Practising Psychology in Rural Settings: Issues and Guidelines*

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Abstract
Rural practice presents important yet challenging issues for psychology, especially given the North American and international distribution of the population, levels of need for psychological services in rural settings, limited availability of rural services, and migration of rural residents to urban centres. Direct service issues include the need to accommodate a wide variety of mental health difficulties, issues related to client privacy and boundaries, and practical challenges. Indirect service issues include the greater need for diverse professional activities, including collaborative work with professionals having different orientations and beliefs, program development and evaluation, and conducting research with few mentors or peer collaborators. Professional training and development issues include lack of specialized relevant courses and placements, and such personal issues as limited opportunities for recreation and culture, and lack of privacy. Psychology will need to address more fully these complex issues if rural residents are to receive equitable treatment and services.

Psychologists who practice in rural settings face many challenges, including geographic issues, unique qualities of rural residents, and considerable need for but lesser availability of services. We document these and other challenges, suggest how psychologists can adapt to rural settings, and identify areas for further research. The paper reviews literature in rural psychology and related areas (e.g., community psychology, rural sociology), and is illustrated by experiences working in rural and northern Manitoba. The issues are also relevant to urban practitioners wishing to adapt services to clients who have migrated from rural settings. Although the world is increasingly urban, many people remain in rural areas (Murray & Keller, 1991). The last Canadian census (Statistics Canada, 1996) classified 22.1% of Canadians as rural, a total of over 6.3 million people. The percentage rural varied from 55.8% for Prince Edward Island to 16.7% for Ontario, but even the latter figure represented 2 million people. In 1990, 24.8% of the U.S. population was rural, representing over 60 million people (Ricketts, Johnson-Webb, & Randolph, 1999).

The number and percentage of people in rural areas is even more dramatic globally, which is relevant to international development and training practitioners for non-Western countries. In 1990 (United Nations, 1991), the percent of people in nonurban regions was over 66% for Oceania (excluding Australia and New Zealand), Asia (excluding Japan), and Africa, and was 25-35% for Eastern and Southern Europe, the USSR, Latin America, North America, and Japan. The figures were under 20% only for Western and Northern Europe, and Australia and New Zealand. Even the relatively low percentages still represented large numbers of rural citizens. International statistics also showed a strong association between ruralness and economic development, with the percent nonurban decreasing markedly from least (80%) to most (27%) developed nations.

Although distinct definitions of rural are used for such statistics, ruralness varies in degree. Some rural regions are close to urban centres, such as the regions of Manitoba that surround Winnipeg, the provincial capital with 600,000 people. At the other extreme are isolated or frontier regions remote from large centres or psychological services, and perhaps accessible only by plane or seasonal ice roads. Many communities fall between these extremes, such as Thompson, Manitoba, a town 800 kilometres north of Winnipeg with approximately 15,000 people. Whether people live in rural areas close to major centres or in more remote locations, the challenges of rural practice (e.g., isolation, transportation, lack of privacy) remain problematic to some degree.

The preceding statistics change constantly as people move between rural and urban settings. Trends for internal migration are toward urban areas, and many immigrants move from rural regions in their home

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countries to urban municipalities in host countries. Despite such shifts, rural sociologists who have examined the continued relevance of their discipline have concluded that ruralness remains important because urbanization is not projected to reach 50% in less-developed countries until 2015 (Singelmann, 1996), urban-rural disparities exist in quality of services (including mental health services), and rural residents could become a neglected minority. Migration to cities also makes rural issues increasingly important for urban psychologists, whose services would benefit from understanding the implications of their rural clients' backgrounds.

The remainder of the paper addresses three broad themes: the delivery of direct services, demands for other professional services, and training of rural psychologists, including important personal matters that affect rural psychologists more than urban practitioners.

Direct Service Issues in Rural Settings

Although not unique to rural environments, a number of factors related to the conduct of assessment, therapy, and other direct clinical services assume greater importance for psychologists operating in rural settings. These factors include: pervasive need for diverse psychological services, unique qualities of rural clients, boundary issues, and practical challenges associated with delivery of direct services in rural environments.

Diversity of Clients and Services

Rural practice puts much pressure on psychologists to be generalists because of two basic considerations, a full spectrum of psychological needs and limited services (Hartley, Bird, & Dempsey, 1999). Haley et al. (1998) expressed this feature of primary care service as: "No Specialists Allowed – Be Prepared for Anything and Everything."

Psychological distress in rural settings. Contrary to misconceptions that rural settings are idyllic, rural residents demonstrate considerable need for psychological services. A recent Gallup poll found that the percentage of people who reported experiencing stress frequently was 52% for rural residents, versus 43% and 36% for urban and suburban residents, respectively. Melton and Childs (1983, p. 434) noted that: "Service needs are often greater but that services are in fact fewer in rural areas," and others have similarly observed that rural needs are certainly not markedly lower than urban needs (Hartley et al., 1999; Murray & Keller, 1991). Keller and Murray (1982, p. 14) concluded that "rural people are susceptible to psychiatric problems and consequently in need of mental health services." Booth and Lloyd (1999) found many UK farmers to have elevated scores on the General Health Questionnaire and the Hospital Anxiety Depression Scale. Cellucci and Vik (2001) found that rural clinicians reported more substance-abusing clients than did urban practitioners. With respect to non-Western people, Guiness (1992) found psychiatric disorders to be more common in rural schools in Africa, and Zacharakis, Madianos, Papadimitriou, and Stefanis (1998) found higher suicide rates in rural than urban Greece.

Other evidence suggests that levels of distress have risen faster in rural areas. Dudley et al. (1997) reported that from 1964 to 1993 suicide rates among young males in Australia increased 12 times in towns with under 4,000 people, versus 4 times in communities of 4,000 to 25,000 people, and only 2.2 times in larger cities. Informal evidence is also consistent with high levels of stress in rural areas, perhaps especially for farmers. A recent issue of a Western Canadian farm magazine included articles on farm stress, young people forced to leave farms, death of a child from a farm accident, unknown consequences of frost, and the impact of increased oil and gas prices. Such provinces as Manitoba and Saskatchewan, with large rural populations, have targetted programs to deal with rural and farm distress. These statistics and observations suggest that psychological needs in rural areas are comparable to urban areas, and may even be higher in some respects. We later consider some unique qualities of rural stressors.

