Issues in Training Psychologists for Rural Settings

Peter A. Keller and J. Dennis Murray
Mansfield State College

David S. Hargrove
University of Nebraska-Lincoln

Harold A. Dengerink
Washington State University

While many would agree that preparation for psychological service delivery in rural settings requires a unique perspective, little information about training for rural roles has been available. The present article is based upon the experiences of three federally funded psychology graduate programs which prepare trainees for rural work. Integration of a rural emphasis into traditional clinical training, preparation of master's level rural psychologists, and rural field experiences are addressed. Each section of the paper identifies important training issues which require further study.

Portions of this paper originally were presented as part of a symposium titled, Preparing Psychologists for Work in Rural Communities, at the American Psychological Association Convention, Los Angeles, August 1981.

All correspondence should be addressed to Peter A. Keller, Department of Psychology, Mansfield State College, Mansfield, Pennsylvania 16933.
Training Psychologists for Work
in Rural Settings

Psychology traditionally has been an urban profession. Recent data support the conclusion that psychologists have been educated in, and, subsequently, have remained in large metropolitan areas or atypical university communities (Keller, Zimbelman, Murray, & Feil, 1980). Consequently, we have tended to neglect the special mental health needs of a significant portion of the American population. Rural settings typically offer a quality of life different from metropolitan areas, and their geographic and social isolation often has fostered certain characteristic attitudes and behaviors.

Not surprisingly, relatively little is known about how best to prepare trainees for work in rural communities (Dengerink & Cross, 1982; Keller & Murray, 1982). In a relevant discussion, Keller & Prutsman, 1982 have proposed that a clinical-community model of preparation will be most effective in preparing psychologists for the wide range of tasks which inevitably will confront them in any rural setting. These authors also noted the importance of training for consultation, program evaluation, and administration skills in addition to traditional clinical skills. Unfortunately, most of that and other relevant discussion are based primarily on experience as opposed to research evidence about rural training. The present article includes the experiences of three psychology graduate programs which have been federally-funded to prepare trainees for rural work in diverse areas of the country. Issues which are addressed include the integration of a rural community emphasis into traditional clinical training, the preparation of master's level community psychologists for rural roles, and planning rural internships.

Integration of Rural Training into Traditional Clinical Programs

It has been a challenging task to integrate a rural perspective into the doctoral clinical program at Washington State University. It is difficult, first of all, because clear-cut conceptual frameworks for rural mental health are lacking. Two different bodies of literature immediately appear relevant but upon closer examination suffer in the application to rural populations. The first of these bodies of literature is that roughly designated as community psychology. Many of the prescriptions and concepts of community psychology (Iscoe, Bloom, & Spielberger, 1977) have been taken up by those who claim to provide services to rural populations. These include the basic tenet of prevention and community organization, as well as the no-

1Harold H. Dengerink is primarily responsible for preparation of this section of the article.
tion of utilizing natural helpers and other community resources (D’Augelli, 1982). While these concepts appear intuitively applicable to the rural situation, that appearance may not endure because the concepts and methodologies of community psychology originally were devised within the context of urban and suburban communities which are geographically less dispersed than rural ones. Urban communities also may be ethnically and culturally less diverse than rural ones. Social communication networks and, perhaps most importantly, values may differ markedly between urban and rural communities (Ford, 1978). Further, small and dispersed populations may not be able to generate the kinds of community resources possible in larger urban communities. For example, returning a chronically mentally ill person from a state hospital to Ferry County, Washington (population = 5,800; area = 2,002 square miles) is very different from returning such a person to an urban community.

A second body of literature which may have some applicability to rural populations is that of cross-cultural psychology (Kleinman, 1980; Katon & Kleinman, 1980). The mental health professional with graduate training in behavioral sciences often is culturally very different from the population which that person attempts to serve in a rural area. Further, it has been pointed out repeatedly that rural communities are quite diverse in ethnic make-up and cultural background. A single rural mental health professional often is required to provide services to many separate cultural and ethnic groups. Thus the developing literature on work with the culturally different may be appropriate. Still the concepts and procedures in that literature often were developed with far greater cultural differences in mind. It is true that the rural practitioner often is called upon to provide services for some persons who are from a very different culture (e.g., white practitioner and traditional Native American client), but there is no assurance that these concepts are applicable to a rural practice per se, or that they are any more relevant for rural than urban mental health.

