Ethics in Rural Psychology

Case Studies and Guidance for Practice

Sara Boilen

ROUTLEDGE

"At a time when writers in urban citadels have turned again to describing rural Americans as stupid, lazy, and even as bad people, it is refreshing to see a book that takes the strengths and weaknesses of rural America seriously. Here, we find a balanced discussion of the heterogeneity of rural America as well as valuable insights about the values, dispositions, and needs of its citizens."

Robert Wuthnow, professor, Princeton University

"As we face unprecedented rates of suicide, addiction, and behavioral health issues in rural America, Dr. Boilen's focus on this issue is timely and crucial. As I work with organizations serving rural areas in Montana and beyond to plan their future strategies and services, I see the real-life implications of the trends Dr. Boilen references in action: the challenge of attracting and retaining trained providers of behavioral health services leaves many undiagnosed, untreated, and isolated. Our communities are suffering because of this gap. While we can be proud of our go-it-alone, independent streak, rural Americans can also teach all of us how much we need each other to survive and thrive (as evidenced by the bars, pie socials, and church potlucks that still survive in otherwise struggling towns). I urge practitioners with any connection to rural America to explore and respond to the ethical and treatment considerations in this book; healing and support from providers who understand the unique needs and strengths of rural America, especially as telehealth brings this 20% of the country more in contact with our existing secondary and tertiary treatment systems. Rural America needs you now more than ever."

Ned Cooney, MSW, facilitator and consultant to organizations
and community groups, Bigfork, Montana

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Ethics in Rural Psychology

Ethics in Rural Psychology provides readers with theoretical underpinnings, practical applications, and empirically based knowledge of the practice of psychology in rural communities.

Dr. Boilen explores the similarities and differences within and across rural American communities to provide a framework for understanding this vast and varied population. Focusing on the ethical considerations unique to these communities, chapters use illustrative case examples, useful exercises, and personal anecdotes to highlight obstacles unique to rural areas. Finally, the book emphasizes the opportunity to be innovative and creative in rural practice, demonstrating how rural practices hold promise for cutting-edge advancements in the field of psychology.

This book will serve practitioners, students, and researchers as a primer, handbook, and road map for the challenging and rewarding clinical work that awaits in rural America.

Sara Boilen, PsyD, is the owner and chief psychologist at Sweetgrass Psychological Services, a community-minded group practice in Northwest Montana. She serves on the Montana Board of Psychologists.

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Contents

List of figures ix
Foreword by Emily M. Selby-Nelson x
Author's Note xii

Introduction 1

SECTION ONE
Rural America 5

1 What Is Rural? 7
2 Cultural Competence and Rural America 13
3 Rural Americans 23
4 The Psychological Landscape of Rural America: Values, Culture, and Norms 42
5 Health in Rural America 55
6 Healthcare in Rural America 70

SECTION TWO
Ethics in Rural Communities 77

7 An Ethical Framework 79
8 Ethics in Rural Practice 84
9 A Road Map for Managing Ethical Dilemmas in Rural Practice 90

10 Dual Roles, Multiple Relationships: No One Is a Stranger Here 107

11 Confidentiality and Privacy: Small-Town Secrets 121

12 The Generalist: Competencies and Necessity 128

13 Life as a Rural Clinician: Isolation, Impairment, and Self-Care 135

SECTION THREE
Innovations and Opportunities: Practical Applications in Rural Communities 149

14 Clinical Practice in Insular Communities 151

15 Recruitment and Retention 154

16 Defining Rural Mental Healthcare 159

17 From Collaboration to Colocation: Integrated, Whole-Person Care in Rural America 173

18 Telehealth: Advances, Advantages, and Limitations 180

19 Creating a Culture: Decreasing Stigma, Increasing Wellness 188

Closing Thoughts 191

Appendix: Recommended Readings and Resources 193
Index 195

Figures

1.1 US Counties and County Equivalents 8
3.1 Rural Lands in America 23
3.2 Poverty Rates by Region and Metro/Nonmetro Status, 2013–2017 27
3.3 2015 American Deprivation Index 29
3.4 Race and Ethnicity in Rural and Small Town America, 2010 30
3.5 Mortality Disparity Rates: American Indian and Alaska Natives, 2009–2011 36
4.1 Rural Values 42
4.2 Urban-Suburban-Rural Divide in Politics 47
5.1 Illicit Drug Use 58
5.2 Suicide Rates, by Sex and Age Group, United States (1999–2017) 61
5.3 Age-Adjusted Suicide Rates by Urbanization Level, United States (1999–2017) 62
5.4 Factors Contributing to Suicide 66
7.1 Professional Behavior 82
7.2 Ethical Guidelines 82
8.1 Primary Ethical Issues in Rural Mental Healthcare 85
9.1 Resolving Ethical Dilemmas 94
9.2 The Nature of Ethical Dilemmas 96
10.1 Types of Multiple Relationships 108
10.2 Multiple Relationship Flow Chart 111
10.3 Multiple Relationships With Client B 113
11.1 Small Town Woes 121
13.1 Essential Elements of Self-Care 140
16.1 Peer-to-Peer Service Requirements 166

