Journal of Rural Mental Health
2013, Vol. 37, No. 1, 37–49

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1935-942X/13/$12.00 DOI: 10.1037/rmh0000002

Challenges and Opportunities Associated With Rural Mental Health Practice

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This manuscript outlines the challenges and opportunities associated with rural mental health practice, and provides descriptive data on the scope of care, area of competence, and clinical training of a group of practitioners providing services in rural central Appalachia. Thematic content analysis reveals ethical challenges encountered, job satisfaction, and the pinnacles and pitfalls of mental health care practice in the region. Implications for training, recruiting, and retaining practitioners to work in underserved rural settings are described. The authors highlight a number of areas that need additional research attention in order to address remaining questions relevant to clinical practice in rural settings.

Keywords: Appalachia, ethics, job satisfaction, mental health practice, rural

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Depictions of rural life in mainstream media vacillate between poles of bucolic pastoral scenes lush with livestock and steep mountain slopes strewn with dilapidated trailers. Indeed, scholars on the rural experience note that rural life is widely diverse in economic resources and racial diversity. Depictions of rural life generally rely heavily on stereotypes (Cooke-Jackson & Hansen, 2008). Rural Appalachia especially has been stereotyped, as residents are depicted as "hillbillies," and cast as backward, fiercely opinionated, impulsive, and clannish (Harkins, 2004).

Yet commonalities exist in rural areas within the domain of mental health and access to care. Compared with metropolitan settings, rural areas have fewer mental health and medical services, higher levels of unemployment, and limited educational opportunities (Economic Research Service, 2004; Murray & Keller, 1991; Reed, 1992). Many practitioners working in rural settings have been trained according to an urban model of therapy, in which boundaries between counselor and client are clear and referral options are plentiful (Helbok, Marinelli, & Walls, 2006). The challenges of counselor visibility, lack of anonymity, and the reality of interfacing with clients in social and community settings can be taxing (Campbell & Gordon, 2003). These and other stressors associated with rural practice, including professional isolation and fewer resources for after-hours emergency care, may contribute to reduced job satisfaction and, ultimately, to burnout.

Although the literature has highlighted a number of challenges associated with rural practice, as of yet, scholars have not attended to factors practitioners find appealing regarding working in a rural setting. We were interested in learning what motivates individuals to work and remain in rural areas. In the next section, we describe the challenges of rural practice, followed by the potential benefits. We then describe a research study in which we surveyed mental health practitioners in the central Appalachian region in an attempt to understand perceived opportunities as well as challenges.

Challenges of Rural Practice

Rural practice presents many special challenges for the clinician. Some degree of professional isolation seems inevitable, given that research consistently points to a shortage of

This article was published Online First May 6, 2013.

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We thank Amy Burns, Mandy Sanderson, Erica Whiting, and Alia Zaro for their assistance in data collection and qualitative analysis.

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mental health professionals in rural areas (Goldsmith, Wagenfeld, Manderscheid, & Stiles, 1997; Health Resources and Services Administration, 2005). For example, in the United States, half of counties with populations between 2,500 and 20,000 lack a master's-level or doctoral-level social worker or psychologist (Holzer, Goldsmith, & Ciarlo, 2000). The majority of Mental Health Professional Shortage Areas, identified by the U.S. government as areas critically in need of mental health practitioners, are, in fact, rural (U.S. Department of Health and Human Services, 2005).

A shortage of mental health professionals translates into having fewer peers with whom to consult on difficult cases and fewer referral options. Isolated clinicians may lack the professional and emotional support professional colleagues provide, and the costs can be significant. For example, in a study examining burnout among clinicians practicing in rural Kansas, Kee, Johnson, and Hunt (2002) found that 65% of participants reported at least moderate levels of burnout. The authors concluded that rural clinicians who lack colleagues with whom to share interests and concerns, and who experience a deficiency of mutually nurturing relationships, were at higher risk for emotional exhaustion. The authors concluded, "Lack of sufficient guidance, reassurance of worth, social integration, and attachment were associated with the rural mental health counselors at high risk for burnout" (p. 10).

Job dissatisfaction and burnout threaten to prompt rural clinicians to leave the area, at a time when one of the most critical issues rural mental health care must face is recruiting and retaining personnel to provide much-needed services (Jameson & Blank, 2007). Professional isolation and lack of support from members of their own discipline are concerns for rural practitioners (Battye & McTaggart, 2003). Helbok (2003) noted, "Although psychologists may obtain phone supervision, it does not replace the day-to-day learning and growing through daily interactions with peers" (p. 378).

