when discussing a situation with a family where the children of a couple had to on an occasion translate for their parents, "…I felt really bad when I had to speak through the oldest child…the parents were more comfortable speaking Dene, no one in our office speaks Dene" (P6). Her frustration was unique in that she purposefully was a bilingual counselor, Spanish and English, to meet more client's needs but was still unable to fill the role of being a native speaker of an indigenous language. She spoke of how she felt being the only bilingual counselor in her community, was not a source of pride because she still couldn't provide mental health services to everyone that needed it. In

turn she reported this impacted her professional practice, confidence, and esteem in her clinical work.

Participants identified a lack of support and services as an example of working conditions they had to manage to work in their communities. Lack of support included inability to access adequate, frequent, or on-site supervision, training, and career opportunities. And lack of services included lack of mental health and behavioral health services for themselves, their clients, and their community. Participants regularly provided examples of working under conditions in their professional roles that severely limited and restricted them because of these barriers to resources, support, other professional mental health and behavioral services and providers in their communities.

Subtheme 2A: Underpaid and Overworked

Participants reported being underpaid and overworked related to their professional clinical work and identified this as a work condition that magnified already stressful environments in their rural communities. Participants felt that they were working too much, too hard, and for too long of a period of time. This feeling was often related to being the only clinical provider in their community, working at agencies that constantly asked them to take on more clients, and feeling obligated to take on more clients to make enough money for themselves and their families. For many participant's restrictions to their income, their licensure type, and their work hours contributed to a poor work environment.

Additionally, participants were able to describe how situations, people, and places actively prevented them from acting or doing what they wanted because of the nature or location of their work and home. Restrictions that participants gave examples of primary had to do with the time they had to practice self-care and the nature of their work in rural communities. They

also frequently mentioned how the effects of the COVID-19 pandemic impacted their ability to provide services and how it impacted their clients.

I have previously described the lack of support and lack of services that participants shared related to their ability to apply for independent licensure and obtain adequate clinical supervision. This lack of support and services for career advancement and professional help limited their career trajectory and financial prospects. However, participants also gave examples of the restrictions they worked under in their jobs and how these restrictions prevented them from being financially stable, have time for themselves, or provide services to clients. For example, P1 shared that, "…working full-time. Working full-time is scheduling 35-40 clients a week." And P8 said, "I think there is this view that I should be making a bunch of money. My [spouse] and family don't understand that that's not how it works." The above examples demonstrated some of the financial burdens that these two participants faced in the nature of their work. As previously reported, more than half of the participants were independent-contractors and did not receive health insurance, dental, vision, or retirement benefits because of the conditions of their work. Those that worked under these conditions were paid hourly and felt pressure to see more clients or make more money to feel financially stable. Two of these participants worked in multiple settings (private practice, a school district, and outpatient clinic) to receive adequate hours to feel financially secure.

In addition to financial pressure, participants also discussed the restrictions and pressure they faced to serve their community. For instance, P3 described how she was continuously pushed outside of her comfort-zone:

> "I feel the pressure to be able to see anybody. Like, the office manager keeps scheduling me with more and more clients online that are seeking treatment for very serious and

> pervasive mental illnesses…I don't feel comfortable meeting with clients for the first time online and then to find out in that first meeting that they should have been referred to inpatient services…" (P3).

This participant was the same participant who previously said,

> "…[city] is a therapy desert. The closest full-service hospital is an hour away and there are no nonprofits to refer to… I feel for clients that can't pay their co-pays or pay out-of-pocket…I know which of us [referring to other private practice providers] will take pro-bono clients or work on a sliding-scale" (P3).

She described mixed feelings related to serving her community by filling a critical need but was also stretched outside of what she was comfortable with because of that same pressure. Her statement recognized the need to serve her community but also acknowledged how this contributed to her feeling overworked and emotionally exhausted by the situation.

Participants felt underpaid and overworked in their work environment, and they were also able to identify how this impacted their clients, who were also facing financial barriers. For example, P5 who worked in a semi-rural methadone clinic said,

> "…getting clients to come down to receive counseling. It's a struggle, they are required to also be seeing us, they come in daily for their methadone…And online telehealth does not work, my patients do not have access to stable housing, they rarely have access to the tech they need to be able to utilize our [telehealth platform]."

P5 empathized with the restrictions that her clients had to operate under to receive counseling services, but also was concerned with their financial stability and access to counseling. She was clearly exasperated with the restrictions because of COVID and further questioned the reasoning behind this, "…I don't understand why they won't let us just call them and do phone sessions"

(P5). She also shared how her pay was directly linked to how many clients presented for counseling, sought services for counseling, and actually attended a full counseling session. She said, "…I don't want to ask them to come down…they need to keep a job…have children to watch…[are] trying their best" (P5) when expressing her guilt of asking clients to regularly attend counseling sessions so she could keep a regular steady income. For P5 her financial stability was directly linked to her client's ability to access to telehealth, her client's ability to attend regular counseling sessions during normal business hours, and her clients desire to attend counseling after receiving their methadone. In summary, participants described many different situations they and their clients were under because of COVID-19 and living and working in a rural community.

Lastly, many participants described lacking professional and career opportunities and resources because of their work schedule and financial stability. They were able to draw a direct connection to how this interfered with their ability to practice self-care. For example, one participant who was an independent contractor (this type of worker is not hired as an employee and does not receive benefits from their employer) made this connection,

> "I get paid by the hour. This means that everything I do outside of session is unpaid…I don't get paid to review case files or to write session notes…it makes it more difficult…I can't work harder than my clients" (P9).

This participant made a clear connection between her economic and financial situation with her ability to feel satisfied with her work and have time for herself. But for many of the participants the constrictive environment they practiced in, such as their rural location, slowly wore on their spirit. This was captured most clearly by (P4) who questioned, "how long can I do this?" when reflecting on her current financial situation, impacts of COVID-19, and career as a counselor.

Participants reported frustration and exhaustion when reporting the many limits, they were living, working, and surviving under in their rural communities. Most of the limit's participants faced were either enabled or enhanced because of the constraints of living in rural communities and because of the COVID-19 pandemic. The limits and restrictions that participants described related to their financial stability and work schedule contributed to their ability to practice self-care and feel well. Being underpaid and overworked were examples of poor working conditions in their rural communities that they identified as a contributed to feeling burnout and exhausted.

Theme 3: The Use of Relationships as a Resource

The third theme related to the use of relationships as a protective factor for participants. Relational support came in many forms for participants and did not just include close friends or immediate family members, but also included community and extended networks. Additionally, often times participant's relationships afforded them other resources and these resources they shared with others. For example, participants gave examples of using their relationships to obtain what they needed to be successful by using creative means and methods.

One resource that participants severely needed and managed to obtain through creative means was professional development, skills, and training. For example, clinical supervision, peer consultation, and training opportunities to support their professional growth and development. One participant disclosed how she managed to receive the professional support she needed by working together with a group of other women to receive critical and supportive feedback related to her counseling practice.

> "I have a group of ladies that I meet with every month through Zoom. Most of the time we talk about whatever is happening in each other's lives, but the purpose was originally

to talk about difficult cases. All of us bonded during our MA program in [another state] and decided to stay connected after graduation" (P2).

When I asked her what benefits, she has received from this group she said,

> "I have the freedom to talk about clients… [in a way] that I wouldn't feel comfortable talking to my site supervisor about. The group gives me an opportunity to talk things out before talking about it with others and gives great advice. Everyone is very supportive and knows exactly when to push back on tough situations" (P2).

She described how these arrangements to work with her peers was for mutual benefit. Each of them had helped each other function more effectively in their professional roles as counselors throughout their career development. Another participant also disclosed how she shared and received professional resources through the private practice she worked at by utilizing a communal electronic app.

> "Our practice has a shared Dropbox, that folder contains resources for clients, worksheets, psychoeducational handouts, books, anything you would need to provide to clients…During sessions I often will reach for my computer to print something relevant related to our work together" (P4).

Participants worked closely with other professionals to receive the supervision, training, and professional resources they needed to feel confident in their skills and training. However, often they were also a provider of those resources. For example, another participant shared how she was a benefactor to other providers in her area and the meaning this gave her. She explained that she spent a lot of time volunteering her time as one of the only qualifying supervisors and experts in her community. She spoke about providing free supervision and connecting other counselors to training opportunities that she was able to supply through her leadership position.

"This my retirement... I enjoy mentoring and ushering counselors through the process. So many helped me, help others…it is a privilege for me to walk the journey of others as they expand their career and improve their skills" (P7). Participants not only maintained persistence by navigating the resources and training they needed for professional support, but they also were knowledgeable about the resources and services available for clients.

Many participants had a deep knowledge and understanding of what clinical mental health and behavioral health services were available geologically near them for clients and what exactly they consisted of. Participants knew what each provider's strengths and weaknesses were and used this knowledge to assist clients, their family, and the community. Such as, this participant who said,

> "…[city] is a therapy desert. The closest full-service hospital is an hour away and there are no non-profits to refer to… I feel for clients that can't pay their co-pays or pay out-of-pocket…I know which of us [referring to other private practice providers] will take pro-bono clients or work on a sliding-scale" (P3).

She spoke of how providers in her community negotiated their services to their clients and worked with each other to serve needs where they could and when they could. Participants used innovative and ingenious methods to meet their clients, each other, and their own professional needs. Regardless of this, they also demonstrated imaginativeness when accumulating resources for themselves personally, especially because of consequences related to the COIVD-19 pandemic.

Seven of the nine participants were interviewed early in the pandemic, during the year of 2020, most of them brought up during the interview the impacts of COVID-19 on their wellness, professional practice, and families. Additionally, many of them were curious what my

experience was like living in the largest city in NM. They assumed I wouldn't understand some of the extreme circumstances they were experiencing, like seeing empty shelves in the grocery store, not being able to find certain products, or experiencing frustration with the reactions of others. But most prominently they were curious about my experience of the psychological toll of the pandemic, such as having uncertain about the future, reading disparaging newspaper articles, and hoping for some type of normalcy to return. Frequently during interviews participants were curious about my experience, living in a different part of the state as them, they sought to know what the situation was like in other places and have a human connection with me, as the interviewer. In this regard, their information seeking behavior was a characteristic of being relationship centered.

Participants valued their relationships, placed high importance on them, and often referred to them to cope with stress and adversity. They leaned on relational support as a resource to support their wellness by (1) having strong family systems and (2) turning to community and social networkers in times of stress. The following two sections will describe and define these subthemes, while also providing examples from participants that support their development.

Subtheme 3A: Family Systems

Evidence of strong and supportive family systems included a mix of immediate family members and/or a mix of extended family members. These family members had qualities that suggested shared appreciation, care for one another, and support and comfort in both times of joy and distress. Many participants spoke highly of the closeness they shared with others, the meaning they deprived from it, and the extent these relationships had on their health and wellbeing. The philosophy surrounding this concept was clarified by the oldest participant in the

study (age 73) who said, “it’s not good to be left alone” (P7) when asked how COIVD has limited her contact with others. Participants relied on family and friends as a source of strength during difficult times. This was demonstrated by one participant who said, “Being able to do this job requires me to call my mom every day. Sometimes I just call her and cry on my drive home. Hearing her voice gives me strength” (P2). This participant spoke of how her continued relationship with her mother helped her manage difficult feelings and emotions related to her job, even though her mother struggled to accept and understand her job.

> “I am the first in my family to go to college. At first my mom wasn’t thrilled that I wanted to leave…and at times we fought while I was in [state] because I would bring up topics that she didn’t accept…counseling LGBT couples, non-monogamous relationships…anything to do with sex or sexuality” (P2).

She clarified that even though her mother didn’t always understand the nature or requirements of her counseling work, she always was available to act as a social support during times of difficult or distress. The same participant, P2, who had a close relationship with her mother also reported having a close relationship with her husband. She contributed his education, experience, and shared values in the helping field as a mitigating factor to decrease stress with patients, cope with generational/family trauma, and as a source of shared healing.

> “I love that we can talk about difficult clients together and be each other’s greatest advocates... It has also made our relationship better because I can call him out on something and he knows what I am talking about…my feelings are valid…It’s made us better listeners, and I think it will be a positive impact on our kids…Neither one of us grew up with parents that should have stayed together…I know our kids are learning skills watching us, that we never got…” (P2).

P2 provided evidence of strong family support by her extended family (her mother) and her immediate family at home (her husband). Frequently participant's romantic partners and children were cited as protective factors against burnout and stress. Five out of nine of the participants reported being involved in a romantic relationship or being married. Additionally, three others reported being divorced. Relationships with children were also frequently brought up by participants. Five participants reported having children, participants reported having 1-5 children, with the average participant having two children.

Participants partners and children were cited as a source of relational support but also a coping mechanism. Participant relied on social support for healing during difficult times, but many also reported that these relationships were not one-sided. Participants discussed how they provided mutual support for their relatives and how that support acted as a checks and balance to their own individual self-care needs. For instance, P4 said,

> "I feel selfish engaging in self-care. I don't think that people believe I am selfish when I practice self-care, but it's hard to believe that it is okay…I feel ashamed to admit that it is often easier for me to take care of my kids. Their needs are immediate…"

However, later she said,

> "Yeah, they can tell when I am stressed or anxious. [her children] know when I am having a bad day or need to have some alone time. I don't want them to be affected by what I have to go through" (P4).

This participant demonstrated the mutual reliance her family had on her and she had on them to take care of each other's needs to stay healthy. This sentiment was also reflected in P1's statement when she asked, "How can I do anything without making sure that my family is taken care of?" Participants that reported being mothers often stated that their self-care and wellness

was dependent on their family's self-care and wellness. Although P4 voiced conflicting feelings related to caring for her own needs, she was also able to reflect on how her relationships with her family provided her peace. She said,

> "Watching my kids grow up has given me a sense of peace, my daughter is wise. [Daughter] has taught me how to be kind, patient, and more understanding...Of course I have been able to bring this into the clinic and it affects my work with clients" (P4).

Relational support, specifically family networks and relationships, influenced the behavior and perception of participant's view of what is self-care, resilience, and wellness. Participants described relying on their families for emotional support, but they also reported engaging in self-care actives with others. They discussed exercising with others, playing with their kids, family gatherings, and engaging in social actives and hobbies with others as a self-care technique. Frequently they had very close knit open and genuine relationships with their friends, family, and community.

Subtheme 3B: Community and Social Networks

Besides the strong and close family networks and relationships participants relied on, they also had close social and community relationships that provided a sense of belonging, safety, and trust. Essentially, they used these social and community connections as a resource they could turn to during times of need but also on a day-to-day basis. Social and community support and relationships provided participants with the strength to carry on and even thrive during the COVID-19 pandemic and during difficult times. These expensive networks of support came in different forms and played different roles in participants lives; some received emotional support, instrumental support, or information support. They received practical help, shared points of view, and shared information from these social and community networks.

Participants who were surrounded by people who provide care and support felt more capable of dealing with the stressors of their work-life balance, the psychological and social toll of the pandemic, and resilience related to difficult client cases. Participants gave examples of meeting with friends as a way to manage their wellness. For example, P5 said, "Self-care is laughing and going out with my friends…it's drinking a beer in the backyard…complaining about work." While another participant whose family participated in a specialized hobby that introduced to her a new group of friends said, "…it's a blessing. I never thought I would be proud to say I am a part of a [group], but everyone has been very accepting and welcoming to our family" (P1). Group membership was used to provide a sense of belonging and support, P9 described volunteering with a group at church as her form of maintaining social and community support. She said, "…showing up and doing the work is healing…when everyone around you has the same mission and purpose" (P9). Enjoying time with a group of friends, membership in a shared group hobby, or church were just a few ways that participants maintained social and community connection as a strategy to cope with stress.

Participants also noted when there was a loss of connection in their social or community networks they prioritized finding a new group to relate to. For instance, after being divorced eight years ago participant P3 described how she managed to cope and develop social support. She said,

> "…it was difficult for me to find a new support group after my divorce, married people usually socialize with other married people. Many of my old friends didn't fit into my new life…I was able to reconnect with old friends who had experienced similar struggles in their marriage and relationships, and they were a huge source of support while I coped with starting over single" (P3).

P8 also spoke of the difficulty of losing her community and church group while attending college for her master's degree out-of-state. She said, "…going to school away from home sucked…no, it was strange because I was anonymous…" (P8). She later followed saying she maintained her social community by "…calling home frequently and driving home on the weekends" (P8) to maintain a sense of belonging with her previous social community.

Lastly, another participant who was in recovery and an addictions counselors said, "I tell everyone I am in recovery. My clients, my peers, anyone that will listen….my colleagues are very supportive. If I need to step out of the building or need someone to talk to, they are always there" (P5). For her, being honest and open about her past history with her colleagues, clients, and with the larger community allowed her to reduce the effects of her own internal struggles, but also allowed her to connect with them on a deeper level. She described her identity as a counselor as a two-way relationship between herself and others. Participants used personal relationships as a resources for social support, self-care, and to build resiliency. Participants relied on family, community, and social networkers as a resource.

Theme 4: Navigating Social and Cultural Expectations

The fourth theme participants described was the impact of culture and gender expectations on their wellness and resilience. Social and cultural expectations acted as social normal and rules that participants felt obligated to conform to because they either believed they should conform to them or because they were expected. Participants gave examples of how others, including family, coworkers, and clients, had very specific beliefs about how they should behave, dress, act, and practice counseling. These often-unspoken norms imposed on them social standards for what was appropriate and wasn't acceptable for them to do in their personal lives and professional career. Participants gave examples of how culture, gender, motherhood, and

ethnic identity were highly influential over their behavior in a variety of context. These examples caused them distress and anxiety and influenced their wellbeing and resilience.

Most of the expectations that participants shared with me were expectations that they attributed to their social and cultural environment. These external environments, such as their families, their communities, or counseling agencies and practices they worked at, influenced their beliefs and values. Participants were expressive and demonstrated strong and deep emotions related to how they felt about how culture influenced their work and ability to practice self-care. For example, participants cited how cultural expectations and norms influenced their willingness and ability to practice wellness and invest in their professional career. One participant talked about her difficulty setting aside money for professional opportunities and training that started early when she began pursuing her education,

> "…I felt selfish going to [school] away from home, it was so expensive. But I also had responsibilities to look after my siblings…when I was away I felt responsible when my little brother got into trouble at school or when my sister wasn't able to get a scholarship…if I was there they would have done better" (P4).

This participant followed up with how her feelings were related to how, even now she struggles to put aside money for professional opportunities (conferences, continuing education, and materials for play therapy) and has guilt about spending time or money to take care of herself. She further shared how she believes her family was affected by her leaving her family and community to go to school when she said,

> "I wish my family could have been more involved in my education. They only saw me graduate from college, but they didn't understand how the process changed me…I know my family is proud of me, they tell me all the time. But somehow I feel like I don't

> belong anymore…like I've been "othered" if that makes sense…like their afraid I'm judging them or using psychology to better them, or I think I am above them somehow" (P4).

For P4, she felt a burden to her family when she left to attend college and struggled to reconnect with them after graduation as a professional. It was P4 that previously reported, the following,

> "I feel selfish engaging in self-care. I don't think that people believe I am selfish when I practice self-care, but it's hard to believe that it is okay…I feel ashamed to admit that it is often easier for me to take care of my kids. Their needs are immediate…"

She experienced guilt and regret from the very beginning of her career journey when she left for graduate school. These feelings continued later in her life when she returned to NM and into her life with her family whenever she did anything for herself. For her, she felt a strong desire to be involved in the lives of her extended and immediate family and going away to college (improving her individual opportunities) or practicing self-care (caring for her own needs) didn't fit into her worldview or understanding of wellness.

P5 was able to provide examples of how she felt she needed to conform to her culture, family, and community by learning to speak Spanish and participate in "Latino" religious services and celebrations. She said, "…I believe that Latinos Christian Christ is very different than American culture Christ...the tradition of the blessing of the families and community…the importance of rest and celebration that is given to us to heal." And "growing up everybody spoke Spanish fluently or had family who did" (P5). Later after describing how these were important parts of her culture, she said, "…I didn't fit, I was a rebel. I fell in-love with a bad guy and got pregnant young…I wasn't the perfect daughter." P5 expressed appreciation and admiration for

her culture but also struggled to belong to it and felt ostracized because she didn't fit into it as expected.

P5 is now an LDAC (Licensed Alcohol and Drug Addiction Counselor) and a LMHC (Licensed Mental Health Counselor). She also disclosed parts of her earlier history that included previously struggling with alcohol and other drugs before becoming a Certified Peer Support Specialist. When reflecting on her recovery and journey to become a counselor she mentioned how she felt stifled by her culture expectations, but that has significantly changed for her now. She stated that she now uses her past history as a tool in training and professional clinical work as a LDAC/LMHC and is proud of how far she has come. When I asked her if her history and disclosure of it carried extra expectations, she said, "fuck that shit, I don't worry about it" (P5). For these two participants their families and culture heavily influenced their counseling career journey and beliefs around resilience and wellness.

Next, participants spoke of the culture related to living and working in rural communities in New Mexico. Although, there is no single set of culture norms related to rural communities, some common values in rural settings include self-reliance, discouragement of disclosing personal problems, and hesitancy to trust outsiders (Dworkin et al., 2017) Furthermore, rural cultural and personal values also include use of informal supports (such as family, friends, neighbors, and church communities) and a strong work ethic that encourages wellness (Nelson et al., 2007). Participants gave examples of how their communities that were located in various degrees of rurality in New Mexico influenced their clinical practice and ability and availability to practice wellness and self-care. One example of how being located in a rural community, including living under cultural expectations, was the value and beliefs around confidentiality. For instance, one participant described how she believed her Latino culture and living and working

in a rural community influenced her willingness and her client's willingness to discuss private struggles and mental illness.

> "I think there is a dual side to it, like uh, hmm you have a strong social support network. You can talk to anyone anytime. But the other side to that, is this culture that you don't air your dirty laundry…that it stays in the family" (P9).

