

Women, Older Adult, and LGBTQ Populations with Disabilities in Rural, Frontier, and Territory Communities

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Overview

In this chapter our discussion of women, older adults, and LGBTQ persons with disabilities represents populations who once occupied positions of anonymity and exclusion and who, thanks to changes in law, attitudes, and understanding, are growing in numbers and visibility in the United States. As distinctly separate populations and as individuals with membership in multiple groups and with intersecting identities, women, older adults, and LGBTQ persons with disabilities have gained political attention that not only specify but, to a certain extent, mandate equal attention and inclusion in policy development, program implementation, and service delivery. Yet, persons belonging to each of these groups in rural regions must contend with the impact of a disability compounded by societal attitudes, stereotypes and biases, limited availability of services, and, frequently, inaccessible infrastructures. In addition, those groups share a high prevalence rate of poverty, mistreatment, victimization, and violence (Balsam & D'Augelli, 2006; Fredriksen-Goldsen et al., 2012; Teaster & Soka, 2016). For those

groups in rural communities, the urgency of attention to their unique challenges cannot be understated. Numerically, 2/3 of the 3142 counties in the United States are rural (Hartman & Weierbach, 2013), and almost 3 out of 10 Americans live in a rural, frontier, territory (RFT) community, or small town (US Census Bureau, 2010a). Approximately 62% of women with disabilities ages 16–64 are reported to have an employment-related disability (US Census Bureau, 2010b). Consistently, research implicitly and explicitly suggests that women and women with disabilities in rural regions have a triple disadvantage (i.e., gender, disability, rurality) that results in both employment and economic inequities (Carstensen, 2008; Hess et al., 2015; Son, Dyk, Bauer, & Katras, 2011; US Department of Agriculture, 2012).

In 2013, the number of females in the United States numbered 161 million, and the number of males was 156.1 million. The elderly population at age 85 and older consisted of 4 million females and 2 million males (<http://www.census.gov/topics/population/age-and-sex/about.html>). It is estimated that approximately 10% of the US population is LGBTQ (Carary, 2012). Ascertaining the number of LGBTQ persons living in rural areas is difficult because of a lack of willingness to self-disclose out of fear, discrimination, and stereotypes. However, many LGBTQ persons live in rural communities and face unique challenges, including access to inadequate, yet sorely needed services. A subgroup among

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LGBTQ persons in rural areas is LGBTQ adolescents who face gender identity and gender expression issues of biased language, harassment, assault, and safety challenges in school (Palmer, Kosciw, & Bartkiewicz, 2012). LGBTQ youth are reported to be at higher risk for mental (e.g., post-traumatic stress disorder, major depression, substance abuse, suicide attempts) (Kim, 2009; Quintana & Rosenthal, 2010) or physical health issues (Duke, 2011). Contrary to the commonly held belief that urban schools are more violent or more dangerous than schools in other areas, in fact, most often, rural schools may pose the greatest threats for LGBTQ students (Kosciw, Greytk, Bartkiewicz, Boesen, & Palmer, 2012). Also, rural areas have a higher percentage of older adults than the rest of the United States and are expected to experience a significant increase in this age group because many rural areas are becoming retirement communities while younger members out-migrate for job opportunities. Similarly, both women with disabilities and older persons with disabilities compose a substantial proportion of residents in rural areas. These shifts in population growth underscore the need for those populations to be critically evaluated, particularly when the predominant focus of service delivery seems to mirror the traditional and normative standard of male, young, heterosexual, and urban dwelling.

The purpose of this chapter is to contextually examine gender, age, and gender and sexual minority identity with regard to the limited availability of services in rural areas; issues of accessibility; community barriers, including community values and beliefs: stereotyping by service providers; and the interplay of gender, age, and gender identity; gender expression; and the influence of rurality for persons with disabilities. Information is also presented on a profile of women, older adults, and LGBTQ populations with disabilities in RFT communities.

Learning Objectives

By the end of the chapter, the reader should be able to:

1. Identify characteristics specific to women, older adults, and LGBTQ populations in rural areas.
2. Identify cultural influences in rural areas on women, older adults, and LGBTQ populations.
3. Understand the unique challenges to service provision for women, older adults, and LGBTQ persons in rural regions.
4. Understand the intersection of disability with gender, age, and gender identity and sexual expression in rural communities.
5. Identify strategies to improve service delivery to women, older adults, and LGBTQ populations in rural, frontier, and territory communities.

Introduction

In rural, frontier, and territory (RFT) regions, difficulties often outweigh opportunities for persons with disabilities, especially women, older adults, and LGBTQ populations. Each of those groups faces complex barriers in obtaining adequate services in healthcare, housing, independent living, community integration, education, and various other support services and in achieving success in employment, financial independence and economic security, and other accommodations. Differences in impairment rates in rural and urban areas illustrate consistent disparities across type of disability, suggesting a systematic relationship between impairment rates and geography highlighting higher rates among rural residents (von Reichert, Greiman, & Myers, 2014).

Data from the Rehabilitation Services Administration (RSA), known as RSA-911, include consumer characteristics, services provided, and employment outcomes of all case closures from vocational rehabilitation (VR) agencies annually. Ipsen, Swicegood, Colling, Rigles, and Asp (2014) examined RSA-911 data for 2008 and 2009 with demographic indicators for service outcome differences based on rural and urban locations. Overwhelmingly, the majority (74%) of VR cases originate in urban locations compared to 14% in large rural, 7% in small rural, and 5% in isolated rural areas. Further examination reveals that across these geographic areas, more males than females

receive VR services: those ages 16–19, 35–44, and 45–54 comprise the larger number of cases; the majority are White, have less than a high school education or are high school graduates, and have mental or physical disabilities. In fact, urban residents had higher rates of primary mental disability compared to each rural region (large rural 33%, small rural 29%, isolated rural 24%), and each rural region (large 30%, small 29%, isolated 24%) had higher rates of physical disability as compared to urban (25%). Persons in large rural (13%), small rural (16%), and isolated rural (19%) areas exhibited higher rates of learning disabilities than did urban residents (14%). Women account for 43% of VR cases in urban areas and 45% each in large, small, and isolated rural communities. Persons age 55 and over represent the smallest percentage of cases in urban (10%) and rural (10–11%) areas. Visual (4%) and sensory (7–8%) make of the lowest percentage of disabilities across all geographic areas. In addition, persons receiving social security benefits (Social Security Disability Income [SSDI] or Supplemental Security Income [SSI]) had low employment outcomes (12–15% for urban and rural). Finally, regardless of geography, VR consumers received assessment proportionately (52–57%), with isolated areas receiving the highest percentage, diagnosis and treatment (25–29%), and counseling and guidance (40–43%). Of other comparative services received, VR consumers in rural areas (18–22%) received fewer services in job placement assistance compared to urban areas (21%) and in transportation (16% vs. 24%). These data suggest that rural VR consumers received fewer dollars of purchased services (Ipsen et al., 2014).

In general, population and geographic challenges of RFT communities present significant barriers for VR service providers. The provision of services to women, older adults, and LGBTQ populations is further complicated by attitudes, beliefs, and cultural attributes in RFT communities, which are discussed later in the chapter. Women, older adults, and LGBTQ populations with disabilities each face many of the same psychosocial, economic, and health concerns and issues of their counterparts in urban areas, but

their status and access to services are affected even more by the social context within which they experience their disability. Disability encompasses not only the physical or mental conditions that affect the body and mind but also the ways in which geographic, social, cultural, and physical environments create obstacles to persons with disabilities (PWDs), especially in RFT communities (Enza & Enza, 2002). Rural residents are greatly influenced by geography, and so is their health, whether by the physical terrain of their environment or the composition of their communities (Crosby, Wendel, Vanderpool, & Casey, 2012). See Research Box 11.1 for barriers to primary care in a two-state study by Iezzoni, Killeen, and O'Day (2006).

Research Box 11.1

See Iezzoni et al. (2006).