Lack of mental health services. Substantial levels of need in rural areas are paired with a shortage of mental health services, perhaps especially psychologists (Hargrove, 1982; Hartley et al., 1999; Murray & Keller, 1991; Sladen & Mozdzierz, 1989). Statistics bear out concerns expressed to us by northern and rural Manitobans (e.g., few school psychologists, limited clinical services at rural correctional institutions). A geographic survey of clinical psychologists in Canada (Bazana, 1999) produced estimates of approximately one psychologist for every 2,195 urban residents, versus one for every 6,842 rural residents. A national survey of 17,600 Canadians revealed that three times as many urban as rural residents had consulted a psychologist at least once during the past 12 months (Hunsley, Lee, & Aubry, 1999), although levels of use were low in both cases (3% versus 1%) despite high levels of distress. Kelleher, Taylor, and Rickert (1992) noted the lack of rural mental health services for children and adolescents, and observed that population density and per capita income correlated with number

of psychologists (see also Murray & Keller, 1991). In addition, rural psychologists had less experience and were less likely to be licensed. Hartley et al. (1999) found that almost all rural states had fewer than the national average of 20.2 psychologists per 100,000 people, some dramatically so (e.g., 5.2 in Mississippi).

Rural areas are also underserved by medical professionals. In 1986, only 10% of Canada's general practitioners worked in rural areas, although 25% of Canadians lived there (Jennissen, 1992). Only 11% of psychiatrists practiced in rural settings, and similar disparities exist in the U.S. (Rosenblatt & Hart, 1999). Diverse mental health workers (social workers, psychiatric nurses) are underrepresented in rural areas, although perhaps not so strongly as the shortage of psychologists (Hartley et al., 1999). Murray and Keller (1991) noted that community support has been particularly lacking in rural areas, although self-help groups are now developing more of a rural presence. Tataryn, Mustard, and Derksen (1994) examined regional variation in Manitoba's provision of *medical* mental health services (i.e., psychiatric and hospital services). Mean yearly visits to psychiatrists and hospitalizations were markedly higher in urban Winnipeg than outside Winnipeg. The discrepancy in contact was greater for psychiatrists than other physicians, and urban-rural differences were particularly marked for low-income residents.

Diversity of clients and services. A full spectrum of psychological needs paired with limited services means that rural psychologists face diverse service demands. Rural settings lack such specialized services as speech and language specialists, women's shelters, programs for the elderly, and rural child care services (Jennissen, 1992). Because referrals to specialized resources are less available (Murray & Keller, 1991), rural psychologists must deal directly with diverse clients. In an urban setting, for example, an elderly person who experienced memory and affective difficulties and was diagnosed with Dementia of the Alzheimer's Type could be referred with his wife to various professionals who specialize in gerontology, to drop-in and day-care centres for recreational activities and respite, to self-help and spousal support groups, to ready sources of well-written guides, and to educational programs about the condition. A lack of services in rural settings places great demands on rural psychologists to provide adequate and current treatment.

Client heterogeneity can compromise the effective use of structured or manual-based groups that focus on a single condition, which is one way to maximize the use of limited resources. There may not be enough clients with the same diagnosis. Rural therapists can treat broad diagnostic categories or group diverse conditions amenable to a common approach (e.g., cognitive behavioural). Self-modification may provide a useful model for such groups in rural settings (e.g., Watson & Tharp, 1977). Such programs incorporate phases of treatment that are applied to heterogeneous conditions (e.g., identify target behaviours, obtain baseline scores, develop treatment plans, monitor effectiveness). However done, creative ways to form groups for diverse rural clients need to be identified and evaluated, especially given issues considered later that further complicate delivery of group services (e.g., privacy, distance). Bibliotherapy also has some potential to alleviate the shortage of therapists in rural settings (cf. Adams & Pitre, 2000).

Working with diverse clients is further complicated by a lack of colleagues to consult about novel cases. Rural psychologists must make special efforts to maintain links with outside experts. By design, psychologists at remote sites in rural and northern Manitoba are part of a network that allows regular communication with practitioners in Winnipeg by telephone or audio-visual conferencing. Demands for diverse services also implicate professional development, as rural psychologists may need to learn new test instruments, or find and adapt treatment programs for conditions with which they have limited prior experience. Such consultation and self-education can increasingly benefit from the internet (e.g., newsgroups, on-line journals), at least in principle. In practice, use of such resources can be limited by time and lack of technical expertise.

Distinct Qualities and Experiences of Rural Clients

In addition to client diversity, rural psychologists may face clients with distinct qualities. An appreciation of special features of clients in rural settings can promote more effective client-therapist relationships (e.g., accurate empathy, therapist credibility) and better treatment. We first consider special sources of stress for rural people.

Rural stressors. Rural settings are associated with different kinds and elevated levels of certain stressors. Kelleher et al. (1992) reviewed ways in which rural life was more stressful than urban life, including higher levels of unemployment, poverty, and accidents. Financial stresses are particularly common in rural settings, in part because of chronic farm crises, and in part because many rural regions depend on a single industry (e.g., mine or paper mill). Walker and Walker (1987) surveyed 1,200 Prairie farmers and found that many stressors were related to finances

(e.g., low commodity prices, rising expenses). Likewise, a major category of stressor on Ide, Carson, and Araquistain's (1997) farm/ranch stress scale contained financial items (e.g., irregular income, debt load, dealing with bankers). Conger, Elder, Lorenz, Simons, and Whitbeck (1994) found high levels of depression in Iowa farmers following the farm crises of the 1980s (few people reported seeking help). Economic stress accounted for 25-33% of variation in depression, and also correlated with less positive parenting practices and more disruptive behaviour in children. Depression in turn led to increased hostility and decreased marital satisfaction. The negative impact of economic factors in rural communities (e.g., Dooley, Catalano, Jackson, & Brownell, 1981; Jahoda, 1988) parallels much urban research (e.g., Feather, 1990).

