

Psychological Practice in Rural Settings: At the Cutting Edge

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This article reviews how psychologists working in rural communities often have to be at the cutting edge of practice because of the issues inherent in rural life. Problems faced by rural residents, such as poverty, unemployment, lack of transportation, lack of education, substance abuse, lack of health and mental health providers, and lack of insurance, complicate living day-to-day and receiving physical and mental health care. In addition to reviewing these topics, we highlight 3 areas of emphasis in psychology in which rural psychologists are on the cutting edge: integrated care, use of technology, and prescription privileges. Implications for professional practice include considering adopting the changes in the field such as pursuing training in telehealth technology, investigating advocacy, the benefits of possible collaboration with rural training programs and researchers, and prescription privileges.

Keywords: psychological practice, rural, small community

According to one estimate, approximately 75% of the counties in the United States are rural and 20% of the population lives in these rural areas (Hart, Larson, & Lishner, 2005). Rural residents face significant problems, including high unemployment, poverty, low educational levels, out-migration of youth, and loss of community (Campbell, Kearns, & Patchin, 2006; Wagenfeld, 2003). As but one example of the severity of issues experienced by rural residents, consider that, for decades, the suicide rate in rural areas has been significantly higher than in urban areas (Mohatt, Adams, Bradley, & Morris, 2006).

Heightening these problems, rural areas are underserved by health and mental health professionals: “Twenty percent of non-metro counties lack mental health services versus only five percent of metro counties” (Gamm, Stone, & Pittman, 2003, p. 166). The New Freedom Commission on Mental Health (2004) stated that 85% of the 1,669 federally designated mental health professional shortage areas are rural and that this lack of providers has been an issue since the Eisenhower Presidential era. Thus, substantial problems need to be addressed and insufficient numbers of providers are available to meet the needs.

This article highlights significant issues faced by people living in rural areas. We also provide a discussion of how solutions that can address these issues (i.e., integrated care, use of technology, and prescription privileges) place rural psychologists at the cutting edge of practice. The authors consider some of the specific issues that people living in rural and frontier communities in the United States encounter and how these issues differ from the experiences of those living in more densely populated metropolitan and urban areas.

Overview of Rural Areas and Communities

Many people hold idealized pictures of rural life, with images of idyllic, bucolic communities located in the midst of beautiful, unspoiled vistas surrounding villages where everyone knows each other and enjoys slow-paced, carefree living. Others, however, see blighted and economically depressed small towns, filled with residents who are hopeless, physically disabled, and trapped while the land, water, and air around them are spoiled and turning toxic. The truth about rural America, naturally, lies between these two poles.

Although there are a variety of definitions of “rural”—even within the federal government—they center around low population density (Wagenfeld, 2003). The New Freedom Commission on Mental Health (2004, p. 8) discussed the ways in which low population density can create difficulties and addressed the fact that, over the past two decades, the rural health care infrastructure has been significantly eroded because many rural hospitals have closed or have switched to a critical care model that only provides emergency services. Further, a community’s inability to generate jobs providing a living wage translates into outmigration being an economic necessity for the younger generation. However, there are limitations to the potential for success for these young adults as approximately 20% of rural youth do not graduate from high school (vs. 15% in urban areas). A small percentage of rural youth go to college (15% vs. 28% in urban settings), and those who do rarely return to rural communities because employment is unavailable, especially employment for which the college degree was

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necessary or useful (see Beaulieu, Barfield, & Stone, 2001). At the same time, older residents are aging in place or have returned to childhood rural roots, leading to concerns about who will care for these individuals when they are unable to live independently safely (Curtin & Hargrove, 2010).

Further, although geographic location can be considered a form of diversity in and of itself, it is important to not make blanket assumptions that all rural areas or rural residents are alike (Sawyer, Gale, & Lambert, 2006). One common stereotype is that rural dwellers are poor, White, "hillbillies." This ignores large African American populations in the South, Native Americans in the Southwest and Upper Midwest, and Latinos in agricultural areas. Further, there are some ethnic minority groups who have been ignored because their numbers appear small; for example, African Americans living in Appalachia (Walker, 2000). In addition, members of ethnic minority groups and recent immigrants are moving to rural areas, increasing the diversity of these communities (Harowski, Turner, LeVine, Schank, & Leichter, 2006). Some areas may feel tension as the demographics of the community change and long-term residents may feel threatened by the presence of new arrivals (Pipher, 2002).