Objective: To learn about the healthcare experiences of rural residents with disabilities.

Study Setting: Rural areas in Massachusetts and Virginia.

Research Design: Adults with sensory, physical, or psychiatric disabilities were recruited through local centers for independent living to participate in focus group interviews.

Data Collection Methods: Verbatim transcripts of interviews were reviewed to identify major themes.

Results: Interviewees described the impediments to healthcare in rural America; disability appears to exacerbate these barriers. They reported substantial difficulties finding physicians who understand their disabilities and sometimes feel that they must teach their local doctors about their underlying conditions. Interviewees described needing travel periodically to large medical centers to get necessary specialty care. Many are poor and are either uninsured or have Medicaid coverage, complicating their searches for

willing primary care physicians. Because many cannot drive, they face great difficulties getting to their local doctor and especially making long trips to urban centers. Available public transportation often is inaccessible and unreliable. Physicians' offices are sometimes located in old buildings that do not have accessible entrances or equipment. Based on their personal experiences, interviewees perceive that rural areas are generally less sensitive to disability access issues than urban areas.

Conclusions: Meeting the healthcare needs of rural residents with disabilities will require interventions beyond healthcare, involving transportation and access issues more broadly.

A Profile of Women with Disabilities in Rural Regions

As a group, women have a life expectancy that is notably longer than that for men, but they also have a higher incidence of disability and spend a greater proportion of their later years with significant disability and decline in functional status (Laditka, Laditka, Olatosi, & Elder, 2005; Murtagh & Hubert, 2004). Moreover, women with disabilities are less likely to receive clinical preventive services (Wei, Findley, & Sambamoorthi, 2006). In our discussion of women in rural communities, we acknowledge that rural women are not a homogenous group; they are diverse in demographics, socioeconomic status, geography, and development. However, rural women share certain characteristics (e.g., distance, lack of transportation, geographic barriers, inadequate funding of services, poverty, stressful life events) that contribute to health and well-being as well as susceptibility to illness, disability, and outcome of treatment (Coward et al., 2005; Mulder et al., 2000). Rural women with disabilities represent a high-risk group (Harper, 2001; Thurston, Leach, & Leipert, 2012) and tend to be poorer, in worse health, less educated,

and more dependent on government programs than their urban counterparts (Szalda-Petree, Seekins, & Innes, 2000; US Department of Health and Human Services et al., 2013). In fact, rural women with disabilities are aptly referred to as the poorest of the poor (Mulder et al.). Significantly, the lower employment rate of women with disabilities most likely contributes to differences in poverty rates (O'Day & Foley, 2008). Further, rural areas have some of the greatest incidences of poverty (Housing Assistance Council, 2012), with remote places exhibiting the greatest disadvantage (Weber, 2007). Rural poverty rates are on the rise, while urban poverty rates are declining (US Department of Agriculture, 2013). See Chap. 2 for additional information on rural poverty.

Ethnicity

Ethnic minority women make up a substantial portion of rural women. According to the US Department of Agriculture (2010), more than 3.7 million women in rural America self-identify as African-American, Hispanic/Latino, or American Indian. As a group, African-Americans have a shorter life expectancy and higher rates of disability than Whites, Latinos, and Asians, and Latinos have a higher life expectancy than Whites. African-American women live a greater percentage of their lives with disability than their male counterparts. African-American women develop functional health challenges earlier than their White counterparts. In general, African-American women experience stress and health disadvantages related to an interaction and multiplicative effects of race, gender, class, and age (Lekan, 2009).

Aging White men appear to have the least disabling limitation on average, but increase slightly until age 75. Latino-American women have on average twice as many physical limitations as do White men. Latino-American men, African-American men, White men, and White women tend not to vary significantly in the rate in which they develop disabilities as they age; however, African-American women gain more disabilities

early on. After their mid-60s, the rate of disabilities begins to decrease for African-American women, and by age 75 the pace of acquiring disabilities stabilize (Warner & Brown, 2011) (See Chaps. 9 and 13 for further discussion of disability and ethnic minorities). Warner and Brown found that life disadvantages such as lower income and lack of access to healthcare surfacing in midlife tend to follow individuals throughout their lives and that women are particularly at risk for such disadvantages. The emergence of physical limitations and disability with the intersection of race/ethnicity, gender, and age illuminates the need for further research and interventions that address the unique health experiences of women, especially African-American women as they age.

Mental Health Risk and Protective Factors

Women with disabilities who live in rural, frontier, and territory areas experience environmental risk factors that increase their propensity for disabilities, especially depression. Environmental factors include unemployment, poverty, exposure to abuse and violence, poorer health, less education, greater dependence on government programs, and other life stressors (Hughes & University of Montana Rural Institute, 2007). It is estimated that five million adult women living in RFT regions are age 65 years and older, and more than four million are identified as having a disability (US Census Bureau, 2010b, c). In addition, women with disabilities in RFT areas face two additional risks for depression: having a disability and living in rural areas. Moreover, barriers to accessing mental health services are more pervasive in RFT areas in which 60% of rural residents live in areas with a shortage of available and qualified mental health professionals (US Department of Health and Human Services, 2012). Access to mental health services is further exacerbated by transportation problems, a lack of mental health service providers, an overburdened healthcare system, stigma, geographic location, inadequately funded mental health services, and concerns about confidentiality because of the social closeness of small communities (Hughes

& University of Montana Rural Institute, 2007; Sawyer, Gale, & Lambert, 2006). See Chap. 26 for an in-depth discussion on mental health.

In general, women are twice as likely as men to have depression. Gender differences occur, particularly in the rates of common mental disorders, including depression, anxiety, and somatic complaints, in which women predominate and may be more persistent in women than men (World Health Organization [WHO], n.d.). In addition, risk factors such as gender-based roles, stressors, negative life experiences and events, gender-based violence, socioeconomic disadvantage and income inequality, low or subordinate social status and rank, advanced age, low education levels, limited employment opportunities, and being unmarried create susceptibilities to depression, to which rural women may be especially vulnerable (Farr, Bitsko, Hayes, & Dietz, 2010; WHO). Explanations for the disparities of mental health issues in rural areas include that RFT residents are less likely to receive treatment at all, as well as barriers such as the cost of treatment, lack of awareness of mental illness, distrust of mental health services, disbelief in a need for treatment, lack of awareness of where to access services, stigma, lack of time to dedicate to treatment, lack of insurance, and lack of anonymity in RFT communities (Talbot & Coburn, 2013). Disproportionately, rural women with physical disabilities exhibit moderate to severe depression and higher than average thoughts of suicide. Among rural women with physical disabilities, those at greater risk for depression are younger, have greater problems with pain, have more limited mobility, and are less satisfied with their social network (Hughes, Nosek, & Roberson-Whelen, 2007).

Research suggests that mental health issues and escalating substance use problems affect women to a greater extent than men across different countries and different settings (WHO, nd). Gender bias in diagnosis and treatment of mental health disorders further disadvantage women in help-seeking behaviors. Women tend to seek help and disclose mental health problems to their primary healthcare physician, while men are more likely to seek help from a specialist in mental healthcare. Men are also the principal users of

inpatient care. Gender stereotyping about proneness to emotional problems in women and alcohol problems in men reinforce social stigma and constrain help seeking along stereotypical lines (WHO). Women who entered treatment for substance abuse were significantly less likely than men to complete treatment (Agency for Healthcare Research and Quality, 2011). These barriers are magnified in rural communities that often ascribe to traditional gender role expectations and values regarding behavior. Often, healthcare providers in rural areas are also influenced by these stereotypical beliefs. Clearly, the complexities of gender bias in conjunction with some rural cultural beliefs increase the vulnerability and victimization of women.