Even as a licensed counselor, P9 said that she probably wouldn't feel comfortable seeking counseling if she was struggling. Another participant also shared this sentiment when she said, "Trust is huge, people talk…" (P6). It seemed that participants recognized the culture of rural communities that prevented clients from seeking services and those same beliefs influenced their willingness and ability to potentially seek help in the future. Cultural expectations and pressure were one of the identified factors participants cited as a barrier to practicing professional counseling, engaging in self-care, and navigating the systemic environments they were a part of.

Gendered expectations included social expectations that participant's internalized as norms for them related to their gender identity and gender roles. This was intermeshed with other societal expectations, such as ethnic identity, cultural identity, and environmental expectations. Nevertheless, participants gave clear examples of how being a woman inflicted gendered expectations of how to practice professional counseling and how to care for self and others. For example, participants shared similar experience related to expectations related to motherhood. With six of the participants reporting having children, with a range of 1-5 kids at home, many participants frequently cited examples of expectations imposed on them related to being a mother, living in a dual-earner family, or even being able to manage their own kids behavioral and mental health. One participant shared the example of how frequently the professional therapeutic relationship is not immune to microaggressions, "When I first meet a new couple or

client they ask me if I am married, if I have kids, sometimes even what religious' views I have" (P9). Another participant shared how she has developed strategies to handle these types of questions,

> "I get asked all the time, are you married or do you have kids. I used to immediately answer these questions to try to build a rapport with clients, but I learned not to provide too much information because…there are these expectations...[like] how can I be providing marriage counseling if I am not a ring wearing women? You know what I mean?" (P2).

Participants discussed how being bombarded with these questions was a unique experience to them that they didn't believe their other male colleagues shared. Participants viewed these questions as a way that clients were evaluating and judging their competency as a professional counselor, while also placing cultural and gender expectations on them. One participant gave an example of how she knew that she was being treated differently when she shared,

> "…the most frustrating thing is that my husband is a social worker in the same outpatient hospital as me and his coworkers are never questioning his parenting skills or how his children are coping at home. He has never been scolded for having OUR children interrupt a session or meeting, but everyone notices and has an opinion when it happens to me." (P8).

This participant demonstrated frustration at the expectations placed on her to be fully responsible for her kid's wellness during COVID, despite many of her colleagues also having relationships with her husband and not asking him. Her experience also highlighted a gendered expectation at the healthcare clinic she and her husband worked at. The expectation she was held to included being an involved nurturing mother but also not doing it while working from home and within

view of others. Her colleagues felt the need to evaluate and judge her parenting as a mother but did not feel the same need towards her husband.

Participants also felt societal pressure to be human givers, a uniquely female experience. Human givers are those who are,

> "…expected to offer their time, attention, affection, and bodies willingly, placidly, to the other class of people, the 'human beings' …they have a moral obligation to give their humanity to others" (Nagoski & Nagoski, 2019, p. xiii).

Woman often are expected to give everything, every moment of their lives, every drop of energy, to the care of others (Nagoski & Nagoski, 2019). Participants gave examples of how they were constantly expected to take care of others without regard for themselves. When I asked participants, what were some barriers to practicing self-care regularly they provided frank and vivid answers. They also were able to easily differentiate how they believed this was different for men when I asked. Beginning with P2 that shared how she was introduced to self-care culture in her counseling program out-of-state, she said,

> "…that's funny that you asked that. I remember in grad school we had to write self-care plans. I had peers that would write things like 'go to Lush and buy a bath bomb' or 'get your hair and makeup done.' And I just sat there thinking that's one of those White girl things."

When I asked her what she wrote in her self-care plan or what resonated with her related to wellness she said, "...I just wanted to survive, you know? I didn't have money or time for those things" (P2). For her, relating to and understanding her White female peers' responses was pointless because they reflected experiences that were so different from her own. Participants had a lot of reasons for not relating to the philosophy of self-care or the notion of putting

themselves first. For instance, “I feel ashamed to admit that it is often easier for me to take care of my kids” (P4) or “I don’t ask for help or say no, what’s the point?” (P9). Participants felt they had an obligation and duty to not burden their family by asking for help or putting their needs first.

One participant also shared a personal example of how felt that other’s had specific expectations of how to take care of herself or not take care of herself after a miscarriage.

> “When I had my first miscarriage, I didn’t know how to tell people. But when I did, I was so angry at their responses. My boss, my male boss, didn’t understand and wanted me back at work as soon as possible. And my family wanted me to grieve. I didn’t feel anything, but everyone had an idea of how I was supposed to be…” (P1).

P1’s disclosure illustrates the mixed-messages she received from others around her about how to care for herself after a traumatic event. Participants often highlighted that being a woman meant that specific expectations were placed on them related to their career, their families, and how they should or shouldn’t care for themselves.

Participants gave examples of social and culture expectations that impacted their sense of self, identity as a counselor, and beliefs and values related to self-care and wellness. Social and cultural expectations that participants encountered were related to family obligations and responsibilities, gender identity and roles, and culture/community expectations related to living and working in a rural area in NM. Participants often cited these expectations as social norms that influenced their work and life.

Theme 5: Connectedness to Social Resources and Community Care

Participants frequently cited examples of social resources and community care as a protective factor that bolstered their resilience. Participants were able to demonstrate the use of

social capital and social resources by having close relationships with their community or maintaining some type of group membership, maintaining a sense of belonging and peace with that group, and engaging in high levels of social engagement within the community. Group membership such as belonging to a social body or organization with other people that have formally or informally accepted them was one example of participant's collection of social capital. For instance, attending church or religious services served as a significant example of social engagement and a social resource for participants. Six of the nine participants reported a religious identity, such as Christian, Catholic, Protestant, or Spiritual. Many participants mentioned their religious identity and practice of religious beliefs as a coping mechanism and a way to practice self-care with others in their family or community. For instance, P5 said "using prayer is healing" and P9 said "trusting in God and seeking God's help brings peace." However, participant's participation and membership in an organized religion also provided social resources and community care. P9 followed up with how she believes her community is healed together, through attendance at church when she said, "…it provides a sense of belonging and peace, when I am there, I feel relaxed and connected to a shared spirit." P9 also described her dedication and commitment to serving on a "worship team" at her church that was healing for herself and the congregation. She said, "…[being] a musician and vocalist is healing…shared worship gives life to others…by honoring God in this way, you feel the energy, you are recharged by each other…" (P9). For this participant, regular attendance at church, meeting in small worship groups, and going to worship practice provided a sense of social connection and cohesiveness.

Many participants also mentioned family and friends as a social resource and community care, this included romantic partners, extended family, neighbors, professional colleagues, and

friends. The social ties and networks in participants lives provided them resources and helped them take care of themselves, their families, and their communities. To illustrate this, one participant narrated how she shares joint childcare and resources with her sister.

> "My sister's daughter is a year younger than mine, and we frequently watch each other's kids…recently I have taken [her daughter] there to play while I use [sister's] treadmill, my sister often has meetings or runs errands during this time, and I get to work out" (P1).

P1's case of mutually benefiting from her family member, her sister, was evident of how she and her family benefit from an arrangement that involves shared resources and care.

Relational support was a source of strength for participants and oftentimes they used that support to acquire resources that they needed to strengthen their professional and personal lives for themselves and others. Another participant gave an example of how strong family support has helped protect her against the hardships of life, specifically COVID, by providing shelter, financial resources, and childcare.

> "We are living with my in-laws while our house is being built…it's a very small space with [participants two daughters] but it's been a godsend. There is always someone there to help them on the computer or answer a questions about homework. I wouldn't have been able to continue going into the office without their help…" (P8).

This participant talked about her extended family's role in supporting her continuing her professional career while facing extenuating circumstances related to the pandemic, most prominently not having access to childcare. Family was often a central role in participants lives, but they also mentioned in conjunction strong community support. For instance, one participant spoke of a hobby that her husband participants in, that her family has group membership, she said,

> "When you travel together you get to know each other very well…we often share hotel rooms with [other families] when we go to tournaments…we watch each other's kids…we cheer on each other's husbands…it's a tight group. That's why, like you said, when someone is struggling it really hurts everyone…" (P1).

This participant described interdependent relationships with other families that provided emotional support and loyalty to each other. Another participant provided an example of how she and her family has benefited from an interdependent relationship with a neighbor. "Our closet neighbor has hens and frequently gives us eggs and, in the summer when we grow vegetables, we provide chilies, tomatoes, and zucchini [to them] …" (P3). Participants not only received emotional and social benefits and wellbeing from their community and relationships, but they also were provided material goods and resources from one another. Because of this, participants were able to engage and acquire strong social resources and community care that contributed to themselves and their family's health and wellbeing in rural New Mexico.

Theme 6: Systemic Oppression

Theme six was related to the systemic oppression that participants described that impacted them, their relationships, and their communities. In this study, participants shared instances of judgement, threats, and intolerance that was directed towards them by other people in various context. Participants shared that the majority of the time when people did this, it was done without sufficient evidence or even in spite of evidence to the contrary. Participants illustrated examples of systemic oppression and injustice by providing various experiences of prejudices and discrimination.

Prejudice refers to unjustified or incorrect negative attitudes towards an individual based solely on that individual's membership in a social group. Prejudice includes pre-formed negative

judgements or attitudes that leads people to view certain individuals or groups as inferior. Microaggressions are a form of prejudice and can include microassaults, microinsults, and microinvalidations. Microassaults are explicit derogation characterized by verbal or nonverbal attacks meant to hurt an individual (Sue, 2010). Microinsults are characterized by communication that conveys rudeness and insensitivity and demeaning to an individual's identity or group membership (Sue, 2010). Microinvalidations are characterized by communicates that exclude, negate, or nullify the psychologically thoughts, feelings, or experiential reality of an individual (Sue, 2010). Participants frequently mentioned examples of prejudice, such as various microaggressions, as a source of distress and trauma in their lives. Participants experienced prejudices based on many different characteristics, identities, and group memberships they occupied.

Examples of prejudice in participants lives included incidents and situations that occurred in their work environment as a professional counselor. Participants frequently listed examples from their professional lives that undermined their confidence in their work. For instance, one participant gave this example of being invalidated,

> "…When clients walk into my office I can instantly feel them sizing me…I went to the waiting room to bring the family back and once they got to my office they asked me when the doctor was going to get there…they were expecting someone else, like I was just the admin assistant walking them back to the real counselor's office" (P6).

This participant described how she feels disrespected by clients that assume that she is not a professional based off of her appearance. Her description illustrates how the physical body she is in, being a Hispanic woman, is not considered a professional body to the dominate culture. Not only did participants give examples of clients questioning their credentials, expertise, and ability

to help them because of their race, gender, and appearance they also felt invalidated by coworkers and employers. Although perceived expertness is typically a function of the counselor's reputation and evidence of proficiency and competency (Pomales & Williams, 1989), participants said that they felt their perceived level of expertness was based on their race, ethnicity, and gender.

Participants spoke of how they were able to identify being perceived as less than at a young age. High school, which was a period to explore their career options and explore their interest seemed to be a particularly salient time. One participant shared a story of her softball coach making rude and insensitive comments after meeting her dad. "I remember I took my father [who is a licensed psychologist] to back-to-school night to meet my softball coach and she commented on how well dressed he was and well he spoke English the next day" (P3). Another participant shared a story of similar comments that a teacher made towards her,

> "…my high school algebra teacher asked me what college I wanted to go to. When I told her, I wanted to go to UNM, she laughed and said that I would never be able to get into UNM because I wasn't the type of student that goes there" (P1).

And lastly, another participant that was seeking career guidance was told by a high school counselor, "…what's worse is my high school COUNSELOR told me that I should focus on my pregnancy" (P6) instead of preparing for college or a career. For many participants these early experiences of prejudices influenced their career outlook and beliefs related to what they were capable of doing with their lives.

Participants gave examples of how they learned to cope with these types of situations, "whenever I hear that, it wears at you, I try to stay away from those type of negative people.…you can't dwell on it" (P2). P7 used similar language of describing how this "wears" at

an individual when counseling clients question her ability to help them. Participants were also very aware of how to identify prejudice and how to immediately recognize it in another person. P5 said, "…it's bullshit when they say they don't see color. When they say that I know right away what's going on." Participants could easily distinguish prejudice and knew how to cope with it.

Participants shared narratives of discrimination varied based on several factors. For one participant that lived close to the U.S.-Mexican border, she shared an example of how she frequently experienced discrimination because of the communities she traveled to.

> "I get anxious driving through checkpoints… Yeah on 1-25 from Las Cruces to Hatch there is a border patrol checkpoint. They will sometimes wave me through, but I have been asked to pull to the side a few times…my heart jumps out of chest, I have been harassed for no reason by Border Patrol agents…They ask questions about why I buy groceries in Las Cruces…where I am coming from, where I am going, where I live, where I was born…" (P9).

P9 reported that she was a Hispanic U.S. Citizen, but felt like she was target by Border Patrol agents because of her race/ethnicity. She also spoke of the shared anxiety and fears that others in her community felt because of this border patrol checkpoint that they frequently had to pass to pick up goods and visit with family and friends in the closest large city near them, Las Cruces. She said, "I know a lot of my clients have also had personal struggles with [Border Patrol agents/border patrol checkpoints] related to their status, I can understand their fears" (P9). This participants experience was influenced by her living and working in a rural area in Southern New Mexico that shares a border with Mexico and has various border checkpoints. The anxiety P9 shared and her strategy of complying to officer's request was her way of protecting herself.

Especially, because those that confront others about racial injustices and discrimination are often viewed as the instigator (Constantine & Sue, 2007). For her, protecting her wellbeing included managing her anxiety by trying not to focus on her likelihood of getting asked to pull over or answering further questions about her status.

For another participant, she shared an example of gender-based discrimination that impacted her regularly when she was concerned about finances. For example, when I was discussing with her the difference between male and female counselors at her workplace, she said this,

> "Yeah, financially stability affects my confidence…two years ago we had a new therapist start that was a man. I found out a few weeks later when he was bragging that he was hired for four dollars more than me an hour, even though we are at the same pay grade. Then a year into his position he asked for an additional two-dollar raise and got it! I have been working [there] for eight years and still make six dollars less than this stupid man that just started out of graduate school" (P3).

This participant noted how this made her feel like an imposter and she started to doubt her self-confidence and skills. "…I have asked [supervisor] to review my performance and have even threatened to leave…I am disposable…only my clients would notice and be impacted if I left" (P3). Her experience spoke to the concept of, imposter syndrome, which is the belief that someone internalizes when they believe they are not as good as others with similar education and experience. The impact of not being seen, acknowledged, or appreciated at her workplace impacted her confidence in her abilities and furthered her distress related to her financial stability.

Many participants' mentioned instances of how they felt marginalized and invalidated by clients and co-workers. A participant demonstrated this when she summarized that clients that made negative assumptions about her clinical competence "wears at your soul" (P7). Collectively participant's experiences when clients questioned their experience and competence to perform their duties as a counselor were difficult. Even when as another participant said, "We have a responsibility to be as accepting, non-judgmental, and empathetic with clients, but sometimes it's hard" (P8). Participants often reporting using strategies to overcome these injustices, they built strong social support networks, found a sense of meaning and purpose, and spent time caring for themselves. It is the researcher's interpretation that participants were most bothered by discrimination that they faced by their peers. To illustrate this, one participant gave an example of how her coworkers, supervisor, and workplace broke her confidence in her safety and directly undermined her confidence and ability to work.

> "Frequently my coworkers make negative comments about Mexican culture that are hurtful…like offensive jokes…I did bring it up with my boss, and he is aware of the situation…nothing changed… it makes me nervous that the only thing I can do is quit my job" (P6).

The hostility she described created a discriminatory work environment that was abusive and intimidating and was ultimately impacting her ability to work and her wellbeing. Hierarchies of power within a clinic or workplace that reinforced discrimination and prejudice were especially harmful and destructive to participants. Participants mostly had empathy and understanding for clients that presented with racist or sexist attitudes or behavior, but it seemed they faced a more difficult dilemma when they faced these same issues in the professional work environment. Actual or perceived discrimination in the workplace is related to negative health outcomes,

employees that experience discrimination have higher levels of psychological distress and health-related problems than employees who do not (Mendias et al., 2001). Participants facing discrimination were impacted by these experiences in the professional work environment and outside of it. In turn, these negative experiences influenced their behavior and beliefs related to their safety, health, and wellness.

Summary of the Findings

In this chapter, I presented the findings and results of the interviews I conducted with nine Hispanic women that were professional counselors in rural communities in New Mexico. The participants narrated their experiences as professional clinical counselors and the factors in multiple settings (personal life, professional life, and communities) that influenced their wellness and practice of self-care for themselves and others. The experiences of these women were remarkably consistent with what is already known in the field related to the experiences of marginalized women, Latinx counselors, and rural working counselors. The next and final chapter of this study includes interpretations of the findings, limitations of the study, recommendations, and implications for future research. In this next chapter, I will discuss the unique findings and recommendations on how the experiences of these women can be harnessed and applied to education, supervision, and training.

Lastly, I feel it is important to mention the honor I experienced in being able to interview the women that participated in my study. Each devoted their time and energy to this study, despite obstacles such as internet connection issues, technology mishaps, and balancing of responsibilities during the interviews. This study would not have been possible, and results would not have been found without their commitment and dedication to meeting with me to share their very personal experiences and stories. I thoroughly enjoyed speaking with them and

getting to know them both personally and professionally. The value of their participation in this cannot be overstated.

Chapter 5: Discussion

This chapter entails the theoretical, professional, and contextual implications emerging from the findings to address the guiding research questions. The purpose of the present study was to explore how Latina women in rural New Mexico make sense of and practice wellness and self-care. As a result, the findings operate in response to the guiding research question: How do female Hispanic counselors in rural New Mexico experience professional counseling, make meaning of their intersecting identities, and navigate their systemic environments while maintaining health and wellness? And the sub-questions: (1) What are the systemic, environmental, and cultural factors that reinforce and strengthen resilience in female Hispanic counselors working and living rural communities? and (2) What are the systemic, environmental, and cultural factors that prevent and act as barriers to rural female Hispanic counselors from maintaining wellness and practicing self-care? Across eighteen interviews from nine participants (i.e., two interviews per participant) identifying as Hispanic women living and practicing counseling in rural New Mexico. Six major themes were identified using rich, thick qualitative data: (a) maintaining a lifelong sense of purpose, (b) managing poor work conditions, (c) the use of relationships as a resource, (d) navigating social and cultural expectations, (e) connectedness to social resources and community care, and (f) systemic oppression. These themes are interconnecting and address how complex identity and systems contribute to a counselor's conceptualization, practice, and beliefs around wellness, self-care, and resilience. The content of this chapter emanates from my interpretations of the findings with relevant literature, previous research studies, and a specific focus on Bronfenbrenner's Bioecological System theory and Intersectionality as research pedagogy and praxis. It was important to use these theories to address how participant's experiences were clearly rooted in context and were impacted by

oppressive environmental and systemic barriers. In this chapter, I also discuss recommendations and implications for counseling practice and supervision, counselor education, and future research. Lastly, I identify limitations and contributions of this study.

Interpretations of Findings in Relation to Research Questions

The interpretations of the key findings are in response to the above mentioned research questions, they highlight the operating intersectional and bioecological framework that ground the complex and rich experiences of the participants. Reiterating some of the key principles of intersectionality in relation to its use as a theoretical framework in research, the following were used in this study: (a) oppression, (b), relationality, (c) complexity, (d) systemic context, (e) comparison, and (d) deconstruction (Collins & Bilge, 2016; Misra et al., 2021). Understanding these key theoretical underpinnings of intersectionality allows for a deeper consciousness of the participants lived experiences and beliefs. Such as, taking a relational approach that makes the analysis of oppression central, which helps to show how different sets of experiences are linked (Misra et al., 2021). Additionally, acknowledging the enduring and persistent forms of interaction in an individual's immediate environment, helps to better comprehend how the participants' experiences are shaped by a complex system of relationships affected by multiple levels of the surrounding environment (Bronfenbrenner & Evans, 2000). This research provided an example of how multidimensional participants lived experience is, as well as how relations of power shaped those experiences (Misra et al., 2021). The convergence of these principles informed the research design, but also captured the systemic nature in which participants' interpretations and narratives were enmeshed. The six superordinate themes provide findings in response to the guiding research question. The following sections unite a dialogue to elaborate on these findings. The interpolation of principles from intersectionality, Bronfenbrenner's

Bioecological System theory, and strategies from an IPA methodological framework provide a critical interpretation.

Finding 1: Maintaining a Lifelong Sense of Purpose

Having a sense of purpose provides a motivation, driving force, and guide to work towards a satisfying life. It includes an individual's feelings that they have purpose or direction in life. It has also been correlated for centuries as being integral for positive health and well-being (Hill et al., 2016). Having a sense of purpose has been found to be an important factor for maintaining health and well-being over the life span (Windsor et al., 2015). Believing in a sense of purpose is not just a positive health outcome, this protective factor, has also been shown to lower an individual's perceived level of stress (Hill et al., 2018). However, sense of purpose varies across culture and geographic location. Within the United States, states with higher rates of employment, greater happiness and less stress, worry, and sadness, and healthier people with fewer diseases and health limitations, have a greater sense of purpose (Baugh et al., 2019). Additionally, Hispanic collectivistic culture places a high value on relationships, familismo, personalismo, and simpatia; these cultural values and behaviors contribute to a sense of identity, purpose, and meaning in life (Ortiz, 2020). For example, a sense of purpose can be influenced by family, personal relationships, career, and social activism (Debats, 1999). Consistent with this research, participants' beliefs and values played a huge role in determining what their sense of purpose was. And a sense of purpose guides the development of goals and goal-oriented behaviors (McKnight & Kashdan, 2009).