In addition to the lack of a conceptual basis for an organizing framework in rural mental health, the rural area lacks relevant empirical bases (Keller & Murray, 1982). The basic tenet of rural mental health is that there is a major link between one’s physical and social environment and both mental health problems and service delivery. The special characteristics of rural environments in relationship to psychopathology and service delivery have not been adequately researched (Mueller, 1981; Wagenfeld, 1982).

Lacking conceptual, empirical, or even traditional bases for developing a program in rural mental health leaves one only with procedures developed on the basis of consensus. During the spring of 1980, Dengerink organized a symposium at Washington State University that brought together severable representatives of programs purporting to train persons for roles in rural mental health (Dengerink & Cross, 1982). These
persons represented programs in psychology, psychiatry, and social work as well as family practice medicine. What follows is a set of suggestions growing from that symposium which have at least some consensual validation as important elements in a rural mental health training program.

1. Perhaps the single most accepted element for rural mental health training is that such persons must be generalists. This point has been made so many times that it is becoming trite. We are in the odd position of developing subspecialties to train generalists. The importance of this element is based upon the understanding that persons who provide services in rural areas must do so for a wide variety of problems and persons. They often do not have specialists to whom particular problems can be referred. Thus the same individual may be required to provide services to children; senior citizens; distressed marital couples; deinstitutionalized, chronically mentally ill; persons in crisis; and alcoholics; or to administer a clinical program, negotiate with county commissioners, etc.

2. Training for rural mental health must include some direct experience with rural populations and issues. Classroom training and conceptual sophistication are not enough. Translation of principles into practice with rural problems is necessary for those who eventually will take rural positions. Failure to provide this kind of experience may be responsible for the often cited rapid turnover in rural mental health agencies. All too often persons take positions in rural areas with some idealized notion of the good life only to find that the realities of the community and job were not what they anticipated.

3. Third, the issues of rural mental health should permeate the training program. Practicum experience with rural communities and a course or two are important, but the issues of rural mental health also relate to the study of psychopathology, assessment, and research procedures as well as more basic areas of psychology.

4. Training for rural positions should have an interdisciplinary focus. Persons in rural areas must interact continually and cooperate with persons from other mental health disciplines and from related professions. For example, the local general practitioner may be the only member of the medical profession who can prescribe and monitor psychotropic medications.

5. Rural mental health training should combine both clinical and community concepts and procedures. This notion is part of the generalist perspective and relates to the need to work within small communities.

6. Many of the differences between urban and rural areas are cultural rather than merely density or geographic ones. Clinical psychology train-
ing for rural areas should include elements which ensure that these persons are knowledgeable about, sensitive and responsive to, cultural differences. Earlier it was noted that we are not sure how such concepts will apply to rural mental health. We are convinced, however, that they are important.

7. It is particularly important not to ignore research training. First, the rural practitioner often is called upon to do program evaluations or similar tasks which require statistical and other research expertise. Second, the lack of data-based information for the rural practitioner is appalling. Doctoral level researchers should help to reduce that void. Third, the scientist-practitioner model helps to ensure that graduates adopt a decision-making strategy which is based upon hypothesis testing. The hypothesis-testing, decision-making model is ultimately self-correcting, while the expert model is not. In an area such as rural mental health in which there are so few givens, a self-correcting, decision-making model is most important.

8. From the small amount of data available, it appears that the values of individuals who select rural positions differ from those who select urban positions. The relevant values are not assured by location of upbringing or other previous rural experiences. They are reflected in attitudes concerning the work environment, attitudes toward extended family and recreational or lifestyle differences (Dengerink, Marks, Hammarlund, & Hammond, 1981). To promote a better match between practitioner and provider, programs should pay greater attention to selection of graduate students.

In summary, it is apparent that rural mental health practitioners must, if anything, be more flexible and more broadly trained than their urban counterparts who can specialize. There is little justification for the evaluation which we sometimes hear from urban professionals that persons take positions in rural areas only if they cannot find something else.