In fact, numerous authors have pointed to rural areas having their own distinct culture, including the distrust of outsiders (see Hargrove, 1986; Helbok, 2003; Slama, 2004). Thus, nonlocals (including psychologists) must expect a certain degree of scrutiny and may need to consider how best to fit in while the rural community waits for them to prove themselves (Schank & Skovholt, 2006). Other characteristics of rural communities and residents may include the presence of complex, interrelated networks with deep historical, social, familial, and political roots; strong family ties; avoiding conflict or discussing feelings; stoic attitudes toward life in general; and high involvement in religious activities in their communities.

This religiosity is an important consideration for a number of reasons, including its potential influence on help-seeking (see Hargrove, 1986; Schank & Skovholt, 2006). Fox and her colleagues (2001) found that virtually all respondents in their sample of rural, impoverished individuals reported they would seek help if they believed mental health services would be helpful. However, respondents generally cited family as their first source of help for psychological distress followed by family physicians and church leaders, who were consistently chosen as primary resources, with non-Whites preferring to receive help from their family physicians or from their churches (Fox et al., 2001). Given these results, psychologists in rural areas should consider ways to collaborate with spiritual leaders and medical professionals.

However, collaboration with other rural professionals can lead to ethical challenges regarding confidentiality and exchange of information (Hargrove, 1986). In addition, most rural psychologists report regularly dealing with ethical dilemmas different from issues addressed in the mostly urban/suburban based training they received (Werth, Hastings, & Riding-Malon, 2010), especially managing unavoidable multiple roles and relationships, ensuring competence to provide care for all seeking services because of a lack of referral options, and dealing with the continuous challenge of protecting the confidentiality of clients in a community where knowing everyone's business may appear to be a way of life. All these experiences and roles require creativity and the ability to navigate the intricacies of interpersonal, personal, and professional

relationships with wisdom and dexterity (Schank & Skovholt, 2006).

The Link Between Rural Areas and Cutting Edge Issues in Psychology

To this point we have focused on many of the negative issues and concerns faced by people living in rural areas. Obviously, psychologists must be aware of these factors and problems when working in rural communities. The American Psychological Association (APA), which created the Committee on Rural Health (CRH) in 1996 during the presidency of Jack Wiggins, recognizes the unique behavioral health care needs of rural Americans, and has subsequently considered many of these needs in their policy decisions. On the other hand, there are significant opportunities for psychologists who work in rural areas. Below we highlight three topics that have received significant attention in the CRH, and that are now at the forefront of the APA's agenda. Rural psychologists can be at the cutting edge of practice in a number of ways.

Integrated Care

In communities that value self-reliance and a stoic approach to life, consulting a mental health professional carries significant stigma and can be an impediment to rural residents consulting a psychologist (Fox et al., 2001; Schank & Skovholt, 2006). Concern that others may know that one is in treatment is realistic given that rural communities have been compared with "fishbowls" in which community members are aware of their neighbors' behaviors (Larson & Corrigan, 2010). Whereas urban clients have a reasonable expectation of remaining anonymous while receiving mental health treatment, rural therapists cannot guarantee that their clients will not be recognized as they enter or leave the premises (Helbok, 2003). Thus a rural client's confidentiality may be compromised without anyone uttering a word, so a rural client is less likely to be able to hide from the stigma associated with receiving mental health care. Therefore, rural mental health professionals able to share office space with other health care professionals may help minimize the stigmatization potential, thereby increasing access for clients.