Other research shows that some aspects of RFT life may offer protective factors against mental health issues for women. On the one hand, the rural nature of the environment plays an important role in increasing the demands for self-reliance and necessity to perform a wide range of life-supporting activities for oneself. On the other hand, interdependence and good relationships with neighbors are essential in the rural environment as precursors to social support and assistance in daily RFT living (Comerford, Henson-Stroud, Sionainn & Wheeler, 2004). For example, women who live on farms scored higher than average on mental health assessments than their urban dwelling counterparts (Hillemeier, Weisman, Chase, & Dyer, 2008). Dorfman, Mendez, and Osterhaus (2009) found that in response to economic hardship, disruption of family life, and fears, uncertainties, and stressors associated with the Great Depression and wars of the twentieth century, older rural women demonstrated resilience through frugality, reliance on social supports, and acceptance. Rural residents have long been known for their resilience in dealing with economic hardship, expressing differential social outlets, and exhibiting a certain kind of grittiness. The general concept is that resilience is primarily explained as an attitude toward life, and resilient people are able to make adjustments to life changes (Gray & Gash, 2014; McManus et al., 2011). (See Chap. 7 for a more

Research Box 11.2

See Wells, M. (2010).

Objective: The purpose was twofold. First, to determine if resilience levels vary in older adults living in rural, urban, or suburban areas. Second, to determine if the relationships of sociodemographic factors (age, income, education, marital and employment status), social networks, health status, and resilience vary with the location in which older adults live.

Research Method: A cross-sectional design was used to collect data from 277 registered voters aged 65 years or over who lived in rural, suburban, or urban locations in New York State. The instruments used were the Resilience Scale, the SF-12v2, and the Lubben Social Network Scale-revised.

Results: No differences were found in resilience levels across the three locations. In regression analysis, stronger family networks, lower household income, and good mental and physical health status were found to be significantly associated with higher resilience levels.

Conclusion: The location in which older adults reside did not affect resilience levels. Strong ties and good mental and physical health were associated with resilience. Finding an association between resilience and low income was unexpected. Mental health status was most strongly associated with resilience. Although more research is needed, screening older adults for resilience levels and intervening when low levels are identified by implementing strategies to build resilience may be clinically relevant.

in-depth discussion on resilience and strength of rural residents.) Wells (2010) conducted a study of older adults to determine if resilience levels vary depending on rural, urban, or suburban location and if the relationships of sociodemo-

graphic, social networks, physical and mental health status, and resilience vary according to the location in which older adults live. Wells found no differences in resilience levels across the three locations, and certain characteristics were found to be associated with high resilience levels. See Research Box 11.2.

Susceptibility to Violence

Among women with disabilities, older adults and women with intellectual and developmental disabilities (IDD) experience disproportionate rates of abuse (Hollomotz, 2011). Research suggests that the extent of abuse is a problem of crisis proportion for women in small rural and isolated areas as compared to urban women (Peek-Asa et al., 2011). Peek-Asa et al. (2011) found that the prevalence, frequency, and severity of domestic violence differ by rurality and geographic access to resources. Specifically, rural women reported a significantly higher severity of physical abuse than their urban counterparts. The average distance to the nearest domestic violence resource is three times greater for rural women, and rural domestic violence programs served more counties and had fewer on-site shelter services. Women in small rural and isolated areas live more than 40 miles from the closest programs compared to less than 1% of women living in urban areas.

In particular, women with disabilities in rural and urban areas encounter unique vulnerabilities beyond those experienced by women in general including physical, emotional, and sexual abuse by caregivers, abandonment, voyeurism, and extortion (Nosek & Howland, 1998; Powers, Hughes, & Lund, 2011; Smith & Strauser, 2008). Additional forms of disability-specific violence include destruction of medical equipment and communication devices, physical neglect withholding, stealing or overdosing of medications, and financial abuse (Curry, Powers, Oswald, & Saxton, 2004; Nosek, Foley, Hughes, & Howland, 2001). Maltreatment by personal care assistants and other service providers is a unique problem facing women with disabilities (Nannini, 2006;

Nosek, Howland, Ritala, Young, & Chanpong, 2001; Saxton et al., 2006). Moreover, women with disabilities who have been abused physically and sexually have higher levels of unemployment than do women without disabilities that have not been abused (Nosek, Hughes, Taylor, & Taylor, 2006; Powers, Hughes, & Lund, 2011; Smith & Strauser).

Rural women experience higher rates of domestic violence or intimate partner violence (IPV) with greater frequency and severity of abuse than their urban counterparts. IPV is different from domestic violence in that the perpetrators include spouses and other domestic partners. Some research suggests that social and geographic isolation may be a contributing factor to the rates and severity of IPV (Breiding, Ziembrski, & Black, 2009; Peek-Asa et al., 2011). Peek-Asa et al. found that 61.5% of isolated rural women reported four or more events of physical violence in the past year as compared with 39.3% of urban women, and more than 30% reported severe to very severe physical violence compared to 10% of urban women. The effects of violence on women produce adverse immediate and short- and long-term physical and psychological health outcomes (Hassouneh-Phillips McNeff, Powers, & Curry, 2005). Frequently, injury as a result of IPV may result in disability. Weeks, Macquarrie, Begley, Gill, and Leblanc (2016) suggest that increased efforts are needed in improving both public and professional education regarding older rural women and IPV.

Although this chapter is focused in part on women, we would be remiss not to mention that men with disabilities, especially developmental, intellectual, and physical disabilities, are as likely as their female counterparts to be victims of sexual abuse (Powers et al., 2011). Powers et al. (2011) indicated that unlike women, men are more likely to be abused by female caregivers, with the abuse producing negative consequences across their lives, including an impediment to employment and a barrier to self-care and to living independently. Compared to men without disabilities, men with intellectual disabilities were more likely to report caregivers manipulating their medications; they are more likely to report

being held against their will and being hit, kicked, slapped, or hurt.

Employment

In general, women with disabilities have higher rates of unemployment compared to women without disabilities, with African-American women with disabilities having the lowest odds of employment (Oberoi, Balcazar, Suarez-Balcazar, Langi, & Lukyanova, 2015; Smith & Alston, 2008). Women with disabilities are more likely than women without disabilities to be employed in the service sector (e.g., food preparation, building and grounds maintenance, medical assistant, personal care). In addition, women with disabilities participate in blue color occupations at higher rates than do women without disabilities and are less likely to be in professional or technical occupations. Overwhelmingly, women with disabilities are clustered in service sector occupations, which often are part-time, the lowest paid, and the least likely to offer health insurance and other benefits (O'Day & Foley, 2008). The role of work in the lives of women is highly correlated not only with economic independence but also with self-concept and social and psychological well-being (Chung & Rubin, 2008).

Additionally, rural women experience complicated challenges in obtaining productive employment that pays a livable wage. Challenges include transportation and under-availability of support services, with persistent and inadequate advocacy skills for women with disabilities in rural communities in each rural geographic region (Carstensen 2008; Parent, 2008). In addition, rural low-income mothers are more vulnerable as compared to their urban counterparts under the current welfare policy, which has a work-first approach (Son et al., 2011). Son et al. argue that the lower level of education, lack of affordable child care, lack of transportation, and time and emotional demands from family members influence three employment trajectories for rural women: continuous employment, intermittent employment, and stable employment. Women

with disabilities in rural areas who access assistance despite the barriers do so with a tenacity iconic of rural living by connecting with the strong social network of small town living. Unfortunately, women who are not part of the interconnectedness of the community remain isolated with their needs unmet (Carstensen).

Carstensen (2008) suggests two areas on which to focus to strengthening employment outcomes for rural women with disabilities. One area is to build partnerships between community services, schools, businesses, self-advocacy and other organizations, and transportation and mobility management (i.e., coordinated mobility). In addition, partnerships between schools and service providers can provide training that increases the use of technology by women with disabilities, in turn changing ways in which rural women access work and compete in the global market (Carstensen). Another area is to capitalize on existing personal or social networks in rural communities and turn them into employment networks so that through social networking, employment can be customized (e.g., job carving, job shaping, flexible schedule) for rural women with disabilities, and employers are more acceptable to such an arrangement when they and the employee have established a relationship. Rural communities provide an advantage because of the "natural opportunity to interact with the same people on a recurring basis and build relationships" (Carstensen, 2008, p. 13). Many of these relationships are life-long ones.

