# Role of Shame in Substance Use Treatment in Rural Appalachia

Rebecca B. Assadnia

A dissertation submitted to the faculty of Radford University

In partial fulfillment of requirements for the degree of

Psy.D. in Counseling Psychology in the Department of Psychology

Dissertation Chair: Dr. Ruth Riding-Malon

December 2021

R. J. Rid — 12/10/2021

Dr. Ruth Riding-Malon
Dissertation Chair — Date

12/11/21

Dr. Valerie Leake
Committee Member — Date

12/10/2021

Dr. Nora Reilly
Committee Member — Date

**Abstract**

Although substance use issues and disorders have been receiving more attention, most of the research and policy discussions focus on more populated areas. This oversight has left rural areas, such as the majority of Appalachia, unexamined. Appalachia is a unique region due to the large expanse of rural land, substance use concerns, socioeconomic factors, and cultural aspects. Whereas the link between shame and substance use is known, there is no mental health provider's view of the role shame plays in the substance use of those living in Appalachia, particularly with the cultural aspects of the area in mind. Much of the research conducted to date is quantitative and survey research, providing little awareness of the environment in which the people of Appalachia reside. A qualitative approach more fully documents the experiences of individuals, aiding in the development of treatment interventions that better meet the needs of those living in rural communities. Given the small number of providers available in Appalachia, the few training opportunities for working in these rural areas, and the unique cultural aspects of the region, it is imperative for mental health providers to have interventions and treatment options tailored to fit this client population. This study begins to fill the void of research related to substance misuse and shame in Appalachia. Utilizing the viewpoint of mental health providers, the current study examined how the negative aspects of shame can contribute to substance use disorder.

## Table of Contents

# Chapter 1

## Summary of Literature

Whereas attention recently moved toward rural areas, one area of the United States that typically is not included in the conversation surrounding how to combat substance misuse is rural Appalachia (Thornton & Deitz-Allyn, 2010). Appalachia consists of 13 states and over 400 counties, making health disparities even more salient, as a large number of individuals are left without adequate care (Hege et al., 2018). Factors such as increased overdose risk, less access to providers, higher unemployment rates, higher job-related injuries, and lower education levels create concern for substance misuse in rural Appalachia (Click et al., 2018; Moody et al., 2017).

Shame has been shown to be associated with patterns of substance use that can be troublesome, such as the initiation and maintenance of a substance use disorder (Luoma et al., 2019). This occurrence may be in part due to the tendency of shame to produce feelings of inadequacy and other negative thoughts and emotions. These thoughts can further the cycle of substance misuse (Dearing et al., 2005).

Stigma and shame in rural Appalachia are tied to the cultural components of stoicism, self-reliance, strong attachment to family/kinship, as well as the self-stigma aspects of shame and embarrassment individuals experience for seeking services (Williams & Polaha, 2014). Rural Appalachian residents strive to manage their own issues attempting to be less of a burden on others and create a stronger community (Gore et al., 2016). In addition to the notable lack of mental health providers and barriers with stigma in rural areas (Smalley et al., 2010), a lack of mental health and substance use training programs for students in health professions leads to a cultural unawareness of clients and furthers the stigma/shame of seeking services (Thomas & Brossoie, 2019). Higher levels of shame from negative experiences with healthcare providers is

associated with an increase in symptoms of depression, lower incidence of seeking services for substance misuse, and more severe substance use symptoms (Wang et al., 2021).

Additionally, rural regions, such as Appalachia, are forced to contend with socioeconomic and resource deficits in areas of transportation, physical health, financial well-being, and opportunities in employment (Hall et al., 2008; Hill et al., 2016; Thornton & Deitz-Allyn, 2010). Yet, the people of the region are resilient (Helton & Keller, 2010). Resilience is the ability to adapt or adjust after an adverse event (Thompson et al., 2018). Resilience builds throughout the lifespan and benefits mental health, physical health, and even combats economic distress issues (Burke-Garcia et al., 2021; Kuhar & Kocjan, 2021; Thompson et al., 2018). Resilience is valuable in effective substance use treatment. A study by Kurtz et al. (2019) showed those with higher levels of resilience exhibiting protective factors and less negative coping behaviors were more likely to have better outcomes on substance use measures.

The following sections discuss the research questions of the current study, along with the method, results, and implications for future research. The aim of this exploratory study was to gather the perspectives of mental health providers in order to gain an understanding of how shame impacts clients with substance use concerns in rural Appalachia.

## Method

### *Focus Groups*

This project utilized focus groups because they are able to gather data from multiple individuals who have an association with the topic at hand (Krueger & Casey, 2009). The study reached the saturation point with three focus groups. Saturation is when no new information is being obtained (Guest et al., 2016). Based on guidelines from Guest et al. (2016), the study proposed that three groups of nine to 15 professionals participate. A total of three online focus

groups, each ranging from 45-60 minutes, occurred. Twelve participants agreed to attend the groups and signed the informed consent document, with 10 participants in actual attendance. Although each focus group had a 90-minute time limit, the needs and schedules of the participants dictated the length of each session.

The number of participants in each group was purposeful as well. Krueger and Casey (2009) gave four to six participants as the appropriate number of individuals per group. However, Nobrega et al. (2021) deemed that, in a virtual format, three to five members per group was most beneficial for focus group facilitation. It was important to maintain a proper number of participants per group given the Zoom virtual format used. Each Zoom focus group was password protected and had a specific link given to participants. To ensure a further layer of protection, participants could only enter the Zoom room once "admitted" by the host.

### *Participants*

Participants consisted of 10 mental health and substance use providers with experience working with clients in rural Appalachia. The study recruited providers from integrated care facilities and community mental health organizations in Tennessee and Virginia. Twelve providers agreed to participate and 10 attended the groups as participants. Six female and four male participants engaged in the study. The participants ranged in age from 24 to 64 years old. The participants varied in gender, age, years of experience working in the subject matter, and levels of credentials. Further chapters detail the collected participant demographics.

### *Procedure*

Once Radford University Institutional Review Board granted approval, participant recruitment and data collection began. Three focus groups were conducted, one each in August, September, and October of 2021. To lessen the burden on participants and to maintain social

distancing recommendations, all focus groups were held over Zoom. Before the groups began, each participant reviewed and signed the informed consent document and filled out the demographic forms. The researcher obtained all informed consents and demographic forms prior to the group's commencement. Participants agreed to be recorded prior to the start of each recording. Focus groups were scheduled and conducted based on participant needs. Following each group, the researcher reflected and wrote down any observations or thoughts prompted by the session. The researcher met with advisor, Dr. Ruth Riding-Malon, after each focus group.

### *Data Analysis*

Once each group was conducted, the researcher employed thematic analysis to generate themes from the data. Themes were then compared across all groups. Dr. Ruth Riding-Malon reviewed data and themes to help protect against bias. Thematic analysis was chosen for the study as a way to identify and organize themes that emerged from the data. The process was outlined by Braun and Clarke (2006) and included six phases. The researcher followed all six phases for each group. These phases are described in more detail further in the document.

### *Results*

Questions asked of participants were based on theory, prior research, and clinical practice. Therefore, the categories below follow a similar format, and at times the wording of the questions asked of participants. Apart from one theme, responses from participants aligned with interview questions and the categories listed in the following sections. Please see Appendix E for a summary of themes.

#### How has shame impacted the actions of clients?

When discussing how shame impacts the actions of clients, participants' responses fit into one theme: the hidden nature of shame. A participant's quote illustrates this theme in detail.

**Hidden nature of shame.** Many participants mentioned the hidden or concealing nature of substance misuse itself. Participants commented on the way clients initially sought help for their substance use. Clients only brought substance use up indirectly, if at all. In one group, participants talked about client substance use being a hidden concern during an initial medical visit unless the issue was brought up by the individual who referred the client, or through screening measures in an integrated care clinic. The shame and stigma associated with substance use is a barrier to care, as clients are hesitant to bring it up for fear of being judged or being assigned a certain label. One participant in the second focus group stated,

> I think a lot of why people don't bring it up themselves initially is by the time they get to us, they've had conversations like this with many other entities, being legal or primary care. And they're used to, I think, feeling judged and feeling labeled and are very hesitant to bring it up.

In these ways, even on the road to recovery, stigma and shame encouraged clients to be dishonest and contributed to their relapse. Thinking patterns of clients will be discussed in a later section of this paper. However, it is important to note the reasons clients gave the focus group participants for engaging in treatment.

**When we think about the clients coming to us and substance misuse, what is their most common presenting problem?**

The previous question elucidates the following two themes related to how shame impacts the actions of clients. Shame is seen in this data as interfering with clients' willingness or ability to self-disclose. The themes emerged from discussions surrounding common presenting concerns. These themes included help-seeking being never directly related to substance use and

the impact of emotions and substance use. In these themes, participants explored the interwoven features of shame and substance use. The themes are discussed in more detail below.

**Never directly related to substance use.** Even though substance use itself was often a main issue for clients, they very rarely disclosed that concern initially. Participants listed multiple reasons with legal, interpersonal, or medical being the top reasons an individual with substance use might initially seek help. Participants mentioned clients disclosing a variety of legal concerns, such as court-mandated treatment, child custody cases, or an issue related to a driving offense. Participants recorded frequently that stressors related to relationships with others was the reason for clients seeking treatment. Many of their clients reported negative effects of misuse on their relationships. For many participants, it was the overall impact of substance use on the lives of their clients that was most salient. The possible contributing factors to, and consequences of, substance use were discussed as primary reasons clients attended appointments. Seldom, if ever, would an individual explicitly state substance use itself was their reason for attending. One participant described this as, "I rarely see a person who comes in and says upfront, my biggest concern is my substance use…there's usually multiple problems that are both a product and a cause of substance use."

**Impact of emotions and substance use.** Participants deliberated about clients using substances to cope with mental or physical health concerns. They mentioned this self-treatment was particularly true when their clients dealt with depression and anxiety. As described by one participant, "…they (client) oftentimes will talk about that as [..] a way that they've coped with anxiety and depression. Although you wonder what which came first, you know?"

Participants reported clients speaking of using substances to self-treat medical conditions by inducing sleep or increasing energy. In these days when marijuana is going through various

stages of being deregulated or decriminalized in several adjoining states including Virginia, participants in the second focus group mentioned the difficulty of managing marijuana for medical issues. One participant stated the topic was a "whole can of worms" while adding that clients themselves mentioned this conundrum.

**What type of words do clients use when describing experiences with shame related to substance misuse?**

This line of questioning began with a simple prompt: **Of the emotions your clients experience, would you agree that shame is one of them?**

Participants in all groups agreed that shame presented in their client populations. Other emotions participants described were all negative and similar to shame, such as guilt, embarrassment, fear, and stigma. Depression, anxiety, sadness, desperation, hopelessness, helplessness, and feeling overwhelmed were also discussed as emotions clients with substance use concerns present.

Not surprisingly, these word choices illustrated the impact of shame on the clients' thinking patterns and on their sense of self. Two themes emerged surrounding word choice, substance use, and shame. These included the impact of thinking patterns and clients' sense of self.

**Impact of thinking patterns**. A theme present throughout each group consisted of the impact of clients' thinking patterns, which providers saw in their self-talk. Self-talk is the way a person talks to and views the self. Participants addressed clients' beliefs surrounding the way others view the clients and the clients' word choices.

All or nothing or black and white thinking patterns were one feature of self-talk mentioned in all three groups. A participant in the second focus group gave an example of this

type of thinking, stating, "…I think …in the rural areas in Appalachia …there's a lot of all or nothing, black or white, good or bad thinking…You're either, you know, a good, non-drug using person or a bad, drug using person."

These types of thoughts were seen as contributing to the cycle of shame and substance use. Participants explained that clients perceived any actions or words in a negative way because of the shame. This type of thinking was further tied to the Appalachian region and cultural values. Participant three in group three described this cultural worldview: "I think in some ways…in the South we value […] our image and […] how is it going to look…shame could encourage us to not talk about it…gotta keep the status quo in our family and friends." Participants described patterns such as these as maladaptive and unhealthy in many contexts, but particularly so in substance use. They spoke about the role of thought patterns and family connection as well. Clients felt disconnected from family after being in active addiction or even while in early recovery and were unsure how to reconnect or earn back the trust lost. Participants described how for some, past actions felt insurmountable, and the shame associated contributed to the belief trust could not be regained with loved ones.

**Sense of self.** Starting with the overwhelmingly negative words used to describe their emotions, it is not surprising that participants explored clients' beliefs surrounding self-esteem and self-efficacy. Participants reported conversations around clients' lack of skill in areas such as socialization and problem solving; they even questioned whether clients' development matched that of others their age. Participants explained that clients seemed to lag behind their peers, in terms of jobs, family life, education, or other aspects of daily life. Participants explored how these differences stemmed from either their re-entry into society as a sober person or from the developmental delays associated with substance use. One participant noted that "… you stop

developing emotionally when you start using…you may have a 35-year-old who is emotionally 18." A final point made by participants was clients being unable to see their own resiliency and strength. Participants reported clients struggled to be kind to themselves and modify their good versus bad belief system.

**How does the environment of individuals affect views of shame?**

Three themes emerged within the category of how the environment impacts views of shame: broader cultural views of substance use, social environment factors, and characteristics of substance use.

**Broader cultural views of substance use**. A factor brought up in groups was the way in which rural Appalachian society views those who use substances. Participants in one group noted the systemic aspects of the United States' legal, healthcare, and general cultural are influenced by societal values. They reflected on the belief that those with a substance use disorder only deserve to be helped when they are willing to help themselves. Furthermore, they thought that our culture as a whole believes that substance use should be punished, instead of being treated as a chronic illness. One participant discussed the cultural divide between those who use and those who do not, and the attitude of those who do not use of looking down on those who do have a substance use concern. In describing this divide, participant one in group three stated many believe that substance misuse "is a moral failing, that … these people are beneath us." Even in certain recovery groups, such as Alcoholics Anonymous, participants talked of clients' reporting stigma. Clients who practiced harm reduction instead of abstinence from substances reported experiencing stigma within these recovery groups, demonstrating the way in which shame and stigma are present throughout society.

**Social environment factors.** Groups delved into the societal messages regarding shame and what is considered culturally appropriate. Rurality and clinic location were areas the groups explored. Participants hailed integrated care facilities that had a primary focus on treatment of substance misuse. They saw these integrated care clinics as safer places from the clients' point of view, and thus said clients were better able to combat shame by opening up and being vulnerable about their substance use. However, they described increased difficulty in confronting substance use in more rural areas where residents are more reserved about self-disclosure. Talking about shame, substance use, or other mental health concerns is not typically done openly in a rural culture and this was evident across groups. Participant one in group one highlighted this rural Appalachian cultural norm, when he stated, "[discussing trauma, substance use, mental health] …and learning how to sit with them and addressing that in the frame of shame. We don't talk about those things, you know, we're in the South…my grandparents didn't talk about that."

One group discussed the lack of funding in the region that blocks community opportunities and activities. This lack of activities pushes young people to experiment with substance use out of boredom. They said their adolescent and young adult clients describe only two social groups to which they can belong: those who use substances *OR* those who are religious and therefore do not use substances. Their younger clients who do not identify with either of these groups feel as if they do not fit in socially, nor do they have safe and fun social activities available to them. Participants thought this dichotomy was more pronounced in rural areas due to lack of funding for schools or community resources. One participant stated, "…more rural schools don't have the money to offer some of the things maybe a city school will offer…like art club…I can't think of a model UN being out here."

These feelings of not fitting in were not limited to adolescents; older clients reported similar feelings. Social disconnect was discussed in two contexts: religiosity and group belonging in recovery. In one group, a participant described the struggle with finding new social circles:

> …a lot of the people that I know, at least in the early stages of recovery, they don't go out because everybody knows them…I know people who can't go to the gas station…we all know people who have moved communities to… change playmates and playgrounds. And that's a really powerful thing, especially in our smaller communities. You know, …there can be really no escape.

Religious and faith-based beliefs of the region were listed as a powerful force for many clients, both in terms of belonging or exclusion. They expressed that using substances meant that you were an immoral person, you lacked willpower, were weak, and that something inside you was the problem. These messages became internalized, and similarly to the adolescent clients previously discussed, adults said the only options were to belong to the social group who uses substances or to a local church group. For those in recovery, one participant noted clients in intensive outpatient groups often spoke of the importance in recovery of finding a new social group and feeling connected to others.

**Characteristics of substance use.** There were noticeable differences between rural and urban settings that participants highlighted in terms of substances used and the perception of substance use by others. Differences in substances used were tied to socioeconomic status in the Appalachian region; certain substances (i.e., cocaine) were listed as too expensive for many to use regularly and therefore were not found in abundance. However, substances such as methamphetamine and opioids were more readily available in Appalachia.

Participants believed that substance use in rural Appalachia was fundamentally different from other areas of the United States. They added that the media perpetuated the belief in these differences. Participants noted that media sensationalized use and de-humanized individuals in general. One particular participant described his views of those who used substances stemming from the stereotypes prevalent in the media. He realized this view was not accurate once he began clinical work. As this participant described it, "…think about how our culture, just by looking at TV, sees substance use…and so many of these people are just, people, they're our grandmothers…they're just good folks."

**How have you seen clients overcome shame?**

Two themes were seen in the conversations surrounding clients' overcoming shame: connection with others and shame as a signal of resilience.

**Connection with others.** Participants in all groups mentioned the importance for their clients to connect with others to talk about shame. This connection could occur in a group setting, with peer recovery specialists, or in individual counseling. They believed that it was this connection with others that helped reduce shame. Participants reported clients finding acceptance and repairing relationships with others, reducing isolation, and understanding they were not alone. They explained that while in active addiction, clients were isolated from others, but that it was important for them to surround themselves with a sober community in recovery in order to move forward. Finding community and connection was essential for clients to no longer feel alone in their experience. Participants described the reduction in shame that occurred once clients recognized that others had similar experiences and they weren't alone in working toward recovery. Additionally, this affinity helped with the feeling reported by clients of being very

different, believing they could not fit in, or that they would not catch up to others in their age group. In group three, participant one described this feeling:

> I think that when a person is in active addiction they're kind of isolated. Not just socially, but mentally…Being in community with other people who are also working on recovery…that can be really helpful to help folks see that they're not the only person who has struggled with this.

Belonging to a recovery community helped clients reconnect with other parts of their lives as well. Participants discussed the use of intensive outpatient programs such as 12 Step groups. These groups helped the clients rebuild their ability to connect with others and themselves in fun and substance-free ways. The clients learned coping skills and sober lifestyle skills to use outside of the treatment environment from these groups.

Participants mentioned that certain clients isolated from others to protect themselves from a relapse. The providers had two different views of this isolation. For some clients, it was understandable that they might feel this way given the substance-ridden environment in which they lived. Even going to the store felt unsafe for these clients. However, participants reiterated the vital importance of a recovery community for their clients, even when the desire to isolate was strong.

Participants cited peer support programs as evidence for connection as an essential feature of recovery. They focused on the power of connecting with others, especially with those who had the unique perspective of being further along in their path of recovery. Participants discussed the importance of the work for those who provide peer support services. They saw this peer support as a testament to how far these clients, or former clients, have come in recovery.

Participants believed it was an example of the strength of their drive to help others and give back to their recovery community. As one participant stated,

> One thing that has impressed me with those who use substances is for those people who have overcome a lot of it. The incredible care they have for those who have used substances and the real desire to help you know, you just see people who are really involved…It's meant so much in their lives and how much they want to help others.

Offering this peer support itself is thus a part of their own recovery.

**Shame as a signal of resilience**. An additional feature of belonging discussed in the groups was the way shame may relate to the desire to connect with others. In some ways, participants saw feeling shame as evidence clients were still connected and caring, or valued connection, and thus were seeking it for their lives. They saw shame as an aspect of resilience because it meant that clients had not given up trying to reconnect with family and were continuing to move forward in recovery. Participants explained the following sequence: (a) clients lost touch with their loved ones because of negative behaviors, such as stealing from family; (b) clients felt shame; and (c) clients sought to repair the relationships. It was the desire to belong and connect with their loved ones that fueled feelings of shame. The participants thought this situation was evidence that clients valued connection to others, which was seen as a sign of resilience. Their evidence was the words and phrases clients used, phrases such as not giving up, and desiring to do better.

**Do you address shame in your work with clients?**

Finally, two themes emerged from participant discussion around addressing shame with clients. Types of work settings and approach to client care were present as themes.

**Types of work settings.** As mentioned in a previous section, rurality and clinic location can have an impact on clients' and providers' comfort levels with substance misuse topics. Participants spoke of the way shame connected to rural cultural values negatively impacting their clients' ability to feel safe opening up about their substance use. Because the types of clinics determined the different approaches to care, participants speculated how clinical settings seemed to influence the way patients reported and discussed their substance use behaviors.

Participants saw the various structural approaches that clinics use when providing services as important to client care overall, and particularly in the level of comfort individuals felt when discussing their concerns. An integrated, team-based approach was listed by two groups as making a difference in client care. Each group discussed this belief in slightly different ways. For participants in one group, integrated care meant primary care providers screening for substance use and an open-door policy for referrals. Participants wondered if choosing a primary care appointment might show that these patients care about their health in general, which would also lead them to caring about their substance use and mental health. Team-based clinic characteristics were deemed important in the third group as well, where participants thought being a part of a multidisciplinary team meant providers were constantly learning from one another. One participant discussed learning from other disciplines when doing a chart review before seeing a client. Furthermore, using an integrated care team meant clients knew the clinic could be a safe space. Participants discussed how clients would come to rely on shared communication. They hypothesized that if clients had a positive interaction with a provider when discussing a socially stigmatized concern, the clients would feel more comfortable knowing the other providers in the clinic would generally share this same approach. Participant two in group three gave an example:

> I think when we set the stage that way it makes them more comfortable in talking with us later on, when things come up around those issues…they know that [the clinic] has heard this before…I think that it's important to have a safe space where they know that they're not going to be judged and can talk about these things.