Foreword

Individuals living in rural and remote regions are known to face significant and challenging barriers to treatment and, consequently, experience higher rates and complexity of both physical and mental health disparities. With ever-increasing national attention on substance use and mental health issues in rural America, the call for improved access to quality mental health services in rural and remote settings has been shouted loudly across our nation. This call climbs from the depths of valleys, over mountains, and across plains, hoping to fall upon the ears of competent, committed, and compassionate mental health practitioners.

Rural residents deserve the same quality and evidence-based treatments available to individuals living in more urban settings but are often isolated from such services. Workforce development issues in rural areas are well known and include insufficient cultural competence, recruitment and retention barriers, challenging practice and practical issues, and clinical and ethical nuances that can add to professional isolation, stress, and burnout. Unfortunately, psychology as a field has historically exhibited an inequity in education and research when it comes to rural psychology training and expertise. Knowledge gained from clinical psychology research and education has historically been obtained from information discovered in more urban settings, which often cannot consistently be applied in rural contexts. Rural communities need expert rural mental health champions to advocate for the needs of these typically underserved populations. All these issues are thoroughly addressed in this book.

Few clinical psychology or other mental health training programs offer rurally focused training to meet the needs of rural, remote, and underserved communities. It is this author's mission to provide culturally specific expertise to supplement generalist training for those either considering entering, or attempting to maintain, a successful rural practice. Without a sustainable rural mental health workforce, the needs of rural communities will never be met. With the right expertise and support, psychologists and other mental health professionals are well equipped to work together and build practices that can reach into valleys, across plains, and over mountains to meet those most in need right in their own communities.

Mental health practitioners who are a good fit to answer the call to rural practice are passionately invested in serving the underserved, have or will develop a clear and deep understanding of rural living (including the beauty and hardship that can be characteristic of that life), and are resilient and tolerant of the ambiguity and challenges that can be inherent in rural practice. If a rural mental health practice is to be successful, it must be designed in unique ways that truly meet the specific needs of each rural community; must balance the implementation of evidence-based practice while translating those services to the specific needs of rural patients or clients; and should integrate provider-focused interventions to address practitioner wellness, burnout, and sustainability of service.

This book effectively and thoroughly addresses the aforementioned aspects of rural practice. The author inspires learners, practitioners, trainers, supervisors, and administrators to answer the call and address the inequity in rural mental healthcare by equipping mental health professionals with the insight, knowledge, and skills needed to build sustainable and culturally relevant mental health practices in rural and remote settings. From a personal and professional point of view, the author offers uniquely engaging, practical, and interactive guidance on the diverse and complex issues that arise in rural practice while passing on the skills and perspectives needed to infuse resilience and commitment into a sustainable and successful rural practice. This book offers a more intimate and experience-based perspective to the already-growing knowledge base that offers guidance to rural mental health professionals. This author goes further by providing specific scenarios and evidence-based recommendations for navigating the nuances of rural practice.

As a psychologist who has dedicated my entire education, training, and professional career to rural mental health practice, research, teaching, and administration, I am motivated and inspired by the idea of the potential improvements this book may contribute to the rural mental health workforce. I have observed trainees and early career rural practitioners struggle with the very issues addressed in this text. I am confident that after reading this book, rural mental health students, trainees, practitioners, educators, and administrators will be better equipped to answer the call of rural mental health practice with enhanced courage, compassion, and creativity.

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Author's Note

In early 2020, while this book was in press, a global pandemic—caused by a novel coronavirus—swept through the world. One of the primary responses used by communities to stop the spread was known as social distancing. Since the virus spreads through droplet transmission, scientists encouraged people to stay in their homes whenever possible and avoid public places. Many therapists, psychologists, and social workers, in a matter of days, closed their offices and pivoted to telehealth.

In Chapter 18, I combined my personal experience, colleagues' anecdotes, and research to write about the practice of telehealth. In the months since I wrote that chapter, much has changed, some of it, perhaps, forever.