Social support may be difficult to find outside the work place as well. Rural community values may make it difficult for a psychologist to be accepted. Stigma regarding mental health practice (Hoyt, Conger, Valde, & Weihs, 1997) and suspicion of outsiders are not uncommonly recounted facets of rural social life. Rural community values tend to be more conservative, with religion playing a central role in residents' lives. Yet mental health providers, as a group, generally endorse more liberal and less religious ideologies (Aten, Mangis, & Campbell, 2010; Campbell & Gordon, 2003). These cultural barriers and a lack of understanding regarding the mental health profession (DeLeon, Wakefield, & Hagglund, 2003) may impact a psychologist's satisfaction in a rural area. A clinician's family may struggle to make connections in the community as well. Worries about employment options for a psychologist's partner and children's educational opportunities may be real concerns for providers contemplating rural practice.

An additional reality of rural practice is the need to serve as a generalist in order to meet the needs of a heterogeneous clientele (Stamm, 2003). Because there are fewer referral options for clients, mental health providers need to work with people presenting with issues across the life span and, as a result, may be challenged in terms of their boundaries of competence (Gamm, Stone, & Pittman, 2003). It is likely that the scope of care for clinicians is very broad. Most research indicates prevalence rates of mental illness in rural areas are comparable with rates in metropolitan areas (Kessler et al., 1994; Roberts, Battaglia, & Epstein, 1999; Robins & Reiger, 1991). However, Wagenfeld and Buffum (1983) suggested that mental health problems in rural areas are more significant than in urban areas, citing stress associated with poverty, farm crises, numbers of high-risk populations, and the effects of natural disasters. Indeed, suicide rates, alcohol abuse, and disability are higher in rural settings (Roberts et al., 1999; Wagenfeld, Goldsmith, Stiles, & Manderscheid, 1988).

Potentially exacerbating the severity of distress is the challenge in finding employment. Unemployment rates tend to be high in rural areas, and many rural residents lack adequate health care coverage. Fewer transportation options and greater distances to travel for care may mean psychologists find it more difficult to deliver uninterrupted coordinated services. The lack of employment opportunities, paired with the difficulty of accessing transportation, affects clients' ability to afford services.

Another stressor for the rural clinician is the visibility often cited as characteristic of rural

areas. Rural scholars frequently describe this dynamic of rural life, some referring to rural residency as living "in a fishbowl." One of our graduate students who had grown up in rural West Virginia referred to it as the "who's your daddy" phenomenon. She recounted numerous incidents in which, when meeting people from adjacent counties, she was asked that very question, as residents attempted to "place" her among her kin. According to Campbell and Gordon (2003),

> People are known in family, social, and historical context. Individuals are known not simply by the work they do or where they live but also by their family legacy in the community. It is common to know someone not only by name but also as someone's son or daughter, aunt, or grandson. (p. 431)

Rural residents recognize each other by their vehicles and tend to know "everything about everybody." The stigma associated with seeking mental health treatment is exacerbated by the difficulty in remaining discreet in small communities.

This persistent visibility can prove stressful for a mental health provider whose professional competence may be inferred by the way her children behave in the supermarket or the degree to which her neighbors perceive her as friendly and accessible. Helbok (2003, p. 380) noted,

> The client may also know of the psychologist's beliefs and values by knowing what church he or she attends, the stand he or she takes on community concerns, the books he or she buys, and from his or her interaction with others in day-to-day community life.

Further, the "lack of control over what is known about the therapist may also increase therapist anxiety" (p. 381).

Another characteristic of rural-living therapists is the increased likelihood of being engaged in multiple relationships with one's clients. This often-cited dynamic is easily imagined when one considers reduced population density and the resulting likelihood of encountering one's clients outside the office. For example, it is conceivable that a client works in the salon in which the psychologist has her hair cut or that she sees the sherriff's son in therapy. These boundary issues are not necessarily problematic, provided the provider is aware of their likelihood and is prepared to address them (Werth, Hastings, & Riding-Malon, 2010), but they can create stress for the clinician and require a sense of hypervigilance, which consumes emotional energy.