Another factor discussed in the clinic level interventions subtheme was the interaction between clinic and community. One group spoke about the power of being an established facility in the community, and the way this brings about trust in rural areas. The role of the facility in the community was an important factor in countering the stigma and shame that can exist at community levels. A participant in the first focus group noted,

> I find myself expressing that [non-judgmental stance] to other people in the larger community, that if you automatically look at somebody with addiction, that something's wrong with them, instead of that it's a disease that you have to work through; that broadens their horizons too…But I really feel like those environments don't just start in our therapeutic settings, but they're in the community.

The message of hope and healing that the facility sends to individual clients can be a model that is extended to the community. By meeting clients where they are and providing whole-person, non-judgmental care, the clinic is able to put forth a message of accepting all individuals, which participants noted brought relief to clients.

**Approach to client care.** Participants explored the role of counselors in decreasing shame and creating a safe therapeutic alliance. A safe therapeutic environment grew from the way counselors approached conversations and presented to clients, by extending acceptance and a non-judgmental attitude and ensuring clients' values were respected. Another participant in the

third group discussed maintaining respect and kindness when a client reported struggling in their recovery journey. The participant described this conversation with clients:

> I just try to commend everything big and small…I just commend the fact that they even came into the clinic…I do try to empower as I get resources to let them do as much as they can, and then again commend the fact that they took that step and they turned in that application and they applied for that job. And so, helping with little things and big things, and encouraging everything they do and trying to reinforce the positives more than focusing on the negatives.

Participants discussed validating the experiences of clients and giving credit when a client did make a choice not to use. This led into a conversation about resilience, as many participants saw resilience in their work with clients. Participants mentioned resilience being present whenever a client chose to avoid substance use or take a new step in that direction, even after a relapse. When discussing client progress and resilience, participant one in group one stated, "You [client] have a struggle on top of the average person…you're pushing harder and harder every day to get where other people are in life but you're trying to play catch up. You have to give yourself credit for where you are." This conversation showed the bidirectional process of building resilience. The client-built resilience by taking steps and making different decisions. However, resilience was reinforced when the counselor pointed out these healthy changes, the progress, and the strength that resided in the client in order to make these decisions. Participants discussed how resilience is built through small steps in addition to the way counselors highlight these small steps to their clients. By celebrating client success and progress, clients reported that pride replaced the feeling of shame.

Providers were seen as holding many roles: being a support, a connector to resources, empowering clients, and providing individualized services that address current concerns. Participants discussed empowering clients in a variety of ways, one of which was providing psychoeducation on substance use and substance use disorders. They listed the following as important information that was beneficial for clients: (1) helping clients to understand the mind-body connection in substance use; (2) the neurological changes that stem from using substances; (3) the connection between mental health symptoms and substance use, and (4) the nature of substance use disorders as a chronic health concern. One group listed changing the view of substance use disorders to a chronic health concern as important in decreasing shame; they believed that it helped clients understand the difference between taking responsibility for the self and holding onto immense amounts of shame and self-blame.

Participants also spoke about interventions revolving around self-talk and helping clients modify their automatic thoughts associated with use. This process required an individualized approach, as each client had different needs and struggles. Providers described working to change the shame thought process by teaching clients to accept emotions without allowing the corresponding feelings to overtake them. They also mentioned using shame as a motivator for forward progress. Helping clients recognize the path they had previously taken, understand that substance use can be a coping skill, and learn new ways of coping were all listed by participants as interventions they employed. They explained that part of their clients' progress was learning how to sit with the uncomfortable nature of shame and to no longer allow it full control. They added highlighting the feelings of hopelessness and helplessness and acknowledging when clients took a different path toward addressing them as effective strategies for clients.

### Theme Based on Participant Discussion: Importance of Connection with Other Providers

In a parallel process to the one they encourage their clients to take, participants mentioned the importance of connecting with other counselors about their work. Participants listed these exchanges as an empowering, hopeful, and uplifting aspect of their work because they highlighted sharing the knowledge of others in the field. These interactions were particularly important given the disconnection in rural areas in general and during the pandemic, when less work was done in-person. Participants continued to discuss the importance of doing individualized work and tailoring evidence-based treatments, especially in rural clinics where there is large provider to client ratio and other rural-based implementation struggles (i.e., transportation for clients). In the third focus group, a participant described this process as "…it's bending and weaving. It's nuances and things that I don't even know that I could explain sometimes, and it's over a long term. It's usually long term, it's relationship-centered." For participants in this focus group, client work was focused on the therapeutic alliance and meeting the individual where they are, modifying evidence-based treatment to fit client needs.

### Summary

This chapter included a description of the results of the thematic analysis. The data produced 13 themes. Themes showed shame to be a truly central aspect of substance use symptoms and in substance use treatment. Shame influenced client self-talk and was found in the social environment of clients. Resilience was seen as able to help reduce shame, particularly as one begins one's recovery journey and shame is decreased through actions and interactions with others.

## Discussion

Because there is a paucity of research on substance use treatment in rural Appalachia, this study's main goal was to explore substance use treatment among this population. In this chapter, I review the study's identified themes and subthemes in connection to the relevant literature. I will consider the similarities and differences between the reports of my Appalachian participants and mainstream American substance misuse treatments. Once themes and previous research have been compared, I examine the limitations of the study. Finally, I conclude with implications for future research and clinical practice.

### Similarities Between the Current Study and the Literature

In this section I discuss the commonalities seen between the current data and the literature.

**Cyclical nature of shame, mental health, and substance use.** Not surprisingly given the focus of the study, the connection between shame and substance use was present across all three groups conducted. For many participants, this discussion revolved around the way shame and substance use together influenced an individual's comfort in disclosing current use when seeking help. The emotions their clients experienced, the consequences of their substance use, and contributing factors were recalled. This study provides support for the literature that describes a close interrelationship between substance use and shame. Kelly and Eddie (2020) described the cyclical relationship between shame and substance use as being the mixture between the chemical properties present in the substances and the inability to regulate the self that results in "harmful consequences…produce behavior incongruous with individuals' own moral code or values, which subsequently leads to remorse, guilt, and shame" (p. 117).

Furthermore, participants in the focus groups agreed with Black et al. (2013), who connected shame to clients' experiences of depression or anxiety.

**General experience of stigma in seeking services.** Shame was seen as a barrier to care for many, as participants noted the ways in which clients initially chose to hide or conceal their true needs. In the same way, Kenton et al. (2019) reported stigma is a common experience for those seeking services for mental health or physical health concerns. The authors stated that stigma acts as a barrier to clients' willingness to seek services in particular for mental health and substance use symptoms. Our study group's participants saw their clients reacting to shame and shame becoming a barrier. They explained that it began with clients feeling judged when discussing a substance use concern, and thereafter, those clients no longer disclosed use unless prompted by another individual or a screening measure in primary care. An article by Clement et al. (2015) detailed multiple types of stigma, such as stigma turned in toward the self and stigma felt from others, speaking to the experiences participants discussed in relation to their own clients. These types of shame were identified as barriers to seeking services by the authors and by our participants.

**Impact of shame on the relationship.** This theme will be discussed in connection to Appalachia and clients from the region in a later section. However, it is important to note the broader impact shame can have on relationships with self and others. Participants discussed how their clients endorsed thinking patterns that led to an overall negative sense of self and others. Participants' discussions surrounding these dichotomous, inflexible thinking patterns appear to fit what the literature describes in mainstream Americans. Black et al. (2013) described how shame impacts the thought process, stating it is a "self-conscious emotion that is characterized by…a desire to be unseen as well as a perception of being deeply flawed, incapable, and

unacceptable" (p. 646). Our study participants spoke of clients trying to hide by not volunteering information about their use or avoiding the topic even when seeking help from physicians in primary care. Furthermore, Black et al. (2013) stated shame creates a sense within the individual that they are unable to cope, and are seen by others as disgusting, someone to reject or to scorn. These descriptions echo the participants' discussions as to the way they witnessed shame impact the belief systems of their clients as well. They reported clients initially sought help for non-substance use issues and responded positively when treated in ways that countered the clients' own perception of being deeply flawed.

**Recovery needs.** Belonging was seen as a great need for people in recovery. Thus, participants listed finding a recovery community and learning to socialize as a sober individual as essential for their clients. Participants added that the skill of helping clients feel comfortable and re-engaging socially was beneficial. Boeri et al. (2016) stated that building community is an important part of recovery, particularly as the process can hold significant stigma. Additionally, the social capital inherent in relationships provides resources to those who, due to their current social status, otherwise would be without. Furthermore, healthy relationships ensure higher rates of sustained recovery from substances (Boeri et al., 2016). The authors attributed this success to the building of new social systems and the ability to avoid old, potentially negative, social ties.

**Broad societal views.** Finally, focus groups discussed societal views of substance use. Particularly relevant were the systemic impacts of those views on legal, healthcare, and the overall treatment of those with a substance use concern. Participants bemoaned the punitive attitude of society towards those who use substances, with one participant stating clients only receive help to the extent they are willing to help themselves. The general public additionally sees substance use as a moral failing, a concern that should be criminalized instead of treated as

chronic illness. These societal views are expressed in the often-punitive journey those who use substances endure through the criminal justice system. This idea is seen in the literature as well, as Shannon et al. (2014) reported criminal court cases for substance use have long overwhelmed court dockets (p. 285).

The social impact of a community working together can also be a power for redemption. A participant in the first group discussed the importance of recovery courts in giving clients a second chance instead of automatic punishment without the opportunity for treatment. Shannon et al. (2014) described how recovery courts emerged when individuals working within these systems began to note the overlap of substance misuse and criminal cases in their courtrooms. Drug courts were created as a way to "intervene with individuals in a nonadversarial manner to break the cycle of substance abuse, addiction, and crime" (Shannon et al., 2014, p. 285). These programs are community based and use a multidisciplinary team, composed of those within the justice system and mental health treatment providers (Shannon et al., 2014). The authors noted consistent benefits from utilizing recovery courts in communities, including a decrease in recidivism and substance use.

**Additions to the Current Literature**

Whereas the literature is teeming with studies focused on the topic of substance use, studies examining treatment for substance use in rural Appalachia remain rare. This exploratory study was designed to gain a better understanding of the relationship between shame and substance use in rural Appalachia. Shame was found to influence seeking services, as well as family bonds and interpersonal relationships. Furthermore, data from the current study highlighted the importance of religious and faith-based beliefs in the region. These beliefs influenced the way clients viewed themselves, community values, and human development. The

study additionally touched on the lack of resources in rural communities, which was seen to influence adolescent development. Resilience building was mentioned as vital, and the way clinicians approached shame in substance use treatment was highlighted.

What emerges from the current study is the suggestion that substance use and shame may have a cyclical relationship with connection and belonging in the region. For some, the lack of connection may lead to substance use with its accompanying shame. Substance use drives behaviors that engender more shame. An individual's actions and shame together sever connections to family and to the community. Isolated individuals in recovery need to wade through shame to build a new community as part of their healing. These findings are discussed in more detail below.

**Impact of shame on connection and belonging.** Previous research found connection and belonging to be a crucial aspect of Appalachian society and culture. Relational style within communities of the region is described as personalistic, with great respect placed on interpersonal interactions, trust, solidarity, and intimacy (Helton & Keller, 2010; Kimweli & Stilwell, 2002). Additionally, the Appalachian region is considered to align with collectivistic cultures when compared to mainstream United States culture, as there is the focus on community and kinship bonds (Kimweli & Stilwell, 2002; Russ, 2010).

These cultural features were clear from the data and participants described the impact of these on their clients. Participants in the current study reported a link between level of rurality and client ability to openly discuss their concerns. Participants noted the strong adherence to the cultural values of clients in rural clinics, tying this to generations of tradition for some families and clients. As discussed previously, stigma and shame surrounding mental health concerns is present regardless of rurality level. However, participant data shows the impact of rural values on

shame and seeking services. This hesitancy to seek services may reflect an enhanced sensitivity to shame, leading to clients feeling uncomfortable bringing their concerns to a stranger because of the cultural boundary of keeping family interactions private. For those who participated in the current study's focus groups, clients felt judged when discussing a substance use concern. In more collective societies, clients are particularly prone to shame because of the way such cultures use it as a behavior regulating tool (Cole et al., 2006).

Moreover, results of the current study indicate the relationship between shame and connection were present with families and other loved ones. Strong familial bonds and tight-knit communities have been cited as influencing level of shame in rural Appalachia (Beachler et al., 2021; Goins et al., 2011). Participants spoke about their clients' difficulties when facing their families and communities while in active addiction and in recovery. They attributed these difficulties to the beliefs and cultural values of the region related to the importance of social connection. Participants reported clients' thought patterns were influenced by these beliefs. They referred to a negative sense of self emerging after trust was lost and damage was done to important social relationships as a result of active addiction. This link between concealing socially deemed shameful acts and losing family trust after engaging in such behaviors was prevalent for the participants' clients.

Culturally, Appalachian communities are known to be close. The current study's results further highlight the immense importance of this concept. As discussed previously, rebuilding community for an individual in recovery is a principal aspect of the recovery process. Participants in the current study noted the difficulties associated with rebuilding community in rural and small communities with few resources and fewer new faces. It is important to consider how a lack of resources impacts an individual in recovery who is rebuilding their community,

particularly in a region where community ties have been discussed as a fundamental aspect of life.

**Rurality and resources.** It was clear from discussion within the groups that lack of resources had an impact on Appalachian residents throughout their lives. The lack of opportunities and activities, combined with feelings of disconnection surrounding beliefs and religious affiliation, extended from adolescents to older clients. Non-religious adults felt this lack of fitting in through their recovery groups, which tended to be based on religious principles (e.g., the "higher power" in 12 Step groups). Not all clients belonged to a faith-based organization, resulting in a lack of community connection. This appeared to mirror the experience of younger clients who felt a similar disconnection between religion, substance use, and community.

Availability of extracurricular activities has been cited as a buffer against negative outcomes in youth. These types of activities help offset the risks that are present in communities with lower socioeconomic status (Shorter & Elledge, 2020). Indeed, connection with individuals outside of the caregiver home can provide protection against negative outcomes and build resilience for youth at risk (Shorter & Elledge, 2020). Lack of recreational activities was a topic discussed by participants. They highlighted the consequences of inadequate local funding for such activities; in rural Appalachia only religious or faith-based extracurricular opportunities exist. Participants relayed how youth from rural Appalachia felt they could only choose between belonging to a religious social group who does not use substances or to a non-religious group who uses them. In a way, the lack of resources creates a social dichotomy of religion or drugs. This choice is too narrow for the social needs of many youths.

This study's results showed the importance of finding strategies that fit with existing rural community systems in order to bypass heightened rural stigma. Shame was discussed as a

barrier to care for those living in Appalachia in an earlier section of this paper. This reality was attributed to cultural norms and beliefs surrounding privacy and trust of others. Integrating substance use treatment and mental health care into rural medical health care facilities has alleviated a portion of the stigma felt by clients. It has also increased access to care to rural communities (Smalley et al., 2010).

Our participants championed integrated care settings as providing additional safety and comfort for clients discussing substance use. They thought that team-based structural approaches created an open-door policy to care and helped clients self-disclose needs to providers. The influence of the clinic on community connections was addressed by participants as well. They spoke about the positive impact of having an established and trusted facility in the community, which could be a mechanism for change. Not only did having a trusted clinic provide clients with a safe environment to address their needs, but it also allowed for providers to be advocates. Providers mentioned advocating against stigma for mental health and substance use concerns as a potential impact of change.

Providers helped by tailoring treatment approaches to clients' needs, thus building resilience. Participants wanted to empower their clients, whether through psychoeducation or highlighting adaptive choices made in recovery. They built resilience through in-session conversations where counselors specifically affirmed examples of client resilience. Participants noted that the clients had been building the resiliency themselves, but it was through the counselors reflecting this back to them that clients were truly able to see themselves as resilient. Finally, participants highlighted the need to tailor their treatment plans or approaches to the population in order to offset clinics' high provider to client ratios. This seems to reflect the way interpersonal features of relationships are a vital part of life for clients for rural Appalachia.

**Role of religious values and beliefs.** Religious and faith-based beliefs have been highlighted as key parts of Appalachian culture, with 78% of the population utilizing prayer (Linscott et al., 2016). Although beliefs vary from person to person, religious affiliation tends be a central component of rural Appalachian communities. It provides routes to promote resilience and wellness as protective factors (Linscott et al., 2016). Participants in the current study noted the complex nature of religious beliefs and values for their clients. They reported these views influenced clients' perception of themselves and the way others perceived them as well. Participants listed beliefs endorsed by their clients about immorality, lacking willpower, weakness, and an inherent negative view of the inner self when breaching the norms. They connected this mentality to religious values, when describing the association between religious teachings, substance use, and an individual's character. Nevertheless, participants noted the possibility of positive aspects of religion in the area for their clients in recovery. There were healing and comforting characteristics mentioned by participants. Indeed, faith-based and religious beliefs have been found to be protective against the onset and relapse of substance use disorders (Kelly & Eddie, 2020). Because the Appalachian culture has such a strong faith base, a further understanding of its impact on substance use and substance use treatment for Appalachian individuals would be a useful addition to the literature.

## Connection to Shame Resilience Theory

There were multiple connections between the shame resilience theory (SRT) proposed by Brown (2006) and the results of the current study. Words used by participants in our study were similar to those used in Brown's SRT when discussing shame. In both instances, participants used terms to convey the intensity of the experience. Isolation was a theme discussed in SRT, particularly in terms of feeling disconnected from others. In both instances, this did not have to

be a physical disconnection, but a "psychological isolation" (Brown, 2006, p. 46) and general lack of connection to others that led to feeling isolated. An additional similarity is the way shame is perpetuated by media and cultural factors. Participants in Brown's study (2006) and in the current study both noted how societal expectations and media presence can influence experiences of shame. This was explained in a slightly different way between the studies given the focus of each, SRT's on women and the current study's on substance use. However, the theme of culture and media were present for both.

A final feature to mention is the focus on decreasing shame and increasing resilience in both studies. Participants mentioned connection to others as an important step in decreasing shame and developing resilience. Brown (2006) described how isolation can be lessened when there is connection with others. Furthermore, Brown (2006) stated connection helps to increase empathy and understanding for others. These findings are similar to those of participants in the current study, who discussed the importance of finding a new community in recovery and rediscovering life without substances.

**Limitations and Directions for Future Research**

It is important to remember that the focus of a qualitative study is on a specific population and culture. The sample of participants was drawn from those serving clients within rural, Central Appalachia, a region with a distinct population and culture. Although there may be some similarities to populations outside of Appalachia, these findings will have limited generalizability to the larger communities and other populations; they may not represent substance use treatment needs in the United States as a whole. Building on these studies findings with more quantitative methods such as surveys and questionnaires will further clarify the situation for substance use in rural areas.

There were limitations to this study that are important to discuss. One such limitation is the use of providers as the only source for data collection. The choice to limit data collection to those who provide mental health or addiction-based services was a conscious one, based on the overall research questions. Future research including a client perspective would help broaden knowledge and provide a more complete picture of the topic. Additionally, the study's sample size was small; although 12 individuals originally signed the informed consent and agreed to participate, data from 10 individuals in three focus groups was collected. Time constraints and difficulty in participant recruitment contributed to this. A larger sample would be beneficial for future studies to obtain more information about the topic.

Future research is needed to more fully understand how treatment can have the greatest impact and effectiveness in rural regions of Appalachia. The literature discussed earlier in this paper and data gathered throughout focus group findings has shown there are distinctive features of Appalachia that should be considered by a treatment provider, including shame and stigma in providing services, the role of religion, resource needs, and the way cultural views impact treatment and client needs. Future research should continue to explore the impact of shame on connection and belonging in the Appalachian region. The current study briefly touched on the topic; however, based on results and participant dialogue, more research is needed to fully understand the link between shame and belonging in rural Appalachia, particularly with regard to substance use.

As discussed previously, there are alarmingly high rates of substance misuse in the rural Appalachian region. To address this deadly situation, treatment providers must be best equipped to understand client needs and the most efficacious treatment options available. Integrated care and multidisciplinary teams were discussed throughout the focus groups as beneficial to client

care and as a route to decreasing shame. Continued research on these settings with an emphasis on reducing shame and substance use treatment would be a helpful addition to the literature and treatment options. Future research should additionally address treatment options in rural areas with low resource or funding availability and high substance misuse. Participant discussions highlighted the lack of funding and opportunities available for clients in the region. Continued understanding into the impacts of few resources and low funding would be a valuable area to explore.

# Chapter 2

# Literature Review

## Appalachia

Appalachia consists of 205,000 square miles (Thomas & Brossoie, 2019), covering an expansive area and housing a large population. The 420 counties included are a 42% rural population, compared to the United States population, which rests at 20% (Thompson et al., 2021). Although it is a substantial mass of land, the region typically is overlooked in areas of policy and research focused on substance use (Thornton & Deitz-Allyn, 2010). Most research and policies concentrate on urban areas, leaving rural areas, such as the majority of Appalachia, unrepresented (Thornton & Deitz-Allyn, 2010). The recent opioid epidemic, along with shrinking economic opportunities and jobs, an increase in poverty levels, and an overall reduction in quality of life in the last 50 years have begun to place more attention on rural areas (Hege et al., 2018). Whereas the emphasis has shifted, economic and health disparities continue to exist in the Central Appalachian region of Kentucky, Tennessee, Virginia, and West Virginia (Hall et al., 2008). These states are typically brought to mind as "Appalachia" for those outside the region (Schoenberg et al., 2015). Thompson et al. (2021) explained that those living in Appalachia have been found to die from preventable causes at younger ages, by as much as 25%. Appalachia has many distinctive qualities, as well as barriers to seeking services. Much of the information gathered through quantitative methods offers little awareness of the environment in which the people of Appalachia reside; and yet context is paramount when developing or ameliorating interventions that better fit their needs (Hege et al., 2018).

