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Critical Factors For Training In Rural Psychology

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CRITICAL FACTORS FOR TRAINING IN RURAL PSYCHOLOGY

by

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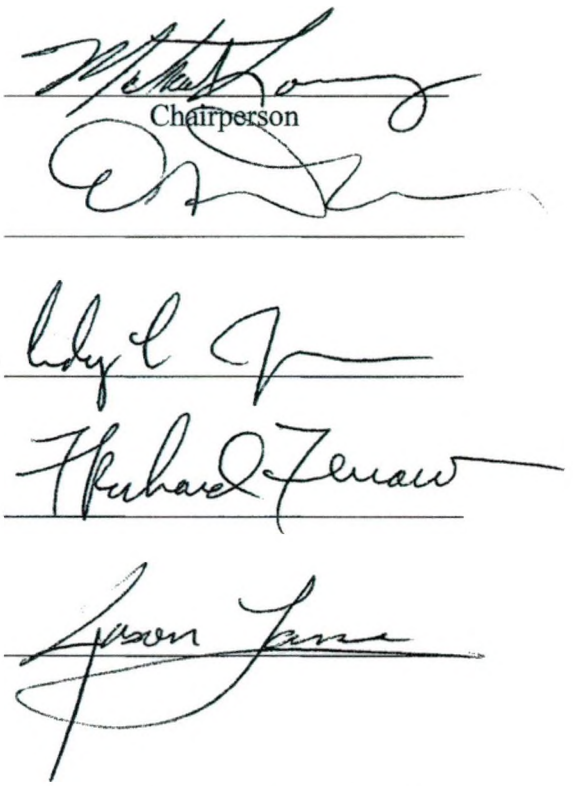

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This dissertation meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.

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I hope the knowledge gained in this study will contribute to further understanding of the need for training for work in the field of rural psychology. This study is close to my heart and as I endeavor to promote rural mental health literacy and mental health services in rural areas I will continuously reflect back on its findings.

ABSTRACT

Students in graduate level psychology training who intend to work in rural settings must be familiar with and educated in how rural life and identity impacts clients. Currently, there are few doctoral training programs in psychology that offer courses specifically tailored to rural populations despite the fact many psychologists are employed, or work with people, in rural settings. As such, there is a need to understand how to best prepare students in doctoral training in psychology for competent work as psychologists in rural areas. Given the nature of rural culture, rural mental health, urban versus rural characteristics, the current status of rural practice, and the overwhelming lack of education regarding rural issues, the purpose of this study was to ascertain critical factors for training in rural psychology.

Through dialogue with 33 current rural psychologists, researchers who have published in the area of rural psychology, and educators in rural psychology (predominantly residing in the United States) via the Delphi method, 129 discrete elements for an effective rural psychology training curriculum were identified. Via the process of the Delphi methodology, 17 factors were noted as critical. Sixty-seven factors were noted as very important. Nineteen more items were reported as very important, but had a variance at or exceeding 1.0, for a total of 86. Ten factors were noted as somewhat important. Sixteen more factors were noted as somewhat important, but reported a variance of 1.0 or greater, for a total of 26.

Critical components centered around the challenges of being the sole practitioner, coping with limited resources, and understanding of ethical principles including multiple relationships, understanding ones' limits of competence, privacy and confidentiality concerns, boundary setting, and reflecting on psychologist's visibility in rural settings. The need for generalist training rang loud and clear. Results also suggested that students must understand the varying roles one might encounter while working in the rural setting and that communication skills were critical. The importance of collaboration and communication with other professionals and community leaders and gaining exposure to multiple rural settings and hands on training were also cited as critical.

CHAPTER I

INTRODUCTION AND REVIEW OF THE LITERATURE

Many researchers of rural psychology and those who practice in rural settings cite the lack of knowledge of rural culture and limited understanding of how living in a rural setting impacts mental health and mental health service utilization as serious concerns. Currently, there are few programs that offer courses specifically tailored to rural psychology despite the fact many psychologists are employed in or deal with people in rural settings. Some psychologists find themselves working in rural communities because of a lack of employment opportunities in more urban settings, while others have chosen to practice in rural areas for a variety of reasons. Those reasons may include upbringing in a rural setting, a desire to serve the underserved, or simply enjoying the life that a rural setting offers. Either way, most doctoral programs in clinical and counseling psychology do not adequately present the differences between working in rural versus urban populations nor do programs often offer coursework for those interested in working in rural areas.

Research points to the idea that rural psychologists need to be generalists in their practice as well as informed on the lifestyle rural folks endure and enjoy. Understanding rural culture, what is rural, rural versus urban characteristics, rural mental health, and mental health service utilization in rural areas is therefore important. Taken further, it is important for students to gain knowledge on rural practice and the clinical skills required for rural practice, ethical issues unique to rural practice, and opportunities or lack thereof

for professional development and continuing education in rural settings. Furthermore, we must consider the process of recruiting and retaining psychologists for work in small communities and consider current training opportunities in rural psychology. Thus, this study was conducted to determine the critical components of training in rural psychology using the Delphi Methodology, a method that allows researchers to generate a consensus among experts through anonymous responses.

The Current Status of Training in Rural Psychology

Though many mental health professionals might work in rural settings, few have received adequate training or continuing education related to practice in small-community practice (Schank, 1998; Murray & Keller, 1991). Schank and Skovholt (1997) found that 10 of 16 rural psychologists had coursework or training in ethical issues, but that none of their degree programs included any training or coursework in the practice of rural psychology. Most psychologists are trained according to an urban model of psychology and most of the practical experiences students undergo, including practica and internships, are occurring in urban areas where there is access to a wealth of and variety of services. Copans, and Schetky (1998) point out that urban-based practice models may take for granted services such as easy access to self-help groups, public transportation, day treatment centers, or community centers among many other services.

Furthermore, urban-based practice models don't always take into account the unique lifestyle, different stressors, and demographic differences rural settings hold. Urban-based training does not prepare students for the challenges to the traditional practice of psychology and these challenges often confront psychologists with problems and dilemmas in rural areas (Helbok, 2003). Many authors point specifically to the fact

that ethics codes in particular are not well suited for rural practice. Schank (1998) commented "understanding the dilemmas of small-community practice is important not only for counselors in these settings, but for their urban colleagues and for governmental and professional policy makers" (p.272). Kropf (2003) argues that within the curriculum coursework and information on health care, economics, and leadership/decision making need to also be included in order to best prepare students for working in rural communities. She elaborated on this notion by adding that we must define the terms diversity and multiculturalism more broadly to include variables such as community context.

Also, from a training perspective, Harowski, Turner, Levine, Schank, & Leichter (2006) comment:

> Current training models in graduate psychology are out of touch with the practice demands of rural psychologists. Our traditional doctoral programs train psychology students in isolation, only in their own discipline, and by their own faculty, and often in their own departmental clinics. Rural practice preparation requires interdisciplinary collaboration among multiple disciplines and health care faculties and a rich diversity of professions rather than a monoculture of psychology. (p.161).

Given the aforementioned concerns, and as Cynthia Belar, APA's executive director for education alluded to in 2003; "requirements of the workplace" need to drive the curriculum.

Harowski, et al. (2006) commented that despite the existence of an APA proposed curriculum in 1995 and some examples of graduate programs providing training in rural

health (both to be discussed in later sections) there has been little incorporation of the training needs of rural psychologists in accredited doctoral psychology programs. They also note that, although nothing in the current *APA Committee on Accreditation's Guidelines and Principles* (2000) prohibits the development of rural training curriculum, the proposed changes only include adding a fourth doctoral program called "professional" which is intended to encourage new models and innovation in training programs in potentially any area, not just rural psychology. These same authors suggest that what might provide even more reassurance for doctoral programs to consider shifts toward rural practice preparation would be "including specific comments in the Guideline and Principles addressing geographic diversity in addressing issues of respect for cultural and individual diversity" (p. 161). These authors conclude, that:

> Specialized education and training are needed to achieve the *New Freedom Commission on Mental Health's, 2004 Goal 3:2*: *Improve access to quality care in rural and geographically remote areas*. Innovative rural psychology training programs need to address the issues of rural communities such as inordinate difficulty in recruiting and retaining mental health professionals because of factors such as lack of training in the unique aspects of rural practice at the graduate or postgraduate level, professional isolation, lack of a cohesive mental health community, the added personal stress of disconnected rural mental health infrastructure, lack of community resources to retain mental health providers, and lack of familiarity with the multidisciplinary crossover culture of mental health delivery in rural areas. (p.162).

Wedel, summed it up nicely back in 1969, predating these more current comments, when he said, "there is danger in that we blindly assume that that which is effective and operational in urban areas should work for small communities and rural areas" (p.437).

Definitions of "Rural"

Before continuing, it is important to define what is meant by "rural." There is considerable debate in the existing literature regarding what constitutes a "rural" community. The United States Census Bureau defines rural populations as less than 2,500 people in open country outside of a Standard Metropolitan Statistical Area (defined as an area with one city larger than 50,000 inhabitants, or with a city larger than 25,000, which together with contiguous populated areas, totals more than 50,000 inhabitants). Using *this* definition, the 2000 census found that there were 59,063,597 people living in rural areas in the United States; accounting for 20.9% of the population. Barbopoulos and Clark (2003) commented that statistics surrounding what is rural and what is urban and the numbers that make up those statistics are constantly changing as people move between rural and urban settings.

A difficulty seems to lie in how "literally" one uses the numbers in their research. The difficulty in defining rural according to Kropf (2003) is that as all urban areas are not alike, rural areas are not all alike irrespective of mere numbers. Each community has different characteristics, populations, structures, mentalities, worldviews, and cultural features, varying by land, people, and industry that probably better represent differences than numbers do. It is for that reason, in the following sections that rural culture and the interplay of rural culture and mental health are discussed.

Rural Culture

Rural communities are complex, interrelated systems of informal and formal political and social units, and relationships among community members are interdependent, complex, and have deep historical, social, political, and familial roots (Harowski, Turner, Levine, Schank, & Leichter, 2006; Helbok, 2003; Hargrove, 1986; Sundet & Mermelstein, 1983). Rural America is a heterogeneous group of people with diversity in cultures, occupations, lifestyle, physical geography and wealth (Harowski et al., 2006; Helbok, 2003; Wagenfield, 2001; Murray & Keller, 1991; Reed, 1992; Wagenfield, 1988; Wilcoxin, 1989). Harowski et al. notes that increasingly, more ethnically diverse populations, including immigrants and refugees are moving to rural areas furthering the diversity of rural communities.

Compared with urban areas, rural areas have traditionally lower educational attainment, greater lack of, or inability to attain, higher formal education, lower family income, and smaller percentages of people in the labor force as compared with urban areas (Murray & Keller, 1991). Rural communities also tend to have more scarce resources, elevated rates of poverty, greater lack of access to employment, higher illiteracy rates, inadequate health services, limited insurance coverage, and higher rates of disabilities as compared to urban residents and areas (Harowski et al., 2006; Helbok, 2003; Wagenfield, 2001; Murray & Keller, 1991; Reed, 1992; Wagenfield, 1988; Wilcoxin, 1989). Oetinger (2007) reports, based on a United States Department of Agriculture report that rural areas have had consistently higher rates of poverty with percentages of 14.2% for rural and 12.1% for urban populations. Rural counties account

for 340 of the 386 persistent poverty countries in the United States, all the meanwhile keeping in mind that over 20% of the US population is designated as rural.

Beyond issues such as high rates of alcohol abuse, chronic illnesses, disabilities, poverty and financial strain, and lack of access to insurance, people residing in rural communities are exposed to a wide array of stressful life events, different from that of their urban counterparts, many of which are unpredictable and out of their control. Residents deal with things such as weather that is not conducive to crop production, natural disasters, and farm crises (Helbok, 2003; Cellucci & Vik, 2001). Barbopoulos and Clark (2003) add to this list young people being forced to leave the family farm to seek employment in urban areas, deaths of family members subsequent to farm accidents, and the impact of an increase in oil and gas prices.

On a more personal level regarding ways of relating to each other, people residing in rural areas tend to avoid conflict and discussion of feelings, have limited tolerance for diversity, high religious involvement, and possess more fatalistic and stoic attitudes (Wagenfield, 2001; Helbok, 2003; Cook, Copans, & Schetky, 1998; Linn, & Husani, 1987). Community members in rural areas often have multiple roles and have been found to possess unique attitudes and beliefs, characterized by more prejudice, less acceptance of deviance, more isolation and ethnocentrism, and a stronger work ethic (Wagenfield, 2001; McSparron, 2002; Linn & Husani, 1987). In a 1998 study, Vermeulen and Minor found that women born and raised in a rural context had a desire for autonomy, strong work ethic, a sense of responsibility, a sense of being a part of a family and a community, and an appreciation of nature as characteristics they hoped for when considering a career choice. In addition, in rural areas there are unique aspects of

family farming that closely tie family members together and reduce outside contact with role models and stress reducing perspectives on life and work (Murray & Keller, 1991). Clearly, variations in these characteristics in rural versus urban populations may contribute to some of the differences that have been found regarding rural mental health.

Differences, on the whole are found in attitudes, beliefs, ways of communicating, and work ethic. However, it is important not to stereotype all rural people as holding all of the same values, just as it is with any other group of people. These differences in characteristics differentially impact the mental health of people residing in rural areas. Thus, it is important for psychologists who plan to or do practice in rural communities to understand how these cultural differences may play out in a therapeutic setting in rural areas. In the following section the interplay of culture and mental health is discussed.

Rural Mental Health

Some authors argue that there is extensive evidence that the prevalence of social and health problems in rural areas generally match, and in many cases exceed those in urban areas. Roberts, Battaglia, and Epstein (1999) found that rural residents experience mood and anxiety disorders, trauma, and cognitive, developmental and psychotic disorders at rates at least as high as residents of urban areas. Barbopoulos and Clark (2003) based on a gallop poll found 52% of rural residents versus 43% and 36% for urban and suburban residents respectively report experiencing stress frequently. These authors further commented that levels of distress have risen faster in rural areas. Conger, Elder, Lorenz, Simons, and Whitbeck (1994) found that economic stress accounted for 25-33% of variation in depression and that this was correlated with less positive parenting practices, more disruptive behavior in children, increased hostility, and decreased marital

satisfaction in rural areas. Additionally, suicide rates have been higher in rural than in urban areas (Roberts, Battaglia, & Epstein, 1999; Zacharakis, Madianos, Papadimitious, & Stefanis, 1998). Also noteworthy is the impact of age and gender on mental health in rural populations. In a report on gender, emotional support, and well-being among the rural elderly by Patrick, Cottrell, and Barnes (2001) they found that family support was a predictor of lower negative affect for both men and women. Positive affect was also predicted by education and friends for the women. This partially substantiates the claim that rural residents tend to rely on one's self or others, specifically family members in the same community, but could suggest that rural men who demonstrate an overreliance on family support may be especially at risk if those family supports disappear. Women are more likely to look outside of their immediate family for social support and thus have a buffer should more natural family supports dissipate. Clearly then, a lack of social support may contribute to decreased well-being, particularity for women. However, particularly in rural men, an overreliance on social support wherein "deeper" issues are not discussed contributes to the "I am fine" attitude and the need for mental health services is often not recognized. Furthermore, rural residents often believe "outsiders" will not understand the nature of their problems (Ide, Carson, & Araquistain, 1997) leading to further avoidance of psychological help should one need those services.

Factors that Influence Mental Health Service Utilization in Rural Areas

Acceptability of mental health services and an understanding of mental health issues, geography, accessibility of services, and availability of services are four considerations that influence mental health service utilization in rural areas. The latter of the three are intertwined considerations as accessibility and availability are certainly

influenced by geography. Meanwhile, just because services are available is does not mean they are accessible due to mere geography or due to concerns around privacy in seeking out services. Telehealth is a means of providing mental health services to lesson some of these concerns, yet telehealth has both pros and cons. Thus, in the following sections the impact of the aforementioned is discussed in relation to rural mental health service utilization.

Acceptability

Mental health service utilization in rural areas is affected, in part, by residents of rural communities who may hold stereotypes about counseling due to the stigma attached to seeking help and partially due to lack of exposure. In rural America, self-sufficiency and self-reliance, including solving one's own problems, is valued (Human & Wasem, 1991). Rural communities are known for their interdependence and cohesiveness in solving problems; probably another contributing factor to why psychological help is rarely sought. Residents of the rural communities may also be mistrusting of psychologists because rural residents are use to knowing about and sharing information about others. Mistrust of "outsiders" or mental health professionals could potentially hinder help seeking among community members who would benefit and further stigmatize those who seek such services. Taken together, these characteristics of rural residents clearly impacts the acceptability of mental health services as it is hindered by these traditions of handling one's own problems, beliefs about the cause of a disorder and a lack of knowledge about emotional disorders and mental health services. It is possible that these traditions coupled with existing training models with an urban orientation also contribute to a lack of accessibility of psychological services.

Geography, accessibility, and availability

Murray and Keller (1991) report that one of the most significant barriers to the delivery of all forms of social service in rural settings is geography. Rural environments in the United States have been consistently lacking in needed resources and services compared to more urban areas (Oetinger, 2007; Campbell, Gordon, & Chandler, 2002). People in rural settings tend to be distributed across wide expanses of land, making it difficult to deliver efficient services. Accessibility and availability can be limited by the large distances people have to travel to obtain services, the lack of transportation, and the lack of mental health outreach services (Human & Wasem, 1991). Irrespective of mental health service utilization, a lack of public transportation also contributes to the isolation that rural communities face. Needs that used to be met by local communities are now met by distant and more formal agencies creating a loss of natural support rural communities once had (Murray & Kupinsky, 1982 as cited in Murray & Keller, 1991). Accessibility and availability are intertwined factors that affect one's decision to seek psychological help.

Financial access to mental health services also plays a large role in rural mental health service utilization in light of the rise of rural poverty in recent years. As reported before, a disproportionate number of the nation's poor are in rural areas and the poorest counties in the United States are rural (Human & Wassem, 1991; Murray & Keller, 1991). McDonald, Harris and LeMesurier (2002) cite cost and lack of insurance as the primary barrier to mental health service utilization. Research indicates that one out of five rural individuals has no health insurance (Smith, 2003; APA, 2000) and for families who

are struggling to pay electricity, food, and a myriad of other bills, even with insurance, psychoactive medications and psychotherapy are still too expensive (Smith, 2003).

Smith (2003) points out the effects of such limits, stating that those with severe mental illness may not receive services needed to maintain healthy functioning and individuals that end up in crisis situations could be prevented if consistent care were received. In many cases, even if health insurance is available, the benefits may only include a limited number of sessions, or none at all. As an example, in Montana, Medicaid has recently reviewed their mental health coverage and will only cover eight sessions of psychotherapy in six months (Smith, 2003). Therefore, in many cases, people who would even consider seeking psychological help could not do so without the monetary means and it is unrealistic to expect that mental health workers could assume the burden for those who are unable to pay (Human & Wasem, 1991). An option to compensate for an inability to pay for services in rural settings is bartering. Though not typically advised by the American Psychological Association, it is ethically acceptable in certain situations (Schank & Skovholt, 2006). Collecting payment can be another difficulty in practice in rural areas due to the nature of personal relationships and the public nature of bill collections, which can be quite informal (Schank & Skovholt, 2006).

Although concerns with service utilization and factors that influence it are not unique to rural settings, psychologists working in rural communities must be willing to address the negative stereotypes about psychology that hinder service utilization (Thorngren, 2003) and work to gain knowledge of and acceptance of unique rural issues. Rural psychologists must consider and work to overcome the challenges they might face in response to rural resident characteristics and limits placed on rural residents because of

stigma, lack of information of mental health issues, geography, or wealth. Telehealth is a means by which health service providers have begun to address limits placed on service utilization because of geography.

Telehealth

Telehealth has emerged over the past four decades and while seemingly a promising method for delivery of mental health services, the concept has had its ups and downs (Schopp, Demiris, & Glueckauf, 2006). Means of carrying out telehealth practices involve video teleconferencing, telephone, email, and other related media. Nickelson (1998) defines telehealth as "the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, education, and information across distance." Thus, telehealth is a broad term ultimately encompassing all aspects of client care from contact with the client to consultation and supervision about a client. Essentially, many of us engage in telehealth practice without considering it telehealth when we use the phone, email, and/or internet to obtain information for client care or consult with other professionals (Stamm, 1998).

Schopp, Demiris, and Glueckauf (2006) speculated on several advantages of using technology to increase service delivery including decreased travel time to rural and remote areas, decreased costs for travel for both the client and clinician and an increase in the number of rural clients a clinician can interact with on a given day. However, the use and success of telehealth is certainly impacted by client and family members' acceptance of *and* ability to use the method, as well as the providers' acceptance of the method.

These same authors also noted the several barriers to promoting and using telecare practices. They purport that billing and reimbursement procedures have a large impact on

"selling" the telecare model as insurance companies and legislation are not entirely sold on the procedure and benefits for clients. They commented that another issue relates to lack of formal training in communication technologies, though for clinicians this is an issue that could be resolved with continuing education programs, guidance, and educational materials. For clientele however, this lack of knowledge around technology could be extremely problematic.

Another issue cited by the authors is privacy, particularly over the Internet though they acknowledge that difficulties with internet security are decreasing. They comment that just as in face-to-face practice, it is important to adopt disclosure and documentations practices that inform clients about the risks of service.

Miller (2006) cites two other liabilities in telehealth; liability for negligence and liability for abandonment, which are not unique to only telehealth services but that can be more problematic because of distance between client and provider, lack of personal contact between client and provider, and equipment failure.

All in all, researchers in the area of telehealth suggest "there is little evidence yet of the cost-effectiveness or even possible long-term cost reduction through use of the Internet or other advanced telecommunications in psychological service delivery" (Schopp, Demiris, & Glueckauf, 2006, p.169). Thus, research needs to be directed to that end. Other future studies, according to these authors need to assess whether telehealth options provide at least the same or greater positive impact on rural clients. Future studies also need to focus on how the lack of personal contact impacts the quality of care though Miller (2006) questions if this limitation will ever be bridged by telehealth technology. Miller notes that what is clear, is that telehealth, where services to patients are not

available in underserved, rural, or distant sites, provides access for clients who would otherwise not receive or seek services.