A number of scholars have asserted that graduate training provides inadequate preparation for rural psychological practice. Academic programs have been described as adhering to an "urban model" of training (Dyck, Cornock, Gibson, & Carlson, 2008; Stamm, 2003), in which boundaries between therapist and client are clear and referral options are plentiful. Hargrove (1991), in speculating about why clinicians may not choose to work in rural areas, asserted that psychologists leave their doctoral programs ill prepared to address the range of problems present in rural areas. Professionals are visible in small communities. Maintaining boundaries between one's personal and professional life, combined with the challenge of interfacing with clients in social settings, can be taxing. These and other stressors associated with rural practice, including professional isolation and fewer resources for after-hours emergency care, may contribute to reduced job satisfaction and burnout.

Opportunities of Rural Practice

Although research is clear that practitioners in rural areas will face unique obstacles and challenges—both in scope and ethics—in providing care, scholars have been less interested in identifying the opportunities that exist for rural care. Within the literature, four areas have been identified: ability to be a generalist, integrated care, financial incentives, and congruence with beliefs and values.

In contrast to urban areas, in which one may need to specialize in order to obtain a referral or admission to insurance panels, rural areas provide the opportunity to serve as a generalist, practicing across the life span (Hargrove, 1982). Additionally, literature suggests that it is not an uncommon practice for individuals to work with members of the same family at the same time (Curtin & Hargrove, 2010). Working within multigenerational families provides a unique opportunity to understand the symptom or problem from multiple informants and may provide a more balanced perspective from which to conceptualize the client and situation.

A number of scholars note that rural practice necessitates integrative and collaborative care

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(e.g., Haxton & Boelk, 2010). Because resources are scarce in rural areas, collaboration becomes a necessary luxury. Given the lack of psychiatrists in rural communities (Holzer et al., 2000), primary care physicians may rely on the skills of psychologists to help guide them in making decisions about medications. As Haxton and Boelk remarked, teamwork and working as a collaborative unit are essential in rural areas where resources such as financial means are at a premium. Collaborative care not only enhances communication (Orchard, Curran, & Kabene, 2005; Suter et al., 2009), as others have noted, but also promotes creativity in the delivery of services (Haxton & Boelk, 2010). Federal attention has been placed on integrated care in rural settings. Both the U.S Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration have called on providers in rural settings to organize, develop, and implement behavioral initiatives that focus on collaborative care across disciplines (Mauch, Kautz, & Smith, 2008).

With median debt for those psychologists entering the helping professions hovering around $70,000 (American Psychological Association, 2007), working in a rural setting has distinct financial advantages. In 1995, the National Health Service Corps Loan Repayment and Scholarship Program began providing additional funding for psychologists and training opportunities for interns in federally underserved areas through the use of Federally Qualified Health Centers (U.S. Department of Health and Human Services, 2005; National Health Service Corps, 2010). More recently, the NHSC program has begun offering loan repayment up to $25,000 a year if the service provider agrees to work in an underserved area (National Health Service Corps, 2010). Resources for paying off student loan debt, paired with lower cost of living (Nord, 2000) in rural areas, has also been identified as a potential advantage of rural practice.

Lonne and Cheers (2004), in their analysis on retention of social workers in rural Australia, found that although a number of practitioners left because of lower salary, large and heavy caseloads, fewer opportunities for supervision and consultation, and limited resources for clients, a number of individuals chose to stay in rural areas despite these challenges. Factors such as a slower pace of life, greater physical safety compared with metropolitan areas, and variability in client problems have been reported as factors that sustain practitioners in rural settings. Indeed, some individuals find the values of rural life appealing. For example, Danbom (1997), in an essay on what Americans value about rural life, argued that, historically, the emphasis on family bonds, self-reliance, and traditional values have been appealing for many Americans. Thus, if individuals share the traditional values typically found in rural areas, they may adapt more easily to the demands of the environment and enjoy the respite from some of the conditions of urban areas. Rural areas typically feature tight communities with little crime, pollution, and traffic, yet they provide abundant recreational activities. The autonomy offered by rural clinical practice and the opportunity to work with a variety of presenting issues may be appealing to some clinicians (Jameson, Blank, & Chambless, 2009).

Although research points to four areas of benefits of rural practice, researchers have yet to measure what mental health practitioners value about their job, and find both rewarding and challenging about rural mental health. To date, researchers have generally focused on the barriers to treatment and the many challenges the providers face in rural care. In an attempt to explore the positive as well as negative factors that helping professionals find in rural care, and to assess the degree to which rural practitioners felt prepared for the realities of rural practice, we proposed the following research questions:

1. What are the benefits and challenges of employment in rural mental health?
2. What are the benefits and challenges of residing in rural areas?
3. To what degree do practitioners view their training as adequate preparation for the demands of rural practice?