Another notable feature of rural stressors is their unpredictable and largely uncontrollable nature. Crops can fail on the many whims of nature (e.g., floods, drought, frost, hail), leaving rural residents at the mercy of elements over which they have little control. Such unpredictable stressors as accidents, weather, and government regulations constituted a second major category in the Ide et al. (1997) survey. Farmers in the Walker and Walker (1987) survey reported considerable stress related to weather (e.g., prolonged bad weather, delay in planting/harvesting), and other unexpected farming hassles (e.g., machinery breakdown, unplanned interruptions). Moreover, the Walker and Walker (1987) study found that events are made stressful by not only aversiveness, but also lack of control, ambiguity, and duration.

Workload issues constitute a third major category of rural stressor. Farm couples have difficulties balancing many roles and lack family recreation time (Ide et al., 1997). Workload issues in the Walker and Walker (1987) survey included time pressures and long work hours. Qualitative analyses by Ide et al. suggested such additional stressors as difficulties with extended farm families and outsiders not understanding the nature of farming. Jennissen (1992) noted that farmers experience greater exposure to toxic chemicals, dangerous machinery, noise, and infectious diseases transmitted by animals. Other stresses reported by UK farmers include paperwork, new legislation, and media criticism (Booth & Lloyd, 1999).

Rural culture. One hypothesis that has been proposed (and questioned) is that rural people may demonstrate a set of qualities identifiable as a "rural culture." Keller and Murray (1982) listed as commonly ascribed rural values an emphasis on hard work and mastery of the environment, the importance of family and community, a commitment to tradition, and fatalism (see also McLeskey, Huebner, & Cummings, 1984). Some proposed differences relate directly to clinical practice. Edgerton (1983) identified as unique rural qualities a "frontier" independence, lack of interest in institutionalized services, and some antipathy towards middle-class, urban practices that focus on self-reflection. Such differences may exacerbate the problems of underservice cited earlier. Sears, Evans, and Perry (1998) similarly reported that rural people may have greater concerns about the stigma associated with psychological disorder and, hence, could make less use of what limited services were available. The increased stigma could result from rural values (e.g., self-reliance), concerns about the impact on family and friends, or simply lower levels of privacy.

The idea of a rural culture is controversial. Melton (1983) warned that impressions about such supposed rural values as authoritarianism or familism may be based on stereotypes, and also noted that contradictory stereotypes are often held about rural residents (e.g., they are romantic and nostalgic, versus naive and unsophisticated). Childs and Melton (1983) similarly cautioned about the weak empirical evidence for many of the proposed differences, and Mulder and Chang (1997, p. 1) concluded that "no ... style of life can be considered representative of the culture 'rural' population." Identification of a unique rural culture could have diverse clinical implications analogous to those found in cross-cultural psychology (e.g., Sue & Sue, 1999). With respect to attitudes, several researchers have suggested that the stigma associated with psychological disorders is more salient in rural settings (Sears et al., 1998), which could lead to some resistance to use of psychological services. Psychological disorders may also manifest themselves in different ways, perhaps physically. Yahraes (1973), for example, described an "Eastern Kentucky Syndrome" in miners that was characterized by such physical symptoms as aches, pains, rapid hearbeat, and feeling smothered. A unique rural culture could also lead to a preference for treatments that are directive, rather than introspective approaches, or for support from informal resources (e.g., family, religious leaders). Campion and Bhugra (1997), for example, found that rural clients in India consulted more often than urban clients with traditional religious healers.

Ethnic and demographic differences. Even if rural life itself did not constitute a distinct culture, such cultural variables as ethnicity, religiousness, and education assume greater import for rural psychologists. Rural residents tend to be less educated than urban populations (Murray & Keller, 1991; Ricketts et al., 1999).

According to the 1996 Canadian census, 18.2% of rural residents over 14 years of age had less than a high school education, versus 12.8% for urban residents. Education level is correlated with attitudes toward mental illness and treatment (Phelan, Bromet, & Link, 1998; Rabkin, 1980). Another demographic factor elevated in rural areas is age. Many young people have left rural homes for education and jobs, and many of the people who migrated to rural areas in the 1980s were older (Murray & Keller, 1991). This elderly population may be at elevated risk for such psychological conditions as dementia (Jennissen, 1992).

Differences in religiousness between urban and rural clients may also have clinical implications. Sorgaard, Sorensen, Sandanger, Ingebrigtsen, and Dalgard (1996) found that rural Norwegians were more religious than urban residents. They were also more likely to visit priests and general practitioners for their difficulties, and less likely to use psychiatrists or psychologists. In both urban and rural settings, religious people were more likely to report that they would contact a priest in the future. In China, respondents living in rural areas were more likely than people in urban areas to believe that schizophrenia was caused by spiritual or mystical factors, such as spirit possession and effects of previous lives (Phillips, Li, Stroup, & Xin, 2000).

Rural areas in Canada, the Western U.S., and rural Australia also have a higher percentage of Aboriginals, a particularly disadvantaged group; Aboriginals constitute 4.2% of rural Canadians versus less than 1% for urban areas. The percentage of Aboriginals is much higher in certain regions, such as the prairie provinces of Manitoba (11.7%) and Saskatchewan (11.4%), versus less than 3% for Canada as a whole (Statistics Canada, 1998). Although the profound ways in which Aboriginal Canadians are disadvantaged may require fundamental societal changes, immediate needs exist for effective mental health services. The Ontario Native Women's Association found that 84% of respondents reported family violence in their communities (cited in Jennissen, 1992). Services for children may be particularly affected by Aboriginal demographics, given their high birth-rate and relatively young age distribution.