Rural Practice

Current research and writings surrounding the practice of rural psychology point to the need for generalist competencies. Further, collaboration with the other professionals in rural practice is highlighted as crucial to provide the best care for clients and to mitigate burnout. Seeking social support whether with peers in the field or folks from other disciplines has been cited as important, also to reduce burnout and to provide the best possible care. More recently, the positive aspects of work in rural communities have been gaining attention suggesting that even though one might assume that working in a rural area results in isolation, in reality there are many enjoyable attributes to living and working in a small community. Each of the aforementioned is highlighted below.

Generalist and Specialist Competencies

Generalist training is important for rural practice and because there are a limited number of referral options in small communities, rural psychologists typically need to be generalists to be able to treat a wide range of problems for a wide range of people (Helbok, 2003). Hargrove and Breazale (1993) add that training models must also motivate and develop practitioners with generalist skills including management and administrative tasks, collaboration with those outside of the field of psychology, and working with others in the community. Those who enjoy the challenges of being a generalist are likely to enjoy and succeed in a rural environment (Harowski et al., 2006; Kersting, 2003; Schank & Skovholt, 2006). The flexibility involved in being a generalist might be viewed as a challenge that motivates rural practitioners to continue learning

(Oetinger, 2007). Practicing as a generalist in a rural community could mean caring not only for your individual caseload, but caring for the needs of the larger community (Oetinger, 2007). As Schank and Skovholt (2006) comment, the rural provider will likely never become bored.

In rural areas there is a dearth of specialized services such as speech specialists, woman's shelters, childcare services, addictions treatment centers, domestic violence groups, or programs for the elderly, to name a few (Barbopoulos & Clark, 2003). A lack of these specialized services in rural settings might require psychologists to push his/her limits of competence and because of the need to be generalists; psychologists in small rural-based settings may often question their competence in dealing with certain issues or populations.

Smith (2003) commented that working with clients beyond one's area of expertise may be the norm more than the exception in rural areas. Psychologists may be called upon to provide care outside of their areas of expertise and without the most favorable consultation opportunities. According to Helbok, in situations such as this, the dilemma lies in the psychologist's ability to figure out how far outside their area of expertise he or she can or is practicing. As mentioned above, the ability to collaborate with other professionals should mitigate some of the fears of, and ethical concerns of working outside one's competence in rural areas.

Collaboration with the other professionals

Interdisciplinary collaboration and cooperation with other professionals should be emphasized when thinking about work in rural communities in particular. Beeson (1998) and Smith (2003) speculated on four key reasons why collaboration is imperative and in

many cases the best-case scenario. First, coordination is necessary for clients' care as often individual's problems are varied and intertwined based on physical health, mental health, financial concerns, or abuse of various sorts. Individuals frequently suffer from numerous problems aside from the presenting mental health issue that might require consultation and collaboration with other professionals such as those from the medical fields, clergy, teachers, judges, police officers, and paraprofessionals, to best serve the client. Second, with collaboration, communities come to understand the services provided by the clinic. Third, with consultation, the exchange of referrals is fostered between the clinic and other services, and finally, interdisciplinary collaboration can serve to open doors for consultation opportunities early on and can later decrease stress, burnout, and professional isolation, and in turn support the retention of providers as burnout and concerns about isolation and lack of social support have often been cited as major concerns for the rural practitioner.

Burnout and social support

According to Schank and Skovholt (2006), when there is a high demand for services, a need to maintain community relationships, and a lack of referral sources, rural practitioners can be easily overwhelmed when they are already one of only a few who provide mental health services. Challenging aspects of work in rural areas include burnout and lack of social support often resulting from feelings of isolation, depression, demoralization, frustration, and feelings of inadequacy (Merwin, Goldsmith, & Mandersheid, 1995; Oetinger, 2007). The occurrence of burnout and lack of social support has received much attention over the years, yet burnout among *rural* clinicians, in particular, has been insufficiently addressed (Oetinger, 2007). Only a few studies have

begun to assess the existence and impact of burnout and lack of social support in rural settings.

A study by Kee, Johnson, and Hunt (2002) assessed the levels of burnout, social support, and the interaction of burnout and social support among rural mental health counselors. In their study, 192 individuals working in a rural area providing mental health services, full-time completed two instruments. Those instruments included the Maslach Burnout Inventory (MBI; Maslach & Johnson, 1981) and the Social Provisions Scale (SPS; Cutrona & Russell, 1987). Criterion validity of the MBI was established by comparing burnout scores to ratings of personal experience, dimensions of job experience, or personal outcome. Further, the authors state that MBI scale scores have been shown to be related to measures of job satisfaction, depression, compassion fatigue, and occupational stress. Construct validity and concurrent validity of the SPS was found between measures looking at attachment, social loneliness, satisfactions with friendships, kin relationships, and work relationships and reliable alliance, reassurance of worth, and social integrations.

Though the authors did not adequately describe the normative group, which is a limitation of the study, they found that approximately 65% of the sample of rural mental health counselors scored at the moderate level or greater in burnout as compared to the normative group, and approximately 72% of the sample scored below the normative sample means for social support. They concluded that changes are necessary to help rural mental health clinicians reduce burnout and receive more social support from colleagues. They contend that because of the increasing mental health needs of rural people, and the

shortage of mental health providers practicing in rural areas, it is imperative to know how to better recruit, train, and retain clinicians for work in rural areas.

Positive aspects of work in rural communities

As Oetinger (2007) pointed out, much of the literature on practicing psychology in a rural area highlights the negative aspects and difficulties one is likely to encounter. Still, many practitioners choose the option of living and working in a rural area for attractive reasons, possibly outside the realm of psychology including cleaner air, natural surroundings, community activities, recreational opportunities, lower cost of living, accessibility of schools, safety, and opportunities for genuine friendships and connections (Schank & Skovholt, 2006).

Schank (1998) also commented that more attention needs to be paid to the positive and life-enhancing qualities of rural practice to combat the dull picture set forth in the literature and to negate stereotypes urban counselors or the general public may have. Helbok (2003) too was a key person in pointing out, there are many positive aspects that surround working in a rural community and commented that psychologists working in a rural community can have a "visible impact within an entire community, which can be more rewarding than practicing in the relative anonymity of an urban community" (p.382). Only a few studies have assessed and highlighted the positive aspects of working in rural communities.

A study by Sullivan, Hasler, and Otis (1993) found that 80% of rural practitioners experienced high job satisfaction. Jerrel and Herring (1983) found that psychologists reported higher work satisfaction than non-psychologist clinicians. They made no mention of how psychologists felt about the benefits of their job, but reported that non-

psychologist clinicians were typically dissatisfied with fringe benefits, salary, and their chances of getting ahead. However, both psychologists and non-psychologists in their study considered their work in rural areas as positive, particularly the opportunities to accomplish something worthwhile, opportunities to develop skills, and their productivity as increasing their satisfaction.

Oetinger (2007), in her study for which she utilized surveys to assess decisions contributing to psychologist's choice to practice in rural areas and rewards contributing to therapist job satisfaction, also highlighted the more positive aspects of working in a rural setting. In Oetinger's sample of 51 rural respondents 47% reported being "very satisfied" and only 11.8% reported being "dissatisfied" with their decision to practice in rural areas.

She found the top five most influential reasons for practicing in rural areas to be: 1) desire to provide care to underserved populations; 2) slower pace of life; 3) opportunity to work as generalist; 4) natural surroundings; and 5) preference for rural area. The least influential reasons she found to be: 1) proximity to metropolitan area; 2) opportunity to use my rural education; 3) opportunity for continuing education; 4) designated area for Loan Repayment Program; and 5) contact with area during graduate training. Interestingly, the latter has been cited in the past as a significant predictor for success in rural settings, yet her results are suggesting it has little influence on the *decision* to work in rural areas. In line with Oetinger's discussion of the results of her study it is encouraging to see a large number of professionals having a desire to provide services to the underserved.

With regard to rewards contributing to therapist job satisfaction in rural settings she found that the most agreed to reward statements were: 1) work requiring a diverse set

of skills; 2) being proud of the work one has done; and 3) often gaining knowledge and experiences in fields outside of one's own. Least agreed to statements included: 1) being rewarded financially for one's work; 2) being satisfied with the opportunities one's work provides for emotional intimacy; and 3) enjoying the opportunity to more fully know one's clients due to the small size of a community. Oetinger (2007) also speculated that because the rural psychologist might be the only one in the county, that the high level of independence and lack of competition might be appealing.

Kramen-Kahn and Hansen (1998), in their literature review and in their own research identified autonomy-independence, diverse work, ongoing self-development, opportunities for emotional intimacy, professional financial recognition and success, and feelings of effectiveness as occupational rewards for therapists in general. Based on aforementioned research, it seems many of these rewards are present in a rural setting.

Freund and Sarata, back in 1983, on the flip side found the level of psychologist's community satisfaction was lower for participants in rural areas. Level of satisfaction was negatively correlated with discrepancy between the size of community where participants live and the size of community in which they preferred to live. Satisfaction was also inversely related to the importance placed on having access to urban communities. The authors suggested that the amenities available in urban environments might contribute to the reluctance of professionals to locate and remain in rural areas. Some participants in their study offered other reasons for leaving a particular community. For example, one person wanted a new school for his child; another wanted to move closer to a lake or ski area. Still, this study was conducted around 25 years ago, and could this suggest rural areas have become more appealing for practicing psychology? Either way, some

professionals, even though there is a lot of research highlighting the positive aspects of work in rural communities will choose not to work in those settings. One reason to chose not to work in a rural setting might be the lack of training ultimately impacting ones' feelings of self-efficacy and competency to work in more rural areas. Other reasons might be more specific. There are indeed inherent ethical challenges involved in rural practice, which are not as often problematic in more urban settings.

Ethical Issues in Rural Practice

Many authors have cited the ethical issues inherent in rural counseling practice. Schank (1998) stated that counselors in rural communities often find themselves considering unique challenges in the attempt to practice ethically and at the same time meet the needs of the clients and the community. Schank, among many other authors, also argues that due to the fact that standards in training, ethical codes and regulations are often developed following an urban model, the existing ethical guidelines are not so easily applied to rural practice.

One of the most common ethical dilemmas psychologists in rural areas face is the existence of multiple relationships. Social and professional boundaries that are encouraged for those practicing in larger communities are often not possible (Oetinger, 2007). Rural psychologists cannot avoid overlapping roles without isolating themselves from the community, which is much different from urban settings in which there are more detached, compartmentalized relationships (Erickson, 2001; Helbok, 2003; Kitchener, 1988; Rich, 1990; Schank & Skovholt, 1997).

Schank & Skovholt (1997) comment that it is likely that the rural clinician will enter into therapeutic relationships with clients who are related or socially connected.

Overlapping relationships could occur in a variety of settings including church, parties, social gatherings, cultural activities, school events, or volunteer activities (Schank, 1998). Additionally, Schank reports that the effects of overlapping relationships on members of the practitioner's own family (i.e., children who attend the same schools), working with more than one family member as clients, providing therapy to family members of colleagues, or with others who have friendships with individual clients can constitute sometimes troublesome overlapping relationships. Helbok, Marinelli, and Walls (2006) in a more recent study on ethical practices across rural and urban communities also found that rural practitioners encounter significantly more multiple relationships than do their urban counterparts. The multiple relationships assessed in their study included purchasing good or services from a client and this relationship was among one of the most significantly different between rural and urban psychologists. Thus, overlapping professional or business relationships will exist such as purchasing good or services from clients (Schank & Skovholt, 1997). If psychologists in rural areas were to try to avoid this dilemma and take their business outside of town they may be disregarded as an outsider.

Confidentiality is another ethical dilemma rural psychologists might face due to the informal communication network inherent in small communities (Oetinger, 2007). Helbok (2003) wrote of the several confidentiality issues rural psychologists face. Those issues could include community members' awareness of who seeks treatment, support staff having relationships with clients, support staff being familiar with clients, and the difficulties arising from sharing of information among agencies. However, in Helbok, et al.'s (2006) same study mentioned above on ethical practices across rural and urban communities, they did not find their expected pattern of rural practitioners having more

difficulty maintaining confidentiality. They speculated that rural psychologists might better prepare clients for chance encounters, and noted that urban psychologists were more likely to discuss clients with colleagues, friends, and others (without revealing identifying information). As reported by Oetinger (2007) and Schank and Skovholt (2006) mental health workers also need to learn how to handle unsolicited information about clients and be cautious about what they discuss both inside and outside of the therapy office. Beyond the practical aspects of confidentiality, when it comes to breaking confidentiality such as in the case of child abuse, compared to urban areas it is more difficult and complex in rural areas as the involvement of the psychologist in the rural community is more obvious.

The topic of psychologist visibility is another potential ethical concern. Helbok (2003) commented that although visibility may not directly lead to ethical dilemmas, it is an issue that can be intertwined. He argues that self-disclosure, because of the inherent visibility in the community may not be as readily controlled as it is in the more urban setting and that it can unintentionally have harmful effects on clients. Further, mental health professionals' personal and professional behavior may be monitored closely and talked about by the residents of the community, particularly, if those actions differ greatly from community norms and expectations (Schank, 1998; Helbok, et al., 2006). Potential clients may often know quite a lot about the psychologist before coming to see them (Helbok, et al., 2006). Some authors argue that for this reason, psychologists should keep a low profile in the community; however, most authors maintain that psychologists should address the dilemma directly versus avoiding it and becoming isolated from the community. Too much privacy could lead to suspicion by the community, thus those who

are able to tolerate a more relaxed boundary without entirely disregarding these lines might find it easier to practice in rural communities (Schank & Skovholt, 2006).

Therefore, the rural psychologist must be comfortable with the high visibility of being known as a professional and interacting in the community (Schank & Skovholt, 2006). In rural areas, all professionals, once accepted, are valued for their expertise, and people will expect and value the psychologist's opinion (Schank & Skovholt, 2006). Psychologists in rural communities need to find ways to be accepted and trusted by the people who constitute the "web of rural social stratification"(Schank & Skovholt, 1997, p.45)

Beyond ethical dilemmas, those training for work in rural psychology should know of the opportunities or lack thereof for professional development and continuing education. The lack of these opportunities adds to the challenges of ethical dilemmas and should be considered before working in rural areas.

Professional Development and Continuing Education in Rural Settings

The benefits of professional development and continuing education opportunities have been well documented, however the lack of these opportunities in rural settings has been cited as considerable. Rural settings provide only rare opportunities to engage in professional development activities and local workshops. Berman (1994) in a study of mental health clinics in Michigan found that fewer than 20% had any staff development programs that were formalized and consistent; he commented that such programs were often the first cut in times of financial need. In articles by Weigel and Baker (2002) and Shanck (1998) they reported that mental health professionals in rural areas also (like potential clients) struggle with geographical distances as they try to engage in

consultation groups and collegial relationships. The costs of traveling to conferences may be restricting and a lack of replacements to manage caseloads only makes this worse (Barbopoulos & Clark, 2003). Still, Coyle (1999) points out that even though there is less opportunity for consultation and continuing education, it still should be a regular part of the practice of psychology. Chur-Hansen, Todd, and Koopowitz (2004) argue that resources need be routed to rural practice in order to recruit and retain psychologists in those areas and to support those who are already working extremely hard under tying conditions. As such, the limited opportunities for professional development and consultation and a lack of education as to how to enhance professional development and consultation opportunities in rural settings may contribute to psychologists in training hesitancy to work in rural communities.

Recruiting and Retaining Psychologists for Work in Small Communities

Some practitioners may have always intended to return to work in a rural area, or eventually return to a rural setting to be close to family and friends and because of having a sense of loyalty to one's hometown rural community (Oetinger, 2007). However, this is not always the case. Because mental health professionals are commonly trained in urban areas, and if those professionals have never resided in rural communities, there may be values and expectations in a particular community that are not congruent with the psychologist's values or expectations of rural community living and work, thus impacting the ability to recruit and retain psychologists for work in rural settings. Doctoral level psychologists entering rural practice, who have not resided in a rural area may not be prepared for responsibilities inherent in working in rural communities and this confusion may create a reluctance to take positions in rural areas (Jerrel & Herring, 1983). Though

the implications of the following influences on work in rural settings have been mentioned in prior sections, they are worth repeating here in the recruiting and retaining section as they are certainly influential in the decision to work in a rural setting.

Psychologists in rural settings, in particular may be requested to participate in community events, organizations, committees, task forces, and educational activities leaving them feeling overwhelmed or burnt out (Schank, 1998). Lack of professional development opportunities, ethical concerns, an appetite for the amenities in an urban environment, and isolation are other reasons it may be difficult to attract rural psychologists. McIlwraith, Dyck, Holms, Carlson, and Prober (2005) also speculated on the influence of long drives that rural psychologists might need to travel though they noted that long drives could be considered as a relaxing opportunity for reflection rather than as a boring inconvenience. The dilemma in this plethora of influential factors is that adequate services cannot be provided by facilities and at times, facilities are unable to employ qualified staff. Therefore, attracting, recruiting, and retaining qualified psychologists to work in these areas are of utmost importance.

Schank and Skovholt (2006) comment that a practitioner who is culturally similar may find the rural lifestyle easier to manage. McIlwraith, Dyck, Holms, Carlson, and Prober (2005) feel that personal interests and lifestyle preferences play a very large role in one's interest in pursuing a rural career and profitable success in rural practice. Kropf (2003) promotes strategies to "home grow" professionals from persons who are part of rural areas. Kropf commented on how this approach proves valuable as it may have an advantage in retaining a workforce where people are already familiar with life and experiences within these contexts.

When it is not possible to "home grow" psychologists for work in rural settings, programs need to actively seek students who have an interest in working in rural practice and actively encourage other students to learn about and work in rural settings (Kropf, 2003; Chur-Hansen, Todd, & Koopowitz, 2004). Some training programs and clinics already actively recruit students with values consistent with those of rural areas to alleviate some of these feelings or possible fears and make long term service more promising (Schank & Skovholt, 2006). Freund and Sarata (1983) argued that programs must develop a method for identifying students who are likely to enjoy rural areas and give priority to applicants who have resided in rural areas. McIlwraith, Dyck, Holms, Carlson, and Prober (2005) commented on their efforts to find good student matches for their rural psychology internship program and stated that they are continuously refining their admissions interview questions to assess potential applicants openness to new experiences, flexibility, and cultural sensitivity.

Kropf (2003) commented that one method of attracting students to this field of practice is providing students with an opportunity to learn more about rural issues through exposure to those issues found within those communities. Students must be taught and see first-hand how the roles of rural psychologists differ from those of psychologists in more urban settings. They must be educated on the lifestyles and responsibilities of rural psychologists. Furthermore, they need to be informed of the ethical issues that may arise in rural settings.

Dengerink, Marks, Hammarlund, & Hammond (1981) found a correlation between current practice in a rural area and rural graduate training. This suggests that recruitment of rural students coupled with providing educational opportunities and

internships in rural settings may directly influence the number of mental health providers practicing in rural locations (Kersting, 2003; Woloschuk & Tarrant, 2002). The Loan repayment program of the National Health Service Corps might also be an incentive for recruiting new psychologists to rural areas.

The National Health Services Corps, "for more than 35 years has been recruiting health professionals to serve in communities where the needs are the greatest—in rural areas where the closest clinic could be miles away…where economic and cultural barriers prevent people from seeking and receiving the health care they deserve"(Online website). Since the mid-1990's, psychologists working in underserved rural areas have been able to qualify for the loan repayment program of the National Health Service Corps (Benson, 2003) and while this has brought many professionals to rural areas since it's inception, there are still large numbers of rural and remote communities without mental health service providers. Still, the program strives to help agencies with recruitment and retention of health care providers.

Overall, in order to recruit and retain students for work in rural areas it is important to review what the field is doing to prepare and provide students with the education, skills, and knowledge they need to work successfully *and* happily in a rural setting. Despite the acknowledgement that there needs to be an incorporation of the training needs of rural psychologists in doctoral psychology programs, only a handful of private initiatives or graduate programs have demonstrated an ongoing commitment to rural training whether it be through coursework or training in actual rural settings.

Specialized Private Initiatives and Graduate Programs with an Emphasis on Rural Psychology

In 1995, APA published a curriculum for rural health training entitled, *Caring for a Rural Community,* which brought together APA, the American Nurses Association, and the Council on Social Work Education (APA, Office of Rural Health, 1995). The curriculum was designed to train and inform nursing, social work, and graduate psychology students in the skills of rural interdisciplinary practice, including, culturally competent program and service development, community assessment, conflict resolution, and interdisciplinary team building in rural communities. The initiative was grant funded and the curriculum has never been put to use.

A search of doctoral programs in psychology yielded a few programs with a specialized emphasis on rural psychology. Among those programs are the University of Florida in their Rural Psychology Program, Manitoba's Rural and Northern Community-Based Training Program, Wheaton College, Montana State University, and the Wyoming Health Care Collaboration, Access, & Rural Empowerment (WyoHealthCARE). The aforementioned programs will be described briefly below. The University of Lincoln-Nebraska Clinical Psychology Training Program has also claimed to have developed a rural mental health specialty track, however, information on the program could not be attained.

University of Florida-Rural Psychology Program

The University of Florida (U of F) Rural Psychology program was developed following Hurricance Andrew, which impacted many of South Florida's rural areas (Sears, Evans, & Perry, 1998). Their program sought to develop both intraprofessional and interprofessional training objectives. The *intraprofessional goals* are: (a) to acquire a

basic understanding about the nature of the underserved mental and behavioral health care needs of rural populations; (b) to innovate and implement a full range of methods to increase the availability, accessibility, and acceptability of psychological services; (c) to engage in program development and evaluation in behavioral health areas, such as smoking cessation, exercise promotion, and stress management; and (d) to learn about the benefits and obstacles associated with creating a satisfying rural practice. The *interprofessional goals* are: (a) to understand the role or roles of other professionals in a rural community; (b) to expand the recognition of the importance and utility of psychological and behavioral health services by other rural health professionals, and (c) to engage in coalition building with the community service delivery systems in place in rural areas.

Kropf (2003), in her research, though not associated with U of F suggested three additional crucial elements in educating students for work in a rural population that expand and elaborate upon the University of Florida's goals. First, she advocates practice in case management whereby interventions may target individuals, family systems, or the surrounding community itself. Case management can help with linkages and methods to promote services residents might not know about or might not understand. Second, she advocates that somewhere within the curriculum students must develop exceptional leadership skills in order to exert influence in communities that often may have characteristics of closed systems. Ideally, students need to learn how to be aware of the local-decision making factors, processes, influential leaders, and power structures as a way to enact change. Third, due to the geographic distances and potential lack of

resources in rural communities, students should be familiar with intervention models such as telemedicine or telehealth.