Rural residents tend to be poor at identifying mental health problems and knowing what treatment options are available, an additional complication that can lead to them entering care later and with more severe conditions (Gale & Lambert, 2006). Thus, even though rates of mental illness are as high in rural as in urban areas, with approximately 20% of people experiencing symptoms of mental illness in any given year and 50% of all individuals having symptoms over a life-time (Kessler, Costello, Merikangas, & Bedirhan Ustun, 2001), people may delay seeking help. Further, even if someone wanted to seek therapy, another factor that impedes accessibility of psychologists is the lack of insurance coverage and the inability to pay for services (Gale & Lambert, 2006).

As a result of these complications and limitations, people living in rural areas are more likely than their urban counterparts to rely on informal support networks or their primary care physician rather than mental health specialists (Gale & Lambert, 2006; Harowski et al., 2006). Unfortunately, the literature indicates that nonpsychiatric physicians are not effective at detecting and treating conditions such as depression (Harowski et al., 2006), which is

not an indictment of the medical doctors but rather a reflection of the reality that they have neither the time nor the training to do a thorough psychological evaluation of their patients. Furthermore, because so many mental health issues tend to be expressed somatically in rural clients (Keefe, Hastrup, & Thomas, 2005), and because rural dwellers tend to seek help for mental distress from their family physician (Harowski et al., 2006), rural therapists would do well to develop a referral network that includes community leaders and other health care professionals, that is, nurse practitioners, physician assistants, pharmacists, social workers, or marriage and family therapists.

All of these factors illustrate why the idea of collaboration between medical professionals and psychologists in rural communities is so appealing—even for physicians (Badger, Robinson, & Farley, 1999). One option is “colocation,” which occurs when the psychologist shares space with one or more medical providers and may receive referrals from them but all parties act independently (Hunter, Goodie, Oordt, & Dombeyer, 2009). Alternatively, “integrated care” means the psychologist is a staff member of the medical practice and provides care alongside the medical staff (Badger et al., 1999; “Health Care Reform,” n.d.; Hunter et al., 2009; Kelly & Coons, 2012). Because the mental health provider in these settings is often referred to as a “behavioral health consultant” who sees patients as a result of a referral from a medical staff member or is called in to meet with a patient either immediately after a medical intervention or while the medical provider is still present, the stigma of seeing a mental health professional is significantly decreased. The psychologist may provide a one-time brief health intervention and not see the person again or may see the patient for a few short follow-up appointments.

Because of the wide variety of forms of interactions and the different types of presenting issues, this manner of practice requires an additional set of skills beyond those most students are taught in graduate school (Blount & Miller, 2009; Bluestein & Cubic, 2009). Behavioral health consultants must be able to provide psychotherapy, brief therapy, and behavioral interventions with individuals, couples, families, and groups. They must be familiar with health psychology, medical problems, and evidence-based practice for physical health problems and psychological issues that co-occur with, mask, or are masked by physical conditions. There typically is not time for in-depth assessment, so they must be skilled diagnosticians.

The APA has recognized the importance of psychologists partnering with medical care providers and has included “expand psychology’s role in advancing health” as one of the organization’s three strategic goals (APA Adopts a Strategic Plan, 2009, p. 77; “Health Care Reform,” n.d.). Integrating mental health services into health care settings serves to decrease stigma for rural clients. Furthermore, research has shown that integrated care is cost-effective and results in better physical and psychological treatment outcomes for the patients (Park et al., 2013; Pomerantz, Corson, & Detzer, 2009).

With these practice opportunities come research possibilities for which psychologists are well-trained because of the need for outcome measures and evaluations regarding the most effective and efficient ways of running these types of organizations (Breckler, 2010; “Health Care Reform,” n.d.). The need for training is obvious and doctoral programs would be well-served to begin attending to the needs of students who will be practicing in

integrated environments. Many rural training programs have incorporated integrated care into their practicum courses, thus ensuring that students are exposed to health psychology as a broader area.