Client Privacy and Boundary Issues

Privacy and confidentiality are more salient issues in the delivery of direct services to rural clients. The small size of rural communities increases the likelihood that people know one another. Clients may even have concerns about being seen in the building where psychology offices are located. Health personnel may have particular difficulty seeking psychological help because of confidentiality concerns. Psychological services in Thompson were located in a building adjacent to the main hospital. A client who worked at the hospital was acutely concerned about being seen by coworkers as she entered the mental health facility. Another source of privacy concerns is the exchange of information between professionals. Files or memos might easily come into the hands of administrative assistants, secretaries, or other staff who are familiar with clients or their families. Rural psychologists should explore with clients ways in which confidentiality might be inadvertently violated (e.g., asking whether acquaintances work in an office that will receive psychological reports), and to develop procedures that reduce accidental disclosures.

Small rural communities also allow numerous opportunities for nonprofessional interactions with clients or with relatives of clients. Ethical guidelines for both the Canadian Psychological Association (CPA) and the American Psychological Association (APA) direct psychologists to avoid such dual relationships, although there is some appreciation that this is not always possible. Nonprofessional interactions are especially likely in rural settings, and can involve relatively minor accidental meetings or more substantial overlapping relationships.

Accidental meetings. Accidental meetings between therapists and clients are common in small rural settings that have limited options for shopping, recreation, and social activities. A survey of college therapists found that 95% had accidental meetings with clients (Sharkin & Birky, 1992). Common emotional reactions were: surprise (87%), uncertainty (87%), and discomfort (83%), uncertainty because not responding may be perceived as rejection, but acknowledging the client could threaten confidentiality. Pulakos (1994) similarly found that almost 60% of clients from a counselling centre at a rural college had experienced incidental encounters with their therapists. The longer clients were in therapy, the more likely such meetings were. The interactions were described as engaging in conversation (about 24% of encounters), brief greetings (60%), or being ignored (9%). When asked about the ideal, about 21% of clients preferred a different response than had occurred, generally more interaction. Concerns about confidentiality may inhibit therapist responses more consistent with client desires.

Clients generally rated their emotional reactions to the chance encounters as quite low (5 = a lot). The highest ratings (2.0-3.0 range) were for such positive feelings as confidence and surprise. The negative emotions with the highest ratings (1.5-2.0 range) were

anxiety, discomfort, embarrassment, and confusion. Even lower ratings were assigned to other negative emotions (e.g., ignored, annoyance). The benign nature of these reactions must be interpreted with caution. Being from a university counselling centre, most clients might not be experiencing major psychological disorders and, being relatively well educated and in a communal environment, could have few concerns about stigma. Other clients may have stronger negative reactions, perhaps especially in rural settings characterized by stigma and more intense concerns about privacy. Given that uncertainty and related emotions resulted from accidental interactions, it is interesting that 71% of clients stated that the encounter was not discussed in therapy. Although even casual encounters raise potential difficulties, these problems are minor compared to dual relationships.

Dual relationships. Rural settings provide many opportunities for therapeutic and nontherapeutic relationships to overlap in substantive ways. Research has verified the high incidence of dual relationships in rural practice. Schank and Skovholt (1997) surveyed 16 members of the Minnesota Psychological Association who practiced in 15 small communities at least 50 miles from major metropolitan areas. Overlapping relationships were sorted qualitatively into four major categories: social, professional, family, and client-client relationships.

All respondents reported overlapping social relationships. Psychologists interacted with clients in diverse settings (e.g., places of worship), and treated children who were classmates or friends of their children. Such dual relationships could not always be predicted nor easily avoided without violating confidentiality (e.g., saying their children could not befriend a child who was a client). A second important category reported by 75% of the rural psychologists involved business or professional relationships (Schank & Skovholt, 1997). Rural psychologists often shopped where clients worked, although some psychologists shopped outside their communities whenever possible. Dual professional roles with medical providers and referral sources were particularly difficult. Therapists could see professionals or their children as clients, yet refer other clients to those same people. One psychologist consulted for a group home at which clients worked.

A substantial 75% of psychologists also reported relationships involving family members (Schank & Skovholt, 1997), such as their own children having clients or former clients as friends. The dilemma was having clients in their homes or breaking confidentiality by setting limits on who their children could see as friends. Spousal contacts comprised another set of problems. A major dilemma was setting boundaries in social roles. One psychologist had to tell her husband that they could not socialize with a couple he had met through his work. Such constraints can be quite restricting in rural settings with fewer options for social relationships. The final category of dual relationships, reported by 56% of psychologists, involved clients with relationships to one another (Schank & Skovholt, 1997). Clients often knew each other and talked together about therapy. In one case in which two new clients were having affairs with each other's partners, it was a challenge to find an alternative therapist given the limited services available in the community.

Coping with boundary violations. Rural psychologists need to develop a repertoire of effective responses for coping with boundary violations. Psychologists who live and work in rural areas might discuss with clients the issue of chance encounters. Both should communicate clearly how they feel about such encounters and how they would like each other to respond. A shared concern about external interactions could even strengthen the client-therapist relationship. With regard to dual relationships, rural psychologists can strive to maintain clear expectations and boundaries and perhaps discuss these explicitly in therapy, especially when such relationships are predictable (e.g., treating the only MD). Other control mechanisms include informed consent, adhering to time limits, taking exceptional steps to protect confidentiality, documenting case progress as fully as possible and with explicit mention of dual relationships, and consulting on cases that involve dual relationships. The temptation to take outside advantage of a client-therapist relationship is further minimized by reflecting about one's motives and by developing a satisfactory personal life outside work. One thing that rural psychologists cannot do is isolate themselves from their communities; indeed, participation in community roles and working collaboratively with other professionals are important elements of effective rural practice.

Not all practitioners are convinced that dual relationships are bad and must be avoided by clinicians, which raises the interesting possibility that certain acceptable kinds of dual relationships might actually be exploited by rural psychologists to their advantage. Borys and Pope (1989) found that nonsexual relationships were more acceptable to rural than urban psychologists. Lazarus (1998) and others (e.g., Sleek, 1994; Zur, 2000) have made a case for the potential of dual relationships to benefit therapy.