Manitoba's Rural and Northern Community-Based Training Program

The Rural and Northern Community-Based Training Program of Manitoba is another program that seeks to inform students of rural practice. It was established in 1996 with a grant from Manitoba Health to support three psychologist positions, two interns, and a post-doctoral resident per year to work in the program. The program was initially designed to continually recruit and train psychologists who could move into jobs in rural areas. The originators of the program thought that recruitment would be much easier if students were exposed to rural practice earlier in their training rather than to recruit graduates. The program was designed to give students a preview of rural practice during their internship so they could evaluate their likelihood of enjoying work in these areas.

The program aimed to train students to be "generalist" clinical psychologists. Skills to work with a variety of populations were taught and the program sought to teach interns how to work with a variety of behavioral health issues, not only mental health. McIlwraith, Dyck, Holms, Carlson, and Prober (2005) noted that competent practice with rural persons requires an understanding of rural culture or "agri-culture." Interns were taught to understand diversity not only in terms of ethnicity or language, but also in ways in which work life and economic factors influence various communities' cultures and individuals' health status and behavior. Training involved preparing interns for assessing and treating diverse clientele, and emphasized to the interns that they will be "wearing many hats and providing services that their urban counterparts would never consider within their score of practice" (Stamm, 2003a, p.17, as cited in McIlwraith, et. al., 2005).

As an example, the program directors presented to interns how rural psychologists often fulfill many roles early in their career including supervisory, administrative, and leadership roles. Furthermore, the authors pointed out that rural psychologists are also often called upon to provide educational opportunities, participate in program development, illness prevention, health promotion, and policy development.

In this program, interns are encouraged to consider their areas of competence and learn to distinguish between cases they can and/or should handle, or cases they could handle with supervision, and cases they should never undertake. In rural areas, troubling as it may be sometimes, consultation is very important. In this program, there is an interesting approach to the relative lack of supervision. It is a model for rural areas that has been attempted, in some cases with clients, but is currently proving to be most useful for supervision.

Students in this program participate in weekly case conferences with psychologists in Winnipeg by means of Manitoba telehealth. McIlwraith, Dyck, Holms, Carlson, and Prober (2005) argue that maximizing the level of support through the university department via telehealth reduces the burnout often associated with working in isolated conditions. They point out that they prefer to use telehealth as mostly a supplement and support to those working in rural areas rather than as a substitute to them.

Wheaton College Psy.D. Program

This program emphasizes service to underserved and marginalized populations through classes, research, and clinical training. Most notably, two of the Wheaton College faculty members established The Center for Rural Psychology to train and encourage graduate students with an interest in rural psychology through internship

experiences in a rural community. The Center purports to provide services in line with rural community living. The Center is "owned" by the community, according to the developers, to take into consideration the attitudes of some community members who may be distrustful of those who are perceived to be making money from the misfortune of others. When employed at this site, practitioners are encouraged to be "down to earth" constantly keeping in mind rural values. On the whole the center strives to be community oriented while working in schools, churches, providing mental health education, conducting needs assessments, and offering sliding scale services. Training, more specifically emphasizes the importance of confidentiality and dual roles, collaboration with physicians, identifying multiple funding sources, and empowering the community.

Montana State University

In 1983, a graduate training clinic was established at Montana State University which sought to serve as a training site for graduates wanting to work in rural areas, to provide low-cost mental health services, to conduct outreach in rural areas, and to provide continuing education for licensed counselors and healthcare providers in the region and state (Smith, 2003). The clinic is a non-profit agency supported by client fees, fundraising, and on occasion, grants. Therefore, as many rural areas face financial crises and the cutting of mental health services due to a lack of federal or state funding, the clinic has been unaffected.

In this experience, students learn about rural individuals and communities beyond formal training, and supervision around ethical dilemmas often faced in rural areas is provided. Students also spend a great deal of time learning about the importance of collaboration with other professionals in rural areas.

The clinic also provides a wealth of community outreach wherein they educate the community about mental health and mental illnesses to decrease the stigma regarding mental illness and to provide a service to the community by working with other agencies and systems to meet a variety of needs of the community. The clinic hosts monthly sack lunch seminars for mental health professionals where speakers from other areas such as law, medical, or other educators present. Smith concludes by stating that this type of clinic is not a solution to all of the issues faced by rural mental health trainees, but that is does fill a gap in preparing students for work in these areas. She commented, that training and opportunities for rural mental health professionals should continue to be addressed.

Wyoming Health Care Collaboration, Access, & Rural Empowerment (WyoHealthCARE)

In Wyoming, all 23 counties have been designated as mental health professional shortage areas. Thus, this initiative was developed as part of the University of Wyoming Counseling Center's APA-accredited internship and was established to train students together from graduate programs in medicine, social work, nursing, and psychology. Faculty from the four disciplines came together to develop curriculum and training goals. Students worked together with patients and participated in a year long professional development group focused on the different provider reactions to each patient (Harowski, et al., 2006).

Based on these aforementioned examples and comments from researchers in the area of rural psychology, it seems that there are programs attempting to enhance students' understanding of rural issues both as psychologists and in understanding rural culture in general. Still, the success of these programs is unclear as most articles are descriptive and

merely cite what they are hoping for from the program and what they are providing to the students.

Summary

The current lack of research and literature surrounding what should be taught about rural practice to graduate students in clinical and counseling psychology poses a threat to the effectiveness of psychological services provided in rural areas. The diversity in cultures, occupations, lifestyle, physical geography and wealth in rural settings need to be considered in preparing students for work in rural areas. Trainees must also understand the unique attitudes and beliefs of rural dwelling individuals as well as the unique aspects of family farming that closely tie family members and communities together.

From a practice perspective it is important to understand how a variety of disorders or presenting concerns are differentially impacted by living in a rural setting. Taken further, psychologists in training need be familiar with factors that influence mental health service utilization in rural areas and the unique challenges and ethical issues one may face in the rural setting. From a training perspective it is also important to emphasize to students to consider the availability of professional development and continuing education opportunities in rural settings.

Purpose of Study

The need for psychologists to be familiar with and educated in the uniqueness of rural living and how rural culture differently impacts potential clients as compared with urban life needs to be understood. Just as sexual orientation, religion, and a variety of other cultural considerations are becoming more acknowledged in the multicultural literature, rural considerations need be as well. There is a need to understand how to best

prepare students in doctoral training in psychology for work as psychologists in rural areas. Given the nature of rural culture, rural mental health, urban versus rural characteristics, the current status of rural practice, and the overwhelming lack of education of rural issues, the purpose of this study is to describe an operational definition of rural psychology training. Through dialogue with current rural psychologists, researchers focused on rural issues, and those teaching courses on practice in rural communities, this study uses the Delphi Method to reveal the important elements of an effective rural training program and what objectives should guide a doctoral program as it attempts to train professionals suited for work in rural areas.

CHAPTER II

METHOD

The Delphi Method

The Delphi method was developed by the U.S. military in the early 1950's to research expert opinion so that a large group of individuals, as a whole, could deal with a complex problem (Linstone & Turoff, 1975). The Delphi method consists of a panel of experts that answer the same questions at least twice. In the first round, the experts answer questions anonymously and without knowledge of the responses of their peers. During subsequent rounds, the experts are provided with the responses of the entire panel and are given the opportunity to revise their responses in light of the group judgment. The primary goal of the Delphi Method is to reach a consensus among the experts.

Delphi polls are said to be economical, time-efficient, and an accurate means of gathering the opinions of a group of experts. Cumulative research indicates that the results of Delphi polls usually provide the most accurate answer to difficult questions compared with other prognostication techniques (Boronson, 1980). The group Delphi consensus also consistently outperforms the opinions of individual experts (Archer, 1978; Limstone & Turoff, 1975). The current study allowed individuals separated geographically to communicate their views expediently. A further advantage of this technique is that the Delphi method attempts to negotiate a reality that can be useful in moving a particular field forward; in this case defining what curriculum is needed to

educate graduate students in counseling and clinical psychology on practice issues in rural areas.

The Delphi method seems particularly suitable for the current study because of its inherent advantages of being time-efficient and ease in gathering the opinions of a group of experts. Many previous studies using the Delphi method attempted to answer questions similar to that of the question proposed in this study. A few past studies using this method have assessed the future of cross-cultural counseling (Heath, Neimeyer, & Pederson, 1988), beginning and maintaining independent practice (Walfish, & Coovert, 1989), operationalizing multicultural training in doctoral programs and internships (Speight, Thomas, Kennel, & Anderson, 1995), the future of psychotherapy (Norcross, Hedges, & Prochaska, 2002), and components for substance abuse counselor education curriculum (Klutschkowski, & Troth, 1995) to name a few. Because the goal of many of these projects was focused on future directions in a particular area and many focused on curriculum development, it further supports the fact that the Delphi method is well suited for the current study.

Procedure

Identifying the Expert Panel

Members of the expert panel were selected from three samples: psychologists currently practicing in rural areas, psychologists who research in the area of rural mental health issues and rural mental health service utilization, and psychologists who teach courses related to rural psychology.

Psychologists practicing in rural areas were selected via web searches of practices, organizations, and rural list serves.

Psychologists whose research interests included rural mental health were recruited based on having two or more publications regarding rural practice in the last 10 years (with authorship in any order). Participants who met this criterion were identified by a PSYCH INFO search using the keywords rural, psychology, mental health, and training (any combination) in the title and abstract selection section. Potential participants were contacted based on the information they provided in the correspondence section of the article.

Educators in psychology programs who teach courses related to rural counseling or psychology were recruited after careful analysis of each program that claimed to offer a course in rural counseling or psychology. Directors of training and web managers of psychology programs claiming to offer rural mental health courses were contacted via email to either participate in the study themselves or provide me with the contact information of the person(s) teaching rural related courses. During the first round of the study all experts identified were given the option to nominate peers meeting the inclusionary criteria for an invitation to participate in the study as well.

Round 1 Data Collection

After Institutional Review Board (IRB) approval was attained, the first round instrument was developed and piloted on several people in the field of psychology. Changes in formatting and wording were made based on piloting feedback.

After all potential participants were identified, an email invitation was sent to the potential participants. The email cover message detailed the inclusionary criteria for which each potential participant was selected to be an expert in the study and the purpose of the study. The participants were assured that their Round 1 response would take no

longer than 10-20 minutes. Within the email, a link to the survey containing the informed consent form, and the Round 1 instruments were provided. In the consent form, the identified experts were informed that participation was voluntary and confidential and that additional rounds of responses were required. No financial or in-kind incentives were offered. Follow-up emails were sent three times (two weeks apart) and initial invitations for participation were sent as current experts provided contact information for additional experts.

All of the identified, potential subjects meeting the aforementioned criteria were invited to participate in Round 1 of the study. The same groups of existing and potential participants were all invited to participate in Round 2 whether or not they participated in Round 1.

Round 1 Instrument

In Section I of the Round 1 instrument, participants provided demographic data (gender, ethnicity, employment, educational attainment, and years of experience). Additionally, participants were encouraged to answer an open ended questions regarding their previous training in rural psychology and length of time associated with rural psychology practice and training.

Section II of Round 1 was an open-ended questionnaire asking respondents to identify 10 or more critical factors that are key characteristics of training in rural psychology.

Section III of Round 1 included two open ended, optional questions. One of them asked participants to provide the name(s) and email address(es) of other people whom they knew fit into one or more of the inclusionary criteria. A second question, allowed

participants the option to provide any further references or sources that might inform the current study.

Participants

Through the aforementioned processes of identifying the expert panel, ninety-one potential participants (predominantly residing in the United States) were identified and invited to participate in the first round of the study. As appropriate, two participants who did not consider themselves experts based on the existing criteria did not participate beyond the initial inquiry and responded to my email invitation stating such. Thirty-six percent (n=33) of the experts chose to participate in the Round 1 investigation. Sixty-four percent (21 of 33) of the expert panelists completed both rounds of the survey. Twelve of the Round 1 participants did not complete Round 2. Six experts joined the investigation in Round 2 for a Round 2 panelist size of twenty-seven. While this number is not large, many Delphi studies and research on the method (Delbecq, Van de Ven, & Gustafson, 1975; Fleming & Monda-Amaya, 2001; Murray & Hammons, 1995; Norcross, Hedges, & Prochaska, 2002; Putnam, Spiegel, & Brunicks, 1995; Vazquez-Ramos, Leahy, & Hernandez, 2007) presented results based on similar sample sizes. Delbecq, et al. (1975) went so far as to say that under ideal circumstances, groups as small as four can perform well. Regarding the drop-out rate from Round 1 to Round 2, it is acknowledged frequently in the literature surrounding the Delphi method that because of the time involved in answering the initial question, the turn-around time for subsequent questions, and the additional time required to answer questions in the subsequent rounds that some participants prematurely abandon the task (Delbecq, Van de Ven, & Gustafson, 1975). Other Delphi studies such as those listed above demonstrate much variance in their

response rates for any number of rounds. More specific to the current sample, is that if the literature and thoughts around rural practice hold true, it might be that potential respondents have only limited time to respond, especially twice to the same study.

More specifically, of those participating in the Round 1 investigation, 19 were women (58%) and 14 were men (42%). Most of the expert panel in Round 1 held a doctorate (94%; 88%, Ph.D., 6% Psy.D, n=31) and 6% had a master's degree. Fifty-eight percent of the panelists in Round 1 reported their specialty as clinical psychology, 15% as psychology, 9% as counseling psychology, 3% as cognitive psychology, 3% as Human Service Organization and Research, and 12% did not report their specialty area. Seventy-five percent indicated that they were licensed or certified. While no effort was made to define "rural" based on the census within the inclusionary criteria, participants resided in various geographical areas of the nation, including 15 states (predominantly eastern), parts of Canada, and parts of Australia. Still, the majority of participants resided in the United States, thus, generalizations to other countries might be unwarranted. Those joining the study in Round 2 included 5 males and 1 female. All held Ph.D.'s and 83% were licensed or certified psychologists.

The expert panelists in Round 1 represented 324.75 years of practicing rural psychology ranging from .75 to 32 years. Twenty-seven of the participants endorsed practicing rural psychology, therefore practicing for an average of 12.02 years. Experts participating in Round 2 added 84 years of practice to the panel.

The expert panelists in Round 1 represented 208 years of researching rural psychology ranging from 1 to 36 years. Twenty-two of the participants endorsed researching in the field of rural psychology, therefore researching for an average of 9.45

years. Forty-nine publications were reported by 10 of the participants endorsing researching rural psychology (M=4.9), while twelve participants did not report a number of publications. Panelists participating in Round 2 added 59 years of research surrounding rural mental health.

The expert panelists in Round 1 represented 118 years of teaching rural psychology ranging from 1 to 26 years. Twelve of the participants endorsed teaching in the field of rural psychology, therefore teaching for an average of 9.83 years. Twenty courses taught were reported by three of the participants endorsing teaching rural psychology (M=6.66), while nine participants did not report the number of rural courses they have taught. Those joining the study in Round 2 added 42 years of teaching courses related to rural psychology.

Of note is that ten of the thirty-three participants endorsed all three of the inclusionary criteria of practicing in rural areas, researching rural issues, and teaching courses related rural psychology. Eight of the participants endorsed both practicing rural psychology and researching rural issues. One person endorsed both practicing and teaching, while two people endorsed both researching and teaching. Thus, 21 of the 33 participants reported being involved in issues related to rural psychology in more than one way.

The Research Team

The research team consisted of four other mental health professionals in the fields of social work, educational psychology, clinical psychology, and counseling psychology. Three of the team members including the primary investigator were involved in the data

analysis and categorization of data. The remaining team member served as auditor for validation of the categorization.

Round 1Data Analysis

The open-ended questionnaire (Section II of the Round 1 instrument) yielded a total of 310 critical factors. Five steps were taken to form categories of critical factors for training to practice in rural areas. First, the three members of the initial research team and I reviewed and discussed each of the critical factors contributed by the panelists and came up with initial category titles. Second, we independently clustered similar items into categories. Third, we came together for consensus building around what category each unique item fell under. Fourth, we combined some categories, as it was evident that there was overlap among categories. Still, categories were not completely orthogonal due to the nature of some of the items. In example, "challenges of being the sole practitioner in a rural area" could fall into a number of categories. This particular item became part of the *unique aspects of a psychological practice in a rural setting* category, yet it could have easily been considered an ethical issue related to competency. Fifth, it became apparent that several items were redundant and with the help of an additional researcher, items that were redundant were group together and instead accounted for by listing the frequency count of the similar items.

Round 2 Data Collection

The purpose of the second round of the Delphi method was to build group consensus regarding the items that are most critical for training in rural psychology. Those who were identified as experts but did not participate in Round 1 were still invited to participate in Round 2.

Thus, in Round 2, the general demographic questions and open-ended questions were moved to near the end of the survey as all of the Round 1 participants had already completed that portion of the survey. Those who participated in Round 2 only were asked to fill out the demographic information and open-ended questions later in the survey.

All of the items contributed by all of the participants during Round 1 were grouped into categories developed by the research team and reported under their respective categories contained in the survey. As mentioned previously, items that were very similar to each other were combined and frequencies were reported. All items were represented in this list, whether reported only once or by many participants.

A column followed each critical factor. Participants were asked to rate the importance of the item for training in rural psychology using a 5-point Likert-type scale (0=not important, 1=not too important, 2=somewhat important, 3=very important, and 4=critical. Space was also provided at the end of each category to add comments, and although not used to change items, gave additional insight into how items were perceived.

During this round participants were also given the opportunity to comment on the survey overall. Participants were also asked if they were willing to be identified in print upon publication, as this is standard in the Delphi methodology.

Although a third round was proposed it was determined after the 2nd round, by myself and my advisor, and with approval from my advisory committee that no more substantial information could be gleaned from the participants.

CHAPTER III

RESULTS

Round 1 Data Analysis

Content analysis of Round 1 data resulted in 14 categories containing 129 discrete critical factors (see Table 1 for a complete list of critical items and respective frequency counts by category). Categories were formed merely for organizational purposes.

The first category, *rural life context*, included 11 discrete items related to rural dynamics and the context of rural living. Understanding the unique lifestyle, values, characteristics, and culture of rural communities seemed to be of critical importance because it was the most frequently mentioned factor. The 10 discrete items in the second category, *unique aspects of psychological practice in a rural setting*, focused on understanding what a psychologist practicing in a rural setting might face both positive and negative. The expert panelists seemed to believe that understanding challenges of being the sole practitioner in a rural area was most important. The third category, *knowledge needed for practice in a rural settings*, yielded seven discrete items, related to knowledge of a rural population needed for practice in a rural settings and differences in rural versus urban mental health issue presentation. Understanding of pride, independence, religious beliefs, trust, attitudes toward mental health, and lack of anonymity in searching out viable treatment options as well as understanding the community (ies) in which one might work were cited most frequently.

Tasks for the rural psychologist, the fourth category included 13 items related to specific tasks the rural psychologist might need to undertake while working in a rural setting, from making and receiving referrals to becoming political activists. Making and receiving referrals, research and program development and evaluation, flexibility and adaptability, and advocacy to support access to care were among the most frequently mentioned in the Round 1 qualitative data collection. The 17 items in the fifth category, *specific topics for training in relation to the rural setting*, focused on specific presenting issues one working in a rural setting might deal with, though the items were not entirely unique to the rural setting. Rural psychology ethics and understanding drinking and other addictive behaviors were among the most frequently noted. The sixth category, *generalist and specialization abilities, role, and pre-service professional knowledge and skill sets*, included 13 specific points of knowledge needed for work in rural areas from a broad base of generalist skills to assessment of client's social support networks. The need for a broad base of generalist skills was the most frequently cited critical factor.

Seven items in seventh category, *considerations for developing a therapeutic alliance in a rural setting* described basic therapeutic skills and only some were more specific to the rural setting. Cultural sensitivity as well as communication skills seemed to be of critical importance. *Promoting access to treatment in rural areas*, category eight, yielded 10 items related to understanding barriers to treatment, the need for flexibility in treatment approach, and providing the best possible treatment with sometimes limited options. Factors with the highest frequency counts included: maximizing the use of technology to improve access to treatment, providing co-locations in primary care facilities, and working with the community to "think in larger terms than tertiary

individual treatment". The ninth category, *ethical considerations for rural practice (roles, relationships, and boundaries with clients, confidentiality, competence, psychologist's anonymity and visibility)*, included 11 items related to ethical practice from negotiating dual roles to bartering. Negotiating the ethics of multiple roles was the most frequently mentioned factor in this category *and* in the entire first round inquiry. Also frequently mentioned were awareness of competence, confidentiality, and implications of running into clients in the community. Category 10, *working with other professionals*, with seven items, focused on community, and interdisciplinary collaboration with other mental health and non-mental health professionals. Experts frequently mentioned partnering and networking with community leaders and agencies, interdisciplinary collaboration, and negotiating and sustaining relationships with non-mental health professionals.

The eleventh category, *supervision and consultation*, with only three discrete items, focused on the necessity of clinical supervision, consultation, and alternate models of supervision and consultation. All of the aforementioned were cited as critical factors more than once. *Professional development/continuing education, burnout, isolation, and self-care*, the twelfth category, yielded six items related to access to professional and personal support as well as access to educational resources available for professional development. The most frequently mentioned critical factors included identifying personal stressors and seeking support, compensating for lack of access to continuing education, and securing access to educational resources for professional development. Category 13, *building and maintaining practice in rural communities*, resulted in eight items focused on developing and maintaining a practice in rural communities ranging

from marketing and financial survival to developing effective administration skills. Understanding the business/practical aspects of making a living in rural areas in general was the most frequent factor offered by participants. The final category, *tips for recruiting, retaining, and preparing students for work in rural communities* (six discrete items) focused on methods for gaining students exposure to rural community psychological practice and recruiting and retaining students/psychologists who will work in rural communities. The most frequently mentioned critical factor related to helping students gain exposure to rural settings during their training; offering hands-on-experience.

TABLE 1. Round 1 Expert Panel Critical Factors placed into Categories, Frequency Counts, and Unique Critical Factors from Round 1.

