

Rural Mental Health Clinician Self-Care:

A Qualitative Study

By Jennifer Elizabeth Stroup

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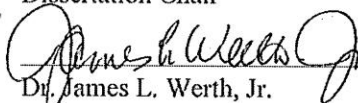
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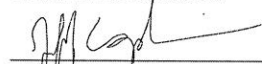
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Abstract

Mental health professionals search for ways to best balance self- and other-care. Rural practitioners face a number of challenges including dual relationships, a lack of clinician privacy, lack of resources, client poverty, and limited referral options. Self-care has been identified as an ethical imperative to maintain clinician wellness and avoid impaired professional competence. Traditional recommendations for self-care strategies include limiting scope of practice, seeking consultation/supervision, and obtaining personal treatment. The current qualitative study used grounded theory to explore whether these traditional recommendations are feasible for the rural clinician faced with the above challenges. Eight mental health professionals providing services in rural areas participated in semi-structured interviews followed by discussions of commonly recommended strategies for practitioner self-care. The therapists discussed common challenges and opportunities associated with rural practice; self-care strategies were noted to be unique to the individual, with commonalities found across clinicians. Participants highlighted the importance of having multiple strategies in addition to using support systems and available resources. Barriers to self-care included finances, distance and travel, and lack of available resources. They reported that strategies of personal therapy and reducing client load were of limited utility. Personal therapy required traveling to avoid dual relationships, thus costing them additional billable hours to attend sessions. Reduction in client load would require some participants to switch to part-time or risk not meeting contract agreements. In communities with limited therapists and great need, these solutions may not be workable. Results suggest rural clinicians engage in self-care using strategies that differ from the traditional recommendations.

Keywords: rural, self-care, distress, practitioner, qualitative

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Chapter 1¹

Mental health practitioners are asked whether or not it is possible to find and maintain a balance between caring for oneself as a practitioner and an individual while simultaneously meeting client needs. According to Maslach and Goldberg (1998), one must care for oneself before being able to care for others. Multiple articles have been written on the topic of clinician self-care and have been included in the ethics, burnout, distress, impairment, and trauma literature. Barnett, Johnston, and Hillard (2005) emphasized that the virtues that underlie the various mental health ethics codes include the idea that practitioners engage in self-care to minimize risk of harm to clients. Distress, burnout, compassion fatigue, vicarious traumatization, and impaired professional competency are all considered potential consequences of failing to properly engage in self-care (Alterman, 1998). Furthermore, the answer to the question opening this paragraph might be different based on whether a clinician is practicing in an urban or a rural area. Clinicians who practice in rural areas are expected to be generalists because they are likely to be the only mental health professional in an entire community (Bushy & Carty, 1994). With limited referral options, practitioners may be repeatedly faced with ethical dilemmas such as multiple relationships and pushing the boundaries of their competence, thus creating additional sources of stress (Werth, Hastings, & Riding-Malon, 2010). This research examined the self-care practices of rural clinicians to determine whether barriers to traditional self-care recommendations existed.

¹ Per the guidelines for dissertations provided in the Psy.D. Student Handbook, Chapter 1 of the dissertation is to be prepared as if it were a manuscript to be submitted for publication. The target journal will therefore influence the way Chapter 1 is structured. I anticipate submitting the manuscript to *Professional Psychology: Research and Practice* and this journal requires manuscripts to be prepared in a different format from typical empirical journals (see <http://www.apa.org/pubs/journals/pro/writing.aspx>). As a result, this Chapter will read differently than a manuscript prepared for a traditional empirical journal.

Rural Mental Health

“The vast majority of all Americans living in underserved, rural, and remote areas also experience disparities in mental health services” (President’s New Freedom Commission on Mental Health, 2003, p 50). The 2010 U.S. Census reported that 19.3% of the total United States population resided in areas that were designated as rural. According to LoPresti and Zuckerman (2004), approximately 55 million Americans live in rural areas with 60% of those rural areas being underserved by mental health care providers.

Compared to urban centers, rural communities tend to have scarcer resources, higher rates of poverty, and more limited job opportunities (Curtin & Hargrove, 2010). Evidence also suggests the prevalence of social and health problems is greater in rural areas; these include increased rates of illiteracy, a lack of pursuit of higher education, minimal or inadequate health services, higher rates of disabilities, fewer available mental health services, as well as limited insurance coverage (Helbok, Marinelli, & Walls, 2006). Basic community services important to the provision of optimal health care such as communication systems, transportation, electricity, and clean municipal water may not be available in isolated rural areas (Roberts, Battaglia, & Epstein, 1999). When funding is available, characteristics such as geographic isolation, population spread across large distances, and a lack of public transportation make the provision of services challenging from a practical standpoint (Roberts et al., 1999).

Available resources are only one component of rural living. Individuals residing in rural areas tend to have some commonly established cultural norms. They are believed to have increased religiosity, to be more politically conservative, less tolerant of nontraditional beliefs, and oriented toward a strong work ethic (Bushy & Carty, 1994). Relationships among community members are considered to be interdependent and complex with deep social,

historical, family, and political roots (Helbok et al., 2006). As such, members often play multiple roles, rely on each other and their family ties, and exhibit a distrust of individuals from outside the community (Curtin & Hargrove, 2010). Further, stigma regarding mental illness and treatment is not an uncommon facet of rural life (Hastings & Cohn, 2013).

An outcome of the above is the difficulty in the recruitment and retention of a multitude of health professionals (LoPresti & Zuckerman, 2004). Approximately 85% of 1,669 federally designated Mental Health Professional Shortage Areas (MHPSA) are located in rural areas (Bird, Dempsey, & Hartley, 2001). A study by Holzer and colleagues (2000) found that the ratio of providers, including psychiatrists, psychologists, and clinical social workers, to the population worsens as rurality increases. Rural residents must therefore travel substantially further distances to access a mental health provider (Mohatt, 1997). The challenges faced by the rural community members translate to considerations for the mental health clinician.

Practitioners working in rural areas face a number of challenges and ethical issues (Schank & Skovholt, 2006), particularly those related to multiple relationships (Curtin & Hargrove, 2010; Schank & Skovholt, 2006). For example, incidental encounters with clients outside of the office are a common occurrence (Curtin & Hargrove, 2010; Hastings & Cohn, 2013). Therefore, boundaries should be wisely managed in order to prevent harm to the client, thus creating an additional source of stress on the rural practitioner (Werth et al., 2010). As a result of practitioner visibility in the community, issues around client confidentiality as well as the potential for clients to know information about the personal life of the psychologist are common (Helbok et al., 2006; Schank & Skovholt, 2006). Although being known in the community is often a challenge, it also provides the opportunity to increase client confidence in

the provider through the transparency of the provider's values, reputation, and commitment to the community (Bradley, Werth, Hastings, & Pierce, 2012).

Hastings and Cohn (2013) conducted a mixed methods study expanding the literature regarding the perceived challenges and opportunities associated with rural practice. They identified some of the common difficulties, including intrusions into privacy, lack of resources and funding, insufficient compensation, an inability to freely express divergent opinions, suspicion associated with "outsiders," limited convenience, lack of after-hours emergency care, and limited professional opportunities. Results from their study of 123 rural practitioners indicated that those individuals best suited to work in rural areas would have strong boundaries, a sense of self, and would value autonomy. Additionally, to continue to recruit and retain rural clinicians, facilities would best be served by providing access to appropriate supervision/consultation, diversity in work tasks, and opportunities to engage in self-care. To meet the needs of the community, rural practitioners need to be generalists and may be expected to work with individuals of all ages and with a wide range of problems (Hastings & Cohn, 2013). Knowledge of the resources in the community (Bushy & Carty, 1994) and cultural sensitivity (Helbok et al., 2006) can help a clinician to meet the needs of their clients. Additionally, practitioners may utilize existing resources such as kin, churches, and other nonprofessional supports in treatment planning (Helbok et al., 2006). The professional demands on rural practitioners are potentially endless; therefore limits on their practice must be set to avoid burnout (Bushy & Carty, 1994).

Although these challenges may seem daunting, rural practice also can have significant benefits and opportunities. Rural clinicians are frequently generalists, providing for variety in client presenting issues, in addition to the opportunity of autonomy as a practitioner (Hastings & Cohn, 2013; LoPresti & Zuckerman, 2004). LoPresti and Zuckerman (2004) highlighted the

possibility of gaining a sense of mission from being one of the only providers available for a given area. Congruence with beliefs and values, a simplified lifestyle, a slower pace, and decreased overall cost of living expenses are additional rewards of rural life (Hastings & Cohn, 2013). Professionals working in rural areas often support one another through the use of interprofessional collaboration (Bradley et al., 2012; Hastings & Cohn, 2013). Finally, as a result of many rural areas being identified as MHPSAs, a number of financial incentives exist through the government for setting up practice in a rural area (National Health Service Corps, 2010; Hastings & Cohn, 2013).

Clinician Distress

Mental health professionals are committed to caring for others and often get substantial satisfaction from this work (Wise, Hersh, & Gibson, 2012). However, this feeling of satisfaction is not always enough to buffer against the numerous stressors encountered daily (Wise et al., 2012). Clinician distress is widely discussed in the mental health literature. The American Psychological Association Board of Professional Affairs Advisory Committee on Colleague Assistance has developed a stress-distress-impairment continuum for psychologists (ACCA, n.d.). Along this continuum, they describe the definitions of each of the stages in the cycle and provide examples. The continuum starts with stress followed by distress then impairment and finally improper behavior. According to the ACCA, stress is experienced by all at different times throughout their lives. The committee emphasized that occupational vulnerabilities associated with the profession of psychology must be managed. Psychologists have an ethical responsibility to care for themselves in the face of occupational stresses such as fighting stigma, decreasing financial rewards, repeated exposure to the suffering of others, and careful maintenance of boundaries with clients, just to name a few. Distress, in this model, refers to an

experience of intense stress that is unresolved, resulting in distraction. The ACCA reported that the distressed individual may have difficulty sleeping, experience changes in appetite, or have obsessive thoughts about the stress.

The next step in the stress-distress sequence is impairment. Impairment compromises the professional functioning of the practitioner to a degree that may be harmful to a client or result in ineffective services. Impairment is a condition for which the psychologist is encouraged to seek services. Although impairment does not equal improper behavior, the risk of inappropriate, unethical, or illegal behavior is increased. It should be noted that being at one point of the continuum does not necessarily indicate that the individual will progress to the next more severe stage (ACCA, n.d.). Burnout is not mentioned along the continuum proposed by the ACCA; however, based upon the descriptions provided, burnout would likely fall between the distress and impairment stages.

According to Rupert and Kent (2007), the most commonly used definition of burnout is that of Maslach and Jackson (1986), which states that burnout is an “emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who ‘do people work’ of some kind” (1986, p. 1). Although burnout is a highly individualized syndrome, commonalities remain. Some of the most cited reasons for the onset of burnout are low salaries, demanding schedules, shift work (Rupert & Morgan, 2005), a lack of financial resources, and low social recognition (Jenaro, Flores, & Arias, 2007). Burnout can also be predicted by the way in which clinicians react to job demands, or their use of personal resources (Jenaro et al., 2007).

Grosch and Olsen (1994) summarized the burnout literature with a comprehensive list of the various symptoms (see also Farber, 1990; Maslach & Goldberg, 1998; Stevanovic & Rupert,

2004). They broke down the symptoms into four overarching categories of physical, psychological, spiritual, and behavioral symptoms. Physical symptoms might include irritability, gastrointestinal problems, physical depletion and fatigue, back pain, headaches, weight loss, and trouble sleeping. They listed psychological features such as feelings of depression; an increasingly negative self-concept; a sense of emptiness; and negative attitudes toward life, work, and other people. Additional symptoms might include guilt, self-blame for clients not improving, or having a sense that, as a practitioner, one is incapable of mistakes. Grosch and Olsen added that a person suffering from burnout could exhibit spiritual symptoms such as a loss of faith, meaning, and purpose. There could be feelings of despair, low spirits, alienation, isolation, as well as a crisis of values. Other spiritual features might include a lack of vitality, courage, or inspiration. Behavioral symptoms included the clinician not coming to work, coming late to work, accomplishing very little despite long hours at work, experiencing a loss of enthusiasm, short temper, boredom, becoming increasingly rigid, and having difficulty with making decisions. Interpersonally, the symptoms might encompass a clinician's withdrawal from colleagues, refusal to listen to new input, and experiencing and showing increased irritation with coworkers. Finally, a clinician might use substances such as alcohol, drugs, or other means of anesthetization to handle the burnout. Coping skills are a key element in the amelioration and prevention of burnout (Jenaro et al., 2007), with self-care being a vital piece of the process.

Self-Care

Mental health professionals are constantly walking a fine line attempting to find a balance between other-care and self-care. However, giving of oneself can often be the requirement for success in the human service fields (Skovholt, 2001, p. 4). Maslach and Goldberg (1998) emphasized that one must help oneself before helping others. A practical

example of this is when flight attendants instruct passengers to place the oxygen mask on themselves before helping others.

The discussion on clinician self-care originated within the psychoanalytic movement, particularly with regard to countertransference (Alterman, 1998). Countertransference can be a confusing concept, because a therapist's reactions can be either a help or a hindrance to the therapy process (Alterman, 1998). Basically, if countertransference feelings go unrecognized, they can potentially have damaging effects on the client, therefore therapists must determine how to use those feelings for the benefit rather than the detriment of the client (Cerney, 1995). Davis (1991) emphasized that personal therapy for the clinician allows for self-exploration and identification of blind-spots to avoid interference in client work. When clinicians are engaged in personal therapy, they increase their own capacity to focus on their clients, and ensure clients are not called upon to meet the needs of the clinician (Fromm-Reichmann, 1960). Countertransference is but one way to consider a need for clinician self-care with personal therapy being the recommended strategy.

Apart from the countertransference literature, clinician self-care also has been identified as an ethical imperative related to preventing impaired professional competence (Alterman, 1998; Barnett, 2008). Clinician self-care is viewed as one way to protect clients from unethical behavior that can arise from clinician distress (Smith & Moss, 2009). Barnett and colleagues (2005) pointed out that all mental health professionals must adhere to various ethics codes, each of which is based upon a series of underlying principles:

beneficence or the duty to do good and help others; nonmaleficence, the obligation to minimize harm in all actions we take as professionals; fidelity, the need to carry out and fulfill our professional obligations to those to whom we provide services; autonomy, the

goal of promoting the independence of those we serve and not taking any actions that would increase their dependence on us; justice, the obligation to afford all individuals the opportunity for equal access to the same high quality treatments; and self-care, the obligation to adequately attend to our own healthy functioning. (p. 258)

The APA Ethics Code (2010) in Principle A: Beneficence and Nonmaleficence makes it clear that psychologists, trainees, and students must aspire to “be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work” (p. 3).

Furthermore, Standard 2.06 (a), Personal Problems and Conflicts, stated that practitioners have an ethical responsibility to “refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner” (APA, 2010 p. 5). Corrective action is mandated when such difficulties are present. Recommendations in the Ethics Code, Standard 2.06 (b) include limiting the scope of work, seeking consultation or supervision, or obtaining necessary treatment (APA, 2010; Barnett & Cooper, 2009). Research has shown that clinicians are at risk for distress, impairment of professional competency, and burnout. As these can affect clinical work in a negative way, self-care must be viewed as a way to practice ethically (Barnett et al., 2007; Richards, Campenni, & Muse-Burke, 2010).

The literature carries a number of recommendations regarding ways for a clinician to engage in self-care, and to work to prevent or counteract distress. There are entire workbooks devoted to the topic of practitioner self-care (e.g. Brady, Norcross, & Guy, 1995; Grosch & Olsen, 1994; Kottler, 1999; Rothschild & Rand, 2006). One of the recommendations is for the clinician to engage in supervision and consultation, as this process can help counteract professional isolation, restore communication, provide reality testing, normalize responses, and

build ongoing professional support systems (Arledge & Wolfson, 2001). Other recommendations include diversity in professional roles, self-awareness, maintaining a balance between one's work and professional life, finding time to rest, and participating in a variety of activities that one finds personally replenishing (Arledge & Wolfson, 2001; Barnett et al., 2005; Grosch & Olsen, 1995).

Once distress is experienced, more specific strategies have been identified, including individual therapy (Coster & Schwebel, 1997; Stevanovic & Rupert, 2004), family therapy, reducing client load, taking a leave of absence, medication (Guy, Poelstra, & Stark, 1989), problem focused coping (Murtagh & Wollersheim, 1997), spending time with spouse or partner (Rupert & Kent, 2007), spending time with colleagues (Kramen-Kahn & Hansen, 1998), physical exercise (Mahoney, 1997), and engaging in leisure activities (Coster & Schwebel, 1997; Rupert & Kent, 2007). Self-care strategies will be specific to the individual, as no one model captures all the different possibilities (Wicks, 2008).

The responsibility to ensure personal wellness is one's ethical duty whether practicing in an urban, suburban, or a rural setting. And yet, it appears that corrective measures set forth in the APA Ethics Code (2010) to limit scope of work, seek consultation or supervision, or obtain necessary treatment, may not be sensitive to the challenges faced in rural practice (Helbok, 2003; Schank & Skovholt, 1997; Werth et al., 2010). The current study was guided by the desire to gain a better understanding of the self-care strategies used by rural practitioners, in addition to the barriers they may experience.

The Study

The qualitative method of grounded theory (Fassinger, 2005; Strauss & Corbin, 1998) was utilized to analyze interviews with eight participants from a Mid-Atlantic State (Appendix

A). Participants were recruited using purposeful sampling based upon inclusion criteria. The first was employment as a licensed Master's- or Doctoral-level mental health practitioner providing full time face-to-face client services. Clinicians in psychology, counseling, and social work were included. The second factor was that the practitioner had to be providing services in a rural or mixed-rural county as defined by Isserman (2005). Seven of the participants worked in a rural county, identified as having a population density less than 500 people per square mile and 90% of the county population is in a rural area, or the county has no urban area with a population of 10,000 or more. One participant worked in a mixed-rural county that did not meet the urban or the rural county criteria and had a population density less than 320 people per square mile.

Twenty-three themes emerged from the interviews. A theme was included if at least three participants (37.5%) endorsed the theme during the interview. Themes arranged by research question are included in Appendix B. Interview questions were developed based upon the existing literature and the researchers' observations of rural mental health professionals. The initial semi-structured interview served as a pilot to test the interview protocol. At the conclusion of the first interview, feedback was elicited from the participant to determine if changes to the protocol were necessary. Because no significant changes were recommended, the data from the pilot interview was included in the final analysis. The interview protocol is available from the authors.

Participant responses were categorized based upon the research questions examining the experiences of rural mental health practitioners to include the challenges and benefits; the ways rural clinicians are caring for themselves, their strategies and the consequences of not engaging in self-care; and barriers experienced with regards to self-care. The challenges and benefits of rural practice provided a context for exploring the self-care practices of rural clinicians, and

therefore are discussed first. This will be followed by an exploration of the self-care related questions. Additional themes that emerged following participant prompting and cross cutting themes not tied to a specific research question are explored last. All of the benefits and challenges of rural practice identified by participants have been discussed extensively in the rural literature, and therefore these sections will be limited. In the following sections, “P” is used to identify the participant being quoted (e.g., “(P1)” means participant 1 is being quoted). Additionally, within each quote the presence of brackets indicates the removal of a minimal encourager used by the interviewer, and ellipses were used to ease the readability of the quotation by removing extraneous words such as “umm” and repeated words.

Challenges of working in a rural area. Participants identified five themes related to the challenges of working in a rural area: travel and transportation concerns for clients (seven participants), being known in the community (six participants), poverty within the community (six participants), lack of professional resources (five participants), and combating the stigma associated with mental health (four participants).

The lack of reliable transportation in combination with long commuting distances increased client no-show rates. In discussing transportation and community poverty, one participant reported,

The whole ... indigent factor going on, you know people's vehicles, you can't get to services, they ...can't make their appointments...the number we have on file is some Tracfone they've bought at Wal-Mart, their minutes run out by the time their next appointment's here, can't get up with them [], then they no-show. (P7)

Being known in the community was problematic with regards to both clinician privacy and client confidentiality (Hastings & Cohn, 2013; Helbok et al., 2006). Being known also increased the

likelihood of incidental encounters, as described by one participant, “You go to the supermarket and you’re very apt to run into... patients and [] clients that you serve, and ... you want to respect their privacy” (P8). Curtin and Hargrove (2010) pointed out that incidental encounters outside the office are a common occurrence in rural communities. Additionally, stigma remains a troublesome reality for both providers and consumers of mental health treatment, consistent with recent research findings (Hastings & Cohn, 2013).