Method

Participants

One hundred twenty-three health mental professionals serving in the Appalachian region responded to an online survey. There were 97 women (78.9%) and 26 men (21.1%). Ninety-six percent of the sample identified as European

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American, 0.8% as African American, 0.8% as Hispanic American, and 1.6% of the sample did not disclose their ethnicity. With regard to highest mental health degree, 86.2% of the sample had obtained a master's degree, 6.5% had a doctoral degree, 4.9% had another type of degree, and 2.4% had an educational specialist degree. Nearly 6% (5.6%) of the sample was over the age of 61, 32% was 51 to 60, 24.8% was 41 to 50, 20.8% was 31 to 40, and 15.2% was 23 to 30.

Instruments

Participants were asked to complete a 40-item questionnaire that measured the domains of job satisfaction, areas of care and practice, competence in areas of care from schooling, and strengths and challenges in providing services in a rural area.

Scope of care, competence, and educational training. Participants were asked to report areas of regular practice within their clinical work, including substance abuse, ethnically diverse clients, clients in poverty, older adults, and other practice areas in responding to the prompt of "In my clinical work, I regularly deal with the following types of clients . . . ." The full list of areas of practice is provided in Table 1. Practitioners were also asked to report on their level of perceived competence as well as whether they believed their educational experience provided training in each of the areas of practice by responding to the following prompts: "I feel competent in dealing with the following clinical issues . . ." and "The program I attended did a good job preparing students to work with . . ." The same 5-point scale (1 = *strongly disagree*, 2 = *disagree*, 3 = *neutral*, 4 = *agree*, 5 = *strongly agree*) was used to assess areas of practice, competence, and educational training.

Job satisfaction. The Andrews and Withey (1976) Job Satisfaction Questionnaire was used to measure job satisfaction with a five-item, 7-point Likert-type scale (1 = *delighted*, 2 = *pleased*, 3 = *mostly satisfied*, 4 = *mixed*, 5 = *mostly dissatisfied*, 6 = *unhappy*, 7 = *terrible*). Items on the scale include measuring how the respondent feels about physical surroundings, resources, people/staff, and the actual tasks that respondent completes. Internal consistency for the Job Satisfaction Questionnaire has been reported at .80 (Rentsch & Steel, 1992). The instrument has been found to correlate with other measures of job satisfaction, including the Minnesota Satisfaction Questionnaire (Rentsch & Steel, 1992; van Saane, Sluiter, Verbeek, & Frings-Dresen, 2003). The measure also has been found to predict job performance and likelihood of employee job termination (Rentsch & Steel, 1992).

Challenges and opportunities. Participants were asked to respond to a series of open-ended questions about their work in a rural setting: (a) what do you like about your job, (b) what are the drawbacks or limitations of your job, (c) what are the drawbacks or limitations of the location where you live, and (d) what are the benefits of the location where you live?

Table 1
*Descriptive Statistics for Scope of Practice (*N = *123)*

Regularly work with:	Degree of agreement percent of sample (frequency)				
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Client of diverse ethnic/racial backgrounds	5.60 (7)	23.4 (29)	20.2 (25)	33.9 (42)	16.1 (20)
Gay, lesbian, or bisexual clients	16.1 (20)	16.1 (20)	21.0 (26)	42.7 (53)	9.7 (12)
Geriatric/older clients	22.6 (28)	21.0 (26)	14.5 (18)	31.5 (39)	9.7 (12)
Children/adolescents	8.9 (11)	10.5 (13)	5.6 (7)	28.2 (35)	45.2 (56)
Clients with disabilities	0.0 (0)	9.7 (12)	11.3 (14)	48.4 (60)	29.0 (36)
Clients with substance abuse problems	2.4 (3)	8.1 (10)	4.8 (6)	33.9 (42)	49.2 (61)
Clients dealing with bereavement	.8 (1)	4.0 (5)	16.9 (21)	57.3 (71)	20.2 (25)
Clients in poverty	1.6 (2)	1.6 (2)	3.2 (4)	36.3 (45)	56.5 (70)
Clients dealing with domestic violence	.8 (1)	1.6 (2)	8.1 (10)	57.3 (71)	31.5 (39)
Clients with relationship/marital problems	1.6 (2)	4.8 (6)	8.9 (11)	41.9 (52)	41.9 (52)

Note. Percentages do not add up to 100 because some respondents chose not to respond.