A Profile of Elders with Disabilities in Rural Regions

In general, "increasing life expectancy is one of the greatest public health achievements of the twentieth century" and "has made disability a linchpin for understanding healthcare resource needs" (Laditka et al., 2005, p. 1). Education is considered as a moderating factor in life expectancy. Individuals with more education live longer, healthier lives than those with less education (Hummer & Hernandez, 2013; Montez 2012). Education may confer protective effects relating

to specific disability, functional limitations, and major diseases for several reasons. First, education may influence an individual's ability to understand risks to health or the propensity to accept or reduce known risks (Fries, 2002; Laditka et al.). Second, education may alter health behavior (e.g., smoking, taking vitamin supplements, better diet, exercise). Finally, education is associated with cognitive functioning, which helps individuals develop higher-order cognitive skills to live healthy and long lives (Baker et al., 2011).

Population aging is a worldwide phenomenon, especially in developed countries (Krout & Hash, 2015). Of the over 40 million people aged 65 and over in the United States (13% of the population), about 15 million (38%) report having one or more disabilities. The oldest-old (age 85 and over) represents the highest percentage of disability in the older population. Women composed a higher percentage of disability (59%) than their older male counterparts (56.8%) (He & Larsen, 2014). Although the majority of older people do not live in rural areas, older adults make up a disproportionate percentage of rural populations (Glasgow & Brown, 2012; Krout & Hash, 2015), with residents aged 65 and older accounting for approximately 15% of the RFT population (United States Administration on Aging, 2007). Glasgow and Brown describe rural aging populations in the United States in two contrasting contexts: (a) areas experiencing natural population decrease (i.e., more deaths than births) and (b) areas experiencing relatively high rates of net in-migration at older ages. Although natural population decreases occur, the phenomenon is geographically concentrated in the United States and characterizes particular regions (i.e., the Great Plains, Western Corn Belt, upper Midwest, and the Appalachian spine from western Pennsylvania through North Carolina). Net in-migration of older ages is concentrated in the South and Southwest (i.e., Ozark Ouachita Plateau of Missouri and north Arkansas, the Upper Great lakes, the Front Range of the Rocky Mountains, and southern Appalachia, especially in North Carolina and Tennessee) (Glasgow & Brown, 2012).

Growth in the US population aged 65 and older will increase exponentially between 2010 and 2030, with baby boomers (persons born between 1946 and 1964) representing a vastly larger portion. Although aging baby boomers will affect both urban and rural areas, its impact is predicted to be especially dramatic for rural areas (Glasgow & Brown, 2012) because older migrants are disproportionately likely to move to rural areas (Brown & Glasgow, 2008). Baby boomers in the United States are also more likely than the previous generation to have a disability as they approach late life. Although baby boomers are living longer than people approximately 20 years older, boomers are not necessarily healthier. King, Matheson, Chirina, Shankar, and Broman-Fulks (2013) found that despite their longer life expectancy over previous generations, baby boomers have higher rates of chronic disease, more disability, and lower self-rated health than members of the previous generation at the same age. Baby boomers have increased rates of obesity, hypertension, diabetes, and hypercholesterolemia, despite lower rates of smoking, emphysema, and myocardial infarction (King et al., 2013; Martin & Schoeni, 2012).

Increasingly, as the population ages, planning services to help in the transition from full health to levels of disability such that older people can live in their communities is essential for their residence in rural areas (Laditka et al., 2005; Redfoot, Feinberg, & Houser, 2013). Particularly relevant to older populations are the health penalties and health advantages of living in rural versus urban areas, which in turn affect health status (see Table 11.1). Although some rural elders are healthy and socially active, many others are not. In general, urban areas offer the advantage of better access to and more cohesion with many necessities of life, even with the migration of the middle class to the suburbs (Vlahov, Galea, & Freudenberg, 2005). Montgomery, Stern, Cohen, and Reed (2003) suggest that the socioeconomic heterogeneity of cities may bring benefits of healthcare and education within reach of more disadvantaged urban residents. Several studies also found that not only do elderly residents in rural areas have

Table 11.1 Health penalty and health advantage of geographic location

Urban		Rural	
Health penalty	Health advantage	Health penalty	Health advantage
Air pollution	Better healthcare system	Limit access to healthcare/facilities	Access to fresh food
Crime	Health-promoting environment (pools, gyms, facilities), access to wide variety of wholesome foods	Higher morbidity, higher disability rate, childhood risk factors	Less likely to relapse into depression or mental illness one recovered
Poor sanitary conditions	Access to public transportation	Increased riskfactors for substance abuse	Sense of community/interdependence
Overcrowding	Proximity to wealth and poverty (service)	Higher poverty	Less daily stress from external factors
Decaying infrastructure	Sustained social organizations	Limited availability of rehabilitation	Long-lasting/more personal relationships
Excess morbidity and mortality	Political support for services	Less developed infrastructure	Easy access to natural world

Adapted from Combs (2006), Laditka et al. (2005), and Vlahov et al. (2005)

higher levels of morbidity but also that those in the Deep South have significantly higher rates of morbidity than those in the North (Hayward & Gorman, 2004; Lin, 2000; Porell & Miltiades, 2002). The greater risk for morbidity was attributed to the higher incidence of stroke and diabetes in the South, with exposure to risk factors early in life predisposing residents to disability later in life. Although both urban and rural living offers health advantages and disadvantages, urban areas may confer more advantages, and “the ultimate health status can be viewed as the sum of the urban advantages minus the sum of the penalties” (Vlahov et al., 2005, p. 4).

Disability rates in RFT regions are higher across all age groups, with noncore counties (nonmetropolitan counties with an urban core population of less than 10,000) experiencing the highest rates overall. Irrespective of age, RFT regions have higher more persons with higher rates of impairment (von Reichert et al., 2014), and coupled with that is that the most significant rural demographic characteristic connected with disability is poverty (Seekins & Associates, 2011). Elders living in poverty are less likely or less able to access healthcare and other support services (US Department of Health and Human Services, 2007). Warner and Brown (2011) found that the emerging patterns in the functional health of older adults were early life events, adult

socioeconomic status, marital status, and health behaviors that explain disparities in the limitations men experienced, but as clearly for women. Disproportionately, low-income elderly people live in rural communities. Although the number of rural elderly and urban elderly people with Medicaid coverage is essentially equal (North Carolina Rural Health Research and Policy Analysis Center, 2009), the percentage is greater in rural areas where there is more reliance on nursing home care because of a lack of community-based alternatives (Rural Policy Research Institute, 2006). Moreover, insurance reimbursement levels for healthcare is a significant barrier for older rural residents because healthcare providers are often unwilling or unable to accept remuneration at such low levels (Iezzoni, Killeen, & O’Day, 2006).

Medicare beneficiaries make up 14% of the total US population. According to Cubanski, Huang, Damico, Jacobson, and Neuman (2010), 24% of all Medicare beneficiaries live in rural areas. Rural beneficiaries comprise more than 50% of the Medicare population in Montana, Nebraska, North Dakota, Ohio, South Dakota, Vermont and Wyoming. A breakdown of the demographics of Medicare recipients reveals that they are predominantly White and female, and those over age 85 make up 12% of recipients. Overwhelmingly, rural Medicare recipients have

limited incomes and face rising premiums and out-of-pocket costs for coverage, even though as 2015, the Affordable Care Act modified some Medigap (supplemental insurance) plans to include cost sharing for some services (Bennett, Lopes, Spencer, & van Hecke, 2013).