Benefits of rural practice. As noted by Bradley (2011), the literature often focuses more upon the challenges of rural practice and the benefits are minimized. Participants in this study discussed the benefits they find in rural practice. They endorsed three themes related to the benefits of rural practice: characteristics of rural communities and rural life (six participants); being known in the community (five participants); and being near family and family ties to the community (three participants). Participants reported these benefits as getting to live in a rural area with the nature and their families, enjoyment of the culture, and the opportunity to be a generalist. Although being a known entity was discussed as presenting challenges, some participants found being known to be beneficial. The benefits included the participant being able to provide a local resource, increased opportunities for referrals based upon one’s positive reputation, and being a part of the community. One participant provided an example of being a resource stating, “You’re serving people that really need your help... that need the services and otherwise they might not have access [] to those services, so there’s some sense of purpose behind that for me” (P6). A final benefit endorsed by three participants was that working in a rural area allowed them to be near family and honor their family ties. The importance of family ties is consistent with rural culture (Curtin & Hargrove, 2010; Helbok et al., 2006). This finding emphasized that rural providers are a part of the existing community.

Strategies for engaging in self-care. Participants endorsed six themes related to self-care strategies: specific strategies (eight participants), professional strategies (eight participants), utilizing one's support system (eight participants), maintaining a balance between personal and professional lives (seven participants), maintaining self-awareness of the need for self-care (five participants), and utilizing available resources (four participants).

The specific strategies utilized by each participant were among the strategies encouraged in the literature. Self-care is a highly individualized process (Wicks, 2008), as noted by the variety of methods endorsed. These strategies included physical exercise (Mahoney, 1997) and engaging in leisure activities that one finds replenishing (Coster & Schwebel, 1997; Rupert & Kent, 2007; Stevanovic & Rupert, 2004). Other strategies reported by multiple participants included faith and prayer; using relaxation, mindfulness, or meditation techniques; going out to lunch; reading for pleasure; maintaining flexibility in one's schedule; eating right; spending time with pets (Grosch & Olsen, 1994); and knowing that personal therapy is an option if needed. Professional strategies often included case consultation (Coster & Schwebel, 1997; Lee, Lim, Yang, & Lee, 2011; Stevanovic & Rupert, 2004) and continuing education (Coster & Schwebel, 1997; Stevanovic & Rupert, 2004). Continuing education trainings were used as a way to network with other professionals and build a professional support system (Arledge & Wolfson, 2001). As noted by one participant, "I usually do that [formal continuing education] at least once a year... and then as opportunities arise... I may go to a workshop here... And there's always networking... with other professionals" (P8). Even though participants identified these strategies as helpful, consultation tended to be informal and continuing education often required traveling, which continues to be problematic for rural practitioners.

Clinicians reported using their support systems such as family, friends, and colleagues in response to professional isolation. This is consistent with the rural literature (Hastings & Cohn, 2013; Helbok et al., 2006). Other participants spoke of setting aside family time, going out to lunch with friends, or engaging in physical sports as ways that they engage with and re-charge with their support systems. Maintaining a balance between personal and professional lives appeared especially relevant for rural practitioners who live and work in the same communities. As noted by several participants, there are always more clients to see and more work to do. Maintaining this balance has been identified as a strategy throughout the self-care literature (e.g. Coster & Schwebel, 1997; Grosch & Olsen, 1994; Rupert & Kent, 2007). Maintaining balance was described as challenging but necessary by one participant,

Yeah, it's a challenge, you know, setting boundaries. And sometimes I feel guilty, sometimes I feel lazy. []...After seven o'clock at night I would just want to go home and not do anything, watch TV, or something very mindless [], but you have to force yourself to do some continuing reading, or again, to get out...sometimes I have to make myself go to choir practice, or...to the youth group meeting, or ... make myself even go out to dinner with my husband, [] or set it up to go out with a couple of friends. I mean, but...it's like anything else, once you get there and do it, it's fun [], and the payoff is huge. (P3)

Preserving self-awareness regarding the need for self-care was another identified strategy. Participant strategies for self-awareness included meditation, relaxation, informal consultation with colleagues, paying attention to small changes within themselves, and reflecting on the interactions with clients. One participant spoke of her efforts to maintain self-awareness in order to prevent countertransference:

So you know in terms of in-depth self-care, I think it's essential to, I'm not saying, everybody has to meditate or do all that stuff, I think those are beneficial ways of doing self-care [], but... if you're going to not just be a technique therapist, but really be able to do some deep developmental work with people, you have to self-care and know when your issues are being triggered, and what's going on. (P2)

Self-awareness was described as a way for the clinician to know when self-care was needed.

One clinician, in discussing why self-care is needed, used the following metaphor,

I think everybody in my life is a Dixie cup and I'm a huge pitcher of water, and I'm pouring into them, but if I don't go back to the faucet... to the one that fills me, [] then I can't fill others up. And I have to keep full at all times, or I can't keep their little Dixie cups full. (P7)

The final self-care strategy that emerged during the interviews was the utilization of available resources. These included resources for exercising such as gyms and nature trails, staying healthy through check-ups with one's primary care physician, and belonging to professional organizations. One clinician expanded on using available resources,

I would say the Y...the colleagues here... I have professional colleagues in other places... so sometimes an email exchange with somebody...if I'm stumped for an idea about something. I've even emailed folks and asked NASW, I think it's a good resource.

The internet is a good resource. (P3)

Several participants commented on using a local gym or exercising outdoors, "Thankfully here in this beautiful town with no red lights...we have a new... sidewalk they just put in last year... so...when it gets warm... I walk around town at lunchtime...and...there is a local gym" (P7).

When participants were prompted with a list of strategies from the literature, additional discussion occurred. Many of the above strategy themes were strengthened. Additionally, two specific strategies of vacation (five participants) and listening to music (three participants) emerged, as did the professional strategy of diversity of professional roles (three participants). Participants then spoke of what happens if they do not use those strategies in an effective manner.

Consequences of not effectively engaging in self-care. Interviewees reported three themes related to the consequences of not effectively engaging in self-care: there is a change in the clinician (seven participants), there is a change within the client interaction (seven participants), and the clinician is not as effective in session with clients (six participants). The consequences of not effectively engaging in self-care are discussed extensively in the clinician distress literature (e.g. Farber, 1990; Grosch & Olsen, 1994; Maslach & Goldberg, 1998; Stevanovic & Rupert, 2004). One participant indicated she knew self-care was needed when,

I'm getting sick [...] I'm not usually a sick person, I mean I don't get sick a lot, but...if I'm having a lot of somatic complaints, or my back's hurting, or I'm actually missing work for being sick. I know something's askew and I've gotta pull back and...do some self-care. (P2)

Another participant indicated she gets overwhelmed if she does not get adequate sleep, "I have to draw a boundary and say I cannot go any further...without having more sleep" (P4).

Participants noted that there is a change in the interaction between themselves and the clients. One example of this provided by five of the participants was that the client might take on the role of checking in on the well-being of the clinician. For example, "if a client ever looked at me and said "are you unhappy, or...is something not right?" I would [...] feel

horrible...because, their responsibility is not to take care of me, that's my responsibility" (P3).

Another participant commented on balancing rural culture and boundaries,

I think [small talk with clients] helps establish that rapport, but you could bring too much into that [] interview and it becomes...counterproductive...for helping someone ... if I bring my own issues in here and pour them out...to the patient. Certainly if... I'm in a lot of pain, or whatever is going on with me, I'm not gonna be able to be present [] if I don't have a place for that already. (P8)

One clinician who also acts as a supervisor spoke of the potential boundary crossings that could occur when self-care was not effective. She stated, "The counselor and the client may become more friends than actually client and therapist [], and I've seen that everywhere... and the other factor to that, is that in their sessions, it's more of a friendship type" (P5).

The final consequence noted of not engaging in self-care was that the practitioner would not be as effective in session. Six of the clinicians spoke of this theme, with several talking of being distracted, "my mind's cluttered, I don't think as easily" (P1). The same clinician reported that she may not use the same techniques when she is overwhelmed, "it affects my...overall effectiveness and the techniques and strategies I might use... probably mostly 'cause of energy" (P1). Another commented that without proper attention to self-care she "wouldn't be fully present for [clients]" (P4). Clinicians identified numerous strategies for self-care and the consequences of ineffective use of those strategies. However, participants also noted barriers that they face when developing a plan for self-care.

Barriers to self-care. When asked about barriers to self-care, participants identified four themes: time and time management make it difficult to engage in consistent self-care (five participants), travel and distance required to take advantage of specific resources (five

participants), finances (four participants), and lack of local continuing education opportunities (three participants). One participant noted most of these themes when asked what barriers she encounters, “I think just time...and geography, and... money” (P4). One clinician, in discussing strategies she would like to use, reported, “my husband and I both work and... I probably consider us middle-class, but still spending money on a lot of the extra things, like a nice massage [...]...is just really out of the question right now” (P1). Similarly, another stated, “vacations, I don’t have the money for that” (P4).

Another clinician spoke of the lack of resources by reminiscing about a program no longer available in her area,

There was a one time a month...where we would go for lunch, and there would be somebody providing training...And that was great, because what that brought, there is no real forum for private practitioners in a rural area...this was...a place where people came together, and we’d share lunch and get trained in something, and have some discussions. I really liked that... we don’t have that anymore. I miss that...having local trainings is also a way for me to connect to clinicians in the area and find out what’s going on and what’s happening. (P2)

One participant mentioned the lack of resources in general, stating, “you have to build that along the way, kind of your resource packet [...]...your go to people, your go to things... ’Cause resources...are few [...] for professionals in... rural practice” (P8).

The barriers to self-care faced by practitioners in rural areas were expanded upon more fully when participants were prompted with self-care strategies from the literature. For example, formal consultation, supervision, and personal therapy were identified as unrealistic options for some due to finances, lack of other local professionals, and the amount of time and distance one

would need to travel to take advantage of those opportunities. Several participants spoke of being open to personal therapy if it was needed. However they stated they would struggle to find someone who could see them because of working similar hours, and that they would likely travel to someone outside of their network and referral sources. One participant explained this challenge,

I've never had personal therapy... I think... finances too would be an issue... I would have to be careful about who I chose because most of them know me, or my family, or whatever because it is such a small community, or it's somebody I refer to [] ... so then you have that role's boundary... I probably have to drive at least 45 minutes to get and then be picky there to find someone who wasn't part of a network [] that I might work with... or socialize with. (P1)

Another stated, "Personal therapy is hard to do because... they generally work the same hours that I do, and right now I don't have health insurance, which is... a barrier to my self-care. I can't currently afford health insurance" (P4). The gas money and time to be taken off work were additional barriers to this self-care strategy.

Four of the participants explained that reducing their client load is not a viable option for self-care. This was identified as being partially a result of the limited number of providers and the needs of the community. One participant stated,

That was the agreement... I negotiated that I would ... see 20-25 clients a week and that would be the service I was providing... but then you get in the midst of it, and the need, and... the pressure, you know from those working around you and the person you are working for...there's never a shortage of work. (P3)

Another description of this theme was,

Reducing client load, that's not gonna happen [...] The only way to reduce client load is to become part time. (P1)

Although reducing client load was not an option for some, three clinicians identified it as a strategy they could potentially use. For example one stated, "If you're overloaded and you're finding that it's impacting you that would be helpful" (P6). Thus, rural practitioners face obstacles to self-care, particularly when trying to use the recommendations from the APA Ethics Code (2010) of reducing client load, seeking consultation or supervision, and seeking personal treatment.

Cross-cutting themes. Two themes were identified that were not tied to any specific research question. The first theme generated by three participants is that self-care is a way for the clinician to be a model of healthy behavior for clients. One participant spoke of "practicing what I preach" (P2). This theme may have emerged as a result of the increased visibility of the practitioner in the community and would therefore be unique to rural practice. Further exploration of this theme is necessary to grasp how the rural culture links to the self-care practices of rural clinicians.

The second cross-cutting theme discussed by all participants was that individuals who wish to practice in a rural area need to have knowledge of the rural culture. When asked whether there was something that would have better prepared them for rural practice, several participants noted that having been raised in a rural area helped them to know and appreciate the culture. One participant explained, "I grew up... in the area, so I was... assimilated to the culture, as I grew up in it, I am the culture" (P1). Between the personal knowledge of what to expect in a rural community and the rural focus of their graduate programs, participants reported minimal unexpected situations. However, when they thought about someone coming into a rural practice

having not been raised in that type of community, there was overwhelming agreement that education and an understanding of the culture would be necessary. Several participants spoke of witnessing individuals from outside the area struggle with being accepted. A clinician who supervises students commented,

I think being from here...I knew what to expect... I supervise students that come into the practice... that are not from a rural community and...I see them struggle with clients who are not necessarily as open [] to someone who's different, a different color maybe, someone with a different...dialect...The rural communities are often very closed [] so, I think that's probably what has made me... more accepted in the rural community as a practitioner, because I'm from here [] I sound like they do, and...I have common interests...I grew up like many of them grew up. So we have that commonality and...it's easier to build rapport [] so I certainly have seen others struggle with that who are not from this, this area. (P8)

Sterling (1992) highlighted the need for psychologists to become educated on the local politics, familial histories, and local power structures in rural communities. Participants also discussed the importance of understanding boundaries, cultural expectations around small talk and gift giving, and how to prepare for incidental encounters and dual relationships. Harowski and colleagues (2006) provide recommendations on best practices in rural practice, training, and advocacy. They argue that there are specific multidisciplinary competencies required for effective rural practice. One practitioner described this theme well, "Rural places can be a wonderful place to work if you're fit for it, if you're not, it's probably not going to work out" (P6).

Limitations and Opportunities for Future Research

As with any research, there are limitations to the findings. Previous research has examined the burnout rates and experiences of rural clinicians. Because there has been no study to date examining the self-care practices of rural providers, this study was designed to be exploratory and provide a starting point for future research. This study was designed to achieve an in-depth understanding of a small sample of the population of rural clinicians in Appalachia. Additional studies would be necessary to determine whether the experiences of these eight mental health professionals are consistent with the experiences of practitioners in other rural areas or small communities.

Second, participant demographics were fairly homogeneous and thus represent a limitation. All participants were Caucasian and from a similar geographic region. Demographics were consistent with the population of the region. Future studies could explore whether there are cultural differences to self-care practices among rural clinicians outside of Appalachia. Additionally, all participants worked in a setting where they are able to interact with other professionals. The existing rural mental health literature discusses how practitioners are often isolated and act as the only provider in a given area (Hastings & Cohn, 2013; Schank & Skovholt, 2006; Werth et al., 2010). Future research is needed to explore whether results are consistent among practitioners in solo practice. Solo-practitioners were contacted, but did not respond to requests for participation, possibly because of time constraints, as was reported by one potential participant who declined. Research has shown practitioners in agency settings are at increased risk for burnout (Raquepaw & Miller, 1989). Future studies could explore the self-care strategies of rural agency practitioners to determine if results of the current study are replicated.

Finally, the themes generated were closely linked to the questions asked, so the research is limited to the interview questions. Only two themes emerged separate from the research questions. Therefore, future research could explore the cross-cutting themes in greater depth. The concept of practicing self-care as a way for providers to model healthy behaviors for clients in a rural environment is a new consideration for further exploration. Further study into the strength of this motivation would be valuable. A greater understanding of the ways in which the rural culture shapes the choices of self-care activities would also be beneficial.

Recommendations for Practitioners and Training Programs

The following are recommendations for programs training clinicians who will work in rural areas, as well as those providers already in practice.

- Obtain specific education on rural culture, particularly if not from a rural area.
- Rural communities often resemble fishbowls; therefore, engaging in self-care is potentially a way to model healthy behaviors for patients and potential patients.
- Develop a professional support system. This could include joining professional organizations, networking at annual conventions, and maintaining contact with other clinicians in the area or from graduate school.
- Create a self-care plan with diverse strategies, particularly those that are consistent with personal values.
- Maintain a balance between personal and professional life. Having appropriate boundaries and consistent engagement with support systems are key strategies to an effective balance.
- Take time to reflect and notice personal triggers for stress, in order to increase self-care and thus avoid overwhelming stress becoming a concern.

- Training programs need to emphasize the role of self-care in being a competent and effective practitioner. Programs should model self-care, as well as provide opportunities for the student to reflect on their personal values and preferred strategies.
- Training programs can start to instill a culture that acknowledges one's own distress, in addition to a willingness to speak to colleagues who appear distraught.
- Consider using technology to connect with family and friends who live outside the community, especially for practitioners new to an area who are still building their support system.

Conclusion

The field of psychology has increased attention to clinician self-care and burnout prevention (e.g. APA, 2006; Barnett & Cooper, 2009; Barnett et al., 2005; Craig & Sprang, 2010; Kee, Johnson, & Hunt, 2002; Richards et al., 2010). Self-care is a way to both prevent and ameliorate distress. The literature has begun to focus on the experiences of rural clinicians, including challenges and opportunities (e.g., Bradley et al., 2012; Hastings & Cohn, 2013; Kee et al., 2002; LoPresti & Zuckerman, 2004; Werth et al., 2010). Kee and colleagues (2002) looked at burnout and social support among rural clinicians. They concluded that rural practitioners are at high risk for burnout and inadequate social support on the job. However, the existing literature does not explore the self-care practices of rural clinicians. We hypothesized that rural practitioners would face barriers to commonly recommended self-care strategies as a consequence of the rural environment.

Findings from this study regarding challenges and benefits of rural practice are consistent with the existing literature and provided context for the self-care strategies used by participants. Rural practitioners used a variety of self-care strategies that reflect the general self-care

literature. Additions to the literature from this study focus mainly on the barriers to self-care in rural practice. The APA Ethics Code (2010) Standard 2.06 (b) recommends limiting scope of practice, seeking consultation or supervision, and engaging in personal treatment. The rural clinicians interviewed identified a number of barriers to engaging in these self-care activities. These included finances, time and distance, and lack of local resources. Consultation was reported to be primarily informal, and continuing education was often used as vacation as clinicians needed to travel to conferences. Participants spoke of reasons personal therapy is not a reasonable recommendation because of the travel distance necessary to avoid a dual relationship. They also reported financial reasons for not being able to miss too much work, and the cost of gas and car maintenance. As a function of both financial needs and continuing to meet the needs of a community with limited resources, the commonly recommended strategy of reducing client load was identified as being of limited utility for rural practitioners.

This study provides a first step into gaining a deeper understanding of the self-care practices of rural mental health professionals. Rural clinicians face a number of stressors such as dual roles and increased visibility. These stressors appeared to affect the choices available to the study's participants for self-care. Deserving of further exploration are the identified barriers to traditional self-care recommendations, in addition to possible alternative self-care options. Self-care is a way to minimize distress and prevent impaired professional competency. As stated by Maslach and Goldberg (1998) one must help oneself before helping others. It is our hope that this research will lead to further understanding of the ways that rural clinicians can care for themselves and their clients.

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Chapter 2²: Literature Review

This chapter provides an overview of the literature that is available on the topic of rural mental health clinician self-care. Self-care is often discussed in the context of preventive measures for symptoms of distress, burnout, impairment/competency, vicarious traumatization, secondary traumatic stress, and/or compassion fatigue; I therefore explore self-care within this framework. I start by providing background on rural mental health care with an examination of the challenges and opportunities facing rural practitioners. This review aims to provide evidence for the reasons that traditional self-care recommendations may be more difficult to follow in rural communities. Second, I review the extensive literature surrounding clinician distress. Third, I define self-care, the need for self-care from the perspectives of countertransference and ethics, and explore the existing research on self-care strategies. Fourth, I identify areas for future research and how they relate to the current study. I conclude with the importance of the research topic, operational definitions, and description of the proposed study.

Rural Mental Health

“The vast majority of all Americans living in underserved, rural, and remote areas also experience disparities in mental health services” (President’s New Freedom Commission on Mental Health, 2003, p. 50). The 2010 U.S. Census reported that 19.3% of the total United States population resided in areas which were designated as rural. According to LoPresti and Zuckerman (2004), approximately 55 million Americans live in rural areas, with 60% of those rural areas being underserved by mental health care providers.

Rural definition. Ambiguity and inconsistencies regarding what constitutes rural exist not only at the government agency level but also at an individual and more personal level (Bushy

² To reflect the qualitative nature of the dissertation, starting with this chapter the author uses the first person, as qualitative literature prefers the more personalized involvement of an author in her writing. Chapter 1 was prepared for publication and therefore utilized a more formal third person format.

& Carty, 1994). Because there are many definitions of what constitutes a *rural* community, decisions regarding which definition to use made by government agencies, researchers, and policy makers depended on their specific needs (U.S. Department of Agriculture, 2008). The definition of choice could be based on a number of factors including identifying one that allows for targeting specific resources or that serves the purposes of health-related research (Bradley, Werth, Hastings, & Pierce, 2012).

The most recent United States Census (2010) classified rural as consisting of all territory, population, and housing units located outside of urbanized areas and urban clusters. Urbanized areas include populations of greater than 50,000. Urban clusters have populations between 2,500 and 50,000 people. LoPresti and Zuckerman (2004) used a different definition of rural, in which rural areas could “range from those within a half-hour’s drive to an urban center, to ‘isolated rural areas,’ to those areas more accurately described as ‘frontier areas’ in which the population is less than 6-7 persons per square mile” (p. 252).