Today, May 5, 2020, I operate a fully telehealth practice. Like many practitioners in the United States, and globally, in the spirit of observing the scientific community's recommendations, I have not sat in my office with a client in over seven weeks. I have conducted all of my recent therapy sessions, weekly consultations, and supervision meetings through face-to-face video conferencing, and have supported my staff in the abrupt transition to working from home. I have read countless articles and engaged in dialog with colleagues near and far. I humbly share what we have learned.

All told, it is hard to connect over video conferencing. I mean this in two ways. First, as rural providers, several members of my team have struggled with the reality that our home internet is insufficient for the heavy requirements of a secure telehealth platform. The same is true for our clients. It has not been uncommon to experience significant delays, buffering issues, and a phenomenon one client describes as "robot head," where the poor connection results in my face becoming distorted and pixilated on the screen. One of my therapists informed me that three weeks into using telehealth exclusively a client asked, "Have none of your other clients mentioned how blurry you are?" Several providers in our clinic live rurally and have faced significant connectivity issues resulting from the lack of broadband internet access in our region. Our clients are no different. We have resorted to phone calls, typically not covered by insurance companies (though they have made exceptions during this time), as a means of remaining in touch with our most remote clients and those who do not have wifi at their homes. Several clients have simply dropped off, indicating that they will return for therapy when in-person sessions become available once again.

Second, as many writers before me have surmised, face-to-face video conferencing is a close approximation but most definitely not an exact replica of in-person contact. Video delays, screen blurriness, and computerized voices all confound our unconscious processing, making it hard for our brains to pick up on the subtle cues of the human experience. Mirror neurons seem to have a hard time functioning in such situations. I may miss a wince or mistake a blur in the screen for a tear. These oddities of virtual connections may short circuit my neural connections, making it hard for me to empathize. Even with the best internet connection, we miss body language and the felt sense of a person in the room, and our brains must work harder to perceive the same amount of data we might get when sitting with someone. My clinicians report greater fatigue, a decreased sense of fulfillment, and a lot more frustration with their work.

Ironically, I have found (and this is anecdotal, of course) that individuals with more avoidant attachment styles have fared better with telehealth. Clients have reported that whereas they may feel tremendously vulnerable and exposed during an in-person therapy session, they feel a bit more protected in a telehealth session, which actually enables them to open up more. I have yet to come across any research regarding attachment styles and telehealth outcomes, but I suspect it would be interesting.

Since the pandemic hit, I have personally completed three new intakes for clients seeking therapeutic services. I initially believed it would be hard to build rapport without actually sitting face-to-face with a client but have found it to be far less challenging than I had imagined. The thing that I have learned, however, is that because subtleties are harder to notice through video conferencing means, I have found our work remains in the realm of the presenting problems and have found it harder to dig into the meatier clinical material that I know lies just below the surface. The one exception, I will note, is with a new couple I started seeing a few weeks into the pandemic. Perhaps because they are in the same room, it seems easier to note their interpersonal dynamics, and I am able to pick up on subtleties better than with individual clients.

Despite this one small victory, more generally, it has proven very difficult to serve children and families through telehealth. Our practice was roughly 25% children and families prior to the shelter-in-place orders that led us to close our offices. During the pandemic, the percentage dropped significantly, with only one in five families choosing to continue services remotely. Much of our work with children is focused on play, art, sand-tray manipulation, and bibliotherapy, and many of these modalities are difficult, though not impossible, to recreate in a telehealth session. While telehealth platforms may create barriers to engagement with children, it also opens up new possibilities, such as allowing children to show their therapists exciting or interesting things in their homes. I have gotten to actually be in one of my client's safe spaces, which is a nook in her bedroom closet that she has arranged, with the help of her parent, based on our work together. I have also had the insight afforded by overhearing casual conversations in the household in which my child lives or seeing his home. In the past, our fields have debated whether or not it is ethical to research our clients on the internet; now we must decide what to do with the information inadvertently gleaned from our video conferences.

While this is incredibly true for children (whose therapy sessions may make the provider nauseous, given the sudden and continuous movements of the camera held by the little one), it also holds true for adult clients who may provide their therapist with information about themselves without realizing it. Colleagues have met their client's children when they barged into the room and piled on their mother. I have been "in bed" with clients who have been too depressed to emerge from their cocoons for our sessions. Sessions have become incredibly intimate, with the details no longer just found in the words spoken but also available in the backgrounds observed.