Ensuring the quality of life of a growing elderly population is considered one of the greatest challenges of the twenty-first century (Redfoot et al., 2013). This is particularly important for rural elders because their needs remain largely ignored, unaddressed, or not prioritized as part of socioeconomic and healthcare policy (Baernholdt, Yan, Hinton, Rose, & Mattos, 2012; Kumar, Acanfora, Hennessy, & Kalache, 2001). In fact, research identified priorities for action for rural older adults that include sustained access to prescriptions, transportation solutions, inadequate access to healthcare workers and facilities, lack of quality healthcare, poor infrastructure and coordination of services, scarce assisted living and in-home care for frail older adults, social isolation, financial constraints, and barriers related to culture, language, and economics (Averill, 2012; Baernholdt et al., 2012; Grymonpre & Hawranik, 2008; Xu & Borders, 2003). According to Iezzoni et al. (2006), "meeting the health care needs of rural resident with disabilities will require intervention beyond health care, involving transportation and access issues more broadly" (p. 1258). Refer to Research Box 11.1 for results of Iezzoni et al. study on barriers to obtaining primary care for rural residents with disabilities.

The intersection of age, gender, and poverty for rural residents requires further inspection. On average, women tend to live longer than men, and the ratio of women to men increases with age (United States Census Bureau, 2010d). Elderly rural women are more likely to have a disability, be widowed, older, and poorer than their urban and suburban counterparts. Older rural women experience more health issues that affect their ability to drive, hamper mobility, and compromise their quality of life than do older rural men. In addition, RFT areas lack many social and health services for older women such as primary care physicians, social workers, and caseworkers

trained in gerontology and geriatrics (Bennett et al., 2013). The most common psychiatric diagnoses in older adults are depression, anxiety, substance abuse, and dementia; however, depression is not a normal part of aging (Hicken, Smith, Luptak, & Hill, 2013). Toner, Ferguson, & Sokal (2009) report that poor physical health can increase risk for mental illness, particularly depression and anxiety, in combined effect with bereavement, poor social support, and functional decline. More so than their urban counterparts, older rural adults admitted for substance abuse treatment were more likely to use alcohol and non-heroin opiates (Center for Behavioral Health Statistics and Quality, 2012). These psychiatric comorbidities occur in a context of limited access to care that greatly complicates effective management (Hicken et al.). Older adults living in rural areas are more likely than urban elders to report being less happy and having worse health. In addition, rural elders are more likely to be institutionalized than are urban elders due to an inability to care for themselves at home (Hutchison, Hawes, & Williams, 2004; Nelson & Gingerich, 2010). Other reports suggest that the rates of mental illness are similar between urban and rural areas, but suicide rates are higher in rural areas (The National Advisory Committee on Rural Health and Human Services, 2008). Yet, other studies suggest positive mental health outcomes for rural older adults in that they may have fewer depressive symptoms than non-rural residents. Ziembroski and Hauck (2004) found that rurality and regional residence might be a buffer against depression.

Elderly residents with disabilities living in rural communities must also contend with issues of mistreatment, and geographic isolation may exacerbate the problem, both in its intensity and due to availability of services. Abused elders living in rural areas may be living with physical disabilities and experiencing dementia and may be residing in community of facility settings. In a study of ten African-American rural North Carolina victims and six abusers, Griffin (1994) found that, while poverty was an underlying factor in all cases, financial exploitation was the most common type of mistreatment with abusers

involved in dependent relationships with the older adults who were abused. Dimah and Dimah (2004) examined six forms of substantiated elder abuse among rural and urban women and found that more rural women experienced physical abuse, emotional abuse, and deprivation than their urban counterparts. Rural women were slightly (88% vs. 86%) more likely to accept services than were urban women. Using a threshold model of abuse, Stone and Bedard (2002) found that Canadian residents in smaller (rural areas) had a lower threshold for elder abuse than did respondents living in larger (urban areas).

Overall, understanding aging and older persons with disabilities in rural, frontier, and territory communities requires counselors and practitioners to consider that people do not age in a “spatial vacuum.” That is, all people age somewhere, and the place of aging has an impact on people and vice versa (Krout & Hash, 2015). Rurality may be both a resiliency factor and a risk factor depending on certain circumstances. Older people with disabilities living in rural areas may continue to experience social, economic, and environmental conditions that threaten their health and perpetuate risks for disability, particularly for those aging in place, while much of the younger population moves away.

A Profile of LGBTQ Persons with Disabilities in Rural Regions

There is a dearth of systematic research and data on LGBTQ populations with disabilities nationally and even more so in rural communities. The information on prevalence of disability among LGBTQ person is based on the overall population and not necessarily specific to those in rural areas. Therefore, any discussion of LGBTQ persons in RFT communities should consider differences as well as commonalities among these groups in terms of health disparity and service needs. According to Disabled World (2015), lesbian, gay, and bisexual (LGB) adults have a higher prevalence of disability than do their heterosexual counterparts. Comparatively, 25% of heterosexual women, 36% of bisexual women,

and 36% of lesbians and 22% of heterosexual men, 40% of bisexual men, and 26% of gay men experience a form of disability. Lesbians and bisexual women exhibit higher rates of smoking, frequent mental distress, arthritis, obesity, asthma, and poor physical health than heterosexual women. Gay and bisexual men are more likely to be smokers and experience frequent poor health and mental distress than heterosexual men, but they are less likely to be obese than heterosexual men. Even after controlling for variables of mental health, physical health, health behaviors, chronic health conditions, and sociodemographic characteristics, LGB adults demonstrated increased prevalence of disability when compared to their heterosexual counterparts. Moreover, the odds of LGB adults experiencing a disability is higher than their heterosexual counterparts of comparable age, even for those who are fairly young, suggesting the age of onset of disability might be lower in these populations (Disabled World). The diversity and subgroups (e.g., lesbians, transgender with sex reassignment) of these populations have different health risks and concerns that are not necessarily shared collectively.

Often, LGBTQ persons face the challenge of “a double coming out” – as a person with a disability and as LGBTQ (Fish, 2007, p. 3). In working with LGBTQ persons with disabilities, we must consider that they commonly face the dual challenge of actual discrimination and fear of discrimination when dealing with health and social service networks (Institute of Medicine, 2011; Lee & Quam, 2013). Thus, many LGBTQ persons with disabilities pass as heterosexual for health and social services because they fear being refused services or treated in a derogatory manner. The result of these high levels of distrust of healthcare providers and human/social service workers can prevent discussion about risk factors for certain kinds of health disorders and disabilities, which may worsen over time, resulting in additional functional limitations. Service providers’ ignorance and insensitivity combine often to be as much of a barrier as the disability itself. Regardless of age, LGBTQ persons in RFT communities encounter two specific obstacles: homo-

bi-trans-phobia and heterosexism. According to Brothers (2003), health and human/social service providers are so focused on attending to medical and functional requirements they neglect to take into account the personal and emotional needs and life experiences of LGBT persons with disabilities.

Overwhelmingly, LGBTQ identities have been studied in urban spaces in both cultural and personal understandings (Kazyak, 2011). Although some studies emphasize positive aspects of rural gay life (e.g., Gugliucci et al., 2013; Oswald & Culton, 2003; Rowan, Giunta, Grudowski, & Anderson, 2013; Wienke & Hill), most research suggests that negative aspects outweigh the positive (e.g., D'Augelli, 2006; Datti, 2012; Eliason & Hughes, 2004; Lee & Quam, 2013). Alternately, others indicate that LGBTQ persons in rural areas have better experiences with family ties and weaker ones with service delivery and civil rights (e.g., Oswald & Culton, 2003). In a study of counselors' attitudes in urban and rural settings about LGTB clients, Eliason and Hughes (2004) found that counselors from both settings had very little formal education regarding the needs of LGBT clients, and nearly half reported negative or ambivalent attitudes. Although urban counselors were more racially diverse and more likely to have grown up in an urban area, reported having considerably more contact with LGBT clients, and had more formal and continuing education about LGBT people than the rural counselors, urban counselors did not translate their knowledge nor experience into favorable perceptions. Ironically, the results suggest that urban counselors are no more knowledgeable of the needs of LGBT populations or are more accepting of LGBT persons than are rural counselors.