### *Cultural Aspects*

Rural areas cannot be placed into one category, as there are distinct cultural features for each (Goins et al., 2011). The lack of interaction with and trust of outsiders that accompanies such a topography promoted the highly esteemed beliefs of individualism and independence (Goins et al., 2011). Due to the isolation and a history of exploitation by coal or lumber companies with monopolies in many of its communities, those living in Appalachia may feel wary of those from outside the region, both individually and organizationally (Russ, 2010). Goins et al. (2011) stated the culture has been shaped by the land, with the "geographic solitude" of a mountainous area influencing strong familial bonds due to limited contact with others outside of the area and the need to help each other survive. Whereas the land is one source of community within Appalachia establishing unique cultural norms, it also garners profound attachment from its people who place great importance on locality (Gore et al., 2016). Land may be passed down through generations, with personal identity tightly tied to it (Russ, 2010). Family get-togethers occur on family land, and one may feel a sense of depression or anxiety from being unable to return if one has left the community (Russ, 2010).

Helton and Keller (2010) described the people of Appalachia as "personalistic, where great value is placed on respecting interpersonal relationships" (p. 153). Respecting interpersonal relationships extends to the community as well, by ensuring there is trust, intimacy, and solidarity at large (Kimweli & Stilwell, 2002). The authors stated that although Appalachia and the culture of the area are Western, the values within are different, with the region being described as an individualistic sub-collectivistic culture. Furthermore, they defined an individualistic sub-collectivistic culture as one that, while not fully collective, still "espouses collective ideals within an individualistic worldview" (Kimweli & Stilwell, 2002, p. 200). Russ (2010) also labeled Appalachian culture as collectivistic when compared with the individualistic

nature of mainstream American culture, with Appalachian personal identity more focused on community and kinship ties. Furthermore, the values of individualism and independence may mean that individuals in Appalachia wish to manage their emotional issues on their own, so as not to burden others or tax the strength of the community at large (Gore at al., 2016). Kimweli and Stilwell (2002) described how in Appalachian culture, what is good for the health of the community therefore becomes good for the health of the individual, and what may be individual mental health concerns can then impact the community at large. In such a communitarian culture, direct confrontation may be avoided, as it may interfere negatively with the overall operation of the community as a group (Russ, 2010). Helton and Keller (2010) illustrated this point further, discussing how individuals may exert major effort to avoid offending others, and place great value on facets of community such as neighborliness and humility.

Two aspects of culture that should not be dismissed are religion and spirituality, with 78% of the population in Appalachia utilizing prayer (Linscott et al., 2016). Religion and spirituality are salient aspects of communities and provide routes to promote resilience and wellness as protective factors (Linscott et al., 2016). In a study conducted by Linscott et al. (2016), members of a rural Appalachian community pronounced how spirituality provides positive impacts for physical and mental health, social engagement, community participation, and a way to maintain traditions. The importance of religion especially can be seen during times of grief and loss, as those from Appalachia may turn to prayer, scripture, worship services, religious figures, and support groups within their religious community as ways to work through feelings of loss (Houck, 2012). Appalachians value a religious upbringing; however, it is important to note spirituality and religious influence may vary depending on the individual

(Linscott et al., 2016). There are other facets of life in Appalachia that are vital to discuss as well.

### *Health and Socioeconomic Disparities*

Whereas there has been sparse attention and research concerning the Appalachian region, more recently researchers began to look more closely at this area of the United States to determine the unique challenges faced therein. Rural Appalachian residents are confronted with a variety of disparities. Indeed, when one considers the differences in health outcomes and the resources available, there are substantial inequalities between residents in urban areas and those in rural areas (Hege et al., 2018). Rural residents have longer travel times and poorer road conditions (Hill et al., 2016); there are substantial disparities in socioeconomic and health insurance statuses, and concerns surrounding privacy and trust (Hill et al., 2016). Linscott et al. (2016) further demonstrated this point, reporting 16.6% live in poverty in Appalachia, whereas 14.9% live in poverty in the United States on average.

Socioeconomic aspects are essential when evaluating accessibility of health services, with rural citizens being more likely to face unemployment and lack of employment-based insurance and transportation (Thornton & Deitz-Allyn, 2010). Other characteristics, such as minimal options for childcare, can also serve as a barrier to treatment (Shamblin et al., 2016). Many in the area have been forced to move away due to lack of employment possibilities, deteriorating the familial and community support systems that are important to those from Appalachia (Hall et al., 2008). Roberts et al. (2019) reported that in areas of health that can lead to earlier death or lack of access to care, such as healthcare coverage, access, and providers, rural Appalachia is consistently in one of the highest percentiles nationally. Indeed, the Appalachian Regional Commission found the area to underperform in 33 out of 41 indicators of health, in

addition to greater levels of heart disease, stroke, diabetes, chronic obstructive pulmonary disease, and suicide (Thompson et al., 2021). Other factors that may not be readily considered, such as cellphone and internet service, can also be restricted, unavailable, or unreliable in rural Appalachia (Roberts et al., 2019). Thompson et al. (2021) found long-term isolation to be linked with an increase in health concerns, such as rate of smoking, obesity, and high blood pressure, with these health issues leading to greater risk of death. Additionally, isolation can impact the ability for residents to obtain healthcare as communities may be in health professional shortage areas or in areas without a hospital. Thompson et al. (2021) discovered that 39% of counties lack an adequate number of primary care providers and 20% do not have access to a hospital.

The impact of socioeconomic conditions on health is particularly striking in the southwest Virginia region of Appalachia. Due to a loss of industries, such as coal and textiles, and lower levels of educational attainment, rural Appalachia has elevated unemployment levels (Thornton & Deitz-Allyn, 2010). Hall et al. (2008) reported poverty rates are twice the national average in the Central Appalachia region. Central Appalachia has premature death rates at 69% higher than the United States rate, and the rate across Appalachia as a whole is 40% higher (Thompson et al., 2021). Furthermore, the difficulties between corporations and those within communities has created distrust of outsiders and their intentions. With its 17 counties and four cities stretching from the Cumberland Gap to the New River Valley, southwest Virginia accounts for a large number of individuals in a financially distressed area (Thornton & Deitz-Allyn, 2010). When these types of systemic barriers are present, accessing needed health services can become more difficult or feel impossible.

## Mental Health Providers

### *Overview*

Whereas seeking treatment for substance use or mental health concerns is complicated by many factors, those factors influencing seeking treatment are especially noticeable for individuals living in rural Appalachia. These characteristics include aspects such as less access to providers, long travel distances to obtain services, providers who may not be trained in evidence-based treatments, and lack of trust in providers (Moody et al., 2017). Because 60% of rural residents live in areas with a limited number of mental health professionals, upwards of 65% of these individuals are seeking services for mental health concerns with their primary care providers (Thornton & Deitz-Allyn, 2010). Primary care and general practitioners see patients with notable mental health concerns, such as depression, anxiety, substance use, and intimate partner violence (Hill et al., 2016). These concerns represent a large portion of primary care appointments in Appalachia (Hill et al., 2016). Indeed, more than 25% of primary care patients meet the criteria for a minimum of one mental health concern and will address that concern with their primary care provider (Hill et al., 2016). Due to a lack of comfort with behavioral health or mental health topics, primary care providers may be reluctant, apprehensive, or anxious about discussing these concerns with their patients (Hill et al., 2016). With the number of mental health professionals 35% below the national average (Thomas & Brossoie, 2019), the need for the integration of behavioral health services is clear.

A study by Smalley et al. (2010) noted that more than 85% of federally designated Mental Health Professional Shortage Areas (MHPSA) are in rural areas, officially naming greatly decreased resources. A study conducted by Shamblin et al. (2016) confirmed Appalachia as a federally designated MHPSA, with a ratio of 1:3,333 mental health providers to community members. Furthermore, these MHPSA also indicate increased stigma surrounding seeking services due to lack of anonymity. Whereas these issues exist in rural communities, Smalley et

al. (2010) discussed how being an advocate for mental health resources and decreasing the stigma of mental health services can help rural clinicians better serve their clients. One such way to address the concern of access to resources is through integrated care, providing behavioral health services within a primary care setting (Smalley et al., 2010). Working together with medical professionals, mental health professionals can be a proponent for early intervention and behavioral health services in rural areas (Smalley et al., 2010). A thorough understanding of the cultural characteristics of the area can help providers better serve the community through behavioral health services.

### *Influence of Sociocultural Beliefs*

Mental health providers are tasked with finding interventions that both demonstrate cultural competence and maximize benefit given the significant barriers (Shamblin et al., 2016). For more effective work, Goins et al. (2011) proposed understanding the ways in which sociocultural beliefs influence the client population. The idea that seeking help for emotional/mental health problems "runs contrary to the 'do-it-yourself', or sometimes stoic approach to solving problems in rural settings" is one example of how sociocultural attitudes can influence client work (Gore et al., 2010, p. 64). The aspects of individual and communal health previously mentioned may also play a part in how clients view seeking services, particularly as individual mental health needs can become community mental health needs (Kimweli & Stilwell, 2002).

An understanding of community cohesiveness within Appalachian culture, as well as how belonging within the community is an adaptive aspect for well-being for clients in Appalachia, are crucial (Kimweli & Stilwell, 2002). Being in harmony with others around them, including family and the community, while also bolstering positive relationships has been shown to be

beneficial for well-being (Kimweli & Stilwell, 2002). Knowledge of research and client defined well-being can help aid mental health professionals in their client work. Shamblin et al. (2016) further discussed barriers and treatment aspects mental health professionals should be aware of, such as the need to veer away from typical trauma-informed care. Rural Appalachia has been described as "trauma-informed in the literal sense; their everyday realities are shaped by chronic economic hardship, pervasive psychosocial adversity, and fragmentation of services" (Shamblin et al., 2016, p. 190). Given this, for those working with clients, having an understanding of meeting basic needs and creating a working relationship with organizations, such as schools, would be beneficial (Shamblin et al., 2016).

Mental health professionals may encounter a lack of trust, as individuals prefer to rely on religious practices, their own healing customs, and other community-based choices as an alternative (Gore et al., 2010). Furthermore, Russ (2010) describes the idea of "cooperative independence." Due to the isolation of the region, those living in Appalachia have developed self-reliance, a closeness with family and those considered kin, and distrust of those outside of Appalachia. This skepticism of the Appalachian community may impact the ability for providers to connect with their clients (Russ, 2010). As personal endorsements by trusted figures within communities can prove powerful, mental health providers may wish to collaborate with local religious leaders (Linscott et al., 2016). Given the cultural significance placed on spirituality and religion, joining together with religious figures in Appalachian communities may help to decrease the concern potential clients may have with trusting someone they do not know (Linscott et al., 2016). This idea is one of many treatment considerations when working with clients from rural Appalachia.

### *Treatment Considerations*

Understanding how clients may perceive session structure is another important feature. As egalitarianism is a vital part of Appalachian culture, showing the client that you do not consider yourself superior, and instead consider them an equal, can help to build rapport (Russ, 2010). Russ (2010) described ways to convey these ideas to clients, from small instances of self-disclosure to engaging in small talk about the community, before beginning a session. Cultural awareness can be displayed through language use with clients from Appalachia as well. Certain phrases and words, such as the use of "nerves" to describe feelings of depression/anxiety/stress, are important to know (Russ, 2010). Language use in terms of directness is also a key piece of client work. Appalachian conversation is typically indirect and displaying directness may be seen as demanding or running against Appalachian cultural ways (Russ, 2010). Providers' lack of cultural awareness may also appear as stigmatized perceptions of clients. Provider beliefs that Appalachian "lifestyle is …simplistic and impoverished, and residents are … weak and uneducated" are barriers to effective treatment (Thomas & Brossoie, 2019, p. 92). Once clients have broken through the initial shame and fears of stigma in order to seek services, mental health providers' awareness of the culture of their clients is paramount. Whereas the previously mentioned challenge of gaining rapport with clients exists, it is nevertheless possible through consistent displays of trust, respect, loyalty, and honesty (Russ, 2010).

Higher levels of somatization and depression may be present, with physical symptoms such as headaches and backaches (Russ, 2010). Acknowledging the need for privacy and distrust of outsiders to the region that may accompany Appalachian clients provides mental health professionals with the information needed to better gain trust and progress (Russ, 2010). Nowhere is the ability of providers to convey non-stigmatizing attitudes to build strong rapport

more important than in the treatment of substance use, particularly so in areas where stigma is conveyed within the community (Victor et al., 2018).

A study examining treatment seeking behaviors of women in Kentucky by Snell-Rood et al. (2017) tackled the multitude of features mental health providers may encounter when working in rural Appalachia. Not only do women in rural communities such as Appalachia face almost twice the national average of mentally unwell days, they also have a cultural expectation to care for everyone other than themselves. As the main care-giver, they are unable to gain support from close relationships (Snell-Rood et al., 2017). When women finally attend mental health treatment, they describe a hesitation about seeking services. They do so when their own situation has become in some way no longer manageable, either due to abuse, inability to fulfill social requirements, family push, or extreme mental health concerns (Snell-Rood et al., 2017). The women interviewed described concern about stigma, difficulty attending appointments due to the location, and feeling as if their symptoms were interpreted as medical concerns (Snell-Rood et al., 2017). Snell-Rood et al. (2017) reported that some women experienced negative interactions with their mental health providers that furthered their feelings of hopelessness, while others had positive experiences that potentially were the turning points for them. The results of their study indicated that in an environment such as rural Appalachia, where the population is both more vulnerable and has fewer options, the quality of mental health providers is paramount to successful interventions (Snell-Rood et al., 2017). Quality of providers and treatment options are even more critical when considering how large the impact substance use has in Appalachia.

## Substance Use

### *Overview*

Substance use is a major concern for those living in rural Appalachia. Death by overdose has risen by 137% since 2000, and it is now considered a public health crisis in rural United States (Schalkoff et al., 2020; Victor et al., 2018). Rural residents are two times more likely to overdose on prescription medication than those living in non-rural areas (Click et al., 2018). Considering Williams et al.'s (2021) report, it is estimated 130 individuals die per day due to opioid overdose in the United States as a whole. Rural residents account for a larger percentage of those overdose deaths each day. Substance misuse has grown in the area at a constant pace over the last two decades (Moody et al., 2017). As substance misuse continues to grow, so have other health concerns that can be connected to substance use. Schalkoff et al. (2020) gave the example of hepatitis C (HCV), human immunodeficiency virus (HIV), and neo-natal abstinence syndrome, all of which have been linked to the increase in substance use and the opioid epidemic. In their article, the authors discussed results of a 2017 study examining injection drug use and HIV/HCV diagnoses, finding counties most susceptible to high cases were in rural Appalachia: Tennessee, West Virginia, Ohio, and Kentucky. Termed "diseases of despair," substance use and co-occurring conditions, such as cirrhosis and overdose, are reported to be higher in the Appalachian region (Thompson et al., 2021, p. 1016). These diseases of despair were found to occur 37% more in Appalachia than in other areas of the United States (Schalkoff et al., 2020).

Additional factors contribute to higher risk levels of substance use in the area. Central Appalachia has higher rates of unemployment, lower education levels, and higher rates of chronic pain from individuals who work, or have worked, as coal miners, loggers, and in other types of physical labor jobs. These individuals are vulnerable to sustain job-related injuries (Moody et al., 2017). Furthering this point, Shannon et al. (2014) reported higher levels of

chronic pain and disability connected to increased rates of prescribed opioid pain medications. Living in the coal-mining and mountain-top removal sections of rural, central Appalachia compounds the risk of developing a substance use disorder compared with those who are not living in the coalmining sections of rural Appalachia (Moody et al., 2017).

Inadequate finances and lack of education have been listed as possible contributors to higher levels of substance use. In Appalachian Kentucky, where 41 out of 54 counties are "economically distressed," poverty level correlates to the rate of substance use (Shannon et al., 2014). Due to the lack of regulation of prescription pain medication, along with the prescription drug companies' marketing to provide those experiencing workplace injuries with prescription medication, central Appalachia experienced a large increase in the availability of these medications (Moody et al., 2017). Perception surrounding the risks of different types of substances has been considered as well. People of Appalachia considered prescription drugs less risky when compared to other types of substances (Shannon et al., 2014). "Nerve pills," a colloquial term for sedative-type prescription medication, was given as an example of one type of substance use considered less risky than other forms of substance use (Shannon et al., 2014, p. 291). The perception of risk may be connected to a finding in a study by Schalkoff et al. (2020) in which death by overdose was found to be accidental in most cases, as well as due to a combination of prescription opioids, benzodiazepines, and/or antidepressants.

In the southwest Virginia part of central Appalachia, prescription medication use is of particular concern (Moody et al., 2017). This area, along with other areas in central Appalachia, has the highest use and overdose of prescription medications in the United States (Moody et al., 2017). Coupled with little health literacy involving substance misuse, the prescription rates for prescription pain medication are five to six times higher in rural Appalachia (Moody et al.,

2017). The prescribed rate for buprenorphine is 10 times higher in southwestern Virginia (Thomas & Brossoie, 2019). A study by Shannon et al. (2014) found, when compared to individuals living in non-Appalachian settings, those in rural Appalachia were 9.5 times more likely to have used an opioid and 10.2 times more likely to have used a benzodiazepine in a non-prescribed manner within the last 30 days.

Gender plays a role in substance use in rural Appalachia. Males reported significantly more lifetime and 30-day use of alcohol and many other substances, such as heroin, methamphetamine, crack cocaine, marijuana, and hallucinogens (Shannon et al., 2011). Males had an earlier initiation age into substance use, 13.6 years old, whereas females age of first use was 15.1 years old (Shannon et al., 2011). According to their research, differences in use between males and females was connected to certain rural cultural beliefs. The research showed that gendered stereotypes surrounding child-rearing and social stigma reduced their use of illegal drugs (Shannon et al., 2011). However, women were found to have higher rates of use of prescription opioid hydrocodone; other prescription substance misuse had few differences (Shannon et al., 2011). The authors additionally noted the impact of feeling powerless to be an active participant in your life and inability to access care as possible contributors to continued use.

Religion plays a part in the stigma surrounding treatment for substance use, as it may be seen as sinful or immoral within the religious community (Russ, 2010). Highlighting this point, Shannon et al. (2011) described the prevalence of alcohol use in the region even with the religious beliefs that exist regarding the negative consequences of alcohol use. For those attempting to access outpatient, short-term residential, or long-term residential treatment for

substance use in rural Appalachia, choices are few and far between, as there are consistently fewer treatment providers and facilities in the area than outside of it (Zhang et al., 2008).

### *Treatment Considerations*

A paucity exists in research of treatment methods within rural Appalachia that consider specific cultural and regional aspects of the population and substance use concerns. There is one study that addressed both substance use and child abuse and neglect in the region and that is the Hall study. Hall et al. (2008) examined a Sobriety Treatment and Recovery Teams model in a rural, central Appalachian community. Those who participated in the study experienced less placement in state custody, less child abuse and neglect recurrence, and the staff gained substantial training that they could theoretically utilize after the study was over (Hall et al., 2008. The same as in non-rural areas, Williams et al. (2021) pointed out that individuals who have experienced adverse childhood experiences, intimate partner violence, or sexual assault have much higher rates of behaviors that adversely impact health, such as substance misuse. Taken together, the Hall et al. (2008) study found that while creating new models of treatment in rural areas with little to no infrastructure highlights the barriers already in place, it is possible to have positive impacts within the community.

Pettigrew et al. (2012) examined substance use in rural Appalachia and adolescents. Adolescent substance use is associated with a variety of possible issues throughout the individual's lifespan, such as decreased school performance, injuries, accidents, mental health symptoms, and increased need for and higher cost of healthcare (Pettigrew et al., 2012). Their study found multiple environmental factors that can contribute to substance use in adolescence, providing a better understanding to inform current and future treatment avenues. Socioeconomic characteristics, including lack of extracurricular activities, low educational attainment, and high

unemployment, were listed as contributing factors to substance use in rural areas (Pettigrew et al., 2021). They concluded many individuals felt they had no other options than to engage in such activities given the lack of other available ventures. Pettigrew et al. (2012) found participants additionally endorsed a belief that obtaining substances was "easy" by being offered substances by family, friends, acquaintances, and even strangers (p. 539). Locations of use, such as outdoor "bush parties," was noted as a difference between rural and urban youth (Pettigrew et al., 2012, p. 542). The method of obtaining substances in rural areas did not list academic settings as a location substances were readily obtained, as has been found for youth in more urban areas (Pettigrew et al., 2012). The authors noted permissive use by caregivers at home was of concern in all regions for adolescents given the increased risk associated with such practices. However, Pettigrew et al. (2012) explained it is important to consider the family system and cultural aspects of rural Appalachia in their study. Many of the participants in their study mentioned concern about disrespecting a family member if they declined their offer whereas others endorsed feeling safe from substances because of family influence. This study highlights the importance of understanding the cultural, socioeconomic, and environmental characteristics of rural Appalachia for substance use treatment.

