

## **Exploring Wellness and the Rural Mental Health Counselor**

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### **INTRODUCTION**

Therapists in rural settings are faced with many professional challenges (Smith, 2003). Professionals tend to have little training in diagnosing, intervening and treating mental illness, even as the need for such skills grows (DeLeon, 2000). For example, "in the United States, at least 15 million rural residents struggle with significant substance dependence, mental illness, and medical-psychiatric co morbid conditions" (Roberts, Battaglia, and Epstein, 1999, p. 497). Compared to urban and suburban settings, rural settings consistently report ever increasing incidences of abusive drinking, suicides, mood and anxiety disorders, and chronic illness (Roberts et al., 1999).

Benefits to counseling in rural settings are well known, including lifestyle (clear skies, slower pace, clean air, close social networks), lower overhead and cost of living, greater autonomy, more collegial relationships, varied tasks and functions, and community identity and recognition (DeLeon, 2000). However, rural mental health counselors often report role overload, heightened stress and burnout, relationship/role/boundary problems, professional isolation, economic issues (scarcity of resources), lack of social/cultural opportunities, and lack of privacy (DeLeon, 2000). This reality in rural areas is often exacerbated by what Smith (2003) calls "a constant search for professional balance and appropriate boundaries.

Weigel and Brown (1999) noted that the major challenges discussed by rural mental health counselors were limited resources, few staff members with large caseloads, varied client issues, geographic isolation, limited supervision and consultation options, and high employee turnover. Weigel and Brown also indicated that there are potential problems with stigma and local credibility of rural counselors due to the close-knit nature of rural communities, [where] therapeutic success or failures are often visible and public. Brownlee (1996) concurred, asserting that the rural mental health professional who participates actively in community life will eventually encounter the dual relationship dilemma, often further contributing to a sense of isolation.

### **Purpose of the Study**

The purpose of this study is to ascertain perceptions from rural community mental health counselors regarding the challenges described, specifically including their job functions, levels of role conflict and burnout, participation in professional development activities, and levels of psychological thriving. Comparison data from previously published studies are also included.

## METHOD

The participants identified were 30 practicing, therapists/counselors selected from rural communities in two rural states within the Rocky Mountain region of the United States. Lists of practicing Masters level therapists/counselors in rural community mental health centers for each state were requested. A number of survey instruments were administered by mail with a return rate of 57% (20 of the 30 participants returned the instruments).

### Instruments

Four survey instruments were utilized. First, a 17-item survey in which the items were derived primarily from prior counselor function and professional development research and literature was used to measure job functions and professional development activities (Coll & Freeman, 1997, Coll & Rice, 1993).

Second, the Maslach Burnout Inventory (MSI), developed by Maslach, Jackson, and Leiter (1981) includes three scales: *emotional exhaustion* measures feelings of being emotionally overextended and exhausted by one's work; *depersonalization* measures an unfeeling and impersonal response toward recipients of one's service, care treatment, or instruction; and *personal accomplishment* measures feelings of competence and successful achievement in one's work (Maslach, et al., 1981). The Maslach consists of 22 items on a 1-6 Likert scale, with strong evidence of validity and reliability over a 20 year span.

Third, the Role Questionnaire (RQ) was used to measure role conflict and consists of 8 items on a 1-7 Likert scale. The RQ specifically measures role conflict related to internal standards, external expectations, heavy role demands, conflicting responsibilities, and incompatible requests from others (Coll & Freeman, 1997). Construct validity for the RQ has been verified through factor analysis and proven across several samples, factor and scale analysis was later substantiated, and internal reliability for numerous groups was measured at .75 (Coll & Rice, 1993). The RQ has been used by teachers, high school supervisors, special education teachers, manufacturing supervisors, foremen, salespersons, clerical staff, nurses, public utility workers, hospital staff, and hospital aides (Coll & Rice, 1993).

Fourth, the Measurement of Psychosocial Development (MPD) was utilized. The MPD is an Eriksonian-based instrument that provides a measure of the positive and negative attitudes associated with each of the 8 developmental stages, the status of conflict resolution at each stage, and an index of overall psychosocial health. The MPD is useful in a variety of clinical, counseling, training, and research settings because interpretation focuses on healthy personality development and growth instead of pathology. The MPD consists of 27 scales and attitudes that describe the basic dimensions of personality are measured by 8 Positive and 8 Negative scales. Users respond to the 112 items on a separate answer sheet using a 5-point scale ranging from *Very Much Like Me* to *Not At All Like Me*. Results are reported as *T* scores or percentiles, and can be plotted on profile forms by sex and by age groups ranging from 13 to 50+ years (Hawley, 1987). The MPD

was normed on a primarily White sample of 2,480 males and females ages 13 to 86 years. Test-retest reliability coefficients for the MPD scales uniformly approach or exceed .80 with one exception (.67). Alpha coefficients for the positive and negative scales range from .65-.84 (Hawley, 1987).