*Middle-Level Psychologists in the Rural Community*¹

Discussion regarding the role of the master's level psychologist in community service has received formal attention within psychology's professional literature for at least the past 25 years, and reports and recommendations regarding establishment of a legitimate place for such individuals have been met with ambivalence at best, and neglect and outright resistance at worst (Perlman & Lane, 1981). The pros and cons of master's degree education and function continue to be debated (Albee,

¹J. Dennis Murray is primarily responsible for preparation of this section of the article.
1977; "ABPP and master's training", 1976; Danish, 1976; Derner, 1976; Dimond, Havens, Rathnow, & Colliver, 1977), but support for this level of psychologist persists in spite of minimal recognition by the American Psychological Association.

Studies on the distribution of American psychologists (Keller, Zimbelman, Murray & Feil, 1980; Richards & Gottfredson, 1978) suggest that psychologists are underrepresented in rural areas in comparison to their urban distribution. Moreover, Hollingsworth and Hendrix (1977) found that those doctoral level psychologists in rural mental health centers were being drawn increasingly into administration and other nonclinical activities while traditional service delivery was undertaken by staff at the master's level or below. In the past, social work has filled much of the rural mental health work force. Overall, these findings suggest a significant lack of psychological expertise at all levels in the rural setting.

Beyond this awareness, we need to examine what kinds of skills and knowledge are needed in rural communities. One can identify several areas that could be addressed by both clinical and community psychology, and in master's level programs, in particular.

These areas of expertise include: (a) an understanding of ecological principles, and awareness of community dynamics as they affect psychopathology, stress, change, and natural helping networks; (b) empirical methodologies for addressing needs assessment, outcome evaluation, program impact, and cost effectiveness in small applied programs; and (c) program development and implementation skills, particularly within the primary and secondary prevention paradigms.

The assumption is that the convergence of clinical and community psychology offers the best hope of training people able to meet these needs. While these fields may not have a monopoly on specific aspects of the required expertise, the particular combinations required by the rural community are best found here.

From the first two authors' experiences in a rural-oriented master's level degree program at Mansfield State College, it appears that most, if not all, of the knowledge and skills mentioned above can be provided by master's level practitioners. The depth of training and expertise available, however, in such things as psychotherapy may be less intense than that provided by a fully trained, PhD clinical psychologist, and supervision and back-up support may be needed in many activities (perhaps, as some have suggested, in the manner a physician supports and monitors a physician's assistant).

Separate from the question of doctoral level availability, the master's level persons offer several potential advantages.

1. They may have the potential to be more satisfied with the living and working environment of the rural community and more resistant to post-
graduate-school culture shock and disillusionment about being isolated from sophisticated educational environments.

2. They may be more easily recruited from the indigenous rural population already oriented toward generalist functioning and involvement in the broad spectrum of small community life.

3. They can be more easily integrated in the human service system of the rural community and perhaps seen as more accessible (and acceptable) by the broader lay community.

4. They can be more accepting of the generalist role required of rural practice, including the breadth of professional activities and the often accompanying lack of specialization. This may include the flexibility to accept a range of role demand from the level of Hollister's (1982) indigenous community service guides to that of community program evaluator, planner, and developer.

It is more difficult to be explicit about the relative roles of master's and doctoral level psychologists in activities guided by the principles of community psychology. Community psychology has been more supportive of master's level functioning in part, we believe, because of a conceptual inclination to view expertise as being organized along a continuum of quantitative depth and experience rather than qualitatively different levels of functioning. Seidman and Rappaport's (1974) educational pyramid illustrates the type of training level hierarchy that would best serve a rural community psychology practice.

Work on the front lines probably will continue to be done by cadres of paraprofessionals both within and without the formal mental health network, and a vital intermediate level can be filled by master's level professionals. This latter group of psychologists can provide on-site expertise (often in small satellite centers) in significant numbers, at reasonable cost, that is sufficient to bring about meaningful change both through traditional services and in more primary and secondary preventive efforts that affect the broader community.