Participants described motivation for entering and remaining in the counseling field, the driving forces that encouraged them to be a helper, and the guides they created for their lives that made them meaningful. Participants demonstrated goal-directedness and achievement motivated

characteristics to guide their lives. Additionally, they carried a distinct mindset related to their career in counseling, this belief was characteristic of being a healer in multiple settings and wasn't limited to their primary work setting.

This finding is consistent with other literature that has examined sense of purpose related to maintaining wellbeing across the lifespan (Windsor et al., 2015). It has been found as a protective factor, that having a sense of purpose lowers individuals perceived and actual levels of stress (Hill et al., 2018). For example, it has been found that the largest effect of resilience is an individual's sense of life satisfaction, optimism, positive affect, self-efficacy, and self-esteem (Lee et al., 2013). Development of goals and goal-oriented behaviors is one way that participants built and achieved a sense of purpose. Goal directedness has previously been found as a characteristic of individuals with a strong sense of purpose (McKnight & Kashdan, 2009). This protective factor has also been previously found to support wellness and self-care in Hispanic helpers (Guzman, 2012; Flores, 2009) and female ethnic minority counselors (Shillingford et al., 2013). For example, Shillingford, Trice-Black, and Butler (2013) found female ethnic minority counselors were found to develop wellness and maintain a holistic balance when they had a self-care plan, motivation to excel, were able to set boundaries, and developed a strong professional identity. Flores (2009) also described her personal journey of becoming an immigrant Latina therapist and how her motivation to succeed helped her conquer barriers, she said:

> "Every barrier I encountered became a challenge I would conquer…But I lived suspended in between nations, loyalties, commitments, and obligations. I was a woman, but I was not free. I was a feminist, but I was bound by traditions and expectations I did not create myself" (Flores, 2009, p.175).

Flores (2009) demonstrated personal commitment, motivation, and sense of purpose to continue to become a helper despite the obstacles she encountered, these characteristics helped her thrive under difficult conditions. Guzman (2012) also echoed similar statements when she shared her educational journey as a Latina Feminist Community Psychologist. She too, spoke of how her immigration status, culture, and gender were intertwined in her career development as a helper and how she preserved through adversity while having a strong sense of purpose (Guzman, 2012). Participant's gender, culture, race/ethnicity, and group identities/memberships influenced their sense of purpose. All participants demonstrated a strong sense of purpose as evidence by being focused on goal-directed behaviors, being motivated to excel, and having a strong sense of identity as a healer. In turn, these behaviors provided participants with personal resilience to use as a strength to conquer adversity and barriers to wellness.

Finding 2: Managing Poor Work Conditions

The second finding was related to the poor working conditions that prevented and restricted participant's ability to practice wellness and feel resilient. Participants were constrained by various external threats and risk, such as the COVID-19 pandemic and the characteristics of living and working in a rural community in NM. It has been widely acknowledged that there are inherent stressors that occur in rural communities (Martens, 2002). Consistent with this study's findings, Nelson et al., (2007) specifically listed some of the barriers related to practicing as a counselor in a rural healthcare system, such as: overlapping relationships, threats to confidentiality, boundary issues, professional-patient relationship, and allocation of resources. Johnson et al., (2006) has also previously reported specific disparities that occur in rural New Mexico and found numerous disparities specifically related to behavioral and mental health care. And counselors working in rural communities face unique challenges

related to their professional practice and their ability to practice social activities and receive social support (Morrissette, 2000). Not only did participants illustrate the distinct stressors related to living and working in a rural community, but these stressors were also compounded by the world-wide effects of the COVID-19 pandemic. Participants shared increased stressors related to the effects of COVID-19 and increased racial tension that was occurring while this study took place. There were various stressors from the period that this study occurred, that further restricted participant's ability to care for themselves and others. Many studies have already shown the effects of the pandemic impacting women more than men (Madgavkar et al., 2020; Kashen et al., 2020). Ethnic minority women were all the more impacted because they were already known to have poorer health outcomes and often receive inadequate health care services compared to men (Mendias et al., 2001). In, Mendias et al., (2001) study that investigated low-income Mexican American women's experiences of health and wellness, self-care practices, and perceptions of health. They found that this population was less likely to receive services and was more likely to seek services for physical manifestations of health (Mendias et al., 2001). The increased racial tension that occurred during the course of this study also further impacted the participant's poor working conditions. The current sociopolitical climate has increased hostility towards Latinx, immigrants, and Hispanic women. Participants lived experiences of being a Woman, Hispanic, and living in rural NM contributed to their stories of disadvantage within particular settings and times.

The compounding factors of living and working in a rural community and the external restrictions and limits participants faced further constricted their ability to practice wellness. Participants primarily reported a lack of support and services, being underpaid and overworked in their work situations. These specific contextual factors influenced their perceived view of

stress and ability to cope with adversity. Despite these barriers related to poor working conditions, participants used coping skills and behaviors to navigate challenges in their lives related to the severe constrictions they worked under.

Finding 3: The Use of Relationships as a Resource

Relational support is defined as the support available to an individual through social relationships to other individuals, groups, or communities (Lin, et al., 1979). Relational support can include any of the following: family, friends, romantic partners, pets, community ties, and coworkers (Li et al., 2021). Having access to rich, functional, and positive social support and networkers is essential for maintaining physical and psychological health (Ozbay et al., 2007). Social relationships protect individuals from negative health outcomes associated with chronic adversity. They also offset and moderate the effects of living in chronically stressful conditions (Hostinar, 2015). High quality social support improves resilience to stress by: protecting against development of trauma-related psychopathology, decreasing the likelihood of trauma-induced disorders, and reduces medical morbidity and mortality (Southwick et al., 2005). Recently, Li et al. (2021) found that sources of social support during the COVID-19 pandemic increased resilience and protection against mental health issues. Close relationships with friends and family served as a protective factor for many participants pre-pandemic and during the ongoing pandemic.

Additionally, Hispanic culture values provide tight social fabrics with family and community, which confers resilience through pathways that promote social support and capital across varied context (Ruiz et al., 2016). *Familismo* a traditional Hispanic culture value is related to a strong sense of identification, respect, and responsibility to immediate family, extended family, and close friends (Gallardo & Paoliello, 2008). Examples of prioritized relational values

include family-centeredness, concern for others well-being, interdependence, and graciousness (Arredondo et al., 2014). Additionally, rural communities and counseling are known to culturally include very close-knit interdependent relationships (Morrissette, 2000). Rural counselors frequently speak of having multiple relationships with clients (Hargrove, 1986; Erickson, 2000; Weigel & Baker, 2002) and being connected in some way to their clients or their clients' children, family, or spouses (Oser et al., 2013; Sexton et al., 2008). Participants in this study also reported the influence of traditional Hispanic culture values and rural community conditions that influenced the type and conditions of their relationships.

This finding was related to the buffer relational support provided to participants during stressful situations and times. Participants relied on relational support with friends, family members, colleagues, and their community in times of need. Participants valued their relationships, placed high importance on them, and often referred to them as a way to cope with stress and adversity. They provided evidence of strong and supportive family systems and connections with their community as examples of relational support. Participants use of relational support provided them a greater sense of wellness and as a coping strategy. Participants behaviors related to relationships as a resource are consistent with existing literature that reiterates social relationships are a primary tool to managing optimum wellness (Clark, 2009; Beaumont et al., 2016).

Participants experiences of relational support provided further evidence of how communities and groups of people can provide mutual support to each other. This is connected to the next theme related to social and community care. Community care, the principle that is grounded more in collectivist cultures that usually serve marginalized communities (Dockray, 2019) was evident in this group of participants. Participant's experiences of wellness and

resiliency was interdependent on their families and communities. This has been previously supported by Airhart-Larraga et al. (2021) who found that leveraging cultural assets, such as cultural legitimacy included being part of a larger Hispanic community provided greater relevance and connection in rural communities. In their study, focusing on Latinx experienced counselors in the Texas Rio Grande Valley, they found that language, mental health perception, and community resources provided professional resilience (Airhart-Larraga et al., 2021). This was also supported by Park and Peterson (2008) who investigated the character strengths of Latinos and found that characteristics of the heart and social relatedness were linked to a better sense of wellbeing than individual character strengths. In turn, culturally grounded values and ethnic pride promotes and reinforces greater connection to family and community and reduce risk of negative mental health symptoms (Berkel et al., 2010). Participants relied on their communities and their families as a means of relational support. Participants frequently mentioned the support of their extended family, children, and spouses. This is also consistent with previous findings that found in a sample of Mexican American women living near the U.S.-Mexican border who were married, their marriage was a buffer to deleterious health behaviors and social stress (Guinn et al., 2009). The strong family and group-oriented culture found in their communities, ethnic/racial identity, and rural location made those with supportive spouses and families to be more resilient to stress (Guinn et al., 2009). As supported by previous studies, relational support was a culture moderator to adversity and stress that participants experienced in various facets of their lives.

Finding 4: Navigating Social and Cultural Expectations

The next finding was related to participants feeling pressure related to societal and culture expectations. They cited unspoken norms and societal standards that were imposed on

them related to their culture, gender, racial/ethnic identity, and various other implicit and explicit identities. Their experiences of facing culture and gender-related expectations and pressure was consistent with previous research findings. It has been found that Hispanic women in professional roles in particular bear psychological stress related to expectations of family, self-expectations, role conflicts, doubts about competence, and double standards in the workplace (Arredondo, 2011). Participants in this study also reported unique psychological stress related to being a Hispanic woman while working as a professional counselor. Participants reported distress related to expectations that others enforced, but they also struggled with internalizing these societal expectations.

Such internalized expectations were consciously and unconsciously assimilated into participants own worldview, beliefs, and feelings related to wellness and self-care. Participants felt a range of emotions related to if they did or didn't meet culture and gender-related expectations and this in turn effected their wellness. Other research has cited feelings of guilt, selfishness, and self-indulgence as normal emotions that challenge counselors when attempting to practice self-care (Brownlee, 2016). However, counselors that view self-care as self-indulgent will often continue to see clients even when they began to feel burnout (Neace & Kottler, 2017). No participant reported being impaired and incapable of continuing their clinical work; however, participants did frequently mention how external expectations influenced their internalized experience. They cited difficult emotions related to practicing self-care, such as guilt related to the cost of indulging in it and the selfishness of putting themselves before the duty they felt related to caring first for their families and communities. Participants various identities and group memberships heavily influenced their perception of wellness and their feelings and beliefs about self-care.

Finding 5: Connectedness to Social Resources and Community Care

Despite institutional and structural systems that serve as barriers, participants spoke about their ability to negotiate and obtain the resources and support they needed. Common challenges and resources that rural communicates lack include rural economic development, broadband internet services, education, health care, and agriculture (Morrissette, 2000; Cohn & Hastings, 2013; Weigel & Baker, 2002). Despite these common challenges, participants relied on each other through extensive networks that provided a sense of safety to deal with anticipated needs and wants. Participants lived in various forms of rurality and utilized collaboration with others to solve issues related to lack of resources, in this way they demonstrated social and community care.

Personal resources are related to belonging to an individual, they are in possession and disposal of the individual. However, social resources are resources that are embedded in one's social network and social ties (Hobfoll, 2002). Social and community care in this study refers to participant's ability to manage, obtain, and share resources to help themselves and their community. This type of specialized skills and behavior can be explained by the Conversation of Resource Model (COR). COR states that individuals under stress will strive to retain, protect, and build resources in unfavorable conditions (Hobfoll, 1989). According to COR theory, social resources address the interrelatedness of resources, that systems are interactive and recursive (Hobfoll et al., 1990). Possessing social resources leads to greater access to social support (Hobfoll et al., 1990) and many participants also leaned on relational support as a means to live and thrive in their communities and chosen profession. Participants built, protected, and retained the resources they had access to or had the ability to acquire. They did this for their family, for

the colleagues they worked with, and to be able to better care for themselves and develop their skills and training in counseling.

Social relatedness and interrelatedness of resources has been found to be a character strength of Latinos (Park and Peterson, 2008) and rural communities (Martens, 2002) linking them to a greater sense of wellbeing. Participants managed to thrive by depending on themselves and others for shared resources and support in difficult times. This unique resource helped them manage distress, cope with the effects of the COVID-19 pandemic and support their loved ones. Maintaining connectedness to social and community care demonstrated participants shared values related to working together, with others, for a common purpose of living harmoniously. Participants were able to demonstrate the use of social and community care by having close relationships with their community or maintaining some type of group membership, maintaining a sense of belonging and peace with that group, and engaging in high levels of social engagement within the community.

Finding 6: Systemic Oppression

Social injustice and systemic oppression issues are related to a lack of fairness or justice and are a formidable barrier to wellness and resiliency. Examples of injustices and oppression include prejudice and discrimination. Discrimination and oppression are formidable barriers that can be manifested overtly (through outright prejudice and discrimination) or covertly (through behaviors and polices that serve to discriminate) (Arredondo et al., 2014). Even in New Mexico, a state that many assume has a prominent Hispanic population, is dominated by European Whites politically, socially, economically, and numerically. Therefore, it stands true in NM, that ethnic minority groups face prejudice and discrimination and are stigmatized as being of a lower social class, less intelligent than Whites, and face unequal educational, judicial, and financial systems

that create and perpetuate this belief (Arredondo et al., 2014). Because of this, it was unsurprising that many participants shared examples of prejudice and discrimination they faced that shaped their professional and personal wellness.

Participants shared various forms of prejudice that they faced, including microaggressions. Despite the emotional and psychological impact of these experiences, participants reported adaptation and the ability to protect their wellness in spite of them. It has been theorized that, because of their various heritages and historically bicultural experiences, Latinos have learned the movidas (steps) for adaption (Arredondo et al., 2014). All participants that shared narratives of prejudice directed towards them, from their youth to their current career, were able to continue to adapt and thrive. Participants took steps to protect themselves and continued to strive towards their goals.

Discrimination is the outcome of prejudice and is often characterized as unfair treatment directed against certain individuals or groups. Discrimination is negative behavior or actions toward an individual or group of people on the basis of their group membership or identity. Discrimination can be based on many different characteristics and identities, such as an individual's age, gender, sexual orientation, race or ethnicity, or religion. For example, discrimination related to race is called racism and discrimination based on gender is referred to as sexism. Vue et al. (2019) explained that that individuals with membership in an underserved or marginalized group will experience unfair treatment, such as discrimination, due to their identity or group membership. Discrimination has been found to contribute to poorer mental health outcomes leading to heightened vigilance, challenges one's beliefs about fairness and justice, creates an internalized stigma toward oneself, and exacerbates pre-existing physiological and psychological stress (Vu et al., 2019). Participants in this study did not report ruminating on

instances of discrimination and any consequences or barriers related to it. Even though participants did not report discrimination as something they believed impacted them in their daily lives frequently, they still reported it impacting them deeply and cited it as a common situation that they had to protect their mental health and wellness against.

Participants shared how instances of judgement, threats, intolerance, and microaggressions impacted them psychologically and how they coped with it. It has been found that 22% of Hispanic workers in the U.S. report experiences of workplace discrimination, compared to 6% of (non-Hispanic) Whites (John J. Heldrich Center for Workforce Development, 2014). Minority stress theory explains that individuals with membership in an underserved or marginalized group will experience unfair treatment due to their identity or group membership (Vu et al., 2019). And discrimination can play a central role to explaining disparities between dominant and minority groups (Vu et al., 2019). To add to this, all participants in this sample represented multiple identities that were not a part of the dominant group. However, participants in this study coped with the "triple lens of oppression" threat to their wellness. This theory goes one step farther than Minority stress theory, and states that Hispanic women in-particular experience increased instances of prejudice and discrimination because of the intersecting social location they inhibit related to race and ethnicity, class, and gender (Pesquera & Segura, 1996). Gonzales et al. (2002) also refers to this as the double-minority effect, which is a phenomenon where two marginalized identities, such as the double-bind of being both Hispanic and a woman, interact and produce a more detrimental effect than any one identity would on its own. The negative societal portrayals of Hispanic/Latinx people such as: implicit and covert racism, monolingual bias, institutional racism, racial profiling, hate crimes, microaggressions, and stereotype threat; are all additional psychological stressors and barriers to career development

and day-to-day life (Arredondo et al., 2014; Ruiz et al., 2016). Not only were these women exposed to racism related to their race and ethnicity, but their intersecting identities and group membership further influenced the injustices they experienced. Because these participants occupied multiple dimensions of identity in a combination of two or more unique ways, it was impossible to generalize the complex realities of belonging to multiple identities and groups and how this contributed to their experience of discrimination.

Participants experienced discrimination in various context of their lives that impacted their clinical work, perception of safety in the workplace, and day-to-day lives. The effects of discrimination and the perceptions of barriers can be demoralizing to some Latinxs and may prove to be more motional to another; however, the more time that Latinx spend thinking about such barriers provides them less availability to care for their needs and the people around them (Arredondo et al., 2014). Although all participants reported experiences of prejudice and discrimination, no participant reported ruminating on these experiences frequently or these experiences significantly impacting their views of themselves, others, or the world. Participants in this study demonstrated resilience by using individual and community coping skills and behaviors to counteract the effects of discrimination to survive and thrive in their prospective rural environments.

Other Important Findings to Report

It is important to note two other finding that heavily influenced the results of this study, primarily the dual pandemics that the world was experiencing during the course the course of this study. A pandemic is a highly stressful event that creates a heavy psychological and emotional burden on all peoples (Li, et al., 2021). During this study seven of the participants were interviewed during 2020, with the remaining two being interviewed in the beginning of

2021. Therefore, while this study was taking place there were pressing environmental and social issues that could have further exacerbated participants experience of exhaustion and reflection of healing. Li et al., (2021) investigated some of the stressors related to the COVID-19 pandemic, such as changes to how individuals live, increased uncertainty, altered daily routines, financial pressure, and social isolation were stressors for most people. The Center for Disease Control and Prevention (2021) has cited increased pandemic-related stressors in many people lives, this includes changes in quality of patterns of sleep, difficulty concentrating and feeling motivated, increased use of alcohol and other drugs, more severe mental health disorder symptomology and increased risk for suicide. COVID-19 has increased the risk factors related to suicide and psychological disorders and relapse by increasing feelings of isolation, loneliness, and boredom (Banerjee et al., 2021). Many have experience fear and uncertainty, economic fallout, increased marginalization, and domestic abuse and intimate partner violence (Banerjee et al., 2021). Banerjee et al., (2021) reported increased risk factors for marginalization groups during the pandemic, by citing contributing factors such as: social stigma, prejudice, blame and xenophobia, and communal sentiments. These increased risk factors that marginalized and underserved groups experienced were dually related to the effects of the COVID-19 pandemic and increased racial tension and inequality.

Effects of COVID-19

The COVID-19 pandemic greatly impacted the psychological well-being and health of the world and it greatly disrupted our work-life balance. The pandemic has unevenly impacted societies most vulnerable and underserved populations, such as women, ethnic minorities, and rural communities. Families lost childcare and access to schools, many lost their jobs, and had to make difficult decisions. The loss of income for mothers, families, communities, and the

economy have been shown to primarily effect Black, Latinx, and Indigenous women (Kashen et al., 2020). Women are more vulnerable to COVID-19 related economic effects because of existing gender inequalities and women are disproportionately represented in industries that are expected to decline to COVID-19 (Madgavkar et al., 2020). Women's jobs are 1.8 times more vulnerable than men's jobs and dropping faster than average (Madgavkar et al., 2020). However, women who face intersecting oppressions are especially struggling with the multiple effects of being more likely to have lost their job, be a front line essential worker, and have to find creative strategies to address childcare challenges (Kashen et al., 2020).

Women that work in professional essential services such as education and clinical mental health also reported unique struggles and challenges related to the COVID-19 pandemic. For instance, counselors and educators that worked from home faced issues related to boundary crossings (Cottliet et al., 2007; Burns, 2019) taking on multiple roles at home and online. Additionally, remote counseling and learning in the pandemic are causing clear challenges for the intersecting identities of female educators (Cicco, 2020; Guy & Arther, 2020). Such as, female authors have published less during the pandemic than male authors (Bell & Fong, 2021). However, within the field of counseling, the need for mental health services has increased and COVID-19 has worsened mental health symptoms for clients in many communities. With many counselors and educators turning to telemental health to continue seeing patients, they needed to develop strategies to cope with the pandemic but also successfully move their work home. The disruption of the COVID-19 pandemic in the daily lives and wellness of this studies participants was reflected throughout the interview process; however, participants also were impacted by the "dual pandemic" beginning during the summer of 2020.

Increased Racial Tension

Besides participants struggling to cope and adapt to the worst public health crisis in decades they were also living through a national reckoning acknowledging racial inequality. The U.S. experienced increased racial tension after a series of high-profile incidents of police violence against Black Americans that renewed calls for nationwide addressing of racial inequality (Horowitz et al., 2020). Just a few of these incidents included the killing of George Floyd, the shooting of Jacob Black, Ahmaud Arbery, and Breonna Taylor. Pew Researcher Center (2020) investigated the difference between White, Black, Hispanic, and Asian beliefs around whether increased focus on race will lead to major policy change in the United States because of global unrest and undervaluing of Black lives. They found (39%) of Hispanics paid a lot of attention to issues or race and racial inequality and (50%) of Hispanic's had done at least some education themselves on the history of racial inequality in the U.S. (Pew Research Center, 2020). However, increased racism continues toward Asian and Black Americans, and this causing Latinx people to experience higher rates of depression, anxiety, and trauma-related symptoms (The Steve Fund, 2020). The effects of racialized trauma, described as the danger related to real or perceived racial discrimination and prejudice (Lipscomb & Ashley, 2020), is also a concern. Racial discrimination and trauma has a significant impact on human relations, mental health, and well-being (Addo, 2020). Furthermore, the American Psychological Association (2020) acknowledged the heavy psychological toll of high-profile racial incidents on mental health when it made a statement saying,

> "We are living in a racism pandemic, which is taking a heavy psychological toll…The health consequences are dire. Racism is associated with a host of psychological consequences, including depression, anxiety, and other serious, sometimes debilitating conditions, including post-traumatic stress disorder and substance use disorders.