### Demographics of Participants

The mean age of the respondents was 41 years with a range of 25-65 years old. Average years of experience in counseling were 8.2 with a range of 3-25 years. 53% of the participants were females and 47 % were male. The average number of years on the present job was 6.5 with a range of 1-25 years. 86% of the participants had a Masters in Counseling; with 6% identifying ethnic group as Native American and 94% European American.

### RESULTS

Results about job functions indicated that the rural mental health counselors surveyed spent most of their time performing record keeping, individual counseling and crisis intervention. Most counselors (75%) noted that they preferred less time on record keeping and about half wanted less time in staff meetings and more time performing individual counseling or in clinical supervision. When comparing this sample to community college counselors (rural and urban participants) per Coll and Rice's study (1993), these respondents spent over three times more per week on administrative tasks and record keeping (13.1 hours compared to 3.9 hours) and noticeably less time engaged in direct counseling (17.5 compared to 25) (see Table 1).

*Table 1*

<b>Current Job Function</b>	<b>Average hrs. per week</b>	<b>Range</b>
<i>Rural Mental Health Counselor</i> (n=20)		
Presentations	.5	0-2
<b>Record keeping</b>	<b>9.3</b>	<b>0-20</b>
Consultation	1.2	0-5
<b>Individual counseling</b>	<b>10.5</b>	<b>0-25</b>
Group counseling	2.1	0-9.5
<b>Crisis intervention</b>	<b>4.9</b>	<b>1-35</b>
Testing/other duties	3.1	0-1.5
Clinical supervision	1.6	0-8
Administration tasks	3.8	0-24
Staff meetings	3.0	0-6

<b>Ideal Job Functions Rural Mental Health Counselor (n=20)</b>	<b>More</b>	<b>Less</b>	<b>OK</b>
Presentations	31%	6%	63%
<b>Record keeping</b>	<b>0%</b>	<b>75%</b>	<b>25%</b>
Consultation	37%	0%	63%
Individual counseling	44%	0%	56%
Group counseling	41%	0%	59%
Crisis intervention	11%	18%	71%
Testing/Other	25%	6%	69%
Clinical supervision	<b>44%</b>	-	<b>56%</b>
Administrative tasks	12%	25%	63%
Staff meetings	12%	47%	41%

<b>Current Job Functions Compared in Hours (Coll &amp; Rice, 1993): Rural and Metro Community college counselor sample</b>	<b>Rural MHC hrs. per week (n=20)</b>	<b>Community college Counselors(n=80) hrs. per week</b>
Direct Counseling	17.5	25
Testing	3.1	1.2
<b>Administrative Tasks and Record Keeping</b>	<b>13.1</b>	<b>3.9</b>
Staff Meetings	3	2
Clinical Supervision	1.5	1.5

Results for role conflict per the RQ indicated that the rural mental health counselors surveyed generally have less role conflict when comparing this sample to school counselors per Coll and Freeman’s study (1997). However, this sample indicated elevated role conflict for ‘doing things that should be done differently’ and ‘receiving an assignment without adequate resources’ (see Table 2).

*Table 2*

<b>Role Conflict Compared with Rural School counselor sample (Coll &amp; Freeman, 1997), expressed as an average (1 = very much so, 6= not at all)</b>	<b>Rural MHC (n=20) 1-6 scale</b>	<b>School Counselors (n=200) 1-6 scale</b>
I have to do things that should be done differently	3.5	3.9
I receive an assignment without adequate resources	3.6	3.5
<b><i>I work with 2 or more groups who operate differently</i></b>	<b>3.0</b>	<b>4.5</b>
I receive an assignment without proper human resources	2.9	3.9
<b><i>I do things that are apt to be accepted by some and not by others</i></b>	<b>2.9</b>	<b>4.2</b>

<b>Burnout in rural mental health counselors compared with National Norm group (n=20)</b>	<b>Mean</b>	<b>Range</b>	<b>National Normed Means (n=+2000)</b>
<i>Emotion exhaustion (EE)</i>	<b>24.3</b>	<b>12-45</b>	<b>17</b>
Depersonalization (DP)	9.2	4-18	10
Personal accomplishments	38.9	29-47	36

<b>Professional development activities among rural mental health counselors*(n=20)</b>	<b>Percentage</b>
American Counseling Association (ACA) members	18%
American Psychological Association (APA) members	12%
National Association of Social Workers (NSAW) members	6%
Total	<b>36%</b>
* compared with community college counselor samples which indicated <b>50%</b> with National Association memberships (n=80).	
<b>Professional development activities among rural mental health counselors*(n=20)</b>	
National conference attendee (within 2 years)	18%
Regional conference attendee (within 2 years)	15%
Total	<b>33%</b>
* compared with community college counselor samples, which indicated <b>50%</b> attended national and/or regional conferences within the last 2 years (n=80).	