The current study used the definition provided by Isserman (2005) based on a county-wide assessment. Isserman identified four types of communities: (a) rural, (b) mixed rural, (c) mixed urban, and (d) urban. A rural county is one with a county population density of less than 500 people per square mile, with 90% of the total county population being within a rural area or the county does not contain an urban area with a population of 10,000 or more people. An example of a rural county in Virginia would be Tazewell County. An urban county is defined as one with a county population density of at least 500 people per square mile, 90% of the county population resides in urban areas, and the county’s population in urbanized areas is at minimum 50,000 or 90% of the county population. In Virginia, Fairfax County meets these criteria. A mixed rural county is one that does not meet either the urban or the rural county criteria and has

a population density of less than 320 people/square mile, such as Washington County in Virginia. Finally, a mixed urban county is one that meets neither the urban nor the rural county criteria and its population density is at least 320 people per square mile, Loudoun County being an example in Virginia. Geography and population are only one aspect of rurality, and although rural areas are heterogeneous, commonalities exist.

Characteristics of rural communities. Rural areas differ from urban centers not only in demographic and geographic variables, but in terms of cultural values. As compared with urban, the “typical” rural lifestyle was described by Bushy and Carty (1994) as being represented by greater spatial distances between people and services; an economic orientation related to the land and nature (agriculture, mining, lumbering, and fishing); work and recreational activities that are cyclic and seasonal in nature; with social interactions that facilitate informal (“face-to-face”) negotiations. (para. 23, lines 5-8)

Further, it has been documented that rural communities tend to have scarcer resources, higher rates of poverty, and more limited job opportunities (Curtin & Hargrove, 2010; Helbok, Marinelli, & Walls, 2006). There also is evidence suggesting that the prevalence of social and health problems is greater in rural areas such as a lack of higher education, increased rates of illiteracy, minimal or inadequate health services, higher rates of disabilities, fewer available mental health services, and limited insurance coverage (Helbok et al., 2006). Additionally, rates of suicide, chronic illness, and alcohol abuse are higher among rural residents (Bushy & Carty, 1994).

Basic community services important to the provision of optimal medical care such as communication systems, transportation, electricity, and clean municipal water may not be available in isolated rural areas (Roberts, Battaglia, & Epstein, 1999). Even when funding is

available, characteristics such as geographic isolation, population spread over large distances, and a lack of public transportation make service provision difficult from a practical standpoint (Jones-Hazledine, McLean, & Hope, 2006; Kee, Johnson, & Hunt, 2002; Roberts et al., 1999). Additionally, Mohatt (1997) pointed out that supportive resources such as housing and vocational training are limited or completely unavailable in rural areas, despite their importance in promoting independence among persons with serious and persistent mental illness.

Individuals who reside in rural areas tend to have some commonly established cultural norms. They are believed to be more politically conservative, less tolerant of nontraditional beliefs, oriented toward a strong work ethic, and have increased religiosity (Bushy & Carty, 1994). Relationships among community members are considered to be interdependent and complex with deep social, historical, family, and political roots (Bushy & Carty, 1994; Helbok et al., 2006). As such, members often play multiple roles, rely on each other and their family ties, and exhibit a distrust of individuals from outside the community (Curtin & Hargrove, 2010; Helbok et al., 2006). Stigma regarding mental illness and treatment is not an uncommon facet of rural life (Hastings & Cohn, 2013). An outcome of the above is the difficulty in the recruitment and retention of a variety of health professionals (LoPresti & Zuckerman, 2004).

The availability of mental health professionals in rural areas is limited. Mohatt (1997) reported that over 60% of rural areas have been designated as Federal Mental Health Professional Shortage Areas (MHPSA). Approximately 85% of 1,669 federally designated MHPSAs are in rural areas (Bird, Dempsey, & Hartley, 2001). For example, only 13% of rural counties have inpatient psychiatric services compared to 95% of urban counties, and outpatient services are available in twice as many urban as rural hospitals (Mohatt, 1997). Additionally, a study by Holzer, Goldsmith and Ciarlo (2000) found that the ratio of providers including

psychiatrists, psychologists, and clinical social workers to the population worsens as rurality increases. Rural residents must therefore travel for substantially further distances to access a mental health provider and are less likely to be offered a full array of behavioral health services (Mohatt, 1997). There are a number of challenges and ethical issues faced by rural practitioners resulting from the above characteristics of rural communities.

Challenges/ethics of rural practice. Rural practitioners need to be generalists in order to meet the needs of the community (Bushy & Carty, 1994; Hastings & Cohn, 2013; Stamm, 2003). Professionals might be expected to work with all age groups who present with a wide range of problems, potentially pushing the boundaries of their competence (Hastings & Cohn, 2013). Additionally, to address professional shortages, clinicians potentially assume multiple roles including case manager, grant writer, crisis worker, administrator, and advocate on top of their regular role as a counselor (Bushy & Carty, 1994). Knowledge of the community resources (Bushy & Carty, 1994) and cultural sensitivity (Helbok et al., 2006) can help a clinician meet the needs of their clients. Clinicians may utilize existing resources such as kin, churches, and other nonprofessional supports in their treatment planning (Helbok et al., 2006). The professional demands on rural practitioners can potentially be endless, leading to burnout if limits are not set on their practice (Bushy & Carty, 1994).

Rural clinicians are likely to encounter a variety of ethical dilemmas, particularly those that are related to the issue of multiple relationships (Curtin & Hargrove, 2010; Hastings & Cohn, 2013; Helbok et al., 2006; LoPresti & Zuckerman, 2004; Schank & Skovholt, 2006). For example, incidental encounters with clients outside of the office are a common occurrence (Curtin & Hargrove, 2010; Hastings & Cohn, 2013). Therefore, boundaries must be managed wisely in order to prevent harm to the client, thus creating an additional source of stress on the

rural practitioner (Werth, Hastings, & Riding-Malon, 2010). As a result of their visibility within the community, issues around client confidentiality as well as the potential for clients to know information about the personal life of the psychologist are common (Helbok et al., 2006; Jones-Hazledine et al., 2006; Schank & Skovholt, 2006; Werth et al., 2010). Although visibility and a lack of anonymity is often a challenge, it also provides the opportunity to increase client confidence in the provider through the transparency of the provider's values, reputation, and commitment to the community (Bradley et al., 2012; Jones-Hazledine et al., 2006).

Another challenge in rural practice relates to the lack of mental health professionals (President's New Freedom Commission on Mental Health, 2003). This results in fewer referral options and a lack of peers with whom to consult on difficult cases (Hastings & Cohn, 2013). Additionally, clinicians who have differing values from the rural community may find it difficult to be accepted and find social connections outside of the workplace (Hastings & Cohn, 2013). This professional isolation and lack of support from individuals within their own profession can be a concern for rural providers (Battye & McTaggart, 2003; Curtin & Hargrove, 2010; Hastings & Cohn, 2013).

Hastings and Cohn (2013) conducted a study in which they examined the challenges and opportunities associated with rural practice. Common challenges identified included intrusions into privacy, lack of resources and funding, insufficient compensation, an inability to freely express divergent opinions, suspicion associated with "outsiders," limited convenience, lack of after-hours emergency care, and limited professional opportunities. Although these challenges may seem daunting, rural practice can also have some significant benefits and opportunities.

Benefits of rural practice. Opportunities exist for the rural clinician in spite of the numerous challenges discussed. Rural clinicians are frequently generalists, providing for variety

in client presenting issues and increased autonomy (Hastings & Cohn, 2013; LoPresti & Zuckerman, 2004). LoPresti and Zuckerman (2004) highlighted the possibility of gaining a sense of mission and importance from being one of the only providers available for a given area; however, this independence could lead to the challenge of functioning without backup or direct consultation. Interprofessional collaboration is a way in which rural health professionals support one another (Hastings & Cohn, 2013). Congruence with beliefs and values, a simplified lifestyle, a slower pace, and decreased overall cost of living expenses are additional rewards of rural life (Hastings & Cohn, 2013; LoPresti & Zuckerman, 2004). Finally, because of many rural areas being identified as MHPSAs, there exist a number of financial incentives through the government for setting up practice in a rural area (Hastings & Cohn, 2013; National Health Service Corps, 2010).

Clinician Distress

Mental health professionals are committed to caring for others and often get substantial satisfaction from this work (Wise, Hersh, & Gibson, 2012). However, this feeling of satisfaction is not always enough to buffer against the numerous stressors encountered in day to day events (Wise et al., 2012). Clinician distress is widely discussed in the mental health literature. Numerous definitions and conceptualizations can be found for forms of clinician distress varying from burnout, vicarious traumatization (VT) and secondary traumatic stress (STS), compassion fatigue (CF), to impaired professional competence. The American Psychological Association Board of Professional Affairs Advisory Committee on Colleague Assistance developed a stress-distress-impairment continuum for psychologists (ACCA, n.d.). Along this continuum, they describe the definitions of each of the stages in the cycle and provide examples. The continuum starts with stress followed by distress then impairment and finally improper behavior. According

to the ACCA, everyone experiences stress at different times throughout their lives. They emphasized that there are occupational vulnerabilities associated with the profession of psychology that must be managed. Psychologists have an ethical responsibility to care for themselves in the face of occupational stresses such as fighting stigma, decreasing financial rewards, repeated exposure to the suffering of others, and careful maintenance of boundaries with the client. Distress, in this model, refers to an experience of intense stress that is unresolved, resulting in distraction. The ACCA reported that an individual experiencing distress may have difficulty sleeping, experience changes in appetite, or have obsessive thoughts about the stress.

The next step in the sequence is impairment. Impairment compromises the professional functioning of the professional to a degree that may be harmful to a client or result in ineffective services. Impairment is a condition for which the psychologist is encouraged to seek services. Although impairment does not equal improper behavior, the risk of inappropriate, unethical or illegal behavior is increased. It should be noted that being at one point along the continuum does not necessarily indicate that the individual will progress to the next more severe stage (ACCA, n.d.). Burnout, as well as VT, STS, and CF are not mentioned along the continuum proposed by the ACCA; however, based upon the descriptions within the continuum, they would likely fall between the distress and impairment stages. The following section reviews the available literature on the impact of trauma work, burnout, and impaired professional competence.

Burnout.

Definition. Burnout, a concept that is utilized in everyday life, is a familiar term even to those outside the mental health field (Rupert & Kent, 2007). Burnout refers to the ongoing negative reactions to work-related stresses and emotional demands that human service professionals often experience (Rupert & Kent, 2007). It has been used interchangeably with

distress in the literature, even though many (e.g., Smith & Moss, 2009) consider the terms to define separate concepts. Lee, Lim, Yang, and Lee (2011) compared the two by stating burnout is work-related stress resulting in the long-term loss of the professional role, whereas distress is considered less severe and includes the experience of relatively mild symptoms that may nonetheless lead to partial impairment of the individuals' functioning. An adverse reaction that often occurs in response to the demands of work (Jenaro, Flores, & Arias, 2007), burnout should be considered as just one of the paths to distress (Smith & Moss, 2009, p. 2).

With regard to the more specific definitions of burnout, Alterman (1998) defined it as a progressive deterioration in the energy, capacity, and available emotional resources of an individual, which occurs over a period of time. Barnett, Johnston, and Hillard (2005) described burnout as a general loss of concern resulting from the chronic nature of many of the stressors encountered daily by clinicians and a loss of positive feelings for one's clients, potentially resulting in a substandard quality of care. Grosch and Olsen (1994) understood it to be a syndrome with physiological, behavioral, psychological, as well as spiritual features. Burnout also could be viewed as a negative internal psychological experience that involves clinicians' feelings, attitudes, motives, and expectations (Ackerley, Burnell, Holder, & Kurdek, 1988). The variation present in these definitions underscores the complexity involved in defining a syndrome that can look different in each individual (Grosch & Olsen, 1994). The common thread among all these definitions appears to be that burnout is a negative reaction to work-related stresses and emotional demands associated with a helping profession (Rupert & Kent, 2007).

According to Rupert and Kent (2007), the most commonly used definition for burnout in the research literature is the one by Maslach and Jackson (1986) which is "emotional exhaustion,

depersonalization, and reduced personal accomplishment that can occur among individuals who ‘do people work’ of some kind” (1986, p. 1). Later, Maslach and Goldberg (1998) refined specific terms in the original Maslach and Jackson (1986) definition; they stated that *emotional exhaustion (EE)* was a feeling of being overextended emotionally as well as being depleted of one’s affective resources. They said that *depersonalization (DP)* (also called cynicism) developed in response to being emotionally exhausted and tended to serve as an initial buffer to protect the individual. They specified that depersonalization was a detached, callous, or negative response to others, which might include a loss of idealism. The primary risk of depersonalization is that it is potentially a precursor to dehumanization, which could potentially negatively impact the clinician’s work with clients. The final aspect of burnout they addressed was that it was accompanied by *reduced personal accomplishment (PA)*, which they viewed as a decline in self-efficacy, in feelings of competence, and in overall work productivity (Maslach & Goldberg, 1998). When discussing this third component of reduced personal accomplishment, Lee et al. (2011) hypothesized that, because being involved with client care is personally and professionally rewarding, psychotherapists, when distressed, might become overinvolved with their clients in an effort to increase their own sense of personal accomplishment. Although not always a negative development, being overly involved with client care could place professionals at risk for emotional exhaustion and possibly cynicism. To avoid these potential negative outcomes, clinicians must remain aware of the effects associated with over-involvement during their pursuit of an increased sense of personal accomplishment (Lee et al., 2011; Rupert & Morgan, 2005).

Maslach and Goldberg (1998) proposed that emotional exhaustion could lead to the development of depersonalization, yet saw the reduction of a sense of personal accomplishment

as a separately occurring phenomenon. Emotional exhaustion is a process that affects the physiological and psychological well-being of the practitioner, whereas depersonalization is a consequence that affects the quality of services provided by the clinician and ultimately impacts the well-being of the client (Jenaro et al., 2007).

Conceptualization of burnout. A meta-analysis conducted by Lee et al. (2011) revealed that job stress, over-involvement, professional identity, and control correlated with the various dimensions of burnout. Emotional exhaustion most closely correlated with job stress and over-involvement with clients, whereas a sense of control and professional identity were found to be equally associated with all three dimensions of burnout: emotional exhaustion, depersonalization, and (lack of) personal accomplishment.

A number of different models for understanding burnout exist in the literature. The conservation of resources model points to the need for resources that allow one to avoid stressors that increase the risk for burnout (Rupert & Kent, 2007). Assets within the model include support and autonomy, and family life that are work-related, combined with more personal characteristics such as coping strategies. In the job demands-resources model, burnout results from an imbalance between the resources available and the demands made upon an individual (Jenaro et al., 2007; Maslach & Goldberg, 1998). Job resources refer to those physical, psychological, social, or organizational aspects of the job that help achieve work goals, reduce job demands, reduce physiological and/or psychological cost, or stimulate personal growth and development. Alternately, job demands refer to those physical, social, or organizational aspects of the job that could include work overload, personal conflict, and exhaustion (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001; Jenaro et al., 2007; Maslach & Goldberg, 1998). Research has shown that although most studies have previously focused on the “self” as the

primary risk factor as opposed to the “environment” (Lee et al., 2011; Maslach & Goldberg, 1998), situational variables are actually more predictive of burnout (Maslach & Goldberg, 1998). Particularly within the human service professions, the imbalance is a result of task overload without the balance of additional resources (Jenaro et al., 2007; Maslach & Goldberg, 1998; Rupert & Kent, 2007).

In order to understand what leads to burnout, Maslach and Leiter (1997) have identified six sources of stress within the environment that may provide clarity: work overload, lack of control, insufficient reward, unfairness, breakdown of community, and value conflict. In response, Skovholt (2001) proposed a model of burnout prevention providing six strategies to counter the work environment stressors identified by Maslach and Leiter. These are sustainable workload; feelings of choice and control; recognition and reward; fairness; respect and justice; a sense of community; and meaningful, valued work.

The multidimensional model of burnout and engagement proposed by Maslach and Goldberg (1998) argued that burnout prevention could be viewed from either a person-centered or a situation-centered viewpoint. Their comprehensive model is an attempt to take the information gained from the research regarding risk factors and make it applicable to practitioners who are experiencing those stressors. They see burnout as an individual experience embedded within a social context involving perception of both self and others. Their model also includes recommended strategies to buffer against symptoms of burnout such as suggesting a change of work patterns, development of preventative coping skills, utilization of social resources, development of a relaxed lifestyle, improvements in health, as well as self-analysis (Maslach & Goldberg, 1998).

Although burnout is a highly individualized syndrome, commonalities remain. Some of the most cited reasons for onset of burnout are low salaries, demanding schedules, shift work (Rupert & Morgan, 2005), a lack of financial resources, and low social recognition (Jenaro et al., 2007). Other reasons that have been identified include high turnover, role ambiguity, conflicting roles (Gibbs, 2001), difficult clients (Gibbs, 2001; Rupert & Morgan, 2005; Sherman & Thelen, 1998), the slow pace of psychotherapy, lack of therapeutic progress (Sherman, 1996), and pressures associated with managed care (DeAngelis, 2002; Sherman & Thelen, 1998). Further, Rupert and Morgan (2005) reported risk factors for occupational burnout being decreased individual control over work, longer duration of work hours, increased time engaged in paperwork or administrative duties, and smaller number of direct pay clients. Additionally, clinicians may experience stress resulting from a required high level of productivity in a variety of work roles (DeAngelis, 2002; O'Connor, 2001; Smith & Moss, 2009). These fall under the umbrella of job demands or environmental stressors. Burnout also can be predicted by the way in which clinicians react to job demands, or their use of personal resources (Jenaro et al., 2007). Coping skills are a key element in the amelioration and prevention of burnout (Jenaro et al., 2007), with self-care being a vital piece of this process.

Symptoms of burnout. There are a number of key terms associated with burnout that help define the symptoms of burnout explored in the following section. Those terms include fatigue, frustration, disengagement, stress, depletion, helplessness, hopelessness, emotional drain, emotional exhaustion, and cynicism (Skovholt, 2001). What constitutes burnout is not readily agreed upon within the literature. The symptoms listed by Maslach and Jackson (1986) are often seen in unique combinations among individuals experiencing the syndrome.

Grosch and Olsen (1994) summarized the literature with a comprehensive list of the various symptoms associated with burnout (see also Farber, 1990; Maslach & Goldberg, 1998; Stevanovic & Rupert, 2004). They broke down the symptoms into four overarching categories of physical, psychological, spiritual, and behavioral symptoms. Physical symptoms might include irritability, gastrointestinal problems, physical depletion and fatigue, back pain, headaches, weight loss, and sleeplessness. Possible psychological features were identified as feelings of depression; an increasingly negative self-concept; a sense of emptiness; and negative attitudes toward life, work, and other people. Additional symptoms might include guilt, self-blame for clients not improving, or having a sense that, as a practitioner, one is incapable of mistakes. They added that a person suffering from burnout could exhibit spiritual symptoms such as a loss of faith, meaning, and purpose. There could be feelings of despair, low spirits, alienation, isolation, as well as a crisis of values. Other spiritual features might include a lack of vitality, courage, or inspiration. Behavioral symptoms included the clinician not coming to work, coming late to work, accomplishing very little despite long hours at work, experiencing a loss of enthusiasm, short temper, boredom, becoming increasingly rigid, and having difficulty with making decisions. Interpersonally, the symptoms might encompass a clinician's withdrawal from colleagues, refusal to listen to new input, and experiencing and showing increased irritation with coworkers. Finally, a clinician might use substances such as alcohol, drugs, or other means of anesthetization to handle the burnout.

Research on burnout. Burnout has a large research basis, with studies using one of several definitions. This lack of consensus regarding the definition leads to a lack of clear understanding regarding the prevalence rates (Smith & Moss, 2009) and limits constructive communication about the problem and its solutions (Maslach & Goldberg, 1998). Some of the

researchers have focused on prevalence rates, while other scholars have attempted to develop a causal model (Rupert & Morgan, 2005). I first provide a summary of studies that focus on prevalence rates of mental health professionals who are distressed and/or suffering from burnout. I then move to research that utilized the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981) allowing for comparison of results across studies.

Prevalence rates. A survey of APA Division 29 (Psychotherapy) psychologists conducted by Pope, Tabachnick, and Keith-Spiegel (1987) revealed that 62.2% of the respondents admitted to “working when too distressed to be effective” in frequencies of “rarely” to “very often,” despite 85.1% of those same individuals reporting their belief that it was unethical to do so. Another study with a sample of 379 members of a Midwestern state psychological association indicated that 10% of their sample reported experiencing distress across a variety of dimensions including loneliness, depression, recurrent physical illness, relationship dissatisfaction, and problem drinking over the past year (Thoreson, Miller, & Krauskopf, 1989). 13.2% of the provider population in a rural southern state sampled by Sprang, Clark, and Whitt-Woosley (2007) revealed that they were at high risk for burnout and/or compassion fatigue based upon the use of the Professional Quality of Life Scale (ProQOL) (Stamm, 2002). Higher scores on the CF subscale of the ProQOL measure indicate that the respondent is at an increased risk for compassion fatigue, and higher scores on the burnout subscale looking at symptoms such as hopelessness and helplessness are indicative of the individual being at risk of burnout (Sprang et al., 2007). Additionally, it was noted that practitioners in areas designated as rural reported higher levels of burnout compared to their urban counterparts (Sprang et al., 2007).