> Moreover, the stress caused by racism can contribute to the development of cardiovascular and other physical diseases."

The COVID-19 pandemic has disproportionally impacted people of color, racial health disparities have further emerged, and the increased racial inequality and tension have exacerbated suffering. Now more than ever, valuing and protecting mental health and practicing wellness and self-care are important and needed. However, during this world-wide reckoning it is time to acknowledge that the counseling field's view of self-care is still centered in a dominate White narrative. Endo (2021) described her experience during the dual pandemic of 2020 as a racialized body, her response to a White women's question about self-care was as follows:

> "…I just listened to a podcast the other day by a Black artist who said he is sick of hearing White people talk about this notion self-care...I really appreciate what he said. I just have never been privileged enough to think about self-care like many of you. Perhaps we could decenter the notion of the self, as life, especially in this moment, is or should be about communal-care, soul-care, and spirit-care" (p. 119).

Her testimonial challenging the individualized notion of self-care that is centered in Whiteness and speaks to Black, Indigenous, and People of Color differing beliefs and attitudes related to healing. Currently, the intellectual, moral, and cultural climate of this era is ripe with change and the ability to challenge the concept of self-care and wellness.

Contributions of this Study

The findings of this study indicate that Hispanic women practicing counseling in rural NM have varied yet similar experiences with resilience, wellness, and self-care. These experiences can be utilized by counselor educators, supervisors, and clinic directors who work with these women in understanding how their experiences may differ from the dominate cultures.

Understanding how their experiences differ from the dominate cultures helps to give their experience validity, supports their professional identity and development, and respects the culture moderators that impact their professional practice in counseling. Currently, to this author's knowledge, there is no previous work or research study that has investigated this topic. Therefore, the findings of this study bring light to the unique experiences of Hispanic women practicing rural counseling in NM and their experiences with resilience, wellness, and self-care.

Besides sharing the narratives of these women, this study also provided support for a shift in the field of counseling. Ferber et al (2007) argued marginalized counselors can be at increased risk because as a population that is diverse, they need strategies that are broader and better examine the communities they are a part of. We can do this by returning to a foundation of holism in counseling and investigating the conceptual and systemic factors that influence a counselor's lived experience. This study uncovered possible solutions to improving marginalized counselors' professional and career development from a wellness context, specifically Latina women in NM. Long et al. (2019) recommended working to understand this group's needs on the micro, meso, and macro levels to support their overall wellness (Bronfenbrenner, 1979). Intersectionality as a theoretical framework is one way that this study sought to understand how these women's experiences and conceptualization of counseling and wellness differed based on their varying identities. Because intersectionality draws attention to the social root causes of vulnerability and resilience. This is important because social groups are neither homogenous nor static; historical, social, culture, and political context need to be taken into account to understand the dynamics that shape vulnerability and resilience (Chaplin, Twigg, and Lovell, 2019). This study examined the diverse experiences of Hispanic women in rural NM and how sociocultural

and bioecological factors influenced their conceptualization and experience of self-care, wellness, and resilience.

Addressing Barriers and Challenges

The participants in this study talked about challenges they faced as things to be overcome and not as something stopping their progress. Participants in this study reported various barriers and challenges, most importantly related to the findings they: (1) had to manage poor working conditions, (2) navigated social and culture expectations, and (3) worked to overcome systemic oppression. These challenges were related to barriers and factors that arose from various domains within the participants' lives, such as home, work, and community. Bronfenbrenner's (1979) Bioecological Systems theory explains that environmental and external stressors affect the lives of individuals and their family's wellbeing at all levels-macro, exo-, meso-, and microsystems (Arredondo et al., 2014). Additionally, these levels converge and contribute to an individual's experience of stressors. And intersectionality further states that these multiple social systems intersect, produce, and regulate inequalities that promote systemic injustices (Grzanka et al., 2017).

It was important for this study to understand the specific burdens and barriers that marginalized counselors face in the context of the broader issues imposed by rural settings. Intersectionality allows for more complex conceptualization of understanding the challenges that these counselor's face, moving away from the philosophy that "one-size-fits-all." Central to Intersectional theory is the idea that all of one's social identities are also linked to macro-and structural-level inequalities (Vu, et al., 2019). Intersectionality recognizes and acknowledges that when counselor belong to multiple disadvantaged groups or identities it convolutes experiences of oppression in various context (Grzanka, 2014). Examples of this including counselors that

belong to multiple disadvantaged or marginalized groups or identities that have fewer resources and face greater barriers. Most importantly, this study sought to understand how the intersecting identities of participants that identified as Hispanic female counselors who lived and worked in rural communities identified barriers and challenges to wellness. By identifying the social root cause of vulnerability, risk, and barriers we further understand how these participants were limited in their ability to practice self-care and be supported as rural professional counselors. Reported barriers and challenges to wellness were directly impacted by participant's social identities and injustices experiences because of those identities.

Barriers to practicing self-care are the factors that prevent or obstruct a person's ability to practice care for themselves or interfere with their ability to have a wellness plan. Risk factors in health research are defined as "those characteristics, variable, or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random from the general population" (Lindenberg et al., 1998) will face a similar challenge, barrier, or symptom. Because of this, it is especially important that "risk" must be carefully defined because it is difficult to make a generalization to all individuals in a particular group and even more difficult to assume that they will experience adversity in the same extent (Raffaelli et al., 2012). Crenshaw (1989) stated that social groups are not a homogenous or static, and historical, social, cultural, and political context impacted vulnerability and resilience. For example, risk factors and barriers can reside within the person, or at-large in the family, community, or institutions (Lindenberg et al., 1998). For this sample, participants frequently struggled to identify concrete, clear, and obvious contextual factors that contributed to barriers and risk. Frequently they discussed these traits in conjunction with resilience and personal and community strengths. Intersectionality reinforces this notion that it would be difficult or impossible for participants to

identify how one of their social identities contributed to their experience of injustice or disadvantage in counseling. Understanding the barriers and challenges to self-care and wellness includes assessing and understanding the individual- and structural- or group-level social processes that impact counselor's ability to practice self-care and wellness.

Resilience

The concept of "resilience" has gained significant traction in research communities in recent years as a way of flipping the script on traditionally deficit-focused narratives for explaining the persistence of disparities in disadvantaged communities. Resiliency is the process of effectively negotiating, adapting to, or managing significant sources of trauma (Bowland, 2015). It is the ability to adapt successfully in the face of stress and adversity (Wu et al., 2013). Stressful events, trauma, and chronic adversity may result in negative health outcomes (Wu et al., 2013). Resilience is a positive adaption in spite of adversity, such as managing exceptionally difficult circumstances (Masten, 2001). Resiliency in the face of adversity is a part of normal human functioning, however, socio-contextual characteristics of stress and adaptation at different points in the lifespan severely impact an individual's ability to face that adversity (Bonanno & Mancini, 2010).

Participants in this study demonstrated individual character traits and behaviors for managing stress and self-care that were both individualistic and communal. Understanding their conceptualization and utilization of self-care was important in uncovering how their culture background acted as a source of strength and moderator of resilience. Bronfenbrenner's Bioecology theory describes how counselor's work involves multiple evolving interactions between individuals and interconnected environments and how these environments impact the individual (Campbell et al., 2009; Bronfenbrenner, 1975). It is impossible to pinpoint any single

system that contributes to a counselor's management of stress and practice of self-care. For example, frequently participants were not able to differentiate between how different systems and environments contributed to their resilience. Lastly, when speaking to their ability to be resilient they gave examples of challenges and barriers they had overcome.

Strengths and Protective Factors

Protective factors or strengths are what mitigate and counteract the symptoms and experiences of impairment and stress that can be experienced and felt at the personal and community level. Protective factors are attributes that allow individuals to ameliorate the negative impact of risk experienced by functioning well despite adversity (Raffaelli et al., 2012). Personal and community strengths often act as protective factors that increase resilience. Resilience is the quality that is attributed to those that, in the face of overwhelming adversity, can adapt and restore equilibrium to their live and avoid the symptoms and effects of stress (Lindenberg et al., 1998). Resilience and protective factors are not just individual personality/characteristics and can be environmental, as long as these traits moderate the negative effects of stress and promote adaption.

Participants in this study reported various strengths and protective factors, most importantly related to the findings they: (1) maintained a sense of purpose throughout their lives and careers, (2) used personal relationships as a resource for themselves and others, and (3) remained connected to social and community care as a coping mechanism. A metaphor for adaption related to the New Mexican desert is that many desert plants live in hot, arid conditions, like those found in rural New Mexico. Many believe these desert environments are extreme and brutal, but many plants have adapted to flourish in these conditions (Morgan, 2021). Like these desert plants, participants in this study showed extreme adaption through personal and

community characteristics, strengths, and protective factors. They reported strength and resilience, flourishing in their retrospective communities despite adversity and stressful conditions. This metaphor of adaption was clearly present in the findings when participants identified their ability to survive and thrive.

Recommendations for Action

This goal of this research was to disrupt the counseling field's ideology surrounding self-care, wellness, and resilience. The notion of decolonizing is "…examining the concepts of power and access to opportunities while critically questioning and disrupting the systems and structures that maintain inequities" (Singh, Appling, & Trepel, 2020, p.262). Decolonizing self-care is to challenge the invisible and visible attempts to socialize and re-socialize counselors, clients, and communities to make them fit into the dominant cultures value system and expectations (Singh, Appling, & Trepal, 2020). Primarily in the field of counseling, resilience focuses on the dominant cultures' experience, however, it has not previously been investigated if resiliency and wellness are conceptualized and practiced differently for marginalized and oppressed groups (Airhart-Larraga et al., 2021). Participants in this study reported similar and different views related to practices of self-care and wellness than the predominately White narrative. A review of the literature did not reveal any studies that previously specifically explored the lived-experience and practice of self-care, wellness, and resilience in Hispanic women working in rural communities. Previous studies did examine Mexican American women's professional identity in counseling (Hinojosa & Carney, 2016), Mexican Americans in Texas view of self-care (Mendias et al., 2001), and Hispanic counselors' resilience in Texas Rio Grande Valley (Airhart-Larraga et al., 2021). However, none looked specifically at the intersectionality of

Woman+Hispanic+Counselor+Rural and none explored the culture identity of living and practicing in New Mexico.

The following sections provided recommendations and implications for Counselor Educators, clinical supervisors, and directions for future research. Implications of the current study for clinical supervision, counselor educators and research are guided towards considering culture moderators as a protective factor and decolonizing the self-care pedagogy. In light of the current findings, several implications for practice should be considered for both those that have power over counselors (supervisors and educators) and for the counseling field collectively. Most importantly, educators, researchers, and supervisors have the power to reconsider the framework that they conceptualize, measure, and view as self-care and wellness in the counseling field.

Decolonizing Self-care and Resilience

A primary challenge of operationalizing "resilience" lies in the colonialist history of the concept's use, particularly in a scientific setting. The "resilience" term in health disparities research reinforces the notion that systematically oppressed populations that experience health disparities should be expected to display positive coping in the face of adversity, rather than holding oppressive structures accountable for producing and magnifying those disparities. When conceptualizing resilience, we must be cognizant of the intersections of social and bioecological contexts that contribute to resilience, both in privileged and oppressed groups. Currently, research on resilience only focuses on individual traits and behaviors or support and individual experiences in their relationships (Friborg 2003; Connor and Davidson 2003). But measuring and promoting resilience must be understood at multiple systemic levels. Many authors have promoted the utilization of self-care as an individual means of building resilience (Beauchemin,

2018; Prikhidko & Swank, 2018; O'Halloran & Linton, 2000; Myers et al., 2000; Merriman, 2015; Lawson & Cook, 2017). Currently, self-care is a vague and ambiguous term that is promoted in the counseling literature and research, described as coping strategies, career sustaining behaviors, or burnout prevention (Brownlee, 2016) that an individual can practice. However, self-care philosophy and attitudes ignore how multiple systems of oppression and environmental stressors can influence the individual counselor's wellness. For example, the effects of social determinants and intersectional epistemology. As a result, understanding barriers to promoting resilience must involve awareness of the ways individuals are prevented from developing resilience due to internal, interpersonal, and institutional processes. And this must occur at every level of the counselor's experience, from the classroom in their counselor education program to the research being conducted to better understand self-care and resilience.

Implications for Counselor Educators and Supervisors

The largest implication of this study is that counselor educators and supervisors must rethink and reconsider how it conceptualizes and assesses self-care and wellness. The very nature of counselor education programs located in an institution of higher education, allows for multiple layers of reflection related to the implications of being in a network of social structures and power relations (Chan, 2019). Like previous mentioned, the counseling field and counselor education programs are grounded in a history of wellness and self-care developed from a dominant perspective. No matter, self-care is a protective factor for stress and other mental health concerns and symptoms (Myers & Sweeney, 2008) and it is important to understand how it operates in these settings. However, many counselors and counseling students have identified barriers to practicing self-care. For example, lack of lack of awareness of needs (Barnett & Sarnel, 2005), lack of knowledge of how to carry out self-care (Sapienza & Bugental, 2000), the

belief that training insulates a counselor from risk of burnout (Barnett, Baker, Elman, & Schoener, 2007), it was not always incorporated into training (Williams, 2001), and not believing in the ideas and theories enough to model a wellness lifestyle (Fuselier, 2003). However, it is an ethical imperative for us to take care of ourselves and each other in the field of counseling (ACA, 2019). Some ways that counselor educators can do this is by modeling, teaching and practicing self-care in graduate training. For example, inviting students to practice and engage in self-care while in their graduate programs allows for students to become accustom to engaging these behaviors. This allows students an opportunity to explore what self-care and wellness means to them within their culture. Doing this in a classroom setting also helps students understand diverse perspectives because students will be afforded the opportunity to hear how their classmates may have similar or differing views then them. Elman (2007) stated that professors and supervisors must communicate self-care and make clear that it is just as important as hard work in school and learning to do it now. Incorporating this into a counseling program philosophy and stated values from the start of a student's entry into the program, at orientation, to the end of the student's experience, during internship, while allow the student to test their ability to cope throughout different experiences and settings. Additionally, practicing self-care as a student will make it easier later in the counseling students' career (Dearing, Maddux, & Tangney, 2005). Furthermore, self-care practices need to be addressed on the individual and systemic levels (Baker, 2007) and educators and supervisors need to consider the barriers for marginalized and underserved groups. Ways that educators can do this is by discussing with students Bronfenbrenner's bioecology model and how there are various systems that impact individual counselors. This can be done by asking students to graph and draw how they will address mental health and wellness at every system that they encounter. This will also encourage

students to re-think about how various external and contextual factors can influence their individual self-care. For example, understanding how a critical incident in their community, such as increased racial tension caused by a tragic event will impact themselves and their communities and how they might heal individually and collectively. When educators encourage students to create self-care plans, they should include how the student will practice wellness at every level of their environment.

A second implications of this study is the need for counselor educators and supervisors to be more iterative and reflexive with interrogating their own social identities with their students and supervisee's. It has previously been suggested that utilizing an intersectional lens and critical reflexivity in the classroom and supervision relationship allows for a greater understanding of power and self in relation to community, context, and power (Chan, 2019). When those in power do this, they demonstrate how integrating reflexivity and awareness of intersectional identities may impact conceptualization, practice, and beliefs around self-care, wellness, and resilience.

Additionally, it is imperative that counselor educators, clinicians, and supervisors be aware of barriers that exist for marginalized women and know how these barriers impact the wellness and self-care of these women by advocating to eliminate the oppressive systems that continue to marginalize women and other intersectional groups (Long et al., 2019). Long et al., (2019) suggest doing this by emphasizing "…the personal strengths (autonomy, self-awareness, self-esteem, resiliency, and intentionally) of this group and connect this to overall wellness promotion" (p.354). It is also suggested to improve Hispanic women's self-care practices by reminding them of their own power of choice and that they are in control and in power to impact their and their families lives (Mendias et al., 2010). Counselor educators should seek cultural competency with working Latinx populations includes most importantly becoming more

cognizant of the roles of colorism and racism in the interpersonal interactions across the developmental spectrum and in different settings (Arredondo et al., 2014). Most importantly educators need "…to understand culture conceptions of strengths, virtutes, and optimal functioning, researchers and practitioners need to attend to the value orientations of different cultures, including relational, time, spirituality, and activity orientations" (Arredondo et al., 2014, p.113). Value orientations of different cultures, such as relational, time, spirituality, and activity orientation, need to be attended to, to understand the cultural conceptions of strength, virtues, and optimal functioning (Sue, 2015). Those in power can do this by allowing diverse groups to present their conceptual framework and understanding of wellness, self-care, and resiliency before training and teaching the dominant cultures view. Reshaping how these terms are defined, conceptualized, and practiced by re-centering knowledge in the classroom will contribute to a greater understanding and respect for these diverse views. Lastly, educators must be careful not to force marginalized students to teach about themselves or be tokens of their group. For example, participants contextualized specific events that occurred within their workplace related to problematic situations related to their experiences and interactions of having to teach or promote culture humility and competency to their peers. This highlights the influence of power differentials and dynamics that occur in institutions. Because counselor educators play such a large role in facilitating the social environment of a classroom setting they should be conscious of the power and influence they have over the context and atmosphere of the classroom.

The fourth implication for supervisors and educators is that they should work to improve society-level discrimination and should work to mitigate the impact of discrimination from the perspective of the individual, family, and communities (Ruiz et al., 2016). Promoting social

justice and wellness with students, clients, and colleagues can help change systems and modify cultural trends that inhibit women's success (Hermann et al., 2014). This will require educators and supervisors to go beyond their offices and advocate to effect policy and promote equitable access to resources such as quality and affordable healthcare services, daycare facilities, transportation assistance (Long et al., 2019). Additionally, educators can encourage students to become more involved in social justice movements by utilizing service learning and experiential learning in the classroom. Service learning is an educational approach that encourages students to apply theories and concepts they learn in class and engage in volunteering and reflection in the community. Experiential learning is the process of learning through experience and requires students to be more hands-on with learning and reflecting on concepts of discrimination and oppression. Both of these methods allow for a deeper understanding and commitment to what is being taught in the classroom, which will further translate to counselors' values and beliefs in their professional career. The following section will also provide implications and direction for further research in counseling to address this.

Directions for Further Research

The results of this study pose several questions that remain for future research, specifically in the area of understanding how marginalized and underserved communities and counselors conceptualize, understand, and practice self-care and wellness. Research should seek to understand the external social determinants and bioecological factors that serve as barriers and challenges for those with intersecting identities. In order for research to become more socially justice it needs to avoid deleterious outcomes that seek to merely dissect self-care from culture. The MSJC's provide and support professional counselors by providing a framework and competencies to address multicultural and social justice issues in their work with clients as

practitioners. However, not much support has been provided to addressing the MSJC's in counseling research and research processes. Ratts et al. (2015) called for,

> "…privileged and marginalized [groups] to become aware, knowledgeable, skilled, and action-oriented in understanding the client's worldview" and for "…privileged and marginalized counselors intervene with, and on behalf, of clients at the intrapersonal, interpersonal, institutional, community, public policy, and international global levels."

Furthermore, Smith et al. (2009) advocated for counselors to combat the social illness that fosters human growth and development in a just society. Using a purposeful research approach to "transform the institutions of research, the deep underlying structures and taken-for-granted ways of organizing, conducting, and disseminating research knowledge" (Smith, 2005). And this includes exploring the narratives and experiences of marginalized groups and increasing culturally specific strategies to use in the counseling room (Sue, 1990), classroom (Tatum, 1992), supervision, and in counselor education training.

Counselor educators, supervisors, and researchers should also purposefully approach research and consider culture moderators and frameworks to understand self-care and wellness. Culture framework needs to be considered when understanding the constructs of wellbeing and happiness (Sue & Constantine, 2008). And a lack of culture competency or not taking into consideration the complex intersectional identities that individuals hold, can result in misinterpretations of cultural values as character flaws or weaknesses (Sue et al., 2007). For example, dismissing cultural strengths and framing cultural values as deficits is determinantal and can be oppressive. Future research should evaluate the efficacy of self-care and wellness models with marginalized populations, especially because no empirical research exists exploring the use of these models with marginalized groups (Long et al., 2019). To reduce deleterious

outcomes, it is critical to first identify as many risk and protective factors that affect groups of people across the developmental spectrum and socioecological and culture contexts, and then to develop interventions to lessen those risk factors and to promote the protective ones (Lindenberg et al., 1998). Research that adds evidence for a better understanding of the experiences of marginalized and underserved populations perceptions, beliefs, and practices of self-care, wellness, and resilience will contribute to the counseling field's commitment to multicultural counseling and social justice.

In summary, there is limited research that has been conducted on the multiple interlocking identities of individuals, with the majority of it focusing on quantitative methods that fail to capture more complex concepts and identity formations (Vera & De Los Santos, 2005). Counselor Educators and supervisors should work to understand group needs on the micro, meso, and macro levels to support their overall wellness and self-care. Lastly, the existing literature does not rely on a consistent or coherent framework for understanding what "resilience" means or how to measure it with diverse populations (Luthar, Cicchetti, & Becker, 2000). Two important recommendations for filling this gap in the current research is to explore culture moderators and the utilization of strength-based approaches in understanding how culture can influence self-care, wellness, and resilience.