While clients seemingly have less privacy over what they reveal, so too does the therapist. Initially, I set up a makeshift home office in our small house in the guest room, with a blank wall behind me and my computer propped up on a couple of old research textbooks. I soon realized that the blank background was, as one client called it, "creepy," and hung some non-descript photographs. The therapist who I see for my own self-care sits in front of a bookshelf displaying photos of people I can only assume are her children. What's more, it can feel as if my clients are in my home, which, depending on the countertransference, can feel safe, neutral, or threatening and quite troublesome.

Privacy is not only compromised by the presence of the therapist in the home of the client and vice versa, but also for the client who may struggle to find a safe space to speak without being overheard. I have had clients sit in their cars for the entire therapy hour and others bundle up in blankets so that they can sit under a tree in their yard. Still others have driven to our office and sat in the parking lot so that they might not only have privacy but also the sense that they actually "went" to therapy. One of my providers set up an office in her camper to ensure her small children wouldn't interrupt her therapy sessions. Meanwhile, my colleague, who works largely with victims of domestic violence, has noticed a significant decline in new client calls because the victims are no longer able to separate from their abusers long enough to safely and securely access help.

Domestic violence victims are not the only group experiencing difficulties accessing services. Mental health professionals who routinely perform evaluations and assessments largely ceased providing such services at the onset of the pandemic. While distributors of testing materials scrambled to provide online access and virtual administration methods, most professionals agreed that the normative data, which is almost entirely based on in-person administration methods, does not support the use of telehealth and testing through virtual means, and the validity and reliability of the resultant findings may be called into question. That has meant that individuals seeking disability determinations and requiring an evaluation, courts waiting to make decisions on sentencing, those needing presurgical screens, and families hoping to finally understand if their child has autism or ADHD or anxiety have had to wait.

Obviously, the sharp pivot to telemental health gave providers and clients little time to prepare. Further, the heightened levels of anxiety and distress caused by the pandemic have likely tainted our experience of virtual therapy, serving as a confounding variable in this informal assessment of efficacy and comfort. All of that said, during this time of great uncertainty and cultural change, we have learned a great deal about what it means to provide services remotely. Nearly every professional reading this book, I suspect, will have tried telehealth for themselves. Despite the frustrations or resistance, we, as a profession, have shifted, rather seamlessly, to this virtual model. We have continued to provide services and have demonstrated the ability to reach those who cannot step into our offices. While we have perhaps swapped physical accessibility issues for technological accessibility issues, we have certainly demonstrated our ability to provide services to those who cannot step into our offices. We may not like it and it may prove challenging for those in rural reaches with poor connectivity, but we now, as a collective profession, have no lingering doubt that it is possible. It remains to be seen, however, what we as a society will carry forth from this time. Perhaps more urban providers will extend their service reach to rural communities and telehealth will continue to break down the traditional barriers of accessibility. And, based on what we learned during the global pandemic, we as a profession will face new obstacles to connectivity and access, including those I have referenced here and many, I suspect, we have yet to understand. I trust we will rise to the challenge, though, I must admit, I am very much looking forward to sitting with my clients, in person, again soon.

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Introduction

> There are some significant differences in factors that affect rural people's mental health, as well as in the manner in which we can most effectively provide mental health services to them. It is not only psychologists working in rural areas who need to attend to the differences, since rural people are often referred to urban areas for secondary and tertiary health care. If you work in a large medical center or a specialized psychology service, you are likely to assess and treat people from outside your city.
>
> (Slama, 2004, pp. 9–13)

The mountains fill the horizon on the drive from Browning to Babb on the Blackfeet Indian Reservation in Northwest Montana. The snowy, jagged peaks of Glacier National Park are like a beacon in the distance, in direct contrast to the dreary isolation on the periphery. Stray dogs and free-range cattle occasionally command the driver's attention; their focus, suddenly pulled back to the present landscape: trailer home roofs layered with old tires (a strategy for combatting the ever-present wind that whips down from the mountains and clears the prairie all the way to Minnesota); the plastic bags stuck to deteriorating fence posts, thrashing against the breeze; slender horses grazing on grass struggling to grow in the infertile soil. I was 20 when I first drove this stretch of highway, simultaneously rattled by the despair and awed by the beauty.