Technology/Telehealth

The use of technology as an alternative or supplement to face-to-face service delivery has existed since the advent of the telephone, although contemporary interpretations of telehealth or the use of technology have centered around the use of computers (see “Telehealth Resources,” 2010). The term “telehealth” focuses on service delivery to clients/patients using technology (Barak, Hen, Boniel-Nissim, & Shapira, 2008; Titov, 2011; Tuerk, Yoder, Ruggiero, Gros, & Acierno, 2010; for a review indicating telemental health may provide equivalent results to face-to-face therapy, see Richardson, Frueh, Grubaugh, Egged, & Elhai, 2009). Technology can be used in other ways by psychologists such as supervision (Wood, Miller, & Hargrove, 2005) and consultation (Frieder, Peterson, Woodward, Crane, & Garner, 2009; Miller, 2006). For an overview of these issues, see Maheu, Pulier, McMenamin, and Posen (2012) and the special issue of *Professional Psychology: Research and Practice* (2011, 42[6]) on “Telehealth and Technology Innovations in Professional Psychology.” In addition to offering opportunities for access to psychologists, the Internet has obvious uses for providing self-help to individuals who avoid providers’ offices or do not have a professional nearby (see Botella, Guillen, et al., 2007; Botella, Quero, et al., 2008).

The APA, in a joint workgroup comprising representatives from the APA, the APA Insurance Trust, and the Association of State and Provincial Psychology Boards, developed guidelines for the practice of telepsychology (American Psychological Association, American Psychological Association Insurance Trust, & Association of State and Provincial Psychology Boards, n.d.). The guidelines address key telepsychology ethical and legal issues, including threats to confidentiality, crossing state and international boundaries, how to handle technical difficulties, and emergency procedures. They cover the use of telecommunication technologies to convey “information in writing, image, sound, or other data” and “may include but are not limited to telephone, mobile devices, interactive videoconferencing, e-mail, chat, text, and Internet” (p. 3). They reiterate statements from the 1997 APA Ethics Committee (APA Ethics Committee, 1997) and the 2010 APA ethics code (APA, 2010) that the ethics code covers use of the phone, teleconference, or Internet just as it does in person interactions. In the new guidelines, the APA puts the onus on the psychologist for two key issues: (a) competence and knowledge must be both for the psychological and technological aspects of services rendered via telecommunication technologies and (b) the need for psychologists to ensure that clients understand the potential risks such as the potential loss of security and confidentiality associated with using such technologies; the guidelines also highlight the importance of a psychologist knowing all relevant laws and regulations for competent interjurisdictional practice across state or national borders (APA et al., n.d.).

The Center for Telehealth and e-Health Law (CTeL) surveyed the reimbursement policies of 50 states and found that “45 states have some type of reimbursement for services provided via telehealth” (CTeL, n.d.). The American Telemedicine Association

(2013) lists clinical psychologists and clinical social workers as eligible to claim reimbursement for remote telehealth services. However, the amount of coverage as well as the specifics of what is covered remains a patchwork of state, federal, and private reimbursements that differ from state to state (American Telemedicine Association, 2013). Moreover, private insurers have long taken their cue from Medicare and Medicaid (Nickelson, 1998). With the advent of the Affordable Care Act (ACA) in 2010, coverage across the nation is changing; states may realize that telehealth is an affordable tool that can promote the coverage mandates of the ACA (Gold, 2013). Thus, the ACA is opening the way for more people to obtain needed health care. A panel of experts speaking at an Alliance for Health Reform event sounded optimistic about the changes for rural populations that have already resulted from the ACA: "Rural health care is more stable than ever before, thanks to technology and initiatives introduced by the Affordable Care Act. But the challenge now is to recruit and retain professionals" (Gold, 2013, para 1).

Within rural areas, telepsychology is often mentioned as a possible way to help alleviate problems associated with limited accessibility and availability of general practice providers, specialty care providers, and supervisors (e.g., Jameson & Blank, 2007; Sawyer et al., 2006). For example, Nelson and Bui (2010) discussed the utility of telepsychology in providing psychological services to children and adolescents in rural areas.

In remote locations, where travel distances are a major barrier, the closest provider may be across state lines. However, current insurance and state licensure regulations vary so that practitioners may not be able to see clients from another state or receive reimbursement for the services provided (American Telemedicine Association, 2013). Therapy across state lines difficulties parallel complications for supervision in another state. The obstacles are particularly problematic when they preclude a trainee offering client services under the supervision of a licensed psychologist. Training programs struggle to manage supervision of students in rural communities where therapy may be provided by mental health professionals who do not meet the APA requirements for approved supervisor credentials. Further, current accreditation requirements interfere with training programs offering telesupervision to students.