Practical Challenges

Rural practice introduces many practical challenges to the delivery of effective services, if only because of the distances involved in providing service to a scattered population, and the lack of public transportation. Clients who come to a central site often face more serious transportation difficulties than in urban settings. Travelling alone may involve hours of driving and place considerable stress on the client or family members. Roads are also more likely to be impassible from snowstorms during the winter months or from other natural causes (e.g., flooding). Distance is similarly complicated when psychologists travel. Time spent travelling seriously erodes nominal service hours (e.g., a month might include a week or more of travel time). Travelling under trying and unsafe weather conditions is also stressful for school psychologists (McLeskey et al., 1984) and other clinicians, which can put them in a frame of mind that compromises treatment. Good service for remote sites also demands careful planning. Forgetting testing materials or failing to confirm an appointment can mean a wasted trip. Conversely, when clients travel, they must be given detailed information about the meeting, including what to bring and time requirements.

Diversity of Other Psychology Services

Delivery of such direct services as assessment and therapy constitutes only one aspect of psychological practice, albeit the major one for many psychologists in urban settings where other facets of practice (e.g., administration, research) may be performed by specialists. Psychologists in rural settings are often expected to perform these diverse functions in addition to providing a full range of direct services. The diverse roles and the greater emphasis on collaboration and consultation fit a community psychology model better than the standard clinical profile. Haley et al. (1998) referred to such demands as "Psychotherapy Ain't Enough."

Collaborative and Interdisciplinary Work

Psychologists in rural settings are placed in an interdisciplinary environment that involves much interaction with other professionals, which Haley et al. (1998) referred to as "No More Lone Ranger – Join the Posse." Several papers in Morris (1997) emphasized the collaborative nature of work in rural hospitals. Interdisciplinary communication and cooperation can be difficult because different professional groups may be committed to distinct styles of practice. Physicians who see many patients for short periods of time may not appreciate the need for psychologists to spend hours with individual clients. Personal experiences in rural and urban Manitoba suggest that interactions with self-help paraprofessionals are also more common in rural settings. Although the introduction of rural community groups (e.g., Canadian Mental Health Association, Anxiety Disorders Association of Manitoba) appears more recent, their roles are increasingly pronounced because of the lack of more formal specialized services. Paraprofessionals may provide referrals, help in treatment (e.g., doing co-therapy with individual clients or co-facilitating groups), and participate in joint professional development activities. Despite a high degree of interaction in rural settings, Hargrove and Keller (1997) noted the lack of sound models for effective interdisciplinary collaboration and of structural and attitudinal barriers to effective interactions. Of particular importance are differences in professional models and lack of relevant training.

Different orientations and beliefs. Rural psychologists must learn to appreciate the different educational and training backgrounds of other mental health professionals and paraprofessionals. Mental health workers from traditional social work programs may have a more sociological, preventative, and political orientation; may view therapy largely from a nondirective, interpersonal, or family orientation; and may have limited experience with psychological tests or empirical research. Psychiatric nurses often have a biological orientation, and again may have limited experience with formal psychological assessment, although they would know psychiatric diagnostic categories. Workers with self-help groups have especially diverse backgrounds, in some cases with their education being based on personal experience with a disorder, beliefs acquired through self-learning, or informal training offered by self-help associations. They are strongly committed to advocacy, and are particularly concerned with personal experiences, stigmatization, and other social problems. It can be difficult to appreciate the orientations of these diverse professionals and to understand how psychology fits into their schema. Learning about other orientations is one step, and another is appreciating that collaborations should not be uni-directional (Tyler, Pargament, & Gatz, 1983). Zusman and Davidson (1972, p. xiii) similarly noted that effective consultation "is a two-way process: wisdom is going in both directions" and that both consultant and consultee should benefit.

Psychology's unique perspective also stands out more sharply in the interdisciplinary rural context. As previously noted, other mental health workers often have a limited appreciation of the role and standard

uses of formal psychological assessment. Rural practice requires becoming more sensitive to where such differences arise, developing ways to advocate for the psychological perspective, presenting psychological information in clear and useful ways, and using assessment results to make concrete recommendations that can be implemented by mental health workers. Research on many of these issues is limited, but some challenges undoubtedly result from the absence of a respected role for psychologists. Janda, England, Lovejoy, and Drury (1998) found that both the general public and university faculty considered psychology less important than medicine or chemistry and viewed psychologists as having less professional expertise (i.e., incremental knowledge over and above a layperson). Educating other professionals about the strengths of psychological services and providing concrete demonstrations of psychology's effectiveness may best be achieved if psychologists implement well-founded treatments, and propose tested treatments when they consult and collaborate with other workers.

Lack of training in collaborative models. One challenge in collaborative work is a lack of relevant training and experience. Such courses as community psychology or experience working with paraprofessionals in nontraditional settings (e.g., group homes) can facilitate positive interactions in rural settings. But many psychologists in rural practice lack experience and graduate training in community or rural psychology methods (Murray & Keller, 1991). Among the rural psychologists surveyed by Schank and Skovholt (1997), none of their graduate programs involved any courses or training in rural practice. Walsh-Bowers (1998) also documented the relative neglect of community psychology in Canadian universities, including a lack of relevant courses. The modest literature on consultation does contain some theoretical models on which to base effective consultation skills, such as Tyler et al.'s (1983) "resource collaborator" model. They recommended an egalitarian approach in which knowledge and expertise are shared in a bidirectional manner. They illustrated their approach with the example of psychologists and religious leaders working to reintegrate institutionalized clients back into their communities.

Difficult issues arise in such collaborations, however. Tyler et al. (1983, p. xx) noted that "When more than one discipline is involved, procedures for resolving differences must be based on grounds more general than those of any discipline's presumptive claims." But clinical psychologists nominally endorse such "presumptive claims" as the use of empirically validated treatments and theories rather than informal folk theories or practices that lack a scientific basis. Reviewing the unfounded techniques often used in the human services, Thyer (1995, p. 93) observed: "Service delivery in the human services is most charitably characterized as being in disarray." Rural psychologists who collaborate closely with practitioners having radically different epistemological or practice beliefs need to balance egalitarianism with professional and ethical responsibilities to clients. Interdisciplinary work can also lead rural practitioners to stray far from their areas of expertise, resulting in unwarranted claims. Zusman and Davidson (1972, p. xiii) warned:

> A dozen primrose paths seem to lead the community psychiatrists further and further away from their own basic area of expertise, until they find themselves in the swamplands of economics, or construction, or politics. Away from their own fields, they are... novices, and their amateurish efforts can imperil the validity of psychiatrically sound expertise.