The lack of a consistent definition continues to limit generalization of findings and knowledge about actual prevalence rates (Smith & Moss, 2009), and thus interferes with having constructive conversations regarding the problem and functional solutions (Maslach & Goldberg, 1998). However, the use of the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981) has increased the possibility of comparing rates and results across studies.

Maslach Burnout Inventory. The research discussed has used a variety of measures to establish whether their participants thought they were distressed or burned out. The Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981), which exhibits good psychometric validity and reliability, has been used in a number of studies to investigate the correlates of burnout such as the stresses of psychotherapeutic work or examinations of global work characteristics (e.g., type of setting, caseload) and demographic variables (e.g., age, years of experience). The MBI, as the standard tool for burnout research, provides a way to measure the three components of the syndrome (i.e., emotional exhaustion, depersonalization, and reduced personal accomplishment; Maslach & Goldberg, 1998; Maslach & Jackson, 1986; Maslach, Jackson, & Leiter, 1996). Psychologists have typically scored in the middle range on most indices of burnout, indicating they are experiencing a constant level of stress (Ackerley et al., 1988; Rupert & Morgan, 2005; Stevanovic & Rupert, 2004). On the positive side, however, psychologists also report high levels of personal accomplishment, identified as a protective factor for burnout (Ackerley et al., 1988; Rupert & Morgan, 2005; Stevanovic & Rupert, 2004).

University counseling centers were found to have counselor and setting characteristics that were predictive of stress and burnout in a study by Ross, Altmaier, and Russell (1989). The sociodemographic and employment-related variables were significantly related to emotional exhaustion and the number of stressful events reported, particularly by the non-minority

participants who had the least number of post-doctorate years. More specifically, increased emotional exhaustion was indicated by staff members who were in supervisory roles, were married, and who had fewer years of experience. They concluded that counselor burnout was associated with an absence of social support (Ross et al., 1989).

One study attempted to determine predictors of burnout using a sample of practicing psychotherapists in Texas (Raquelpaw & Miller, 1989). The results indicated that demographic variables and treatment orientation were not accurate predictors of burnout; however, working for an agency did indicate increased levels of burnout. Findings from a national study by Ackerely et al. (1988) indicated that predictors of burnout included being young, having a low income, engaging in limited individual psychotherapy, experiencing feelings of lack of control in the therapeutic setting, and feeling overcommitted to clients. These findings came from a sample of 562 licensed doctoral-level, practicing psychologists employed in a variety of practice settings. Approximately 40% of the sample scored in the high range for burnout on the subscale of emotional exhaustion and 34% scored in the high range for depersonalization.

Thornton (1992) conducted an investigation using 234 full-time, mental health professionals working in a large state psychiatric center to examine the relationship between burnout and coping strategies. She found that the use of inactive coping strategies, such as medication and avoidance, were positively correlated with symptoms of burnout. She noted that the frequency of escape-avoidance behaviors increased as the level of burnout increased.

Rupert and Morgan (2005) sought to examine the effect of work setting on rates of burnout. Using the MBI, the authors randomly selected 588 licensed psychologists with a clinical setting as their primary place of employment from the APA membership. They compared the respondents based upon work setting of independent practitioners, group

practitioners, and agency practitioners. Participants scored in the average or middle range on emotional exhaustion and average range on depersonalization, with higher scores on personal accomplishment. These results replicated previous survey findings that practitioners in independent practice settings reported lower levels of emotional exhaustion and an increased sense of personal accomplishment when compared to peers in group practice or agency settings (Rupert & Morgan, 2005).

Jenaro et al. (2007) surveyed 211 human service practitioners working as child protection workers or in-home caregivers and asked them to complete the MBI as one of several measures. They found that approximately 50% of their sample scored in the medium to high range on the emotional exhaustion scale and approximately 60% scored in the medium to high range on depersonalization. These rates are comparable to what has been reported in other studies. Rates of burnout were compared with participant responses on the COPE Dispositional Inventory, used to assess cognitive and behavioral coping strategies (Carver, Scheier, & Weintraub, 1989). Results suggested that the use of more active coping strategies might contribute to increased job satisfaction for individuals experiencing burnout (Jenaro et al., 2007).

As can be seen by the above discussion, research regarding burnout among mental health professionals has consisted primarily of investigations into the stresses of psychotherapeutic work or the correlates of burnout such as work characteristics (e.g., caseload, type of work setting) and demographic variables (e.g., age, years of experience, theoretical orientation), and has produced mixed results (Rupert & Morgan, 2005). Some studies have found that there is no relationship between age/professional experience to burnout (e.g., Hellman, Morrison, & Abramowitz, 1987; Raquepaw & Miller, 1989; Thornton, 1992), yet others have found a negative correlation (e.g., Ackerley et al., 1988; Ross et al., 1989). Some have uncovered a

relationship between a clinician's caseload and stress level (e.g., Hellman et al., 1987), whereas others have been unable to find a relationship between the amounts of time spent in direct service and burnout symptoms (e.g., Ackerley et al., 1988; Raquepaw & Miller, 1989). The lack of consistency in results might be the result of different operational definitions, different sample sizes, selection biases, or a number of other variables unique to each study.

One consistent finding to date, however, has been the relationship between work setting and burnout. Practitioners in independent practice report less burnout and less stress than peers in agency settings (e.g., Ackerley et al., 1988; Farber, 1985; Raquepaw & Miller, 1989; Rupert & Morgan, 2005). Hypotheses explaining this finding include the possibility that clinicians working in independent practice may have less paperwork and other bureaucratic responsibilities, have greater control over their work activities, and may have a caseload of clients with less severe pathologies (Rupert & Morgan, 2005). These hypotheses should be considered when comparing studies and study samples.

Until a clear understanding of burnout is achieved, researchers and practitioners are unable to move forward with developing effective strategies for prevention (Rupert & Morgan, 2005).

Impaired Professional Competence.

Definition of impairment. A possible consequence of burnout is that of impaired professional competence (Barnett, Baker, Elman, & Schoener, 2007). As a discipline, psychology has had difficulty in addressing the concerns of professional distress and impairment (APA, 2006). In the 1980s, the APA created the Committee on Impaired Psychologists (ACIP; APA, 2006). It initially focused on the use of alcohol and substances by clinicians, and occasionally addressed the "wounded healer" (Sherman, 1996). With increased focus on

professional competence, the committee was later renamed the Advisory Committee on Colleague Assistance (ACCA; APA, 2006). Self-care, prevention, and early intervention became priorities for both APA and ACCA (APA, 2006). One of the primary difficulties in identifying impairment in mental health professionals has been the lack of consensus regarding its definition as noted by the APA in the following statement: “A universal definition of distress and impairment in professional functioning has not yet been created, although most definitions demonstrate common themes” (APA, 2006, p. 6; Smith & Moss, 2009).

The term impairment is often used interchangeably with distress in the literature and in practice; however, Alterman (1998) made the distinction between distress and impairment by stating that impairment involved something within a professional's behavior or environment that is interfering with the professional's work. Comparatively, distress could be viewed as a warning sign for potential impairment (Alterman, 1998; Baker, 2003; Smith & Moss, 2009), although not necessarily resulting in impairment (Alterman, 1998; O'Connor, 2001). Munsey (2006) described the difference as distress being “an experience of intense stress that is not readily resolved affecting well-being and functioning, or disruption of thinking, mood and other health problems that intrude on professional functioning,” whereas impairment was “a condition that compromises the psychologist's functioning to a degree that may harm the client or make services ineffective” (p. 35). Thus, distress and impairment are similar but distinct concepts interconnected with the well-being of the clinician (Smith & Moss, 2009).

There are additional definitions for impairment outside of the distress literature. Barnett et al. (2007) reported that clinicians may experience impaired professional competence as a direct result of using maladaptive coping strategies in light of ongoing distress. They may resort to the use of alcohol or other substances; seeking emotional support or gratification from clients;

or engaging in minimization, denial, or rationalization, all of which decrease their ability to be effective in sessions (Barnett et al., 2007). Clinical incompetence and negative consequences for the profession, the individual, and the client can result when a clinician is impaired (Barnett et al., 2005). Schwebel, Skorina, and Schoener (1994) explained impairment as being a marked change in the professional functioning of an individual. Further, an impaired psychologist is one whose work-related performance has diminished in quality, although this may not necessarily be apparent to others. Guy (1987) saw it as “a diminution or deterioration of therapeutic skill and ability due to factors which have sufficiently impacted the personality of the therapist to result in potential clinical incompetence” (p. 199). Impairment has occurred when there is a decline in occupational functioning or provision of a substandard of care due to distress (Smith & Moss, 2009). Finally, APA (2006) noted that failing to follow professional standards of care or providing services that are inconsistent with legal and professional codes may be indicative of impaired professional competence (Smith & Moss, 2009).

Symptoms of impairment. Just as there are a number of symptoms and behaviors associated with burnout, there are common characteristics associated with a psychologist who is impaired. Barnett and Cooper (2009) reported that impaired psychologists may experience symptoms such as a loss of objectivity, engagement in harmful boundary violations, depression, anxiety, other mental health difficulties including suicidal ideation, irritability with clients, as well as a lack of empathy for client needs. Impairment could include stress, burnout, physical and mental disability, substance abuse and dependence, alcoholism, loss of motor skills, natural cognitive decline as a result of aging, and ethical violations including sexual involvement with a patient (Freudenberger, 1990). Lalotis and Grayson (1985) described mental illness, chemical dependency, and/or personal conflict as possible concerns related to impairment. In their

publication regarding clinician distress and impairment, Kilburg, Nathan, and Thoreson (1986) included stress, burnout, substance abuse, emotional and mental disorders, and ethical violations as dire as sexual involvement with clients, as possible consequences faced by an impaired practitioner.

Finally, the interaction of personal histories and vulnerabilities, the nature of mental health work, and ongoing life events increase the vulnerability of clinicians to symptoms of distress and impairment (Barnett et al., 2005). Some signs of early distress, including reduced energy, decreased patience, impaired concentration, and decreased confidence (Gilroy, Carrol, & Murra, 2002) may be more easily noticed by the clinician affected than by peers (Smith & Moss, 2009). However, just as psychologists fail to identify and intervene with peers who are impaired, they can fail to identify the same signs in themselves (Smith & Moss, 2009). Clinicians may be more likely to rationalize their own behaviors (Smith & Moss, 2009), to not realize they may be impaired and assume that they should be able to handle whatever stressors they are experiencing.

Research on impairment. Several studies regarding impaired psychologists have attempted to understand the characteristics of impairment as well as factors that place a clinician at risk. Coster and Schwebel (1997) conducted 2 studies (one qualitative and one quantitative) examining factors that contribute to well-functioning in professional psychologists. Their results suggested that impairment was not the result of a deficiency of the professional's skills, but rather a lack of adequate coping resources to deal with the overwhelming stressors facing the individual. They further suggested that impairment can be avoided through the strengthening of coping resources. As mentioned earlier, Pope et al. (1987) reported that there were a number of practitioners (62%) who reported working while feeling too distressed to be effective with clients. This behavior was reported by 85% of those psychologists in spite of their awareness of

the ethical implications of such actions. One study surveying 318 randomly selected members of APA recounted that 75 % of psychologists surveyed reported having experienced distress in the past three years, with approximately 38% of those individuals believing that they had decreased patient care as a result of their distress (Guy, Poelstra, & Stark, 1989). The fact that distressed and impaired clinicians continue to engage in direct service of clients highlights the need for prevention efforts in addition to those which aim to rehabilitate the already impaired professional (Coster & Schwebel, 1997; Guy et al., 1989). Whereas there has been considerable research on clinician distress, impairment has been viewed as only one segment of that spectrum. The empirical research available on impaired professional competence is sparse.

This review of clinician distress has included a look at the stress-distress-impairment continuum in addition to definitions and research associated with the range of distress reactions such as burnout, VT, STS, and CF. Clinician self-care has been identified as the method with which to ameliorate symptoms of distress (Alterman, 1998). It is important for practitioners and educators to understand the risk factors and symptomology associated with these syndromes to effectively identify, prevent, and/or minimize their effects (Newell & MacNeil, 2010). Figley (1995) stated “By understanding this process we cannot only prevent additional subsequent traumatic stress among supporters, we can also increase the quality of care for victims by helping their supporters” (p. 10). What follows is a discussion of the available literature on self-care including conceptualization, rationale from a psychoanalytic countertransference perspective and from an ethical perspective, concluding with recommended strategies.

Self-Care

Rationale for self-care. Mental health professionals are constantly walking a fine line attempting to find a balance between other-care and self-care. However, giving of oneself can

often be the requirement for success in the human service fields (Skovholt, 2001, p. 4). This has been termed the pull between altruism and self-preservation. However, as stated by Maslach and Goldberg (1998) one must help oneself before helping others. This is consistent with emergency instructions on an airplane, where the flight attendant instructs the passengers to place the oxygen mask on themselves before helping others. The rationale for finding this balance is provided from the perspectives of countertransference and of ethics in the following sections.

Rationale – countertransference. The discussion surrounding self-care originated within the psychoanalytic movement, particularly with regard to countertransference (Alterman, 1998). First coined by Sigmund Freud in 1910 (Davis, 1991), countertransference was a topic he wrote about extensively despite his failure to define it systematically (Alterman, 1998; Levy, 1990). However, he did clearly state in 1937 that the qualities, characteristics, and personal mental health of the clinician contributed to the process of therapy and therefore had to be understood and addressed (Davis, 1991; Freud, 1937). According to Dalenberg (2000), the label of countertransference can be applied to the strong positive or negative feelings that a clinician experiences in response to a client. Depending on theoretical orientation views, countertransference can mean either the conflict-based emotional reactions to a client, or all emotional reactions and related behaviors by the clinician (Dalenberg, 2000). Countertransference can be further presented as the antagonist to the neutrality and objectivity of the therapist (Dalenberg, 2000).

Countertransference can be a confusing concept, because a therapist's reactions can be either a help or a hindrance to the therapy process (Alterman, 1998). Basically, if countertransference feelings go unrecognized, they potentially can have damaging effects on the client, therefore therapists must determine how to use those feelings for the benefit rather than

the detriment of the client (Cerney, 1995). Indeed, therapists can use their personal feelings to help gain insight into what might be happening with the client (Alterman, 1998).

Within the countertransference literature, the primary strategy for self-care and for processing and understanding one's countertransference has been personal therapy (Alterman, 1998). Freud (1937) emphasized that the quality of care provided by a clinician was impacted by his or her mental health and well-being, and that engaging in one's own analysis was a way to prepare for such work. Countertransference is an obstacle to treatment identified as something the clinician overcomes in personal therapy (analysis) through the recognition and resolution of personal issues (Alterman, 1998). Davis (1991) emphasized that personal therapy for the clinician allows for self-exploration and identification of blind-spots to avoid interference in client work. When clinicians are engaged in personal therapy, they increase their own capacity to focus on their clients, and ensure clients are not called upon to meet the clinician's needs (Fromm-Reichmann, 1960). Countertransference is but one way to consider a need for clinician self-care with personal therapy being the recommended strategy to address the countertransference.

Rationale – ethics. Apart from the countertransference literature, clinician self-care also has been identified as an ethical imperative related to preventing impaired professional competence (Alterman, 1998; Barnett, 2008). Clinician self-care is viewed as one way to protect clients from unethical behavior that can arise from clinician distress, as discussed in previous sections (Alterman, 1998; Norcross; 2000; Smith & Moss, 2009). Barnett and colleagues (2005) pointed out that all mental health professionals must adhere to various ethics codes, each of which is based upon a series of underlying principles:

beneficence or the duty to do good and help others; nonmaleficence, the obligation to minimize harm in all actions we take as professionals; fidelity, the need to carry out and fulfill our professional obligations to those to whom we provide services; autonomy, the goal of promoting the independence of those we serve and not taking any actions that would increase their dependence on us; justice, the obligation to afford all individuals the opportunity for equal access to the same high quality treatments; and self-care, the obligation to adequately attend to our own healthy functioning. (p. 258)

The APA Ethics Code (2010) in Principle A: Beneficence and Nonmaleficence makes it clear that psychologists, trainees, and students must aspire to “be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work” (p. 3). Furthermore, Standard 2.06 (a), Personal Problems and Conflicts, stated that practitioners have an ethical responsibility to “refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner” (APA, 2010 p. 5). Corrective action is mandated when such difficulties are present. Recommendations in the Ethics Code, Standard 2.06 (b), include limiting the scope of work, seeking consultation or supervision, or obtaining necessary treatment (APA, 2010; Barnett & Cooper, 2009; Pope & Tabachnick, 1994). Within the ethical guidelines for the American Counseling Association, an active pursuit of wellness is mandated (Hendricks, Bradley, Brogan, & Brogan, 2009).

Research has shown that clinicians are at risk for distress, impairment of professional competency, and burnout. Each of these could potentially affect clinical work in a negative way, therefore self-care must be viewed as an ethical imperative (Barnett et al., 2007; Richards, Campenni, & Muse-Burke, 2010). Ultimately, professionals are left with the responsibility to

pursue personal wellness, concurrently maintaining awareness of the effects their personal problems may have on their clients (American Counseling Association, 2005; American Mental Health Counselors Association, 2010; APA, 2010; Richards et al., 2010).

Self-care strategies. Researchers have studied self-care resources and personal coping strategies, believing that engaging in these behaviors would increase the professionals' personal wellness and satisfaction (Rupert & Kent, 2007). The literature has used various terms including self-care strategies (Mahoney, 1997), strategies for well-functioning (Coster & Schwebel, 1997), and career-sustaining behaviors (Kramen-Kahn & Hansen, 1998; Stevanovic & Rupert, 2004). Using these, researchers have systematically examined what behaviors contribute to effective functioning and professional satisfaction, including a mixture of internally and externally focused strategies (Rupert & Kent, 2007).

The first finding was a need to maintain a balance between personal and professional lives (Coster & Schwebel, 1997; Grosch & Olsen, 1994; Kramen-Kahn & Hansen, 1998; Mahoney, 1997; Maslach & Goldberg, 1998; Norcross, 2000; Rupert & Kent, 2007; Stevanovic & Rupert, 2004). Behaviors that contributed to this balance (e.g., engage in leisure activities, spend time with spouse and friends) were rated as high in importance for well-being (Coster & Schwebel, 1997; Kramen-Kahn & Hansen, 1998; Mahoney, 1997; Rupert & Kent, 2007; Stevanovic & Rupert, 2004). Cognitive strategies, such as maintaining self-awareness (Coster & Schwebel, 1997; Grosch & Olsen, 1994; Kramen-Kahn & Hansen, 1998; Maslach & Goldberg, 1998; Norcross, 2000; Stevanovic & Rupert, 2004) and having a sense of humor (Kramen-Kahn & Hansen, 1998), were also considered important. Additionally, Rupert, Stevanovic, and Hunley (2009) suggested that strategies to prevent burnout would need to consider family life. They stated that the work lives of psychologists might benefit from organizing and managing their

various life roles more effectively. Family support in the form of someone to talk to and help manage demands at home was identified as being important for enabling the clinician to be more flexible in managing their multiple roles (Coster & Schwebel, 1997; Rupert et al., 2009; Stevanovic & Rupert, 2004).

Also of note, gender differences were identified in several studies. Women tended to score higher on ratings of the use and sense of importance of career-sustaining behaviors (Kramen-Kahn & Hansen, 1998; Stevanovic & Rupert, 2004) and well-functioning strategies (Coster & Schwebel, 1997). The specific educational and relational behaviors endorsed by women were noted to vary considerably from case consultation to supervision (Coster & Schwebel, 1997; Grosch & Olsen, 1995; Kramen-Kahn & Hansen, 1998; Lee et al., 2011; Mahoney, 1997; Stevanovic & Rupert, 2004), to continuing education (Coster & Schwebel, 1997; Kramen-Kahn & Hansen, 1998; Stevanovic & Rupert, 2004).

The literature contains a number of recommendations regarding ways for a clinician to engage in self-care and to work to prevent or counteract distress. There are entire workbooks devoted to the topic of practitioner self-care (e.g., Brady, Norcross & Guy, 1995; Grosch & Olsen, 1994; Kottler, 1999; Rothschild & Rand, 2006). One of the recommendations is for the clinician to engage in supervision and consultation, as this process can help counteract professional isolation, restore communication, provide reality testing, normalize responses, and build ongoing professional support systems (Arledge & Wolfson, 2001). Other recommendations include having some diversity in professional roles, promoting self-awareness, maintaining a balance between one's work and professional life, finding time to rest, and participating in a variety of activities that one finds personally replenishing (Arledge & Wolfson, 2001; Barnett et al., 2005; Grosch & Olsen, 1995).