Shannon et al. (2014) discussed a multilevel approach to treatment through the use of drug recovery courts in Kentucky. Recovery court is "a human service program designed to provide treatment to individuals with substance abuse problems involved in the criminal justice system" and were created due to the large number of court cases with substance use and crime aspects (Shannon et al., 2014, p. 285). The authors continued to state recovery court involves judges, attorneys, parole officers, law enforcement officers, as well as mental health providers, social services, and substance use treatment providers to address the cyclical nature of substance

use and crime in a cooperative fashion. Not only does this enable collaboration between multiple providers, community safety officers, and the individual, it is an individualized and community-based approach with long-term care in mind (Shannon et al., 2014). Recovery courts are beneficial for participants and the community. The authors listed decreased recidivism as a major benefit, with rates down from 50% to 38% overall, in addition to decreased substance use. Further recovery court benefits listed include higher productivity and income, more stability, and less reliance on outpatient mental health services (Shannon et al., 2014).

A study by Schoenberg et al. (2015) shows the effectiveness of faith-based treatment. Schoenberg et al. (2015) looked at a smoking cessation program focused on tobacco use in a rural Kentucky population where residents were two times more likely to smoke than Americans overall. As previously stated, religion and spirituality can play a defining role in the lives of those living in the region, and participants viewed this religious aspect of the program favorably (Schoenberg et al., 2015). Participants reported feeling less stigmatized, with the location of the church providing spiritual support and trust, as well as positively viewing the aspect of bringing people to the church itself (Schoeberg et al., 2015). Schoenberg et al. (2015) reported participants feeling comfortable in a familiar religious institution, accepted, and appreciated the "values of love, compassion, and support" (p. 607). The study demonstrated that stigma, while it was not pushed forth by religious leaders themselves, was a deeply held internalized stigma felt by participants. The participants' trust of religious leaders and their advocacy engaged participants in the process of recovery (Schoenberg et al., 2015). Shame and stigma can be seen in this study as an aspect of substance use that has the ability to impact an individual's willingness and desire to seek help.

## Shame and Stigma

### *Overview*

Shame, or negative appraisals of the self, has the ability to prompt an individual to withdraw socially (Luoma et al., 2019). Shame is "experienced as an overwhelming assault on self-concept and identity" where "the primary means of assault are negative judgments, whether these judgments originate from others or from oneself" (Van Vliet, 2008, p. 237). Shame is distinct from guilt: Shame is a negative feeling involving the self that is in response to a shortcoming or wrongdoing, whereas guilt is a negative feeling about an event (Dearing et al., 2005). Whereas both emotions can be painful, feelings involving shame can be debilitating and lead to concerns in other aspects of life, such as substance use and low self-esteem (Dearing et al., 2005). Shame, when discussing its critical link to other aspects of life, has been called "the master emotion of everyday life" (Brown, 2006, p. 43).

According to Brown (2006), the concept of shame has been researched in connection to its role in self-esteem and self-concept, substance use, eating disorders, bullying, suicide, violence within the home, and sexual assault. Shame is linked to depression and withdrawal from social contact (Van Vliet, 2008). Shame causes feelings of worthlessness, inferiority, posttraumatic stress disorder, anxiety, substance use disorders, personality disorders, and suicide (Beduna & Perrone-McGovern, 2019). Shame is present in a variety of violent and/or abusive relationships as well. Irwin et al. (2019) stated shame can lead to future issues and is a persistent, strong emotional cue for the individual who experiences it. Additionally, shame stemming from previous violent or abusive situations can contribute to revictimization later in life. Irwin et al. (2019) studied the role of negative cognitions after a traumatic event, which may lead to attributional styles of self-blame and shame. The authors stated attributional styles with high

levels of shame and self-blame can contribute to environments with higher risks of revictimization. Not only is shame connected with a multitude of mental health concerns, but it is a primary emotion felt by clients, more so than anger or fear (Brown, 2006).

Hartling et al. (2000) illustrated the impact of shame further, stating that whereas individuals may deeply desire to connect with others, shame decreases their ability to have mutually empathic relationships. Those who experience shame can believe they deserve their feelings of shame, that they are "unworthy of connection" (Hartling et al., 2000, p. 3). Social isolation plays into lack of connection, as well as a sense of being exposed or overly seen by others during feelings of shame (Van Vliet, 2008). Even though those experiences of exposure may prompt an individual to escape or hide, the powerlessness associated with shame is overwhelming, leaving them stuck (Van Vliet, 2008). People experience isolation when they withdraw from social contact to avoid judgment or rejection, a behavior that has been previously mentioned as a response to shame (Van Vliet, 2008).

Aggression may be a response to the experience of shame. Men possibly feel more comfortable expressing aggression due to its cultural acceptance and relationship to masculinity (Gebhard et al., 2019). In their 2019 article, Gebhard et al. outlined the way in which aggression allows men to "bypass" feelings of shame (p. 429-430). They postulated that when an individual believes they should be experiencing shame and begin to feel the extremely negative features associated with it, they have the urge to hide, avoid, or push those feelings of shame onto others. By doing so, the shamed individual bypasses their feelings of shame and gains back the sense of control lost during the perceived shameful experience (Gebhard et al., 2019). Shame is an outcome of bullying. With bullying, shame is internalized as a coping mechanism (Beduna & Perrone-McGovern, 2019).

Multiple studies have considered the association between shame and traumatic events. Shame is listed within the DSM-5 due to its relevance in trauma symptomology (Schoenleber et al., 2021). Leonard et al. (2020) documented that posttraumatic symptom (PTS) will not develop in all who are survivors of traumatic events, but shame is one possible indicator of future PTS concerns. Shame is a "known predictor" of posttraumatic stress disorder and is thought to both hamper trauma processing as well as to keep PTS present (Leonard et al., 2020). It has been classified as a peritraumatic emotion due to its presence in the immediacy after a traumatic event, leading to negative self-appraisals and isolation behaviors after the event (Hood et al., 2020). Furthermore, higher levels of peritraumatic shame have been connected to more intense posttraumatic stress disorder symptomology (Hood et al., 2020). Stigma and shame are very closely tied, particularly the concept of self-stigma. Williams and Polaha (2014) described self-stigma as the shame and embarrassment components of personal beliefs about oneself. In this description, shame is a key component of stigma, linking the two concepts. Clement et al. (2015) listed several different types of stigma that can impact an individual's decision to seek help, such as internalized stigma, the way a person views themselves for seeking treatment, and treatment stigma, stigma that is associated with treatment for mental health concerns. Both internalized stigma and treatment stigma negatively impact the decision to seek services for mental health concerns (Clement et al., 2015). Therefore, the types of stigma found in the beliefs about mental illness and behavioral health can influence the seeking of services (Clement et al., 2015). Stigma influences seeking services in rural communities and can be a barrier for those needing treatment.

### *Theories of Shame and Stigma*

Many theories of shame and stigma have been proposed. Scheff (2000) examined multiple theories from a sociological and psychological lens. One of the first theories discussed in the Scheff article is by Cooley (1922), in which shame is seen as a "social emotion" wherein one is consistently monitoring the self (p. 88). This monitoring of the self is influenced by both actual interactions with others and perceived beliefs others hold about the individual (Scheff, 2000). Another sociological theory referenced in the Scheff (2000) article, by Lynd (1958), stated that although shame is kept hidden, it is seen throughout life. Furthermore, shame is described as a "weakness and dissolution of the self, even for the wish that the self would disappear" (Scheff, 2000, p. 92). However isolating an emotion shame is, the Scheff (2000) article summarized Lynd's finding that when the experience is shared, shame has the ability to nourish the bond between individuals.

A final feature discussed in Scheff (2000) was proposed by Lewis (1971), who noticed the large number of key words related to the shame-emotion in her research. Scheff (2000) described Lewis' findings, such as the social nature of shame and the inability to discuss shame directly or at all. Connecting shame to social structures proposed by Lewis is similar to the social features of shame discussed earlier in the Scheff (2000) article by Cooley (1922). It is of interest that Lewis reported shame as a topic hidden in conversation by both counselor and client; although present in sessions, the word shame was not specifically mentioned (Scheff, 2000). Scheff (2000) described Lewis' findings as showing client difficulty in naming shame as the emotion behind the experience in the room or client response of quickly moving topics as a way to deflect from the conversation around shame.

Wiechelt (2007) discussed theories of shame in relation to substance misuse. As described in their article, shame is present in various ways throughout the lives of individuals with substance use concerns and can even interfere with recovery. The concept of shame connects to "exposure of a flawed self." Whether this exposure occurs in an individual context or around many others, Weichelt (2007) stated shame is ultimately about the negativity one feels about the self (p. 400). Cultural features of society have also led to a tendency to hide shame. It is not an experience that is discussed or expressed regularly, leading to misunderstandings or difficulty in articulating it (Weichelt, 2007). Furthermore, shame is about feeling inferior. The author described how affect theory differentiates between how emotions are experienced. What is felt when shame is experienced is inferiority. This inferiority is expressed through physical behaviors like putting the head or eyes down (Weichelt, 2007). In some ways shame is thought to produce self-monitoring behavior in healthy ways. Individuals become aware of behavior that may need to be adjusted or limited (Weichelt, 2007). However, the article also stated that prolonged exposure to shame cues can become internalized and "part of the identity rather than a self-regulatory affect" (p. 401). The author elucidated that shame can then be experienced as an isolating, painful, and lonely state. Weichelt (2007) described shame in substance use as a cycle. Using a substance is found to dull the experience of pain or discomfort; the individual continues to use and discovers the need for increased use, developing a sense of increased shame as a result of the "loss of control," therefore using more of the substance to feed both the addiction and to further numb the shame and pain felt (p. 403). The incidence of shame is higher in those who misuse substances, and its presence contributes to higher rates of relapse and more difficulty in recovery (Weichelt, 2007).

### *Stigma in Rural Communities*

The stigma involved with mental health topics plays a part in the comfort level of individuals receiving services in Appalachia. Stigma is repeatedly listed as a barrier for rural community members seeking treatment for mental health related concerns (Williams & Polaha, 2014). Beachler et al. (2021) defined stigma as "a sociocultural phenomenon in which specific social groups are devalued, rejected, and excluded on the basis of a socially discredited health condition" (p. 30). They continued to explain stigma in rural areas as driven by close social connections, an environmental and social feature of the area. Within the rural communities of Appalachia, there are strong values of independence and self-reliance, which can cause individuals to not seek help and services for mental health and substance use concerns (Thornton & Deitz-Allyn, 2010). Shannon et al. (2014) stated not only can the value of self-reliance create difficulty in seeking services, but the distrust in mental health services and lack of anonymity in those services additionally impedes access to care. Fewer than 10% of treatment facilities for substance use concerns are located in rural areas, contributing to both lack of privacy and the need to seek care outside of one's known location (Shannon et al., 2014). Combining the values of self-reliance and independence with the lack of anonymity characteristic of small and rural communities intensifies concerns about stigma for individuals living in these areas (Hill et al., 2016).

The inclination toward independence in rural Appalachia, which can appear as a preference for self-reliance and stoicism, creates a reluctance to seek services (Williams & Polaha, 2014). It can also be seen as community members' attempts to maintain privacy. Privacy, fear of stigma, and the desire to avoid involving a fellow community member in their healthcare were all reasons listed by participants in a study by Thompson et al. (2021) regarding the health

of women in Appalachia. Hill et al. (2016) described how many individuals reported wanting to keep their mental health concerns hidden, feeling judged, or feeling "recognized publicly for something shameful or to be exposed as inferior and suffering a public loss of respect" (p. 86). These feelings of shame extend to substance use as well.

### *Shame in Substance Use*

Shame has been tied to substance use, particularly as a contributing factor to its use, and to the maintenance of substance use disorders (SUDs) (Hernandez & Mendoza, 2011). Beachler et al. (2021) reported addressing stigma as a barrier is a goal of the Substance Abuse and Mental Health Services Administration in lessening the amount of overdose from opioids. Dearing et al. (2005) related shame-proneness to substance use problems. Dearing et al. (2005) differentiated shame and guilt-proneness as two separate entities. Shame-prone individuals experience more focus on a "defective self" whereas those who are guilt-prone are "more inclined to take responsibility for their actions" and have better adaptive characteristics (Dearing et al., 2005, p. 2). Dearing et al. (2005) found that for individuals who are prone to shame and substance use issues, the experience of negative feelings creates a cycle of use and shame. It is important to note that those who are guilt-prone, not shame-prone, perhaps have a higher protective factor against developing substance use issues at a troublesome rate (Dearing et al., 2005). This finding is indicative of how shame is associated with substance use concerns (Dearing et al., 2005). The concepts of shame-proneness and guilt-proneness were discussed in Young et al. (2021), providing further evidence to the ideas proposed by Dearing et al. (2005). In their 2021 article, Young et al. defined shame-proneness as withdrawal and distancing behavior due to the negative feeling associated with what is believed to be a public wrongdoing, whereas guilt-proneness is the negative feeling and desire to repair relationships associated with what is believed to be a

private transgression. An important feature of shame and guilt noted by the authors is that they have behavioral aspects that can be shaped by cultural customs: Shame creates a withdrawal response whereas guilt creates an engage-to-repair response.

Wang et al. (2021) documented the effects of shame as higher amounts of depressive symptoms, lower incidences of seeking services related to SUDs, and more severe substance use. These effects have all been linked to experiences of prejudice and discrimination from trusted others, along with internalized shame associated with the negative stereotypes of SUDs. Furthering the assertions made in the 2021 article by Wang et al., Matsumoto et al. (2021) stated "stigma and discrimination negatively affect health outcomes, particularly mental health outcomes with effects such as elevated levels of symptoms associated with depression, general psychological distress, posttraumatic stress disorder (PSTD), and the use of substances" (p. 152).

There is a connection between PTSD and substance use, as they frequently co-occur with one another (Held et al., 2018). It has been reported that in their lifetimes, 52% of men and 28% of women with criteria for PTSD will additionally meet the criteria for alcohol use disorder, demonstrating the close relationship between the two issues (Held et al., 2018). Although an event is traumatic in and of itself, the aftermath may be just as traumatic. Held et al. (2018) discussed the development of PTSD, where the symptoms of flashbacks, nightmares, and shame are painful, thereby creating difficulty in one's recovery journey. Those who cope with trauma and shame symptoms through substance use may find fleeting relief followed by shame associated with the substance use, leaving the individual to cope with shame in addition to the trauma (Held et al., 2018).

For those actively using substances or in recovery from a SUD, experiencing stigma can be a regular factor in day-to-day life. SUDs have been cited as one of the most stigmatized

diagnoses throughout the world (Ashford et al., 2019). Stigma was one of the biggest barriers to treatment for substance use concerns listed by Jackson and Shannon (2012), as well as by Wang et al. (2021). Those interviewed in the study conducted by Jackson and Shannon (2012) described the shame and stigma felt as a fear of "being labeled a bad or fallen woman," with this fear being particularly strong in an environment where privacy is not guaranteed, such as rural Appalachian Kentucky (p. 1767).

The language surrounding SUD, shame, and stigma is powerful and word choice matters when discussing the topic of SUDs. In their 2019 article, Ashford et al. described how language used during discussions about substance use can impact stigma and bias. The authors stated that the chosen vocabulary used when discussing SUDs can perpetuate the stigma surrounding recovery and use, as well as increase negative bias towards those with a SUD. Stigma may also be perpetuated through lack of understanding surrounding etiology of substance use disorders. In their 2020 study, Beachler et al. reported this deficit of knowledge to be particularly true in opioid use disorder. The authors continued to state whereas opioid use disorder is oftentimes seen as a "moral failure, defect, or willing choice," it is more accurately described as a "chronic, relapsing brain disease" (p. 30).

Additionally, the negative impacts of stigmatizing language extend to those in recovery and those in active use, who refer to themselves as an "addict" (Ashford et al., 2019). Those who used less stigmatizing or non-stigmatizing language when discussing their recovery were found to experience less shame and stigma, have longer time periods in recovery, and have higher levels of flourishing in areas of well-being (Ashford et al., 2019). As shame and stigma have the ability to be such powerful negative forces for both individual and community health,

determining how it can be lessened holds great significance. Resilience, a powerful force in wellness, could be beneficial in decreasing feelings of shame and stigma.

**Resilience**

Resilience has been conceptualized in a variety of ways, such as the positive way in which someone adjusts following an adverse event (Thompson et al., 2018), or as a psychosocial variable involved in positively adapting after physical or psychological trauma (Sima et al., 2019). It can be thought of as the ability to "bend, but not break, and to bounce back from adversity" (Sippel et al., 2015, p. 1). Kuhar and Kocjan (2021) described theories of resilience as strength-based, with factors such as coping mechanisms, beliefs of self-efficacy, support systems, and other individual characteristics important to conceptualization. The authors stated resiliency is not only an inherent trait, but one that can be cultivated throughout the lifespan. Resilience is a protective factor against mental health concerns, such as posttraumatic stress disorder and adverse events (Thompson et al., 2018). Resilience combats somatic symptoms that can be associated with trauma-related experiences and other various mental health concerns (Kuhar & Kocjan, 2021). Characteristics of resilience, such as the ability to use more adaptive coping mechanisms and reach out to support systems, are thought to be a contributing factor in lessening the impact of somatic symptoms after traumatic experiences (Kuhar & Kocjan, 2021).

Resilience can exist at the individual, family, and community levels, with community resilience involving the overall wellness of the population (Sippel et al., 2015). Community level resilience requires trust, close connection between members, and strong leaders in place (Burke-Garcia et al., 2021). The authors noted this type of resilience has been valuable during large-scale, stressful events.

Family resilience is tied to the idea of social support and the timing and amount of support are very important for positive outcomes (Sippel et al., 2015). Additionally, resilience has been defined based on presenting concern and population. Individual resilience was noted for adults with physical health concerns based on their treatment adherence, activity level, and self-efficacy (Burke-Garcia et al., 2021). In another example provided by the authors, adults living with economic distress showed resilience when they utilized problem-solving skills and felt a sense of mastery. Support systems in the family or community were also beneficial. Resilience in Appalachia is unique in the way it is conceptualized, with particular nuances to the region.

### *Resilience in Appalachia*

In Appalachian culture particularly, resilience can be reinforced through spirituality (Linscott et al., 2016). Spirituality and religion in Appalachian culture are reflective of the closeness within communities, as many describe attending the same spiritual services for multiple generations, as well as the same religious institution as their community members (Linscott et al., 2016). Not only does spirituality provide support within the community, which can help to bolster resilience, but it also fosters support felt through a relationship with a higher power (Linscott et al., 2016). Individuals in rural Appalachia have reported comfort in the notion that “you’ve got somebody to take your troubles to” (Linscott et al., 2016, p. 103). Spirituality is beneficial during times of major adjustment, with those living in Appalachia noting the stability of their beliefs being distinctly useful (Linscott et al., 2016). Houck (2012) described how using religion to cope with stressful and grim circumstances is different from other managing techniques, in that the individual is using their own spiritual beliefs to make meaning in their lives through the experience. These features of resilience can play a part in treatment and how services are utilized.

### *Theories of Resilience*

**Resilience During Times of High Stress.** As will be discussed in the next section, community-level resilience has been found to be a valuable resource during widespread and stressful events. However, many of the ways in which resilience is cultivated have been difficult to find due to the infectious capabilities of COVID-19 (Burke-Garcia et al., 2021). For many, resilience is built on connection with others, whether through spiritual, family, or other community relationships (Burke-Garcia et al., 2021). Connecting with others has proven to be challenging during the pandemic, as individuals navigate isolation and quarantine. Not only has COVID-19 had incredible infectious capabilities, but it has also influenced finances and access to care.

Burke-Garcia et al. (2021) noted that finances and access to care are important to the concept of resilience. Access to care and the ability to utilize treatment options for mental and physical health are critical factors of life. However, those with preexisting health conditions and financial stress have found themselves at higher risk during the pandemic for depression and anxiety symptoms (Burke-Garcia et al., 2021). The authors explained that in the United States, depressive disorders rose by 400% between 2019 and 2020, with those in more vulnerable categories being significantly more likely to experience such symptoms. Inability to connect with support systems, poor access to resources due to job loss or health insurance loss, lack of childcare, and increased stress associated with fear of COVID exposure are among the variables listed as ways in which resilience is tested during high stress events. The study by Burke-Garcia et al. (2021) reflected the difficulty of maintaining or cultivating resilience during times of intense stress. However, the authors found shared themes in how participants of their study created strength. Many participants reported learning from past experiences of difficult times,

leaning on support systems, feeling part of their community by helping others, working toward a goal, and the support from religious and faith-based organizations as bolstering strength. Burke-Garcia et al. (2021) additionally found for those within the Spanish-speaking population, community service acts and family bonds both promoted resilience and affirmed cultural identity.

**Shame Resilience Theory.** Qualitative interviews, initially with women, involving shame and the impact of shame resulted in the shame resilience theory proposed by Dr. Brené Brown (Brown, 2006). Her work on SRT created a working definition of, and conceptual identity for, shame as well as describing the main concerns of those experiencing shame and the ways in which individuals can build up shame resilience (Brown, 2006). SRT defines shame as a very painful feeling individuals have of believing they are flawed and unworthy of acceptance or belonging. The main concerns are feelings of powerlessness, isolation, and being trapped (Brown, 2006). Brown (2006) illustrated powerlessness as the feeling that an individual is unable to act in a way that would offset shame or would have marked difficulty in behavior offsetting shame. Isolation was reported to be a result of being both trapped and powerless, particularly when individuals were disconnected. Whereas the feeling of being trapped was described as a feeling of "an unreasonable number of unrealistic expectations put upon them, but very few options in terms of meeting the expectations" (Brown, 2006, p. 46). Participants described shame in their own words, using terms such as "devastating, noxious, consuming, excruciating" and explained shame as a "flawed or bad self" (Brown, 2006, p. 45).

SRT discusses shame as a psycho-social-cultural construct due to the psychological, social, and cultural aspects involved (Brown, 2006). Brown (2006) characterized its psychological aspect in terms of the emotions, behaviors, and thoughts related to the individual;

the social aspect as the interpersonal component of shame; and the cultural aspect of the construct as the prominent expectations in culture and the shame related to the failure of meeting these expectations.