Culture Moderators. In this study, culture moderators, identity, and group membership heavily influenced participant's perception of wellness and self-care. This study supported the idea that cultural moderators heavily influence the psychological resilience of an individual and how that individual perceives the meaning and purpose of their well-being (Lightsey, 2006). Teran et al. (2017) found that culture plays a mediating role related to burnout in bilingual Hispanic Latinx clinicians, and as a group they fare better than their English-speaking, monolingual counterparts

related to burnout. This speaks to the "Hispanic Paradox" also known as the "Latino Paradox" is an epidemiological paradox that refers to the trend that Hispanic and Latinx Americans have better health outcomes, even compared to Whites, or those with higher social economic statuses (Ruiz et al., 2016; Arredondo et al., 2014). For instance, outcomes of this paradox include significant lower rates of mood, anxiety, and substance disorders (Teruya & Bazargan-Hejazi, 2013). Additionally, this paradox has shown that women in particular appear to have lower rates of lifetime disorders (Viruell-Fuentes, 2007). Additionally, there are significant issues with the existing use of the concept of self-care and resilience when applied to communities of color. Specifically, focus on resilience can ignore the root causes of suffering and place responsibility on oppressed individuals for processing and persevering in the face of inequitable structural conditions (Prowell, 2019). And the existing literature ignores how communities and community membership provides resilience to an individual. Researchers exploring culture moderators can add to the existing literatures understanding of how culture contributes to individuals and community's resilience.

Strengths-Based Approaches. Strengths-based approaches acknowledge protective factors can be either bioecological or psychosocial in nature and reside in either the individual, the family, the community, or institutions (Lindenberg et al., 1998). Although the counseling field rejections traditional medical models, current research trends and education have not yet entirely focused on strength-based decolonized perspectives. A ten-year review (1998-2007) of American Counseling Association (ACA) division affiliated journals found only 6% published research focusing on the effectiveness of outcome-based research and interventions (Ray et al., 2011). Additionally, counseling research has not yet actually yielded culturally relevant or socially just practice behaviors and client outcomes in research (Hays, 2020). Counseling research is

preoccupied with analyzing the risk, vulnerabilities, and deficits, and pathologies of clinical and non-clinical populations. We should avoid conducting damaged-center research that intends to only document the pain, loses, or brokenness of an individual, community or tribe (Tuck, 2009). Instead, interventions that address the micro-level include strengths-based interventions such as exploring personal strengths and how they can use their strengths to enhance their wellness and support their overall health (Long et al., (2019). However, all levels of an individual's bioecological system need to be addressed to fully understand how each of these systems can contribute to an individual's resiliency and strengths. In conclusion, strength-based approaches allow researchers and counselors to acknowledge that each individual and community has a unique set of strengths and abilities that they can employ to overcome adversity and challenges.

Limitations

As with any qualitative research study, there are several notable limitations related to the interpretation and applications of the findings for the current study. Below I detail three limitations of this study related to: the diversity of the sample, sample size and participant responses, and my positionality and identity as the researcher. Because of these limitations, there are limitations to how these findings can be applied to other populations.

Diversity of the Sample

The first limitation to this research study being proposed is the specific population that the research is drawing from. Ruiz et al., (2016) found that most health outcome research on Hispanic communities is limiting because it puts them in a homogenous group, but this has significant implications because it ignores their different backgrounds, culture, and racial makeup. For example, the term Hispanic or Latinx can encompass more than 20 national origins groups, with vastly different ancestry, sociodemographic and cultural characteristics, migration

and U.S. geographic distribution (Gallo et al., 2014). The problem with this is there are critical knowledge gaps addressing the mental health needs and experiences of Hispanic/Latinx populations. The research specifically recruited women that racially or ethnically identified as Hispanic, Latina, or Chicana and are licensed counselors (LPCs or LMHCs) in the state of New Mexico practicing counseling in rural areas to underserved populations, however, even the Hispanic community in NM is diverse and is not a homogenous group. Gomez (2018) acknowledged the regions peculiar racial dynamics that she describes as, "New Mexico's Chicano exceptionalism" (p.9). New Mexican American's are a diverse group culturally; one of the unique status is the intense, long-standing claim to Spanish, instead of Mexican heritage (Gomez, 2018). Gomez (2018) defined this unique sociocultural group of Mexican Americans as a mixed racial ancestry of Spanish, Indian, Mexican, and African ancestry who lived in the Spanish colony of New Spain, which is now known as the American Southwest. Specifically, New Mexico Chicano's have a unique experience in that many Northern families cling to an intense, long-standing claim to Spanish, rather than Mexican heritage (Gomez, 2018). Within the sample many participants used different words to describe their identity based on the purpose they have drawn from it and the cultural context of relating to a specific identity. Gomez's (2018) analysis of New Mexican Mexican-Americans shows a robust claim to be apart and often downplay their Mexican or Indigenous roots in favor of a Spanish heritage. Additionally, the demographics of the participants in regard to gender and sexual orientation further served as a limitation to this study. All of the sample identified as female and heterosexual. By not knowing more about the experiences of other gender identities and other sexual orientations can limit the generalizability of the findings to individuals that share the identity of being female, Hispanic,

and heterosexual. Lastly, participant voices or narratives do not represent the stories of all Hispanic women practicing counseling in rural New Mexico.

Sample Size and Responses

A second limitation of this study was the sample size and the participant's responses. The sample size of nine participants limits the application and transferability of the results to other individuals outside of the sample demographics. Hence, the findings are limited to understanding the experiences of the participants and others who share similar situations (i.e., practicing clinical counseling in rural New Mexico and identify as a Hispanic women) and lack the ability to be generalized to other populations. Even though the sample size was small, the depth and richness of the data gathered from the interviews from each participant led to a blooming of understanding of the collective experiences of these women. Furthermore, one of the benefits of this type of rich descriptions is that it provided a complete whole understanding of how the participants interpreted the purpose of self-care, how they practiced wellness, and how they made meaning of their professional identity development in relation to their culture, community, and family. Generating rich thick descriptions through qualitative research methods also encourages the field of counseling to learn more about the personal introspective and subjective experiences of Hispanic women practicing professional counseling.

Another possible limitation related to the experiences and narratives of the participants was their responses. In regard to measurement bias, it is probable that participants tended to give socially desirable answer to portray themselves in the best possible way, which is a common risk with self-reflection. Relate to this, the findings of this study are also limited in that they represent what participants recalled during the interview. During the member check process four participants mentioned verbally or through email that they were surprised by the answerers they

gave at the moment during the interview, one even argued that they could provide deeper "more throughout-out" answers if they were given the questions before the interview. Lastly, volunteer bias was also possible, often times the most eager to speak out might have been more likely to respond to flyers and listserv request. Although self-selection is a not a typical limitation of all research, the willingness of participants to volunteer for this study, means they may have had more time, energy, resiliency, and other influential attributes than other potential participants (Anderson et al., 2009). Lastly, many participants were eager to share their experiences and narratives with the researcher, the participant's eagerness and comfortability, could have very well influenced the type of narratives and experiences that the researcher collected.

My Positionality as the Researcher

Another potential limitation was my own researcher bias, due to my social location and identities. Because I was the primary researcher, the findings provided one viewpoint of interpretation. Essentially, as an outsider, a White woman originally from California, my experiences in New Mexico and familiarity with rural NM was limited to a few years. It was important for me, as the researcher, to bracket my experiences as a counselor, researcher, and educator; however, this required effort and constant reflection. As the researcher, I had to be aware of how my positionality both as a women and as White, influenced my perceptions of the data. I, the researcher, struggled with my Whiteness and the colonizing education that influenced my perception of what it means to practice care for oneself and community.

The research journal I kept throughout the research process, from the inception of the study to the data analysis, was used to further attempt to bracket my bias and track my internal responses to the information received from participants. It also served as a reminder of my thoughts and feelings with each participant. Documenting my experiences over the course of the

research study allowed me to improve upon my approach with participants. A possible limitation related to my positionality as the researcher was very early on in data collection, I tried to remain objective and professional with participants, however, this seemed to further distance me from my participants. Participants were very curious about my own life, interest in the study, and if I experienced similar situations as them in my practice of self-care and counseling. Avoiding these questions or reminding participants of the time limitation we were under was seen as untrustworthy. My research journal showed that throughout the course of the study my approach slowly changed, and I became more open with discussing my experience, life, and interest with participants before, after, and during interviews. In fact, it seemed these conversations that happened outside of our recorded time or between interviews was more influentially to participants vulnerability and openness. Therefore, throughout the course of the study my research journal documented a change within me, as the researcher, in my approach to building a relationship with participants.

In conclusion, transferability or the ability for the research to be generalized to other settings and populations is limited. The researcher acknowledges in qualitative research the lack of ability to generalize finds to other settings, however, this was not the purpose of the research. The findings of this study was a basis for understanding the lived-experiences of diverse counselors and their interpretation, beliefs, and values related to self-care and wellness and how they differ from established norms in the field of counseling.

Conclusion

This study is unique in that is the first of its kind to provide a comprehensive analysis of the elements that foster wellness and resilience in Hispanic women practicing clinical counseling in rural New Mexico. The barriers and challenges were cited as examples of the means by which

the experiences of self-care may affect the experiences and perceptions among Hispanic women. Likewise, the protective factors and supports were named to better understand the elements that contribute to the wellness and professional career development of Hispanic women. This is critical because most of the literature on self-care is centered around the philosophy that individuals are personally responsible for their own wellbeing and the only way to go about doing this is by utilizing Westernized versions of self-care actives. Additionally, most empirical research on self-care and wellness has focused on the challenges that counselors and clients experienced instead of the factors they perceive that help them succeed. Furthermore, this study allowed participants that belonged to multiple intersecting identities and groups share their experiences with Counselor Educators and supervisors that might learn more about this group and their unique practice and understanding of wellness and self-care. It is the researcher's hope that this study serves as a reminder that the complex, multi-stressor predicaments of individuals cannot be void of their personal, cultural, community, and familial strengths.

This chapter discussed the results of this study and how they can be applied to future research, training and education of counselors, and during the supervision of clinical counselors. There is still much more to explore and understand related to the experiences of Hispanic women practicing counseling in rural New Mexico and the experiences of diverse counselors and their interpretation and practice of self-care and wellness. However, it is important to highlight that despite the challenges that participants encountered, they emerged as resilient individuals. Many participants spoke of the trials and barriers that they encountered and overcame during their training and career development, but all participants reported a satisfaction and sense of purpose in the counseling field. They also experienced tremendous growth that impacted them psychologically and as social and cultural beings. It is this researcher's interpretation that all

participants demonstrated traits of a resilient person, however, those personal and community characteristics were not the typical reported behaviors and skills of self-care that are reported in the current literature.

Closing Remarks

Reflecting on my experience as a researcher, I felt honored and humbled to collect the stories and narratives of my participants regarding their experiences and journeys of discovering what self-care and wellness meant to them. Before embarking on the data collection process, I was anxious about what kind of participant's responses would emerge and whether participants would be willing to share with me their deeply personal lived-experiences as counselors. Because of the severely limited information related to the experiences of marginalized counselors' beliefs, values, and perceptions of wellness and resilience, I was grateful for the opportunity to address the topic. Utilizing qualitative research skills, such as keeping a reflexive journal and allowing for self-reflection, significantly helped me to continually monitor my biases and emotional reactions to participant's stories. For me, I was challenged with the intensely personal nature of the study and managing my own emotional reactions to participant's narratives that at times could be devasting, frustrating, and despairing. Additionally, my experience with participants often made me question my own views of self-care and wellness and further question the knowledge that I was taught as a doctoral student and researcher. My reflection of the research process was mostly characteristic of how and why I interpreted the data in certain ways, specifically during the coding, categorizing, and thematic development stages.

References

Acker, G. M. (2012). Burnout among mental health care providers. *Journal of Social Work, 12*, 475-490.

Adams, S.A. (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education in Professional Psychology, 2*, 26-34.

Addison, C.C., Campbell-Jenkins, B.W., Sarpong, D.F., Kibler, J., Singh, M., Dubbert, P., Wilson, G., Payne, T., & Taylor, H. (2007). Psychometric evaluation of a coping strategies inventory short-form (CSI-SF) in the Jackson Heart study cohort. *International Journal of Environmental Research and Public Health, 4*(4), 289-295.

Addo, I.Y. (2020). Double pandemic: Racial discrimination amid coronavirus disease 2019. *Social Sciences & Humanities Open, 2*(1), 1000074.

Alarcon, G.M., Edwards, J.M., & Menke, L.E. (2011). Student burnout and engagement: A test of the conservation of resources theory. *The Journal of Psychology, 145*(3), 211-227. DOI: 10.1080/00223980.2011.555432

Aleman, S.M. (2018). Mapping intersectionality and Latina/o and Chicana/o students along educational frameworks of power. *Review of Research in Education, 42*(1), 177-202.

Alexander-Albritton, C. & Hill, N.R. (2015). Familial and institutional factors: Job satisfaction for female counselor educators. *Counselor Education and Supervision, 54*(2), 109-121.

Alkema, K., Linto, J.M., Davies, R. (2008). A study of the relationship between self-care, compassion satisfaction, compassion fatigue, and burnout among hospice professionals. *Journal of Social Work in End-of-Life & Palliative Care, 4,* 110-119.

Airhart-Larraga, S., Lloyd-Hazlett, J., & Purgason, L.L. (2021). Resilience narratives of Hispanic counselors in the Texas Rio Grande Valley, *Journal of Professional Counseling: Practice, Theory, & Research, 48*(1), 15-30.

Arredondo, P. (1999). Multicultural counseling competencies as tools to address oppression and racism. *Journal of Counseling & Development,* 78, 102-108.

Arredondo, P. & Arciniega, G.M. (2001). Strategies and techniques for counselor training based on the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 29,* 263-273.

Arredondo, P. (2011). The "borderlands" experience of women of color as higher education leaders. In J.L. Martin (Ed.), *Women as leaders in education* (pp.275-298). Santa Barbara, CA: Praeger.

Arnold, D., Calhoun, L.G., Tedeschi, R., Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45*, 239-263.

American Counseling Association (2009). *The ACA Encyclopedia of Counseling.* Alexandria, VA: American Counseling Association.

American Counseling Association (ACA). (2014). 2014 ACA Code of Ethics. ACA Governing Council.

American Psychological Association. (2017). Stress in America: The State of Our Nation. Stress in America Survey.

American Psychological Association. (2020, May 29). 'We are living in a racism pandemic,' Says APA President. APA Racism, Bias, and Discrimination. https://www.apa.org/news/press/releases/2020/05/racism-pandemic

Atieno Okech, J.E. & Rubel, D. J. (2019). *Counselor education in the 21st century: Issues and experiences.* Alexandria, VA: American Counseling Association.

Bakker, A.B. & Demerouti, E. (2007). The Job Demands-Resources model: State of the art. *Journal of Managerial Psychology, 3*, 309.

Baker, E. K. (2007). Therapist self-care: Challenges within ourselves and within the profession. *Professional Psychology: Research and Practice, 38*(6), 607-608.

Bakker, A.B., Demerouti, E., & Verbeke, W. (2004). Using the job demands-resources model to predict burnout and performance. *Human Resource Management, 43*(1), 83-104.

Bakker, A.B., Demerouti, E., & Euwema, M.C. (2005). Job resources buffer the impact of job demands on burnout. *Journal of Occupational Health Psychology, 10*(2), 170-180.

Bakker, A.B., Hakanen, J.J., Demeroui, E., Xanthopoulou, D. (2007). Job resources boost work engagement, particularly when job demands are high. *Journal of Educational Psychology, 99*(2), 274-284.

Banerjee, D., Kosagisharaf, J.R., and Rao, S.T.S. (2021). 'The dual pandemic' of suicide and COVID-19: A biopsychosocial narrative of risks and prevention. *Psychiatry Research*, 1-8.

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). In pursuit of wellness: The self-care imperative. *Professional Psychology: Research and Practice, 38*(6), 603-606.

Bauer, G.R. (2014). Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity. *Social Science & Medicine, 110*, 10-17.

Baugh, G.A., Pfund, G.N., Hill, P.L., & Cheung, F. (2019). Fifty states of purpose: Examining sense of purpose across the United States. *The Journal of Positive Psychology*, 38-45.

Baxter, P. & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report, 13*(4), 544-559.

Bercier, M.L. & Maynard, B.R. (2013). Interventions for secondary traumatic stress with mental health workers: A systematic review. *Research on Social Work Practice, 25*, 81-89.

Bernard, J.M. (1979). Supervisor Training: A Discrimination Model. Counselor Education and Supervision, 60-68.

Bermudez, J.M., Muruthi, B.A., & Jordan, L.S. (2016). Decolonizing research methods for family science: Creating space at the center. *Journal of Family theory & Review, 8*(2), 192-206.

Berkel, C., Knight, G.P., Zeiders, K.H., Tein, J.Y., Roosa, M.W., Gonzales, N.A., & Saenz, D. (2010). Discrimination and adjustment for Mexican American adolescents: A prospective examination of the benefits of culturally related values. *Journal of Research on Adolescence, 20*, 893-915.

Beauchemin, K. (2018). Through the looking glass: Reflecting on counsellor dreams for enhanced self-care and effective practice. *International Journal of Advancement of Counselling, 40,* 52-59.

Beaumont, E., Durkin, M., Martin, C.J.H., & Carson, J. (2016). Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioral psychotherapists: A quantitative survey. *Counselling and Psychotherapy Research, 16*, 15-23.

Bell, D. (1992). *Faces at the bottom of the well: The permanence of racism.* New York: New York; Basic Books.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3, 77-101.

Breen, D.J. & Drew, D.L. (2012). Voices of rural counselors: Implications for counselor education and supervision. *Ideas and Research You Can Use: VISTAS 2012, Volume 1.*

Brookehouse, R., Msetfi, R.M., Cohen, K., & Joseph, S. (2011). Vicarious exposure to trauma and growth in therapists: The moderating effects of sense of coherence, organizational support, and empathy. *Journal of Traumatic Stress, 24*(6), 735-742.

Bloomberg, L.D. & Volpe, M. (2016). Completing your qualitative dissertation: A road map from beginning to end. United States of America: SAGE Publications, Inc.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2020). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research, 26*(3), 1802-1811.

Brockhouse, R., Msetfi, R.M., Cohen, K., & Joseph, S. (2011). Vicarious exposure to trauma and growth in therapists: The moderating effects of sense of coherence, organizational support, and empathy. *Journal of Traumatic Stress, 24*(6), 735-742.

Bronfenbrenner, U. (1976). The experimental ecology of education. *Educational Researcher, 5*(9), 5-15.

Bronfenbrenner, U. & Ceci, S.J. (1994). Nature-nurture reconceptualized in development perspective: A bioecological model. *Psychological Review, 101*(4), 568-586.

Bronfenbrenner, U. & Evans, G.W. (2000). Developmental science in the 21st century: Emerging questions, theoretical models, research designs and empirical findings. *Social Development, 9*(1), 115-125.

Bronfenbrenner, U. (1974). Development of research, public policy, and the ecology of childhood. *Child Development, 45*(1), 1-5.

Bronfenbrenner, U. (1975). Reality and research in the ecology of human development. *Proceedings of the American Philosophical Society, 119*(6), 439-469.

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research Perspectives. *Developmental Psychology, 22*(6), 723-742.

Brownlee, E. (2016). How do counsellors view and practice self-care? *HEALTHCARE Counselling and Psychotherapy Journal.*

Bober, T., Regehr, C., & Zhou, Y.R. (2006). Development of the coping strategies inventory for trauma counselors. *Journal of Loss and Trauma, 11*, 71-81.

Bonifacio, L. Gushue, G.V., Mejia-Smith, B.X. (2018). Microaggressions and ethnic identity in the career development of Latina college students. *The Counseling Psychologist, 46*(4), 505-529.

Bonilla-Silva, E. (2018). *Racism without Racist: Color-blind racism and the persistence of racial inequality in America*. New York: Rowman & Littlefield.

Bonanno, G.A., & Mancini, A.D. (2012). Beyond resilience and PTSD: Mapping the heterogeneity of responses to potential trauma. Psychological Trauma: Theory, Research, Practice, and Policy, 4(1), 74-83.

Bowland, S. (2015). Aging in place or being warehoused? African American trauma survivors in mixed-age housing. *Traumatology*, 21, 172-180.

Biggerstaff, D. & Thompson, A.R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research, *Qualitative Research in Psychology,* 5:3, 214-224.

Bryan, S.M. (2019). Report: More behavioral health services needed for rural areas in New Mexico. *Las Cruces Sun News*. (September 18, 2019).

Buchanan, M., Anderson, J.O., Unlemann, M.R., & Horwitz, E. (2006). Secondary traumatic stress: An investigation of Canadian mental health workers. *Traumatology, 12*(4), 272-281.

Cacari Stone, L., Diaz Fuentes, C., Lopez, N., Raj Joshi, J., Castillo, F., & Lauvidaus, M. (2017). *The Heart of Gender Justice in New Mexico: Intersectionality, Economic Security, and Health Equity (Part 2: Quantitative Data Analysis).* Santa Fe, NM: NewMexicoWomen.org (a program of New Mexico Community Foundation).

Carroll, L., Gilroy, P.J., & Murra, J. (2003). The effect of gender and self-care behaviors on counselor's perceptions of colleagues with depression. *Journal of Counseling & Development, 81*, 70-77.

Carlisle, B.L. & Murray, C.B. (2020). The role of cultural mistrust in health disparities. *The Wiley Encyclopedia of Health Psychology.*

Carter, N., Bryant-Lukosius, D., DiCenso, A., Bluthe, J., & Neville, A. (2014). The use of triangulation in qualitative researcher. *Oncology Nursing Forum, 41(5),* 545-547.

Campbell, R., Dworkin, E., Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. *Trauma, Violence, & Abuse, 10*(3), 225-246.

Capielo C., Mann L., Nevels B., Delgado-Romero E. (2014) Multicultural Considerations in Measurement and Classification of Positive Psychology. In: Teramoto Pedrotti J., Edwards L. (eds) *Perspectives on the Intersection of Multiculturalism and Positive Psychology. Cross-Cultural Advancements in Positive Psychology*, vol 7. Springer, Dordrecht. https://doi.org/10.1007/978-94-017-8654-6_3

Cavazos, J., Holt, M.L., Flamez, B. (2011). The use of narrative therapy with Latina/o students pursuing higher education: Implications for school counselors and counselor educators. *Arizona Counseling Journal, 27*(1), 4-14.