Another way to strengthen rural mental health care systems is to collaborate with other mental health care providers, including psychiatrists, using technology. As early as 1991, the University of Kansas Medical Center enabled rural children and adolescents to access psychiatric consultation services via telemedicine, thereby allowing these young patients to receive care within their own communities (Ermer, 1999). Similar services exist in other rural communities where telepsychology can provide access to psychologists working in crisis stabilization units as well as to psychiatrists who can prescribe medications as an adjunct to therapy.

Prescription Privileges

Beyond collaborating with psychiatrists via telehealth, another avenue to providing for the mental health care of rural dwellers is the possibility of adding prescription privileges for properly trained psychologists. The APA has made seeking prescription privileges for psychologists a priority since its 1995 (APA, 1995) resolution. To date, Guam has passed prescription privileges; in

the United States, New Mexico (in 2002) and Louisiana (in 2004) have enacted legislation permitting appropriately trained psychologists prescription privileges. A similar model has been successfully employed by the Department of Defense for over two decades, by providers in the U.S. Public Health Service, and by providers in the Indian Health Service (Munsey, 2010).

In 2009, the APA Council approved both a Recommended Postdoctoral Education and Training Program in Psychopharmacology for Prescriptive Authority (APA, 2009b) and Model Legislation for Prescriptive Authority (APA, 2009a) and published a set of "Practice Guidelines Regarding Psychologists' Involvement in Pharmacological Issues" (APA, 2011). McGrath (2010) estimated that, by 2010, 1500 psychologists had obtained the necessary postdoctoral training—usually consisting of a minimum of 450 training hours—for prescription privileges; of these, 230 had passed the APA Psychopharmacology Examination for Psychologists (PEP) competency examination.

Dating back over the past 20 years, the rationale for obtaining prescription privileges has revolved around the need for prescribers in rural and other underserved areas (DeLeon, Fox, & Graham, 1991; Fox et al., 2009; Harowski et al., 2006; Jameson & Blank, 2007). The National Alliance on Mental Illness (n.d.) stated that in New Mexico, the lead proponent of the prescribing privileges legislation noted that only 18 psychiatrists of the state's 90 licensed psychiatrists are located outside of Santa Fe or Albuquerque, whereas 175 of the 400 licensed psychologists in the state reside outside of these two population centers.

However, Baird (2007) surveyed psychologists in Illinois and found that although there was support for prescription privileges among his participants, rural counties had so few psychologists that even adding prescription privileges would not necessarily be a significant improvement in accessibility for rural residents. We have not found data about service provision to rural residents in New Mexico or Louisiana by prescribing psychologists.

The arguments on both sides of the issue revolve around multiple interrelated issues including the professional identity of psychologists, licensing laws, appropriate training, and insurance and liability (Gutierrez & Silk, 1998). For example, proponents argue that adding the ability to prescribe psychotropic medication to their range of interventions would merely be extending the existing role of psychologists as behavioral health specialists because most psychologists agree that a combination of biological and environmental factors is involved in the etiology of mental illnesses (Gutierrez & Silk, 1998). On the other hand, opponents insist that psychology would follow the path taken by psychiatry and eventually focus on medications to the exclusion of psychotherapy. Whether extending prescription privileges to provide care for the underserved would actually increase care or prove to be cost-effective and thus reduce costs for the elderly, children, and rural populations are empirical questions for which there are no answers yet (Dittman, 2004; Lavoie & Barone, 2006).

McGrath and Sammons (2011) noted that there is a natural link between psychologists practicing in integrated care settings and the pursuit of prescription privileges. Although the use of technology may appear to reduce the need for psychologists who can prescribe on site, the possibility that primary care providers write 60% of the prescriptions for psychotropic medication reveals that as many prescribers as possible are needed in these sites. Thus, technology could provide specialist consultation for rural prescribers.

ing psychologists when necessary; however, having professionals on site remains the best alternative.