The distance to Babb was profoundly far, both physically and metaphorically, for me. I grew up in a suburban area just beyond the limits of one of the largest cities in the country. I was living there when my father died, and my mother, struggling with her own despair, dutifully brought me to see a therapist (Joan) who aimed to help me with my grief. Ineffective and perhaps inexperienced with childhood grief, she somberly explained to my mother that there was little known about childhood grief and how to treat it. After a few sessions, we stopped going, the grief unresolved, my pain combined with shame and hopelessness. Some years later, at a conference in New York, just 30 miles from my childhood home, I met a therapist in her 60s who had been working with childhood grief for nearly 40 years. She and I had lunch, and she explained that my therapist was mistaken; they (the collective psychological helpers of the day) did know and understand childhood grief and had been implementing best practices for decades. Somehow, Joan was uninformed or ill equipped and my connection to her—a fluke of a referral made by a caring friend of my mother's—destined me to enduring pain that I would only come to resolve in my 20s. My heart sank with the overwhelming awareness that if I had had access to a different professional, if my mother had driven west toward Manhattan instead of east toward Joan's office, the course of my grief—my life—might have been different. Profoundly different. Though I grew up in a populated suburban region with access to a wealth of cultural experiences and opportunity, by chance, I simply did not get the very thing I needed. Years later, when I would move to an Indian reservation in Northwest Montana, the realities of this hit me hard: there were places in our country, even in an era of Google and Uber, where it wasn't simply about not finding the *right* therapist; it was about there being no therapist at all. Of course, this anecdote not only fueled my journey to become a competent and skilled therapist but is also at the heart of my passion to ensure equity in accessibility of mental health services, regardless of where someone lives, who they know, or what their health literacy status is.

Indeed, the town of Babb, Montana, my landing point after launching from the New York suburbs as a college student, has no mental health workers. Provider density is usually proportionate to population density, and so we simply see more providers living in suburban and urban areas. The proportions, however, are not equivalent, and those living in rural landscapes have even less access due to provider shortages. Utilization issues are not limited to numbers alone. Stigma, values, and other cultural factors influence the availability and acceptability of mental health treatment usage. Further, those providers who have elected to practice in a rural area face numerous threats to efficacy and sustainability, including inadequate training, burnout, and limited resources.

By the end of this book, you will know what is required of you to become an ethically sound provider of services to rural populations. Ethical service provision requires practitioners to develop and maintain cultural competence and understand and apply their ethical codes of conduct in such a way as to assure virtuous action and individualized care (Allen-Meares, 2007). Perhaps you are an individual provider living in, or aspiring to live in, a rural community; an urban-based provider exploring or expanding telemental health services to rural areas in your state; or a graduate student aiming to become culturally and ethically competent with this unique but heterogenous cultural group. As you may know, or will quickly come to learn, the need is tremendous, and our training often overlooks rural Americans as a culturally distinct group worthy of our attention, internships and fellowships rarely occur in rural communities (Association of Psychology Postdoctoral and Internship Centers, n.d.), and rural America is frequently neglected on the whole (Wuthnow, 2019).

Despite rural Americans making up nearly 20% of the nation's populace, they remain an under-studied, misunderstood, and underserved group (Smalley, Warren, & Rainer, 2012). Though struggling at rates similar to their urban counterparts, rural Americans receive services with significantly less frequency (Rural Health Quarterly, 2017), and rurality is often associated with poorer overall psychological outcomes (Reschovsky & Staiti, 2005).

Most professionals also do not receive training in cultural competence—the ability to understand, appreciate, and interact with people from cultures different from our own (DeAngelis, 2015)—as it pertains to rural Americans. As Slama (2004) beseeches us, it is our task—as psychologists, social workers, psychiatrists, mental health counselors, and researchers—to get to know rural America and, ultimately, to serve them well.

Of course, rural America—including, but not limited to, the idyllic rolling hills of Southern Appalachia, the cornfields of the Midwest, and the rugged desert of the Southwest—is a diverse place. It is homogeneous neither in its landscape nor in its peoples. It is beyond the purview of this book to provide you with all you need to know about each subset of the rural population to adequately ensure your cultural competence. Rather, I aim to have this book serve as a foundation for knowledge upon which each of you, based on your locale and your clientele, can build a culturally competent and ethical practice. Drawing on my own experience in the Rocky Mountain region, I hope to provide you with a sense of what culturally competent practice looks like in rural America and some recommendations for deepening your own.

With a heightened awareness of the cultural elements that make rural Americans unique, we will then move to a discussion of ethical challenges unique to, or amplified by, rural practice.

Finally, we will review the various barriers to the more equitable provision of rural services and solutions to the problem of rural access in the spirit of ensuring that this long-underserved group may finally begin to gain some traction.

In this book, I aim to educate those who might be working with rural Americans in the spirit of improving the mental wellness of a marginalized and at-risk group. Follow me as I wander down the country roads, belly up to bars in Podunk towns, and meet the locals on an Indian reservation. By the end, I suspect you will agree not only that rural Americans are an overlooked minority worthy of your attention, but also that it is your ethical responsibility to serve them.

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Section One

Rural America