Once distress is experienced, more specific strategies include individual therapy (Coster & Schwebel, 1997; Guy et al., 1989; Pope & Tabachnick, 1994; Stevanovic & Rupert, 2004), family therapy, reducing client load, taking a leave of absence, medication (Guy et al., 1989), problem focused coping (Murtagh & Wollersheim, 1997), spending time with spouse or partner (Rupert & Kent, 2007), spending time with colleagues (Kramen-Kahn & Hansen, 1998), physical exercise (Mahoney, 1997), and engaging in leisure activities (Coster & Schwebel, 1997; Kramen-Kahn & Hansen, 1998; Mahoney, 1997; Rupert & Kent, 2007; Stevanovic & Rupert, 2004). The way to practice self-care will be specific to the individual, as no one model captures all the different possibilities (Wicks, 2008).

The responsibility to ensure personal wellness is an ethical mandate whether one practices in an urban, suburban, or a rural setting. Despite an increased risk of burnout and lack of social support for rural clinicians (Kee et al., 2002), it appears that corrective measures set forth in the APA Ethics Code (2010) to limit scope of work, seek consultation or supervision, or obtain necessary treatment, may not be sensitive to the challenges faced in rural practice (Helbok, 2003; Schank & Skovholt, 1997; Werth et al., 2010). Furthermore, potentially being the only practitioner for a given area means that rural practitioners must remain cognizant of their boundaries and self-care in order to avoid burnout (Bushy & Carty, 1994).

Areas for Future Research

The literature is replete with recommendations for ways for clinicians to engage in self-care practices, as well as rationales for doing so. Further research is necessary to identify what coping strategies are most successful for meeting the demands of mental health practice (Stevanovic & Rupert, 2004). A review of the literature shows that research specific to the self-care needs and possible limitations experienced by rural clinicians is lacking. Recent studies that

addressed the topic of burnout in rural practitioners have been quantitative in nature (Kee et al., 2002), measuring rates of burnout, but no studies have been conducted that explore the self-care or burnout prevention methods used by practitioners in rural areas. More specifically, there is no information related to the experiences of rural clinicians with regard to prevention strategies for burnout and impairment in professional competency. In a mixed methods, two-part study, Coster and Schwebel (1997) used qualitative interviews of six psychologists in order to gain a deeper understanding of what themes were important in contributing to their well-functioning. Results from that initial study were then used to refine an existing Well-Functioning Questionnaire. However, none of the practitioners used in the qualitative portion of the study were practicing in rural areas; therefore, it is unclear whether this measure would be useful with rural clinicians. Richards et al. (2010) stated that future research would need to explore how work settings or status as a student or professional may relate to self-care practices. I respond to this call for additional research by focusing on the self-care practices of rural clinicians. I utilized grounded theory to discover how rural clinicians engage in self-care and what barriers they might encounter as a result of the environment in which they practice. A better understanding of the lived experiences of rural clinicians and of ways in which they manage the challenges to minimize impairment adds to the existing literature. Furthermore, findings about rural practitioners would provide valuable information for training programs that so far seem to have focused on training students from an urban tradition (Werth et al., 2010). This information could help to inform future therapists about ways to more effectively cope with the demands of rural practice.

Conclusion

The role of a therapist is unique, challenging, and multi-faceted. Alterman (1998) discussed self-care from a variety of perspectives. She reported that the role that is filled by a clinician is in bearing witness to the suffering of others, promoting their growth and well-being, and assisting them to find ways to live a fulfilling life. A mental health profession can be rewarding as well as demanding and exhausting because of the level of energy, restraint, creativity, and skill that it requires. Effective practitioners must deal with the emotional demands of the work, the lack of reinforcement around client progress, the need to maintain hope and faith while instilling them in the client, manage the triggering of their own issues within the therapeutic relationship, as well as the difficulties of leaving work at the office; all these factors make for a relationship that takes a toll on the mental health professional. Throughout the emotionally charged and intense context that comprises a therapy session, the clinician must remain available, engaged, calm, compassionate, and non-reactive. Clinician self-care is protective for the clients in that it energizes the professional, minimizes the risk of ethical violations and impaired service delivery, and engenders increased self-awareness (Alterman, 1998).

Self-care is a topic that is not commonly discussed in depth during graduate training programs (Barnett & Cooper, 2009). However, to ignore caring for oneself can be the first step toward burnout and possibly impairment of professional competence (Barnett et al., 2005). The APA Ethics Code (2010) emphasizes the ethical importance of maintaining awareness of personal functioning to promote competent practice and protect clients. Research has demonstrated that mental health practitioners do experience personal problems (Mahoney, 1997). Furthermore, mental health professionals' self-care is often discussed in the literature as either a preventive or reactionary measure to symptoms of burnout, vicarious traumatization, distress

and/or impairment. However, based upon the available research, the concept of self-care seems like an ideal that may not always be attainable by the practitioner. Before providing the research questions, I will operationally define the terms used in the study.

Operational Definitions

Because of inconsistencies in the literature, the following list of operational definitions used in the current study is provided. This will help to form a basic foundation for discussing self-care and burnout prevention from the perspective of the rural practitioner.

- *Burnout* consists of “emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who ‘do people work’ of some kind” (Maslach & Jackson, 1986, p.1).
- *Countertransference* refers to the process of seeing oneself in the client, of over identifying with the client, or of meeting one’s needs through the client (Corey, 1991).
- *Distress* is a general term that encompasses other terms including burnout, impairment, compassion fatigue, vicarious traumatization, and secondary traumatic stress.
- *Impairment* constitutes a “diminution or deterioration of therapeutic skill and ability due to factors which have sufficiently impacted the personality of the therapist to result in potential clinical incompetence” (Guy, 1987, p. 199).

Mental Health Professional (MHP) includes practitioners within the various professional specialties of psychology, counseling, marriage and family counseling, and social work. Synonyms for MHP include practitioner, therapist, clinician, and counselor.

- *Mixed Rural County* is defined as one that does not meet either the urban or the rural county criteria and has a population density of less than 320 people per square mile (Isserman, 2005).

- *Rural County* is defined as one in which the population density of the county is less than 500 people per square mile, with 90% of the total county population being within a rural area or that the county does not contain an urban area with a population of 10,000 or more people (Isserman, 2005).

Research Questions

The current study was designed to expand the available literature on self-care as practiced by rural clinicians. Rural clinicians have a number of challenges and opportunities, and I sought to understand how these clinicians balanced the needs of the self and the needs of their clients. The traditional self-care recommendations include such behaviors as limiting case loads, seeking personal therapy, engaging in professional consultation and/or supervision, continuing education, and making time for leisure activities. However, because of professional isolation, physical distance, lack of referral options, and the need for being a generalist, these recommendations may not be feasible for rural clinicians. Therefore, the current study investigated the ways that rural clinicians engage in self-care.

This study's research questions included

- (1) What are the experiences of mental health practitioners in a rural area?
- (2) In what ways are rural clinicians currently caring for themselves?
- (3) What are the barriers experienced by rural clinicians to engaging in self-care?

Chapter 3: Methodology

As noted in Chapter 2, there exists a significant void in the literature with respect to the self-care practices of rural clinicians. The current study was designed to establish a deeper understanding of the ways in which rural practitioners engage in self-care. In this chapter, I describe the rationale for the research design, illustrate the inclusion criteria for participation, review the instruments that were utilized, and conclude with a discussion of how the interview data were analyzed.

Design Rationale

The current study utilized grounded theory methodology. Grounded Theory, as first developed by Glaser and Strauss (1967), is a qualitative research design in which the researcher gathers data with the purpose of gaining new insights and an understanding about the lived experiences of the participants. Qualitative inquiry was ideal for the current study, in that through the use of detailed, experiential information from a sample of participants who are representative of the population of interest, the researcher can develop theories that are derived from the data (Alterman, 1998). Grounded theory is a method that works to close the persistent gap between theory and empirical research while simultaneously increasing the real-world relevance of established research for practitioners in the field (Glaser & Strauss, 1967). Fassinger (2005) emphasized that grounded theory is a useful method for building a bridge between science and practice. Ponterotto (2005) found that within *Journal of Counseling Psychology* articles, grounded theory was one of the most frequently used qualitative methods and he considered it to be “one of the most established and respected qualitative methods” (p. 133). Additionally, it has been identified as being at the forefront of the qualitative research movement (Charmaz, 2000; McLeod, 2001; Ponterotto, 2005).

The data obtained through in-depth interviews were analyzed utilizing grounded theory methodology. In-depth interviews allowed for a more thorough investigation of the experience of the participants and provided enough information for an exploratory study (Strauss & Corbin, 1998). At the core of grounded theory is the goal of constructing an overarching theory that is based in the lived experiences of participants. By using an open-ended interview response format, grounded theory increases the opportunity to develop a greater understanding of the perspective of the participant (Alterman, 1998; Patton, 2002). Strauss and Corbin (1998) emphasized that grounded theory analyses are designed to “provide the grounding, build the density, and develop the sensitivity and integration needed to generate a rich, tightly woven, explanatory theory that closely approximates the reality it represents” (p. 57). A broad research question combined with a working, flexible hypothesis helps to guide and focus the inquiry process while providing structure and organization of the observation process and underlying interview questions (Strauss & Corbin, 1998). This methodology allows for an information-rich exploration of the types of self-care practices utilized by rural practitioners.

Participants

Participants for this study were recruited based on specific inclusion criteria. The criteria included that they were over the age of 18; were currently licensed as a Licensed Clinical Psychologist (LCP), Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), or Licensed Marriage and Family Therapist (LMFT); and were providing full time face-to-face services as a Master’s- or Doctoral-level mental health practitioner. The availability of psychologists in rural areas is limited (Bradley, 2011); therefore, clinicians varied with respect to professional background and training. Five of the participants were LCSWs, 2 were LPCs, and one was a Licensed Clinical Psychologist.

The other criterion for inclusion in the study was that the participant was currently providing face-to-face services in a rural or mixed rural community. Definitions for what constitutes a rural community vary in the literature. The definition provided by Isserman (2005) was utilized in the current study. Seven of the participants were working in a community classified as rural with a population density of less than 500 people per square mile, and 90 percent of the county population is in a rural area. One participant was working in a mixed rural community which does not meet criteria for rural or urban county classification, and has a population density of less than 320 people per square mile. Participants ranged in age from 29 to 60 years old. Six participants were female and two were male with all participants identifying as Caucasian or White. Participants worked in either a group private practice setting (five) or an integrated care setting (three). All participants hold their licensure in Virginia with one participant indicating an additional licensure in Tennessee. Two participants reported also being certified substance abuse counselors (CSAC). Participants have been practicing for a combined total of approximately 100 years. Six participants have been licensed for less than 10 years, one for 12 years, and one participant for 32 years. Of the participants, six identified themselves as having an eclectic or integrated theoretical orientation, with one identifying cognitive-behavioral, and another reporting existential and solution-focused. For a brief summary of participant demographics, see Appendix A.

Participants were recruited through the use of purposeful sampling and snowball sampling. Purposeful sampling allowed the researcher to identify potential participants who were able to provide the most in-depth and information-rich responses to the interview questions. Patton (2002) stated that information-rich cases are those obtained through purposeful sampling from which the participants provide their knowledge on the central issues of the research. These

individuals were identified through the use of consultation with professional contacts, through professional organizations, and searching for providers listed in directories for rural areas. Once initial practitioners were identified, additional providers were recruited through snowball sampling. Snowball sampling involved having individuals who had already engaged in the research provide contact information for additional individuals they thought might be appropriate and interested in taking part.

Qualitative research does not typically indicate a predetermined number of participants (Patton, 2002). Specifically with grounded theory, the researcher continues to conduct interviews until saturation has been reached (Strauss & Corbin, 1998). A study is considered to have reached saturation once additional participants are no longer providing new themes with respect to the research question(s); saturation is commonly reached between 8 and 15 interviews (Morrow & Smith, 2000). In the present study, data collection continued until the point of saturation, which was met after eight interviews. Participant interviews were transcribed and analyzed concurrently with data collection to determine when the point of saturation was met. No new significant information was obtained in interviews seven and eight, and therefore data collection was discontinued.

Instruments

Each participant completed a demographic information form and responded to questions according to a semi-structured interview format and the following procedure.

Demographic information form. I contacted prospective participants, provided information about the study, and answered any questions. Once they expressed interest in participation, and provided verbal informed consent, they were asked demographic questions over the phone. Basic information was obtained with the purpose of verifying that they met

inclusion criteria for the present study. The demographic questionnaire (see Appendix C) included basic demographics (e.g., age, sex, ethnicity, degree, type of license(s), years practicing, and community type) as well as questions regarding type of practice setting, typical caseload, theoretical orientation, and social supports. These latter three areas have each been identified as factors influencing self-care practices; therefore, this information was necessary to compare results with the existing self-care literature.

Semi-structured interview. I developed the questions for a semi-structured interview based on personal experience as a student in rural mental health, consultation with other practitioners, and a review of the existing literature on self-care. A draft of the interview questions was provided to my advisor and committee members for additional edits. Changes were made and incorporated into the interview guide (see Appendix D). Fassinger (2005) recommended that the interview guide be structured with minimal prompts oriented toward process rather than content, in order to avoid imposing constrictions on participants. Strauss and Corbin (1998) suggested the use of a funnel design where the questions start out broadly and move toward more specificity. After the proposal was approved by the Institutional Review Board (IRB), a pilot interview was conducted with a person who met all criteria for inclusion in the study. That individual was asked for feedback regarding the interview experience and thoughts specific to the questions including wording, flow, and content. No significant changes were found to be necessary following the pilot interview, and therefore data from that interview were included in the final analysis.

Researcher as an instrument. In qualitative research, the researcher is viewed as a tool for gathering data (Fassinger, 2005; Morrow & Smith, 2000; Patton, 2002). Because of the semi-structured format of the interview protocol, the investigator asks a series of prompts and

encourages in-depth exploration of question responses (Fassinger, 2005). Additionally, through the interaction between the interviewer and the interviewee, there is the possibility for the researcher to influence the research process and the data collected. The principal investigator also is involved with the data analysis stage following collection of interview data; therefore, this is another place where researcher bias can influence the results (Patton, 2002). Because of the potential for bias, Patton (2002) stressed the importance of the researcher being reflexive:

Reflexivity reminds the qualitative inquirer to be attentive to and conscious of the cultural, political, social, linguistic, and ideological origins of one's own perspective and voice as well as the perspective and voices of those one interviews and those to whom one reports. (p. 65)

Morrow (2005) recommended several ways in which to be reflexive. She encouraged researchers to explore personal assumptions from their own experiences as well as the literature, be honest regarding any emotional involvement related to the research topic, and monitor the ongoing impact that can arise from the interactions with each of the participants.

Based on the suggestions made by Morrow (2005), I now discuss my personal experiences as they are relevant to the current study. I am a single female in my early 30's. I am currently working on my doctorate in counseling psychology from a university situated in rural Appalachia. I have attended school in this region of the state for my undergraduate degree, master's degree, and now my doctorate. I am originally from a part of the state that is more urban in its composition, providing me with the opportunity to observe firsthand the differences in resources available in urban versus rural communities. Following graduation from my Master's program, I worked in a hospital setting in a growing area of the state. It was during my tenure at the hospital that I was able to see how limited the area was with respect to mental

health providers, where clients seen in the hospital would often have to wait between 3 and 6 weeks to be seen by an individual therapist, potentially longer if the patient lacked insurance. This experience provided me with firsthand knowledge of some of the barriers faced by clients and practitioners in rural areas. Rural mental health is considered one of the major foci of my doctoral program, and therefore I have been exposed to the unique needs of rural practice, including the evident challenges as well as the more hidden benefits.

A value that has been emphasized in my current program is the necessity for self-care. As students, the demands can be exhausting, and therefore faculty have encouraged students to make a self-care plan as well as understand and recognize signs and symptoms of burnout in ourselves and others. The need for self-care has been primarily addressed from the standpoint of it being an ethical imperative. The APA (2010) Ethics Code has emphasized that it is unacceptable to continue seeing clients when potentially impaired. As I began to explore the literature around self-care practices, it became evident that the recommendations did not seem to address rural areas. It is this lack of knowledge regarding what strategies are used by rural clinicians, particularly with respect to the reported professional isolation and other potential barriers that piqued my interest in conducting the current study.

Procedure

Prior to starting data collection, I obtained approval from the Radford University Institutional Review Board (IRB). After IRB approval, the pilot interview was conducted. No modifications were made to the interview guide, therefore data collection continued. Purposeful sampling was utilized to identify individuals to contact for study involvement. Additional participants were identified through snowball sampling. Potential participants were mailed a letter inviting them to participate (see Appendix E), as well as the informed consent document

(see Appendix F), which included information regarding the purpose of the study, benefits and risks associated with participation, and contact information for the principal investigator and my advisor.

Approximately one week after interest letters were mailed, I followed-up by phone as outlined in the participation letter to determine the individuals' level of interest regarding participation. After they agreed to participate in the study, I verbally reviewed the informed consent document with them (see Appendix F). Once they agreed to continue with the study, I asked questions from the demographic information sheet (see Appendix C). I reviewed the responses from the participant to determine eligibility for inclusion in the study. To be eligible for participation, the clinician met inclusion criteria of being an adult, licensed mental health professional who is working full time providing face-to-face services to clients in rural Appalachia. Once eligibility was determined, the participant and I set up a mutually agreeable time and place to conduct the in-person interview. The interviews took place at participant offices and/or Radford University. All phone responses to the demographic questionnaire were verified with the participant in person prior to conducting the semi-structured interview. Participant interviews lasted an average of one hour.

Prior to starting the interview, I introduced myself and expressed thanks for the participants' willingness to participate. I then reviewed the informed consent document, which contained contact information for me and my advisor. Participants were reminded of their ability to withdraw from the study at any time with no penalty. After they agreed to participate and signed the informed consent document, we proceeded with the semi-structured interview (see Appendix D) followed by a brief checklist of self-care strategies (see Appendix G) and a burnout measurement tool. The list of self-care strategies from the literature was used to identify any

additional strategies participants may have used but did not consider during the initial interview, and allowed for further probing of barriers to strategies not utilized. The Professional Quality of Life Scale-5 (ProQOL-5) is a brief tool designed by B. Hudnall Stamm (2009) to evaluate current levels of burnout, secondary traumatic stress, and compassion satisfaction experienced by the clinician over the past 30 days. It is a 30-item self-report measure of the positive and negative aspects of caring including subscales of Compassion Satisfaction (CS), Burnout, and Secondary Traumatic Stress (STS). Alpha reliability for CS subscale is 0.88, Burnout is 0.75, and STS is 0.81, with more than 200 published studies using the ProQOL to demonstrate it is a valid measure (Stamm, 2010). The results from this instrument were used to place responses into context, as well as serving as a pilot for possible future quantitative study on rural clinician self-care.

The in-depth interviews were recorded using a digital audio recorder and subsequently transcribed for analysis purposes. Once transcription of the interview was completed and double checked for accuracy, the audio recording was deleted in order to provide for confidentiality and minimize the risk of individuals being identified based on their voices. All participant information was kept confidential, with each person being assigned a number at the time of the interview transcription and the list of matched names and numbers being kept separate from the other information. Soon after the interview session, I sent a letter expressing my gratitude for their time and willingness to be a part of the research (see Appendix H). Once the data analysis was complete, the clinicians were sent a copy of the results and asked to provide comments regarding the accuracy of my representation of what they shared. The letter requesting feedback (see Appendix I) emphasized that it is an analysis of all the interviews; however, the participants were told that they should be able to see themselves represented within the larger context. All

interactions were conducted in accordance with the APA (2010) Ethics Code in addition to Radford University Institutional Review Board policies.

Analysis

There are three distinct phases of data analysis in grounded theory: open coding, axial coding, and selective coding (Fassinger, 2005). There is constant comparison occurring during the various stages of data analysis, which involves:

a) comparing and relating subcategories to categories, b) comparing categories to new data, c) expanding the density and complexity of the categories by describing their properties (attributes of a category) and dimensions (ordering of the properties along a continuum), and d) exploring variations (e.g., disconfirming instances) in the data and reconceptualizing the categories and their relationships as necessary. (Fassinger, 2005, p. 160)

Coding allows for interpretation and construction of meaning from the narrative data, and development of a substantial theory that is grounded in the lived experiences of participants (Fassinger, 2005).

Coding. The first stage of coding is “open coding.” Open coding, according to Strauss & Corbin (1998, p. 101), identifies the initial concepts in the data together with their properties. The transcribed data are broken down into units of meaning (concepts) and labeled with words close to those of the participant (Fassinger, 2005). The actual size of the concepts or units of meaning can vary, with different researchers subscribing to different sizes; length of meaning units can range from several words to several pages, although most are several lines or a short paragraph (Charmaz, 2000; Fassinger, 2005; Morrow & Smith, 2000; Rennie, 1995). Once concepts were given a label, they were analyzed for possible alternative meanings (Fassinger,

2005). Concepts were grouped together to form categories, which help explain how the concepts are related. As additional data were gathered, the various themes were modified, recategorized, or placed into new categories.