Critical Factors within Categories	n	Total, n	Unique, n
RURAL LIFE CONTEXT		26	11
Unique lifestyle, values, characteristics and culture of rural communities (i.e. customs, rituals, etc.; cultural strengths as well as weaknesses)	13		
Demographics and definitions	2		
Knowledge of family agriculture and the impact it has on rural residents	2		
Social pressures in dense environments and the risk of nonconformity	2		
Homogeneity issues (e.g., lack of cultural/ethnic groups, lack of diversity, lack of social contacts and activities)	1		
Home/work issues that may affect marriage connected with family agriculture	1		
Dynamics of grief and loss issues when economics threaten economic viability of family enterprises	1		
Role of trauma in creating and maintaining symptoms	1		
The importance of social capital as a resource for rural communities	1		
The importance of sense of community to rural people	1		
Rural (and semi-rural) economic class issues, especially poverty	1		
UNIQUE ASPECTS OF A PSYCHOLOGICAL PRACTICE IN A RURAL SETTING		13	10
Challenges of being the sole practitioner in a rural area	3		
Coping with limited resources for clinician (referral, training, consultation, etc.)	2		
Greater professional freedom	1		
Few social opportunities for practitioner/family of practitioner	1		
An emphasis on the underserved aspects of rural work	1		
Decreased likelihood of litigation	1		
Lower reimbursement/benefits	1		
Joys and rewards of living and practicing in a small town or rural region	1		

TABLE 1 cont.

Critical Factors within Categories	n	Total, n	Unique, n
Not being accepted quickly	1		
Coping with limited resources for client	1		
KNOWLEDGE NEEDED FOR PRACTICE IN A RURAL SETTING		17	7
Understanding of pride, independence, religious beliefs trust in searching out viable treatment options, attitudes toward mental health, and lack of anonymity as barriers to mental health treatment	8		
Knowing the specific rural community (ties) in which one works	3		
Awareness of how mental health issues may be presented differently than in urban/suburban areas	2		
The importance of not pathologizing cultural practices/beliefs: visions, religious beliefs, family dynamics, "the old ways"	1		
Understanding how mental illness and psycho-social difficulties can be more severe in rural locations due to already limited experiences/opportunities	1		
The "informal" aspects of practicing in a rural community	1		
Knowledge of directive approaches to counseling that meet the cultural needs of the population (e.g., the right balance between providing concrete solutions but not being pushy)	1		
TASKS FOR THE RURAL PSYCHOLOGIST		33	13
Making and receiving referrals	8		
Research, program development and evaluation; (e.g., assessing the needs of the community and working to meet those needs, finding out what the community considers the problems to be and tackle those first, before identifying other problems that you have observed but which they do not then recognize)	6		
Flexibility, adaptability, and creativity in treatment approach in resource limited locations (e.g., treating fear of crowds in a very small town)	4		
Advocacy for initiatives that support access to care and other important rural health care issues; Becoming political activists	3		
Having stake in the community, living there, and having your future on the line as much as those you serve	2		
Developing strategies for community development	2		
Compensating for limited resources and programs (voc rehab, transportation, sheltered workshops)	2		
Learning about and practicing in new areas as needed by the community	1		
Learning about the legal issues that impact rural areas and broader state/federal issues	1		
Adapting manualized therapies depending on the population (e.g., the sub-literate)	1		
Finding creative ways to provide services and make the long-haul in rural mental health and thinking about problems in ways that are not "typical" to psychology	1		
Funding work through grant writing and other options for treating patients in underserved, underinsured, economically depressed areas	1		
Lobbying for funding for local services that are currently needed but not provided	1		
SPECIFIC TOPICS FOR TRAINING IN RELATION TO THE RURAL SETTING		26	17
Rural psychology ethics	6		
Drinking and other addicting behaviors	3		
Rural service models	2		
Population health principles and rural health	2		

TABLE 1 cont.

Critical Factors within Categories	n	Total, n	Unique, n
Contextual factors in psychological difficulties in rural clients (e.g. isolation, transport, life/work interaction)	1		
Family systems (e.g., what we see as "enmeshed" may be the norm in a more rural area)	1		
Workforce issues	1		
Gerontology; given that rural communities are disproportionately older	1		
Rural employment and economic development	1		
Rural education	1		
Racial, ethnic, and cultural diversity	1		
Mental health literacy	1		
Injury	1		
Disaster preparedness	1		
Disability	1		
Domestic violence	1		
Health Care Finance/Economics	1		
GENERALIST AND SPECIALIZATION ABILITIES, ROLES, AND PRE-SERVICE PROFESSIONAL KNOWLEDGE AND SKILL SETS		29	13
Broad base of generalist skills	13		
Specialty training skill sets to include, but not limited to, community psychology, staff development, leadership training, psychopharmacological consultation, primary care psychology	2		
Assessment and psychological treatment skills	2		
Psychopathology and interventions	2		
Psychopharmacology (given the paucity of psychiatry in small rural towns)	2		
Comfort with varying roles (e.g., consultant-supervisor, multi-disciplinary team advisor, workshop facilitator)	1		
Psychological bases and theory	1		
Family and group therapy	1		
Crisis intervention	1		
Training in short-term, empirically supported treatments	1		
Assessment of client's social support networks	1		
Psychotherapy	1		
Scientist practitioner training	1		
CONSIDERATIONS FOR DEVELOPING A THERAPEUTIC ALLIANCE IN A RURAL SETTING		10	7
Cultural Sensitivity	3		
Communication skills	2		
Understanding the use of metaphor and story telling with rural populations	1		
Engaging clients; Being able to be present and welcoming	1		
Consciously addressing stereotypes/prejudices on both therapist and client's part	1		
Comfort with more casual interactions with clients (e.g., not appearing "uppity")	1		
Basic engagement skills	1		
PROMOTING ACCESS TO TREATMENT IN RURAL AREAS		20	10
Maximizing use of technology (internet/telephone) to improve access to treatment	6		
Providing co-locations in primary care facilities	3		

TABLE 1 cont.

Critical Factors within Categories	n	Total, n	Unique, n
Working with the community as a client; Healing communities, (i.e., thinking in larger terms than tertiary individual treatment)	3		
Flexibility in scheduling (i.e., people wait weeks for appointments and then can't make it, and return to the end of the line. This is hard for them or 90 min session for people who drive a long distance)	2		
Understanding staffing difficulties, especially with finding appropriate MD support	1		
Negotiating restrictions in service availability	1		
Understanding the lack of anonymity in finding services on a local basis as a barrier to mental health service utilization	1		
Understanding financial barriers to seeking psychological services	1		
Knowing your way around basic social services could really help as many individuals and families need case management	1		
Determining how to provide the greatest number of services with, at times, few patients (e.g., groups)	1		
ETHICAL CONSIDERATIONS FOR RURAL PRACTICE (ROLES, RELATIONSHIPS, AND BOUNDARIES WITH CLIENTS, CONFIDENTIALITY, COMPETENCE, PSYCHOLOGIST'S ANONYMITY AND VISIBILITY)		48	11
Negotiating the ethics of multiple/dual roles/relationships with clients	25		
Awareness of limits of competence and appropriate ways of responding to pressures to practice outside one's area of competence	6		
Privacy and confidentiality	5		
Understanding the "Life in a fishbowl" phenomenon of practicing in a rural community (e.g., implications of running into patients in the community)	3		
Establishing boundaries with family/friends/acquaintances	2		
Comfort with increased visibility in community	2		
Boundaries of appropriate self-disclosure	1		
Rural practice: dos and don'ts with sideline occupations and secondary business	1		
Bartering	1		
Perception/status of practitioner in community	1		
Ability to say no when you do not have the time or resources to provide a particular service	1		
WORKING WITH OTHER PROFESSIONALS AND AGENCIES		28	7
Partnering and networking with credible community leaders and agencies regarding advocacy and dealing effectively with rural community institutions (e.g., churches, government clergy persons, civic leaders, schools, etc.) to increase service utilization, promote services and reduce shame/stigma	8		
Interdisciplinary collaboration	7		
Negotiating and sustaining relationships with other non mental health professionals (e.g., school counselors, social workers, etc.)	6		
Working and networking with other practitioners who provide rural mental health services	2		
De facto service systems; developing and sustaining relationships with primary care physicians who provide the bulk of mental health care in small towns	2		
Negotiating and educating other professionals about boundaries and ethics	2		
Maintaining positive relationships with urban tertiary care centers	1		
SUPERVISION AND CONSULTATION		10	3
Clinical supervision	5		
Consultation with people in similar fields	3		

TABLE 1 cont.

Critical Factors within Categories	n	Total, n	Unique, n
Alternate models/technology as a means of obtaining supervision and consultation	2		
PROFESSIONAL DEVELOPMENT/CONTINUING EDUCATION, BURNOUT, ISOLATION, AND SELF-CARE		27	6
Identifying personal stressors and seeking support	16		
Compensating for lack of access to continuing education (e.g., having to drive to other towns for personal growth activities)	4		
Access to educational resources for professional development, staying current in the profession, and client care	3		
Using technology effectively to inform treatment practices	2		
Obtaining support for personal and professional development in rural communities	1		
Strengthening independence while encouraging continued professional support	1		
BUILDING AND MAINTAINING PRACTICE IN RURAL COMMUNITIES		14	8
Understanding the business/practical aspects of making a living while working in a rural area; practical information financial/payment/reimbursement setting up billing, etc.	5		
Marketing, business, and human resources	2		
Financial survival in a small population base community	2		
Developing effective administrative skills (psychologists in rural settings often take these on early in their careers)	1		
Navigating managed care	1		
Maintaining a practice among low-income rural populations	1		
Making your practice "home like"	1		
Ensuring file and test security in settings other than your own office	1		
TIPS FOR RECRUITING, RETAINING, AND PREPARING STUDENTS FOR WORK IN RURAL COMMUNITIES		9	6
Exposure to multiple rural settings and immersion in those settings; offering hands on experience	4		
Gaining funding for students in training	1		
Courses that will target needs specific to rural settings	1		
Having students reflect on personal motivations for practicing in rural areas	1		
Recruit students from rural areas	1		
Recruiting and training graduate students who will actually serve in rural areas after training is completed	1		

Round 1 Qualitative Analysis of Panelist's Prior Training in Rural Psychology

In response to the open-ended inquiry asking participants to describe their own training in rural psychology (whether it be courses completed, professional development, or continuing education), 37 of 39 of the participants replied. Interestingly, 20 of the participants, specifically stated in one way or another that they had no formal training in rural psychology during the course of their graduate education. One participant stated,

"None! Sink or swim on first job!" Two others echoed, "None! Just learn as you go" and "My training was in an urban environment and my experience in rural psychology has been 'on the job.'" Another commented that he or she had "no formal training, just life experience" while two others related that he or she could have used some and that it would have been helpful. Others of the 20 commented generally that they engaged in self-directed learning through reading, writing, completing research (i.e., dissertations), and attendance in conferences/seminars related to the practice of rural psychology. Only three of the participants mentioned the opportunity to engage in a course specific to rural psychology.

Keeping in mind that the open ended question inquired about courses completed, professional development opportunities, *and* continuing education, the remaining 16 participants spoke of practicum and internship opportunities specializing in rural practice that they engaged in. Others spoke of the current places they work wherein rural psychology is a focus. Some spoke of research they are engaged in through their employment. Some also spoke of being supervised by psychologists who work in or whom have interest in rural settings.

Round 2 Data Analysis

Following completion of Round 2, means, variances, and standard deviations for each critical factor were obtained. An a priori decision was made based on Delphi method guidelines (Delbecq, Van de Ven, & Gustafson, 1975; Murray & Hammons, 1995) and on previous Delphi research (Fleming & Monda-Amaya, 2001; Norcross, Hedges, & Prochaska, 2002; Putnam, Spiegel, & Brunicks, 1995; Vazquez-Ramos, Leahy, & Hernandez, 2007) to establish the criterion for determining factor importance.

Items with a mean of 2.5 with a variance of no more than 1.0 indicated at least moderate importance. The purpose of reporting the variance among the respondent's ratings was to shed light onto the level of agreement between panelist's ratings of each item. For example, some panelists may have regarded a factor as very important, while others may have rated the same factor as not important, thus resulting in a high variance. The variance identified which factors had the least consensus, which was just as noteworthy as uncovering the most critical factors in some cases.

Thus, factors with a mean of $\geq$ 3.5 and a variance of no more than 1.0 were considered to be the most highly critical factors. Factors with means of 2.5 to 3.49 with a variance of no more than 1.0 were considered to be very important, while factors with means of 1.5 to 2.49 were considered to be somewhat important. Factors with means of .05 to 1.49 were considered to be not too important. Items with a mean $\leq$ to .49 were considered not important. None of the factors fell into the latter two groupings of not too important and not important. This makes sense given that in this study, the panelist's generated the factors that comprised the Round 2 survey. It seems evident that items would not have been mentioned in Round 1 had they not been at least somewhat important.

Variables Necessary for Effective Training in Rural Psychology

In the category, rural life context (see Table 2), 27% (n=3) of the 11 items were rated at a level above 2.5 with a variance of no more than 1.0 and none of the items met the criteria of greater than 3.5 for a critical item. The items surpassing the 2.5 level included: unique lifestyle, values, characteristics and culture of rural communities (i.e. customs, rituals, etc.; cultural strengths as well as weaknesses) (3.38), the importance of

sense of community to rural people (3.19), and rural (and semi-rural) economic class issues, especially poverty (3.27). The importance of social capital as a resource for rural communities (2.58) held a variance of 1.29.

Seven of the items fell within the somewhat important range, while four of those had variances of greater than 1.0. Demographics and definitions (2.46), knowledge of family agriculture and the impact it has on rural residents (2.23), and dynamics of grief and loss issues when economics threaten economic viability of family enterprises (2.42) had variances of less than 1.0. Social pressures in dense environments and the risk of nonconformity (2.31, V=1.58), homogeneity issues (e.g., lack of cultural/ethnic groups, lack of diversity, lack of social contacts and activities) (2.31, V=1.10), home/work issues that may affect marriage connected with family agriculture (2.19, V=1.04), and role of trauma in creating and maintaining symptoms (1.81, V=1.44) each had variances of greater than 1.0.

TABLE 2. Category 1. Rural Life Context -Means, Variances, and Standard Deviations.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Very Important			
Unique lifestyle, values, characteristics and culture of rural communities (i.e. customs, rituals, etc.) cultural strengths as well as weaknesses) (13)	3.38	.57	.75
The importance of sense of community to rural people (1)	3.19	.72	.85
Rural (and semi-rural) economic class issues, especially poverty (1)	3.27	.76	.87
Very Important with Variance of 1.0 or Greater			
The importance of social capital as a resource for rural communities (1)	2.58	1.29	1.14
Somewhat Important			
Demographics and definitions (2)	2.46	.73	.86
Knowledge of family agriculture and the impact it has on rural residents (2)	2.23	.82	.90
Dynamics of grief and loss issues when economics threaten economic viability of family enterprises (1)	2.42	.81	.90
Somewhat Important with Variance of 1.0 or Greater			
Social pressures in dense environments and the risk of nonconformity (2)	2.31	1.58	1.25
Homogeneity issues (e.g., lack of cultural/ethnic groups, lack of diversity, lack of social contacts and activities) (1)	2.31	1.10	1.05

TABLE 2. cont.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Home/work issues that may affect marriage connected with family agriculture (1)	2.19	1.04	1.02
Role of trauma in creating and maintaining symptoms (1)	1.81	1.44	1.20

Forty percent of the items in the unique aspects of a psychological practice in a rural setting (see Table 3) category met criteria and one additional item meat the criteria for a mean of greater than 2.5, but held a variance of greater than 1.0. Challenges of being the sole practitioner in a rural area (3.81) and coping with limited resources for clinician, (referral, training, consultation, etc.) (3.6) met the cutoff point of greater than 3.5 to be cited as critical factors. Joys and rewards of living and practicing in a small town or rural region (2.88) and coping with limited resources for client, (3.42) were the other two items falling into the "very important" category. An emphasis on the underserved aspects of rural work (2.85, V=1.34) met the cutoff point for the mean, yet the variance was greater than 1.0.

Five of the items fell in the somewhat important range with three of them having variances above 1.0. Few social opportunities for practitioner/family of practitioner (2.4) and decreased likelihood of litigation (1.56) held variances of less than 1.0, while greater professional freedom (2.33, V=1.01) lower reimbursement/benefits (1.92, V=1.16), and not being accepted quickly (2.15, V=1.10) had variances of greater than 1.0.

TABLE 3. Category 2. Unique Aspects of a Psychological Practice in a Rural Setting-Means, Variances, and Standard Deviations.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Critical			
Challenges of being the sole practitioner in a rural area (3)	3.81	.16	.40
Coping with limited resources for clinician (referral, training, consultation, etc.)(2)	3.6	.33	.58
Very Important			
Joys and rewards of living and practicing in a small town or rural region (1)	2.88	.91	.95
Coping with limited resources for client (1)	3.42	.65	.80
Very Important with Variance of 1.0 or Greater			
An emphasis on the underserved aspects of rural work (1)	2.85	1.34	1.16
Somewhat Important			
Few social opportunities for practitioner/family of practitioner (1)	2.4	.92	.96
Decreased likelihood of litigation (1)	1.56	.92	.9
Somewhat Important with Variance of 1.0 or Greater			
Greater professional freedom (1)	2.33	1.01	1.01
Lower reimbursement/benefits (1)	1.92	1.16	1.0
Not being accepted quickly (1)	2.15	1.10	1.05

Only one of the seven items, knowledge of directive approaches to counseling that meet the cultural needs of the population (e.g., the right balance between providing concrete solutions but not being pushy) (2.32, V=1.31) in the knowledge needed for practice in a rural setting category (see Table 4), did not meet criteria for *both* the mean and variance. Understanding of pride, independence, religious beliefs trust in searching out viable treatment options, attitudes toward mental health, and lack of anonymity as barriers to mental health treatment (3.4), knowing the specific rural community (ties) in which one works (3.38), awareness of how mental health issues may be presented differently than in urban/suburban areas (2.96), and the importance of not pathologizing cultural practices/beliefs: visions, religious beliefs, family dynamics, "the old ways" (2.96) fell within the very important range and met the variance criteria. Understanding how mental illness and psycho-social difficulties can be more severe in rural locations

due to already limited experiences/opportunities (2.84, V=1.22) and the "informal" aspects of practicing in a rural community (3, V=1.12) fell into the very important range but held variances above the 1.0 cutoff point.

TABLE 4. Category 3. Knowledge needed for Practice in a Rural Setting-Means, Variances, and Standard Deviations.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Very Important			
Understanding of pride, independence, religious beliefs trust in searching out viable treatment options, attitudes toward mental health, and lack of anonymity as barriers to mental health treatment (8)	3.4	.75	.87
Knowing the specific rural community (ties) in which one works (3)	3.38	.65	.80
Awareness of how mental health issues may be presented differently than in urban/suburban areas (2)	2.96	.84	.92
The importance of not pathologizing cultural practices/beliefs: visions, religious beliefs, family dynamics, "the old ways" (1)	2.96	.68	.82
Very Important with Variance of 1.0 or Greater			
Understanding how mental illness and psycho-social difficulties can be more severe in rural locations due to already limited experiences/opportunities (1)	2.84	1.22	1.11
The "informal" aspects of practicing in a rural community (1)	3	1.12	1.06
Somewhat Important with Variance of 1.0 or Greater			
Knowledge of directive approaches to counseling that meet the cultural needs of the population (e.g., the right balance between providing concrete solutions but not being pushy) (1)	2.32	1.31	1.145

In the category, tasks for the rural psychologist (see Table 5), 69% (n=9) of the 13 items were rated at a level above 2.5 with variances less than 1.0 and none of the items met the criteria for a critical item. Meeting the criteria for very important were the items: making and receiving referrals (3.19), research, program development and evaluation (2.85), flexibility, adaptability, and creativity in treatment approach in resource limited locations (3.23), advocacy for initiatives that support access to care (2.73), developing strategies for community development (2.54), compensating for limited resources and programs (2.85), learning about and practicing in new areas as needed by the community (2.88), finding creative ways to provide services and make the long-haul in rural mental

health and thinking about problems in ways that are not "typical" to psychology (2.96), and lobbying for funding for local services that are currently needed but not provided (2.54).

Having stake in the community, living there, and having your future on the line as much as those you serve (2.69, V=1.02) had a variance of greater than 1.0, but would have otherwise met the mean cutoff point for very important. Learning about the legal issues that impact rural areas and broader state/federal issues (2.46) was regarded as somewhat important. Funding work through grant writing and other options for treating patients in underserved (2.42) was also regarded as somewhat important. Adapting manualized therapies depending on the population (e.g., the sub-literate) (1.92, V=1.51) held too high variance.

TABLE 5. Category 4. Tasks for the Rural Psychologist-Means, Variances, and Standard Deviations.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Very Important			
Making and receiving referrals (8)	3.19	.72	.85
Research, program development and evaluation; (e.g., assessing the needs of the community and working to meet those needs, finding out what the community considers the problems to be and tackle those first, before identifying other problems that you have observed but which they do not then recognize) (6)	2.85	.77	.88
Flexibility, adaptability, and creativity in treatment approach in resource limited locations (e.g., treating fear of crowds in a very small town) (4)	3.23	.66	.82
Advocacy for initiatives that support access to care and other important rural health care issues; Becoming political activists (3)	2.73	.84	.92
Developing strategies for community development (2)	2.54	.98	.99
Compensating for limited resources and programs (voc rehab, transportation, sheltered workshops) (2)	2.85	.94	.97
Learning about and practicing in new areas as needed by the community (1)	2.88	.91	.95
Finding creative ways to provide services and make the long-haul in rural mental health and thinking about problems in ways that are not "typical" to psychology (1)	2.96	.84	.92
Lobbying for funding for local services that are currently needed but not provided (1)	2.54	.98	.99
Very Important with Variance of 1.0 or Greater			
Having stake in the community, living there, and having your future on the line as much as those you serve (2)	2.69	1.02	1.01
Somewhat Important			

TABLE 5. cont.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Learning about the legal issues that impact rural areas and broader state/federal issues (1)	2.46	.66	.81
Funding work through grant writing and other options for treating patients in underserved, underinsured, economically depressed areas (1)	2.42	.73	.86
Somewhat Important with Variance of 1.0 or Greater			
Adapting manualized therapies depending on the population (e.g., the sub-literate) (1)	1.92	1.51	1.23

The specific topics for training in relation to the rural setting category yielded 41% (7 of 17) of items meeting the a priori criteria (see Table 6). One of those items, rural psychology ethics (3.81) made the cutoff point for a critical item with very little variance (V=.16). The additional six of the seven items were regarded as very important and included: drinking and other addicting behaviors (3.19), rural service models (2.88), population health principles and rural health (2.73), contextual factors in psychological difficulties in rural clients (e.g. isolation, transport, life/work interaction) (3.23), family systems (e.g., what we see as "enmeshed" may be the norm in a more rural area) (2.96), and gerontology; given that rural communities are disproportionately older (2.54). The items racial, ethnic, and cultural diversity (2.65, V=1.36), mental health literacy (2.6, V=1.0), and domestic violence (2.69, V=1.02) met the cutoff point for the mean to be regarded as very important but had variances greater than 1.0.