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Procedure

Participants were recruited through a regional counseling conference electronic mailing list, professional organizations, and contacts at mental health centers. Individuals were directed to a Web page that provided information regarding informed consent. Participants indicated their consent by clicking on a hyperlink that took them to the survey Web page. Data were collected from each participant without collecting identifying information such as name or address. Completion time for the survey was under 30 min. Approval was granted by the institutional review board prior to starting the study.

Data Analysis

Once data were collected on the four open-ended questions on work setting and rural life, responses to each question were distributed to five team members, four of whom were graduate students familiar with the literature on rural practice and their faculty research advisor. The team used open coding to capture impressions of participant responses. Each research team member generated a list of predominant themes that were then presented to the group. Categories were allowed to emerge from the data, using codes developed by group consensus to identify key themes. One team member maintained memos of the group's process to ensure that the coding strategies eventually adopted would reflect the original data set. Given the interaction between subject and researcher, keeping notes or memos on the process of coding helps limit the impact of the researchers on the material (Fassinger, 2005). In addition to the use of memoing, the faculty member served to audit the coding process, evaluating each of the themes and assuring the individual responses from respondents aligned with the theme. Team members ranked emergent categories to prioritize those that appeared more important to participants.

Results

Scope of Care, Competence, and Training

Table 1 provides data on the areas of practice for the participants. In general, participants practice within a variety of clinical domains. In particular, rural practitioners reported that they regularly see clients with substance abuse concerns (83.1% agreeing or strongly agreeing). Nearly 90% of participants agreed or strongly agreed that they routinely saw clients with domestic violence concerns, and almost 80% reported regularly working with clients with disabilities. Given the frequency of working with clients with disabilities, and thus the greater likelihood that these individuals may need government assistance, 92.8% of the sample agreed or strongly agreed that they worked with individuals in poverty. Within areas of less frequent practice, 52.4% of participants agreed or strongly agreed that they routinely work with lesbian, gay, or bisexual (LGB) clients. Forty-one percent (41.2%) of participants strongly agreed or agreed that they routinely worked with older clients.

Table 2 reports the level of agreement for feeling competent to work with eight areas of practice. In general, most participants felt com-

Table 2
*Descriptive Statistics for Areas of Competence (*N = *123)*

	Degree of agreement percent of sample (frequency)				
Feel competent working with:	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Depressive disorders	0.0 (0)	.8 (1)	1.6 (2)	33.1 (41)	63.7 (79)
Anxiety disorders	0.0 (0)	.8 (1)	.8 (1)	42.7 (53)	54.8 (68)
Substance abuse disorders	3.2 (4)	12.9 (16)	16.1 (20)	29.8 (37)	36.3 (45)
Marital/relationship concerns	0.0 (0)	8.1 (10)	6.5 (8)	46.0 (57)	38.7 (48)
Sexual offender treatment	32.3 (40)	35.5 (44)	14.5 (18)	11.3 (14)	5.6 (7)
Anger management treatment	.8 (1)	10.5 (13)	7.3 (9)	41.9 (52)	38.7 (48)
Parent training	1.6 (2)	5.6 (7)	15.3 (19)	39.5 (49)	37.1 (46)
Child behavior disorders	4.8 (6)	9.7 (12)	13.7 (17)	34.7 (43)	36.3 (45)

Note. Percentages do not add up to 100 because some respondents chose not to respond.

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petent to work with many groups. Sexual offender treatment had the lowest level of competency, with 67.8% of the sample reporting that they disagreed or strongly disagreed that they were competent to treat these concerns. Most practitioners agreed or strongly agreed that they felt competent to treat depressive disorders and anxiety disorders, 96.8% and 97.5%, respectively. Although 83.1% of the sample reported that they agreed or strongly agreed that they routinely saw clients with substance abuse concerns, only 66.1% reported that they agreed or strongly agreed that they felt competent to treat individuals with these concerns.

Participants were asked to report to what degree their educational training program did a good job preparing students to work in different domains. Educational training experiences are reported in Table 3. Understandably, graduate programs cannot anticipate all the needs their students may face. However, 25% of the sample disagreed or strongly disagreed that their training program had prepared them to work with LGB clients. A quarter of the sample (25.8%) reported a neutral training experience with LGB clients in their educational programs. Nearly 30% (29.9%) of the sample reported disagreeing or strongly disagreeing that their educational program did a good job preparing them to work with older clients, but only 12.9% of the sample disagreed or strongly disagreed that their program did a good job training to work with children. The lack of formalized training in working with older adults could be a significant concern for rural practitioners who may have fewer options to refer clients for who they have little training or experience.