The second level of coding involved axial coding, which groups concepts identified during the open coding phase into larger categories thus linking concepts according to their properties and dimensions (Strauss & Corbin, 1998, p. 123). The main goal of this stage was to contemplate explanations as well as gain an understanding of the phenomena (Strauss & Corbin, 1998). It was here that the connections and associations among themes were examined. Axial coding is a process in which the small units or concepts established during the open coding process are grouped into key categories and subcategories. Key categories tend to be broad and explanatory, whereas subcategories are more specific in describing the various aspects of the participants' experiences (Strauss & Corbin, 1998). I analyzed interview data within the axial coding process with themes being modified as necessary with each additional participant. This constant comparison allowed me to identify when categorical saturation was reached and data collection could cease. This point is reached when additional interview data do not provide any new information regarding the lived experiences of the participants, which was after eight participants were interviewed. This number is consistent with the literature on grounded theory (Morrow & Smith, 2000).

The third and final stage of coding in grounded theory is selective coding. The goal of this level of coding is to create a substantive theory, when possible. The most relevant and important aspects of the data are integrated with each other to create a central category. The central category is an "explanatory whole" that subsumes the lower categories and is observed frequently within the data (Fassinger, 2005; Strauss & Corbin, 1998). Throughout this stage of

the analysis, I repeatedly referred to the original transcript data to ensure that the themes, key categories, and subcategories were accurately represented.

Trustworthiness. Trustworthiness in qualitative research can be considered equivalent to discussions of validity and reliability in quantitative methods (Morrow, 2005).

Trustworthiness is demonstrated through providing evidence that the researcher has done due diligence. Specifically, this is accomplished by having an established rationale for the study, a clear description of the data collection procedures and data analytic methods, and providing information on how the data were interpreted (Choudhuri, Glauser, & Perego, 2004). The current study addressed trustworthiness through the use of an outside auditor. Auditing the data is a process in which someone other than the principal investigator monitors the process and final product in an effort to verify that acceptable procedures were followed (Fassinger, 2005). I included an auditor who has a strong background and experience with grounded theory-based dissertations and who was involved throughout the research process.

Another step I took to engender trustworthiness was to follow recommendations of Strauss and Corbin (1998). They suggested providing participants with a copy of the analysis and soliciting comments regarding its representation of their experience. Participants were sent a draft copy of the results and provided an opportunity to provide comment. I received responses from five of the participants expressing that the results were a good representation of their experience, and I took the lack of response from the other three to indicate the same. Each of these efforts should help to demonstrate that the results are trustworthy.

Conclusion

The current study allowed me to examine the self-care practices of rural clinicians. There is some literature suggesting that the experience of rural practitioners differs from that of their

urban counterparts. Therefore, the self-care practices of rural practitioners may differ from the traditional recommendations.

Chapter 4: Results

In this chapter I review the results of the research. The analysis of the data showed that the themes aligned with interview questions and that two additional themes emerged separately from the questions being asked. For this reason, I organized the results based on the questions answered by participants. I included themes if three or more of the eight participants discussed that theme (i.e., each included theme was endorsed by at least 37.5% of the participants). I provided quotations to give a more detailed description of the participants' experience (e.g., P1 is participant 1) with a given theme (Bradley, 2011). Within each quote, the presence of brackets indicates the removal of a minimal encourager that I gave the participant, and ellipses were used to ease the readability of the quotation by removing extraneous words such as "umm" and repeated words. The section headers are either the question I asked the participants or a larger concept behind a series of questions. See Appendix B for a summary of the themes, listed by question.

What are some of the challenges associated with working in a rural area?

When questioned about the challenges associated with working in a rural area, participants' responses fit into five themes: client travel and transportation challenges (seven participants), being known in the community (six), poverty within the community (six), lack of professional resources (five), and combating the stigma associated with mental health (four). Every participant was able to identify and report at least one challenge. Next, I describe each theme in detail, using participant quotes to more fully illustrate the identified theme.

Client travel and transportation challenges. The most commonly identified challenge of working in a rural area was related to client travel and transportation. Seven of the participants spoke about this idea, indicating that the lack of reliable transportation combined

with long commute distances increases client no-show rates. One participant discussed his local practice as benefiting the community, particularly those clients with transportation challenges:

benefits for the clients is of course travel, transportation, because the majority of clients that we have actually have transportation issues. And they have barriers financially...and then just the distance, although... the mountain area may say 17 miles, it's a long 17 miles. A lot of times... two lane roads (P5)

Another participant stated,

living in a rural area, people do not have a lot of money ... So, often having the gas money in a vehicle that runs to get to the appointment ... is not feasible. And so, there tends to be a lot of no-shows (P1).

One clinician emphasized the rural geography when discussing serving the clients, stating, “we have folks who live far enough away, and due to the terrain that they drive two hours [] one way to get here” (P3). Another participant referred to the weather affecting travel stating, “transportation is a problem where I’m at; the roads are bad if it snows. And I’ll go to work and I’ll only have one or two people show up that day, if I’m lucky” (P1).

Poverty in the rural community. Six of the participants endorsed a related theme of poverty within the community. When asked about challenges, one stated, “lack of resources, insurance, being able to pay for services” (P8). Another spoke about this challenge in conjunction with the previous theme of client transportation,

The whole ... indigent factor going on, you know people’s vehicles, you can’t get to services, they ... can’t make their appointments...the number we have on file is some Tracfone they’ve bought at Wal-Mart, their minutes runs out by the time their next appointment’s here, can’t get up with them [], then they no-show (P7).

One participant spoke of clients' lack of resources particularly around healthcare and insurance coverage.

They go to the free clinics [] and stuff, and ...even though some of them have insurance, meaning there's deductibles, is very hard to do...The kids that we have here, probably I'd say a percent of them we're seeing are Medicaid...and majority are ... low income, first generation (P5).

Being known in the community. Being known within the community was reported as burdensome by six of the participants. This was in part because of the increased likelihood of incidental encounters or possible dual relationships. Participants described incidental encounters as happening frequently in rural practice. For example, "You go to the supermarket and you're very apt to run into... patients and [] clients that you serve, and ... you want to respect their privacy" (P8). Another elaborated,

That's what you get in a 4,000 town, person town... I'm not going to their house and hanging out on the weekends, or they're not mowing my yard, but I'll see them at Wal-Mart or you know, they may see me at church or something [] like that (P7).

Clinician privacy. Being known in the community interfered with clinician privacy. One participant stated, "cause it's a small community you get earmarked, and everyone knows you and knows what you do. And so boundaries become tricky in terms of having ... a life" (P2). The same participant talked about trying to expand her social supports after moving into the town where she worked,

I mean everywhere I go, the things that I have ventured out into []...it's not horrible, it can be done, but I have to be "on" in a way that I would rather not be "on" [] because I

have to be aware of that person, and even though maybe I haven't seen them, I... know so much about them, that I can see it in their face and they are a little tense (P2).

She also discussed her experiences with trying to maintain boundaries,

When I moved into this neighborhood ... the neighbor came and said ... "I wanna see you". And I said, "I can't do that" ... and to this day, I think she feels like that was a putdown []...that was like I didn't like her or something (P2).

Client confidentiality. Client confidentiality is another concern related to clinician visibility. One participant spoke about the difficulty of getting clients to come for treatment as a result of fears around confidentiality and privacy.

Confidentiality and privacy, 'cause everybody knows everybody... I've had people show up in my office who are a cousin of mine ... who know my father, or they know somebody who knows somebody... and so to me, that makes it difficult for them to feel comfortable with the privacy aspect... I think too because in small towns, people like to talk about ... what everybody's doing... []... so one of the first things that I do in practice is explain confidentiality and privacy, and explain what's gonna happen if they run into me at Wal-Mart. So that they know what to expect and they know what I will tell people and what I won't tell people (P1).

One participant described the way she tries to increase her anonymity when engaging in a self-care exercise stating, "I love biking [], because I put on sports glasses, and helmet, and nobody recognizes me" (P2). She expressed how this prevented clients from being identified when they ran into her on the trail. She also stated "I'm pretty vigilant about confidentiality, because I feel in a rural area you have to be hypervigilant [] about it" (P2).

Lack of professional resources. Five of the participants spoke about a lack of professional resources as being a challenge of rural practice. With limited local trainings, several participants reported choosing to attend conferences where they could obtain multiple continuing education units (CEU) at one time. As reported by one participant, “the training is an issue.” The participant added “to have the training most of the time, you know, we’re going to Abingdon or Bristol [], that’s a full day for me” (P5). That participant went on to say,

We need training, you know, we need CEUs and things, but to take the time out of my day to go do that, and then take maybe my resident with me, or one of the other licensed persons [] really puts us short staffed (P5).

Another spoke of the lack of networking opportunities, resulting in traveling for trainings to obtain CEUs. They stated, “having the kinds of training in this area that were beneficial was very hard and ... the kind of exposure to other professionals, but I started early on going and training some in New York” (P2).

One participant discussed the feeling of professional isolation even in a group practice, “we are [] somewhat isolated from one another. We’re all in our own little compartments here. [] It it’s nice though [] ... it’s a good group of people, we just don’t [] see each other much” (P4).

Combating the stigma associated with mental illness. The stigma associated with mental health in rural areas was discussed by four participants. One participant stated “in a rural area ...you still have a lot of people that think [] mental health therapists are doing voodoo” (P7). He went on to describe the stigma in more depth, “That’s been a challenge ...[] ... people... think well if I go there everybody’s gonna think I’m crazy... I don’t want ... Billy Bob down the road seeing me going into your practice ‘cause they think I’m insane” (P7). Another reported, “I think that’s one of the challenges too, is that there’s a real stigma in the rural community...,

especially to mental health care... people who come they'll say 'you're not gonna send me to that crazy house are ya?'" (P1).

What are some of the benefits of practicing in a rural area?

When participants discussed the benefits of working in a rural area, three themes emerged. These themes included characteristics associated with rural life (six), being known in the community (six), and being near to family and having family ties to the community (three). The benefits were often associated with challenges, demonstrating that a difficult situation may also provide an opportunity.

Characteristics associated with rural life. Six of the participants thought a benefit to rural practice was being able to live in a rural area. One participant discussed his personal reasons for working in a rural area,

The benefit for me is that I love living in a rural area, I like the country, I like the slow pace ...generally it's characteristic of rural areas. I like being part of a community...

Fishing ponds are close [], ... there's usually nature... There's usually national forests or other state forests, other place to access it [] pretty easily (P6).

Another participant noted "I enjoy the culture and there is a very personable nature to the people that I work with, so to me that's ... a benefit to what I'm doing" (P1). One clinician identified the opportunity to be a generalist, "the benefit is the whole wide array, because it is a rural area, and there aren't so many resources... it fits me well, because I tend to be a generalist anyway" (P3).

Being known in the community. Although being a known entity in the rural community entails challenges, five participants also spoke of the benefits. Some of those benefits included being able to provide a local resource, increased opportunities for referrals based upon one's

positive reputation, and being a part of the community. Three of the participants noted how being able to provide a service that clients would not have otherwise was a benefit to rural practice. One explained, “You’re serving people that really need your help... that need the services and otherwise they might not have access [] to those services, so there’s some sense of purpose behind that for me” (P6). Another participant agreed, saying

I think prior to opening [name of practice], pretty much people had the CSB to go to, and then you’re looking at probably at least a 50 mile drive if they wanted to go to another practice somewhere. And so I think it benefits people just from a financial perspective and convenience factor of having ... something in their own backyard (P7).

One participant spoke of the reputation that the practice has built within the community that has led to increased referrals, “So in one form or fashion, department of social services has known me. And, I developed a trust, and that really helps. And so everybody in our practice ... has... developed this trust with the other agencies” (P5).

Being near to family and family ties to the community. According to three participants, working in a rural area allows them the opportunity to be near family and honor family ties. One participant said, “The benefit is working close to home; I’m ... originally from this area.... So I moved back to my home ... my roots are in a rural area... It’s a benefit for me” (P8). Another stated the reason she works in a rural area is,

Because I live there ... There is a tendency to stay within the area because of family bonds... I live there because 90% of my family lives [here] and so I didn’t want to move out of the county because there’s a lot of family support that you get in the area. (P1)

One participant, raised outside the community, cherished the family bonds and sense of community she had obtained visiting as a child.

I found being with my grandparents, the things that they were able to teach me about family, and about farming ... they would have everybody on the mountain come up and they would do these big sugarcane stir offs, and as kids we would run and play and you know, and I was accepted (P5).

What strategies are you using to engage in self-care?

Six themes developed through responses by participants to the question of self-care strategies. These themes included specific individualized strategies for self-care (eight), professional strategies (eight), utilizing one's support system (eight), maintaining a balance between personal and professional lives (seven), maintaining a self-awareness regarding the need for self-care (five), and utilizing available resources (four).

Specific individualized strategies for engaging in self-care. When asked about what strategies they used for self-care, participants gave a variety of responses, with many commonalities across individuals. All eight participants reported that exercise was a strategy that they used. Other strategies that were reported by multiple participants included faith and prayer; using relaxation, mindfulness, or meditation techniques; going out to lunch; reading for pleasure; maintaining flexibility in one's schedule; eating right; spending time with pets; and knowing that personal therapy is an option if needed. Participants often reported using more than one strategy, and that strategies were chosen based on their needs. One participant described his self-care routine:

I was always very athletic... I... play racquetball... run, jog, whatever, just try to stay in shape ..., and relieve stress that way []...I also listen to praise and worship music... if I'm having a stressful day... I have a breathe and relax app on my iPad, and I do some deep breathing [] ... I'll bust that thing out and ... just listen to some praise and worship

music while I'm doing that... So, not only do I do the secular ...looking at my breathing, but also do the spiritual and focus on God and how big He is and how awesome He is. And, ... once I start thinking about you know, what God has done for me, and how He's blessed me, and how He has my interest at heart, the things that's bothering me start to feel really small, ..., it's not uncommon for me to cut the lights out, lock the door, dare someone to interrupt me, and just kind of get along with God, and meditate or whatever. (P7)

One participant responded to the question of whether he used specific strategies:

Yes, there are. Umm I exercise regularly... on my way home from work I have about an hour drive, but ... I stop by a gym at least 3 to 4 days a week...do strength training and cardiovascular training ... each day... It relieves stress for me, it helps me have an opportunity to ...process any type of frustration or something that I haven't completely dealt with from the day, or if I have a really busy day, maybe I can't process all that during the day, so it gives me an opportunity to do that []. The drive helps as well...to just be by myself. (P6)

Another participant listed the following,

Definitely a lot of prayer... physical outlets, I...try to go to the gym most mornings before coming to work []...I figure I can either engage in my own mental health therapy or I can go work out at the gym. Sometimes I need to do both, but... taking care of yourself physically, eating right, getting enough sleep, setting boundaries. (P3)

Professional strategies. Participants named more than one strategy they used in caring for themselves. Six participants spoke of professional strategies such as the use of informal consultation and attending continuing education. Professional strategies were endorsed by the

other two participants when given pre-determined prompts asking if they had other professionals with whom they could engage in consultation. For example, relying on a mentor for both personal and professional guidance,

having a mentor, that you can speak with, go to,... in that self-care process of being a professional... whether it's a group or someone that you go to [] for...that clinical guidance and that personal guidance, I think that's key. (P8)

After being prompted, another spoke about the friendship she has with a co-worker with whom she attended school, "She and I go to lunch together... I wouldn't say it's supervision...but she and I...have bounced cases" (P4). This informal consultation was described by some as a method for navigating dual role and other situations.

If you have sound clinicians that you're bouncing things off with, you negotiate those [dual roles] in professional ways, so that you...know... when you need to back out, but you know when you can't avoid the dual role, but...it's not gonna, hopefully [] infringe on the work that you're doing with people. Because in a small area, the ways that you get tied in, is incredible. (P2)

The integrated care setting provided one practitioner an opportunity for interprofessional collaboration and consultation.

I don't have a lot of clinical questions, usually... it's more... system issues, or...I just want to talk about how something is affecting me. Whether it be the countertransference [] or something of that nature. It's usually with the co-workers there that I have, [] that can keep things confidential. I think that's one of the biggest things, because ...in the practice I'm in... there's an open record between myself and the provider [], it's one

document, electronic document. So sharing something with them about a patient is ok, and so, in that way we can support each other. (P1)

Continuing education was viewed by participants as not only a training opportunity, but a chance to travel and network with others. This was the case for one participant, who had gone to a conference in North Carolina.

I usually do that [formal continuing education] at least once a year... and then as opportunities arise... I may go to a workshop here... And there's always networking... with other professionals and... finding out what other people are doing... different, or people you haven't seen in a long time [], so it's good to connect with those folks. (P8)

Utilizing one's support system. All eight clinicians recounted the use of their support systems. Support systems were described as consisting of family, friends, colleagues, professional organizations, and/or church. One participant spoke of the way she uses her support system:

I guess too in taking care of my own emotional issues, so I don't end up bringing those into work, and not letting things build and build and build... usually through my friends and... my church, and my family, I'm able to work through things that are difficult in life... I find that pretty helpful. So I surround myself with people who I can talk to about things. (P1)

Another characterized the variety of supports he has, "I spend a lot of time with family and friends, and... it's helpful to... have some close friends that are also in the same profession as well []... But, my family of course" (P6). When asked about resources available for self-care, a participant stated,

When I'm spending time with my wife...she's my favorite person in the whole wide world. And...that's helpful for me to just spend time with her... and then...I have two daughters, and ... I enjoy spending time with them. My parents, thank God, are still living, and my dad is...my hero. (P7)

Other participants spoke of their professional organizations not being active in their region, however found the listserv beneficial for keeping informed of updates such as changes to practice guidelines and billing. Additionally, it was identified as a way to get a consult on a challenging case.

Maintaining a balance between personal and professional lives. Seven participants emphasized the importance of finding a balance between their personal and professional lives. Each described her or his own ways of maintaining those boundaries. Having a large family circle in the community has required one clinician to be on guard with her boundaries.

It's something that...being from here that I find that ... it's a consistent boundary. I'm always guarded with my boundaries, like my family time... because I'm from here ... there's people that know me, large family [] circle, they're like "oh yeah, you need to go see her" and...so it's that educational, where it's like... I can't see you professionally, and here's some advice and here's someone you can go and see. (P8)

Finding the balance was described as challenging by one participant:

Yeah, it's a challenge, you know, setting boundaries. And sometimes I feel guilty, sometimes I feel lazy. []...After seven o'clock at night I would just want to go home and not do anything, watch TV, or something very mindless [], but you have to force yourself to do some continuing reading, or again, to get out...sometimes I have to make myself go to choir practice, or...to the youth group meeting, or ... make myself even go out to

dinner with my husband, [] or set it up to go out with a couple of friends. I mean, but...it's like anything else, once you get there and do it, it's fun [], and the payoff is huge. (P3)

Two participants spoke of having family members working for their clinics, while others emphasized having structured family time each week as a way to maintain balance. For example, "So we're able to...kind of lean on each other as support. On Sundays after church we'll either cook, or go get something to eat, and come back and play Phase Ten" (P5). Setting priorities for self-care and recognizing the impact of the emotional work they are doing was emphasized by several participants.

Maintaining self-awareness regarding the need for self-care. Five of the participants discussed the need for maintaining self-awareness. One spoke of her efforts to maintain self-awareness in order to prevent countertransference and to be the best possible clinician:

So you know in terms of in depth self-care, I think it's essential to, I'm not saying, everybody has to meditate or do all that stuff, I think those are beneficial ways of doing self-care [], but... if you're going to not just be a technique therapist, but really be able to do some deep developmental work with people, you have to self-care and know when your issues are being triggered, and what's going on. (P2)

Self-awareness was a way for the clinician to know when self-care was needed. One clinician, in discussing why self-care is needed, used the following metaphor,

I think everybody in my life is a Dixie cup and I'm a huge pitcher of water, and I'm pouring into them, but if I don't go back to the faucet... to the one that fills me, [] then I can't fill others up. And I have to keep full at all times, or I can't keep their little Dixie cups full. (P7)

Utilizing available resources. Four of the participants reported trying to use the resources that are available to them. One clinician stated,

I would say the YMCA...the colleagues here.... I have professional colleagues in other places... so sometimes an email exchange with somebody...if I'm stumped for an idea about something. I've even emailed folks and asked NASW, I think it's a good resource.

The Internet is a good resource. (P3)

Another spoke about her physician being a resource for her in addition to looking for local trainings and workshops, "I have a certain time I go to the doctor... every three months... I do a weekly... get away from everything, but trying to find in the papers workshops and different trainings" (P5). Several participants commented on using a local gym or exercising outdoors, "Thankfully here in this beautiful town with no red lights...we have a new... sidewalk they just put in last year... so...when it gets warm... I walk around town at lunchtime...and...there is a local gym" (P7).

What are the consequences of not effectively engaging in self-care?

Participant responses to what happens when a clinician does not engage effectively in self-care were categorized into three themes. The themes included there being a change in the clinician (seven), a change within the interactions with clients (seven), and the clinician not being as effective in sessions (six).