Rural education (2.35), injury (2.04) and disaster preparedness (1.69) were regarded as somewhat important while workforce issues (2.42, V=1.05), rural employment and economic development (2.42,V=1.29), disability (2.19, V=1.28), and health care finance/economics (2.27, V=1.32) were regarded as somewhat important but each held variances beyond the 1.0 cutoff point.

TABLE 6. Category 5. Specific Topics for Training in Relation to the Rural Setting-Means, Variances, and Standard Deviations.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Critical			
Rural psychology ethics (6)	3.81	.16	.40
Very Important			
Drinking and other addicting behaviors (3)	3.19	.40	.63
Rural service models (2)	2.88	.75	.86
Population health principles and rural health (2)	2.73	.92	.96
Contextual factors in psychological difficulties in rural clients (e.g. isolation, transport, life/work interaction) (1)	3.23	.34	.59
Family systems (e.g., what we see as "enmeshed" may be the norm in a more rural area) (1)	2.96	.92	.96
Gerontology; given that rural communities are disproportionately older (1)	2.54	.82	.91
Very Important with Variance of 1.0 or Greater			
Racial, ethnic, and cultural diversity (1)	2.65	1.36	1.16
Mental health literacy (1)	2.6	1	1
Domestic violence (1)	2.69	1.02	1.01
Somewhat Important			
Rural education (1)	2.35	.96	.98
Injury (1)	2.04	.76	.87
Disaster preparedness (1)	1.69	.94	.97
Somewhat Important with Variance of 1.0 or Greater			
Workforce issues (1)	2.42	1.05	1.03
Rural employment and economic development (1)	2.42	1.29	1.14
Disability (1)	2.19	1.28	1.13
Health Care Finance/Economics (1)	2.27	1.32	1.15

In the category, generalist and specialization abilities, roles, pre-service knowledge and skill sets (see Table 7), 10 of the 13 items were rated at a level above 2.5 with a variance of no more than 1.0. Four of the items met the criteria of greater than 3.5 for a critical item. Items meeting the cutoff point to be designated as critical included: broad base of generalist skills (3.88), assessment and psychological treatment skills (3.62), psychopathology and interventions (3.62), and comfort with varying roles (e.g., consultant-supervisor, multi-disciplinary team advisor, workshop facilitator (3.5).

Six of the items were regarded as very important and held variances below 1.0. Those items included: specialty training skill sets to include, but not limited to, community psychology, staff development, leadership training, psychopharmacological consultation, primary care psychology (3.23), psychological bases and theory (2.85), family and group therapy (2.96), crisis intervention (3.23), assessment of client's social support networks (3), and psychotherapy (3.08).

The remaining three items, psychopharmacology (given the paucity of psychiatry in small rural towns) (2.58, V=1.69), training in short-term, empirically supported treatments (3.19, V=1.28), and scientist practitioner training (2.92, V=1.11) met the cutoff point for the mean to be regarded as very important, yet held variances over the 1.0 mark.

TABLE 7. Category 6. Generalist and Specialization Abilities, Roles, Pre-Service Knowledge and Skill Sets-Means, Variances, and Standard Deviations.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Critical			
Broad base of generalist skills (13)	3.88	.11	.33
Assessment and psychological treatment skills (2)	3.62	.41	.64
Psychopathology and interventions (2)	3.62	.41	.64
Comfort with varying roles (e.g., consultant-supervisor, multi-disciplinary team advisor, workshop facilitator) (1)	3.5	.66	.81
Very Important			
Specialty training skill sets to include, but not limited to, community psychology, staff development, leadership training, psychopharmacological consultation, primary care psychology (2)	3.23	.82	.91
Psychological bases and theory (1)	2.85	.94	.97
Family and group therapy (1)	2.96	.92	.96
Crisis intervention (1)	3.23	.50	.71
Assessment of client's social support networks (1)	3	.64	.8
Psychotherapy (1)	3.08	.71	.85
Very Important with Variance of 1.0 or Greater			
Psychopharmacology (given the paucity of psychiatry in small rural towns) (2)	2.58	1.69	1.3
Training in short-term, empirically supported treatments (1)	3.19	1.28	1.13

TABLE 7. cont.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Scientist practitioner training (1)	2.92	1.11	1.06

Eighty-five percent (n=6) of the items in the category considerations for developing a therapeutic alliance in a rural setting (see Table 8) met the a priori criteria to be regarded as at least moderately important. Communication skills (3.54) narrowly made the cutoff point to be cited as a critical factor. Cultural Sensitivity (3.38), engaging clients; Being able to be present and welcoming (3.23), consciously addressing stereotypes/prejudices on both therapist and client's part (2.81), comfort with more casual interactions with clients (e.g., not appearing "uppity") (3), and basic engagement skills (3.35) were regarded as very important. Cited as only somewhat important was understanding the use of metaphor and story telling with rural populations (2.4, V=1.33) yet the variance was quite high.

TABLE 8. Category 7. Considerations for Developing a Therapeutic Alliance in a Rural Setting-Means, Variances, and Standard Deviations.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Critical			
Communication skills (2)	3.54	.42	.65
Very Important			
Cultural Sensitivity (3)	3.38	.89	.94
Engaging clients; Being able to be present and welcoming (1)	3.23	.82	.91
Consciously addressing stereotypes/prejudices on both therapist and client's part (1)	2.81	.88	.94
Comfort with more casual interactions with clients (e.g., not appearing "uppity") (1)	3	.64	.8
Basic engagement skills (1)	3.35	.72	.85
Somewhat Important with Variance of 1.0 or Greater			
Understanding the use of metaphor and story telling with rural populations (1)	2.4	1.33	1.16

Eight of the 10 items in the category promoting access to treatment in rural areas (see Table 9) were regarded as very important and held variances less than 1.0. The two additional items met the cutoff point for the mean to be designated as very important but had variances of greater than 1.0. Maximizing use of technology (internet/telephone) to improve access to treatment (3.08), providing co-locations in primary care facilities (3), working with the community as a client; healing communities, (i.e., thinking in larger terms than tertiary individual treatment) (2.65), flexibility in scheduling (i.e., people wait weeks for appointments and then can't make it, and return to the end of the line. This is hard for them or 90 min session for people who drive a long distance) (2.96), understanding staffing difficulties, especially with finding appropriate MD support (2.77), negotiating restrictions in service availability (2.73), understanding the lack of anonymity in finding services on a local basis as a barrier to mental health service utilization (2.96), and knowing your way around basic social services could really help as many individuals and families need case management (3.32) were among those meeting the criteria. The remaining two: understanding financial barriers to seeking psychological services (2.92, V=1.03) and determining how to provide the greatest number of services with, at times, few patients (e.g., groups) (2.8, V=1.08) held variances greater than 1.0.

TABLE 9. Category 8. Promoting Access to Treatment in Rural Areas-Means, Variances, and Standard Deviations.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Very Important			
Maximizing use of technology (internet/telephone) to improve access to treatment (6)	3.08	.63	.77
Providing co-locations in primary care facilities (3)	3	.88	.94
Working with the community as a client; Healing communities, (i.e., thinking in larger terms than tertiary individual treatment) (3)	2.65	.80	.89
Flexibility in scheduling (i.e., people wait weeks for appointments and then can't make it, and	2.96	.68	.82

TABLE 9. cont.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
return to the end of the line. This is hard for them or 90 min session for people who drive a long distance) (2)			
Understanding staffing difficulties, especially with finding appropriate MD support (1)	2.77	.82	.90
Negotiating restrictions in service availability (1)	2.73	.76	.87
Understanding the lack of anonymity in finding services on a local basis as a barrier to mental health service utilization (1)	2.96	.52	.72
Knowing your way around basic social services could really help as many individuals and families need case management (1)	3.32	.56	.75
Very Important with Variance of 1.0 or Greater			
Understanding financial barriers to seeking psychological services (1)	2.92	1.03	1.02
Determining how to provide the greatest number of services with, at times, few patients (e.g., groups) (1)	2.8	1.08	1.04

Within the category, ethical considerations for rural practice (roles, relationships, and boundaries with clients, confidentiality, psychologist's anonymity and visibility), the category resulting in the most critical items (n=5), in total, 73% of the items met the a priori criteria (see Table 10). Negotiating the ethics of multiple/dual roles/relationships with clients (3.81), awareness of limits of competence and appropriate ways of responding to pressures to practice outside one's area of competence (3.73), privacy and confidentiality (3.65), understanding the "Life in a fishbowl" phenomenon of practicing in a rural community (e.g., implications of running into patients in the community) (3.58), and establishing boundaries with family/friends/acquaintances (3.5) met the cutoff point to exist as critical items. Items meeting the very important criteria included: Comfort with increased visibility in community (3.35), boundaries of appropriate self disclosure (3.38), and ability to say no when you do not have the time or resources to provide a particular service (3.04).

Items meeting the very important cutoff point but which did not meet the variance cutoff point included rural practice: dos and don'ts with sideline occupations and

secondary business (3, V=1.25) and perception/status of practitioner in community (2.92, V=1.96). Bartering (2.4) was regarded as somewhat important, yet yielded a significant variance (2.17) in responses making this the item with the most variance in the entire list of the 129 items.

TABLE 10. Category 9. Ethical Considerations for Rural Practice (Roles, Relationships, and Boundaries with Clients, Confidentiality, Psychologist's Anonymity and Visibility)-Means, Variances, and Standard Deviations.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Critical			
Negotiating the ethics of multiple/dual roles/relationships with clients (25)	3.81	.24	.49
Awareness of limits of competence and appropriate ways of responding to pressures to practice outside one's area of competence (6)	3.73	.28	.53
Privacy and confidentiality (5)	3.65	.32	.56
Understanding the "Life in a fishbowl" phenomenon of practicing in a rural community (e.g., implications of running into patients in the community) (3)	3.58	.25	.50
Establishing boundaries with family/friends/acquaintances (2)	3.5	.42	.65
Very Important			
Comfort with increased visibility in community (2)	3.35	.64	.80
Boundaries of appropriate self-disclosure (1)	3.38	.49	.70
Ability to say no when you do not have the time or resources to provide a particular service (1)	3.04	.87	.94
Very Important with Variance of 1.0 or Greater			
Rural practice: dos and don'ts with sideline occupations and secondary business (1)	3	1.25	1.12
Perception/status of practitioner in community (1)	2.92	1.16	1.08
Somewhat Important with Variance of 1.0 or Greater			
Bartering (1)	2.4	2.17	1.47

All of the items in the category working with other professionals and agencies yielded results that met the a priori criteria ($M=\geq 2.5$, $V=\leq 1.0$) to indicate at least moderate importance (see Table 11). Three of the items, partnering and networking with credible community leaders and agencies regarding advocacy and dealing effectively with rural community institutions (e.g., churches, government clergy persons, civic leaders, schools, etc.) to increase service utilization, promote services and reduce shame/stigma (3.5), interdisciplinary collaboration (3.62), negotiating and sustaining

relationships with other non mental health professionals (e.g., school counselors, social workers, etc.) (3.58) met the criteria to be constituted as critical items (e.g, ≥3.5).

Working and networking with other practitioners who provide rural mental health services (3.38), de facto service systems; developing and sustaining relationships with primary care physicians who provide the bulk of mental health care in small towns (3.42), negotiating and educating other professionals about boundaries and ethics (3), and maintaining positive relationships with urban tertiary care centers (2.58) were regarded as very important.

TABLE 11. Category 10. Working with Other Professionals and Agencies-Means, Variances, and Standard Deviations.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Critical			
Partnering and networking with credible community leaders and agencies regarding advocacy and dealing effectively with rural community institutions (e.g., churches, government clergy persons, civic leaders, schools, etc.) to increase service utilization, promote services and reduce shame/stigma (8)	3.5	.42	.65
Interdisciplinary collaboration (7)	3.62	.33	.57
Negotiating and sustaining relationships with other non mental health professionals (e.g., school counselors, social workers, etc.) (6)	3.58	.33	.58
Very Important			
Working and networking with other practitioners who provide rural mental health services (2)	3.38	.49	.70
De facto service systems; developing and sustaining relationships with primary care physicians who provide the bulk of mental health care in small towns (2)	3.42	.41	.64
Negotiating and educating other professionals about boundaries and ethics (2)	3	.88	.94
Maintaining positive relationships with urban tertiary care centers (1)	2.58	.89	.95

Within the category supervision and consultation (see Table 12), each of the three items reached only the very important cutoff point. Clinical supervision (3.44) narrowly missed the cutoff point to be considered critical. Consultation with people in similar fields (3.16) and alternate models/technology as a means of obtaining supervision and consultation (3.13) also indicated much importance.

TABLE 12. Category 11. Supervision and Consultation-Means, Variances, and Standard Deviations.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Very Important			
Clinical supervision (5)	3.44	.67	.82
Consultation with people in similar fields (3)	3.16	.56	.75
Alternate models/technology as a means of obtaining supervision and consultation (2)	3.13	.81	.90

Each of the six items in the professional development/continuing education, burnout, isolation, and self-care category were regarded as very important (see Table 13). The specific items in this category were: identifying personal stressors and seeking support (3.4) Compensating for lack of access to continuing education (e.g., having to drive to other towns for personal growth activities) (2.88), access to educational resources for professional development, staying current in the profession, and client care (3.36), using technology effectively to inform treatment practices (2.92), obtaining support for personal and professional development in rural communities (2.8), and strengthening independence while encouraging continued professional support (2.63).

TABLE 13. Category 12. Professional Development/Continuing Education, Burnout, Isolation, and Self-care-Means, Variances, and Standard Deviations.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Very Important			
Identifying personal stressors and seeking support (16)	3.4	.58	.76
Compensating for lack of access to continuing education (e.g., having to drive to other towns for personal growth activities) (4)	2.88	.78	.88
Access to educational resources for professional development, staying current in the profession, and client care (3)	3.36	.49	.70
Using technology effectively to inform treatment practices (2)	2.92	.58	.76
Obtaining support for personal and professional development in rural communities (1)	2.8	.75	.87
Strengthening independence while encouraging continued professional support (1)	2.63	.59	.77

Half of the items (4 out of 8) in the category building and maintaining a practice in rural communities resulted in very important status (see Table 14). Understanding the business/practical aspects of making a living while working in a rural area; practical information financial/payment/reimbursement setting up billing, etc. (3.31), marketing, business, and human resources (2.8), financial survival in a small population base community (2.79), and developing effective administrative skills (psychologists in rural settings often take these on early in their careers) (2.8) comprised those items.

Navigating managed care (2.71, V=1.09), maintaining a practice among low-income rural populations (2.71, V=1.09, and ensuring file and test security in settings other than your own office (2.64, V=1.16) did not meet the variance cutoff, yet their means would have suggested at least moderate importance. Making your practice "home like" (1.5, V=1.04) was the lowest rated item of the 129 items.

TABLE 14. Category 13. Building and Maintaining a Practice in Rural Communities-Means, Variances, and Standard Deviations.

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Very Important			
Understanding the business/practical aspects of making a living while working in a rural area; practical information financial/payment/reimbursement setting up billing, etc. (5)	3.31	.62	.79
Marketing, business, and human resources (2)	2.8	.92	.96
Financial survival in a small population base community (2)	2.79	.87	.93
Developing effective administrative skills (psychologists in rural settings often take these on early in their careers) (1)	2.8	.75	.87
Very Important with Variance of 1.0 or Greater			
Navigating managed care (1)	2.71	1.09	1.04
Maintaining a practice among low-income rural populations (1)	2.71	1.09	1.04
Making your practice "home like" (1)	1.5	1.04	1.02
Ensuring file and test security in settings other than your own office (1)	2.64	1.16	1.08

Five of the items in the final category (see Table 15), tips for recruiting, retaining, and preparing students for work in rural communities were considered to be of at least

moderate importance with one of the five being termed critical. Exposure to multiple rural settings and immersion in those settings; offering hands on experience (3.54) was considered critical. Courses that will target needs specific to rural settings (3.15), having students reflect on personal motivations for practicing in rural areas (2.54), recruit students from rural areas (3.23), and recruiting and training graduate students who will actually serve in rural areas after training is completed (3.42) were considered to be very important. Gaining funding for students in training (3.04, V=1.08) resulted in too high variance to be considered very important.

TABLE 15. Category 14. Tips for Recruiting, Retaining, and Preparing Students for Work in Rural Communities-Means, Variances, and Standard Deviations

Factors organized by level of importance (Round 1 Frequency Count)	Round 2 M	V	SD
Critical			
Exposure to multiple rural settings and immersion in those settings; offering hands on experience (4)	3.54	.58	.76
Very Important			
Courses that will target needs specific to rural settings (1)	3.15	.46	.68
Having students reflect on personal motivations for practicing in rural areas (1)	2.54	.82	.91
Recruit students from rural areas (1)	3.23	.98	.99
Recruiting and training graduate students who will actually serve in rural areas after training is completed (1)	3.42	.41	.64
Very Important with Variance of 1.0 or Greater			
Gaining funding for students in training (1)	3.04	1.08	1.04

In total there were 17 factors noted as critical, all with a variance less than 1.0. Sixty-seven factors were noted as very important, with a variance less than 1.0. Nineteen more items were reported as very important, but had a variance at or exceeding 1.0, for a total of 86. Ten factors were noted as somewhat important with a variance less than 1.0. Sixteen more factors were noted as somewhat important, but reported a variance of 1.0 or

greater, for a total of 26. Table 16 represents the list of factors grouped by level of importance.

Table 16. Factors across all Categories Grouped by Level of Importance

Importance Rating	Category
Critical	
Challenges of being the sole practitioner in a rural area	2
Coping with limited resources for clinician (referral, training, consultation, etc.)	2
Rural Psychology Ethics	2
Broad base of generalist skills	6
Assessment and psychological treatment skills	6
Psychopathology and interventions	6
Comfort with varying roles (e.g., consultant-supervisor, multi-disciplinary team advisor, workshop facilitator)	6
Communication skills	7
Negotiating the ethics of multiple/dual roles/relationships with clients	9
Awareness of limits of competence and appropriate ways of responding to pressures to practice outside one's area of competence	9
Privacy and confidentiality	9
Understanding the "Life in a fishbowl" phenomenon of practicing in a rural community (e.g., implications of running into patients in the community)	9
Establishing boundaries with family/friends/acquaintances	9
Partnering and networking with credible community leaders and agencies regarding advocacy and dealing effectively with rural community institutions (e.g., churches, government clergy persons, civic leaders, schools, etc.) to increase service utilization, promote services and reduce shame/stigma	10
Interdisciplinary collaboration	10
Negotiating and sustaining relationships with other non mental health professionals (e.g., school counselors, social workers, etc.)	10
Exposure to multiple rural settings and immersion in those settings; offering hands on experience	14
Very Important	
Unique lifestyle, values, characteristics and culture of rural communities (i.e. customs, rituals, etc.; cultural strengths as well as weaknesses)	1
The importance of sense of community to rural people	1
Rural (and semi-rural) economic class issues, especially poverty	1
Joys and rewards of living and practicing in a small town or rural region	2
Coping with limited resources for client	2
Understanding of pride, independence, religious beliefs trust in searching out viable treatment options, attitudes toward mental health, and lack of anonymity as barriers to mental health treatment	3
Knowing the specific rural community (ties) in which one works	3
Awareness of how mental health issues may be presented differently than in urban/suburban areas	3
The importance of not pathologizing cultural practices/beliefs: visions, religious beliefs, family dynamics, "the old ways"	3
Making and receiving referrals	4
Research, program development and evaluation; (e.g., assessing the needs of the community and working to meet those needs, finding out what the community considers the problems to be and tackle those first, before identifying other problems that you have observed but which they do not then recognize)	4
Flexibility, adaptability, and creativity in treatment approach in resource limited locations (e.g., treating fear of	4

Table 16. cont.

Importance Rating	Category
crowds in a very small town)	
Advocacy for initiatives that support access to care and other important rural health care issues;	4
Becoming political activists	
Developing strategies for community development	4
Compensating for limited resources and programs (voc rehab, transportation, sheltered workshops)	4
Learning about and practicing in new areas as needed by the community	4
Finding creative ways to provide services and make the long-haul in rural mental health and thinking about problems in ways that are not "typical" to psychology	4
Lobbying for funding for local services that are currently needed but not provided	4
Drinking and other addicting behaviors	5
Rural service models	5
Population health principles and rural health	5
Contextual factors in psychological difficulties in rural clients (e.g. isolation, transport, life/work interaction)	5
Family systems (e.g., what we see as "enmeshed" may be the norm in a more rural area)	5
Gerontology; given that rural communities are disproportionately older	5
Specialty training skill sets to include, but not limited to, community psychology, staff development, leadership training, psychopharmacological consultation, primary care psychology	6
Psychological bases and theory	6
Family and group therapy	6
Crisis intervention	6
Assessment of client's social support networks	6
Psychotherapy	6
Cultural Sensitivity	7
Engaging clients; Being able to be present and welcoming	7
Consciously addressing stereotypes/prejudices on both therapist and client's part	7
Comfort with more casual interactions with clients (e.g., not appearing "uppity")	7
Basic engagement skills	7
Maximizing use of technology (internet/telephone) to improve access to treatment	8
Providing co-locations in primary care facilities	8
Working with the community as a client; Healing communities, (i.e., thinking in larger terms than tertiary individual treatment)	8
Flexibility in scheduling (i.e., people wait weeks for appointments and then can't make it, and return to the end of the line.This is hard for them or 90 min session for people who drive a long distance)	8
Understanding staffing difficulties, especially with finding appropriate MD support	8
Negotiating restrictions in service availability	8
Understanding the lack of anonymity in finding services on a local basis as a barrier to mental health service utilization	8
Knowing your way around basic social services could really help as many individuals and families need case management	8
Comfort with increased visibility in community	9
Boundaries of appropriate self-disclosure	9
Ability to say no when you do not have the time or resources to provide a particular service	9
Working and networking with other practitioners who provide rural mental health services	
De facto service systems; developing and sustaining relationships with primary care physicians	10

Table 16. cont.