Although effective consultations can be a challenge, several factors facilitate positive collaborative relationships in rural settings, including the fact that mental health workers in rural areas often appreciate the relative lack of services and welcome qualified professionals. But taking full advantage of these opportunities may require special skills. Rural psychologists must decide, for example, whether to approach other mental health workers in an assertive way, or wait for natural opportunities to intervene. They must also monitor commitments closely, and deliver on promises. Bray, Enright, and Rogers (1997) identified concrete ways to promote effective collaboration between physicians and psychologists (e.g., mutual referrals, regular meetings, working in close proximity). The Thompson Consultation Team, which included a supervising registered psychologist, a psychiatrist, a psychiatric nurse, an occupational therapist, and a social worker, for example, worked closely together, met regularly, and occupied adjacent offices in a building that also included other social service professionals. Interactions across such broad administrative structures are common in rural settings (Murray & Keller, 1991).

Educational Activities

Clinical psychologists in rural settings will find many opportunities to function as educators, again performing functions that are often conducted by urban specialists (e.g., university professors, staff at teaching hospitals, mental health administrators, external experts).

Professional development for other mental health professionals. Close interactions with other mental health professionals and a relative lack of professional development activities in rural mental health settings provide rural psychologists with opportunities to plan workshops and provide other educational services to communicate recent developments in psychology. Rural psychologists with sufficient resources may also arrange guest speakers, who are much appreciated by rural mental health workers. More informally, psychologists can help to organize interdisciplinary journal clubs or peer consultation groups that meet regularly. Such training activities tend to be more common in urban settings because of existing administrative structures, and only rarely do they depend on the initiatives of solitary practitioners. Consultation, collaboration, and co-therapy, as discussed earlier, provide additional occasions to inform mental health workers about psychological practice.

The need and potential for psychologists (and others) to contribute to professional development in rural settings is considerable. Berman (1994) found that fewer than 20% of public mental health clinics in Michigan had any formalized staff development programs. Moreover, such programs were among the first cut in times of fiscal restraint. The many benefits of staff training programs include: initiating change and innovation, increasing confidence and effectiveness, contributing to job satisfaction, and providing opportunities to interact with other practitioners. Such benefits may be particularly strong in rural settings, where staff might feel isolated both geographically and professionally. In Thompson, one presentation on anxiety disorders by a Winnipeg specialist was attended by over 30 people from different disciplines and a wide geographic region. That number was exceptional for this rural setting.

Education for self-help organizations and laypeople. Individual rural psychologists also have numerous opportunities to participate in public presentations and other community activities related to mental health. Psychologists are resource people available to talk with interested members of the public, to answer questions, to strengthen relationships between psychological services and community organizations, and to promote a psychological approach to mental health problems. Research activities provide additional opportunities for community education. While working in rural and northern Manitoba, the first author gave several community presentations on the stigma associated with mental illness, participated in a variety of community awareness or education days (e.g., Mood Disorders Association Information Evening, Mental Health Day, and Depression Screening Day), conducted a community research project on stigma and mental health, and wrote short articles for rural newsletters. Such activities can address important psychological issues. At one mood disorders meeting, for example, a psychiatrist presented a biomedical model (e.g., promoting medication). The psychologists present could educate the public about psychology (e.g., note the equivalent effectiveness of psychological interventions, provide information about assessment issues, advertise the availability of psychological services).

Program Development, Evaluation, and Research

In urban settings, administrators and policy specialists generally lead the development and evaluation of new services, perhaps with some contribution by clinical experts. Research-related functions are similarly left primarily to clinicians with academic appointments in universities or teaching hospitals. Such specialization is again not so common in rural settings.

Program development and evaluation. There is much need to develop and evaluate rural mental health programs and policies, and contributions from psychology will generally come from the same people who provide clinical services. In addition to contributing to development of traditional mental health programs, rural practitioners can also participate in developing prevention and outreach programs, which may be a particularly useful model for effective rural services (Sundberg, 1986). Although rural and urban women are equally at risk for violence perpetrated within the home, for example, preventative services are less well-developed in rural settings (Bachman, 1992, 1994). Rural programs could be developed and implemented in collaboration with schools, law enforcement agencies, medical units, and other organizations that are particularly important and somewhat more integrated in rural settings. The visibility of rural psychologists also provides opportunities to develop policies for regional mental health services. Psychologists in Thompson, for example, participated in a Crisis Response Team responsible for responding to local emergencies (e.g., a mine disaster, a forest fire). There are many clinical implications of such disasters (e.g., death or disfigurement from a mine explosion).

Psychologists working to introduce program changes into rural settings need to appreciate some distinct challenges. Dissemination and adoption of new ideas may be slower in rural cultures (Melton, 1983), or clinicians may be viewed as outsiders (someone from "away," as locals would say in Eastern Canada), which can lead innovations to be dismissed

as inappropriate, foreign, and threatening (McLesky et al., 1984). Such views may lead rural residents to resist new ideas (Keller & Murray, 1982). A gradual approach (e.g., small pilot programs to demonstrate efficacy) can allow for the growth of community support, without activating resistance from the community or self-appointed "gate-keepers" whose authority might be threatened by change. Such an approach is sound, not only politically, but also clinically, ethically, and scientifically. Perhaps of special importance given our scientist-practitioner orientation are opportunities to design evaluation procedures to document the efficacy of new programs and identify ways in which to strengthen programs. Psychologists have exceptional training in the research functions necessary for valid evaluation of programs (e.g., research design, statistics).

Research in rural settings. We have already alluded to the many opportunities for rural psychologists to engage in sorely needed research and program evaluation activities. Teaching hospitals and university programs in urban settings include specialists who conduct research on a broad range of conditions, and offer services to affected populations. If rural research is to be conducted, however, it is again practitioners who will generally carry out these functions. In addition to the normal challenges faced by clinicians (e.g., heavy service demands), rural settings present special barriers to research. One challenge is the lack of collaborators and mentors. Getting research programs started may be a particular challenge for psychologists with limited experience. Despite many opportunities for research, rural psychologists must assume unanticipated leadership roles at very early stages in their careers and without strong guidance. Networks of rural researchers could provide one mechanism to ameliorate this limitation.