There is a change in the clinician. A consequence of not effectively engaging in self-care identified by seven of the participants was a change in the clinician. Common changes were reported to be somatic complaints, getting physically sick, a sense of irritability or anxiety, missing work, avoiding clients or being relieved by no-shows, and minimal grooming. One participant responded,

I usually get sick. Like a bad cold...what I think happens is that your immunity gets lower [] when you're more stressed... normally I'm a pretty healthy person [], but I do work in a doctor's office, so I'm exposed to a lot of things. But I can tell if I've been really stressed, there's a tendency for me to get sick, [] quicker with things... or I'm not doing...as much...grooming. Like, I might go two weeks and realize I haven't put lipstick on []. Or...I've been wearing a ponytail too many days in a row, and...not actually fix my hair []...that sort of thing. And that usually tells me I'm not caring about myself, that I'm just doing stuff, or...just don't care about it I guess. (P1)

Another confided she had high blood pressure and noted that "stress actually runs mine up" (P5). One experienced a physical warning sign, "muscle tension...when I notice that, then it's telling me...that something's going on for me [] that I need to pay attention to" (P6). Yet another participant indicated that she became overwhelmed if she was not getting adequate sleep, commenting, "I have to draw a boundary and say I cannot go any further...without having more sleep" (P4). Finally, one participant responded she knew self-care was needed when

I'm getting sick []. I'm not usually a sick person, I mean I don't get sick a lot, but...if I'm having a lot of somatic complaints, or my back's hurting, or I'm actually missing work for being sick. I know something's askew and I've gotta pull back and...do some self-care. (P2)

A change occurs within the interaction with clients. Another consequence noted by seven of the participants was a change within the client-counselor interaction. One example provided by five of the participants was that the client might take the role of checking in on the well-being of the clinician. For example, "if a client ever looked at me and said 'are you unhappy, or...is something not right?' I would [] feel horrible...because, their responsibility is

not to take care of me, that's my responsibility" (P3). Along the same lines, another stated clients will take a personal interest in you as a clinician.

I think [small talk with clients] helps establish that rapport, but you could bring too much into that [] interview and it becomes...counterproductive...for helping someone ... if I bring my own issues in here and pour them out...to the patient. Certainly if... I'm in a lot of pain, or whatever is going on with me, I'm not gonna be able to be present [] if I don't have a place for that already. (P8)

One clinician who also acts as a supervisor spoke of the potential boundary crossings that could occur when self-care was not effective. She stated, "The counselor and the client may become more friends than actually client and therapist [], and I've seen that everywhere... and the other factor to that, is that in their sessions, it's more of a friendship type" (P5). When asked how the client interaction changed, one participant stated, "I probably...get more active, less patient [], more directive" (P6). On a similar note, one clinician commented,

I get dreading getting to see certain people [], you know, the drain people...who are pretty stuck...If I'm doing self-care I still see it as their process... I'm fairly direct in my treatment, so people may know, but I know that when I'm dreading to see people, that... I'm getting myself too burned out, and...I'm not taking care of what I need to. (P2)

The clinician reports not being as effective in sessions. A final consequence is that the clinician is potentially not as effective in session. Six of the clinicians spoke of this theme, with several talking of being distracted, "my mind's cluttered, I don't think as easily" (P1). The same clinician reported that she may not use the same techniques when she is overwhelmed, "it affects my...overall effectiveness and the techniques and strategies I might use... probably mostly

'cause of energy" (P1). Another commented that without proper attention to self-care she "wouldn't be fully present for [clients]" (P4). Expanding on this further, one participant stated, "When I'm distracted, or feeling overwhelmed, or not feeling good about the job, I start not paying attention. [] ... I get an attitude where I don't wanna go the extra mile, and in almost every therapy session there is something that requires the extra mile. (P3)

What are the barriers experienced by rural clinicians with regard to engagement in self-care?

Participants were asked to consider what might or might not interfere with their attempts to focus on self-care. The participant responses were classified into four themes: the distance and amount of traveling required to take advantage of specific resources (five), limited time and thus the need for time management to schedule self-care activities (five), limited financial stability (four), and a lack of local continuing education opportunities (three). One participant noted most of these themes when asked what barriers she encounters, "I think just time, ... geography, and, ... money" (P4).

Distance and amount of traveling required for taking advantage of specific resources. The geography of a rural area and the distance to travel to resources was identified as a challenge in rural practice, particularly with regard to getting clients to sessions. However, five participants also discussed these barriers within the context of minimizing self-care options. One painted the following picture,

When you live in a rural area, you have to...travel to shop... to go out to dinner or to a movie could be an hour's trip []...so there's planning involved...in doing those... kind of things. So the distance...is a huge barrier for anything that you want to do that's for self-care. (P8)

Another participant spoke of her experiences with traveling at least 30 minutes to various resources, “I had acupuncture one time, and I just really liked that [], but in our area... there’s nobody I know of that does it within... an hour’s travel” (P1). Another participant discussed the distance to her friends and how that interfered with using that particular resource. She stated,

My friends are also spread out. A lot of my friends are in Tennessee []. And I already drive two hours plus a day... just to work here, and... it’s not easy for me to, after I drive that far, then to drive an extra 30 or 45 minutes to an hour to meet with friends. (P4)

Limited time and the need for time management to schedule self-care activities.

When participants were asked about the barriers they encountered when trying to engage in self-care, five of them mentioned time. One participant noted, “time and energy...self-care brings us energy, but it takes energy []...being a private provider... I...set my own schedule [] ...So ...typically I don’t come in till 10, and then I see clients sometimes as late as six o’clock” (P3). Another related the way time was a barrier for her.

Time management I think [is a barrier]...if you’re very busy and, and don’t set self-care as a priority, the time management will...just eat away at you... There’s always gonna be more patients to see...more things to do... more projects to work on... so...I really think that time, can get away from you [] and...it’s just important to, to really structure that self-care [] and remain true to that. (P8)

Limited financial stability. The lack of financial stability was identified as a barrier to self-care by four of the participants. One example of this was “my husband and I both work and..., I probably consider us middle-class, but still spending money on a lot of the extra things, like a nice massage []...is just really out of the question right now” (P1).

Two of the participants noted that, particularly in private practice, if they are not billing, they are not getting paid. A participant in an administrative role emphasized,

I have cut my schedule back to where I'm seeing maybe around 5 [clients] a day right now []. So I'm trying to have time to do more administrative duties, it's like, do you rob Peter to pay Paul? If you don't see clients then there's some income not coming in, and you have to have time to do paperwork too [] so it's a catch 22. (P7)

As an independent practitioner, one participant spoke of having to stay on a budget to afford health insurance and pay taxes. She elaborated,

I have more insurances and I deal with Medicaid, but we have to always be current on what the changes are...[] because as you're billing... your check may not always...be what you want it to be... or it may take a month or two or three months to get payment for something. [] So you have to be...able to budget. (P5)

Finances were discussed as being a barrier to taking vacations. As noted by one participant when discussing vacation, "this is the tough thing about private practice, is that if I'm not working, I don't get paid" (P3). Similarly another stated, "vacations, I don't have the money for that" (P4).

Lack of local continuing education opportunities. Three clinicians commented on the lack of local continuing education courses, noted previously as a self-care strategy for some. One stated, "I wish there was more...frequent offerings for low cost training right in this area []. It's kind of lacking...because something will be offered once every six months somewhere [], and it's hard often to schedule that in" (P3). One clinician who has been practicing in the same area for years commented on a program that was once available, but no longer exists.

We had barter lunches, where we provided training and then...there was a one time a month...where we would go for lunch, and there would be somebody providing training. And... what you did is, if you participated in it on a regular basis, she wanted you to provide a training [] and other clinicians provided training. And that was great, because what that brought, there is no real forum for private practitioners in a rural area [] you know... the Ph.D.'s go over there, and the LPCs go over there, and the LCSWs go over there...this was...a place where people came together, and we'd share lunch and get trained in something, and have some discussions. I really liked that... we don't have that anymore. I miss that...having local trainings is also a way for me to connect to clinicians in the area and find out what's going on and what's happening []. But there's none, I regret not having that. (P2)

One participant mentioned the lack of resources in general,

that's something that you have to create early on in a career if you're gonna work in rural communities... you have to build that along the way, kind of your resource packet []...your go to people, your go to things...that you do. 'Cause resources...are few [] for professionals in... rural practice. (P8)

Additional Cross-Cutting Themes

During the analysis, participant responses allowed for two cross-cutting themes that did not align with any of the previous categories. The first was that self-care served as a way for the clinician to model healthy behavior for clients (three) and the second theme, which was identified by all eight participants, was that knowledge about rural culture was recommended prior to engaging in rural practice.

Self-care as a way for the clinician to be a model of healthy behavior for clients.

Three participants spoke about wanting to model healthy behaviors for clients. One clinician, while talking about using a consultation group, stated, “one of my major strategies is...practicing what I preach, figuring out what is going on with me. Learning how to deal with my own stuff that comes up... I went through a period where I meditated every day” (P2). She also noted practicing what she preached with regard to going to personal therapy when needed. Another clinician described it as,

If ...we’re gonna go talk to people about how important exercise...is, then I think we need to try at least be putting out effort [] to do at least some of those things ourselves...Most of us talk to our patients about compassion and self-care, and so on and so forth, and if we can’t do that ourselves, then how should we expect patients to do it, especially when they have so few resources [] compared to us typically, at least in rural areas they do. (P6)

Knowledge about the culture is recommended prior to engaging in rural practice.

Participant responses allowed for the emergence of one final theme, that clinicians needed to understand rural culture prior to engaging in a rural practice. One participant noted “Rural places can be a wonderful place to work if you’re fit for it, if you’re not, it’s probably not going to work out” (P6). When asked whether there was something that would have better prepared them for rural practice, several participants noted that having been raised in a rural area helped them to know and appreciate the culture. One participant explained, “I grew up in in the area, so I was... assimilated to the culture, as I grew up in it, I am the culture” (P1). Another clinician who supervises students commented,

I think being from here []...I knew what to expect... I supervise students that come into the practice... that are not from a rural community and...I see them struggle with clients who are not necessarily as open [] to someone who's different, a different color maybe, someone with a different...dialect...The rural communities are often very closed [] so, I think that's probably what has made me... more accepted in the rural community as a practitioner, because I'm from here [] I sound like they do, and...I have common interests...I grew up like many of them grew up. So we have that commonality and...it's easier to build rapport [] so I certainly have seen others struggle with that who are not from this, this area. (P8)

This same participant added that she thought coursework on Appalachia would be beneficial.

Several participants noted they felt prepared for rural practice not only because of being raised in the culture, but also because of their academic training. For example, when asked if anything would have better prepared him for rural practice, one participant responded,

Honestly... I cannot think of anything because I felt so well prepared for rural practice [] because my training program was focused on rural practice... And, in addition to that...I've already worked...in a rural area. Before that, I grew up in a rural area... I feel like my entire existence has been...I've been part of rural community. (P6)

Another specified that her academic program, "did an excellent job about training us in rural areas [] and the dynamics and stuff" (P2). Finally, one participant, in discussing her experiences reflected,

I was blessed to have a mother who was from the area, and so pretty much grandparents they born and raised here and died here, so I know a lot about the area. And that's helped

me... But someone without that, yeah it would be hard for them, coming in to 'cause...as

I said, the people we deal with, deal with so many different disadvantages. (P5)

As suggested by this cross-cutting theme, being a part of and understanding the culture is important, and is a challenge when practicing as an “outsider”. Although not considered a stand-alone theme due to only being endorsed by two participants, the lack of a local support system, such as friends living at a distance, is a potential threat to self-care. This was identified as leading to a lack of consistent engagement with support systems, and those participants were also noted to be the ones for whom finding a balance between personal and professional lives was most demanding. This is suggestive of the importance of a strong social support system, particularly for rural clinicians engaged in practice in a rural community.

Responses Based On Prompting

At the end of the interviews, I provided participants with a list of self-care activities from the literature that allowed for additional discussion. Some of the participants noted strategies they used, while others noted the barriers to specific types of self-care activities. Themes that were strengthened upon prompting included benefits of being known in the community, such as getting referrals and reputation (six participants total); benefits related to characteristics of rural community, such as interprofessional collaboration (four); challenges of rural practice around combating the stigma of mental health (five); specific strategies for self-care, such as faith and prayer (six); professional strategy of informal consultation (eight). Additionally, the theme of there being a change in the clinician was illustrated with examples of clinicians becoming ill (six), experiencing anxiety and irritability (four), and having somatic complaints (four). Finally, the barriers to self-care, such as a lack of CEU opportunities (four) and finances (five), were discussed.

However, several themes that emerged through prompting had not been self-generated during the original interview. The first theme was related to self-care barriers. Four of the participants spoke of how reducing their client load is not a viable option for self-care. This was identified as being partially because of the limited number of providers. One participant stated,

That was the agreement... I negotiated that I would ... see 20-25 clients a week and that would be the service I was providing... but then you get in the midst of it, and the need, and... the pressure, you know from those working around you and the person you are working for...there's never a shortage of work. (P3)

Another description of this theme was,

Reducing client load, that's not gonna happen []... the barriers to that is, there is only a certain number of ...counseling jobs in the area, and so you... take what you can get.

The only way to reduce client load is to become part time. (P1)

When prompted, four participants reported reasons why reducing client load was not an option, while three clinicians identified it as a strategy they could potentially use. One participant spoke of her recent health concerns and having to step back her administrative duties, “limiting that has been a breath of fresh air, and allowed me to focus on more of my self-preservation that I needed too, or I'd probably not be in good shape physically or emotionally” (P8). Another mused about reducing client load, “if you're overloaded and you're finding that it's impacting you that would be helpful” (P6).

Additionally, three participants spoke of personal therapy specifically not being a self-care option. Reasons reported were finances, confidentiality, and the distance they would need to travel. One participant explained this challenge:

I've never had personal therapy... I think... finances too would be an issue... I would have to be careful about who I chose because most of them know me, or my family, or whatever because it is such a small community, or it's somebody I refer to [] ... so then you have that roles boundary... I probably have to drive at least 45 minutes to get and then be picky there to find someone who wasn't part of a network [] that I might work with... or socialize with. (P1)

Another stated, "Personal therapy is hard to do because... they generally work the same hours that I do, and right now I don't have health insurance, which is... a barrier to my self-care. I can't currently afford health insurance" (P4).

A second theme that fits under professional strategies was the strategy of diversifying one's professional roles. In thinking about this strategy, one participant explained, "I feel like I'm probably one of the few here that has a very strong diversity [] because I'm a supervisor... I do many different things just besides outpatient" (P5). When reflecting on her previous places of employment, another participant stated "one of the ways I've found to combat burnout is to do a lot of different things" (P3).

Prompting reminded participants of other specific strategies such as taking a vacation (five) and listening to music (three). One participant agreed "I'm a huge fan of vacations" (P7) before describing the various trips he and his family have planned for the year. Another spoke of trying to take vacations when finances allowed, "I try to go at least once in the summer" (P1). When discussing the strategy of visiting her family in Kentucky, one stated "when I decide that I need time off, it might not be a lot of days, but... one or two days, I can change my schedule... to fit that and take off" (P5). Additionally, three participants reported listening to music as an

effective self-care strategy. One participant suggested “music, it can be an outlet” (P8), while another focused on listening to prayer and worship music while meditating.

Thus, providing prompts with a list of self-care strategies from the literature allowed for a more in-depth discussion of rural clinician self-care. The discussion particularly emphasized some of the barriers experienced by the participants, even though during the initial portion of the interview, they may not have necessarily shared these potential barriers.

Professional Quality of Life Scale Version 5 (ProQOL-5)

Participants were asked at the end of the interview to complete a short measure, the Professional Quality of Life, Version 5 (ProQOL-5), to examine current levels of burnout, secondary traumatic stress, and compassion satisfaction. Participants’ scores on the ProQOL-5 were fairly uniform and did not result in differentiating between participants. All eight participants scored low on subscales of burnout ($\chi = 15.65$; $\sigma = 1.99$) and secondary traumatic stress ($\chi = 18.12$; $\sigma = 2.10$). Six of the participants scored as being in the high range for compassion satisfaction, with the other two scoring in the average range ($\chi = 43.87$; $\sigma = 4.73$). These results suggest that the self-care strategies of all eight participants were effective at the time of their interviews.

Summary

The data analysis revealed that the majority of the themes emerged as a direct result of the questions being asked. I began by examining the themes associated with the benefits and challenges of rural practice. I reviewed themes related to self-care including self-care strategies, the results of not effectively engaging in self-care, and barriers to self-care. The first cross-cutting theme was identified as self-care being a way for clinicians to be a model for clients. The other cross-cutting theme related to the recommendation by all eight participants that knowledge

of rural culture be encouraged before practicing in rural areas. I provided prompts to participants including a list of self-care strategies, which elicited additional themes, particularly around barriers to specific strategies. In the next chapter, I compare the results of the current study to the existing literature and explore potential implications.

Chapter 5: Discussion

In this chapter I discuss the results in response to the research questions. I begin by reviewing the themes that emerged during the interviews and discuss the ways in which these relate to the existing literature. Results and implications for the field are examined, in addition to recommendations for current practitioners and training programs. This is followed by limitations of the current study. I conclude with possibilities for future research.

Research Questions

Professionals working in rural areas face any number of stressors, including attempting to manage dual relationships, lack of resources, and professional isolation (Hastings & Cohn, 2013; Schank & Skovholt, 2006). The literature has increasingly focused on describing rural practice and ways in which it differs from practice in more urban areas. Additionally, the literature has described commonly used self-care strategies and the ethical obligation for clinicians with respect to caring for themselves. However, the literature does not mention self-care for the mental health professional working in a rural area. The study was guided by three research questions aimed at gaining a greater understanding of the ways rural clinicians engage in self-care. The current chapter will discuss the results and examine how the findings support and extend the current literature regarding self-care practices of rural mental health providers.

A total of 23 themes were identified during the initial interview phase with another five unique themes emerging when participants were prompted with strategies identified in the literature. A theme was included if at least 37.5 % (three participants) endorsed it during the interview. The themes that developed remained closely linked to the questions asked of the participants, and therefore were able to be tied to the original research questions.

Research question 1: What are the experiences of mental health professionals in rural areas?

Challenges of working in a rural area. When asked about challenges of practicing in rural areas, participants provided responses that were classified in five themes: client travel and transportation challenges, being known in the community, poverty within the community, lack of professional resources, and combating the stigma associated with mental health. Participant responses were consistent with the existing literature on challenges of rural practice.

Seven participants reported difficulties related to client travel and transportation. Distances to be traveled and the lack of reliable transportation often resulted in higher rates of appointment no-shows. In rural areas, there tend to be greater physical distances between people and services (Bushy & Carty, 1994), meaning that residents must often travel greater distances to access a mental health provider (Mohatt, 1997). Participants emphasized that weather and geography made travel more difficult. One participant explained that challenges within rural communities were tied to the economy and poverty of the region. Six participants spoke of their patients' lack of resources, lack of health insurance, and inability to afford services. This is consistent with the literature stating that rural areas tend to have scarcer resources, higher rates of poverty (Curtin & Hargrove, 2010; Helbok et al., 2006), and limited insurance coverage (Helbok et al., 2006).

Being known in the community and the associated complications was another theme. One of the primary challenges identified was the increased likelihood of incidental encounters or possible dual relationships. One of the participants spoke of these being simply a fact of rural life. Multiple relationships have been identified as a common ethical dilemma faced by rural practitioners (Bradley et al, 2012; Curtin & Hargrove, 2010; Hastings & Cohn, 2013; Helbok et

al., 2006; LoPresti & Zuckerman, 2004; Schank & Skovholt, 2006). Curtin and Hargrove (2010) pointed out that incidental encounters outside of the office are an ordinary occurrence in rural communities.

Visibility within the community also leads to lack of privacy for the clinician and concerns about confidentiality on behalf of current clients (Helbok et al., 2006; Schank & Skovholt, 2006; Werth et al., 2010). With these potential dual relationships, appropriate boundaries have been identified as a necessary strategy for managing stress on the part of the rural practitioner (Helbok et al., 2006; Werth et al., 2010). The challenge of maintaining boundaries, especially outside of office hours, was emphasized by one participant.

Participants reported an additional challenge of the lack of professional resources including limited opportunities for local continuing education as well as professional isolation. Mohatt (1997) reported that over 60% of rural areas have been designated as Federal Mental Health Professional Shortage Areas (MHPSA). Approximately 85% of 1,669 federally designated MHPSAs are in rural areas (Bird et al., 2001). This paucity of professionals increases the sense of professional isolation experienced by rural clinicians (Bushy & Carty, 1994). According to participants, continuing education provides not only an opportunity to receive training, but is an occasion to network with other professionals, thus helping to keep clinicians abreast of community resources. Participants in the study by Hastings and Cohn (2013) also provided support for the assertion that rural clinicians experience professional isolation and lack of professional supports.

Combating the stigma associated with mental illness was the final theme that emerged from clinician discussion of challenges related to rural practice. The presence of stigma related to mental illness and treatment is not an uncommon facet of rural life (Hastings & Cohn, 2013).