Cavazos, J. Alvarado,V., Rodriquez, I., & Iruegas, J.R. (2009). Examining Hispanic students' worries: A qualitative approach. *Journal of School Counseling, 7*(12), 1-22.

Centers for Disease Control and Prevention. (2021). Stress and coping. https://www.cdc.gov/coronavirus/2019-ncov/daily -life-coping/managing-stress-anxiety.html.

Cerezo, A. (2020). Expanding the reach of Latinx psychology: Honoring the lived experiences of sexual and gender diverse Latinxs. *Journal of Latinx Psychology, 8*(1), 1-6.

Chan, C.D., Cor, D.N., & Band, M.P. (2018). Privilege and oppression in counselor education: An intersectionality framework. *Journal of Multicultural Counseling and Development, 46*, 58-73.

Chan, C.D., Henesy, R.K., Erby, A.N. (2019). Toward praxis, promise, and futures of intersectionality in multimethod counseling research. *Counseling Outcome Research and Evaluation, 10*(1), 12-18. s

Chavez-Duenas, N.Y. Adames, H.Y., Perez-Chavez, J.G., & Salas, S.P. (2019). Healing ethno-racial trauma in Latinx immigrant communities: Cultivating hope, resistance, and action. *American Psychologist, (1)*, 49.

Chavez-Duenas, N.Y., Adams, H.Y., Perez-Chavez, J.G., & Salas, S.P. (2019). Healing ethno-racial trauma in Latinx immigrant communities: Cultivating hope, resistance, and action. *American Psychologist, 74*(1), 49-62.

Choate, L.H. (2008). Girls and women's wellness: Contemporary counseling issues and interventions. *American Counseling Association*: Alexandria, VA.

Christopher, J.C. & Maris, J.A. (2010). Integrating mindfulness as self-care into counselling and psychotherapy training. *Counselling and Psychotherapy Research, 10*(2), 114-125.

Christensen, A.D. & Jensen, S. (2012). Doing intersectional analysis: methodological implications for qualitative research. NORA: Nordic Journal of Women's Studies, 20(2), 109-125.

Clark, P. (2009). Resiliency in the practicing marriage and family therapist. *Journal of Marital and Family Therapy, 35*(2), 231-247.

Coduti, W.A. & Luse, M.M. (2015). Rural ethics and mental health: An overview for rehabilitation counselors. *Journal of Applied Rehabilitation Counseling, 46*(1), 40-47.

Cohn, T.J. & Hastings, S.L. (2013). Building a practice in rural settings: Special considerations. *Journal of Mental Health Counseling, 35*(3), 228-244.

Collins, P.H. (1990). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment.* London: HarperCollins.

Collins, P. H. (2000). Black feminist thought: Knowledge, consciousness, and the politics of empowerment. London, England: Routledge. Collins, P. H., Bilge, S. (2016). Intersectionality. Cambridge, UK: Polity Press.

Collins, P.H. (2019). *Intersectionality as Critical Social Theory*. Duke University Press: United States.

Cole, B. (1988). Teaching in a time machine: The "make do" mentality in small-town schools. *Phi Delta Kappan, 70,* 139-172.

Connor, K.M. & Davidson, J.R. (2003). Development of a new resilience scale: The Connor-Davidson Resilience Scale (CD-RISC). *Depression Anxiety, 18*(2), 76-82. Constantine, M.G. & Sue, D.W. (2007). Perceptions of racial microaggressions across Black supervisees in cross-racial dyads. *Journal of Counseling Psychology, 54*(2), 142-153.

Cooper, C.L. (1998). Theories of Organizational Stress. Oxford University Press, Inc: New York.

Corey, G., Muratori, M., Austin II, J.T., & Austin, J.A. (2018). Counselor Self-care. Alexandria, VA: American Counseling Association.

Creswell, J.W. (2013). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches (4th ed.).* Thousand Oaks, CA. Sage Publications.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. University of Chicago Legal Forum, 140, 139-167.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. Stanford Law Review, 43, 1241-1299.

Crenshaw, K. (2011.) Postscript. In Lutz, H., Herrera Vivar, M.T., Supik, L. (Eds.), Framing intersectionality: Debates on a multi-faceted concept in gender studies (pp. 221–234). Burlington, VT: Ashgate.

Dainkeh, F. (2019). *Beyond self-care: Understanding community care and why it's important.* Diversity, Equity, and Inclusion.

Dearing, R. L., Maddux, J. E., & Tangney, J. P. (2005). Predictors of psychological help seeking in clinical and counseling psychology graduate students. *Professional Psychology: Research and Practice, 36*(3), 323-329.

Debats, D.L. (1999). Sources of meaning: An investigation of significant commitments in life. *Journal of Humanistic Psychology, 39*(4), 30-57.

Delgado, R. & Stefancic, J. (2001). *Critical Race Theory: An Introduction.* New York: New York University Press.

Del Toro, J. & Yoshikawa, H. (2020). Invited Reflection: Intersectionality in quantitative and qualitative research. *Psychology of Women Quarterly, 40*(3), 347-350.

Demerouti, E., Bakker, A.B., Nachreiner, F., & Schaufeli, W.B. (2001). The Job-Demands Resources Model of Burnout. *Journal of Applied Psychology, 86*(3), 499-512.

Devilly, G.J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress of simply burnout? Effect of trauma therapy on mental health professionals. *Australian and New Zealand Journal of Psychiatry, 43*(6), 373-385.

Dickson, G.L., Argus-Calvo, B., Tafoya, N.G. (2010). Multicultural counseling training experiences: Training effects and perceptions of training among a sample of predominately Hispanic students. *Counselor Education & Supervision, 49*(1), 247-265.

Dinsmore, J.A. & England, J.T. (1996). A study of multicultural counseling training at CACREP-accredited counselor education programs. *Counselor Education and Supervision, 36*, 58-76.

Dockray, H. (2019). *Self-care isn't enough. We need community care to thrive*. Mashable: Culture.

D'Souza, F., Egan, S.J., & Rees, C.S. (2001). The relationship between perfectionism, stress and burnout in clinical psychologist. *Behaviour Change, 28*, 17-28.

Duran, A. & Jones, S.R. (2019). Using intersectionality in qualitative research on college student identity development: Considerations, tensions, and possibilities. *Journal of College Student Development, 60*(4), 455-471.

Dworkin, E.R., Zambrano-Vazquez, L., Cunningham, S.R., Pittenger, S.L., Schumacher, J.A., Stasiewicz, P.R., & Coffey, S.F. (2017). Treating PTSD in pregnant and postpartum rural women with Substance Use Disorder. *Rural Mental Health, 41*(2), 136-151.

Falvey, J.E. (2002). Managing Clinical Supervision: Ethical practice and legal risk management. Brooks/Cole; Pacific Grove, CA.

Farooqi, M. (2018). We need to decolonize the self-care movement-here's why. *The Tempest*.

Ferber, A.L., O'Reilly Herrera, A., Samuels, D.R. (2007). The matrix of oppression and privilege: Theory and practice for the new millennium. *American Behavioral Scientist, 51*(4), 516-531.

Figley, C.R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In B.H. Stamm (Ed.), *Coping with secondary traumatic stress disorder in those who treat the traumatized.* New York; NY: Brunner/Mazel.

Figley, C.R. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B.H. Stamn (Edu.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators.* Lutherville, MD: Sidran Press.

Fitzpatrick, M.R., Kovalak, A.L., and Weaver, A. (2010). How trainees develop an initial theory of practice: A process model of tentative identifications. Counseling and Psychotherapy, 10(2), 93-102.

Flick, U. (2014). *An introduction to qualitative research* (Ed 5). Sage; Los Angeles, CA.

Flores, Y.G. (2009). On becoming an elder: An immigrant Latina therapist narrative. *Women and Therapy*, (2-3). 170.

Franklin, J.D., Smith, W.A., & Hung, M. (2014). Racial battle fatigue for Latina/o students: A quantitative perspective. *Journal of Hispanic Higher Education, 13*(4), 303-322.

Freudenberg, H.J. & Richelson, G. (1980). *Burnout: The high cost of high achievement.* New York: Anchor Press.

Frosch, D. (2013). Fraud investigation unsettles mental health care in New Mexico. *The New York Times.* (September 16, 2013). From http://nytimes.com/2013/09/14/fraud-investigation-unsettle-mental-health-care-in-new-mexico.html?

Friborg, O., Hjemdal, O., Rosenvinge, J.H., & Martinussen, M. (2003). A new rating scale for adult resilience: What are the central protective recourses behind healthy adjustment? *International Journal of Methods in Psychiatric Research, 12*(2), 65-76.

Fuselier, D. (2003). Self-care among psychology graduate students and psychologists: Implications for physical, mental, and spiritual well-being. Psy.D. dissertation, University of Northern Colorado, United States –Colorado.

Eatough, V. & Smith, J.A. (2017). Interpretative phenomenological analysis. In: Willig, C. and Stainton-Rogers, W. (eds.) Handbook for Qualitative Psychology 2nd Edition. London, UK: Sage, 193-211.

Eckart, E.C. & Ziomek, D.J. (2019). An investigation of the variables that influence female

counselors' work-family conflict. *Journal of employment counseling, 56*(2), 50-68.

Edelkott, N., Engstrom, D.W., & Herandez-Eolfe, P. (2016). Vicarious resilience: Complexities and variations. *American Journal of Orthopsyicatrity,86*(6), 713-724.

Eddington, N. & Shuman, R. (2011). Famous therapist errors. *Continuing Psychology Education Inc.,* 1-19.

Elman, N. S. (2007). Who needs self-care anyway? We all do! *Professional Psychology: Research and Practice, 38*(6), 608-610.

Emery, S., Wade, T.D., & McLean, S. (2009. Associations among therapist beliefs, personal resources and burnout in clinical psychologist. *Behaviour Change, 26*, 83-96.

Enochs, W.K. & Etzbach, C.A. (2004). Impaired student counselors: Ethical and legal considerations for the family. *The Family Journal, 12*(1), 396-400.

Endo, R. (2021). On holding various truths to (not) be self-evident: Leading during the dual pandemics of 2020 as a racialized body. *Cultural Studies Cultural Methodologies, 21*(1), 116-121.

Erickson, S.H. (2001). Multiple relationships in rural counseling. *The Family Journal: Counseling and Therapy for Couples and Families, 9*(3), 302-304.

Eriksson, M., Ghazinour, M., & Hammarstrom, A. (2018). Different uses of Bronfenbrenner's ecological theory in public health research: What is their value for guiding public mental health policy and practice? *Social Theory Health, 16*(1), 414-433.

Gaubatz, M.D. & Vera, E.M. (2002). Do formalized gatekeeping procedures increase programs' follow-up with deficient trainees? *Counselor Education and Supervision, 41*(4), 294-305.

Galea, S., & Vlahov, D. (2002). Social determinants and the health of drug users: socioeconomic status, homelessness, and incarceration. *Public health reports (Washington, D.C.: 1974)*, *117 Suppl 1*(Suppl 1), S135–S145.

Gallo, L.C., Penedo, F.J., Espinosa de los Monteros, K., & Arguelles, W. (2009). Resiliency in the face of disadvantage: Do Hispanic cultural characteristics protect health outcomes?. *Journal of Personality, 6,* 1707.

Gentry, J.E. (2002). Compassion fatigue: A crucible of transformation. *Journal of Trauma Practice*, 3, 37-61.

Gill, R. (2018). *Beyond individualism: The psychosocial life of the Neoliberal University.* Marc Spooner & James McNinch, eds. Dissident Knowledge in Higher Education. University of Regina Press, 193-216.

Gloria, A.M. & Rodriguez, E.R. (2000). Counseling Latino university students: Psychosocial issues for consideration. *Journal of Counseling and Development, 78*(1), 145-154.

Goodsell, T.L., Zvonkovic, A., Peter, N.Y., & Kushner, K.E. (2015). Theoretical triangulation as an extension of feminist intersectionality in qualitative family research. *Journal of Family Theory and Review, 3*, 284.

Gomez, L.E. (2018). *Manifest destinies: The making of the Mexican American race.* New York: New York University Press.

Gonzales, P.M., Blanton, H., & Williams, K.J. (2002). The effects of stereotype threat and double-minority status on the test performance of Latino women. *Personality and Social Psychology Bulletin, 28*(5), 659-670.

Greenberg, J.P., Vinjamuri, M., Williams-Gray, B., & Senreich, E. (2018). Shining the light on intersectionality: The complexities of similarity and differences in the therapeutic process

from the perspective of black and Hispanic social workers. *Smith College Studies in Social Work, 88*(1), 59-81.

Grollman, E.A. (2017). The importance of representation: Voice, visibility, and validation in America. World Press.

Grimes, E.L., Haskins, N., Paisley, P.O. (2014). "So, I went there": A phenomenological study on the experiences of rural school counselor social justice advocates. *Professional School Counselor, 17*(1), 40-51.

Grunenfelder, J. & Schurr, C. (2015). Intersectionality- A challenge for development research and practice? Development in Practice, 25(6), 771-784.

Grandey, A.A. & Cropanzano, R. (1999). The conservation of resources model applied to work-family conflict and strain. *Journal of Vocational Behavior, 54*(1), 350-370.

Grzanka, P.R., Santos, C.E., & Moradi, B. (2017). Intersectionality research in counseling psychology. *Journal of Counseling Psychology, 64*(5), 453-457.

Guinn, B., Vincent, V., & Dugas, D. (2009). Stress resilience among border Mexican American women. *Hispanic Journal of Behavioral Sciences, 31*(2), 228-243.

Guzman, B. (2012). The educational journey of a Latina feminist community psychologist. *Journal of Community Psychology, 40*(1), 62-76.

Hakanen, J.J., Schaufei, W.B., & Ahola, K. (2008). The job demands-resource model: A three-year cross-lagged study of burnout, depression, and commitment, and work engagement. *Work & Stress, 22*(3), 224-241.

Hann-Morrison, D. (2011). The varied roles of school counselors in rural settings. *Georgia School Counseling Association Journal, 18*(1), 26-33.

Halbesleben, J.R.B., Neveu, J., Paustian-Underdahl, S.C., & Westman, M. (2014). Getting to the "COR": Understanding the role of resources in conservation of resources theory. *Journal of Management, 40*(5), 1334-1364.

Halbesleben, J.R.B., Harvey, J., & Bolino, M.C. (2009). Too engaged? A conservation of resources view of the relationship between work engagement and work interferences with family. Journal of Applied Psychology, 94(6), 1452-1465.

Hancock, A.M. (2016). *Intersectionality: An Intellectual History*. Oxford University Press.

Hansen, J.T. (2014). *Philosophical Issues in Counseling and Psychotherapy: Encounters with four questions about knowing, effectiveness, and truth*. Lanham, Maryland: Rowman & Littlefield.

Harland, T. (2014). Learning about case study methodology to research higher education. *Higher Education Research & Development, 33*(6), 1113-1122.

Hardy, K.V. & Bobes, T. (2016). Culturally Sensitive Supervision and Training: Diverse Perspectives and Practical Application. Taylor & Francis; New York, NY.

Harkonen, U. (2007). The Bronfenbrenner ecological systems theory of human development. Scientific Articles of V International Conference. Daugavpils University, Saule, Latvia.

Haskins, N.H. & Singh, A. (2015). Critical race theory and counselor education pedagogy: Creating equitable training. *Counselor Education and Supervision, 54*, 288-301.

Harney, P.A. (2007). Resilience processes in context: Contributions and implications of Bronfenbrenner's person-process-context model. *Journal of Aggression, Maltreatment & Trauma, 14*(3), 73-87. DOI: 10.1300/J146v14n03_05

Harrison, R.L. & Westwood, M.J. (2009). Preventing vicarious traumatization of mental health therapist: Identifying protective practices. *American Psychological Association, 46*(2), 203-219.

Harvey, M.R. (1996). An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress, 9*(1), 3-23.

Hays, D.G. (2020). Multicultural and social justice counseling competency research: Opportunities for innovation. *Journal of Counseling & Development, 98*(3), 331-344.

Healthy People 2030. (2020). U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/social-determinants-health.

Healthy People 2020. (2020, September 30). *Social determinants of health.* https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Hermann, M.A., Ziomek, D.J., & Dockery, D.J. (2014). Motherhood and counselor education: Experiences with work-life balance. *Adultspan Journal, 13*(2), 109-119.

Hernandez, P., Gangesi, D., & Engstrom, D. (2007). Vicarious resilience: A new concept in work with those who survive trauma. *Family Process, 46*, 229-241.

Hinojosa, T.J., & Carney, J.V. (2016). Mexican American women pursuing counselor education doctorates: A narrative inquiry. *Counselor Education & Supervision, 55*(3), 198-215.

Hill, N.R., Leinbaugh, T., Bradley, C., & Hazier, R. (2005). Female counselor educators: Encouraging and discouraging factors in academia. *Journal of Counseling & Development, 83*(3), 374-380.

Hill, P.L., Turiano, N.A., Mroczek, D.K., & Burrow, A.L. (2016). The value of a purposeful life: Sense of purpose predicts greater income and net worth. *Journal of Research in Personality, 65*(1), 38-42.

Hill, P.L., Sin, N.L., Turiano, N.A., Burrow, A.L., & Almeida, D.M. (2018). Sense of purpose moderates the associations between daily stressors and daily well-being. Annals of Behavioral Medicine, 52(8), 724-729.

Hobfoll, S.E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist, 44*(3), 513-524.

Hobfoll, S.E. (2001). The influence of culture, community, and the nested self in the stress process: Advancing conservation of resources theory. *Applied Psychology: An International Review, 50*(3), 337-421.

Hobfoll, S.E. (2002). Social and psychological resources and adaptation. Review of General Psychology, 4, 307.

Hobfoll, S.E., Freedy, J., Lane, C., & Geller, P. (1990). Conservation of social resources: Social support resource theory. *Journal of Social and Personal Relationships, 7*(1), 465-478.

Hobfoll, S.E., Vinokur, A.D., Pierce, P.F., & Lewandowski-Romps, L. (2012). The combined stress of family life, work, and war in air force men and women: A test of conservation of resources theory. *International Journal of Stress Management, 19*(3), 217-237.

Hobbs, M., Rice, C. (2018). Mapping the terrain of Gender and Women's Studies. Gender and Women's Studies: Critical Terrain, 2nd edition (pp. xvii-xxix). Toronto, ON: Canadian Scholar's Press/Women's Press.

Hood, R. (2016). Combining phenomenological and critical methodologies in qualitative research. *Qualitative Social Work, 15*(2), 160-174.

Homrich, A.M. and Henderson, K.L. (2018). Gatekeeping in the Mental Health Professions. American Counseling Association; Alexandria, VA.

Hostinar, C.E. (2015). Recent developments in the study of social relationships, stress response, and physical health. *Current Opinions in Psychology, 5*, 90-95.

Horwath, J. & Terrell, S. (2016). Balderas: Last 2 behavioral health providers cleared of Medicaid fraud. *Santa Fe New Mexican*. (April 5, 2016). From http://santafenewmexican.com.

Horowitz, J.M., Parker, K., Brown, A., & Cox, K. (2020, October 6). *Amid national reckoning, Americans divided on whether increased focus on race will lead to major policy change.* Pew Research Center: Social & Demographic Trends https://www.pewresearch.org/social-trends/2020/10/06/amid-national-reckoning-americans-divided-on-whether-increased-focus-on-race-will-lead-to-major-policy-change/

Huff, J.L., Smith, J.A., Jesiek, B.K., Zoltowski, C.B., Graziano, W.G., & Oakes, W.C. (2014). From methods to methodology: Reflection on keeping the philosophical commitments of interpretative phenomenological analysis. *2014 IEEE Frontiers in Education Conference (FIE) Proceedings, Frontiers in Education Conference (FIE), 2014 IEEE,* 1-9.

Imig, A. (2014). Small but mighty: Perspectives of rural mental health counselors. *The Professional Counselor, 4*(4), 404-412.

"Integrating the Neurobiology of Minority Stress with an Intersectionality Framework for LGBTQ-Latinx Populations." *US Official News*, 26 Jan. 2019. *Gale OneFile: News*, link.gale.com/apps/doc/A571655616/STND?u=albu78484&sid=STND&xid=b8765cd2.

Ito, J.K. & Brotheridge, C.M. (2003). Resources, coping strategies, and emotional exhaustion: A conservation of resources perspective. *Journal of Vocational Behavior, 63*(1), 490-509.

Jangha, A.G., Magyar, R.G., & O'Grady, K. (2018). Power within the counselor identity development of African American women in pastoral counseling. *Counseling & Values, 63*(1), 76-90.

Jenkins, S.R. & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *International Society for Traumatic Stress Studies, 15*(5), 423-432.

John J. Heldrich Center for Workforce Development. (2014). "A Workplace Divided: How Americans View Discrimination and Race on the Job." Rutgers, The State University of New Jersey.

Jordan, K. (2010). Vicarious trauma: Proposed factors that impact clinicians. *Journal of Family Psychotherapy, 21*, 225-237.

Johnson, M.E., Brems, C., Warner, T.D., Roberts, L.W. (2006). Rural-urban health care provider disparities in Alaska and New Mexico. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(4), 504-507.

Kashen, J., Glynn, S.J., & Novello, A. (2020, October 30). *How COVID-19 sent Women's workforce progress backward.* Center for American Progress.

https://www.americanprogress.org/issues/women/reports/2020/10/30/492582/covid-19-sent-womans-workforce-progress-backward/

Kaplan, D. (2015). How can we rescue ourselves from vicarious trauma? In G. Quitango & M.R. Evces (Eds.), *Psychosocial stress series. Vicarious trauma and disaster mental health: Understanding risks and promoting resilience* (pp. 135-155). New York, NY, US: Routledge/Taylor & Francis Group.