There are some unresolved issues, of course. For example, rural models of service delivery that effectively utilize middle-level psychologists need to be developed. Graduates of innovative programs initially meet work environments that may not be prepared to take advantage of their expertise. Also, we need to implement models of professional practice that clearly define and integrate the various levels of preparation. We do not presently have many models which effectively integrate doctoral and master's psychologists and paraprofessionals in complementary roles.
Resolution of these and related issues could well alter the practice of mental health services in rural communities and allow psychologists at all levels of training a more meaningful role in the development of services.

Practicum and Internship Training

Practica and internships in community-clinical education for rural mental health practice provide the contexts in which important components of the training process are integrated and made meaningful. Consistent with the initial intent of clinical psychology training, neither academic work nor the laboratory of practice stands alone in the preparation of the clinician. The integration of the academic and practical components, giving concrete meaning to general principles of psychology has been an historical emphasis (Shakow, 1947).

This section identifies three domains of training in community-clinical psychology for rural practice and illustrates integrative functions of the practicum/internship experiences with the academic preparation.

Assumptions

Integration of practicum and internship with academic training is based on three assumptions about the practice of psychology in the rural environment:

1. Psychologists and other mental health professionals working in the rural setting must function as generalists (Hargrove, 1982a, 1982b).

2. Professionally trained individuals will rise rapidly in the service delivery organization, assuming administrative responsibility without regard to training or experience (Hollingsworth & Hendrix, 1977).

3. Staff frequently are isolated and experience a high degree of visible interrelatedness between private and professional lives (Mazer, 1976).

Three levels of training in which integrative tasks are important follow from these assumptions. They include the integration of theory and practice, the integration of personal and professional styles of operation, and the integration of training experiences with the rural environment. Each level of training is discussed and examples are provided from the rural mental health speciality in community-clinical psychology training at the University of Nebraska-Lincoln.

David S. Hargrove is primarily responsible for preparation of this section of the article.
The Integration of Theory and Practice

The first level of training requires the integration of general psychological theory and general psychological practice. At Nebraska, typical of many doctoral level community-clinical training programs, students spend the 1st year in core courses in psychology and research methodology. During the 2nd year of the program, students are exposed to two types of practicum settings to begin the process of integration. These settings include the on-campus Psychological Consultation Center, operated by the department of psychology, and a rural human service delivery agency in the immediate vicinity of the university. Both experiences are under the supervision of faculty and agency supervisors.

In the 2nd year of practicum placements, students begin to develop a perspective of psychological functioning beyond that of the individual person. The activity of an individual in a larger community context and the agency among other agencies in a community take on immediate importance as areas in which psychological knowledge may be applied. Clinically, the beginning student, integrating general theory with practice, learns the importance of accurately assessing the impact of a therapeutic procedure and preparing for its consequences in the life of the client and related others. On a broader community level, the student gains new appreciation of the problems of credibility and community expectations, funding, political and governmental relationships, board activity, and accountability, in addition to the traditional clinical role of most psychologists.

The integration of general psychological theory with mental health practice occurs on both the clinical and wider community levels early in the student’s development. This dual focus should enable the students to gain a balance of perspective, particularly as they develop individual styles of practice.

The Integration of Personal and Professional Styles of Operation

The second level of integrating practicum and internship experiences concerns the development and interaction of personal and professional styles of operation. This level of integration typically takes place in the 2nd or 3rd year of training, depending on the personal development of a given trainee as a clinician. An important indicator of this level of integration is a trainee’s ability to relax and respond to the ambiguity and disorder of a clinical situation instead of merely reacting with arbitrarily determined assessment and intervention procedures. There is, then, less likelihood of rigid personal and professional styles of operation, which results in more genuine and authentic behavior by the professional.
The development of authenticity in both personal and professional roles is important in rural practice because of the high degree of visibility in a small community. Hargrove (Note 1) and Riggs and Kugel (1976) have pointed out the importance of both personal and professional styles of behavior in rural communities. The rural mental health professional is in a position remarkably similar to that of the country preacher.

It is at this integrative level that trainees begin to discover the power of their personalities as a factor in the therapeutic relationship with clients and as a member of a clinical team. This is a discovery that comes with time and experience, usually through a process of close supervision, trial and error practice, and self-examination. It begins early in the trainee’s career and increases as clinical work occupies more individual time and effort. Further, this discovery of one’s self as a therapeutic variable builds the base for further professional and personal development after graduation and entry into the profession.