In order to develop and build shame resilience, individuals need to decrease the feelings of powerlessness, being trapped, and isolated while gaining connection, power, and freedom through the emotions, thoughts, and behaviors they experience (Brown, 2006). Brown (2006) asserted there are four facets to shame resilience that when combined help to decrease shame: being able to both recognize and accept vulnerability, becoming aware of sociocultural expectations, gaining mutual empathy and reaching out to others, and knowing the language surrounding shame to be able to discuss and deconstruct it.

SRT has been used among those with substance use issues as an intervention for recognizing shame, increasing the ability to reach out to others for empathy, and increasing the ability to ask for needs and express feelings (Hernandez & Mendoza, 2011). A study by Hernandez and Mendoza (2011) examined the utility of SRT as a treatment modality for substance use among women at residential treatment facilities in California. Their findings indicated lowered shame-induced self-talk and increased shame resilience, which were seen to be beneficial in combatting shame associated with substance use disorder (Hernandez & Mendoza, 2011). Hernandez and Mendoza (2011) reported SRT to be advantageous in treatment for shame as a component of substance use disorder and as an intervention in gender responsive treatment models. Using SRT interventions reduces levels of shame associated with substance use (Hernandez & Mendoza, 2011),

### *Resilience in Treatment*

Williams et al. (2021) described how personal resources can be a form of resilience. These internal or external sources can benefit treatment. The authors stated internal resources, such as coping skills, and external resources, such as support systems, are useful because they can be modified and worked with in or as interventions. A study by Kurtz et al. (2019) examined resilience factors in young adults who used substances and those with, and without, experiences of traumatic stress. Kurtz et al. (2019) reported those with higher resilience, as demonstrated by higher scores on measures of protective factors and lower scores on negative coping behaviors, had better outcomes on substance use measures than those with lower resilience level scores.

A study by Helton and Keller (2010) noted the specific factors that strengthen resilience in Appalachian women. Close kinship ties, humor/environment/religious support, bonds with neighbors, personalism, humility/modesty, and self-reliance/pride/independence increased resilience (Helton & Keller, 2010). Environment, characterized by feelings of connection and warmth to their home and land, and a belief that women were able to take care of themselves were identified in this study as examples of beneficial factors in strengthening resilience (Helton & Keller, 2010). Other factors described by Helton and Keller (2010), such as maintaining a lack of pretentiousness (i.e., humility) and the belief that personal relationships are paramount (i.e., personalism), are tied not only to resiliency, but also to the previously mentioned cultural aspects. The results of the study by Helton and Keller (2010) indicate that cultural values within Appalachian communities are consistent with building resiliency. Grant (2007) shared excerpts from her study on rural Appalachian women, the process of substance use and recovery, and how the women make meaning throughout it.

Grant (2007) described a “personal resilience” that was helpful in both continuing on the recovery journey and in the change process (p. 535). The women with whom she spoke used resilience in order to gain insight into their past, which in turn helped them in their current lives (Grant, 2007). Grant (2007) acknowledged a lack of many different resources in the area, but the study showed that the participants used the resources available to them from within their own cultural context and were their own “knowing agents” in the push for recovery (p. 536).

In areas such as rural Appalachia, where resources may be more limited, it is important to note the ways in which resilience can be improved through other methods (Roberts et al., 2019). There are protective factors within Appalachian culture and communities that can be used as a way to reinforce resilience (Roberts et al., 2019). Roberts et al. (2019) stated important cultural aspects such as self-reliance, fulfilling roles within the community, and spiritual well-being helping to build resilience, along with other protective factors such as gratitude or forgiveness that can be bolstered in community and social settings.

Sippel et al. (2015) identified community and social connections as resources for resilience, reporting that research indicates the well-being of one is tied to the well-being of others with whom one is socially tied. Both family and community level resilience has been identified as important for well-being, with both components contributing to strengthened social networks (Sippel et al., 2015). The importance of resilience can be seen, as well as its usefulness in learning how to resist shame and other negative outcomes.

# Chapter 3

## Method

It has been reported an estimated 130 million individuals die due to overdose of opioids in the United States each day (Williams et al., 2021), with those living in rural areas two times more likely to overdose on prescription medication (Click et al., 2018). However, even with these statistics, rural Appalachia has lagged behind other areas of the United States in addressing substance misuse (Thornton & Deitz-Allyn, 2010). The paucity of training programs and the inadequate number of practicing mental health providers in such areas further intensifies the need for competent care (Thomas & Brossoie, 2019). The present study utilized a qualitative approach to the perspectives of mental health providers in rural Appalachia.

## Project Design

The aim of this project was to obtain more information about the needs of clients in the Central Appalachian area; the study examined the way providers see shame impacting their clients with substance use concerns in rural Appalachia. Based on this research question, I used a qualitative research methodology. Qualitative research is "interested in understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences" (Merriam & Tisdell, 2017, p. 6). The qualitative data comes from the communication, both verbal and nonverbal, gathered throughout the research process that leads to a descriptive end product (Merriam & Tisdell, 2017). Given the focus on participant experience, I used thematic analysis with the information gathered. This type of analysis is often used in qualitative research and allows for detailed data that adheres to participant reported experiences and meaning (Braun & Clarke, 2006). Focus groups were the primary method of collecting data in this project, as they provided an avenue for gathering data in a qualitative form.

In Krueger and Casey (2009), the authors stated focus groups allow for individuals to discuss the topic with other individuals in a more natural environment, as well as allow for multiple opinions to be discussed at one time.

## Focus Groups

Conducted to obtain information about a specific topic, a focus group consists of individuals chosen due to the association they have to the topic at hand (Krueger & Casey, 2009). More than one focus group with multiple participants is needed in order to reach saturation. Data saturation has been described as the point when no other information can be gained or will produce change (Guest et al., 2016). In a study conducted by Guest et al. (2016), with groups of six to eight individuals, two to three focus groups reached 80% saturation, whereas three to six focus groups obtained 90% of the themes from a conducted focus group. Therefore, for this study, it was decided a total of nine to 15 participants were to be included to gain an understanding of how shame relates to substance abuse treatment in Appalachia. As shown in Guest et al. (2016), conducting three focus groups will ensure the collection of meaningful data and help achieve data saturation.

I held a total of three focus groups, each ranging from 45 to 60 minutes. However, as groups were held after or during work hours, they were conducted to fit the scheduling needs of participants.

Furthermore, the number of individuals in each group should be attended to. When considering focus group size, Holle et al. (2020) pointed out that it is important to maintain appropriate discussion and ensure participants feel safe sharing. Indeed, Holle et al. (2020) in their study found that too large a group left individuals feeling uncomfortable and made targeted discussions difficult. A total of four to six participants was originally determined to be the

appropriate number of participants for each focus group, as it allows for participants to be comfortable in the setting (Krueger & Casey, 2009). However, once focus groups moved to an online format because of COVID-19, it was decided that maintaining a small number of participants, three to five, was ideal for this type of facilitation (Nobrega et al., 2021).

## Setting of Focus Groups

When the project was originally planned, focus groups were to be held at locations convenient for participants, such as their work facility after work hours. These focus groups were to be held in-person, allowing for multiple members of the research team to be present during the groups as well. I would conduct the focus groups with the help of the research team leader, and one other member of the research team. Each person involved was going to have a separate role: leading the group, co-leading the group, and setting up the recording technology and taking notes. Another member of the team and I were primarily going to ask questions and redirect conversation as needed. The third team member was going to set up and maintain the recording technology, as well as take notes throughout. However, this plan was changed due to the COVID-19 pandemic and out of concern for the well-being of both participants and researchers.

## Use of Technology

The impact of COVID-19 in 2020 and 2021 cannot be ignored; its effects have been felt in most areas of our lives. As noted in Nobrega et al. (2021), the pandemic has limited our ability to work in-person, with research being no exception. The authors stated technology has become the primary mode of communication, impacting how research data is collected (p. 1). Given the necessity of social distancing during the pandemic, facilitating proper focus groups using technology became of even more importance.

Focus groups had been held virtually before the COVID-19 pandemic (Krueger & Casey, 2009). Using the telephone as the method of connecting when holding focus groups allowed for participants from different geographic regions to discuss topics, lower cost, and increased flexibility when compared to in-person methods (Krueger & Casey, 2009; Nobrega et al., 2021). However, the use of the telephone did not allow for visual or non-verbal cues, an issue virtual video conference on the internet could help alleviate (Nobrega et al., 2021). Using online video options could create a real-time interview, allowing for the inclusion of those non-verbal cues, which are beneficial in qualitative research (Nobrega et al., 2021). Nobrega et al. (2021) mentioned the other benefits to both participants and researchers include automated transcription and recording options, flexibility in terms of devices used to participate and location, and lower cost.

Although some aspects of virtual focus groups must be considered, such as poor reception, technical difficulties, and fewer non-verbal cues, there is evidence to suggest the data quality justifies its use (Nobrega et al., 2021). As discussed in their article, the amount of information shared during in-person interviews was "marginally better" whereas the number of topics discussed during video focus groups did not change (p. 2). Furthermore, the authors found that using Zoom decreased travel burden, enhanced flexibility, and participants felt comfortable sharing via such method.

Therefore, the study's focus groups were held virtually over Zoom to allow for social distancing. Participants were sent a password-protected link to a Zoom room specific to their focus group and were "admitted" into the room by the host. This process provided an extra layer of protection against un-invited individuals entering the Zoom room during the focus group. Holding the focus groups virtually provided the opportunity for me, as the researcher, to record

the groups in the moment, lessening the burden on the research team. As Zoom allows for audio/visual recording, I was also able to record the groups myself, take notes immediately after the groups concluded, and transcribe using the Zoom recording. As stated in the informed consent, all recordings were deleted once transcribed. Additionally, it was my hope that virtual focus groups would also decrease the burden on participants and allow for flexibility. Indeed, participants would be able to log in to the group from their current location without needing to commute to the location of an in-person group.

## Participants

Participants included in this study were mental health providers in rural Appalachia. They worked in either integrated care or community mental health settings. I contacted community health centers and mental health providers in Southwest Virginia and East Tennessee to gauge their interest in participating. Twelve providers initially agreed to participate in the groups, with 10 providers attending across the three groups. Six female and four male participants engaged in the study. The participants ranged in age from 24 to 64 years old. Participants were asked to list their provider credentials in addition to the number of years working with substance use concerns. Credentials varied throughout groups and participants: a peer specialist (1), doctors in psychology or internal medicine (5), a licensed clinical social worker (1), and a bachelor's in social work (1) were among those listed. The amount of time spent working with clients with substance use issues also varied, with four participants listing more than six years' experience, one participant listing between 4-6 years, one participant listing between 2-4 years, and two participants listing less than 2 years. Participants indicated multiple different training and work experiences, ranging from continuing education seminars, assessment, and experience in medication assisted treatment programs. One aspect of the demographic form assessed current

provider location and clients served; these questions garnered responses not only with zip codes, but also with information regarding how participants saw their work expanding to multiple counties. Participant location varied and the sample was split between providers who worked in rural areas (3) and those who served clients from rural areas (5).

Determining which community health centers and mental health providers to contact via personal invitation was based on the demographic characteristics relevant to this study. Rurality, location, and client population served were the main features considered when determining possible participants to invite. This process followed the process description provided in Merriam and Tisdell (2017). The authors stated selection of participants should be of a smaller number and chosen purposefully, in order to gain a more comprehensive understanding of participant experience. Krueger and Casey (2009) outlined steps for recruiting members from organizations that might be interested in participating. The authors stated the importance of thoroughly explaining the nature of the study, its relevance and helpfulness to the community in gaining participation from organizations. As the purpose of this study is to better understand relevant cultural aspects of the area and their interaction with shame in substance misuse, I too explained these aspects to prospective focus group members. The informed consent document and the recruitment scripts (Appendices A, B) both discussed these aspects.

## Instruments

### *Informed Consent*

The informed consent document was reviewed and signed by all participants before the focus groups were conducted. Group rules, such as confidentiality for clients and group members, were discussed before each group began. In addition, video and audio recording of the group did not begin until all members were present and had verbally agreed to being recorded.

Participants were told they were able to leave the Zoom room or refrain from answering a question if they were not comfortable at any point during the focus group.

### *Demographic Form*

Before the focus groups themselves began, participants were asked a few demographic questions (Appendix C). They were asked (a) their credentials as mental health providers or addictions counselors and their experience with substance use treatment and/or other training; (b) how they defined rurality, as well as the county and zip code for the area where they currently work; (c) if they currently work in a rural area and how long they have worked in a countryside setting; (d) duration of time they have worked with substance use clients; and (e) their age. In Central Appalachian states such as Virginia, West Virginia, and Tennessee, individuals are able to become Certified Substance Abuse Counselors, Alcohol and Drug Counselors, or Alcohol and Drug Abuse Counselors with varying levels of experience and education. Participants of varying credentials were included to obtain a fuller view of substance use concerns in rural areas, as different types of experiences would be able to be discussed. Participants were asked if they currently work in a rural area, as well as the county and zip code in which they worked, to ensure the participant sample indeed consisted of rural providers. Age, experience with substance use treatment and/or training, and length of work with substance use clients were asked to consider how these factors may influence a provider's technique with clients.

### *Focus Group Questions*

The content of the focus group discussions pertained to providers' experiences of the impact of shame for their clients dealing with substance misuse. Participants were asked to discuss broad questions surrounding how they have seen therapy clients with substance use disorder contend with shame. The questions served as a guide for the groups and allowed for

flexibility in terms of the order of the questions. Prompts were included if more detail was needed for the question or topic at hand. The questions and prompts were created by the research team as they prepared the study (Appendix D).

## Researcher as Instrument

In qualitative research, the researcher is considered one of the instruments for both collecting and analyzing data, and is able to "be immediately responsive and adaptive" as the data is gathered (Merriam & Tisdell, 2017, p. 16). The researcher can gain more comprehensive understanding of the information through exploration of responses, verbal and non-verbal cues, and processing data as it is given. However, Merriam and Tisdell stated that the use of the researcher in such a way means the lens with which the researcher views the world is included in gathering and processing information and includes their biases and subjective thinking present. Levitt et al. (2018) believed it is because of this feature of the process that qualitative research has a value of transparency throughout research proceedings. Indeed, they add that researchers should specifically outline their own connections to the work. This transparency helps maintain trustworthiness, as the reader can understand how the researcher's lens was present in the process and the ways in which it was managed. Following the guidelines in Levitt et al. (2018), I will provide an overview of my personal perspectives and experiences that are relevant to this research project.

I consider Appalachia my home, having lived in East Tennessee for 20 years and spent many of my formative years in the area. Growing up in rural Appalachia, I witnessed many of the topics discussed in the present study, particularly the growing opioid epidemic and lack of providers in the region. I saw how opioids impacted families, the systemic nature of substance misuse; I also noticed the way in which our local economy relied on many industries that are

associated with higher rates of opioid misuse. Over time, I mourned the members my community lost to overdose, a cause of death I believe could be prevented through treatment. Although it did not impact my family directly, watching the surrounding community struggle was impactful in its own way. My mother currently holds a position as a judge in the local Recovery Court, helping those with substance use concerns in their recovery journey.

These experiences have greatly influenced my desire to work in rural Appalachia, particularly with a focus on decreasing stigma around treatment for mental health and substance use through integrated care. I worked in a residential substance use facility during my Master's program; additionally, the curriculum at Radford University where I completed my doctoral training focused on rural care and social justice. Whereas this personal, academic, and professional involvement helped to create the lens through which I see the world and conduct research, it has also assisted me to understand the importance of listening to the experience of others. I firmly believe in respecting the autonomy and voice of other individuals; I believe this value I hold to be an asset in this current research project. Utilizing my research advisor, observing my own reactions, and discussing issues are they arose were additional ways in which I monitored myself and the process.

## Procedure

Approval from the Radford University Institutional Review Board was granted before any data collection began. Once approval was obtained, three focus groups were conducted, one each in August, September, and October of 2021 during the COVID-19 pandemic. All focus groups were held virtually over Zoom to maintain social distancing guidelines and lessen the burden on participants. Participants reviewed and signed the informed consent documents in person or via email prior to each focus group. Aspects of the informed consent document, such

as maintaining confidentiality and audio/visual recording, were briefly discussed with potential participants before each group began. Finally, each participant completed a demographic form, which was returned as a physical copy or through email.

I used the audio/visual recording feature offered through Zoom to tape each focus group. Participants were informed prior to recording beginning. I was present for, and conducted, each group using the questions listed previously as a progress guide as we talked through the topic. I allowed for flexibility in the groups, listening to the way conversations evolved to determine which question should be asked next or whether a prompt was needed. Focus groups were scheduled to fit in with participants' schedules, with each group lasting between 45-60 minutes. There was no compensation for participating in the group. Immediately following each group, I wrote down any observations or thoughts I had during the group. I also had a meeting with my advisor, Dr. Ruth Riding-Malon, after each group. In these meetings we discussed the group, my thoughts as I prepared and conducted the group, any issues that arose and my reactions to these, and finally my plan for the following group, if applicable.

## Analysis

Following the conclusion of each focus group, I began the analysis by looking for themes using thematic analysis. Once all focus groups were completed, themes were compared across all groups. Dr. Ruth Riding-Malon, a licensed clinical psychologist and professor at Radford University with several years of research experience, helped to review data and protect against bias by evaluating the themes presented.

Thematic analysis was chosen for the current study as a method for identifying and organizing themes found in the data gathered from the focus groups (Braun & Clarke, 2006). Themes and categories emerged from the analyses of the data gathered in all the transcripts of

the focus groups. The following process outlined by Braun and Clarke (2006) was used for data analysis:

*Phase 1:* In this phase, the researchers are to familiarize themselves with the data. A transcription of the recordings was completed concurrently while recording the focus group on Zoom. These transcripts were used to find themes discussed in each focus group. Accuracy of the transcription were checked by me after each focus group before each recording was deleted as discussed in the informed consent document.

Although I collected the data through the focus groups and have some prior knowledge, I read over any notes taken during the groups and immediately following the groups to remember any particular event and consider the general context surrounding each group.

*Phase 2:* Phase 2 is described as creating the first list of codes found in the data. These were the codes found when I initially looked at the data. Braun and Clarke (2006) stated writing down ideas as the work progresses can be helpful.

*Phase 3*: In this phase, I analyzed and combined the previously found codes into themes. By combining, I was able to consider any relationships that may exist between themes.

*Phase 4*: Next, I conferred with my auditor to determine which themes listed were approved by us both and thus should continue as themes, and which did not actually fit as themes or needed to be further combined. Both the auditor and myself helped analyze the data, contributed the codes and themes we found.

*Phase 5*: As themes are now better organized, the researcher can analyze data within themes once they are better understood. To understand each theme, Braun and Clarke (2006) suggested writing a detailed analysis of each.

*Phase 6*: The final phase involved the final analysis of the themes and writing the report that listed all the themes and described how they all work together. The final report was then concluded and finalized.

## Trustworthiness

My own background allows for a prior experiential understanding of the context of the topic and aspects of the study. Braun and Clarke (2006) stated one must recognize how one's own values and theoretical positions are connected to the research conducted, as researchers are active in the process of analyzing data. Therefore, acknowledging my own potential biases and outlining ways in which to guard against bias is beneficial.

Much of my passion for this study and desire to continue working in this particular area stems from my experiences in rural Appalachia. As previously stated, this can be a positive accompaniment to the research process, as it allows for increased background knowledge. However, it must also be monitored to ensure trustworthiness.

Additionally, Levitt et al. (2018) stated one should engage in self-reflection and understanding how one's own values influenced the research process. This step adds to the transparency of the research as well as builds trustworthiness (Levitt et al., 2018). I participated in this effort by writing down any thoughts, issues, or questions that arose immediately after each group. This exercise was a way for me to review the group, in addition to understanding the role I played in group dynamics. I discussed my thoughts and questions with my advisor, Dr. Ruth Riding-Malon, in our meetings following each focus group. Not only did this provide another viewpoint on each group, but it also helped guard against bias as we discussed my role.

There were other aspects of methodological integrity and trustworthiness I worked to maintain. Conducting a focus group comes with many different ethical considerations, such as

issues with consent, confidentiality, and harm avoidance (Sim & Waterfield, 2019). Focus groups have a unique issue involving disclosure; whereas participants are able to forgo answering a question, they have less say in what happens throughout the focus group with other participants and their responses (Sim & Waterfield, 2019). Withdrawal from the study is also an aspect that is typically considered more easily done in studies not utilizing a focus group. Indeed, removing data throughout a transcript and the act of physically leaving the group can both be difficult to manage (Sim & Waterfield, 2019). However, I made sure to inform participants they had the option of withdrawing either during or after the conclusion of the focus group without penalty. No participant took advantage of this option, even though it was offered.

Confidentiality and anonymity within the focus group are further topics that can create issues for participants. It is important to differentiate between the two words, as data will be kept anonymous, but not confidential as anonymous quotes from the focus group may be used (Sim & Waterfield, 2019). Considering risk of harm within focus groups is important as well, particularly if there is a breach of anonymity or the focus group is used in a way other than its original purpose (Sim & Waterfield, 2019). Sim and Waterfield (2019) stated the moderator may create group rules or work through any distress as it arises to help with risk of harm.

In the current study, the informed consent document outlined confidentiality for both clients and focus group participants. Group rules discussed before each focus group reviewed these topics. These aspects of consent, anonymity, and harm avoidance were particularly notable with the present study given the rurality of location, the participants, and the topic of discussion. As a lack of trust toward mental health providers may already be present in the community (Gore et al., 2010), ensuring that anonymity was maintained was vital for the participants to continue their work uninterrupted after the focus group. It was important for the lives they live within the

communities as well, where trust and intimacy in interpersonal relationships within the community are essential aspects (Kimweli & Stilwell, 2002).