Job Satisfaction

Internal consistency for the Andrews and Withey Job Satisfaction Scale was $\alpha = .74$. Of those responding to the survey, nearly 24% were "delighted" with their job and 29.3% were "pleased." Twenty-six percent ($n = 32$) indicated they were "mostly satisfied" with their current job and 13% were mixed about their satisfaction. Fewer numbers were dissatisfied, with 5.7% indicating they were mostly dissatisfied and less than 1% (.8%) were either unhappy or "terribly unsatisfied." The mean job satisfaction rating for the item assessing overall job satisfaction was 2.53 ($SD = 1.26$, range 1 to 7). An overall index score was calculated by summing responses on all five items, with higher scores indicating greater dissatisfaction (minimum score possible = 5; maximum score possible = 35). In the current study, the range on the job satisfaction index was 5 to 19, with a mean score of 12.72 ($SD = 4.51$).

Perceived Opportunities

Responses to open ended questions revealed themes, which are reported in Table 4. When

Table 3
*Descriptive Statistics for Educational Training (*N = *123)*

Educational training program preparation area:	Degree of agreement percent of sample (frequency)				
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Client of diverse ethnic/racial backgrounds	.8 (1)	9.7 (12)	14.5 (18)	50.8 (63)	22.6 (28)
Gay, lesbian, or bisexual clients	4.0 (5)	21.0 (26)	25.8 (32)	37.1 (46)	9.7 (12)
Geriatric/older clients	6.5 (8)	23.4 (29)	24.2 (30)	35.5 (44)	8.9 (11)
Children/adolescents	4.0 (5)	8.9 (11)	16.1 (20)	38.7 (48)	30.6 (38)
Clients with disabilities	1.6 (2)	21.0 (26)	25.0 (31)	34.7 (43)	16.1 (20)
Clients with substance abuse issues	1.6 (2)	20.2 (25)	21.8 (27)	37.9 (47)	16.1 (20)
Clients dealing with bereavement	1.6 (2)	12.1 (15)	23.4 (29)	47.6 (59)	13.7 (17)
Clients in poverty	3.2 (4)	12.1 (15)	16.1 (20)	44.4 (55)	21.8 (27)
Clients dealing with domestic violence	18.5 (23)	16.9 (21)	28.2 (35)	34.7 (43)	18.5 (23)
Depressive disorders	0.0 (0)	5.6 (7)	11.3 (14)	39.5 (49)	36.3 (45)
Martial/relationship concerns	0.0 (0)	8.9 (11)	18.5 (23)	43.5 (54)	27.4 (34)
Sexual offender treatment	26.6 (33)	34.7 (43)	21.0 (26)	15.3 (19)	15.3 (19)
Anger management	3.2 (4)	16.9 (21)	32.3 (40)	32.3 (40)	12.9 (16)
Parent Training	1.5 (2)	18.5 (23)	28.2 (35)	33.1 (41)	16.1 (2)

Note. Percentages do not add up to 100 because some respondents chose not to respond.

Table 4
Themes Related to Work and Living Location

Open-ended questions	Participant themes
What do you like about your job?	Making a difference
	Freedom, flexibility, autonomy
	Diversity of clients and client issues
	Coworkers
	My family is close by
What do you dislike about your job?	Salary/benefits
	Funding/resources/clients lack insurance
	Overworked
	Agency problems and politics
	Travel, distance, driving
What do you like about where you live?	"I was born here"
	Peace and quiet
	Live away from clients
	Landscape
	Rural people/rural lifestyle
	Few city problems (low crime, less light pollution, clean water and air, etc.
	It's "close enough" to conveniences
	Close to family/friends
	Low cost of living
What do you dislike about where you live?	Limited access to stores (especially book stores), services, and professional opportunities
	Little diversity
	Conservative community
	Lack of privacy
	Driving distances

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given the opportunity to express benefits associated with practicing in a rural environment, the most commonly occurring topics include freedom and flexibility in their personal practices; this theme typifies practitioners' enjoyment of the freedoms associated with general practice as well as the utilization of creative techniques in their direct work with clients. One respondent said, "I love the flexibility of my work schedule. . . . I enjoy creating my own niche (early childhood mental health) in the community and being recognized as someone to contact for challenges related to this." Another commented,

> I like my peers/coworkers. I enjoy feeling part of a team that provides quality counseling services to the community. I like being able to provide assessments to engage people in our services; I get satisfaction in helping individuals feel grounded in beginning the treatment process.