Rural communities are not typically seen as places compatible with the needs and wants of LGBTQ persons. The prevailing view is that sexual minorities are better off living in large cities (Wienke & Hill, 2013). LGBTQ persons' identities or behavior are perceived as undermining the culture in rural communities and considered a threat to social order; thus, sanctions are used to promote expulsion or conformity

(Harley, 2016b; Harley, Stansbury, Nelson, & Espinosa, 2014). Many LGTBQ persons live in rural areas out of choice or necessity because their families have lived in their community for generations (kinship systems) or because they are migrant farm workers (National Center for Lesbian Rights, 2016, www.nclrights.org/pur-work/rural-communities/). For LGBTQ persons who migrate to urban areas and return to rural communities, the return can create high levels of stress (Oswald, 2002).

For instance, Wienke and Hill suggest that rural versus urban LGBTQ residence should be examined from four competing perspectives. The first is that rural life is less beneficial (e.g., social isolation, intolerance, limited supports) to LGBTQ persons' well-being than urban life. The second is that rural life is more beneficial (e.g., low cost of living, less stress, stronger social ties, and shared traditions) to LGBTQ persons' well-being than urban life. The third perspective is that any observed differences between rural and urban LGBTQ residents are attributed to differences between the two populations in terms of the composition of ethnic, age, family status, and other demographic characteristics, not due to the characteristics of the geographic setting. The final perspective suggests that any observed differences in well-being may reflect a selection process in which well-adjusted LGBTQ persons remain in the areas in which they were raised (nonmigration), and poorly adjusted persons move away (select migration).

In interviews with LGBTQ persons in rural areas, Kazyak (2011) suggests that an "artificial anonymity" emerges in which interviewees asserted that others do not explicitly recognize their sexual identity either positively or negatively. Visibility of LGTBQ persons in rural areas is tied to being seen with the same person at various places (e.g., bank, grocery store). Thus, others might know about and tacitly accept their sexual identity, which is attributed to the close-knit nature of rural life. In addition, interviewees describe the sense of anonymity that stems from the close-knit nature of rural life as tied to a sense of safety in which everyone knows and will continue to see them around, which lessens the

opportunity to express the hostility that may happen in urban settings.

Although LGBTQ persons in rural areas face the same issues as their urban counterparts (bias, rejection, stigma), these issues are accentuated by the lack of a visible gay community, social isolation, an overall lack of LGBTQ-specific services and resources, a more conservative political climate with an emphasis on fundamentalist religious beliefs, and cultural values endemic to RFT communities (Harley, 2016a; Hastings & Hoover-Thompson, 2011), as well as political and economic inequities between rural and urban areas (Comerford et al., 2004) and challenges for persons with disabilities in general. In addition, community closeness and interdependence in RFT areas often blur boundaries of privacy and result in information being shared through local venues and throughout the community (Harley, 2016a). LGBTQ persons have lower levels of openness and “outness” and higher levels of guardedness with people, including family relationships and close friends (Lee & Quam, 2013). Many LGBTQ persons residing in rural communities create private or secretive lives that focus on relationships within closed support networks that may include biological and legal kin, families of choice, and friends and neighbors (Lee & Quam, 2013). Overwhelmingly, research suggests that the emphasis on privacy is a personal preference and a strategy for surviving within a hostile climate (Lee & Quam; Oswald & Culton, 2003). LGBTQ elders living in rural areas may become more isolated from their families of origin than others. Often, elderly lesbians and gay men may be single, childless, and estranged from family members, which can result in isolation (and susceptibility to mistreatment, mentioned earlier) (Barker & Krehely, 2012).

Geographic location is a significant variable that, due to social, cultural, and economic differences between rural and urban settings, influences how LGBTQ persons experience and express sexual and gender identity worldview (Lee & Quam, 2013) and disability identity (Gay and Lesbian Medical Association [GLMA], 2010). Too often, rural environments allow for only limited information about sexual minorities

and typically include aspects of shame, negativity, and pathology (Datti, 2012). Moreover, regardless of the age of the individual, Datti suggested that heterosexist worldviews can be internalized and can affect self-worth, self-perception, and healthy functioning.

Service Delivery Implications for the Vocational Rehabilitation Counselor

Although each human service agency has its own mission, procedures, and policies broadly defined, the responsibilities of human service agencies encompass efforts that are described as helping, preventing, ensuring, empowering, and linking people to resources to improve quality of life. Rehabilitation counselors and other human service providers working with populations with disabilities in rural communities need to consider ways to provide comprehensive and integrated services with multiagency responses. For example, research suggests that, for persons with disabilities, progress in vocational and employment areas is limited until the basic needs of housing, food, and safety are addressed. In addition, service providers need to be trained in understanding how rurality affects the rehabilitation needs of women, older adults, and LGBTQ persons. When individuals seek services, the expectation is that service providers will meet their needs, and, moreover, they trust that the service provider has the requisite knowledge, skills, and abilities to meet their needs (Hartman & Weierbach, 2013).

Rehabilitation counselors first need to conduct a self-evaluation of their values, attitudes, and beliefs about providing services to rural women, older adults, and LGBTQ persons with disabilities. Counselors who are aware of and comfortable with their own identities and *positionalities* are better suited to work with clients of different groups (Sue & Sue, 2013). They should be aware of how unconscious bias may affect their vocational planning and placement for working with those populations. Similarly, rehabilitation counselors should understand the adverse impact of

negative societal messages that are often presented and promoted about specific groups. In turn, these messages may influence how an individual responds to services, as well as the perceptions they formulate about their own self-image and abilities. Too often as a result of being marginalized, negative messages and images create further obstacles to empowerment and lessen opportunities for rural women, older adults, and LGBTQ persons (with and without disabilities). For some, there may be further subjugation to a status of invisibility.

Second is a need for an analysis of the current reality of knowledge, service delivery approach, and training needs of rural rehabilitation counselors for working with gender, age, and sexuality-/gender-specific populations. It may be presumptuous to assume that counselors who have been taught about unconditional positive regard, post-modernism, person-environment fit, or another counseling approach are able to apply the concept with women, older adults, and sexual minorities living in rural areas. In fact, education and mandatory diversity training for counselors should be required. Given that a range of years may have passed since some counselors have completed their education, training can provide knowledge that may have not been part of their formal training. Currently, counseling organizations and counselor education curricula include LGBTQ sexuality within the definition of diversity, which may help to reduce resistance from un- and under-informed counselors.

Third, counselors are mandated to practice under the guidelines of a code of professional ethics (e.g., American Counseling Association, American Psychological Association, Commission on Rehabilitation Counselor Certification). Ethical codes of conduct require counselors to provide services that are unbiased, respectful, and nondiscriminatory. Counselors are to engage in behaviors that are affirming of clients. Also, cultural competence in working with people of minority backgrounds is now prescribed by counseling and other human services professions.

Counselors are professionals who are credentialed to provide an array of services to various

populations and settings. Thus, counselors can contribute to benefit women, older adults, and LGBTQ persons living in rural areas in several ways: (1) share professional expertise as a member of an advisory committee or task force focused on improving services, (2) engage in research on education, employment, poverty, and disability disparities that affect services, (3) organize and promote advocacy for self-improvement, (4) gain an understanding regarding support systems and begin to understand the needs for gender-age-and-LGBTQ appropriate services, and (5) identify and help develop LGBTQ resources and services. Moreover, counselors need to be aware of age-sensitive issues of rural LGBTQ adolescents who may be at greater risk of experiencing anti-LGBTQ biases due to their lack of maturity and dependence on school and family (Datti, 2012; Yarbrough, 2003) as well as how these experiences affected adult populations. Because women, the elderly, and LGBTQ persons with disabilities in rural areas each have specific challenges, the remainder of this section will identify service needs specific to each population. It is beyond the scope of this chapter to be all-inclusive of service needs of various groups; thus, the focus is to present specific dimensions of service needs. In addition, the reader is reminded to conceptualize the relevance of the Internet in rural areas. Access to the Internet offers opportunities to converse with doctors, specialists and other medical practitioners, and counselors and human service providers from remote locations. However, for many persons in RFT communities, access to the Internet is still a barrier to connect to services.