Furthermore, the participants were mental health providers, meaning their adherence to the Health Insurance Portability and Accountability Act (HIPAA) needed to be maintained while discussing client work during the focus group. A breach of HIPAA could be considered a considerable harm to the client, as well as harm to the participant. Therefore, an essential group rule was to maintain HIPAA standards at all times during the focus group. Indeed, participants might, even unintentionally, repeat information heard from another participant in the focus group, thus breaking confidentiality. Because participants were mental health care providers who are held by their codes of ethics to protect client confidentiality, the risk of a naïve, inadvertent disclosure was considered lessened in these focus groups. Nevertheless, because adhering to HIPAA is an essential part of client work for all mental health professionals, a brief reminder to maintain confidentiality at the beginning of each group was considered important for client welfare and the integrity of the current study.

# Chapter 4

## Results

In this chapter, I review the results of the data analysis. This study explored the overarching theme of shame in individuals with substance use concerns in rural Appalachia. Questions asked of participants were based on theory, prior research, and clinical practice. Therefore, the categories below follow a similar format of the questions asked of participants. Apart from one theme, responses from participants aligned with the interview questions and the categories listed in the following sections. Please see Appendix E for a summary of themes.

### Demographic Information

Before the focus groups began, participants were asked demographic questions regarding (a) their credentials as mental health providers or addictions counselors and their experience with substance use treatment and/or other training; (b) how they defined rurality, as well as the county and zip in which they currently work; (c) if they currently work in a rural area and how long they have worked in a countryside setting; (d) duration of time worked with substance use clients; and (e) their age (see Appendix C). Twelve providers agreed to participate in the groups, with 10 providers ultimately attending across the three groups. Participants included in this study were mental health providers in rural Appalachia who worked in either integrated care or community mental health. Participants of varying credentials were included to obtain a more fully encompassed view of substance use concerns in rural areas, as more experiences would be able to be discussed. Credentials varied among participants and throughout the groups: a peer specialist (1), doctors in psychology or internal medicine (5), a licensed clinical social worker (1), and a bachelor’s in social work (1) were among those listed.

Although two participants did not return the demographic form, they did discuss their client experiences during the focus group. Participants disclosed that they currently worked in a rural area, as well as the county and zip code in which they worked, to ensure that the participant sample did indeed consist of rural providers. Participant location varied and the sample was split between providers who worked in rural areas (3) and those who served clients from rural areas (5). With those providers who did not work in rural clinics, many commented about the drive their clients made to the clinic from surrounding counties, indicating that they provide services to a wide range of clients in the area. Age, experience with substance use treatment and/or training, and length of work with substance use clients were collected to determine how these factors may influence a provider's technique with clients. There were female (6) and male (4) participants ranging in age from 24 to 64 years of age. The amount of time spent working with clients with substance use issues also varied. Four participants listed more than 6 years' experience, one participant listed between 4-6 years, one participant listed between 2-4 years, and two participants listed less than 2 years. Participants indicated multiple different training and work experiences. Four participants endorsed utilizing continuing education seminars, two participants had experiences in assessment of substance use, and two participants indicated formal training in substance use disorders. Almost all returned demographic forms (7) that indicated work experience in substance use, with four participants also endorsing experience with medication in the treatment of substance use. Finally, one participant reported "lived experience" for this demographic question, as their role involved peer recovery.

**How has shame impacted the actions of clients?**

When discussing how shame impacts the actions of clients, participants' responses fit into one theme: the hidden nature of shame. A participant's quote illustrates this theme in detail.

**Hidden nature of shame.** Many participants mentioned the hidden or concealing nature of substance misuse itself. Participants commented on the way clients initially sought help for their substance use. Clients only brought substance use up indirectly, if at all. In one group, participants talked about client substance use being a hidden concern during an initial medical visit unless the issue was brought up by the individual who referred the client, or through screening measures in an integrated care clinic. The shame and stigma associated with substance use is a barrier to care, as clients are hesitant to bring it up for fear of being judged or being assigned a certain label. One participant in the second focus group stated,

> I think a lot of why people don't bring it up themselves initially is by the time they get to us, they've had conversations like this with many other entities, being legal or primary care. And they're used to, I think, feeling judged and feeling labeled and are very hesitant to bring it up.

In these ways, even on the road to recovery, stigma and shame encouraged clients to be dishonest and contributed to their relapse. Thinking patterns of clients will be discussed in a later section of this paper. However, it is important to note the reasons clients gave the focus group participants for engaging in treatment.

**When we think about the clients coming to us and substance misuse, what is their most common presenting problem?**

The previous question elucidates the following two themes related to how shame impacts the actions of clients. Shame is seen in this data as interfering with clients' willingness or ability to self-disclose. The themes emerged from discussions surrounding common presenting concerns. These themes included help-seeking being never directly related to substance use and

the impact of emotions and substance use. In these themes, participants explored the interwoven features of shame and substance use. The themes are discussed in more detail below.

**Never directly related to substance use.** Even though substance use itself was often a main issue for clients, they very rarely disclosed that concern initially. Participants listed multiple reasons with legal, interpersonal, or medical being the top reasons an individual with substance use might initially seek help. Participants mentioned clients disclosing a variety of legal concerns, such as court-mandated treatment, child custody cases, or an issue related to a driving offense. Participants recorded frequently that stressors related to relationships with others was the reason for clients seeking treatment. Many of their clients reported negative effects of misuse on their relationships. For many participants, it was the overall impact of substance use on the lives of their clients that was most salient. The possible contributing factors to, and consequences of, substance use were discussed as primary reasons clients attended appointments. Seldom, if ever, would an individual explicitly state substance use itself was their reason for attending. One participant described this as, "I rarely see a person who comes in and says upfront, my biggest concern is my substance use…there's usually multiple problems that are both a product and a cause of substance use."

**Impact of emotions and substance use.** Participants deliberated about clients using substances to cope with mental or physical health concerns. They mentioned this self-treatment was particularly true when their clients dealt with depression and anxiety. As described by one participant, "…they (client) oftentimes will talk about that as [..] a way that they've coped with anxiety and depression. Although you wonder what which came first, you know?"

Participants reported clients speaking of using substances to self-treat medical conditions by inducing sleep or increasing energy. In these days when marijuana is going through various

stages of being deregulated or decriminalized in several adjoining states, including Virginia, participants in the second focus group mentioned the difficulty of managing marijuana for medical issues. One participant stated the topic was a "whole can of worms" while adding that clients themselves mentioned this conundrum.

**What type of words do clients use when describing experiences with shame related to substance misuse?**

This line of questioning began with a simple prompt: **Of the emotions your clients experience, would you agree that shame is one of them?**

Participants in all groups agreed that shame presented in their client populations. Other emotions participants described were all negative and similar to shame, such as guilt, embarrassment, fear, and stigma. Depression, anxiety, sadness, desperation, hopelessness, helplessness, and feeling overwhelmed were also discussed as emotions clients with substance use concerns present.

Not surprisingly, these word choices illustrated the impact of shame on the clients' thinking patterns and on their sense of self. Two themes emerged surrounding word choice, substance use, and shame. These included the impact of thinking patterns and clients' sense of self.

**Impact of thinking patterns**. A theme present throughout each group consisted of the impact of clients' thinking patterns, which providers saw in their self-talk. Self-talk is the way a person talks to and views the self. Participants addressed clients' beliefs surrounding the way others view the clients and the clients' word choices.

"All or nothing" or "black and white" thinking patterns were one feature of self-talk mentioned in all three groups. A participant in the second focus group gave an example of this

type of thinking, stating, "…I think …in the rural areas in Appalachia …there's a lot of all or nothing, black or white, good or bad thinking…You're either, you know, a good, non-drug using person or a bad, drug using person."

These types of thoughts were seen as contributing to the cycle of shame and substance use. Participants explained that clients perceived any actions or words in a negative way because of the shame. This type of thinking was further tied to the Appalachian region and cultural values. Participant three in group three described this cultural worldview: "I think in some ways…in the South we value […] our image and […] how is it going to look…shame could encourage us to not talk about it…gotta keep the status quo in our family and friends." Participants described patterns such as these as maladaptive and unhealthy in many contexts, but particularly so in substance use. They spoke about the role of thought patterns and family connection as well. Clients felt disconnected from family after being in active addiction or even while in early recovery and were unsure how to reconnect or earn back the trust lost. Participants described how for some, past actions felt insurmountable, and the shame associated contributed to the belief trust could not be regained with loved ones.

**Sense of self.** Starting with the overwhelmingly negative words used to describe their emotions, it is not surprising that participants explored clients' beliefs surrounding self-esteem and self-efficacy. Participants reported conversations around clients' lack of skill in areas such as socialization and problem solving; they even questioned whether clients' development matched that of others their age. Participants explained that clients seemed to lag behind their peers, in terms of jobs, family life, education, or other aspects of daily life. Participants explored how these differences stemmed from either their re-entry into society as a sober person or from the developmental delays associated with substance use. One participant noted that "… you stop

developing emotionally when you start using…you may have a 35-year-old who is emotionally 18." A final point made by participants was clients being unable to see their own resiliency and strength. Participants reported clients struggled to be kind to themselves and modify their good versus bad belief system.

**How does the environment of individuals affect views of shame?**

Three themes emerged within the category of how the environment impacts views of shame: broader cultural views of substance use, social environment factors, and characteristics of substance use.

**Broader cultural views of substance use**. A factor brought up in groups was the way in which rural Appalachian society views those who use substances. Participants in one group noted the systemic aspects of the United States' legal, healthcare, and general cultural are influenced by societal values. They reflected on the belief that those with a substance use disorder only deserve to be helped when they are willing to help themselves. Furthermore, they thought that our culture as a whole believes that substance use should be punished, instead of being treated as a chronic illness. One participant discussed the cultural divide between those who use and those who do not, and the attitude of those who do not use of looking down on those who do have a substance use concern. In describing this divide, participant one in group three stated many believe that substance misuse "is a moral failing, that … these people are beneath us." Even in certain recovery groups, such as Alcoholics Anonymous, participants talked of clients' reporting stigma. Clients who practiced harm reduction instead of abstinence from substances reported experiencing stigma within these recovery groups, demonstrating the way in which shame and stigma are present throughout society.

**Social environment factors.** Groups delved into the societal messages regarding shame and what is considered culturally appropriate. Rurality and clinic location were areas the groups explored. Participants hailed integrated care facilities that had a primary focus on treatment of substance misuse. They saw these integrated care clinics as safer places from the clients' point of view, and thus said clients were better able to combat shame by opening up and being vulnerable about their substance use. However, they described increased difficulty in confronting substance use in more rural areas where residents are more reserved about self-disclosure. Talking about shame, substance use, or other mental health concerns is not typically done openly in a rural culture and this was evident across groups. Participant one in group one highlighted this rural Appalachian cultural norm, when he stated, "[discussing trauma, substance use, mental health] …and learning how to sit with them and addressing that in the frame of shame. We don't talk about those things, you know, we're in the South…my grandparents didn't talk about that."

One group discussed the lack of funding in the region that blocks community opportunities and activities. This lack of activities pushes young people to experiment with substance use out of boredom. They said their adolescent and young adult clients describe only two social groups to which they can belong: those who use substances *OR* those who are religious and therefore do not use substances. Their younger clients who do not identify with either of these groups feel as if they do not fit in socially, nor do they have safe and fun social activities available to them. Participants thought this dichotomy was more pronounced in rural areas due to lack of funding for schools or community resources. One participant stated, "…more rural schools don't have the money to offer some of the things maybe a city school will offer…like art club…I can't think of a model UN being out here."

These feelings of not fitting in were not limited to adolescents, older clients reported similar feelings. Social disconnect was discussed in two contexts: religiosity and group belonging in recovery. In one group, a participant described the struggle with finding new social circles:

> …a lot of the people that I know, at least in the early stages of recovery, they don't go out because everybody knows them…I know people who can't go to the gas station…we all know people who have moved communities to… change playmates and playgrounds. And that's a really powerful thing, especially in our smaller communities. You know, …there can be really no escape.

Religious and faith-based beliefs of the region were listed as a powerful force for many clients, both in terms of belonging or exclusion. They expressed that using substances meant that you were an immoral person, you lacked willpower, were weak, and that something inside you was the problem. These messages became internalized, and similarly to the adolescent clients previously discussed, adults said the only options were to belong to the social group who uses substances or to a local church group. For those in recovery, one participant noted clients in intensive outpatient groups often spoke of the importance in recovery of finding a new social group and feeling connected to others.

**Characteristics of substance use.** There were noticeable differences between rural and urban settings that participants highlighted in terms of substances used and the perception of substance use by others. Differences in substances used were tied to socioeconomic status in the Appalachian region; certain substances (i.e., cocaine) were listed as too expensive for many to use regularly and therefore were not found in abundance. However, substances such as methamphetamine and opioids were more readily available in Appalachia.

Participants believed that substance use in rural Appalachia was fundamentally different from other areas of the United States. They added that the media perpetuated the belief in these differences. Participants noted that media sensationalized use and de-humanized individuals in general. One particular participant described his views of those who used substances stemming from the stereotypes prevalent in the media. He realized this view was not accurate once he began clinical work. As this participant described it, "…think about how our culture, just by looking at TV, sees substance use…and so many of these people are just, people, they're our grandmothers…they're just good folks."

**How have you seen clients overcome shame?**

Two themes were seen in the conversations surrounding clients' overcoming shame: connection with others and shame as a signal of resilience.

**Connection with others.** Participants in all groups mentioned the importance for their clients to connect with others to talk about shame. This connection could occur in a group setting, with peer recovery specialists, or in individual counseling. They believed that it was this connection with others that helped reduce shame. Participants reported clients finding acceptance and repairing relationships with others, reducing isolation, and understanding they were not alone. They explained that while in active addiction, clients were isolated from others, but that it was important for them to surround themselves with a sober community in recovery in order to move forward. Finding community and connection was essential for clients to no longer feel alone in their experience. Participants described the reduction in shame that occurred once clients recognized that others had similar experiences and they weren't alone in working toward recovery. Additionally, this affinity helped with the feeling reported by clients of being very

different, believing they could not fit in, or that they would not catch up to others in their age group. In group three, participant one described this feeling:

> I think that when a person is in active addiction they're kind of isolated. Not just socially, but mentally…Being in community with other people who are also working on recovery…that can be really helpful to help folks see that they're not the only person who has struggled with this.

Belonging to a recovery community helped clients reconnect with other parts of their lives as well. Participants discussed the use of intensive outpatient programs such as 12 Step groups. These groups helped the clients rebuild their ability to connect with others and themselves in fun and substance-free ways. The clients learned coping skills and sober lifestyle skills to use outside of the treatment environment from these groups.

Participants mentioned that certain clients isolated from others to protect themselves from a relapse. The providers had two different views of this isolation. For some clients, it was understandable that they might feel this way given the substance-ridden environment in which they lived. Even going to the store felt unsafe for these clients. However, participants reiterated the vital importance of a recovery community for their clients, even when the desire to isolate was strong.

Participants cited peer support programs as evidence for connection as an essential feature of recovery. They focused on the power of connecting with others, especially with those who had the unique perspective of being further along in their path of recovery. Participants discussed the importance of the work for those who provide peer support services. They saw this peer support as a testament to how far these clients, or former clients, have come in recovery.

Participants believed it was an example of the strength of their drive to help others and give back to their recovery community. As one participant stated,

> One thing that has impressed me with those who use substances is for those people who have overcome a lot of it. The incredible care they have for those who have used substances and the real desire to help you know, you just see people who are really involved…It's meant so much in their lives and how much they want to help others.

Offering this peer support itself is thus a part of their own recovery.

**Shame as a signal of resilience**. An additional feature of belonging discussed in the groups was the way shame may relate to the desire to connect with others. In some ways, participants saw feeling shame as evidence clients were still connected and caring, or valued connection and thus were seeking it for their lives. They saw shame as an aspect of resilience, because it meant that clients had not given up trying to reconnect with family and were continuing to move forward in recovery. Participants explained the following sequence: (a) clients lost touch with their loved ones because of negative behaviors, such as stealing from family; (b) clients felt shame; and (c) clients sought to repair the relationships. It was the desire to belong and connect with their loved ones that fueled feelings of shame. The participants thought this situation was evidence that clients valued connection to others, which was seen as a sign of resilience. Their evidence was the words and phrases clients used, phrases such as not giving up, and desiring to do better.

**Do you address shame in your work with clients?**

Finally, two themes emerged from participant discussion around addressing shame with clients. Types of work settings and approach to client care were present as themes.

**Types of work settings.** As mentioned in a previous section, rurality and clinic location can have an impact on clients' and providers' comfort levels with substance misuse topics. Participants spoke of the way shame connected to rural cultural values negatively impacting their clients' ability to feel safe opening up about their substance use. Because the types of clinics determined the different approaches to care, participants speculated how clinical settings seemed to influence the way patients reported and discussed their substance use behaviors.

Participants saw the various structural approaches that clinics use when providing services as important to client care overall, and particularly in the level of comfort individuals felt when discussing their concerns. An integrated, team-based approach was listed by two groups as making a difference in client care. Each group discussed this belief in slightly different ways. For participants in one group, integrated care meant primary care providers screening for substance use and an open-door policy for referrals. Participants wondered if choosing a primary care appointment might show that these patients care about their health in general, which would also lead them to caring about their substance use and mental health. Team-based clinic characteristics were deemed important in the third group as well, where participants thought being a part of a multidisciplinary team meant providers were constantly learning from one another. One participant discussed learning from other disciplines when doing a chart review before seeing a client. Furthermore, using an integrated care team meant clients knew the clinic could be a safe space. Participants discussed how clients would come to rely on shared communication. They hypothesized that if clients had a positive interaction with a provider when discussing a socially stigmatized concern, the clients would feel more comfortable knowing the other providers in the clinic would generally share this same approach. Participant two in group three gave an example:

> I think when we set the stage that way it makes them more comfortable in talking with us later on, when things come up around those issues…they know that [the clinic] has heard this before…I think that it's important to have a safe space where they know that they're not going to be judged and can talk about these things.

Another factor discussed in the clinic level interventions subtheme was the interaction between clinic and community. One group spoke about the power of being an established facility in the community, and the way this brings about trust in rural areas. The role of the facility in the community was an important factor in countering the stigma and shame that can exist at community levels. A participant in the first focus group noted,

> I find myself expressing that [non-judgmental stance] to other people in the larger community, that if you automatically look at somebody with addiction, that something's wrong with them, instead of that it's a disease that you have to work through; that broadens their horizons too…But I really feel like those environments don't just start in our therapeutic settings, but they're in the community.

The message of hope and healing that the facility sends to individual clients can be a model that is extended to the community. By meeting clients where they are and providing whole-person, non-judgmental care, the clinic is able to put forth a message of accepting all individuals, which participants noted brought relief to clients.

**Approach to client care.** Participants explored the role of counselors in decreasing shame and creating a safe therapeutic alliance. A safe therapeutic environment grew from the way counselors approached conversations and presented to clients, by extending acceptance and a non-judgmental attitude and ensuring clients' values were respected. Another participant in the

third group discussed maintaining respect and kindness when a client reported struggling in their recovery journey. The participant described this conversation with clients:

> I just try to commend everything big and small…I just commend the fact that they even came into the clinic…I do try to empower as I get resources to let them do as much as they can, and then again commend the fact that they took that step and they turned in that application and they applied for that job. And so, helping with little things and big things, and encouraging everything they do and trying to reinforce the positives more than focusing on the negatives.

Participants discussed validating the experiences of clients and giving credit when a client did make a choice not to use. This led into a conversation about resilience, as many participants saw resilience in their work with clients. Participants mentioned resilience being present whenever a client chose to avoid substance use or take a new step in that direction, even after a relapse. When discussing client progress and resilience, participant one in group one stated, "You [client] have a struggle on top of the average person…you're pushing harder and harder every day to get where other people are in life but you're trying to play catch up. You have to give yourself credit for where you are." This conversation showed the bidirectional process of building resilience. The client built resilience by taking steps and making different decisions. However, resilience was reinforced when the counselor pointed out these healthy changes, the progress, and the strength that resided in the client in order to make these decisions. Participants discussed how resilience is built through small steps in addition to the way counselors highlight these small steps to their clients. By celebrating client success and progress, clients reported that pride replaced the feeling of shame.

Providers were seen as holding many roles: being a support and a connector to resources, empowering clients, and providing individualized services that address current concerns. Participants discussed empowering clients in a variety of ways, one of which was providing psychoeducation on substance use and substance use disorders. They listed the following as important information that was beneficial for clients: (1) helping clients to understand the mind-body connection in substance use; (2) the neurological changes that stem from using substances; (3) the connection between mental health symptoms and substance use; and (4) the nature of substance use disorders as a chronic health concern. One group listed changing the view of substance use disorders to a chronic health concern as important in decreasing shame; they believed that it helped clients understand the difference between taking responsibility for the self and holding onto immense amounts of shame and self-blame.

Participants also spoke about interventions revolving around self-talk and helping clients modify their automatic thoughts associated with use. This process required an individualized approach, as each client had different needs and struggles. Providers described working to change the shame thought process by teaching clients to accept emotions without allowing the corresponding feelings to overtake them. They also mentioned using shame as a motivator for forward progress. Helping clients recognize the path they had previously taken, understand that substance use can be a coping skill, and learn new ways of coping were all listed by participants as interventions they employed. They explained that part of their clients' progress was learning how to sit with the uncomfortable nature of shame and to no longer allow it full control. They added highlighting the feelings of hopelessness and helplessness and acknowledging when clients took a different path toward addressing them as effective strategies for clients.