Importance Rating	Category
who provide the bulk of mental health care in small towns	
Negotiating and educating other professionals about boundaries and ethics	10
Maintaining positive relationships with urban tertiary care centers	10
Clinical supervision	11
Consultation with people in similar fields	11
Alternate models/technology as a means of obtaining supervision and consultation	11
Identifying personal stressors and seeking support	12
Compensating for lack of access to continuing education (e.g., having to drive to other towns for personal growth activities)	12
Access to educational resources for professional development, staying current in the profession, and client care	12
Using technology effectively to inform treatment practices	12
Obtaining support for personal and professional development in rural communities	12
Strengthening independence while encouraging continued professional support	12
Understanding the business/practical aspects of making a living while working in a rural area; practical information financial/payment/reimbursement setting up billing, etc.	13
Marketing, business, and human resources	13
Financial survival in a small population base community	13
Developing effective administrative skills (psychologists in rural settings often take these on early in their careers)	13
Courses that will target needs specific to rural settings	14
Having students reflect on personal motivations for practicing in rural areas	14
Recruit students from rural areas	14
Recruiting and training graduate students who will actually serve in rural areas after training is completed	14
Very Important with Variance of 1.0 or Greater	
The importance of social capital as a resource for rural communities	1
An emphasis on the underserved aspects of rural work	2
Understanding how mental illness and psycho-social difficulties can be more severe in rural locations due to already limited experiences/opportunities	3
The "informal" aspects of practicing in a rural community	3
Having stake in the community, living there, and having your future on the line as much as those you serve	4
Racial, ethnic, and cultural diversity	5
Mental health literacy	5
Domestic violence	5
Psychopharmacology (given the paucity of psychiatry in small rural towns)	6
Training in short-term, empirically supported treatments	6
Scientist practitioner training	6
Understanding financial barriers to seeking psychological services	8
Determining how to provide the greatest number of services with, at times, few patients (e.g., groups)	8
Rural practice: dos and don'ts with sideline occupations and secondary business	9
Perception/status of practitioner in community	9
Navigating managed care	13
Maintaining a practice among low-income rural populations	13
Ensuring file and test security in settings other than your own office	13

Table 16. cont.

Importance Rating	Category
Gaining funding for students in training	14
Somewhat Important	
Demographics and definitions	1
Knowledge of family agriculture and the impact it has on rural residents	1
Dynamics of grief and loss issues when economics threaten economic viability of family enterprises	1
Few social opportunities for practitioner/family of practitioner	2
Decreased likelihood of litigation	2
Learning about the legal issues that impact rural areas and broader state/federal issues	4
Funding work through grant writing and other options for treating patients in underserved, underinsured, economically depressed areas	4
Rural education	5
Injury	5
Disaster preparedness	5
Somewhat Important with Variance of 1.0 or Greater	
Social pressures in dense environments and the risk of nonconformity	1
Homogeneity issues (e.g., lack of cultural/ethnic groups, lack of diversity, lack of social contacts and activities)	1
Home/work issues that may affect marriage connected with family agriculture	1
Role of trauma in creating and maintaining symptoms	1
Greater professional freedom	2
Lower reimbursement/benefits	2
Not being accepted quickly	2
Knowledge of directive approaches to counseling that meet the cultural needs of the population (e.g., the right balance between providing concrete solutions but not being pushy)	3
Adapting manualized therapies depending on the population (e.g., the sub-literate)	4
Workforce issues	5
Rural employment and economic development	5
Disability	5
Health Care Finance/Economics	5
Understanding the use of metaphor and story telling with rural populations	7
Bartering	9
Making your practice "home like"	13

Category Numbers: (1) Rural Life Context, (2) Unique aspects of a Psychological Practice in a Rural Setting, (3) Knowledge needed for practice in a rural setting, (4) Tasks for the Rural Psychologist, (5) Specific Topics for Training in Relation the Rural Setting, (6) Generalist and Specialization Abilities, Roles, and Pre-Service Professional Knowledge and Skill Sets, (7) Considerations for Developing a Therapeutic Alliance in Rural Settings, (8) Promoting access to treatment in Rural Areas, (9) ethical considerations for rural practice (roles, relationships, and boundaries with clients, confidentiality, competence, psychologist's anonymity and visibility), (10) Working with Other Professional and Agencies, (11) Supervision and Consultation, (12) Professional Development/Continuing Education, Burnout, Isolation, and Self-care, (13) Building and Maintaining Practice in Rural Communities, (14) Tips for Recruiting, Retaining, and Preparing Students for Work in Rural Communities

CHAPTER IV

DISCUSSION

The current study was designed to identify critical factors for teaching effective strategies for working as psychologists in rural communities. The Delphi method was used to provide an exchange of ideas between teachers, researchers, and psychologists interested in or working with rural issues. The qualitative aspect of the investigation yielded a large collection of elements thought to be necessary for preparing psychologists for work in rural areas. The results presented here represent each participant's best judgment and do not necessarily represent the views of all professionals concerned with rural psychology. Still, the extensive list of elements is reflective of the vast experience and knowledge of the expert panelists who did participate in the study.

The experts frequently listed elements that have been consistently covered in the current professional literature such as the following: unique life context in a rural setting and it's impact on mental health and mental health service utilization, rewards of working in a rural setting, ethical challenges involved in working in a rural setting, the need for generalists competencies in a rural setting, access difficulties for rural folks, opportunities or lack thereof for professional development and continuing education, the importance of supervision and consultation, and recruiting, retaining, and preparing students for work in rural communities. However, their responses often extended beyond the literature to be more specific to what students in graduate school in psychology need to learn to be prepared for this type of work. These specific examples are likely more unique to the

rural setting. For example, specific, more "rural" critical factors included: understanding family agriculture and it's impact on rural residents and families, having greater professional freedom, awareness of how mental health issues may be presented differently than in urban areas, having a stake in the community, understanding family systems, paying attention to the use of metaphor and storytelling with rural clients, flexibility in scheduling due to time and travel constraints, lack of anonymity in seeking services, understanding the "life in a fishbowl" phenomenon, understanding and working with de facto service systems, dealing with isolation, financial survival in a small community, and specifically recruiting students who will work in a rural area. In the following section the importance of both the common and unique items generated by the expert panel are discussed within their respective categories.

Critical Factors for Training in Rural Psychology

Rural Life Context

Panelists indicated that when preparing for work in rural settings it very important to understand the rural life context including unique lifestyles, values, and characteristics of rural communities, class issues, and the importance of sense of community. This echoes much of the previous research (Harowski, Turner, Levine, Schank, & Leichter, 2006; Helbok, 2003; Murray & Keller, 1991; see also Barbopoulos & Clark, 2003; Sundet & Mermelstein, 1983; Reed, 1992; Wagenfield, 2001; Wagenfield, 1988; Wilcoxin, 1989;) indicated in the literature section. Understanding the demographics of a particular area was rated less high, though still rated as somewhat important potentially due to the difficulty in defining rural to begin with. As Harowski, Turner, LeVine, Schank, and Leichter (2006) pointed out, definitions in terms of geography and location

lack consensus and are ever changing. Thus, it may be the panelists' perception of what constitutes rural and it is less important to solidify the definition.

Understanding family agriculture and family enterprises and their impact on mental health were also regarded as somewhat important. This could be a result of the different geographical locations participants reside in. In some cases, rural living might not include farming. There are other industries in rural areas such as forestry or mining, yet neither was mentioned by any of the participants in the first round.

There was considerable variance in the lowest rated factors and again this might point to the difficulty defining rural, the different types of rural whether remote, frontier, or near a major metropolis. Interestingly, each of the four items regarded as only somewhat important and with high variances were also mentioned only once in the first round. With regard to the items, one participant noted that "the importance of religion is rural areas" was not noted. Another participant noted that when it comes to discussion about poverty that it is important to realize that there are many people whom are quite wealthy in rural settings as well.

Unique Aspects of a Psychological Practice in a Rural Setting

Consistent with the findings of this study, other researchers (Harowski, Turner, Levine, Schank, & Leichter, 2006; Helbok, 2003; Kersting, 2003; Oetinger, 2007; Schank & Skovholt, 2006) have found that working with the challenge of being the sole practitioner in a rural area and coping with limited resources for clinicians including referral, training and consultation opportunities to be of critical importance. These same authors also cited understanding the joys and rewards of living and practicing in a small

town or region and coping with limited resources for clients as important. Panelists in this study echoed their views rating the aforementioned as very important.

Being prepared for an emphasis on the underserved aspects of rural work was regarded as very important, yet the variance in responses was high. Still, the modal rating for this item was four. Panelists gave somewhat important ratings to items such as understanding that there may be fewer social opportunities and decreased likelihood of litigation. Little to no research has addressed the likelihood of litigation in either a rural *or* urban setting. Researchers (Helbok 2003; Oetinger, 2007; Schank & Skovholt, 2006) would argue to the contrary that while there may be fewer social opportunities, people in rural settings tend to enjoy the natural surroundings and a slower pace of life. In one study Oetinger (2007) found that of 51 rural respondents 47% reported being "very satisfied" with their work in a rural setting with only 11% being dissatisfied.

The existence of greater professional freedom, the possibility of lower reimbursement benefits, and the potentiality of not being accepted quickly each demonstrated high variance. Again, this might point to the setting in which one works or it might be related to the extent at which this study involved self-report and each panelists' own perceptions of what exists at their own, unique location. In her most recent study (Oetinger, 2007), the statement "I am rewarded financially for my work" was the least agreed with statement in a study of rewards of working in a rural setting. Also, in Oetinger's study the 51 participants tended to endorse having a lot of independence in their work, having flexibility, and being satisfied with their professional autonomy. In the literature there has been speculation around not being accepted quickly in a rural setting (Ide, Carson, & Araquistain, 1997; Murray & Keller, 1991) and it was mentioned only

once in this survey but there have been no studies to corroborate the notion, rather it seems to have been an assumption based on the existing characteristics of rural folks.

Knowledge Needed for Practice in a Rural Setting

Findings in relation to knowledge needed to practice in a rural setting again supported previous findings by stating that understanding of pride, independence, religious beliefs, and trust in searching out viable treatments options, as well as attitudes toward mental health and lack of anonymity as barriers to seeking treatment is very important to understand (Harowski, Turner, Levine, Schank, & Leichter, 2006; Helbok, 2003; Human & Wasem, 1991). Furthermore, the need to know the specific community in which one works, the need for awareness of how mental health issues may be presented differently in rural settings as compared to more urban-suburban areas, and understanding the importance of not pathologizing cultural practices or beliefs in a given rural setting were also cited as very important and resemble past writings (Schank & Skovholt, 2006).

Three of the factors in this category that did not make criteria were more specific and included understanding directive approaches, understanding how psychosocial difficulties can be more severe in rural areas due to already limited experiences/opportunities, and understanding the "informal" aspects of practicing in a rural setting. The first of these three would have been regarded as somewhat important, yet there was considerable variance. The latter two both met criteria to be considered very important, yet the panelists varied significantly in their ratings of these items. In fact, the modal numbers for the latter two were three and four respectively. Still, past research (Barbopolous & Clark, 2003; Conger, Elder, Lorenz, Simons, & Whiteback,

1994; Patrick, Cottrell, & Barnes, 2001; Roberts, Battaglia, & Epstein, 1999; Zacharakic, Madianos, Papadimitioucs, & Stefanis, 1998) suggests that the prevalence of social and health problems in rural areas generally match and in many cases exceed those in urban areas, but did not speculate that symptoms are exacerbated by already limited experiences/opportunities in the rural setting.

Regarding the more "informal" aspects of working in a rural setting, it is unclear as to what was meant by this statement, yet I would speculate it has to do with becoming a part of the community, a neighbor, a leader, and someone a person would say "Hi" to in the local grocery store.

The need for more directive approaches in a rural setting may have held greater variance due to each psychologist striving to maintain their view and approach to the counseling process regardless of the setting in which they work. Still, there were a few factors presented by panelists stating things such as [in the rural setting needing to…] "provide the right balance between providing concrete solutions but not being pushy" and [in the rural setting] "the clients we work with complain about therapists who just 'sit and listen'."

Tasks for the Rural Psychologist

Many of the tasks for rural psychologists were cited as very important. As in previous work (Beeson, 1998; Oetinger, 2007; Smith, 2003; Thorngren, 2003), panelists seemed to believe that understanding and utilization of the referral process, research, program development and evaluation, flexibility and adaptability in treatment approach with limited resources, and developing strategies for community development were very

important. Of note is that each of the aforementioned was cited more than once in the initial Round 1 inquiry.

Similarly, as in previous findings (Schank, 1998; Schank & Skovholt, 2006;), the experts cited understanding the need to learn about practice in new areas need by the community and finding creative ways (i.e., thinking about problems in ways that are not "typical" to psychology) to provide those services as very important.

Echoing reports by Harowski, Turner, Levine, Schank, and Leichter (2006), learning about advocacy for initiatives that support access to care, understanding how to compensate for limited resources and programs, and lobbying for funding were found to be of high importance. One participant made an interesting comment related to advocacy: "I am aware that in the USA, rural psychology advocates are often also prescription privilege advocates. Advocacy for more resources for rural psychology is sometimes a "Trojan horse" which conceals the real agenda of the prescription privilege advocates."

Understanding legal issues that impact rural areas as well as an understanding of grant writing to enhance treatment options were regarded as somewhat important. Panelists in the current study regarded adapting manualized therapies as only somewhat important. Barbopoulos and Clark (2003) commented that the diversity of clientele in rural settings can limit the use of effective structured or manual-based groups or treatments that allow most practices the ability to maximize the use of limited resources.

Specific Topics for Training in Relation to the Rural Setting

With regard to specific topics for training in relation to the rural setting, it is important to note that the factors listed were not necessarily unique to the rural setting, but that they may need to be viewed or understood differently in a rural community.

Again, the categories were not designed to be orthogonal. The specific topics in this category might be best deemed as teaching points.

Not surprisingly rural psychology ethics was deemed to be of critical importance (mentioned six times by participants without reference to a specific ethical consideration) and it is addressed more specifically in a following section. Drinking and other addictive behaviors in rural communities were cited as very important to understand. Panelists paralleled Kropf's (2003) view when they cited that understanding gerontology, given that rural communities are disproportionately older, was very important. Her writings point to the idea that rural areas may have higher concentrations of older adults who have different life histories, social support systems, and experiences with formal service networks than similarly aged persons who reside in more urban areas.

Understanding the impact of potential isolation, lack of transport, and the interaction of life and work, as well as how family systems might differ in rural areas and their impact on difficulties folks in rural settings face were also considered to be very important, similar to that of past findings (Campbell, Gordon, & Chandler, 2002; Human & Wassem, 1991; Murray & Keller, 1991; Oetinger, 2007; Smith, 2003). Understanding rural service models, though a very broad concept, was deemed very important as well, although it is expected that delivery models would vary by location, type of organization, and funding sources. Understanding population health principles was regarded highly important by participants, yet again was a very broad term that likely varies by location.

Racial, ethnic, and cultural diversity was another broad category, yet with a high variance. Panelists may have been looking to rate more specific diversities and therefore

this topic has been addressed in other sections more specifically. Understanding mental health literacy was rated as very important yet was accompanied by much variance.

Issues related to domestic violence resulted in a modal rating of 3 but varied among respondents. In the current study, it might be that in some of the locations in which the participants reside there are services specifically related to domestic violence matters or it might be that due to the sensitive nature of domestic violence, it is often not a topic discussed early on in work with clients. Either way, Eastman and Bunch (2007) noted that while existing research indicates that rates of domestic violence are similar across rural and urban areas, that geographic isolation, limited employment opportunities, limited access to services, insufficient housing, the absence of public transportation, and attitudes of tolerance of domestic abuse exacerbate the impact of domestic violence for rural victims; thus, another topic needing further exploration.

Other broad factors that were regarded as somewhat important included knowledge of rural education, injury in rural areas (most likely related to occupation), and disaster preparedness. Workforce issues, employment and economic development, and health care finance yielded high variances in their ratings of importance. Overall, this category as evidenced by the naming of the critical factors may have been too broad for panelists leaving items open to much difference in interpretation and ultimately their ratings.

Generalist and Specialization Abilities, Roles, Pre-Service Knowledge and Skill Sets

Generalist and specialization abilities, specific psychologists' roles and pre-service knowledge and skills sets represented a category with numerous items critical or very important to training in rural psychology. Panelists, similar to other researchers

(Barbopoulos & Clark, 2003; Hargrove & Breazale, 1993; Helbok, 2003; Harowski, Turner, Levine, Schank, & Leichter, 2006; Kersting, 2003; Oetinger, 2007; Schank & Skovholt, 2006; Smith, 2003), cited gaining a broad base of generalist skills as critical during training for work in rural settings. This very factor was also noted 13 times in the Round 1 qualitative data collection.

Interestingly, it seems that what generalist skills are comprised of were those items that fell in the same category and were also rated as critical, including a wide range of assessment and psychological treatment skills, a good understanding of psychopathology and various interventions for various diagnoses, and comfort with varying roles in a rural setting which may include but are not limited to consultant, supervisor, team advisor, or workshop facilitator. Specialty skills sets related to community psychology, staff development, leadership training, psychopharmacological consultation, and primary care psychology, a broad understanding of psychological bases and theories, family and group therapy, crisis intervention, ability to assess social support networks, and knowledge of psychotherapy were cited as very important.

Training in short term, empirically supported treatments was regarded highly by the experts as well, yet it held a very high variance despite the modal rating number being a four. The need to have a good understanding of psychopharmacology also produced a very high variance in the panelist's ratings. Those practitioners who do not have access to medical professionals may have rated this item higher, while those who do have ongoing medical consultation opportunities may have viewed this as less important.

The value of a scientist-practitioner training resulted in a high variance between panelists' ratings, but would have otherwise been considered to be very important. It is

not entirely clear how this participant intended this item to be critical for training in rural psychology yet I would speculate that the intended meaning was that it is important in rural practice, as in all practice, to have practice well informed by research and research well informed by practice.

Considerations for Developing a Therapeutic Alliance in a Rural Setting

When considering the development of a therapeutic alliance in a rural setting (though not all items contributed were unique to rural settings as noted by one participant), panelists cited communication skills as a critical factor. Panelists rated cultural sensitivity, engaging clients--being present and welcoming, the ability to consciously address stereotypes on both the client and therapist's part, and basic engagement skills as very important factors when training for work in a rural setting. Again, one participant mentioned religion when considering the need for cultural sensitivity. He or she commented that understanding and respectfully handling the role of church and religion in rural populations can be much more of an issue than in urban settings.

Seemingly more specific to the rural setting, the experts noted that it is very important that the rural practitioner is comfortable with more casual interactions with clients. Also more specific to the rural setting and rated less highly by participants, was the need to understand the use of metaphor and storytelling in rural populations.

Promoting Access to Treatment in Rural Areas

When it comes to learning about promoting access to psychological treatment in rural areas panelists generally agreed on their ratings. The use of the internet/telephone to improve access was mentioned six times in the Round 1 data collection and was regarded

as very important in Round 2 as well. As mentioned in the literature review, Schopp, Demiris, and Glueckauf (2006) noted that the concept of telehealth has had its ups and downs. Advantages cited included decreased travel time and costs for both client and clinician and an increase in the number of clients a clinician can interact with on any give day. Pitfalls included acceptance by insurance companies and ultimately billing procedures, concerns about privacy, lack of knowledge of technology for both client and clinician, the risk of liability for negligence and abandonment, and most importantly discerning whether telecare options provide at least the same or greater positive impact on rural clients in the absence of a physical presence with a client. Still, in line with how panelists responded, training in the use of telehealth is important as it is a potential model of service delivery in rural and remote settings.

Negotiating restrictions in service availability, which might include providing co-locations in primary care facilities was also regarded as very important. Understanding the need for flexibility in scheduling and understanding how a lack of anonymity in seeking services can be a barrier to mental health service utilization were cited as very important as well. Furthermore, panelists suggested that a good understanding of social services/case management could be helpful, understanding the approach to finding MD support, and in general, working with the community as a client (i.e., healing communities; thinking in larger terms than tertiary individual treatment) were very important.

The need to understand financial barriers to seeking services and determining how to provide the greatest number of services with, at times few patients were deemed less important by panelists as a whole. Interestingly, none of the participants specifically

mentioned the need to understand the impact of lack of or limited insurance. Past research (McDonald, Harris, & LeMesurier, 2002; Schank & Skovholt, 2006; Smith 2003) commented that cost and lack of insurance is a significant barrier to mental health service utilization in rural settings. Smith (2003) found that one of every five rural individuals has no health insurance. Thus, students training for work in rural settings need to understand options for payment and at times be creative to encourage reimbursement for services.

Ethical Considerations for Rural Practice (Roles, Relationships, and Boundaries with Clients, Confidentiality, Psychologist's Anonymity and Visibility)

When it comes to training in the ethical practice of psychology, it is no surprise that portions of the ethical code would be regarded as of utmost and critical importance whether working in rural or urban setting. Understanding the need to negotiate the ethics of multiple/dual roles/relationships with clients, awareness of limits of competence, privacy and confidentiality, the "life in a fishbowl" phenomenon, and establishing boundaries were all regarded as critical factors for training. These findings were not unexpected given the extensive discussion in the literature citing the importance of ethics in general and more specifically the differences in ethical practices in rural versus urban communities (Erickson, 2001; Helbok, 2003; Helbok, Marinelli, & Walls, 2006; Kitchener, 1988; Oetinger, 2007; Rich, 1990; Schank, 1998; Schank & Skovholt, 1997; 2006). Many of these same researchers have previously argued that the existing ethical codes are not well suited for practice in rural areas and have done widespread research in the area.

Multiple Relationships

In the most recent study (Helbok, Marinelli, & Walls, 2006) on ethical practices across rural and urban communities, psychologists in small towns/rural areas reported encountering significantly more multiple relationship behaviors and situations than their urban counterparts. In the study, 58.4% of respondents from a rural setting reported running into clients sometimes or more often. One participant in the current study relayed the following comment:

> The most critical issue for rural providers is managing "dual roles". Such dual roles are specifically contradicted in the ethical guidelines, but completely unavoidable in rural practice. Over time a practitioner will encounter patients in a variety of settings outside the clinic setting—grocery store, church, community activities and organizations, or right down the street from home. Practitioners may have to treat people whom they know from other settings, because there may not be anyone else who can treat them. It may be necessary to initiate an emergency hold order on a friend because there is no one else to do the necessary task. Dual roles are an unavoidable reality of clinical practice in rural communities—and ethical discussions about avoiding such dual roles are not realistic in those settings. What is much more helpful is discussion and practical strategies for managing (not avoiding) such realities. There has been nothing else in over 30 years of practice in rural settings that has been as challenging.