Service Needs of Women

The magnitude of challenges among women with disabilities in RFT communities is enormous. Rehabilitation counselors and other human service providers must take into account unique characteristics that may influence service needs of women in general and, more specifically, women in RFT communities. First, women are more frequently affected by chronic conditions

and disability than men, and both severe and moderate disability is more common among women than men across age groups. Second, women with disabilities have a higher incidence of certain types of disabilities and have difficulty in accessing healthcare services, social services, or childcare services. Third, women with disabilities are more likely to be poor and unemployed and have limited social support. Fourth, disability affects women's lives in various ways because women are often caregivers for children, spouses, or other family members. Finally, elderly women and women living poverty with disabilities are more vulnerable in general and thus require more targeted policies and interventions (DesMeules, Turner, & Cho, 2004).

In working with women with disabilities in RFT communities, the following recommendations are provided to rehabilitation counselors and other human service providers. First, consider working collaboratively with other human service agencies to provide transportation and coordinate the scheduling of appointments. Availability and access to transportation for poor and elderly women in rural areas are major barriers to accessing services. Resources that can be utilized by partnering agencies' resources may enhance knowledge about persons with disabilities among various professionals and increase agencies as referral source. Second, include strategies to improve health literacy, awareness of the signs of mental illness, advocacy, and financial literacy of rural women as part of counseling and guidance. Third, develop targeted approaches of outreach and case-finding for women in RFT communities. Fourth, educate physicians and healthcare providers about vocational rehabilitation services. Fifth, develop a working knowledge of the signs of domestic and intimate partner violence and neglect and mistreatment because counselors are often one of the first service providers to either suspect or recognize these signs. Women with disabilities who are living in rural areas can face considerable hardships, such as the cyclic effects of poverty, lack of access to shelters and services to address violence, and poor systemic responses to domestic violence, abuse, and assault. All over the world, for women living

with disabilities and who are living in rural areas, violence is a growing concern.

Rehabilitation counselors can offer women with disabilities in rural areas a means to strengthen their economic potential through employment, education, or training. Parent (2008) suggests using the approach of "thinking outside the box" in order to assist women with disabilities to gain competitive employment. Options include supported and customized employment (e.g., created jobs, carved jobs, self-employment). In addition, Parent (2008) urges rehabilitation counselors to be role models for women with disabilities as a means of facilitating their goals. Implicit to role modeling is for the counselor to avoid gender stereotyping of what women and men can and cannot. Similar caution must be taken to avoid stereotyping of women due to their geographic location.

Service Needs of Older Adults

There has been little attention given to needs of elderly people living in RFT communities and their needs within vocational rehabilitation (Kampfe, Harley, Wadsworth, & Smith, 2007; Kettaneh, Kinyanjui, Slevin, Slevin, & Harley, 2015), as has been the attention given at the national level by program and policy makers (Krout & Hash, 2015). In a content analysis of select rehabilitation counseling journals, Kettaneh et al. found only 24 articles on aging between 2000 and 2012. This finding is especially disturbing given that older adults make up a greater percentage of rural populations and, compared with their urban counterparts, are more disadvantaged on quality of life indicators (i.e., health, housing, economic resources). In the case of rural elderly people, residential context matters (Krout & Hash). Moreover, Glasgow and Berry (2013) suggest that an understanding of rural aging contributes to the knowledge of impacts of aging in general.

Changes in the economy of rural areas (e.g., decline of extraction industries, manufacturing jobs, and small farms) have reduced employment options and spurred the exodus of a

younger workforce. Emphasis has shifted from a sustainable rural economy to one bolstered by government and voluntary and nonprofit subsidies. Further, rural older adults have little political voice due to their race and ethnicity and low socioeconomic backgrounds (Bull Howard, & Bane, 1991). Because many rural older adults will increasingly need to access healthcare, transportation and access to these services are especially critical despite the fact that isolation in RTF areas is magnified by distance to services, especially hospitals, challenging terrain, and quality of roads (Bull, Krout Rathbone-McCuan, Shreffler, 2008). Bull et al. stress that rural areas continue to experience a shrinking tax base, decreases in corporate giving, and reductions in social services as well as health-care providers (e.g., hospitals, doctors, nurses) as well as an under-trained labor pool, which hampers the introduction of helpful technology, such as the use of the Internet, mentioned above. Mental health providers are also in extremely short supply, and isolation may exacerbate mental health problems.

Case Study

Juanita has lived in a rural area all her life. She dropped out of school after the 8th grade due to her family's need for her to work and married at age 17 to escape her family's impoverished situation. By age 18, she had one child with another born 7 years later. Her husband also had an 8th grade education and ran a small dairy farm on mountainous land until his poor health forced him to sell off most of his farm equipment and land. Their oldest son died of cancer before he turned 40, leaving the younger son, who left the area to pursue an education and to find employment, to help with his mother. Juanita's husband died, leaving her alone in the home and experiencing depression and other health problems to the point that she eventually needed a guardianship. The son, also the guardian,

checks on her weekly and phones her daily, but her physical and mental health has deteriorated to the point that she has not left her home in over a year. She is also somewhat afraid to leave the home due to a drug dealer who has moved to property adjacent to her and sharing a common easement that now has a gate and several large and barking dogs. Neighbors do what they can to help, and a relative is paid to bring in food and help with medications. Still, because of the isolation of the rural area, there are very few visitors, and home health services are sporadic in both availability and quality. Also, particularly since her husband's death, Juanita is suspicious of anyone who offers help to her. She vows that if she is forced to go in a nursing home, she will die and blame her son forever for putting her there.

The case study above is representative of many of the problems of older adults whose physical and mental health is deteriorating and who are aging in place in a rural area. Clearly, counselors attending to the needs of older adults must marshal needed services (in particular mental health services) that are too often in short supply. The inadequacy of services for rural older adults increases their vulnerabilities to mistreatment (see above). Counselors must confront the growing social and healthcare needs of older adults who are living in rural areas and find creative ways to target and deliver services to them, services that are of the highest quality possible and delivered in a timely way. Useful strategies include cooperative arrangements for transportation and service delivery. Counselors must be attune to cultivating and enhancing the viable services that do exist as well as the creation of new services as they are needed, being careful to understand that some needs are unique to rural elderly people and are not just urban needs transposed upon rural ones.

Service Needs of LGBTQ Persons

As with the older adults discussed earlier, lack of knowledge on the part of counselors about LGBTQ persons residing in rural communities and a lack of familiarity with their communities, cultures, and worldviews contribute to both LGBTQ persons' status as a hidden minority and their invisibility overall (Datti, 2012; Elisaon & Hughes, 2004; Harley et al., 2014; Harley, Hall, & Savage, 2000). Dispenza, Viehl, Sewell, Burke, and Gaudet (2016) assert that "deficient knowledge regarding sexual minorities living with chronic illness and disability (CID) poses significant implications for rehabilitation counselors, especially as they are expected to ethically address issues of cultural diversity and CID" (p. 144). Additionally, few services exist that are specific to the needs of LGBTQ persons as well as very little outreach to this community (Hughes, Harold, & Boyer, 2011). In 2012 the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) approved counseling competencies for lesbian, gay, bisexual, queer, questioning, intersex, and ally individual (LGBQIQIA) (Harper et al., 2013) and for transgender clients in 2009 (American Counseling Association, [ACA], 2010). The Association's competencies are geared toward ensuring that professionally trained counselors to provide a framework for "creating safe, supportive, and caring relationships with LGBQIQIA individuals, groups, and communities that foster self-acceptance and personal, social, emotional, and relational development" (Harper et al., p. 2). The competencies are based on a wellness, resilience, and strength-based approach (ACA).