Special challenges can also arise with research involving certain rural groups (e.g., Hutterites, Aboriginals) due to heightened concerns about the stigma of psychological disorders, lack of privacy and confidentiality, or even attitudes toward science. Some cultural groups are reluctant to participate in research by outsiders, nominally because of perceived lack of benefit or exploitation by past researchers. The sheer number of research opportunities also constitutes a challenge. There are so many issues to investigate, new services to develop and evaluate, and existing rural programs waiting for program evaluation. Rural scientist-practitioners need to choose projects that are central to rural practice and manageable, such as ways in which demonstrated treatments might be adapted to rural settings, or specific issues related to ruralness, such as those discussed in the present paper (e.g., how rural clients perceive accidental meetings, attitudes toward psychology, effectiveness of continuing education).

In addition to the scientific and program evaluation functions of research, one important reason to promote rural research is that applied research programs often augment the provision of clinical services. Evaluation of a group treatment, for example, clearly requires the provision of group treatment services. Without support from experimenters and research grants, such services may not be offered. Thus service and clinical research often complement one another, and the lack of strong research programs in rural settings may limit research-related services for rural clients. The potential contributions of rural researchers thus assume real clinical significance. Rural settings may offer research assistance from other professionals or paraprofessionals who value research and evaluation, although other professionals may be less committed to research than psychologists trained as scientist-practitioners. Indeed, there are even people in psychology and other fields who disparage the value of traditional research (e.g., Gergen, 1992).

Selection and Training of Rural Psychologists

A number of training issues arise from the unique features of rural settings. Issues discussed in the present paper implicate selection of candidates for rural psychology training, the nature of training in graduate programs and internships, and postgraduation career development.

Selection of Rural Psychology Candidates

Implicit in much of the preceding discussion are important professional considerations in identifying candidates who are likely to thrive and remain in rural settings. Suitable candidates have a broad vision of clinical and scientific psychology, feel comfortable working with diverse colleagues and yet strong enough in their commitment to core psychological values (e.g., the scientist-practitioner model) to avoid compromised modes of delivery, and able to work autonomously and to acquire the diverse skills and technical knowledge needed to provide contemporary and effective psychological services in a challenging and isolated environment. Such issues constitute relatively direct implications of our review, but professional issues are not the only considerations in selecting rural psychologists. Murray (1990, p. 16) noted: "Many 'failures' in adjustment to rural practice are determined more by personal issues than professional concerns." Difficult personal issues arise when consid-

ering who is suited for rural practice given the isolated and restricted environments in which rural psychologists work and live.

Lack of privacy. Our discussion of practice issues referred to the dual relationships that often arise in rural settings. One implication of that discussion is that personal lives are less anonymous in small rural communities. Most forms of public activity have a high probability of becoming known to clients. Clients will learn whether psychologists attend a place of worship, will know their social activities, and may even participate in the same activities (e.g., baseball teams, exercise clubs). Clients will see their psychologists dressed casually (e.g., exercise clothes, social attire at a local bar). Clients will know whether psychologists are married or dating, and could learn easily of a separation or a divorce, and about political or sexual orientation. Some information can affect treatment. Psychologists working with families, for example, could be compromised by client knowledge of marital break-ups or difficulties with their own children.

Limited ties to the community and lack of social relationships. Beginning practice in rural settings often means starting a new personal life, except in rare cases when psychologists come from the communities in which they will work. One factor that contributes to social isolation in rural settings is the reduced likelihood that psychologists remain where they were trained or return to their home communities. Another important factor is the relative lack of "similar" people with whom to develop relationships. People typically socialize with similarly trained and like-minded people, which could make it difficult to form bonds in communities with no other psychologists and few professionals.

Limited opportunities for recreational and cultural activities. Psychologists and their families may find that even moderate-sized communities provide limited recreational and cultural opportunities. Thompson, Manitoba was a rural town of about 15,000 residents, but it had no commercial bookstore, only a single-screen movie theatre, little live theatre or performances, and only a few restaurants and local bars. The primary shopping facility was a WalMart store, and the nearest city with more amenities required an 8-hour drive or expensive flight. The natural environments of many rural communities do support outdoor activities (e.g., boating, swimming, fishing, cross-country skiing), and some rural residents invest in electronics that allow for in-house recreational activities ("cocooning").

Given such limitations, Murray (1990) suggested qualities to guide selection of rural psychologists. One proposal was that candidates have lived or trained in rural settings, although limiting selection to people from rural settings could greatly restrict the availability of rural psychologists. Recruiting psychologists from urban backgrounds appears inevitable, in which case, such individuals need full information about the personal issues addressed here. Developing new relationships in rural settings may be easier for certain types of people, such as religious people who attend a place of worship, people who participate in sports or engage in school activities associated with their children, and people having obtained accurate information and relevant experience in their educational programs.

Education for Rural Psychology

We have alluded to aspects of graduate education that compromise training for rural practice (e.g., a lack of relevant courses on rural or community psychology), a limited scholarly literature, largely urban institutions that have difficulty providing rural practica, and the limited availability of professional development activities in rural settings. Amelioration of such limitations is quite feasible and would do much to strengthen rural practice.

Fostering skills relevant to rural practice. Urban programs can provide experiences for training rural practitioners by focussing on relevant skills. Practica, for example, can emphasize experiences relevant to rural settings, such as treating diverse clients, leading heterogeneous treatment groups, consulting with paraprofessionals, initiating independent research programs, and community-based activities. There may be local clinics in urban settings that operate according to community models similar to those found in rural settings. Rural internships could also be designed to strengthen specific skills. A special challenge is the fact that rural trainees generally interact with a single supervisor, who may lack expertise on all clinical cases, promote a unitary perspective, face great demands themselves to service clients, and have limited rural experience. Programs need to find, train, and retain rural supervisors who exemplify the competencies entailed in effective rural practice, such as modelling a "self-guided learning" approach to novel cases and provision of multiple, nontraditional services.