### Theme Based on Participant Discussion: Importance of Connection with Other Providers

In a parallel process to the one they encourage their clients to take, participants mentioned the importance of connecting with other counselors about their work. Participants listed these exchanges as an empowering, hopeful, and uplifting aspect of their work because they highlighted sharing the knowledge of others in the field. These interactions were particularly important given the disconnection in rural areas in general and during the pandemic, when less work was done in-person. Participants continued to discuss the importance of doing individualized work and tailoring evidence-based treatments, especially in rural clinics where there is large provider to client ratio and other rural-based implementation struggles (i.e., transportation for clients). In the third focus group, a participant described this process as "…it's bending and weaving. It's nuances and things that I don't even know that I could explain sometimes, and it's over a long term. It's usually long term, it's relationship-centered." For participants in this focus group, client work was focused on the therapeutic alliance and meeting the individual where they are, modifying evidence-based treatment to fit client needs, and following their gut instincts.

## Summary

This chapter included a description of the results of the thematic analysis. The data produced 13 themes. Themes showed shame to be a truly central aspect of substance use symptoms and substance use treatment. Shame influenced client self-talk and was found in the social environment of clients. Resilience was seen as able to help reduce shame through actions and interactions with others, particularly as one begins one's recovery journey.

# Chapter 5

## Discussion

Because there is a paucity of research on substance use treatment in rural Appalachia, this study's main goal was to explore substance use treatment among this population. In this chapter, I review the study's identified themes and subthemes in connection to the relevant literature. I consider the similarities and differences between the reports of my Appalachian participants and mainstream American substance misuse treatments. Once themes and previous research have been compared, I examine the limitations of the study. Finally, I conclude with implications for future research and clinical practice.

### Similarities Between the Current Study and the Literature

In this section I discuss the commonalities seen between the current data and the literature.

**Cyclical nature of shame, mental health, and substance use.** Not surprisingly given the focus of the study, the connection between shame and substance use was present across all three groups conducted. For many participants, this discussion revolved around the way shame and substance use together influenced an individual's comfort in disclosing current use when seeking help. The emotions their clients experienced, the consequences of their substance use, and contributing factors were recalled. This study provides support for the literature that describes a close interrelationship between substance use and shame. Kelly and Eddie (2020) described the cyclical relationship between shame and substance use as being the mixture between the chemical properties present in the substances and the inability to regulate the self that results in "harmful consequences…produce behavior incongruous with individuals' own moral code or values, which subsequently leads to remorse, guilt, and shame" (p. 117).

Furthermore, participants in the focus groups agreed with Black et al. (2013), who connected shame to clients' experiences of depression or anxiety.

**General experience of stigma in seeking services.** Shame was seen as a barrier to care for many, as participants noted the ways in which clients initially chose to hide or conceal their true needs. In the same way, Kenton et al. (2019) reported stigma is a common experience for those seeking services for mental health or physical health concerns. The authors stated that stigma acts as a barrier to clients' willingness to seek services in particular for mental health and substance use symptoms. Our study group's participants saw their clients reacting to shame and shame becoming a barrier. They explained that it began with clients feeling judged when discussing a substance use concern, and thereafter, those clients no longer disclosed use unless prompted by another individual or a screening measure in primary care. An article by Clement et al. (2015) detailed multiple types of stigma, such as stigma turned in toward the self and stigma felt from others, speaking to the experiences participants discussed in relation to their own clients. These types of shame were identified as barriers to seeking services by the authors and by our participants.

**Impact of shame on the relationship.** This theme will be discussed in connection to Appalachia and clients from the region in a later section. However, it is important to note the broader impact shame can have on relationships with self and others. Participants discussed how their clients endorsed thinking patterns that led to an overall negative sense of self and others. Participants' discussions surrounding these dichotomous, inflexible thinking patterns appear to fit what the literature describes in mainstream Americans. Black et al. (2013) described how shame impacts the thought process, stating it is a "self-conscious emotion that is characterized by…a desire to be unseen as well as a perception of being deeply flawed, incapable, and

unacceptable" (p. 646). Our study participants spoke of clients trying to hide by not volunteering information about their use or avoiding the topic even when seeking help from physicians in primary care. Furthermore, Black et al. (2013) stated shame creates a sense within the individual that they are unable to cope, and are seen by others as disgusting, someone to reject or to scorn. These descriptions echo the participants' discussions as to the way they witnessed shame impact the belief systems of their clients as well. They reported clients initially sought help for non-substance use issues and responded positively when treated in ways that countered the clients' own perception of being deeply flawed.

**Recovery needs.** Belonging was seen as a great need for people in recovery. Thus, participants listed finding a recovery community and learning to socialize as a sober individual as essential for their clients. Participants added that the skill of helping clients feel comfortable and re-engaging socially was beneficial. Boeri et al. (2016) stated that building community is an important part of recovery, particularly as the process can hold significant stigma. Additionally, the social capital inherent in relationships provides resources to those who, due to their current social status, otherwise would be without. Furthermore, healthy relationships ensure higher rates of sustained recovery from substances (Boeri et al., 2016). The authors attributed this success to the building of new social systems and the ability to avoid old, potentially negative, social ties.

**Broad societal views.** Finally, focus groups discussed societal views of substance use. Particularly relevant were the systemic impacts of those views on legal, healthcare, and the overall treatment of those with a substance use concern. Participants bemoaned the punitive attitude of society towards those who use substances, with one participant stating clients only receive help to the extent they are willing to help themselves. The general public additionally sees substance use as a moral failing, a concern that should be criminalized instead of treated as

chronic illness. These societal views are expressed in the often-punitive journey those who use substances endure through the criminal justice system. This idea is seen in the literature as well, as Shannon et al. (2014) reported criminal court cases for substance use have long overwhelmed court dockets (p. 285).

The social impact of a community working together can also be a power for redemption. A participant in the first group discussed the importance of recovery courts in giving clients a second chance instead of automatic punishment without the opportunity for treatment. Shannon et al. (2014) described how recovery courts emerged when individuals working within these systems began to note the overlap of substance misuse and criminal cases in their courtrooms. Drug courts were created as a way to "intervene with individuals in a nonadversarial manner to break the cycle of substance abuse, addiction, and crime" (Shannon et al., 2014, p. 285). These programs are community based and use a multidisciplinary team, composed of those within the justice system and mental health treatment providers (Shannon et al., 2014). The authors noted consistent benefits from utilizing recovery courts in communities, including a decrease in recidivism and substance use.

**Additions to the Current Literature**

Whereas the literature is teeming with studies focused on the topic of substance use, studies examining treatment for substance use in rural Appalachia remain rare. This exploratory study was designed to gain a better understanding of the relationship between shame and substance use in rural Appalachia. Shame was found to influence seeking services, as well as family bonds and interpersonal relationships. Furthermore, data from the current study highlighted the importance of religious and faith-based beliefs in the region. These beliefs influenced the way clients viewed themselves, community values, and human development. The

study additionally touched on the lack of resources in rural communities, which was seen to influence adolescent development. Resilience building was mentioned as vital, and the way clinicians approached shame in substance use treatment was highlighted.

What emerges from the current study is the suggestion that substance use and shame may have a cyclical relationship with connection and belonging in the region. For some, the lack of connection may lead to substance use with its accompanying shame. Substance use drives behaviors that engender more shame. An individual's actions and shame together sever connections to family and to the community. Isolated individuals in recovery need to wade through shame to build a new community as part of their healing. These findings are discussed in more detail below.

**Impact of shame on connection and belonging.** Previous research found connection and belonging to be a crucial aspect of Appalachian society and culture. Relational style within communities of the region is described as personalistic, with great respect placed on interpersonal interactions, trust, solidarity, and intimacy (Helton & Keller, 2010; Kimweli & Stilwell, 2002). Additionally, the Appalachian region is considered to align with collectivistic cultures when compared to mainstream United States culture, as there is the focus on community and kinship bonds (Kimweli & Stilwell, 2002; Russ, 2010).

These cultural features were clear from the data and participants described the impact of these on their clients. Participants in the current study reported a link between level of rurality and client ability to openly discuss their concerns. Participants noted the strong adherence to the cultural values of clients in rural clinics, tying this to generations of tradition for some families and clients. As discussed previously, stigma and shame surrounding mental health concerns is present regardless of rurality level. However, participant data shows the impact of rural values on

shame and seeking services. This hesitancy to seek services may reflect an enhanced sensitivity to shame leading to clients feeling uncomfortable bringing their concerns to a stranger because of the cultural boundary of keeping family interactions private. For those who participated in the current study's focus groups, clients felt judged when discussing a substance use concern. In more collective societies, clients are particularly prone to shame because of the way such cultures use it as a behavior regulating tool (Cole et al., 2006).

Moreover, results of the current study indicate the relationship between shame and connection were present with families and other loved ones. Strong familial bonds and tight-knit communities have been cited as influencing level of shame in rural Appalachia (Beachler et al., 2021; Goins et al., 2011). Participants spoke about their clients' difficulties when facing their families and communities while in active addiction and in recovery. They attributed these difficulties to the beliefs and cultural values of the region related to the importance of social connection. Participants reported client's thought patterns were influenced by these beliefs. They referred to a negative sense of self emerging after trust was lost and damage was done to important social relationships as a result of active addiction. This link between concealing socially deemed shameful acts and losing family trust after engaging in such behaviors was prevalent for the participants' clients.

Culturally, Appalachian communities are known to be close. The current study's results further highlight the immense importance of this concept. As discussed previously, rebuilding community for an individual in recovery is a principal aspect of the recovery process. Participants in the current study noted the difficulties associated with rebuilding community in rural and small communities with few resources and fewer new faces. It is important to consider how a lack of resources impacts an individual in recovery who is rebuilding their community,

particularly in a region where community ties have been discussed as a fundamental aspect of life.

**Rurality and resources.** It was clear from discussion within the groups that lack of resources had an impact on Appalachian residents throughout their lives. The lack of opportunities and activities, combined with feelings of disconnection surrounding beliefs and religious affiliation, extended from adolescents to older clients. Non-religious adults felt this lack of fitting in through their recovery groups, which tended to be based on religious principles (e.g., the "higher power" in 12 Step groups). Not all clients belonged to a faith-based organization, resulting in a lack of community connection. This appeared to mirror the experience of younger clients who felt a similar disconnection between religion, substance use, and community.

Availability of extracurricular activities has been cited as a buffer against negative outcomes in youth. These types of activities help offset the risks that are present in communities with lower socioeconomic status (Shorter & Elledge, 2020). Indeed, connection with individuals outside of the caregiver home can provide protection against negative outcomes and build resilience for youth at risk (Shorter & Elledge, 2020). Lack of recreational activities was a topic discussed by participants. They highlighted the consequences of inadequate local funding for such activities; in rural Appalachia only religious or faith-based extracurricular opportunities exist. Participants relayed how youth from rural Appalachia felt they could only choose between belonging to a religious social group who does not use substances or to a non-religious group who uses them. In a way, the lack of resources creates a social dichotomy of religion or drugs. This choice is too narrow for the social needs of many youths.

This study's results showed the importance of finding strategies that fit with existing rural community systems in order to bypass heightened rural stigma. Shame was discussed as a

barrier to care for those living in Appalachia in an earlier section of this paper. This reality was attributed to cultural norms and beliefs surrounding privacy and trust of others. Integrating substance use treatment and mental health care into rural medical health care facilities has alleviated a portion of the stigma felt by clients. It has also increased access to care to rural communities (Smalley et al., 2010).

Our participants championed integrated care settings as providing additional safety and comfort for clients discussing substance use. They thought that team-based structural approaches created an open-door policy to care and helped clients self-disclose needs to providers. The influence of the clinic on community connections was addressed by participants as well. They spoke about the positive impact of having an established and trusted facility in the community, which could be a mechanism for change. Not only did having a trusted clinic provide clients with a safe environment to address their needs, but it also allowed for providers to be advocates. Providers mentioned advocating against stigma for mental health and substance use concerns as a potential impact of change.

Providers helped by tailoring treatment approaches to clients' needs, thus building resilience. Participants wanted to empower their clients, whether through psychoeducation or highlighting adaptive choices made in recovery. They built resilience through in-session conversations where counselors specifically affirmed examples of client resilience. Participants noted that the clients had been building the resiliency themselves, but it was through the counselors reflecting this back to them that clients were truly able to see themselves as resilient. Finally, participants highlighted the need to tailor their treatment plans or approaches to the population in order to offset clinics' high provider to client ratios. This seems to reflect the way interpersonal features of relationships are a vital part of life for clients for rural Appalachia.

**Role of religious values and beliefs.** Religious and faith-based beliefs have been highlighted as key parts of Appalachian culture, with 78% of the population utilizing prayer (Linscott et al., 2016). Although beliefs vary from person to person, religious affiliation tends be a central component of rural Appalachian communities. It provides routes to promote resilience and wellness as protective factors (Linscott et al., 2016). Participants in the current study noted the complex nature of religious beliefs and values for their clients. They reported these views influenced clients' perception of themselves and the way others perceived them as well. Participants listed beliefs endorsed by their clients about immorality, lacking willpower, weakness, and an inherent negative view of the inner self when breaching the norms. They connected this mentality to religious values, when describing the association between religious teachings, substance use, and an individual's character. Nevertheless, participants noted the possibility of positive aspects of religion in the area for their clients in recovery. There were healing and comforting characteristics mentioned by participants. Indeed, faith-based and religious beliefs have been found to be protective against the onset and relapse of substance use disorders (Kelly & Eddie, 2020). Because the Appalachian culture has such a strong faith base, a further understanding of its impact on substance use and substance use treatment for Appalachian individuals would be a useful addition to the literature.

## Connection to Shame Resilience Theory

There were multiple connections between the shame resilience theory (SRT) proposed by Brown (2006) and the results of the current study. Words used by participants when discussing shame were similar in both studies. In SRT, Brown stated participants used words such as "devastating, rejected, small, and worst feeling ever" (p. 45). In the current study, participants used descriptor words such as fear, desperation, hopelessness, and feeling overwhelmed. In both

studies, participants used terms to convey the negative intensity of the experience. Isolation was a theme discussed in both studies, particularly in terms of feeling disconnected from others. In both studies, this did not have to be a physical disconnection, but a "psychological isolation" (Brown, 2006, p. 46) and general lack of connection to others that led to feeling isolated. An additional similarity is the way shame is perpetuated by media and cultural factors. Participants in Brown (2006) and in the current study both noted how societal expectations and media presence can influence experiences of shame. This experience was explained in slightly different ways between the studies given the focus of each, SRT on women and the current study on substance use. However, the theme of culture and media were present for both. Decreasing shame and increasing resilience was present in both studies as well. For participants, connection to others was mentioned as an important step in decreasing shame and developing resilience. Brown (2006) described how isolation can be lessened when there is a connection with others. Furthermore, Brown (2006) stated connection helps to increase empathy and understanding for others. These findings are similar to participant statements in the current study, who discussed the importance of finding a new community in recovery and rediscovering life without substances.

There were additional connections between the four facets of SRT and individual or group sessions, and 12 Step programs. Whether individual, group, or 12 Step, participants in the current study noted the way clients were open to the first facet of SRT, recognizing and accepting vulnerability. For those in 12 Steps groups, participants described how working through the 12 steps helped to confront shame and accept its presence. The steps themselves specifically addressed shame for participant clients. Twelve Step programs additionally addressed the second facet of SRT, awareness of sociocultural expectations. Participants spoke

about the way sociocultural aspects impacted their clients and their recovery journey. For those in the current study, it was surfaced through the legal, healthcare, and other cultural characteristics their clients faced. The third facet of SRT involved mutual empathy and reaching out, which was seen as clients were both working through the 12 steps and connecting with others to create their recovery community. By reaching out to others and finding connection, participants' clients found their own community and acceptance. Finally, the last facet of SRT, the ability to know and discuss the language surrounding shame, was seen as clients worked in individual, group, or 12 Step programs. Counselors within these settings helped their clients work through shame and openly discuss their experiences.

**Limitations and Directions for Future Research**

It is important to remember that the focus of a qualitative study is on a specific population and culture. The sample of participants was drawn from those serving clients within rural, Central Appalachia, a region with a distinct population and culture. Although there may be some similarities to populations outside of Appalachia, these findings will have limited generalizability to the larger communities and other populations. They may not represent substance use treatment needs in the United States as a whole. Building on this study's findings, more quantitative methods such as surveys and questionnaires will further clarify the situation for substance use in rural areas.

There were limitations to this study that are important to discuss. One such limitation is the use of providers as the only source for data collection. The choice to limit data collection to those who provide mental health or addiction-based services was a conscious one, based on the overall research questions. Future research including a client perspective would help broaden knowledge and provide a more complete picture of the topic. Additionally, the study's sample

size was small; although 12 individuals originally signed the informed consent and agreed to participate, data from 10 individuals in three focus groups was collected. Time constraints and difficulty in participant recruitment contributed to this data size. A larger sample would be beneficial for future studies to obtain more information about the topic.

Future research is needed to more fully understand how treatment can have the greatest impact and effectiveness in rural regions of Appalachia. The literature discussed earlier in this paper and data gathered throughout focus group findings has shown there are distinctive features of Appalachia that should be considered by a treatment provider. Treatment providers need to be cognizant of shame and stigma in providing services, the role of religion, resource needs, and the way cultural views impact treatment and client needs. Future research should continue to explore the impact of shame on connection and belonging in the Appalachian region. The current study briefly touched on the topic. However, based on results and participant dialogue, more research is needed to fully understand the link between shame and belonging in rural Appalachia, particularly with regard to substance use.

As discussed previously, there are alarmingly high rates of substance misuse in the rural Appalachian region. To address this deadly situation, treatment providers must be best equipped to understand client needs and the most efficacious treatment options available. Integrated care and multidisciplinary teams were discussed throughout the focus groups as beneficial to client care and as a route to decreasing shame. Continued research on these settings with an emphasis on reducing shame and substance use treatment would be a helpful addition to the literature and treatment options. Future research should additionally address treatment options in rural areas with low resource or funding availability and high substance misuse. Participant discussions highlighted the lack of funding and opportunities available for clients in the region. Continued

understanding into the impacts of few resources and low funding would be a valuable area to explore.

## Conclusion

The current study indicates shame impacts comfort in seeking services and in disclosing of needs for substance use issues in rural Appalachia. Additional concerns surrounding the impact of community and cultural norms, as well as lack of resources within the region were found to affect client care. Attention has previously been placed elsewhere, and only recently have structural changes to substance use care systems been created (Thornton & Deitz-Allyn, 2010). The results of this study demonstrate the need to continue to research these topics in this region of the world.

Cultural features of an area should be attended to, particularly as treatment for mental health is such a personal experience. Data from this study and the literature show that the relationship between clinician and patient is an extremely important aspect of the treatment regimen (Black et al., 2013). Providing services that are individualized to the population needs, such as integrated care, should continue to be considered. Future research that addresses cultural characteristics, as well as mental health and substance use needs, would be an important addition.

## References

Andraka-Christou, B., & Capone, M. J. (2018). A qualitative study comparing physician-reported barriers to treating addiction using buprenorphine and extended-release naltrexone in U.S. office-based practices. *International Journal of Drug Policy*, *54*, 9–17. https://doi.org/10.1016/j.drugpo.2017.11.021

Ashford, R., Brown, A., Ashford, A., & Curtis, B. (2019). Supplemental material for recovery dialects: A pilot study of stigmatizing and nonstigmatizing label use by individuals in recovery from substance use disorders. *Experimental and Clinical Psychopharmacology*, pha0000286.supp. https://doi.org/10.1037/pha0000286.supp

Beachler, T., Zeller, T. A., Heo, M., Lanzillotta-Rangeley, J., & Litwin, A. H. (2021). Community attitudes toward opioid use disorder and medication for opioid use disorder in a rural Appalachian county. *The Journal of Rural Health*, *37*(1), 29–34. https://doi.org/10.1111/jrh.12503

Beduna, K. N., & Perrone-McGovern, K. M. (2019). Recalled childhood bullying victimization and shame in adulthood: The influence of attachment security, self-compassion, and emotion regulation. *Traumatology*, *25*(1), 21–32. https://doi.org/10.1037/trm0000162

Berkout, O. V., & Gross, A. M. (2013). Externalizing behavior challenges within primary care settings. *Aggression and Violent Behavior*, *18*(5), 491–495. https://doi.org/10.1016/j.avb.2013.07.004

Black, R. S. A., Curran, D., & Dyer, K. F. W. (2013). The impact of shame on the therapeutic alliance and intimate relationships: Shame, therapeutic alliance, and intimate relationships. *Journal of Clinical Psychology*, *69*(6), 646–654. https://doi.org/10.1002/jclp.21959

Boeri, M., Gardner, M., Gerken, E., Ross, M., & Wheeler, J. (2016). “I don’t know what fun is”: Examining the intersection of social capital, social networks, and social recovery. *Drugs and Alcohol Today*, *16*(1), 95–105. https://doi.org/10.1108/DAT-08-2015-0046

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brown, B. (2006). Shame resilience theory: A grounded theory study on women and shame. *Families in Society: The Journal of Contemporary Social Services*, *87*(1), 43–52. https://doi.org/10.1606/1044-3894.3483

Burke-Garcia, A., Johnson-Turbes, A., Mitchell, E. W., Vallery Verlenden, J. M., Puddy, R., Mercado, M. C., Nelson, P., Rabinowitz, L., Xia, K., Wagstaff, L., Feng, M., Caicedo, L., & Tolbert, E. (2021). How right now? Supporting mental health and resilience amid COVID-19. *Traumatology*, *27*(4), 399–412. https://doi.org/10.1037/trm0000322

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*(1), 11–27. https://doi.org/10.1017/S0033291714000129

Click, I. A., Basden, J. A., Bohannon, J. M., Anderson, H., & Tudiver, F. (2018). Opioid prescribing in rural family practices: A qualitative study. *Substance Use & Misuse*, *53*(4), 533–540. https://doi.org/10.1080/10826084.2017.1342659

Cole, P. M., Tamang, B. L., & Shrestha, S. (2006). Cultural variations in the socialization of young children’s anger and shame. *Child Development*, *77*(5), 1237–1251. https://doi.org/10.1111/j.1467-8624.2006.00931.x

Dearing, R. L., Stuewig, J., & Tangney, J. P. (2005). On the importance of distinguishing shame from guilt: Relations to problematic alcohol and drug use. *Addictive Behaviors*, *30*(7), 1392–1404. https://doi.org/10.1016/j.addbeh.2005.02.002

Gebhard, K. T., Cattaneo, L. B., Tangney, J. P., Hargrove, S., & Shor, R. (2019). Threatened-masculinity shame-related responses among straight men: Measurement and relationship to aggression. *Psychology of Men & Masculinities*, *20*(3), 429–444. https://doi.org/10.1037/men0000177

Goins, R. T., Spencer, S. M., & Williams, K. (2011). Lay meanings of health among rural older adults in Appalachia: Lay meanings of health among rural older adults. *The Journal of Rural Health*, *27*(1), 13–20. https://doi.org/10.1111/j.1748-0361.2010.00315.x

Gore, J. S., Sheppard, A., Waters, M., Jackson, J., & Brubaker, R. (2016). Cultural differences in seeking mental health counseling: The role of symptom severity and type in Appalachian Kentucky. *Journal of Rural Mental Health*, *40*(1), 63–76. https://doi.org/10.1037/rmh0000041

Grant, J. (2007). Rural women's stories of recovery from addiction. *Addiction Research & Theory*, *15*(5), 521–541. https://doi.org/10.1080/16066350701284065

Guest, G., Namey, E., & McKenna, K. (2016). How many focus groups are enough? Building an evidence base for nonprobability sample sizes. *Field Methods*, *29*(1), 3–22. https://doi.org/10.1177/1525822x16639015

Hall, J. A., Smith, D. C., Easton, S. D., An, H., Williams, J. K., Godley, S. H., & Jang, M. (2008). Substance abuse treatment with rural adolescents: Issues and outcomes. *Journal of Psychoactive Drugs*, *40*(1), 109–120. https://doi.org/10.1080/02791072.2008.10399766

Hartling, L., Rosen, W., Walker, M., & Jordan, J. (2000). Shame and humiliation: From isolation to relational transformation. *Work in Progress-Wellesley Centers for Women, 88*, 1–16.