Dispenza et al. (2016) conducted a study in an effort to understand the effective practices that rehabilitation counselors (RC) reported exhibiting when working with sexual minority persons living with chronic illness and/or disabilities (CID). The results yielded construction of a model of affirmative intersectional rehabilitation counseling with affirmative intersectionality as the core category and four supporting categories: professional attributes (values, virtues, self-awareness), working alliance (empa-

thy and emotion validation, confidentiality, shifting professional role types, and intentional self-disclosure), intersectional sensitivity (collaborative empowerment and nurturing autonomy), and intersectional interventions (appraising intersectional contextual barriers, mobilizing adaptive resources, and social justice actions). Affirmative intersectionality was the mechanism fueling RCs' overt and covert cognitive, affective, and behavioral processes when delivering professional services to LGBTQ persons living with CID. Each of the supporting categories is salient and is equivalent to the next, with each uniformly contributing to the practice of affirmative intersectional rehabilitation counseling with LGBTQ persons (Dispenza et al.). Dispenza et al. concluded that affirmative intersectionality demonstrates malleability and fluidity and did not focus on any particular counseling theory or technique. That is, when RCs are already operating from diverse and empirically intentional counseling frameworks, the affirmative intersectionality approach lends itself to be pan-theoretical. RCs are able to understand a client from behavioral, cognitive, and emotional perspectives, focusing on a client from a holistic approach that allows for integration of multiple rather than a singular or specialized technique.

Among the many counseling approaches conducive to working with LGBTQ persons, Datti (2012) presents a combination of three known to be helpful: person-centered counseling, feminist theory, and cognitive behavioral therapy. Person-centered counseling emphasizes positive regard, honest relationships, and a nonjudgmental attitude. The application of person-centered counseling starts with a welcoming and safe environment. For LGBTQ persons in rural areas, such an environment signifies trustworthiness and objectivity that affirms their identity to an extent that may not have existed before. A feminist perspective can be used to address societal discrimination experienced by LGBTQ persons in rural settings and allow them to deal with a spectrum of internalized negative attitudes toward sexual minorities and gender identities. Cognitive-behavioral techniques can be used to

examine LGBTQ persons' problematic thought processes and substitute more adaptive responses (Datti).

As a function of their job, rehabilitation counselors are required to be familiar with community resources. In rural communities, resources are more limited, and LGBTQ-specific services are virtually nonexistent. For available services, the focus should be on advocacy that includes LGBTQ-sensitive programming (Harley, 2016b). In addition, it may be helpful for RCs to develop a resource manual for themselves and their clients (Datti, 2012). With employment as the primary goal of vocational rehabilitation services, RCs should assist LGBTQ clients with issues accompanying coming out or self-disclosure in the workplace and potential ramifications. Often, the first question is should an individual come out to employers and coworkers? If an individual chooses to come out, the RC, if not knowledgeable, concerning working with LGTBQ populations, should refer the client to someone who is qualified to work with him or her. If the RC proceeds in working with an LGBTQ individual, he or she should discuss workplace-related issues such as discrimination concerns, job accommodations, legal implications, confidentiality, and employer and coworkers' potential responses. Potential negative outcomes for LGBTQ persons in the workplace are adverse impacts on mental and physical health, wage and employment disparities, and forced concealment of sexuality orientation (Sears & Mallory, 2015). (See Bolles, 2015 and TUC Guide, 2013 as workplace resources). RCs should work with employers to identify and promote LGBTQ-friendly and safe-spaces and non-offending language. Counselors always need to be mindful of the workplace setting as well as the cultural views of rural settings toward LGBTQ persons.

Summary

Women, older adults, and LGBTQ populations with disabilities are groups that present unique issues and require specific and sensitively appropriate responses and approaches. Often, these

groups may share intersecting identities. Counselors have a unique role in the pantheon of service provision in rural areas, such that they can both help these populations using feminist theories and person-centered counseling at the individual level as well as inform communities about their needs. Because of the special issues that may accompany living in rural areas, women, older adults, and LGBTQ persons with disabilities who are living in rural communities may require services from multiple service providers. When services are well coordinated, individuals tend to receive appropriate services and vulnerabilities to abuse and declines in health may be abated. However, if services are undersourced and the workforce providing them is inadequately trained, vulnerabilities are exacerbated to the point that health and well-being may be severely compromised. The informed, well-trained rehabilitation counselor has the potential to significantly improve the lives of women, older adults, and the LGBTQ populations who are living in rural areas.

Resources

- Benchmark Institute (Effective Outreach to GLBT Disability Community): <http://www.benchmarkinstitute.org/GLBT/disability-and-GLBT-resources.htm>
- Gay and Lesbian Alliance Against Defamation (GLAAD): <http://www.glaad.org>
- Human Rights Campaign: <http://www.hrc.org>
- National Center on Elder Abuse: <http://www.ncea.aoa.gov/>
- National Council of Aging: <http://www.ncoa.org>
- National Institute on Aging: <http://www.nia.nih.gov>
- National Resource Center on LGBT Aging. (2013). *Inclusive questions for older adults: A practical guide to collecting data on sexual orientation and gender identity*. New York, NY: Author
- Rural Health Information Hub: <http://www.rural-healthinfo.org>
- Womenshealth.gov: <http://www.womenshealth.gov/index.php>

Learning Activities

Self-Check Questions

1. What are some distinguishing needs of women in rural communities that differ from their counterparts in urban areas?
2. What type of environmental factors do rural women face?
3. What are the priorities for action for older adult in rural setting to be able to sustain quality of life?
4. How might rural communities help prevent the mistreatment of its older residents?

Experiential Exercises

1. Develop a report on the status of women with disabilities in a rural area within or near your community.
2. Imagine that you have been asked to testify before Congress about the employment needs of older persons with disabilities. Identify key points and research to support your presentation.
3. Imagine that you are a friend Juanita in the case study earlier in the chapter. What would you do to help her? Her son?

Multiple-Choice Questions

1. What is one of the greatest problems facing older adults living in rural areas?
 - (a) Isolation
 - (b) Poverty
 - (c) Decline in manufacturing
 - (d) All of the above
 - (e) None of the above
2. Because of a paucity of available service, what is the overall mental and physical health of people living in rural areas as compared to people living in urban areas?
 - (a) Better
 - (b) Worse
 - (c) Same
 - (d) No difference
3. Which of the following groups in rural areas is referred to as “the poorest of the poor”?
 - (a) LGBTQ
 - (b) Children
 - (c) Women
 - (d) Older adults
4. Which of the following groups send more of their adult lives living with a disability?
 - (a) White men
 - (b) White women
 - (c) Latino men
 - (d) Black women
5. What is the average distance to the nearest domestic violence resource for women in rural areas as compared to women in urban areas?
 - (a) Two time greater
 - (b) Three times greater
 - (c) Four times greater
 - (d) Six times greater
6. Compared to urban elderly, rural elderly have a heavier reliance on which of the following because of a lack of community-based alternatives?
 - (a) Day treatment programs
 - (b) Senior center
 - (c) Nursing homes
 - (d) Disability resource center
7. LGBTQ persons in rural areas face which of the following as a person with a disability?
 - (a) Double support
 - (b) Double coming out
 - (c) Increased service opportunities
 - (d) Better experiences with civil rights
8. Which of the following is more of an issue for LGBTQ persons in rural areas than their counterparts in urban areas?
 - (a) Lack of a visible gay community
 - (b) Lack of LGBTQ-specific services
 - (c) Social isolation
 - (d) All of the above
 - (e) None of the above
9. Which of the following is implicit to role modeling for the counselor to avoid in working with women in rural areas?

- (a) Gender stereotyping of male and female roles
 - (b) Familiarity with community resources for women
 - (c) Referral to qualified service providers
 - (d) Identification of wage and employment disparities
10. Compared to urban areas, which of the following make up a greater percentage of rural populations?
- (a) Women
 - (b) LGBTQ
 - (c) Children
 - (d) Elderly

Key

- 1 – D
- 2 – B
- 3 – C
- 4 – D
- 5 – B
- 6 – C
- 7 – B
- 8 – D
- 9 – A
- 10 – D

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