Kent, V., Runyan, H., Savinsky, D., & Knight, J. (2020). Mentoring doctoral student mothers in Counselor Education: A phenomenological study. *Professional Counselor, 10*(4), 532-547.

Kilanowski, J.F. (2017). Breadth of the socio-ecological model. *Journal of Argromedicine, 22*(4), 295-297.

King, K.M. & Borders, L., D. (2019). An experimental investigation of White counselors broaching race and racism. *Journal of Counseling & Development,* 97*,* 341-351.

Kiselica, M.S. & Robinson, M. (2001). Brining advocacy counseling to life: The history, issues, and human dramas of social justice work in counseling. *Journal of Counseling & Development, 79,* 387-397.

Kisner, J. (2017). The politics of conspicuous displays of self-care. *Cultural Desk.*

Kornbluh, M. (2015). Combatting challenges to establishing trustworthiness in qualitative research. Qualitative Research in Psychology, 12(4), 397-414.

Kottler, J.A. (2003). *On Being a Therapist*. San Francisco, CA: Jossey-Bass A Wiley Imprint.

Kottler, J.A. & Balkin, R.S. (2017). *Relationships in counseling and the counselor's life.* Alexandria, VA: American Counseling Association.

Kybdervikdm D.A. & Belwood, M.F. (2000). The best kept secret in counseling: Single-case (N=1) experimental design. *Journal of Counseling & Development, 78*, 92-102.

LaMantia, K., Wagner, H., & Bohecker, L. (2015). Ally development through feminist pedagogy: A systemic focus on intersectionality. *Journal of LGBT Issues in Counseling, 9*(2), 136-153.

Larkin, M., Eatough, V., & Osborn, M. (2011). Interpretative phenomenological analysis and embodied, active, situated cognition. *Theory & Psychology,* 21(3), 318-337.

Larkin, M. & Thompson, A. (2012). Interpretative phenomenological analysis. In A Thompson & D Harper (Eds), *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners.* John Wiley & Sons, Oxford, 99-116.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology,* 3:2, 102-120.

Lau, J. & Ng, K. (2014). Conceptualizing the counseling training environment using Bronfenbrenner's ecology theory. *International Journal of Advanced Counselling, 36*, 423-439. DOI: 10.0007/s10447-014-9220-5

Lawson, G. & Cook, J. M. (2017). Wellness, self-care, and burnout prevention. *Clinical Mental Health Counseling, 313-335.*

Lawson, G. (2011). Counselor wellness and impairment: A national survey. *The Journal of Humanistic Counseling, Education and Development, 46*(1), 20-34.

Leach, M. (2019). *How community care makes self-care a social justice act.* The Tempest: Community, Love, Wellness, and Social Justice.

Lee, J.H., Nam, S.K., Kim, A., Kim, B., Lee, M. Y., & Lee, S.M. (2013). Resilience: A meta-analytic approach. *Journal of Counseling & Development, (91)*,3, 269-279.

Lee, R. T., & Ashforth, B. E. (1990). On the meaning of Maslach's three dimensions of burnout. *Journal of Applied Psychology, 75*(6), 743–747. https://doi.org/10.1037/0021-9010.75.6.743

Lebowitz, L., Harvey, M.R., & Herman, J.L. (1993). A stage-by-dimension model of recovery from sexual trauma. *Journal of Interpersonal Violence, 8*(3), 378-391.

Leiter, M.P. & Maslach, C. (1999). Six areas of work life: A model of organizational context of burnout. Journal of Health and Human Services Administration, 21 (4), 472-489.

Leiter, M. (2008). A Two Process Model of Burnout and Work Engagement: Distinct Implications of Demands and Values. Giornale italiano di medicina del lavoro ed ergonomia. 30. A52-8.

Lent, J. & Schwartz, R.C. (2012). The impact of work setting, demographic characteristics, and personal factors related to burnout among professional counselors. *Journal of Mental Health Counseling, 34*(4), 355-372.

Lerma, E., Zamarripa, M. X., Oliver, M. & Cavazos Vela, J. (2015). Making our way through: Voices of Hispanic counselor educators. *Counselor Education & Supervision, 54,* 162-175.

Lewis, J.A., Ratts, M., Paladino, D.A., & Toporek, R.L. (2011). Social justice counseling and advocacy: Developing new leadership roles and competencies. *Journal for Social Action in Counseling & Psychology, 3*(1), 5-16.

LFC Hearing Brief. (2019). Expanding community-based behavioral health services. *New Mexico Legislative Finance Committee.* (July 10, 2019). From http://nmlegis.gov

Lorde, A. (1988). A burst of light and other essays.

Lopez, N., Erwin, C., Binder, M., & Chavez, M.J. (2018). Making the invisible visible: Advancing quantitative methods in higher education using critical race theory and intersectionality. *Race, Ethnicity and Education, 21*(2), 180-207.

Lieberman, L.S., Stoller, E.P., & Burg, M.A. (1997). Women's health care: Cross cultural encounters within the medical system. *Journal of Florida Medical Association, 84*, 364-373.

Lin, N.S.R., Ensel, W.M., & Kuo, W. (1979). Social support, stressful life event, and illness a model and an empirical test. *Journal of Health and Social Behavior, (20)*, 2, 108-119.

Liu, Y., Kuo, R., & Shih, S. (2020). COVID-19: The first documented coronavirus pandemic in history. *Biomedical Journal, 43*(4), 328-333. http://doi.org/10.1016/j.bj.2020.04.007

Lightsey, O.R. (2006). Resilience, meaning, and well-being. *The Counseling Psychologist, 34*(1), 96-107.

Lincoln, Y. & Guba, E. (1985). *Naturalistic Inquiry,* Sage; Beverly Hills, CA.

Lingdenberg, C.S., Solórzano, R.M., Krantz, M.S., Galvis, C., Baroni, G., Strickland, O. (1998). Risk and resilience: Building protective factors. *The American Journal of Maternal/Child Nursing, 23*(2), 99-104.

Lipscomb, A. E., & Ashley, W. (2020). Surviving being Black and a clinician during a dual pandemic: Personal and professional challenges in a disease and racial crisis. *Smith College Studies in Social Work, 90,* 221-236. doi: 10.1080/00377317.2020.1834489.

Long, S.M., Clark, M., Ausions, C.D., Jacoby, R., & McGhee, C. (2019). The wellness and self-care experiences of single mothers in poverty: Strategies for mental health counselors. *Journal of Mental Health Counseling, 41*(4), 343-353.

Llorens, S., Bakker, A.B., Schaufeli, W., & Salanova, M. (2006). Brief Report: Testing the robustness of the job demands-resources model. *International Journal of Stress Management, 13*(3), 378-391.

Luthar, S.S, Cicchetti, D., Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71*(3), 543-562.

MacLeod, A. (2019). Interpretative Phenomenological Analysis (IPA) as a tool for participatory research within Critical Autism Studies: A systematic review. *Research in Autism Spectrum Disorders, 64*, 49-62.

MacLeod, B.P. (2013). Social justice at the microlevel: Working with clients' prejudices. *Journal of Multicultural Counseling and Development, 41*, 169-184.

Madgavkar, A., White, O., Krishnan, M., Mahajan, D., & Azcue, X. (2020, July 15). COVID-19 and gender equality: Countering the regressive effects. McKinsey Global Institute. https://www.mckinsey.com/featured-insights/future-of-work/covid-19-and-gender-equality-countering-the-regressive-effects

Malinowski A. J. (2013). Characteristics of job burnout and humor among psychotherapists. Humor, 26, 117–133. DOI: 10.1515/humor-2013-0007

Marsiglia, F.F., Kulis, S., Perez, H.G., & Bermude-Parsai, M. (2011). Hopelessness, family stress, and depression among Mexican-heritage mothers in the southwest. *Health & Social Work, 36*(1), 7-18.

Martens, C. (2000). Othering boundaries: Rural geography and mental illness. *International Journal of Rural Psychology, 3*(12).

Maslach, C., Schaufeli, W.B., & Leiter, M.P. (2001). Job burnout. *Annual Review of Psychology, 52*, 397-422.

Maslach, C. (1993). *Burnout: A multidimensional perspective.* In W. B. Schaufeli, C. Maslach, & T. Marek (Eds.), *Series in applied psychology: Social issues and questions. Professional burnout: Recent developments in theory and research* (p. 19–32). Taylor & Francis.

Maslach, C. (2006). *Understanding Job Burnout.* In Rossi, A.M. (2006). *Stress and Quality of Working Life: Current Perspectives in Occupational Health*. Information Age Publishing: Greenwich, Connecticut.

Masten, A.S. (2001). Ordinary magic: Resilience processes in development. American Psychologist, 56(3), 227-238. https://doi.org/10.1037/0003-066X.56.3.227

McCann, I.L. & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131-149.

McDowell, T. & Hernandez, P. (2010). Decolonizing academia: Intersectionality, participation, and accountability in family therapy and counseling. *Journal of Feminist Family Therapy, 22*(2), 93-111.

McCormack, H.M., MacIntre, T.E., O'Shea, D., Herring, M.P., & Campbell, M.J. (2018). The prevalence and cause(s) of burnout among applied psychologist: A systemic review. *Frontiers in Psychology, 9*, 1897.

McCoy, L. K. (2017). Longitudinal qualitative research and interpretative phenomenological analysis: philosophical connections and practical considerations. *Qualitative Research in Psychology, 14*(4), 442-458.

McKnight, P.E. & Kashdan, T.B. (2009). Purpose of life as a system that creates and sustains health and well-being: An integrative, testable theory. *Review of General Psychology, 13*, 242-251.

Meany-Walen, K.K., Davis-Gage, D., & Lindo, N.A. (2016). The impact of wellness-focused supervision on mental health counseling practicum students. *Journal of Counseling & Development, 94*(4), 464-472.

Medina, S. & Magunson, S. (2009). Motherhood in the 21st century: Implications for counselors. *Journal of Counseling & Development, 87*(1), 90-96.

Merriman, J. (2015). Enhancing counselor supervision through compassion fatigue education. *Journal of Counseling & Development, 93,* 370-378.

Merriman, O. & Joseph, S. (2016). Therapeutic implications of counselling psychologists' responses to client trauma: An interpretative phenomenological analysis. *Counselling Psychology Quarterly, 31*(1), 117-136.

Mendias, E.P., Clark, M.C., & Guevara, E.B. (2001). Women's self-perception and self-care practice: Implications for health care delivery. *Health Care for Women International, 22*(3), 299-312.

Meyer, I.H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674.

Meyers, I.H. (2016). Does an improved social environment for sexual and gender minorities have implications for a new minority stress research agenda? *Psychology of Sexualities Review, 7*(1), 81.

Misra, J., Curington, C.V., & Green, V.M. (2021). Methods of intersectional research. *Sociological Spectrum, 1*, 9.

Moate, R.M., Gnilka, P.B., West, E.M, & Brunes, K.L. (2016). Stress and burnout among counselor educators: Differences between adaptive perfectionists, maladaptive perfectionists, and nonperfectionists. *Journal of Counseling and Development, 2,* 161

Moffatt, G.K. (2018). The hurting counselor. *Counseling Today.*

Moraga, C. & Anzaldua, G.E. (1981). *The Bridge Called my Back*. London, UK: Persephone Press.

Monteiro-Leitner, J., Asner-Self, K.K., Milde, C., Leitner, D.W., & Skelton, D. (2006). The role of the rural school counselor: Counselor, counselor-in-training, and principal perceptions. *Professional School Counseling, 9*(3), 248-251.

Morrissette, P.J. (2000). The experiences of the rural school counselor. *Professional School Counseling, 3*(3), 197-207.

Myers, J.A., Sweeney, T.J., & Witmer, J.M. (2000). The wheel of wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling & Development, 78*, 251-266.

Myer, R.A. & Moore, H.B. (2006). Crisis in context theory: An ecological model. *Journal of Counseling & Development, 84*, 139-147.

Myers, L. (2018). Building client and counselor resilience. *Counseling Today.*

Nash, J.C. (2008). Re-thinking intersectionality. *Feminist Review, 89*(1), 1-15.

Nakano Gleen, E. (2015). "Settler Colonialism as Structure: A Framework for Comparative Studies of US Race and Gender Formation." *Sociology of Race and Ethnicity, 1*(1), 52-72.

Nealce, R.T. & Kottler, J.A. (2017). Congruence as self-care: Practicing what we preach. *Counselor,* 28-31.

Nelson, K.W. & Jackson, S.A. (2003). Professional counselor identity development: A qualitative study of Hispanic student interns. *Counselor Education & Supervision, 43*, 2-14.

Nelson, W., Pomerantz, A., Howard, K., & Bushy, A. (2007). A proposed rural healthcare ethics agenda. *Journal of Medical Ethics, 33*(3), 136-139.

Nelson, J.R., Hall, B.S., Anderson, J.L., Birtles, C., & Hemming, L. (2018). Self-compassion as self-care: A simple and effective tool for counselor educators and counseling students. *Journal of Creativity of Mental Health, 13*(1), 121-133.

Neville, H.A. & Heppner, M.J. (1999). Contextualizing rape: Reviewing sequelae and proposing a culturally inclusive ecological model of sexual assault recover. *Applied & Preventive Psychology, 8,* 41-62.

New Mexico Department of Health. (2018). State of Mental Health in New Mexico: Injury and behavioral epidemiology bureau, Epidemiology and response division New Mexico Department of Health. From http://www.nmhealth.org

New Mexico Department of Health. (2020). New Mexico substance use disorder treatment gap analysis. From http://nmhealth.org.

Nunez, A. (2014). Employing multilevel intersectionality in educational research: Latino identities, contexts, and college access. *Educational Researcher, 43*(2), 85-92.

O'Halloran, T.M. & Linto, J.M. (2000). Stress on the Job: Self-care resources for counselors. *Journal of Mental Health Counseling, 22*(4), 354-364.

Oliver-Hoyo, M. & Allen, D. (2006). The use of triangulation methods in qualitative educational research. *Journal of College Science Teaching, 35*(4), 42.

Olive, T. (2008). Desire for higher education in first-generation Hispanic college students enrolled in an academic support program: A phenomenological analysis. *Journal of Phenomenological Psychology, 39*, 81-110.

Olson-Garriott, A.N. Garriott, P.O., Rigali-Oiler, M., & Chao, R.C. (2015). Counseling psychology trainees' experiences with debt stress: A mixed methods examination. *Journal of Counseling Psychology, 62*(2), 202-215.

Ortiz, F.A. (2020). Self-actualization in the Latino/Hispanic culture. *Journal of Humanistic Psychology, 60*(3), 418-435.

Osborne, N. (2015). Intersectionality and Kyriarchy: A framework for approaching power and social justice in planning and climate change adaption. Planning Theory, 14(2), 130-151.

Oser, C.B., Biebel, E.P., Pullen, E., & Harp, K.L.H. (2013). Causes, consequences, and prevention of burnout among substance abuse treatment counselors: A rural versus urban comparison. *Journal of Psychoactive Drugs, 45*(1), 17-27.

Ozbay, F., Johnson, D.C., Dimoulas, E., Morgan, C.A., Charney, D., & Southwick, S. (2007). Social support and resilience to stress: From neurobiology to clinical practice. *Psychiatry (Edgemont), 4*(5), 35-40.

Park, N. & Peterson, C. (2008). Positive psychology and character strengths: Application to strengths-based school counseling. *Professional School Counseling, 12*(2), 85-92.

Park, H.I., Jacob, A.C., Wagner, S.H., & Baiden, M. (2014). Job control and burnout: A meta-analytic test of the conservation of resources model. *Applied Psychology: An International Review, 63*(4), 607-642.

Park, H.I., O'Rourke, E., & O'Brien, K.E. (2014). Extending conservation of resources theory: The interaction between emotional labor and interpersonal influence. *International Journal of Stress Management, 21*(4), 384-405.

Pan, J.C. (2020). *Why diversity training isn't enough: Addressing inequality requires more than consciousness raising.* The New Republic.

Payne, J.S. (2017). "It's kind of a dichotomy:" Thoughts related to calling and purpose from pastors working and counseling in urban resource-poor communities. *Journal of Religious Health, 56*(1), 1419-1435.

Pelling, N. & Butler, B. (2015). Rural counselors and psychologists in Australia: A descriptive survey of professionals and practice. *International Journal of Mental Health, 44*(1-2), 94-106.

Pesquera, B.M. & Segura, D.A. (1996). With quill and torch: A Chicana perspective on the American women's movement and feminist theories. In D.R. Maciel & I.D. Ortiz (Eds.) *Chicanas/Chicanos at the crossroads: Social, economic and political change* (pp.231-247). Tucson: University of Arizona Press.

Peters, H. C. (2017). Multicultural complexity: An intersectional lens for clinical supervision. *International Journal for the Advancement of Counselling, 39* (2), 176-187.

Pietkiewicz, I. & Smith, J.A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal, 20*,1, 361-369.

Pierce, L.A., Herlihy, B. (2013). The experience of wellness for counselor education doctoral students who are mothers in the Southwestern Region of the United States. *Journal of International Women's Studies, 14*(3), 108-120.

Prowell, A.N. (2019). Using post-structuralism to rethink risk and resilience: Recommendations for social work education, practice, and research. *Social Work, 64,* (2), 123-130.

Prikhidko, A. & Swank, J.A. (2018). Emotional regulation for counselors. *Journal of Counseling & Development, 96,* 206-212.

Purvanova, R.K. & Muros, J.P. (2010). Gender differences in burnout: A meta-analysis. *Journal of Vocational Behavior, 77*(2), 168-185.

Raffaelli, M., Tran, S.P., Wiley, A.R., Galarza-Heras, M., & Lazarevic, V. (2012). Risk and resilience in rural communities: The experiences of immigrant Latina mothers. *Family Relations, 61*(4), 559-570.

Rasmussen, B & Bliss, S. (2016). Beneath the surface: An exploration of neurobiological alterations in therapist working with trauma. *Smith College Studies in Social Work, 84*(2), 332-349.

Rats, M.J., Singh, A.A., Nassar-McMillian, S., Butler, K.S., & McCullough, J.R. (2015). Multicultural and social justice counseling competencies. *Association for Multicultural Counseling and Development: American Counseling Association.*

Rats, M.J., Singh, A.A., Nassar-McMillian, S., Butler, K.S., & McClullough, J.R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development,* 44, 28-48.

Ratcliffe, M., Burd, C., Holder, K., & Fields, A. (2016). Defining rural at the U.S. Census Bureau: American community survey and geography brief. U.S. Department of Commerce Economics and Statistics Administration. U.S. Census Bureau.

Ray, D.C., Hull, D.M., Thacker, A.J., Pace, L.S., Swan, K.L., Carson, S.E., & Sullivan, J.M. (2011). Research in counseling: A 10-year review to inform practice. *Journal of Counseling & Development,* 89, 349-359.

Rehfuss, M.C. & Gambrell, C.E. (2014). Themes that facilitate the success of female counselors in specialty areas. *Journal of employment counseling, 51*(4), 180-191.

Reichbach, M. (2016). AG clears ten behavioral health providers of fraud allegations. *NM Political Report.* (February 8, 2016). From htttp://nmpoliticalreport.com

Rezvani, F. & Aflakifard, H. (2018). Relationships between job satisfaction and self-efficacy with organizational commitment among female counselors. Indian Journal of Positive Psychology, 9(4), 470-472.

Rogers, C.R. (1945). Counseling review of educational research. *Counseling Guidance and Personal Work, 15*(2), 155-163.

Rogers, C.R. (1948). The attitude and orientation of the counselor in client-centered therapy.

Rogers, C.R. (1952). A personal formulation of client-centered therapy. *Marriage and Family Living, 14*(4), 341-361.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103.

Rogers, C.R. (1964). Toward a modern approach to values: The valuing process in the mature person. *Journal of Abnormal Psychology.*

Rohleder, P. & Lyons, A.C. (2015). Qualitative research in clinical and health psychology. Palgrave Macmillian.

Rosa, E.M. & Tudge, J. (2013). Urie Bronfenbrenner's theory of human development: Its evolution from ecology to bioecology. *Journal of Family Theory & Review, 5*(1), 243-258.

Roysircar, G. (2009). The big picture of advocacy: Counselor, heal society, and thyself. *Journal of Counseling & Development, 87,* 288-294.

Rubel, D. & Atieno Okech, J.E. (2017). Qualitative research in group work: Status, synergies, and implementation. *The Journal of Specialists in Group Work, 42*(1), 54-86.

Ruiz, J.M., Campos, B., Garcia, J.J. (2016). Special issue on Latino physical health: Disparities, paradoxes, and future directions. *Journal of Latina/o Psychology, 4*(2), 61-66.

Rupert, P.A. & Morgan, D.J. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research and Practice, 36*(5), 544-550.

Rupert P. A., Kent J. S. (2007). Gender and work setting differences in career-sustaining behaviors and burnout among professional psychologists. Professional Psychology: Research & Practice, 38, 88. DOI: 10.1037/0735-7028.38.1.88

Saakvitne, K.W. (2002). Shared trauma: The therapist's increased vulnerability. *Psychoanalytic Dialogues, 12*(3), 443-449.

Samios, C. (2018). Burnout and psychological adjustment in mental health workers in rural Australia: The role of mindfulness and compassion satisfaction. *Mindfulness, 9*(4), 1088-1099.

Samios, C., Rodzik, A.K., Abel, L.M. (2012). Secondary traumatic stress and adjustment in therapist who work with sexual violence survivors: The moderating role of posttraumatic growth. *British Journal of Guidance & Counselling, 40*(4), 341-356.

Sapienza, B. G., & Bugental, J. F. T. (2000). Keeping our instruments finely tuned: An existential-humanistic perspective. *Professional Psychology: Research and Practice, 31*(4), 458-460.

Schauben, L.J. & Frazier, P.A. (1995). Vicarious Trauma: The effects of female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, *19*(1), 49-64.