A third stated, "I get to be a part of making a difference in the lives of families." These practitioners relish their role in the community. Their visibility permits an awareness of individual families and an ability to make a difference, and they use the resultant respect to collaborate with other professionals to provide the most effective multimodal treatment. Interestingly, two of these sample responses contradict aspects of rural practice frequently discussed in the literature. The first respondent, for example, introduced the notion of "creating a niche" in her community with young children. As discussed earlier, the literature on rural practice typically emphasizes the need for clinicians to equip themselves with generalist skills to meet the varying demands of their underserved area. Yet this clinician was able to identify a specific area of need and adapt to meet it. The second participant's response stresses the value of working with a team. Again, the literature on rural practice focuses on clinicians often lacking support of colleagues who may be miles away. However, it is worth noting that an earlier study examining mental health counselors in rural Kansas (Kee et al., 2002) found that rural practitioners who had greater social support were less likely to suffer the effects of burnout. It appears our sample captured an example of a clinician with nurturing collegial relationships,

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and in this clinician's case, these relationships significantly enhanced her satisfaction with her rural position.

Other positive qualities related to residing in rural environments that emerged in the research pertained to familial ties to the community, stunning vistas, a negligible cost of living, and appreciation of small town culture. As one respondent commented, "I have lived here for 34 years, have made many friends, and I feel at home here. There's a less stressful lifestyle. I have a supportive community of friends, and it's beautiful!" Another remarked,

> People in the community seem to know one another better than in a larger city. This can lend itself to looking out for one another. The area is mountainous and very picturesque. I share the values of the locals and the appreciation for simplicity.

Small town culture is characterized by a sense of community responsibility, individual agrarian values, commonality of religion, and a general fund of knowledge regarding one's neighbors. Several respondents commented on leaving doors unlocked at night and enjoying scenic commutes to work that do not involve heavy traffic or interstates.

Perceived Challenges

Many of the reported benefits of rural work can also be some of the greatest impediments, such as intrusions into privacy. One respondent commented, "There's a lot of gossip among the staff because everyone knows everyone." Another stated,

> A lot of the staff have not worked anywhere outside of here, so their experiences with a variety of clients and issues is limited, as is their exposure to new techniques, and so forth This also lends to them knowing personal histories of clients and their families, which can sometimes lead to prejudgment of the clients.

Other challenges included inadequate funding, resources, and insufficient compensation. One of the primary concerns included the pervasive tedium of duties not associated with providing direct care to clients, such as travel time, paperwork, and battling managed care and state mental health reforms. "The limitations of the job are that there is too much work and not enough licensed staff to go around. Overwhelmed caseloads make you feel like you cannot always provide quality when you are pushing nonsensical state paperwork," noted one respondent.

In order to maintain self-care and competence in a general practice, professionals engage in consultation and collaboration with their colleagues. However, because of insufficient support in rural areas, many are not receiving this type of support or the only assistance is by individuals without the appropriate training. One respondent stated, "There is a tremendous amount of paperwork. The work duties and expectations are increasing. In short, there are less people doing more work than in the past. I wish that I felt more supported by administration."

Additional responses noted difficulties with lack of privacy, inability to freely express divergent opinions, and suspicion associated with nonindigenous practitioners ("outsiders"). Poor economic growth is associated with limited resources, limited convenience, and limited professional opportunities. These factors exacerbate existing social problems, including widespread substance abuse, insufficient mental health care, and poor access to medical care.

Implications and Future Research

The findings from the current study have implications for individuals who are interested in working in rural settings. Because of the special demands of practicing in a rural setting, mental health practitioners interested in rural work need to find opportunities to acquire both knowledge and experience in order to practice professionally in a rural environment.

The results from this study provide insight into whom to recruit to work in rural settings. Individuals who have strong boundaries but are able to balance the demands of the fluid nature of privacy in a rural area may be best suited to rural practice. Further, individuals with a strong sense of self and who value autonomy may be best suited for rural practice. In order to keep practitioners in rural areas, facilities may have to provide greater opportunities for receiving supervision from appropriately credentialed supervisors, peer mentoring, consultation, diversity in work-related tasks, and opportunities for self-care.