Another panelist commented, "I am the only treating psychologist in the hospital and have been faced with treating relatives, children of friends and colleagues, and even old boyfriends!" The aforementioned comments provided by the panelists certainly reflects

the challenges of managing dual roles that, in turn, were also rated as critical by the entire panel for students in training to learn about.

Competency

When it comes to concerns about competency, Helbok et al. (2006) reported being surprised to find that practitioners in a rural setting did not self-report struggling with having to maintain their competency and having to take clients beyond their scope of training. Instead, the authors report, therapists across both rural and urban communities reported being more concerned about their colleagues' competency.

Privacy and Confidentiality

Privacy and confidentiality issues in Helbok et al. (2006) study were also significant across settings (Helbok et al.2006). The authors reported that urban therapists are more likely to discuss their work with friends, colleagues, and other professionals, but that anecdotally, participants emphasized that they did not use identifying information.

Psychologist Visibility

Rated as very important were knowledge of the impact of psychologist's visibility in the community, knowledge of the boundaries of appropriate self-disclosure, and skills to say no when there is not time or resources to provide a particular service. Helbok, Marinelli, and Walls' (2006) study also addressed psychologist's visibility in the community. As they predicted, therapists in small towns and rural communities reported being more likely to feel like they are therapists 24 hours a day and are more likely to participate in activities in which clients are also involved. Consistent with their literature review, they add that whether the therapist is comfortable with it or not, in rural communities clients are likely to know a great deal about the therapist.

Boundaries

Understanding the dos and don'ts with sideline occupations and understanding how the perception/status of the practitioner in the community can impact services would have been rated as very important, yet the panelists varied significantly in their ratings. Bartering, the factor with the most highly varied ratings in the entire list of factors would have otherwise been regarded as somewhat important. In Helbok et al's (2006) study on ethics in rural and urban settings, 70.8% and 85.9 % of rural and urban respondents, respectively, have never accepted goods or services in lieu of a fee. 20.4% of rural respondents reported rarely. In the current study, it is a question whether panelists' rated this item on the basis of whether *they* would barter with clients or whether it was important for training.

Working with Other Professionals and Agencies

Results in the working with other professionals and agencies category support the importance of partnering with community leaders and other agencies regarding advocacy for services, developing strategies for increasing service utilization and reducing the stigma associated with seeking help documented in existing literature (Beeson, 1998; Smith, 2003).

The need for understanding the importance of interdisciplinary collaboration rang loud and clear, whether it is collaborating with churches, government, clergy person, civic leaders, schools, or social workers. Interestingly, the need to work with other professionals providing mental health services and the need to establish working relationships with primary care physicians, urban tertiary centers, and de facto service systems were rated just a bit lower. Reports by Harowski, Turner, Levine, Schank, and

Leichter (2006) noted that with the lack of psychologists in rural areas, up to 60% of all rural mental health care is delivered by primary care physicians and community health centers. Geller (1999) noted that some primary care physicians estimated that 10% of their practice is devoted to mental health care. Geller added that many rural physicians find themselves unprepared to treat mentally ill patients because of a lack of training and lack of community support services on top of an already heavy/time-constrained patient load (Geller, 1999). Therefore, it seems evident that both the medical and mental health professions would benefit from understanding and utilizing interdisciplinary collaboration in order to provide clients with the most well-rounded and informed care. Also rated very important within this category was negotiating and educating other professionals about boundaries and ethics, a topic that has received very little attention in the literature.

Supervision and Consultation

The importance of supervision and consultation in the practice of psychology has been well documented. One participant noted "these are important for all professionals, and people need to make their own choices about what they need and what will help them." Still, many studies (Chur-Hansen, Todd, & Koopowitz, 2004; Coyle, 1999) more specific to rural areas, note the difficulty in gaining supervision and consultation opportunities due to lack of access, lack of others with whom to consult, or lack of time. The manner in which panelists viewed the importance of supervision and consultation is also of importance to note. While each of the three factors (supervision, consultation with people in similar fields, and the use of alternate models as a means of obtaining supervision) were deemed very important, it was a bit shocking that none were rated as

critical. Nonetheless, the modal ratings were four, three, and four respectively. Again, it is important to consider how the experts may have interpreted the items (i.e., how much *they* engage in each, how important *they* think it is to occur, or how important it is to consider when training for work in rural areas). Thus, these are areas needing further attention in the rural psychology literature.

Professional Development/Continuing Education, Burnout, Isolation, and Self-care

The importance of professional development, continuing education, and self-care in response to the risk of burnout and the effects of isolation in rural settings has also been well documented (Barbopoulos & Clark, 2003; Berman, 1994; Chur-Hansen, Todd, & Koopowitz, 2004; Coyle, 1999; Helbok, Marinelli, & Walls, 2006; Schank, 1998; Merwin, Goldsmith, & Mandersheid, 1995; Oetinger, 2007; Schank & Skovholt, 2006; Weigel & Baker, 2002). Panelists, like the findings of past research (Kee, Johnson, & Hunt, 2002) agreed that identifying personal stressors and seeking support was of great importance. In the Kee et al study they found that 65% of their sample of 152 rural therapists experienced at least a moderate level of burnout. Helbok, Marinelli, and Walls (2006) in their study on the differences in ethical practice among rural and urban practitioners found (contrary to their predictions) that rural psychologists did not endorse items indicative of burnout more highly. They noted however, that urban psychologists appeared to be more likely to seek counseling related to burnout should the need arise yet they could not specify whether this was due to availability of resources or to different value systems. This is certainly another interesting possibility for a follow-up study.

Panelists also believed that finding manageable and creative ways to access educational resources, stay current in the profession, and enhance client care was very

important. However, panelists also acknowledged that when working in a rural setting it is important to find ways compensate for the *lack of* access (i.e., having to drive long distances, not having monetary support) and commented that using technology to inform practice was important.

Building and Maintaining Practice in Rural Communities

When it comes to learning about building and maintaining a practice in rural communities, panelists acknowledged the importance of practitioners needing to understand the business/practical aspects of making a living while working in a rural area. One panelist termed it "financial survival in a small population base." On the whole, panelists agreed that training around billing, financial management, marketing, administrative duties, and human resources were very important. Again, little research has addressed building and maintaining a practice in a rural setting.

The need to understand how to navigate managed care and ensuring file and test security in settings outside of one's own office did not generate consensus among the experts, though this could be due to the specificity of the two items. Making your practice "home like" was even more specific and was the lowest rated item in the entire list and was mentioned only once in the first round. One participant appropriately responded stating "many people may work in social service agencies where some of these issues are not the same as for the small business person in private practice."

Tips for Recruiting, Retaining, and Preparing Students for Work in Rural Communities

The final category related to recruiting, retaining, and preparing students for work in rural communities not only provided the panelists the opportunity to rate each item for it's importance within training, but to highlight the need for training to work in rural

areas. Similar to reports by Harowski, Turner, Levine, Schank, & Leichter, 2006, among many others, panelists agreed that offering hands on experience with exposure to multiple rural settings was of critical importance. Panelists also cited offering courses targeting needs specific to rural settings as very important. Furthermore, the experts generally agreed that recruiting students from rural areas to serve in rural areas, and recruiting students who will serve in rural settings regardless of whether they were raised in rural settings as very important. Pathman (1996) stated, based on a review of medical student career choices, that students' preexisting rural background or commitment to rural practice was a much more powerful determinant of eventual practice type of location than the effect of exposure to rural practice during training.

Having students reflect on personal motivations for practicing in rural areas was narrowly regarded as very important (Mode=2), yet the intended meaning of this item may have been unclear to participants. Gaining funding for students in training is an item that was only mentioned once in the first round data collection and it yielded high variability in the panelist's ratings, again possibly due to the lack of clarity of the item.

Implications for Training

The rural experts in this study have provided a list of specific elements, along with their relative importance critical to training in rural psychology. Still, as one respondent commented:

> The questions [in the survey] are narrowly biased toward only one type of rural practice environment: farming communities with family farms. There is nothing to reflect the knowledge base one needs to have to practice effectively in other kinds of rural or remote communities, e.g., Indian Reservations or single-industry

towns (e.g., mining, forestry). The former are often characterized by multi-generation families, chronic poverty and unemployment, social problems and intense local politics. Mining or forestry towns, by contrast, may have very transient populations, high turnover, very few or extended multi-generational families, young populations, union-labor management conflicts (not seen on farms), in other words, a completely different set of social stressors and strengths than farm communities.

Later this same panelist added:

> Again, you seem only to be talking about farming communities. Other rural communities, for example Indian Reservations or single industry (paper mill, mine) towns have younger populations than the typical big cities or national norms, e.g. the most remote…regions have the youngest populations, and the highest rates of teen pregnancy, vehicle accidents, teens smoking, alcohol abuse, etc. The challenge of training psychologists for work in rural communities is to teach them to "see" the community or communities they are working in, not to just impose a one-size-fits-all set of assumptions about rural areas. For example, some small rural towns have vibrant arts and culture, and openly gay groups; in other rural towns of smaller size, the culture centers on local bars and anyone assumed to be gay will fear for their lives.

This respondent keenly pointed out the idea that there just may not be a one-size-fits-all approach to training in rural psychology. However, it may be important to note that out of 33 rural psychology experts, this was the only person to point out the importance of the differences between different types or rural communities. The reason that mention of

rural communities with Indian Reservations, forestry-or mining based economics were not in Round 2 questionnaires is because the expert who raises the issue in response to Round 2 did not respond to Round 1. This may speak to a serious gap in the current literature *and* knowledge around rural psychology which will ultimately impact our ability to develop effect training programs. An alternative hypothesis is that this could be a hint of group think, though it is not likely given each participant had the opportunity to respond independently, twice, in this study.

Indeed comments by the respondent certainly point to a plethora of future research directions. Nonetheless, the results of this study can provide guidance to graduate programs in psychology as they attempt to develop effective rural training curriculum. Perhaps most importantly, these specific categories containing these specific critical factors may function as objectives for psychology programs as they try to expand or initiate their rural psychology training efforts.

Those programs or persons interested in utilizing the results of this study might use the critical factors as teaching points or modules for a course or seminar on rural psychology. The critical factors might serve well as umbrella terms, while the items rated as only very important and somewhat important could fall within. In example, interdisciplinary collaboration as an overarching module might break down into topics including 1) the importance of collaboration, 2) different types of collaboration (i.e., referrals, consultation, presentations, etc.), 3) collaboration with different professional and community agencies ranging from churches to government to medical professionals (i.e., the best ways to approach each), 4) educating other professionals about the field of mental health, and 5) educating about the process of therapy and boundaries in the

practice of psychology, to name a few. As you read on, it becomes apparent that many of the items cited as critical could be broken down in a similar fashion.

Interpretation of Critical Items

Participants in the current study had the opportunity to contribute factors they deemed as critical to training in rural psychology and in turn participants were able to review items contributed by other panelists as well. The consensus-based approach utilized in this study allowed me the opportunity to generate a list of items for the panel to rate for their relative importance ranging from critical to training in rural psychology to not too important. Central to this study is that the expert panel was able to agree that seventeen factors were of utmost importance.

The current study highlights critical components of training in rural psychology as centering on understanding the challenges of being the sole practitioner in a rural setting and learning how to cope with limited resources for referrals, training, and consultation. Thus, it would seem important that training emphasized innovative and creative ways to mitigate these struggles.

This study also denotes understanding of ethical principles in rural settings as critical and therefore, a large portion of training for work in rural settings regarding ethical challenges should ensue. This study specifically highlighted the need to understand how to negotiate multiple roles with clients in rural settings, understanding ones' limits of competence, privacy and confidentiality concerns in small communities, boundary setting, and reflecting on psychologist's visibility in rural settings as critical.

The need for generalist training rang loud and clear in this study, and as such, when students are preparing for work in rural settings, they will be best suited with a

broad base of generalist skills in the areas of assessment and psychological treatment skills, and, as well, a broad understanding of psychopathology and appropriate interventions.

Students in training must also understand the varying roles one might encounter while working in the rural setting. Communication skills were cited as critical, and in the rural setting one might speculate, that communicating with clients regarding the therapeutic process, informed consent, confidentiality, privacy, and chance encounters, for example, might be just as important as three other identified critical factors regarding collaboration and communication with other professionals.

Understanding the need to partner with other community leaders and other disciplines is then also of critical importance and the participants agreed that interdisciplinary collaboration will help to increase service utilization, promote services, help to reduce shame and the stigma around seeking help, and most importantly could provide consumers with the best possible, well-informed, and well-rounded treatment.

Gaining exposure to multiple rural settings and hands on training, which the panelists also reported as critical will serve to bring together the reality of the necessity to understand the need to have training on the aforementioned critical factors.

Summary of Interpretations

When considering the opportunity to develop curriculum around rural psychology it becomes evident that the aforementioned critical factors emerging from the current study should be included.

Factors cited as "very important" (see Table 16) and "somewhat important" (see Table 16) in the current study warrant serious attention as well. A multitude of factors

narrowly missed the cutoff point to be considered critical. The item "Coping with limited resources for client" is one item warranting consideration when looking at how to best prepare students for work in rural areas. Students should be informed of these limited resources and encouraged early on to engage in creative and innovative thinking to mitigate this limitation. The broad item related to pride, beliefs, and attitudes toward mental health also calls for attention throughout a rural training curriculum. Without working with the community to reduce the potential shame and stigma surrounding mental health services, services might not be utilized at all, despite there being a great need. Therefore, students might be taught how to appropriately and innovatively promote mental health awareness.

The item "De facto service systems; developing and sustaining relationships with primary care physicians who provide the bulk of mental health care in small towns" was another item only just missing the critical cutoff point. This particular items fits nicely with the two previously mentioned items as with the addition of training around these three items, students are able to understand the importance of de facto service systems being a resource to mental health practitioners as well as mental health services being a resource to medical professionals. Furthermore, students must understand that by partnering with other health professionals, as a group, we can work to reduce the shame and negative beliefs around help-seeking on the whole on top of being both a resource and a support for one another.

The panelists were very close to citing the item "Clinical supervision" as critical and while it seems evident that supervision is of utmost important in any setting, it is a wonder why it did not meet the critical off point. Nonetheless, it is imperative that

students preparing for work in rural settings be educated about the process and necessity of supervision. Students might be informed of the possible difficulty in receiving clinical supervision in the rural setting due to lack of resources, other practitioners, or time. Therefore, they should be encouraged to think early on about how to engage in supervision to ultimately provide the best possible services to their clientele. Potentially related to this item is "Identifying personal stressors and seeking support" which also missed the critical cutoff point by a small margin. It should be emphasized in training that the ability to identify personal stress both inside and outside the work setting might be hindered by feelings of being the only practitioner for miles and therefore, one must carry on. Therefore, supervision as mentioned above, and striving to maintain contact with other health care providers should be emphasized to reduce or seek strategies to lessen burnout. Also of note then, is the importance of self-care, which too should be covered in any curriculum preparing students for work in the helping professions.

Future Research Directions

Future studies might use the current survey to canvas the opinion of a larger pool of participants across the United States. Researchers could develop surveys based on certain categories presented in the current study, based on certain items contained in the survey, or simply send the current survey to additional participants.

The decision to consider the variance among responses in participant's ratings of the items present opportunities for further research as well. Future or follow-up studies might inquire as to why such variance in response to some items exists. As seen in Tables 1-15, items that would have otherwise been classified as very important, or somewhat important often held too high variance. Because the current study did not look at group

differences in attempt to gain a consensus of the whole, this could be achieved by looking specifically at group differences (i.e., numbers of years practicing, researching, or teaching). Those factors with high variance might also be related to differences in location, industry, and cultural make-up and should also be considered. Clearly, with an entirely different sample of participants whether they differ by experience or location, items not regarded as critical in the current study may well be in another.

Also related to the variance in responses, future studies might also consider taking those items with a variance of greater than 1.0 (indicating little consensus) and employing future rounds of the Delphi survey until consensus is achieved (i.e., V=<1.0) to gain a better understanding of where each item appropriately falls along the continuum of importance.

Future studies might also attempt to ascertain exactly which factors (similar to those offered by the panel in this study) are strictly unique to the rural setting. In example, ethical issues have consistently been cited as different in rural areas, yet are the processes of supervision and consultation different in rural areas? Are they regarded as less important? Why? Is it a lack of time or resources? Do supervision and/or consultation occur more or less frequently in a rural setting? How might it be different? Both are topics that would hopefully be covered in any graduate training curriculum in psychology. Still, understanding differences among these and many factors would prove to be insight-gaining opportunities to further understand the differences between work in a rural and urban setting.

With the *current* data, one could ascertain how the current pool of panelists, whether they were researchers, practitioners, professors (or a combination of the three),

combined with number of years of experience in each area rated each item. It would be interesting to see how those more novice practitioners compared with those presumed to have much wisdom rated items differently. All-in-all, directions for future research are abundant and throughout the previous discussion opportunities for further exploration have been highlighted.

Limitations

A limitation of this research comes directly from the method used. The cohort of participants was selected and not chosen at random. Certain standards were used to select the pool of experts; psychologists currently practicing in rural areas, psychologists who research in the area of rural mental health issues and rural mental health service utilization, and psychologists who teach courses related to rural psychology. Results were presented based on the consensus of all participants across all three sets of standards and because of the standards selected, no attempt was made to use a census-based definition of rural, because, for example, one might research rural issues, but not work or live in a rural community. Similarly, one might teach a course on rural psychology in an urban setting. Further, because of the strategies employed to obtain the potential cohort, the expert panel may be biased toward psychologists practicing in rural settings who have the ability to market their services online, the more productive researchers who successfully publish, and those graduate programs who promote their rural training emphasis. There was also no way to control the potential participants who were recommended by those who were invited to participate in Round 1 (in fact, some of the people suggested and invited for participation replied stating that their work is not at all related to rural psychology or that they are no longer employed in/interested in rural practice). Thus, the

participants may only represent a subset of experts in rural psychology. However, descriptive statistics of the sample suggest years of experience within the field of rural psychology whether it be through practice, research, and/or teaching.

A further limitation is that while we took care to represent all of the 310 critical factors contributed by the Round 1 participants in Round 2 by reviewing existing literature, a laborious categorization process, instrument piloting, and most importantly panelists' contributions, in the final fourteen categories that eventually contained 129 discrete, critical factors, it is possible that some important, unique variable(s) may have been overlooked, omitted, or combined. One participant, though they completed Round 1 and Round 2 stated, "1. I applaud your idea of identifying these factors. 2. Many of your items had too many statements or concepts in them. They need to be separated so that one factor is represented in each item." Other participants commented how maybe some items overlapped too much and suggested that more could be combined. A very few others commented that they had a hard time rating some items, seemingly related to the semantics.

Another limitation is that, while I attempted to be sensitive to the time demands on the pool of participants by keeping the requests as brief as the data would allow, it appeared that during the second round some participants thought the task to be daunting. One respondent replied to the email invitation stating the survey was "way too long". Another, though they completed both rounds, stated "it was long; I had to keep coming back to it." Two people began the study, but did not complete it despite being invited to return to the site to complete it. Still, each of the initial critical factors was rated based on their level importance by the experts choosing to participate in the study. The list of

factors and their relative importance are based on participants' best judgment and the culmination of each individual participant's years of experience regarding rural psychology.

Conclusion

In conclusion, the field of psychology must train future psychologists for work in diverse rural communities as their needs are increasing, demographics are constantly changing, and providing mental health services with limited resources is continuously challenging. The current study has demonstrated that operationalizing and defining rural training is a complex endeavor, yet it has provided a basis for which to begin. This dialogue with rural experts has highlighted the ethical and professional challenges of working in rural communities, the positive and life-enhancing opportunities when working as a practitioner in rural settings, and, as well, some of the inherent differences from that of working in an urban area. It is hoped that this investigation is a starting point in providing some specific and practical guidelines for effective rural training.

APPENDICES

Appendix A
Round 1: Email Invitation to Participants

Greetings:

I am contacting you because you were identified as an expert, i.e., either a licensed psychologist practicing in a predominantly rural area, an author of at least two research publications related to rural psychology since 1997, and/or someone who teaches a course related to rural psychology. You are invited to participate in this online study as an expert based on the aformentioned criteria. The purpose of this study is to aid in the development of a curriculum plan for training in clinical and counseling psychology in rural settings based on the consensus of experts in the field.

Thoughtful, yet brief responses are appreciated and the survey should take no longer than 10-20 minutes to complete. Please read the "Intro Letter" carefully. The study employs the use of the Delphi Method which requires responses to two subsequent rounds which are based on data from prior rounds. I will regularily send follow-up emails and most importantly, please watch for emails containing the final two rounds of the study.

To take the survey, please click on this link, or copy this web address into your browser:

http://www.surveymonkey.com/s.aspx?sm=7jx_2fMDepceRAT2FjFIR_2ffA_3d_3d

If you know of any other qualified candidates (i.e., licensed psychologists practicing in a predominantly rural area, authors of at least two research of at least two research publications related to rural psychology since 1997, and/or someone who teaches a course related to rural psychology) appropriate for this study, please forward their name(s) and
email address(es) to me via email at your earliest convenience or type them within the survey as there is space provided .

If you have any questions about the survey, email christine.boulton@und.nodak.edu

Thank you in advance for your time and dedication to rural mental health service delivery!

Christine M. Boulton (Olson), MA

Appendix B
Round 1: Email Inquiry to Web Managers

Dear Web Manager,

I am a Ph.D. Candidate in Counseling Psychology at the University of North Dakota under the direction of Dr. Michael I. Loewy, Associate Professor and Chairperson of the Department of Counseling. My dissertation research is in the area of rural psychology training. I am informing you of my dissertation research endeavors because I hope that you will be able to provide me with the contact information of people in your department/organization that are either:

1) licensed psychologists practicing in a predominantly rural area,
2) a researcher of rural psychology and/or
3) someone who teaches a course related to rural psychology

Given the mass of people I am sending this to, it is entirely expected that not all of the above mentioned inclusion criteria will apply to everyone as I realize I am emailing organizations and departments of psychology.

If you are not the most appropriate person to respond to this email, I would greatly appreciate your forwarding this message to the best person.

All I am requesting is the person's name and email address. I am hoping this will be an easy task for you. You can reply directly to this email (christine.boulton@und.nodak.edu).

Thank you so so so much! Your help is greatly appreciated!