The Nebraska program requires a summer block placement in a rural mental health agency away from the Lincoln campus prior to the clinical psychology internship. Ideally, the student should utilize this placement when sufficient clinical ability has been demonstrated to form a basis for significant effort toward professional and personal identity. The internship should occur when the student has received the bulk of both academic and clinical training in the university and is ready for more independent work.

*The Integration of Training Experiences with the Rural Environment*

The third level of integrative function of the practicum and internship is to establish a context in which the trainee can develop both clinical and community skills within the rural environment. Academic, clinical, and administrative skills in addition to the developing a sense of personal and professional identity are subject to the peculiarities of practice in the rural community. Practicum experiences and the internship enable this level of integration to be accomplished in several ways.

The first way it is accomplished is in the specifically rural content of academic work in the curriculum. At Nebraska, each trainee must enroll in the “Issues in Rural Mental Health” seminar, which is the only uniquely rural academic program. This seminar enables students to study the issues of rural mental health service delivery which are being introduced in practicum settings and to explore the basic concepts of rural sociology. These academic issues are studied continually in research teams while the student is experiencing other rural placements.

The second way the integration of training and the rural environment is accomplished is in the summer block placement which usually occurs
during the summer following the student’s 3rd year in the program. In this setting, the student lives and works away from the campus, immersed in the life and work of a rural agency. This degree of involvement enables students to identify and work on strengths and weaknesses in their repertoire of skills as well as their personal maturity in a setting removed from the university. The constraints and opportunities of rural practice become realized in a situation which facilitates development of the trainee’s internal resources.

While there are few rural internships for clinical psychologists being developed, it is not yet clear whether the internship in a rural setting is the most desirable alternative for training for rural work. The traditional clinical internship in a large facility which offers a wide range of clientele and diagnostic and intervention procedures offers invaluable breadth and depth to the clinician who must call on a multiplicity of skills in rural practice. On the other hand, the rural internship with sufficient emphasis on the administrative and clinical practices directly applicable to rural practice offers invaluable experience to the worker who expects to practice in such an environment. Presently, the issue of the best location of the internship for the rural trainee is undecided.

**Conclusions**

This article has provided no firm conclusions regarding the training of psychologists for rural settings but has placed in perspective several important issues which must be addressed. Foremost is the need to clearly define a conceptual and empirical basis for rural training. While a community-oriented model intuitively makes sense, there are little data to support its application in rural training programs. There exists the most unanimity on the simple conclusion that rural training must involve some direct experiences with rural populations and issues and that consideration of these issues should occur throughout the curriculum.

In this paper we have raised the question of appropriate levels of training. The case has been presented that middle-level practitioners may adapt more readily to the rural setting and can be prepared to perform most of the tasks which seem to be expected of rural mental health professionals. Indeed, many doctoral level personnel seem to move rapidly into administrative as opposed to clinical-community functions. While questions about training master’s level practitioners probably will never be completely resolved, the issues might be cast in a somewhat different light for rural settings.

The role of field experiences in preparing rural psychologists is extremely important because of the overlap of personal and professional roles. In this paper we also have raised the question of whether or not rural
internships have the potential for providing the depth of experiences which may be required. Many would agree that most rural service delivery sites lack sufficient personnel for comprehensive training experiences. This leads to the important question of how to balance field experiences in a way which will fully prepare trainees for the broad range of tasks they will face in rural programs.

Reference Note


References


ABPP and master's training. Division of Community Psychology Newsletter, 1976, 9(3), 6-7.

Danish, S. Entry level training issues — a response to Division 12 and ABPP. Division of Community Psychology Newsletter, 1976, 10(1), 10.


Hargrove, D. S. The rural psychologist as generalist: A challenge for professional identity. Professional Psychology, 1982, 13, 302-308. (b)


Perlman, B., & Lane, R. The “Clinical master’s degree. Teaching of Psychology, 1981, 8, 72-77.


Shakow, D. Recommended graduate training program in clinical psychology. American Psychologist. 1947, 2, 539-558.