Psychologists are considering the importance and relevance of prescription privileges for the field and for their own careers. We assume training programs introduce their students to issues of prescription privileges, thus allowing trainees to determine whether this is a good idea for the field (Harowski et al., 2006).

Implications for Professional Practice and Training

The discussion surrounding prescription privileges may have immediate implications for new graduates who oppose them for psychologists and who end up working in rural areas; they may find their perspectives change once they are in a community without services or if they are working in an integrated care setting where access to physician consultation encourages collaboration among professionals.

Along with the controversy accompanying prescription privileges, the following issues have implications for rural practitioners: the use of technology for a variety of psychological services or applications, advocacy for rural practitioners, and collaborative practice with other professionals, with training programs, or with researchers.

The use of technology in all aspects of psychology will continue to grow, especially in rural and other underserved areas where the accessibility and availability of mental health professionals is limited and seeking mental health care is stigmatized. Established practitioners would benefit from learning about the opportunities and challenges for telepsychology and seeking ways to incorporate this new technology in their practices. Further, practitioners living near training programs may want to initiate a relationship with their local training program and request educational outreach programs on technology and its professional applications.

The Internet can alleviate some of the difficulties rural providers have in obtaining continuing education units. Although some states may limit the number or percentage of hours that can be accrued online as opposed to in-person, for rural providers who struggle to find training opportunities close enough to attend without losing an entire day of work, any assistance is welcome (Heath et al., 2008; Johnson, Brems, Warner, & Roberts, 2006). In this instance, rural practitioners may find that they can advocate for their needs through membership in state and national psychological organizations and boards.

Training programs should educate future practitioners about telehealth issues including reimbursement, while addressing the licensing, legal, fiscal, and ethical questions that accompany practicing across state lines. When possible, training programs should train students with technology-based supervision to familiarize them with such service delivery (Stamm, 2003).

Wood, Miller, and Hargrove (2005) reviewed ways in which telesupervision can be helpful in rural areas, whereas Cornish and colleagues (2003) reviewed how technology can be used in consultation or education for rural mental health workers. Including telepsychology in training programs would allow trainees to develop the technological competence endorsed by the APA (APA et al., n.d.) while enabling students to do practicum in outlying areas where psychologists are not present on site (Stamm, 2003). The APA Commission on Accreditation (2010) has acknowledged that telesupervision may have a place in training but has limited its use

while some states have started allowing telesupervision for providers in rural areas who are working toward licensure (Virginia Board of Psychology, 2012). We urge the APA to consider the special needs of remote areas in making decision about telesupervision, license eligibility, and accreditation.

Furthermore, in an effort to include rural perspectives more fully at the state, regional, or national levels, individual rural practitioners may want to consider a systemic approach. Because rural circumstances remain largely unknown in urban settings and in many statewide organizations, the opportunity for a pronounced impact exists for the rural psychologist willing to join boards and organizations. State associations have a voice in licensing and credentialing issues; they can greatly influence decisions about telehealth, licensing, accreditation, reimbursement, and other issues particularly salient to rural and frontier communities.

Beyond collaborating with training programs to enhance their technological knowledge and skills as mentioned earlier, therapists may consider possible collaboration with rural researchers who are helping describe the needs of rural practitioners and of their clients. Research collaborations between rural training programs and rural practitioners, who would thereby gain an audience for their voice about conditions in the field, appear to carry benefits for both parties, and would enrich psychology's understanding of the contexts of rural practice. Finally, one of the simplest, most stigma reducing collaborations for a practitioner may be office colocation with other health care professionals.

People living in rural areas have had to be resilient, creative, and interdependent to survive in often harsh environments. However, the geographic dispersion of people makes service provision more costly and therefore less appealing to providers, which decreases the availability and accessibility of psychologists. This article has presented a variety of ways in which psychologists can improve the quality, amount, and extent of care in rural areas and can offset the inhibiting effects of stigma while also practicing at the cutting edge of the field.

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