Christine Boulton

Appendix C
Round 1 and 2: Intro Letter/Consent Form (Online)

I am contacting you because you were identified as an expert, i.e., either a licensed psychologist practicing in a predominantly rural area, an author of at least two research publications related to rural psychology since 1997, and/or someone who teaches a course related to rural psychology. I am Christine Boulton, M.A., a Ph.D. Candidate in Counseling Psychology at the University of North Dakota under the direction of Dr. Michael Loewy, Associate Professor and Chairperson of the Department of Counseling. My dissertation research is in the area of rural psychology training. This research is important because psychologists should be better educated in how rural life and culture impacts clients so as to provide more competent services. The purpose of this study is to develop a curriculum plan for training in clinical and counseling psychology in rural settings based on the consensus of experts in the field.

I am informing you of my dissertation research endeavors because, since you are an expert, I hope that you will participate as a panelist in my study. I am using the Delphi method, which requires a panel of experts to answer the same questions in three rounds. In the first round, you will answer questions anonymously and without the knowledge of the responses of other identified panelists. During the two subsequent rounds, you will be provided with the responses of the entire panel and be given the opportunity to revise your responses in light of the group judgment. It is hard to estimate how long your participation will take during each of the three rounds. The questionnaire is very brief and focused on your opinions about rural psychology training, yet we would appreciate your thoughtful responses.

Participation in this study is strictly voluntary and you can discontinue participation at any time without any consequences to you. Risks for completing this study are extremely low. Possible benefits for this study include knowing that you are contributing to a scholarly work designed to identify critical factors in rural psychology training and that you are part of an expert panel consisting of other psychologists practicing, teaching, and/or researching rural psychology.

Throughout your participation in the study, your name and responses will remain anonymous and confidential. However, it is standard practice in using the Delphi method to acknowledge the panel of experts upon publication. In the final round you will be asked permission to be identified in print.

Only the research team members and the people responsible for research compliance will have access to the data. If you have any questions, please feel free to contact me, Christine Boulton at 701-594-9489 or christine.boulton@und.nodak.edu; or Michael

Loewy at 701-777-3744 or michael.loewy@und.nodak.edu. If you have any other questions or concerns, please call Research Development and Compliance at 701-777-4279. Your time and help is greatly appreciated!

I have read the above information, my questions about this research have been answered to my satisfaction, and by clicking next I agree to participate in this study.

Appendix D
Round 1: Demographics and Survey (Online)

PAGE 1:

1. Demographics
   Name:
   Gender:
   Racial, ethnic, and/or cultural identities:
   City and State/Province of work:

2. Please check your highest degree attained.

_____ Ph.D.
_____ Psy.D.
_____ M.A.
_____ M.S.
_____ B.A.
_____ B.S.
_____ Other

3. Employment (In the textboxes below please indicate how many years you have worked in each role. It is not expected that you have worked in all three roles. If zero years, please enter 0.) For the "researching psychology" option, please place a comma after the number of years, and then indicate how many publications related to rural psychology you have. For the "teaching rural psychology" option, please place a comma after the number of years, and then indicate how many courses you have taught related to rural psychology.

practicing rural psychology _____
researching rural psychology _____
teaching rural psychology _____

4. Are you a Licensed and/or Certified Psychologist?

_____ Yes
_____ No

5. Please briefly describe your own training in rural psychology (i.e., courses completed, professional development, continuing education). A response is optional.

PAGE 2:

6. In the spaces below please provide 10 or more critical factors that you believe are key elements/characteristics of training in rural psychology. This is a "brainstorming" activity. An example of a critical factor could be "negotiating the ethics of multiple roles and relationships with clients as a psychologist in a rural community." You do not have to group or rank you ideas, just provide as many critical factors as you can think of as clearly as you can formulate them. 10 critical factors are required, but feel free to add more critical factors in the final textbox.

7. Please provide the name(s) and email address(es) of other people whom you know that fit into one or more of the three criteria of an expert in rural psychology (i.e., a licensed psychologist practicing in a predominantly rural area, an author of at least two research publications related to rural psychology since 1997, and/or someone who teaches a course related to rural psychology. A response is optional.

8. If you have any further references or sources that might inform this study, you may provide them here. A response is optional.

Appendix E
Round 1: Thank You (Online)

THANK YOU!

Thank you for taking the time to complete this first round. I hope that you will continue to participate as a panelist in my study. As mentioned in the "Intro Letter" I am using the Delphi method, which requires a panel of experts to answer the same questions in three rounds. During the tow subsequent rounds, you will be provided with the responses of the entire panel and be given the opportunity to revise your responses in light of the group judgment. It is hard to estimate how long your continued participation will take, but it is expected that future rounds will take less time, so please watch for emails coming soon.

Participation in this study is strictly voluntary and you can discontinue participation at any time without any consequences to you. Again, possible benefits for this study include knowing that you are contributing to a scholarly work designed to identify critical factors in rural psychology training and that you are part of an expert panel consisting of other psychologists practicing, teaching, and/or researching rural psychology. In the final round you will be asked permission to be identified in print.

If you have any questions, please feel free to contact me, Christine Boulton at 701-594-9489 or christine.boulton@und.nodak.edu; or Michael Loewy at 701-777-3744 or michael.loewy@und.nodak.edu.

Your time, help, and dedication to rural mental health service delivery is greatly appreciated.

Appendix F

Round 2: Email Invitation to those who participated in Round 1

Greetings and thank you for your thoughtful responses to the first round of my study:

Participants in the 1st round provided 10 or more critical factors that you believe are key elements/characteristics of training in rural psychology.

You are encouraged to continue participating by completing this 20-minute, round 2 data collection as an expert in the field. Again, the purpose of this study is to aid in the development of a curriculum plan for training in clinical and counseling psychology in rural settings based on the consensus of experts in the field.

Instructions for completing the survey are outlined in the actual survey contained in the following link. Please read the directions throughout the survey carefully.

http://www.surveymonkey.com/s.aspx?sm=H7YvMrcekzed4k8Ytk405g_3d_3d

I will regularly send follow-up emails, but would appreciate your responses at your earliest convenience.

If you have any questions about the survey, email christine.boulton@und.nodak.edu. Thank you in advance for your time and dedication to rural mental health service delivery.

Appendix G

Round 2: Email Invitation to those who DID NOT participate in Round 1

Greetings,

I contacted you beginning in June because you were identified as an expert related to rural psychology.

EVEN IF YOU DID NOT PARTICIPATE IN ROUND 1, you are invited to participate in this 20-minute online study as an expert. The purpose of this study is to aid in the development of a curriculum plan for training in clinical and counseling psychology in rural settings based on the consensus of experts in the field.

Participants in the 1st round provided 10 or more critical factors that they believe are key elements/characteristics of training in rural psychology. Instructions for completing the survey are outlined in the actual survey contained in the following link. Please read the directions throughout the survey carefully.

http://www.surveymonkey.com/s.aspx?sm=H7YvMrcekzed4k8Ytk405g_3d_3d

I will regularly send follow-up emails, but would appreciate your responses at your earliest convenience.

If you have any questions about the survey, email christine.boulton@und.nodak.edu. Thank you in advance for your time and dedication to rural mental health service delivery.

Appendix H
Round 2: Survey and Demographics (Online)

PAGE 1: Intro Letter/Consent Form (Online)

PAGE 2. Tracking: Please provide your name for tracking purposes.

PAGE 3. Survey:

> Participants in the 1st round provided 10 or more critical factors that they believe are key elements/characteristics of training in rural psychology.
>
> All items have been grouped into categories and reported under categories in the following pages. All items should be represented in this list, whether reported only once or by many participants. Some items that were very similar to each other were combined and frequencies are reported in parentheses.
>
> In the process of combining items it is possible that your unique, intended meaning was lost. If you notice any items you reported in the first round not represented here you may add it at the end of each category page. Space will also be provided at the end of the survey for you to make comments about the overall survey.
>
> Your task now is to rate each factor. A 5-point Likert-type scale will be used. It is important to note that each item should be RATED independently (not ranked against each other).

0=Not important
1=Not too important
2=Somewhat important
3=Very important
4=Critical

PAGE 4:
RURAL LIFE CONTEXT (30)

0=Not important
1=Not too important
2=Somewhat important
3=Very important
4=Critical

Unique lifestyle, values, characteristics and culture of rural communities (i.e. customs, rituals, etc.; cultural strengths as well as weaknesses) (13) ____

Demographics and definitions (2) ____

Knowledge of family agriculture and the impact it has on rural residents (2) ____

Social pressures in dense environments and the risk of nonconformity (2) ____

Homogeneity issues (e.g., lack of cultural/ethnic groups, lack of diversity, lack of social contacts and activities) (1) ____

Home/work issues that may affect marriage connected with family agriculture (1) ____

Dynamics of grief and loss issues when economics threaten economic viability of family enterprises (1) ____

Role of trauma in creating and maintaining symptoms (1) ____

The importance of social capital as a resource for rural communities (1) ____

The importance of sense of community to rural people (1) ____

Rural (and semi-rural) economic class issues, especially poverty (1) ____

If you noticed any critical factors missing, you may note them here with a brief explanation. A response is optional.

PAGE 5:

UNIQUE ASPECTS OF A PSYCHOLOGICAL PRACTICE IN A RURAL SETTING (13)

0=Not important
1=Not too important
2=Somewhat important
3=Very important
4=Critical

Challenges of being the sole practitioner in a rural area (3) ____

Coping with limited resources for clinician (referral, training, consultation, etc.)(2) ____

Greater professional freedom (1) ____

Few social opportunities for practitioner/family of practitioner (1) ____

An emphasis on the underserved aspects of rural work (1) ____

Decreased likelihood of litigation (1) ____

Lower reimbursement/benefits (1) ____

Joys and rewards of living and practicing in a small town or rural region (1) ____

Not being accepted quickly (1) ____

Coping with limited resources for client (1) ____

If you noticed any critical factors missing, you may note them here with a brief explanation. A response is optional.

PAGE 6:

KNOWLEDGE NEEDED FOR PRACTICE IN A RURAL SETTING (17)

0=Not important
1=Not too important
2=Somewhat important
3=Very important
4=Critical

Understanding of pride, independence, religious beliefs trust in searching out viable treatment options, attitudes toward mental health, and lack of anonymity as barriers to mental health treatment (8) ____

Knowing the specific rural community (ties) in which one works (3) ____

Awareness of how mental health issues may be presented differently than in urban/suburban areas (2) ____

The importance of not pathologizing cultural practices/beliefs: visions, religious beliefs, family dynamics, "the old ways" (1) ____

Understanding how mental illness and psycho-social difficulties can be more severe in rural locations due to already limited experiences/opportunities (1) ____

The "informal" aspects of practicing in a rural community (1) ____

Knowledge of directive approaches to counseling that meet the cultural needs of the population (e.g., the right balance between providing concrete solutions ____

but not being pushy) (1)

If you noticed any critical factors missing, you may note them here with a brief explanation. A response is optional.

PAGE 7:

TASKS FOR THE RURAL PSYCHOLOGIST (33)

0=Not important
1=Not too important
2=Somewhat important
3=Very important
4=Critical

Making and receiving referrals (8) ____

Research, program development and evaluation; (e.g., assessing the needs of the community and working to meet those needs, finding out what the community considers the problems to be and tackle those first, before identifying other problems that you have observed but which they do not then recognize) (6) ____

Flexibility, adaptability, and creativity in treatment approach in resource limited locations (e.g., treating fear of crowds in a very small town) (4) ____

Advocacy for initiatives that support access to care and other important rural health care issues; Becoming political activists (3) ____

Having stake in the community, living there, and having your future on the line as much as those you serve (2) ____

Developing strategies for community development (2) ____

Compensating for limited resources and programs (voc rehab, transportation, sheltered workshops) (2) ____

Learning about and practicing in new areas as needed by the community (1) ____

Learning about the legal issues that impact rural areas and broader state/federal issues (1) ____

Adapting manualized therapies depending on the population (e.g., the sub-literate) (1) ____

Finding creative ways to provide services and make the long-haul in rural mental health and thinking about problems in ways that are not "typical" to psychology (1) ____

Funding work through grant writing and other options for treating patients in underserved, underinsured, economically depressed areas (1) ____

Lobbying for funding for local services that are currently needed but not provided (1) ____

If you noticed any critical factors missing, you may note them here with a brief explanation. A response is optional.

PAGE 8:

SPECIFIC TOPICS FOR TRAINING IN RELATION TO THE RURAL SETTING (26)

0=Not important
1=Not too important
2=Somewhat important
3=Very important
4=Critical

Rural psychology ethics (6) ____

Drinking and other addicting behaviors (3) ____

Rural service models (2) ____

Population health principles and rural health (2) ____

Contextual factors in psychological difficulties in rural clients (e.g. isolation, transport, life/work interaction) (1) ____

Family systems (e.g., what we see as "enmeshed" may be the norm in a more rural area) (1) ____

Workforce issues (1) ____

Gerontology; given that rural communities are disproportionately older (1) ____

Rural employment and economic development (1) ____

Rural education (1) ____

Racial, ethnic, and cultural diversity (1) ____

Mental health literacy (1) ____

Injury (1) ____

Disaster preparedness (1) ____

Disability (1) ____

Domestic violence (1) ____

Health Care Finance/Economics (1) ____

If you noticed any critical factors missing, you may note them here with a brief explanation. A response is optional.

PAGE 9:

GENERALIST AND SPECIALIZATION ABILITIES, ROLES, AND PRE-SERVICE PROFESSIONAL KNOWLEDGE AND SKILL SETS (29)

0=Not important
1=Not too important
2=Somewhat important
3=Very important
4=Critical

Broad base of generalist skills (13) ____

Specialty training skill sets to include, but not limited to, community psychology, staff development, leadership training, psychopharmacological consultation, primary care psychology (2) ____

Assessment and psychological treatment skills (2) ____

Psychopathology and interventions (2) ____

Psychopharmacology (given the paucity of psychiatry in small rural towns) (2) ____

Comfort with varying roles (e.g., consultant-supervisor, multi-disciplinary team advisor, workshop facilitator) (1) ____

Psychological bases and theory (1) ____

Family and group therapy (1) ____

Crisis intervention (1) ____

Training in short-term, empirically supported treatments (1) ____

Assessment of client's social support networks (1) ____

Psychotherapy (1) ____

Scientist practitioner training (1) ____

If you noticed any critical factors missing, you may note them here with a brief explanation. A response is optional.

PAGE 10:

CONSIDERATIONS FOR DEVELOPING A THERAPEUTIC ALLIANCE IN A RURAL SETTING (10)

0=Not important
1=Not too important
2=Somewhat important
3=Very important
4=Critical

Cultural Sensitivity (3) ____

Communication skills (2) ____

Understanding the use of metaphor and story telling with rural populations (1) ____

Engaging clients; Being able to be present and welcoming (1) ____

Consciously addressing stereotypes/prejudices on both therapist and client's part (1) ____

Comfort with more casual interactions with clients (e.g., not appearing "uppity") (1) ____

Basic engagement skills (1) ____

If you noticed any critical factors missing, you may note them here with a brief explanation. A response is optional.

PAGE 11:

PROMOTING ACCESS TO TREATMENT IN RURAL AREAS (20)

0=Not important
1=Not too important
2=Somewhat important
3=Very important
4=Critical

Maximizing use of technology (internet/telephone) to improve access to treatment (6) ____

Providing co-locations in primary care facilities (3) ____

Working with the community as a client; Healing communities, (i.e., thinking in larger terms than tertiary individual treatment) (3) ____

Flexibility in scheduling (i.e., people wait weeks for appointments and then can't make it, and return to the end of the line. This is hard for them or 90 min session for people who drive a long distance) (2) ____

Understanding staffing difficulties, especially with finding appropriate MD support (1) ____

Negotiating restrictions in service availability (1) ____

Understanding the lack of anonymity in finding services on a local basis as a barrier to mental health service utilization (1) ____

Understanding financial barriers to seeking psychological services (1) ____

Knowing your way around basic social services could really help as many individuals and families need case management (1) ____

Determining how to provide the greatest number of services with, at times, few patients (e.g., groups) (1) ____

If you noticed any critical factors missing, you may note them here with a brief explanation. A response is optional.

PAGE 12:

ETHICAL CONSIDERATIONS FOR RURAL PRACTICE (ROLES, RELATIONSHIPS, AND BOUNDARIES WITH CLIENTS, CONFIDENTIALITY, COMPETENCE, PSYCHOLOGIST'S ANONYMITY AND VISIBILITY) (48)

0=Not important
1=Not too important
2=Somewhat important
3=Very important
4=Critical

Negotiating the ethics of multiple/dual roles/relationships with clients (25) ____

Awareness of limits of competence and appropriate ways of responding to pressures to practice outside one's area of competence (6) ____

Privacy and confidentiality (5) ____

Understanding the "Life in a fishbowl" phenomenon of practicing in a rural community (e.g., implications of running into patients in the community) (3) ____

Establishing boundaries with family/friends/acquaintances (2) ____

Comfort with increased visibility in community (2) ____

Boundaries of appropriate self-disclosure (1) ____

Rural practice: dos and don'ts with sideline occupations and secondary business (1) ____

Bartering (1) ____

Perception/status of practitioner in community (1) ____

Ability to say no when you do not have the time or resources to provide a particular service (1) ____

If you noticed any critical factors missing, you may note them here with a brief explanation. A response is optional.

PAGE 13:

WORKING WITH OTHER PROFESSIONALS AND AGENCIES (28)

0=Not important
1=Not too important
2=Somewhat important

3=Very important
4=Critical

Partnering and networking with credible community leaders and agencies regarding advocacy and dealing effectively with rural community institutions (e.g., churches, government clergy persons, civic leaders, schools, etc.) to increase service utilization, promote services and reduce shame/stigma (8) ____

Interdisciplinary collaboration (7) ____

Negotiating and sustaining relationships with other non mental health professionals (e.g., school counselors, social workers, etc.) (6) ____

Working and networking with other practitioners who provide rural mental health services (2) ____

De facto service systems; developing and sustaining relationships with primary care physicians who provide the bulk of mental health care in small towns (2 ____

Negotiating and educating other professionals about boundaries and ethics (2) ____

Maintaining positive relationships with urban tertiary care centers (1) ____

If you noticed any critical factors missing, you may note them here with a brief explanation. A response is optional.

PAGE 14:

SUPERVISION AND CONSULTATION (10)

0=Not important
1=Not too important
2=Somewhat important
3=Very important
4=Critical

Clinical supervision (5) ____

Consultation with people in similar fields (3) ____

Alternate models/technology as a means of obtaining supervision and consultation (2) ____

If you noticed any critical factors missing, you may note them here with a brief explanation. A response is optional.

PAGE 15:

PROFESSIONAL DEVELOPMENT/CONTINUING EDUCATION, BURNOUT, ISOLATION, AND SELF-CARE (27)

0=Not important
1=Not too important
2=Somewhat important
3=Very important
4=Critical

Identifying personal stressors and seeking support (16) ____

Compensating for lack of access to continuing education (e.g., having to drive to other towns for personal growth activities) (4) ____

Access to educational resources for professional development, staying current in the profession, and client care (3) ____

Using technology effectively to inform treatment practices (2) ____

Obtaining support for personal and professional development in rural communities (1) ____

Strengthening independence while encouraging continued professional support (1) ____

If you noticed any critical factors missing, you may note them here with a brief explanation. A response is optional.

PAGE 16:

BUILDING AND MAINTAINING PRACTICE IN RURAL COMMUNITIES (14)

0=Not important
1=Not too important
2=Somewhat important
3=Very important
4=Critical

Understanding the business/practical aspects of making a living while working in a rural area; practical information financial/payment/reimbursement setting up billing, etc. (5) ____

Marketing, business, and human resources (2) ____

Financial survival in a small population base community (2) ____

Developing effective administrative skills (psychologists in rural settings often take these on early in their careers) (1) ____

Navigating managed care (1) ____

Maintaining a practice among low-income rural populations (1) ____

Making your practice "home like" (1) ____

Ensuring file and test security in settings other than your own office (1) ____

If you noticed any critical factors missing, you may note them here with a brief explanation. A response is optional.

PAGE 17:

TIPS FOR RECRUITING, RETAINING, AND PREPARING STUDENTS FOR WORK IN RURAL COMMUNITIES (9)

0=Not important
1=Not too important
2=Somewhat important
3=Very important
4=Critical

Exposure to multiple rural settings and immersion in those settings; offering hands on experience (4) ____

Gaining funding for students in training (1) ____

Courses that will target needs specific to rural settings (1) ____

Having students reflect on personal motivations for practicing in rural areas (1) ____

Recruit students from rural areas (1) ____

Recruiting and training graduate students who will actually serve in rural areas after training is completed (1) ____

If you noticed any critical factors missing, you may note them here with a brief explanation. A response is optional.

PAGE 18: Demographics Questionnaire:

If you DID NOT participate in Round 1, please fill out the demographic information below (contained in the next five questions). If you DID participate in Round 1, please proceed to the next page.

1. Demographics
   Name:
   Gender:
   Racial, ethnic, and/or cultural identities:
   City and State/Province of work:

2. Please check your highest degree attained.

_____ Ph.D.
_____ Psy.D.
_____ M.A.
_____ M.S.
_____ B.A.
_____ B.S.

_____ Other

3. Employment (In the textboxes below please indicate how many years you have worked in each role. It is not expected that you have worked in all three roles. If zero years, please enter 0.) For the "researching psychology" option, please place a comma after the number of years, and then indicate how many publications related to rural psychology you have. For the "teaching rural psychology" option, please place a comma after the number of years, and then indicate how many courses you have taught related to rural psychology.

practicing rural psychology _____
researching rural psychology _____
teaching rural psychology _____

4. Are you a Licensed and/or Certified Psychologist?

_____ Yes
_____ No

5. Please briefly describe your own training in rural psychology (i.e., courses completed, professional development, continuing education). A response is optional.

PAGE 19: Further Information

1. It is standard practice in using the Delphi method to acknowledge the panel of experts upon publication. Are you willing to be identified?

_____ Yes
_____ No

2. Please comment on the survey overall. A response is optional.

Appendix I
Round 2: Thank You (Online)

THANK YOU!

Thank you for participating in my study as an expert in rural psychology and for your contribution to a scholarly work designed to identify critical factors in rural psychology training.

If you have any questions/concerns/comments, please feel free to contact me, Christine Boulton at 701-594-9489 or christine.boulton@und.nodak.edu; or Michael Loewy at 701-777-3744 or michael.loewy@und.nodak.edu.

Your time, help, and dedication to rural mental health service delivery is greatly appreciated!

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