Schaufeli, W.B. & Taris, T.W. (2014). A critical review of the job demands-resources model: Implications for improving work and health. In. G.F. Bauer and O. Hamming, *Bridging Occupational, Organizational and Public Health: A Transdisciplinary Approach.* Springer Science & Business.

Schutz, P.A. (2014). Inquiry on teachers' emotions. *Educational Psychologist, 49*(1), 1-12.

Schure, M.B., Christopher, J., & Christopher, S. (2008). Mind-body medicine and the art of self-care: Teaching mindfulness to counseling students through yoga, meditation, and qigong. *Journal of Counseling & Development, 86*, 47-56.

Sedgwick, M. & Spiers, J. (2009). The use of videoconferencing as a medium for the qualitative interview. *International Journal of Qualitative Methods, 8*(1), 1-11.

Skovhold, Grier, & Hansen (2001). Career counseling for longevity: Self-care and burnout prevention strategies for counselor resilience. *Journal of Career Development, 27,* 167-176.

Skovholt, T.M. & Trotter-Mathison, M. (2016). *The resilient practitioner: Burnout and compassion fatigue prevention and self-care strategies for the helping professions.* Routledge.

Shapiro, E.R. & Atallah-Gutierrez, C. (2011). Latina re-visioning's of participatory health promotion practice: Cultural and exosystemic perspectives linking personal and social change. *Women & Therapy, 35*(1-2), 120-133.

Sheffield, D.S. (2011). Counselor impairment: Moving toward a concise definition and protocol. *The Journal of Humanistic Education and Development.*

Shillingford, M.A., Trice-Black, S., & Butler, S.K. (2013). Wellness of minority female counselor educators. *Counselor Education and Supervision, 52*(4), 255-269.

Shin, R.Q., Welch, J.C., Kaya, A.E., Yeung, J.G., Obana, C., Sharma, R., Vernay, C.N., & Yee, S. (2017). The intersectionality framework and identity intersections in the Journal of Counseling Psychology and The Counseling Psychologist: A content analysis. *Journal of Counseling Psychology, 64*(5), 458-474.

Shinebourne, P. (2011). The theoretical underpinnings of interpretative phenomenological analysis (IPA). *Existential Analysis, 22*(1), 16-31.

Solberg, V.S. & Villarreal, P. (1997). Examination of self-efficacy, social support, and stress as predictors of psychological and physical distress among Hispanic college students. *Hispanic Journal of Behavioral Sciences, 19*(2), 182-201.

Sommer, C.A. (2008). Vicarious traumatization, Trauma-sensitive supervision, and counselor preparation. *Counselor Education and Supervision, 48*(3), 61-71.

Soto Vega, K. & Chavez, K.R. (2018). Latinx rhetoric and intersectionality in racial rhetorical criticism. *Communication and Critical/Cultural Studies, 4*, 319.

Southwick, S.M., Vythilingam, M., Charney, D.S. (2005). The psychobiology of depression and resilience to stress: Implications for prevention and treatment. *Annual Review Clinical Psychology, (1),* 255-291.

Singh, A.A., Appling, B., & Trepal, H. (2020). Using the multicultural and social justice counseling competencies to decolonize counseling practice: The important roles of theory, power, and action. *Journal of Counseling & Development, 98*(3), 261-271.

Smalley, B.K., Yancey, T.C., Warren, J.C., Naufel, K., Ryan, R., & Pugh, J.L. (2010). Rural mental health and psychological treatment: A review for practitioners. *Journal of Clinical Psychology: In session, 66*(5), 479-489.

Smith, L.T. (2005). *On Tricky Ground: Research in the Age of Uncertainty.* Denzin & Lincoln (Eds.). Handbook of Qualitative Research. Sage, New York, NY.

Smith, J.A. (2018). "Yes it is Phenomenological:" A reply to Max Van Manen's critique of interpretative phenomenological analysis. *Qualitative Health Research, 2*8(12), 1955-1958.

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method, and Research.* Thousand Oaks, CA: Sage.

Smith, W.A., Allen, W.R., & Danley, L.L. (2007). "Assume the position…You fit the description" Psychosocial experiences and racial battle fatigue among African American male college students. *American Behavioral Scientist, 51*(4), 551-578.

Smith, A. Jarman, M., & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murrah K. Chamberlain (Eds.) *Qualitative Health Psychology.* Sage.

Smith, W.A., Hung, M., & Franklin, J.D. (2011). Racial battle fatigue and the miseducation of black men: Racial microaggressions, societal problems, and environmental stress. *The Journal of Negro Education, 80*(1), 63-82.

Stamm, B.H. (2009). *Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL).*

Stamm, B.H. (2010). The Concise ProQOL Manual, 2nd Ed. Pocatello, ID: ProQOL.org.

Stanger, N.R.G. (2011). Moving "eco" back into socio-ecological models: A proposal to reorient ecological literacy into human developmental models and school systems. *Human Ecology Review, 18*(2), 1-8.

Stebnicki, M.A. (2008). *The professional counselor's desk reference* (5th ed.). New York, NY: Springer Publishing Company.

Storlie, C.A., Hilton, T.L., Duenyas, D., Archer, R., & Glavin, K. (2018). Career narratives of African American female college students: Insights for college counselors. *Journal of College Counseling, 21*(1), 29-42.

Speyer, E., Morgenstrern, H., Hayashino, Y., Kerr, P.G., Raynr, H., Robinson, B.M., and Pisoni, R.L. (2016). Reliability and validity of the coping strategy inventory-short form applied to hemodialysis patients in 13 counties: Results from the dialysis outcomes and practice patterns study (DOPPS). *Journal of Psychosomatic Research, 91*, 12-19.

Splevins, K., Cohen, K., Bowley, J., & Joseph, S. (2010). Theories of posttraumatic growth: Cross-cultural perspectives. *Journal of Loss and Trauma, 15*, 259-277.

Spicer, A. (2019). *'Self-care': How a radical feminist idea was stripped of politics for the mass market*. The Guardian.

Sue, D.W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation.* Hoboken, NJ: Wiley.

Sue, D.W., Capodilupo, C.M., Torino, G.C., Bucceri, J.M., Holder, A., Nadal, K.L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), 271-286.

Sue, D.W. & Constantine, M.G. (2008). Optimal human functioning in people of color in the United States. In W.B. Walsh (Ed.), *Counseling Psychology and Optimal Human Functioning* (pp.151-169). Mahwah, NJ: Erlbaum.

Sweeney, T. J., & Witmer, J. M. (1991). Beyond social interest: Striving toward optimum health and wellness. Individual Psychology, 47, 527-540.

Swick, K.J. & Williams, R.D. (2006). An analysis of Bronfenbrenner's bio-ecological perspective for early childhood educators: Implications for working with families experiencing stress. *Early Childhood Education Journal, 33*(5), 371-378.

Syed, M. (2010). Disciplinarity and methodology in intersectionality theory and research. American Psychologist, 65(1), 61-65.

Teran, V. G., Fuentes, M.A., Atallah, D.G., & Yang, Y. (2017). Risk and protective factors impacting burnout in bilingual, Latina/o clinicians: An exploratory study. *Professional Psychology, Research and Practice, (1),* 22.

Teruya, S.A. & Bazargan-Hejazi, S. (2013). The immigrant and Hispanic paradoxes: A systematic review of their predications and effects. *Hispanic Journal of Behavioral Sciences, 35*(4), 486-509.

Testa, R., Habarth, J., Peta, J., Balsam, K., and Bockting, W. (2015). Development of the gender minority stress and resilience measure. Psychology of Sexual Orientation and Gender Diversity, 2(1), 65.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP). (2016). *2016 CACREP Standards.*

Torres, L., Mata-Greve, F., Bird, C., & Hernandez, E.H. (2018). Intersectionality research with Latinx mental health: Conceptual and methodological considerations. *Journal of Latina-0 Psychology, 6*(4), 304-317.

The Combahee River Collective. (1978). A Black Feminist Statement. *Capitalist Patriarchy and the Case for Socialist Feminism, Monthly Review, 42*(3), 271-280.

The Steve Fund. (2020, October 2). *The impact of the dual pandemic on Black, Indigenous and students of color. H*igher Education Today: American Council on Education. https://www.higheredtoday.org/2020/10/02/impact-dual-pandemic-black-indigenous-students-color/

Thomas, M., Kohli, V., & Choi, J. (2014). Correlates of job burnout among human services workers: Implications for workforce retention. *The Journal of Sociology & Social Welfare, 41*(4), 69-90.

Thomas, D.R. (2017). Feedback from research participants: Are member checks useful in qualitative research? *Qualitative Research in Psychology, 14*(1), 23-41.

Trahan, A. (2011). Qualitative research and intersectionality. *Critical Criminology, 19*(1), 1-14.

Trepal, H.C. & Stinchfield, T.A. (2012). Experiences of motherhood in Counselor Education. *Counselor Education & Supervision, 51*(2), 112-126.

Trippany, R.L, Kress, V.E.W., & Wilcoxon, A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors? *Journal of Counseling and Development, 32*(7), 31-37.

Tuck, E. (2009). Suspending Damage: A letter to communities. *Harvard Educational Review, 79(*3), 409-427.

Tudge, J.R.H., Payir, A., Mercon-Varga, E., Cao, H., Liang, Y., Li, J., & O'Brien, L. (2016). Still misused after all these years? A reevaluation of the uses of Bronfenbrenner's bioecological theory of human development. *Journal of Family Theory & Review, 8*(1), 427-445.

Tudge, J.R.H., Mokrova, I., Hatfield, B.E., & Karnik, R.B. (2009). Uses and misuses of Bronfenbrenner's bioecological theory of human development. *Journal of Family Theory & Review, 1*(1), 198-210.

Twigg, J. (2000). *Bathing-the Body and Community Care*, Psychology Press. 1-230.

van Manen, M. (2018). Rebuttal rejoinder: Present IPA for what it is-interpretative psychological analysis. *Qualitative Health Research, 28*(12), 1959-1968.

van Woerkom, M., Bakker, A.B., & Nishii, L. (2016). *Accumulative job demands and support for strength use: Fine-tuning the job demands-resources model using conservation of resources theory.* Cornell University ILR School.

Vasquez, M.J.T. (2002). Complexities of the Latina experience: A tribute to Martha Bernal. *American Psychologist, 57*(11), 80-88.

Vera, H. & De Los Santos, E. (2005). Chicana identity construction: Pushing the boundaries. *Journal of Hispanic Higher Education, 4*(2), 102-113.

Viehl, C., Dispenza, F., McCullough, R., & Guvensel, K. (2017). Burnout among sexual minority mental health practitioners: Investigating correlates and predictors. *Psychology of Sexual Orientation and Gender Diversity, 4*, 354-361.

Viehl, C. & Dispenza, F. (2015). Burnout and coping: An exploratory comparative study of heterosexual and sexual minority mental health practitioners. *Journal of LGBT Issues in Counseling, 9*, 311-328.

Vishnevsky, T., Cann, A., Calhoun, L.G., Tedeschi, R.G., & Demakis, G.J. (2010). Gender differences in self-reported posttraumatic growth: A meta-analysis. *Psychology of Women Quarterly, 34*(1), 110-120.

Vishnevsky, T., Lawrence, A.C., Tedeschi, R.G., & Demakis, G.J. (2010). Gender difference in self-reported posttraumatic growth: A meta-analysis. *Psychology of Women Quarterly, 34*, 110-120.

Viruell-Fuentes, E. (2007). Beyond acculturation: Immigration, discrimination, and health research among Mexicans in the United States. *Social Science & Medicine, 65*, 1524-1535.

Vries, S., McDonald, D., & Mayorga, M.G. (2017). Utilizing action research to improve counseling education course work for culturally diverse students. *I-manger's Journal on Educational Psychology, 11*(2), 11-17.

Vredenburgh L. D., Carlozzi A. F., Stein L. B. (1999). Burnout in counseling psychologists: Type of practice setting and pertinent demographics. Counseling Psychologist Quarterly, 12, 293–302. DOI: 10.1080/095150799082540

Vu, M., Li, J., Haardorfer, R., Windle, M., & Berg, C.J. (2019). Mental health and substance use among women and men at the intersections of identities and experiences of discrimination: Insights from the intersectionality framework. *BMC Public Health, 19*(108).

Way, N., Ali, A., Gilligan, C., & Noguera, P. (2018). *The Crisis of Connection: Roots, Consequences, and Solutions.* New York University Press; New York.

Weigel, D.J. & Baker, B.G. (2002). Unique issues in rural couple and family counseling. *The Family Journal, 10*(1), 61-69.

Westman, M., Hobfoll, S.E., Chen, S., Davidson, O.B., & Laski, S. (2005). Organizational stress through the lens of conservation of resources (COR) theory. *Exploring Interpersonal Dynamic: Research in Occupational Stress and Well Being, 4*, 167-220.

Weisner, T.S. (2008). The Urie Bronfenbrenner top 19: Looking back at his bioecological perspective. *Mind, Culture, and Activity, 15*(3), 258-262.

Williams, V., & Pomales, J. (1989). Effects of level of acculturation and counseling style on Hispanic students' perceptions of counselor. *Journal of Counseling Psychology, (1)*, 79.

Wilson, T.A., Knezevic, B., Kibugi, B., Peterson, P., & Polacek, E. (2018). Experiences and retention among rural mental health counselors. *Journal of Mental Health Counseling, 40*(3), 240-248.

Willging, C. E., Lamphere, L., & Rylko-Bauer, B. (2015). The transformation of behavioral healthcare in New Mexico. *Administration and Policy in Mental Health*, *42*(3), 343–355. https://doi.org/10.1007/s10488-014-0574-0

Windsong, E.A. (2018). Incorporating intersectionality into research design: An example using qualitative interviews. *International Journal of Social Research Methodology, 21*(2), 135-147.

Windsor, T.D., Curtis, R.G., & Luszcz, M.A. (2015). Sense of purpose as a psychological resource for aging well. *Developmental Psychology, 51*(7), 975-986.

Witmer, J. M., & Sweeney, T. J. (1992). A holistic model for wellness and prevention over the lifespan. Journal of Counseling and Development 71, 140-148.

Witmer, J.M. & Young, M.E. (1996). Preventing counselor impairment: A wellness approach. *Journal of Humanistic Education and Development,* 3, 141.

Worzbyt, J.C. & Zook, T. (1992). Counselors who make a difference: Small schools and rural settings. *The School Counselor, 39*(5), 344-350.

Wu, G., Feder, A., Cohen, H., Kim, J.J., Calderon, S., Charney, D.S., & Mathe, A.A. (2013). Understanding resilience. *Frontiers in Behavioral Neuroscience*, 7, 10.

Xanthopoulou, D., Bakker, A.B., Demerouti, E., & Schaufeli, W.B. (2007). The role of personal resources in the job demands-resource model. *International Journal of Stress Management, 14*(2), 121-141.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*, 215-228.

Yin, R.K. (2003). *Case study research: Design and methods* (3rd Ed.). Thousand Oaks, CA: Sage.

Yin, R. (1989). *Case Study Research: Design & Methods* (2nd ed.) Beverly Hills: Sage.

Zinn, M.B. & Zambrana, R.E. (2019). Chicanas/Latinas advance intersectional thought and practice. *Gender & Society, 33*(5), 677-701.

Ziomek-Daigle, J. & Bailey, D.F. (2009). Culturally responsive gatekeeping practices in counselor education. *The Journal of Counseling Research and Practice, 1*(1), 14-22.

Appendix A

Greetings New Mexico Counselors,

My name is Melissa C Henry and I am a doctoral candidate at the University of New Mexico under the supervision of my dissertation advisors, Dr. Kristopher Goodrich and Dr. Thomas Chavez. I am writing to invite you to participate in my doctoral dissertation study. The purpose of this study is to explore and share the experiences of Latina counselors in New Mexico serving clients in rural areas. This study seeks to uncover how these professional counselors navigate their professional and personal roles by situating their stories within their personal, cultural, and historical context to influence their identities.

To participate in this study, you must meet the following criteria:

1. Participants must identify racially/ethnically as Hispanic or Latina women/woman
2. Participants must be licensed counselors (LPC's or LMHC's)
3. Participants must be practicing counseling in New Mexico and serving rural clients

This study will involve one structured interview focusing on demographic and personal characteristic questions that will be 30-60 minutes and one semi-structured interview that will last up to 30-90 minutes. Participants will also be invited to engage in member checks to review their personal verbatim interview transcripts. Interviews will be conducted using Zoom Pro (HIPPA protected online medium). Any information collected will be de-identified and stored under the participant's preferred pseudonym to protect confidentiality. All interviews will also be audio recorded.

If you would like to participate in this study, please email me directly at melissachenry@unm.edu, and I will send you the informed consent to get us started. I look forward to connecting with you! Thank you advance for your time, consideration, and willingness to participate in this important and necessary study. Please feel free to contact me at melissachenry@unm.edu or my advisors at kgoodric@unm.edu and tachavez00@unm.edu if you have any questions or concerns.

Sincerely,

Melissa C Henry
Doctoral Candidate
University of New Mexico

Appendix B

THE UNIVERSITY OF NEW MEXICO

Seeking Hispanic female counselors in New Mexico to participate in a research project.

Study Aims: To examine the narratives of Hispanic female counselors practicing in rural areas of New Mexico. And to understand impairment risk and protective factors that influence counselor resilience and wellness.

If you decide to join the project, you will be asked to:

- Participate in two interviews via Zoom, each interview is 30-90 minutes each

This project is being conducted by Dr. Thomas Chavez (Assistant Professor of Counseling), Dr. Kristopher Goodrich (Professor of Counseling), and Melissa C Henry (Counseling Doctoral Candidate) from UNM.

Contact Information: Please call 559-321-5533 or email melissachenry@unm.edu to get more information or to schedule an appointment.

Appendix C

Examining self-care practices from a systems perspective: Understanding the lived experiences of Hispanic female counselors in rural areas
Informed Consent for Interviews
07/10/20

Dr. Thomas A Chavez and Melissa C Henry, from University of New Mexico's College of Education, Department of Individual, Family, and Community Education, Counselor Education program is conducting a research project. The purpose of the research is to understand how rural Hispanic women manage, mitigate, and conquer the stress and emotional toll of working as a professional counselor. You are being asked to participate because you meet the following inclusion criteria:

1. Identify as a woman
2. Identify racially/ethnically as Hispanic, Mexican American, Latinx, or Chicana
3. Hold a license in counseling in the state of New Mexico (i.e., LMHC or LPC)
4. Currently be providing clinical counseling services to clients in rural New Mexico

Participants must be over the age of 18, speak English, agree to the informed consent, and will need their own personal electronic device and internet to participate in the interviews via Zoom.

Your participation will involve two interviews via Zoom and an email to confirm the verbatim transcriptions of the interviews. If you agree, participation in this study will involve one structured interview focusing on demographic and personal characteristic questions that will be 30-60 minutes and one semi-structured interview that will last up to 30-90 minutes. The second interview will involve questions about your experience as a professional counselor and how you engage in self-care practices. Participants will also be invited to engage in member checks to review their personal verbatim interview transcripts.

Your involvement in the research is voluntary, and you may choose not to participate. You can refuse to answer any of the questions at any time. There are no names or identifying information associated with your responses. There are no known risks in this research, but some individuals may experience discomfort or loss of privacy when answering questions. Data will be stored de-identified on the researcher's personal computer which is password protected. Your information collected for this project will not be used or shared for future research, even if we remove the identifiable information like your name.

The findings from this project will provide information on the lived experiences of minority counselors and their experience in the professional counseling field. If published, results will be presented in summary form and will include quotes that are not associated with participant names or identifying information.

If you have any questions, concerns, or complaints about the research, please feel free to call the PI Dr. Thomas A Chavez at (917) 763-5559 or the student researcher at (559) 321-5533. If you have questions regarding your rights as a research participant, or about what you should do in case of any harm to you, or if you want to obtain information or offer input, please contact the UNM Office of the IRB (OIRB) at (505) 277-2644 or irb.unm.edu.

By participating in the interview, you will be agreeing to participate in the above described research.

Appendix D

Demographic Interview Protocol

1. Dimension A
    a. How old are you?
    b. What is your cultural background?
    c. What is your ethnic background?
    d. What is your race?
    e. What is your gender?
    f. What is your preferred language? What languages do you speak?
    g. What is your sexual orientation?
    h. What social class would you say you belong to?
2. Dimension B
    a. What is your educational background?
    b. What geographic location are you in?
    c. What are some hobbies/recreational interest you have?
    d. Do you have any military experience?
    e. What is your relationship status?
    f. Are you involved in a religion? Or practice elements of spirituality?
    g. What is your work experience?
    h. Is there any health care practices or beliefs you would like me to know?
3. Dimension C
    a. Are there historical moments/eras that influenced your development and work as a professional counselor?

4. Questions related to professional identity:
    a. What type of licensure do you hold in the state of New Mexico?
    b. How long have you held this licensure?
    c. Do you currently see clients full-time, part-time, or are you retired?
    d. What kind of agency do you work at? (example: hospital, non-profit, private practice, or home-based care)

Appendix E

Semi-Structured Interview Protocol

1. Tell me about your community.
2. What does it mean to you to maintain wellness, and what are some barriers to wellness as a professional counselor?
    a. Are there differences between males and females?
    b. Do you believe working in a rural environment effects your work with clients? IF so, how?
    c. Culturally how do you conceptualize wellness and self-care?
3. What are some environmental, community, or professional resources, events, or people that have contributed negatively or positively to your professional satisfaction?
4. Describe your experience growing self-care strategies throughout your growth as a professional from graduate school to working as a professional counselor?
    a. What do you consider self-care?
    b. How does your culture, family/friends, professional work, or community support or impact your ability to engage in effective self-care?

Thank you for your time. Is there anything else that you think it is important for me to know or anything else you would like to say before we conclude the interview?