<b>Thriving/Distress among rural mental health counselors (per MPD)</b>		
<b>Psychological Thriving</b>	<b>Average Score (n=20)</b>	<b>National Norms (n=+1800)</b>
Industry	62%	50%
Generativity	54%	49%
<b>Psychological Distress</b>		
Trust	24%	50%
Intimacy	35%	49%
Isolation	62%	49%
Despair	76%	50%

Burnout information per the MSI revealed that the rural mental health counselors surveyed were well above the national norm group for emotional exhaustion and within the average range for depersonalization and personal accomplishments (see Table 2).

For professional development activities, compared to community college counselors per Coll and Rice's study (1993), rural mental health counselors indicated lower national professional membership (36% compared to 50% for community college counselors), and less participation than community college counselors in regional or national conferences (33% within the last 2 years compared to 50%) (see Table 2).

In terms of thriving and distress per the MPD, this sample indicated above average scores for industry (62<sup>nd</sup> percentile), defined as high productivity, seeing a project to the end and

generativity (54<sup>th</sup> percentile)- defined as sharing what you know. However this sample indicated high psychological distress especially related to lack of trust (24<sup>th</sup> percentile), low sense of intimacy 35<sup>th</sup> percentile), and very negative feelings of isolation (62<sup>nd</sup> percentile) and despair (76<sup>th</sup> percentile). (See Table 2).

## **DISCUSSION**

These results support the challenges discussed for rural mental health counselors. Indeed as supported by the professional literature, these rural mental health counselors reported low participation in conference and professional associations, lack of resources and overload of administrative duties and paperwork, emotional exhaustion related to overload, low levels of trust and intimacy and high levels of isolation and despair.

One could speculate that too much time with record keeping, administrative tasks, and staff meetings may be taking away from job 'ideals' (counseling, consultation, clinical supervision, presentations) thus possibly contributing to higher levels of emotional exhaustion, role conflict and psychological distress. Lack of opportunities for training at regional and national conferences may also be a contributor to these challenges. For rural mental health agencies, cost savings related to retention and assurance of quality of services provided may be at stake.

Further study is needed to clarify these notions. Limitations of this study include a small sample size and geographic limitation of the sample.

Suggestions, (with ideas from Smith, 2003):

(1) Consultation is essential in the counseling field to reduce isolation and increase intimacy. The rural mental health counselor can create an interdisciplinary consultation group by collaborating with teachers, clergy, police officers, judges, and paraprofessionals all of which bring specific expertise and appropriate care to the mental healthcare area. This activity could also reduce emotional exhaustion and lack of resources. Rural mental health facilities are encouraged to pay for state and perhaps national memberships to professional organizations.

(2) Continuing education is another important and perhaps neglected area (low reported participation in conferences, associations). Again, collaboration with other professionals may bring this needed information. Professionals such as attorneys, medical professionals, domestic violence educators, and inviting mental health counselors from other communities could provide continuing education and advancement. Promoting online training courses and continuing education classes may also reduce isolation and increase professional development. Agencies are encouraged to offer to pay for such opportunities.

(3) Applying for grants, conducting fundraisers, and promotion can help rural clinics provide low cost services and will be much less affected by state and federal funding cuts and may promote additional resources and reduce overload.

(4) Partnerships with local helping professional training programs may promote practicum and internship hours at various rural sites. Agencies are encouraged to provide opportunities to receive additional credentials within 2-3 years of employment (e.g., license, clinical supervision credential).

(5) Conducting community outreach programs provides an opportunities for introductions to members of the community, for explaining services, and for decreasing the stigma of counseling. Agencies are encouraged to promote and fund memberships to local organizations for counselors (e.g., Rotary, Loins Club).

(6) Enhanced training in computer information systems can relieve record keeping and administrative time. Agencies are encouraged to invest in effective and efficient computer systems as a retention strategy.

It is the hope that by implementing these mentioned strategies (as well as others), rural mental health counselors will increase trust and reduce despair (and perhaps turnover), thus promoting retention and quality of services.

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