Hege, A., Ball, L., Christiana, R. W., Wallace, C., Hubbard, C., Truesdale, D., Hege, J., & Fleming, H. (2018). Social determinants of health and the effects on quality of life and well-being in 2 rural Appalachia communities: The community members' perspective and implications for health disparities. *Family & Community Health*, *41*(4), 244–254. https://doi.org/10.1097/FCH.0000000000000201

Held, P., Owens, G. P., Thomas, E. A., White, B. A., & Anderson, S. E. (2018). A pilot study of brief self-compassion training with individuals in substance use disorder treatment. *Traumatology*, *24*(3), 219–227. https://doi.org/10.1037/trm0000146

Helton, L. R., & Keller, S. M. (2010). Appalachian women: A study of resiliency assets and cultural values. *Journal of Social Service Research*, *36*(2), 151–161. https://doi.org/10.1080/01488370903578124

Hernandez, V. R., & Mendoza, C. T. (2011). Shame resilience: A strategy for empowering women in treatment for substance abuse. *Journal of Social Work Practice in the Addictions*, *11*(4), 375–393. https://doi.org/10.1080/1533256X.2011.622193

Hill, S. K., Cantrell, P., Edwards, J., & Dalton, W. (2016). Factors influencing mental health screening and treatment among women in a rural south central Appalachian primary care clinic: Mental health screening in rural primary care. *The Journal of Rural Health*, *32*(1), 82–91. https://doi.org/10.1111/jrh.12134

Holle, D., Teupen, S., Graf, R., Müller-Widmer, R., Reuther, S., Halek, M., & Roes, M. (2020). Process evaluation of the response of nursing homes to the implementation of the

dementia-specific case conference concept WELCOME-IdA: A qualitative study. *BMC Nursing, 19*(1). https://doi.org/10.1186/s12912-020-0403-6

Houck, J. (2012). Finding a voice: Affirming religious coping among disenfranchised Appalachians. *Journal of Appalachian Studies*, *18*(1), 189–204.

Irwin, A., Li, J., Craig, W., & Hollenstein, T. (2019). The role of shame in chronic peer victimization. *School Psychology, 34*(2), 178–186. https://doi.org/10.1037/spq0000280

Jackson, A., & Shannon, L. (2012). Barriers to receiving substance abuse treatment among rural pregnant women in Kentucky. *Maternal and Child Health Journal, 16*(9), 1762–1770. https://doi.org/10.1007/s10995-011-0923-5

Kelly, J. F., & Eddie, D. (2020). The role of spirituality and religiousness in aiding recovery from alcohol and other drug problems: An investigation in a national U.S. sample. *Psychology of Religion and Spirituality*, *12*(1), 116–123. https://doi.org/10.1037/rel0000295

Kenton, N., Broffman, L., Jones, K., Albrecht Mcmenamin, K., Weller, M., Brown, K., Currier, J., & Wright, B. (2019). Patient experiences in behavioral health integrated primary care settings: The role of stigma in shaping patient outcomes over time. *Psychology, Health & Medicine*, *24*(10), 1182–1197. https://doi.org/10.1080/13548506.2019.1595685

Kimweli, D., & Stilwell, W. (2002). Community subjective well-being, personality traits and quality of life therapy. *Social Indicators Research*, *60*, 193–225.

Krueger, R. A., & Casey, M. A. (2009). *Focus groups: A practical guide for applied research*. Sage Publications.

Kuhar, M., & Zager Kocjan, G. (2021). Adverse childhood experiences and somatic symptoms in adulthood: A moderated mediation effects of disturbed self-organization and resilient

coping. *Psychological Trauma: Theory, Research, Practice, and Policy*. https://doi.org/10.1037/tra0001040

Kurtz, S. P., Pagano, M. E., Buttram, M. E., & Ungar, M. (2019). Brief interventions for young adults who use drugs: The moderating effects of resilience and trauma. *Journal of Substance Abuse Treatment, 101,* 18–24. https://doi.org/10.1016/j.jsat.2019.03.009

Leonard, K. A., Ellis, R. A., & Orcutt, H. K. (2020). Experiential avoidance as a mediator in the relationship between shame and posttraumatic stress disorder: The effect of gender. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(6), 651–658. https://doi.org/10.1037/tra0000601

Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., & Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA Publications and Communications Board task force report. *American Psychologist, 73*(1), 26–46. https://doi.org/10.1037/amp0000151

Linscott, J., Randolph, A. L., & Mayle, T. (2016). The impact of spirituality on wellness for Appalachian older adults. *Adultspan Journal, 15*(2), 96–108. https://doi.org/10.1002/adsp.12024

Luoma, J. B., Chwyl, C., & Kaplan, J. (2019). Substance use and shame: A systematic and meta-analytic review. *Clinical Psychology Review, 70*, 1–12. https://doi.org/10.1016/j.cpr.2019.03.002

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

Matsumoto, A., Santelices, C., & Lincoln, A. K. (2021). Perceived stigma, discrimination and mental health among women in publicly funded substance abuse treatment. *Stigma and Health*, *6*(2), 151–162. https://doi.org/10.1037/sah0000226

Merriam, S. B., & Tisdell, E. J. (2017). *Qualitative research: A guide to design and implementation*. Langara College.

Moody, L. N., Satterwhite, E., & Bickel, W. K. (2017). Substance use in rural Central Appalachia: Current status and treatment considerations. *Journal of Rural Mental Health*, *41*(2), 123–135. https://doi.org/10.1037/rmh0000064

Nobrega, S., Ghaziri, M. E., Giacobbe, L., Rice, S., Punnett, L., & Edwards, K. (2021). Feasibility of virtual focus groups in program impact evaluation. *International Journal of Qualitative Methods*, *20.* https://doi.org/10.1177/16094069211019896

Pettigrew, J., Miller-Day, M., Krieger, J., & Hecht, M. L. (2012). The rural context of illicit substance offers: A study of Appalachian rural adolescents. *Journal of Adolescent Research*, *27*(4), 523–550. https://doi.org/10.1177/0743558411432639

Roberts, L., Banyard, V., Grych, J., & Hamby, S. (2019). Well-being in rural Appalachia: Age and gender patterns across five indicators. *Journal of Happiness Studies*, *20*(2), 391–410. https://doi.org/10.1007/s10902-017-9951-1

Russ, K. (2010). *Working with clients of Appalachian culture*. 11. http://counselingoutfitters.com/vistas/vistas10/Article_69.pdf

Salyers, K. M., & Ritchie, M. H. (2006). Multicultural counseling: An Appalachian perspective. *Journal of Multicultural Counseling and Development*, *34*(3), 130–142. https://doi.org/10.1002/j.2161-1912.2006.tb00033.x

Schalkoff, C. A., Lancaster, K. E., Gaynes, B. N., Wang, V., Pence, B. W., Miller, W. C., & Go, V. F. (2020). The opioid and related drug epidemics in rural Appalachia: A systematic review of populations affected, risk factors, and infectious diseases. *Substance Abuse, 41*(1), 35–69. https://doi.org/10.1080/08897077.2019.1635555

Scheff, T. J. (2000). Shame and the social bond: A sociological theory. *Sociological Theory, 18*(1), 84–99. https://doi.org/10.1111/0735-2751.00089

Schoenberg, N. E., Bundy, H. E., Baeker Bispo, J. A., Studts, C. R., Shelton, B. J., & Fields, N. (2015). A rural Appalachian faith-placed smoking cessation intervention. *Journal of Religion and Health, 54*(2), 598–611. https://doi.org/10.1007/s10943-014-9858-7

Schoenleber, M., Collins, A., & Berenbaum, H. (2021, March 4). Proneness for and aversion to self-conscious emotion in posttraumatic stress. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. http://dx.doi.org/10.1037/tra0001020

Shamblin, S., Graham, D., & Bianco, J. A. (2016). Creating trauma-informed schools for rural Appalachia: The partnerships program for enhancing resiliency, confidence and workforce development in early childhood education. *School Mental Health, 8*(1), 189–200. https://doi.org/10.1007/s12310-016-9181-4

Shannon, L. M., Havens, J. R., Mateyoke-Scrivner, A., & Walker, R. (2009). Contextual differences in substance use for rural Appalachian treatment-seeking women. *The American Journal of Drug and Alcohol Abuse, 35*(2), 59–62. https://doi.org/10.1080/00952990802441394

Shannon, L. M., Havens, J. R., Oser, C., Crosby, R., & Leukefeld, C. (2011). Examining gender differences in substance use and age of first use among rural Appalachian drug users in

Kentucky. *The American Journal of Drug and Alcohol Abuse*, *37*(2), 98–104. https://doi.org/10.3109/00952990.2010.540282

Shannon, L. M., Perkins, E. B., & Neal, C. (2014). Examining substance use among rural Appalachian and urban non-Appalachian individuals participating in drug court. *Substance Use & Misuse*, *49*(3), 285–294. https://doi.org/10.3109/10826084.2013.832326

Shorter, R. L., & Elledge, L. C. (2020). Family functioning and adjustment in Appalachian youth: Moderating role of extracurricular participation. *Journal of Child and Family Studies*, *29*(10), 2745–2758. https://doi.org/10.1007/s10826-020-01757-7

Sim, J., & Waterfield, J. (2019). Focus group methodology: Some ethical challenges. *Quality & Quantity*, *53*(6), 3003–3022. https://doi.org/10.1007/s11135-019-00914-5

Sima, A. P., Yu, H., Marwitz, J. H., Kolakowsky-Hayner, S. A., Felix, E. R., Bergquist, T. F., Whiteneck, G., Kreutzer, J. S., & Johnson-Greene, D. (2019). Outcome prediction from post-injury resilience in patients with TBI. *Rehabilitation Psychology*, *64*(3), 320–327. https://doi.org/10.1037/rep0000263

Sippel, L. M., Pietrzak, R. H., Charney, D. S., Mayes, L. C., & Southwick, S. M. (2015). How does social support enhance resilience in the trauma-exposed individual? *Ecology and Society*, *20*(4), art10. https://doi.org/10.5751/ES-07832-200410

Smalley, K. B., Yancey, C. T., 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*, *66*(5). https://doi.org/10.1002/jclp.20688

Snell-Rood, C., Hauenstein, E., Leukefeld, C., Feltner, F., Marcum, A., & Schoenberg, N. (2017). Mental health treatment seeking patterns and preferences of Appalachian women

with depression. *American Journal of Orthopsychiatry*, *87*(3), 233–241. https://doi.org/10.1037/ort0000193

Thomas, M. E., & Brossoie, N. (2019). Appalachia mental healthcare: An interpretative phenomenological analysis study to identify training program needs. *Journal of Rural Mental Health*, *43*(2–3), 91–102. https://doi.org/10.1037/rmh0000116

Thompson, J. R., Risser, L. R., Dunfee, M. N., Schoenberg, N. E., & Burke, J. G. (2021). Place, power, and premature mortality: A rapid scoping review on the health of women in Appalachia. *American Journal of Health Promotion*, *35*(7), 1015–1027. https://doi.org/10.1177/08901171211011388

Thompson, N. J., Fiorillo, D., Rothbaum, B. O., Ressler, K. J., & Michopoulos, V. (2018). Coping strategies as mediators in relation to resilience and posttraumatic stress disorder. *Journal of Affective Disorders*, *225*, 153–159. https://doi.org/10.1016/j.jad.2017.08.049

Thornton, G. B., & Deitz-Allyn, K. (2010). Substance abuse, unemployment problems, and the disparities in mental health services in the Appalachian southwest region. *Journal of Human Behavior in the Social Environment*, *20*(7), 939–951. https://doi.org/10.1080/10911359.2010.516690

Van Vliet, K. J. (2008). Shame and resilience in adulthood: A grounded theory study. *Journal of Counseling Psychology*, *55*(2), 233–245. https://doi.org/10.1037/0022-0167.55.2.233

Victor, G., Kheibari, A., Staton, M., & Oser, C. (2018). Appalachian women's use of substance abuse treatment: Examining the behavioral model for vulnerable populations. *Journal of Social Work Practice in the Addictions*, *18*(2), 192–213. https://doi.org/10.1080/1533256X.2018.1450264

Wang, K., Schick, M. R., Quinn, D. L., & Weiss, N. H. (2021). The role of emotion dysregulation in the association between substance use stigma and depressive symptoms among trauma-exposed, substance-using individuals. *Stigma and Health*. https://doi.org/10.1037/sah0000313

Wiechelt, S. A. (2007). The specter of shame in substance misuse. *Substance Use & Misuse*, *42*(2–3), 399–409. https://doi.org/10.1080/10826080601142196

Williams, J. R., Cole, V., Girdler, S. S., & Cromeens, M. G. (2021). Personal resource profiles of individuals with a history of interpersonal trauma and their impact on opioid misuse. *Psychological Trauma: Theory, Research, Practice, and Policy*, *14*(S1), S119–S130. https://doi.org/10.1037/tra0001089

Williams, S. L., & Polaha, J. (2014). Rural parents' perceived stigma of seeking mental health services for their children: Development and evaluation of a new instrument. *Psychological Assessment*, *26*(3), 763–773. https://doi.org/10.1037/a0036571

Young, I., Razavi, P., Cohen, T., Yang, Q., Alabernia-Segura, M., & Sullivan, D. (2021). Supplemental material for a multidimensional approach to the relationship between individualism-collectivism and guilt and shame. *Emotion*, *21*(1), 108–122. https://doi.org/10.1037/emo0000689.supp

Zhang, Z., Infante, A., Meit, M., English, N., Dunn, M., & Bowers, K. (2008). *An analysis of mental health and substance abuse disparities & access to treatment services in the Appalachian region* (Final Report; p. 305). National Opinion Research Center and East Tennessee State University. https://www.arc.gov/wp-content/uploads/2020/06/AnalysisofMentalHealthandSubstanceAbuseDisparities.pdf

## Appendix A: Phone and Email Invitation Script

Hi, my name is Rebecca Assadnia and I am in the Counseling Psychology doctoral program at Radford University. I am currently in the process of completing my dissertation researching the role of shame in substance use treatment in rural Appalachia. As a substance use treatment provider in the area, I am wondering if you would be interested in participating in a focus group to better understand how shame impacts substance use in rural Appalachia. I believe obtaining a substance use providers viewpoint is beneficial to client care.

If you choose to participate, the focus group would consist of other substance use treatment providers such as yourself and would last 60-90 minutes total. You would only be asked to participate in one focus group. The focus group would be conducted through Zoom and be password protected and HIPAA-compliant. All focus group members would be asked to respect the privacy of other group members, as well as to follow mandated HIPAA guidelines to respect client privacy.

If you are interested in this opportunity, I can send the informed consent document for the research project and discuss scheduling. Additionally, please let us know if you are aware of other substance use treatment providers who you believe would be interested in participating. We are interested gathering many perspectives from this area.

# Appendix B: Zoom Script

Hello,

Thank you for participating in today's focus group. Below you will find a link to the password protected, HIPAA-compliant Zoom room set up for the focus group. Please contact the focus group facilitator through email or phone at rassadnia@radford.edu or 423.492.3675 if you have any trouble accessing the Zoom room.

Thank you,

Rebecca Assadnia

*Zoom Link*

# Appendix C: Demographic Survey

**Response to the following questions is optional.**

What are your credentials as a mental health provider or as an addictions' counselor?

___PsyD, PhD

___LMHC, LCSW

___Certified Substance Abuse Counselor, Alcohol and Drug Counselor, etc.

___LPC

___Other; please list.

Please describe the type of training and/or experience you have had working in substance use in the space below:

Please describe how you define rurality in the space below:

What zip code and county do you currently work in?

_____

Do you currently work in a rural setting? If so, for how long?

___Yes Duration: _____

___No

How long have you worked with clients with substance use concerns?

___0-2 years

___2-4 years

___4-6 years

___6+ years

What is your age?

_____

# Appendix D: Focus Group Questions

This focus group is about your perceptions of the experiences of clients dealing with substance misuse, all the questions we will explore surround clients dealing with substance misuse.

1. When we think about the clients coming to us and substance misuse, what is their most common presenting problem?
    a. Prompt: What emotions tend to underlie that concern?

2. Of the emotions your clients experience, would you agree that shame is one of them?
    a. Prompt: How has shame impacted client substance use?

3. What type of words do clients use when describing experiences with shame related to substance misuse?
    a. Prompt: How have you seen shame influence the self-talk of clients?

4. How has shame impacted the actions of clients?

5. How does the environment of individuals affect views of shame?
    a. Prompt: How do values affect views of shame?

6. How have you seen clients overcome shame?
    a. Prompt: How does it relate to resilience?

7. Do you address shame in your work with clients?
    a. Prompt: If so, how?

Appendix E: Interview Themes

**Research Question: How has shame impacted the actions of clients?**

*Hidden Nature of Shame*

-Reluctance to bring up substance use (may be brought up by screeners or another party)

-Worry of being judged or labeled (barrier to care)

**Research Question: When we think about the clients coming to us and substance misuse, what is their most common presenting problem?**

*Never Directly for Substance Use*

-Legal pressures-child custody, court mandated treatment

-Interpersonal issues-between family or other loved ones impacted by client substance use

-Medical stressors-client health negatively impacted by substance use (screeners)

*Impact of Emotions and Substance Use*

-Using substances to cope with mental health or physical health issues

-Substance use as a way to induce sleep or increase energy

**Research Question: Of the emotions your clients experience, would you agree that shame is one of them?**

*Descriptors of Emotions Experienced*

-Shame, guilt, stigma, embarrassment, fear

-Depression, anxiety, sadness

-Desperation, helplessness and hopelessness, overwhelmed

**Research Question: Research Question: What type of words do clients use when describing experiences with shame related to substance misuse?**

*Impact of Thinking Patterns*

-Negative self-talk (black and white thinking, all or nothing thought patterns)

-Thinking patterns perpetuating cycle of substance use

-Role of thought patterns and connection with others

*Sense of Self*

-Developmental differences and skill level (between those who have used substances and those who have not)

-Connection and belonging (prev. comfort in socializing or re-entering society without substances)

(comes from environment)

**Research Question: How does the environment of individuals affect views of shame?**

*Broader Cultural Views of Substance Use*

-Legal, healthcare, and cultural processes influenced by beliefs

-Moral failing versus chronic disease

*Social Environment Factors*

-rural culture values

-Role of religious and faith-based beliefs and values

-Lack of resources for youth activities

*Characteristics of Substance Use*

-Types of substances used

-Perception of substance use influenced by media

**Research Question: Research Question: How have you seen clients overcome shame?**

*Connection with Others*

-Connection helped clients find acceptance and understanding

-Reduced isolation and helped to build a sober community

-Learning to have fun in a sober environment

*Shame as Resilience*

-Experiencing shame was an indicator for caring and connection to others

**Research Question: Do you address shame in your work with clients?**

*Types of Work Settings*

-Rurality and clinic location

-Clinic settings and approaches to care had impacts on shame (multidisciplinary, integrated care, open-door policy on referrals)

-Clinic and community interactions (established facility, advocating within the community)

*Approach to Client Care*

-Meeting clients where they are, respecting values

-Empowerment through multiple roles (resource connector, psychoeducation, support)

-Addressing thought patterns and self-talk

**Themes Based on Participant Discussion**: Importance of Connection with Other Providers