Professional development for rural psychologists. Rural settings provide only rare opportunities for typical professional development activities: There are few local workshops, the expense of travel to conferences may be prohibitive, and rural psychologists lack

replacements to manage their case load while they attend relevant programs. There may be few library resources and little contact with academic, clinical psychologists, or other experts. Some of these limitations can be minimized to some degree (e.g., by access to a university library resource centre associated with a local hospital, videoconferences). A more difficult issue related to professional development for rural psychologists concerns the lack of scientific knowledge about many professional activities that arise in rural practice, a topic to which we turn shortly.

Technological advances. Historically, rural practice has entailed considerable professional isolation from colleagues and excessive demands for services, but technology has the potential to reduce such challenges. Although rural psychologists should take advantage of *appropriate* developments in technology (Stamm, 1998), new technologies raise potential difficulties. Agee, Blank, Fox, Burkett, and Pezzoli (1997) documented some problems with the introduction of computer-assisted telephone support in a community mental health setting. Staff and clients were frustrated by aspects of the system (e.g., messages not delivered, mandatory passwords), and thought some forms of automation could even undermine therapy. Clients who avoid social interactions, for example, may use such systems to avoid social interactions. Technology can also require considerable resources, such as computers, training time, and support staff.

Developing a Rural Psychology Knowledge Base

Of fundamental importance for advancing rural psychology is the creation of a body of relevant empirical evidence and well-founded theory. We lack solid research on many topics of specific relevance to rural psychologists, such as principled guidelines for effective interactions with other professions and paraprofessionals, preferred treatments or alternative manifestations of disorders for special populations that are common in rural settings (e.g., farmers, miners), the effects of professional isolation on practitioners, and personal or professional qualities that promote success and retention in rural settings (Elkin & Boyer, 1987). If rural psychology programs are to be effective in training psychologists to work in other nations, we must also determine the extent to which one can generalize to other cultures and ethnic groups the findings obtained for rural people in the West, where much of the current research is done. An especially important element in any effective knowledge scheme would be a conceptual model in which to situate the multiplicity of complex issues that arise in the practice of rural psychology.

Attention also needs to be paid to the dissemination and adoption of research findings relevant to rural practice. Research and theory must be distributed in an effective manner to clinical practitioners, and rural practitioners need to develop skills for adapting research to rural settings. More contemporary versions of integrated and comprehensive approaches of the past (e.g., Childs & Melton, 1983) may benefit rural practice more than isolated articles, especially given the apparent lack of use of research articles by clinical practitioners in general (Thyer, 1995). Dissemination and innovation may be especially difficult if research-minded practitioners are less likely to choose rural settings because of the lack of a strong research infrastructure.

Psychology has recognized the need for increased scholarly attention to rural practice (Murray & Keller, 1991). Initiatives of the American Psychological Assocation include an APA Rural Health Task Force, an Office of Rural Health, a Rural Health Bulletin that is published twice a year, and the internet resource RuralPsych (www.apa.org/rural/). Other organizations have taken similar initiatives (e.g., a Frontier Mental Health Resource Network has been established at www.wiche.edu/mentalhealth/Frontier), and training institutions have responded to needs for improved psychological services in rural settings (Murray & Keller, 1991). The University of Florida has established a rural track (Sears et al. 1998), and the University of Manitoba has rural internships and residencies that have dramatically increased the presence of professional psychologists in rural and northern Manitoba. On the publication side, the *Journal of Rural Community Psychology* was specifically concerned with rural psychology, but lack of subscribers led to the demise of the journal, and to its later rebirth as an electronic journal. APA has already published a collection of articles on rural practice in hospital settings (Morris, 1997) and another has recently been released on behavioural health care in rural areas (Stamm, 2003).

Conclusion

We have reviewed many issues that arise in the practice of psychology in rural settings, have suggested a general framework for thinking about such issues (i.e., direct service, other demands, selection and training), and have identified a number of areas for future research. There are many challenges to working in rural settings, as well as some speculative and some empirically-supported suggestions for coping with those challenges. Future work needs to continue research on the nature of rural practice, and also to develop a more comprehensive model of the diverse

aspects of clinical practice in rural settings, including especially the dissemination and use of research findings and of well-founded theoretical and clinical practices. Efforts toward these ends will be more successful if all psychologists appreciate that an understanding of rural psychology will benefit not only rural clients and practitioners, but also psychologists preparing to work in other nations with largely rural populations, and urban psychologists who treat populations with increasingly large numbers of rural clients.

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Résumé

La pratique de la profession de psychologue en région rurale pose des difficultés à la fois importantes et stimulantes compte tenu, en particulier, de la répartition de la population, en Amérique du Nord et à l'échelle internationale, de l'étendue des besoins en services de psychologie en milieu rural, de la disponibilité restreinte des services ruraux et de la migration des résidents des régions rurales vers les centres urbains. Les difficultés qui vont de pair avec la prestation de services de première ligne comprennent notamment la nécessité de tenir compte d'une grande variété de problèmes de santé mentale, les problèmes liés à la vie privée, les limites des clients ainsi que d'autres défis d'ordre pratique. Les difficultés qui vont de pair avec le service indirect comprennent le besoin accru de recourir à des activités professionnelles variées, y compris la collaboration avec des professionnels ayant des orientations et des croyances différentes, l'élaboration et l'évaluation de programmes et la conduite d'activités de recherche sans le recours à un grand nombre de mentors ou de collaborateurs parmi les collègues. Les difficultés que posent la formation professionnelle et le perfectionnement comprennent le manque de cours spécialisés et de stages pertinents ainsi que certaines considérations d'ordre personnel, les possibilités de loisirs et d'activités culturelles étant limitées, ainsi que l'absence d'intimité. La psychologie devra se pencher sérieusement sur ces questions complexes si l'on compte vraiment offrir aux résidents des régions rurales des services et un accès au traitement équitables.

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