An unexpected finding in this study was the age range of participants. The largest represented group consisted of people ages 51 to 60 (32.0%). If this is an accurate reflection of the

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mental health work force in some rural areas, then within the next 10 years, a significant proportion of providers will be nearing retirement. Thus, there may be additional opportunities for new professionals to establish homes and careers to meet the needs of an underserved population. Mental health agencies may benefit from considering the age distribution of their work force to ensure adequate service delivery in the future. Further, agencies likely will need to be active in recruiting counselors to work in rural areas. Highlighting the benefits of rural work, including overall job satisfaction of counselors, collaboration with colleagues, and opportunities to utilize creative, innovative approaches to counseling will likely be attractive to potential candidates.

In the future, researchers may want to examine two areas regarding what individuals find attractive about rural practice and what helps individual stay in rural practice. Jameson and colleagues (2009) surveyed graduate students and found that, in theory, graduate students indicated that there were not necessarily opposed to practicing in a rural area. Thirty-five percent of respondents had a mildly, moderately, or strongly positive attitude toward working in a rural setting. In actuality, however, practitioners may be less inclined to select a rural area than a suburban or metropolitan setting. For example, Mills and Millsteed (2002), in exploring rural practice in Australia, reported that both recruiting and retaining practitioners (occupational therapists, primary care physicians, and psychologists) has been especially difficult in rural settings. Therefore, it may be helpful to understand what aspects of rural life are appealing or attractive for potential practitioners. The current study clarified what people value once they are in a rural setting as well as indicating that, in general, practitioners are satisfied with their job; in the future, it may be helpful to understand what practitioners find attractive about the rural setting before they enter rural practice. Further, additional study may help determine whether students who are trained in rural psychology work and stay in rural areas.

An additional area of research within the area of rural practice is to understand the impact of stressors on the rural clinician. If the clinician must be ever vigilant for potential boundary crossings and dual relationships, how does this vigilance influence the practitioner's overall sense of well-being and security? Moreover, if the clinician is in a "fish bowl" and something "goes wrong" personally or professionally, how do those stressful events impact the rural practitioner? Is the effect of the stress different from that experienced by practitioners in a metropolitan area in which he or she can more easily fade into the masses? Future research could compare levels of stress and burnout among rural mental health providers versus those in more metropolitan areas.

There are a number of limitations to the current study. In general, the majority of the participants were quite satisfied with their job, so it is possible that individuals who were not satisfied may have been less likely to respond. Additionally, given that some participants were recruited from listservs, it is possible that the overworked and overburdened practitioner may not have had resources (e.g., time or energy) to complete the survey, thus minimizing the challenges reported concerning rural practice. Moreover, given the potential difficulties and risk of burnout in rural practice, individuals who are highly dissatisfied may move to urban areas and therefore would not have been included in this research. Additionally, this research sample was comprised of practitioners in the central Appalachian region. Although the sample provides a snapshot of mental health practitioners in this area of North America, samples from other regions may appear quite different on some important dimensions. Because of the breath of rural practice, the ability to generalize the current findings to all areas of rural practice may be limited.

Conclusions

In the current study, practitioners' views of the benefits and challenges of rural mental health practice show many trends, primarily that, often, the very aspects of the area that make it most appealing can also lead to many challenges in providing mental health services. For example, although some participants commented on the easy-going nature of rural life and the peace and quiet they enjoy, others noted the difficulty of accessing resources such as bookstores, the performing arts, and museums. Findings also indicated that practitioners need to have experience that allows them to practice

competently with clients ranging across the life span and thus will need to have exposure, experience, and training to treat a variety of concerns. Additionally, results indicated that these training experiences may not be available in the graduate programs, and, therefore, students may have to make special efforts to seek out opportunities for rural practice.

Practitioners who enter training programs that place emphasis on working within a developmental framework and focusing on prevention and psychoeducation may be especially well-suited for rural practice. Training programs would assist their students by incorporating more information about rural practice, especially regarding rural cultural norms and boundary negotiation, and providing training experiences serving rural populations. In addition, programs could help clinicians in training develop skills to assess the needs of small communities in order to identify any special areas of practice that would benefit those communities.

Finally, the potential for therapists to make a significant impact in rural settings appears to be increasing. In our sample, large numbers of practitioners will be retiring within the next 8 to 10 years, exacerbating the long-standing shortage of rural providers. Early career counselors and graduate students who have not considered rural practice may want to explore the possibilities of working in these underserved areas.

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Received November 27, 2012
Revision received March 15, 2013
Accepted March 18, 2013 ■

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