Stigma was identified as a barrier to getting patients in the door, and of getting them to trust the provider. All the challenges discussed by participants reiterated those previously identified within the literature on rural mental health, suggesting participants had similar experiences to those described in the literature. Although the challenges are not new, they provided context for the self-care strategies and barriers experienced by rural clinicians, which will be expanded upon in later sections. As noted by Bradley (2011), the literature often focuses more upon the challenges of rural practice and the benefits are minimized and yet anecdotal evidence points to rural practitioners being satisfied with their work. Participants in this study discussed the benefits they find in rural practice.

Benefits of practicing in a rural area. Three themes emerged when participants discussed the benefits of working in a rural area. Themes included the characteristics associated with rural life, being known in the community, and being near to family and having family ties to the community. One benefit noted was the characteristics of rural life. Some of these characteristics focus on the natural beauty of rural areas and a slower pace of life (e.g., Bradley et al., 2012; Hastings & Cohn, 2013; LoPresti & Zuckerman, 2004). Additionally, the ability to be a generalist has been identified as a way for a practitioner to work with a variety of client issues (Hastings & Cohn, 2013; LoPresti & Zuckerman, 2004). This provides for diversity in the day of the clinician, a strategy identified in the self-care literature (Arledge & Wolfson, 2001; Barnett et al., 2005; Grosch & Olsen, 1995).

Participants reported being known in the community as being both a challenge and a benefit. Five of the participants reported benefits to being known: being able to provide a local resource, increased opportunities for referrals based upon a positive reputation, and being a part of the community. Being able to offer a service that would not otherwise be available within a

limited geographic area and gaining a sense of purpose from such service is consistent with previous literature (Hastings & Cohn, 2013). Additionally, being a known entity helps the providers to overcome the previously identified challenge of stigma attached to mental health treatment. Although practitioners often find themselves having to be “on” when interacting within the community, this openness and visibility increases the trust of the clinician and eases the development of rapport (Helbok et al., 2006). These opportunities have been previously discussed within the context of community involvement and acceptance (e.g. Schank & Skovholt, 2006; Schank et al., 2010). Finally, participants’ identification of the benefit of being near family and having family ties to the area was consistent with the literature on rural communities (Curtin & Hargrove, 2010; Helbok et al., 2006). The finding further emphasized that rural practitioners are part of their existing communities.

Research question 2: In what ways are rural clinicians currently caring for themselves?

Self-care strategies. Six separate themes emerged when discussing the participants’ self-care strategies. These themes included specific individualized strategies for self-care, professional strategies for self-care, utilizing one’s support system, maintaining a balance between personal and professional lives, maintaining a self-awareness regarding the need for self-care, and utilizing available resources. All the participants discussed their individualized self-care plans, and although all had strategies unique to themselves (Wicks, 2008), there were many strategies that were consistent across participants.

The specific strategies endorsed by each participant were among those encouraged in the literature. These included physical exercise (Mahoney, 1997) and engaging in leisure activities such as reading and listening to music (Coster & Schwebel, 1997; Kramen-Kahn & Hansen,

1998; Mahoney, 1997; Rupert & Kent, 2007; Stevanovic & Rupert, 2004). Professional strategies often included case consultation (Coster & Schwebel, 1997; Grosch & Olsen, 1995; Kramen-Kahn & Hansen, 1998; Lee et al., 2011; Mahoney, 1997; Stevanovic & Rupert, 2004) and continuing education (Coster & Schwebel, 1997; Kramen-Kahn & Hansen, 1998; Stevanovic & Rupert, 2004). Continuing education trainings were used as a way to network with other professionals and build a professional support system (Arledge & Wolfson, 2001). Whereas participants identified these strategies as helpful, consultation tended to be informal and continuing education often required traveling, which continues to be problematic for rural practitioners.

Clinicians use their support systems such as family, friends, and colleagues in response to professional isolation. This is consistent with the rural literature (Hastings & Cohn, 2013; Helbok et al., 2006). The participants who acknowledged being raised in the community in which they practice often spoke of large support systems, whereas those who relocated to the area had fewer nearby support systems. The absence of a support system has been identified as a risk factor for burnout (Ross et al., 1989). The two participants who spoke of difficulties engaging with their supports, such as friends living at a distance, were also the ones who expressed greater difficulty with maintaining a balance between their personal and professional lives. These participants identified their support systems as currently missing. This suggests that having a strong support system nearby is beneficial for use of those supports and maintaining a balance. Other participants spoke of setting aside family time, going out to lunch with friends, or engaging in physical sports as ways that they engage with and re-charge with their support systems.

Maintaining a balance between personal and professional lives appeared especially relevant for rural practitioners who live and work within the same communities. This balance has been described as the pull between altruism and self-preservation. As noted by several participants, there are always more clients to see and more work to do. Maintaining this balance has been identified as a strategy throughout the self-care literature (e.g. Coster & Schwebel, 1997; Grosch & Olsen, 1994; Kramen-Kahn & Hansen, 1998; Mahoney, 1997; Maslach & Goldberg, 1998; Norcross, 2000; Rupert & Kent, 2007; Stevanovic & Rupert, 2004).

Preserving self-awareness regarding the need for self-care is another identified strategy. The various professional organizations for mental health practitioners emphasize the need for awareness, particularly with regard to the effects of one's personal problems on clients (ACA, 2005; AMHCA, 2010; APA, 2010; Richards et al., 2010). Participants' strategies for self-awareness included meditation, relaxation, informal consultation with colleagues, paying attention to small changes in themselves, and reflecting on interactions with clients. Personal therapy is a strategy often encouraged for achieving this self-awareness; however, when prompted about this strategy, the majority of participants indicated that personal therapy was not considered a reasonable option. I will expand the discussion of this finding further in the section on additions to the literature.

The final self-care strategy that emerged during the interviews was the utilization of available resources. These included resources for exercising such as gyms and nature trails, staying healthy through check-ups with one's primary care physician, and belonging to professional organizations. Maslach and Goldberg (1998) discussed the use of preventative coping skills as being a buffer against burnout. Professional organizations were reportedly not very active in the area where the study took place. They were, however, identified as a way for

the professional to receive feedback on difficult cases in addition to keeping participants up to date on changes to insurance billing codes through use of the listserv.

What happens when practitioners are not effectively engaging in self-care? Three themes regarding the consequences of the practitioner not effectively engaging in self-care emerged. These included a change in the clinician, a change in client interaction, and clinicians feeling less effective in session with clients. Researchers have discussed these changes in the clinician distress literature (e.g., Grosch & Olsen, 1994; Maslach & Goldberg, 1998; Stevanovic & Rupert, 2004). The participants noted many personal changes that occur as a warning sign that more self-care is needed. These included somatic complaints, getting physically sick, getting irritable or anxious, minimal grooming, and avoiding clients or being relieved by no-shows. These symptoms are possible consequences of burnout, secondary traumatic stress, vicarious traumatization, or compassion fatigue (e.g., Grosch & Olsen, 1994). Additionally, as one participant noted, these symptoms are “seasonal” in nature and will wax and wane dependent on circumstances. This is consistent with the literature reporting that predictors of burnout are often situational or environmental (Maslach & Goldberg, 1998). Some of the clinicians reported previously being employed in agency settings. They found the flexibility of private practice in addition to the diversity of professional roles was helpful in preventing burnout. This finding is consistent with research that has found individuals working in agency settings indicated increased levels of burnout (Raquelpaw & Miller, 1989).

Participants described the changes that occur in interactions with clients as possible boundary crossings, countertransference, and the potential for the client to inquire into the well-being of the clinician. Countertransference is the process of seeing oneself in the client, of over-identifying with the client, or of meeting one’s needs through the client (Corey, 1991). Self-care,

particularly through personal therapy, has been identified as a strategy to obtain self-awareness and minimize the impact of countertransference reactions on the client (Davis, 1991; Fromm-Reichmann, 1960). Potential boundary crossings, which run the gamut from self-disclosure to sexual relations with a client, are more thoroughly discussed in the ethics literature (Alterman, 1998). The countertransference literature (Alterman, 1998; Davis, 1991) and the APA Ethics Code (2010) point to personal therapy as a recommended strategy for alleviating distress. Other recommended strategies include limiting scope of work and seeking consultation (APA, 2010).

Participants stated that these strategies, when possible, provide a break in addition to having another professional aid in the process of self-awareness. The types of changes in the client-clinician interaction are dependent on the clinician and other situational variables; for example, one clinician reported becoming more direct in session, whereas another reported becoming more passive. As noted by the ACCA, there is a continuum from stress to distress to impairment to improper behavior (ACCA, n.d.). Distress represents the experience of intense stress that is unresolved and results in distraction. Impairment further compromises the professional functioning of the clinician to a degree that may be harmful to a client or result in ineffective services. Because of the potential negative impact on clients, self-care should be viewed as an ethical imperative (Barnett et al., 2007; Richards et al., 2010).

Research Question 3: What are the barriers experienced by rural clinicians in relation to engaging in self-care? Barriers to self-care have not been discussed extensively in the literature. The obstacles identified in this study add to the existing self-care and rural literature. They include finances, lack of local continuing education opportunities, lack of local resources, time, and required distance to travel to self-care options. These themes were more

strongly endorsed after participants were prompted with a list of potential self-care activities, allowing them to consider reasons they do not use various options.

Additions to the Existing Literature

Although the literature is replete with suggestions for self-care strategies and the rationale for the importance of self-care, the experiences of rural mental health professionals are absent. Rural clinicians face a number of stressors in their daily practice (e.g., Helbok et al., 2006; Schank & Skovholt, 2006); however, it is unclear whether these stressors impact their self-care strategies. This study has been an initial exploration of whether the traditional self-care strategies in the literature are adequate for the rural practitioner. The study highlighted the importance of individual self-care processes, while showing that commonalities existed among rural therapists. Rural clinicians spoke of using their support systems, taking advantage of the environment around them, and striving to maintain a balance between their personal and professional lives.

After being reminded of potential self-care strategies, participants more thoroughly discussed the barriers to many common recommendations from the literature. For example, formal consultation, and personal therapy were identified as unrealistic options for some because of finances, lack of other local professionals, and the amount of time and distance one would need to travel to take advantage of those opportunities. Several participants spoke of being open to personal therapy if it was needed, however they would struggle to find someone who could see them as a result of working similar hours. Furthermore, in an effort to minimize the likelihood of a dual relationship in their local network, they would likely travel to someone outside of their network and referral sources. The probable need to travel presents its own barriers because of the extra time away from work and thus the loss of billable hours added to the

cost of traveling. One participant, who did report occasional use of personal therapy, indicated doing so in another state.

Whereas continuing education is often touted as a way to maintain competency, rural practitioners spoke of it also being a networking opportunity and often a vacation, given that the conferences were generally a long distance away. Finances were an additional obstacle to self-care as participants admitted not being able to afford a gym membership, personal pampering such as massage, or the cost of gas and car maintenance to travel for a night out with their spouse. Spending time with a significant other is a recommended self-care strategy (Coster & Schwebel, 1997; Rupert & Kent, 2007). It remains unclear whether the financial limitations are related to rural practice or to private practice in general; however, it is hypothesized that the challenges of rural living exacerbate these limitations.

The APA Ethics Code (2010) recommends alleviating distress by seeking consultation or supervision, reducing client load, and seeking personal treatment. I mentioned reducing client load while giving participants a list of possible self-care options. There were mixed reactions to this recommended strategy, with some identifying they would use it; others reporting it was not possible for various reasons. Finances were one of the primary reasons for being unable or unwilling to decrease client load, particularly the premise that if you are not billing, you are not getting paid. Those in private practice stated that as a function of their independent contracts, they would not be fulfilling their obligations to the practice if they cut back their hours. Those in an integrated care setting thought that the only way to cut back client hours would be to work part-time. Each of these options would have significant financial repercussions for the practitioner and therefore was identified as an option only for significant health reasons. A health problem was identified by one participant as the reason that she had taken time off; health

concerns continued to limit her scope of work and led her to give up her administrative responsibilities upon returning to her practice. The participant thought the change was necessary, yet she acknowledged that it was an emotional challenge to admit she could no longer function in the same capacity she had been. Another participant spoke of how she had planned on only providing limited services upon starting at the practice, but quickly found herself feeling over-extended due to being in the “midst of all the need” and pressures from her colleagues to take on a larger caseload. So for her, cutting back on client hours would be difficult and require her to be strong against those pressures. Therefore, as a function of both financial constraints and continuing to meet the needs of a community with limited resources, the commonly recommended strategy of reducing client load was identified as being of limited utility for rural practitioners.

The current study indicates that there are additional considerations for rural practitioners when designing a self-care plan. Some of the commonly used strategies such as setting boundaries and maintaining a balance between personal and professional lives are necessary but difficult given the culture of rural communities. As the rural literature points out (e.g., Helbok et al., 2006; Schank and Skovholt, 2006; Werth et al., 2010), the participants relayed that applying boundaries looks different in rural communities. Murray and Keller (1991) suggested that the rural professional needs a community orientation, having flexible involvement in the community. Being a part of the community leads to increased trust and allows rapport to be built more easily, while simultaneously limiting the opportunity for the practitioner to truly relax and go into personal mode (Helbok et al., 2006). While this is partially a consequence of the need for maintaining a positive reputation in the community, it also requires being vigilant about protecting the confidentiality of clients and keeping straight where information about clients may

have come from (Helbok et al., 2006). One participant spoke of how she might know something about someone she has never met, and must keep straight where information came from if she meets that individual at a community function. The way the rural clinician chooses to handle these incidental encounters and possible dual roles appears dependent on the comfort level of the practitioner and client. Some practitioners choose to avoid participation in community organizations, while others viewed the encounters as simply part of rural life and managed the best they could through addressing dual relationships explicitly in the informed consent process with their clients.

An additional theme that emerged involved self-care being a way for clinicians to be a model for their clients. It is hypothesized that this theme emerged as a result of the increased visibility of the practitioner in the community compared to urban areas. Increased visibility comes with its own challenges, but it appears that for some it creates an opportunity to practice what they preach. This seemed to be a strong motivator for therapists who tend to live in a fish bowl under observation by community members. Further exploration of this theme is necessary to grasp how the rural culture links to the self-care practices of rural clinicians.

A final cross-cutting theme developed in response to the question of whether anything could have better prepared clinicians for practicing in a rural area. The majority of participants reported that they felt adequately prepared for rural practice, but that it was a result of having been raised in a rural area. Between the personal knowledge of what to expect in a rural community and the rural focus of their graduate programs, the clinicians reported minimal unexpected situations. However, when they thought about someone coming into a rural practice that had not been raised in that type of community, there was overwhelming agreement that education and an understanding of the culture would be necessary. Sterling (1992) highlighted

the need for psychologists to become educated on the local politics, familial histories, and local power structures in rural communities. Participants discussed the importance of understanding boundaries, cultural expectations around small talk and gift giving, and ways to prepare for incidental encounters and dual relationships. Several participants spoke of witnessing practitioners from outside the area struggle with being accepted. One participant, who had been raised in a different rural area, spoke of her struggle to be accepted in the community, reporting it took her several sessions to develop rapport with many clients. Another participant who supervises clinicians in training stated that she has had to educate trainees on the culture. Harowski and colleagues (2006) provide recommendations on best practices in rural practice, training, and advocacy. They argued that there are specific multidisciplinary competencies required for effective rural practice.

Limitations and Opportunities for Future Research

As with any research study, there are limitations to the findings. Previous research has examined the burnout rates and experiences of rural clinicians. As there has been no research to date examining the self-care practices of rural providers, this study was designed to be exploratory and provide a starting point for future research. The study was designed to achieve an in-depth understanding of a small sample of the population of rural clinicians in Appalachia. There were a number of idiosyncratic responses that did not develop into themes, but were consistent with the literature. These focused primarily on the benefits and challenges of rural practice. Additional studies would be necessary to determine whether the experiences of these eight mental health professionals are consistent with the experiences of practitioners in other rural areas or small communities.

Additionally, participant demographics were fairly homogeneous, which represents another limitation. All participants were Caucasian and from a similar geographic region. Demographics were, however, consistent with the population of the region. Future studies could explore whether there are cultural differences to self-care practices among rural clinicians outside of Appalachia. Additionally, all participants worked in a setting where they are able to interact with other professionals. The existing rural mental health literature discusses how practitioners are often isolated and act as the only provider in a given area (Hastings & Cohn, 2013; Schank & Skovholt, 2006; Werth et al., 2010). Both of these forms of homogeneity constitute a limitation of the study.

Future research is needed to explore whether results are consistent among practitioners in solo practice. Solo-practitioners were contacted, but did not respond to requests for participation, possibly due to time constraints, as was reported by one potential participant who declined. Research has shown practitioners in agency settings are at increased risk for burnout (Raquelpaw & Miller, 1989). Therefore, future studies could explore the self-care strategies of rural agency practitioners to determine if results of the current study are replicated. Of potential interest was the lack of emphasis on the use of technology to overcome barriers to self-care in a rural practice. Use of online resources such as email, video-chat, and online CEU trainings could be viewed as creative solutions to minimize professional isolation, seek consultation, and maintain competency. The benefit of using technology in a self-care plan for practitioners in rural areas is an area for future exploration.

Finally, as the themes generated were closely linked to the questions asked, the research is limited to the interview questions. Only two themes emerged separately from the research questions. As such, future research could explore the cross-cutting themes in greater depth. The

study introduced the concept, proposed by several participants, that practicing self-care was a way for them to model healthy behavior for clients in a rural setting. Further study into the strength of this motivation would be valuable. Additionally, future research could aim to better understand the ways in which the choices for self-care activities are influenced by the rural culture.

Recommendations for Practitioners and Training Programs

The following are recommendations for programs training clinicians who will work in rural areas, as well as those providers already in practice.

- Obtain specific education on rural culture, particularly if not from a rural area.
- Rural communities often resemble fishbowls; therefore engaging in self-care is potentially a way to model healthy behaviors for patients and potential patients.
- Develop a professional support system. This could include joining professional organizations, networking at annual conventions, and maintaining contact with other clinicians in the area or from graduate school.
- Create a self-care plan with diverse strategies, particularly those that are consistent with personal values.
- Maintain a balance between personal and professional life. Having appropriate boundaries and consistent engagement with support systems are key strategies to an effective balance.
- Take time to reflect and notice personal triggers for stress, in order to increase self-care and thus avoid overwhelming stress becoming a concern.

- Training programs need to emphasize the role of self-care in being a competent and effective practitioner. Programs should model self-care, as well as provide opportunities for the student to reflect on their personal values and preferred strategies.
- Training programs can start to instill a culture that acknowledges one's own distress, in addition to a willingness to speak to colleagues who appear distraught.
- Consider using technology to connect with family and friends who live outside the community, especially for practitioners new to an area, who are still building their support systems.

Conclusion

The field of psychology has increased the attention placed on clinician self-care and burnout prevention (e.g. APA, 2006; Barnett et al., 2007; Barnett & Cooper, 2009; Barnett et al., 2005; Craig & Sprang, 2010; Figley, 2002; Jenaro et al., 2007; Kee et al., 2002; Munsey, 2006; Richards et al., 2010). Self-care is a way to prevent distress and ameliorate its treatment. Research has begun to focus on the experiences of rural clinicians, including challenges and opportunities of practicing in small communities (e.g., Bradley et al., 2012; Hastings & Cohn, 2013; Kee et al., 2002; LoPresti & Zuckerman, 2004; Werth et al., 2010). Kee and colleagues (2002) looked at burnout and social support among rural clinicians. They concluded that rural practitioners are at high risk for burnout and inadequate social support on the job. However, the existing literature does not explore the self-care practices of rural clinicians. I was interested in seeing if the traditional self-care recommendations of personal therapy, seeking consultation, reducing client load, and limiting scope of practice were useful to the rural practitioner. The current study is an important first step in exploring this gap in the literature.

The study explored the experiences of rural mental health providers. Responses indicated that the experiences of the participants were consistent with the existing literature on rural mental health. Thus, this study supplied empirical evidence to support general descriptions found in the literature. Participants in the study agreed that the rural area in which they work is characterized by greater spatial distances between people and services, scarcer resources, high rates of poverty, and minimal or inadequate health services. Additionally, the availability of mental health professionals is limited, with residents having to travel substantially further to access services. Rural practitioners reported being generalists to meet the needs of the community. Clinicians face the challenges of dual roles and stigma regarding mental illness and treatment. Rural practice has benefits for those who enjoy a slower pace of life and have values consistent with the rural community. It provides for collaboration with other professionals such as medical providers and faith leaders, and can lead to a sense of purpose from being one of the only mental health providers for an area.

The second research question looked at the ways rural clinicians care for themselves. Endorsed self-care strategies were highly individualized. Engaging in a mixture of internally and externally focused strategies is recommended (Rupert & Kent, 2007). Participants each noted using a variety of self-care strategies specific to their individual needs and situation. The study's participants were aware of the differences they experience when feeling overwhelmed or distressed. Changes were consistent with the distress literature, including irritability, fatigue, back pain, headaches, sleeplessness, missing work, anxiety, and the potential for harmful boundary crossings (Barnett & Cooper, 2009). Participants reported that when distressed they may get distracted and not be as effective in session; these reports are consistent with previous research (Pope et al., 1987). Participant scores on the Professional Quality of Life Scale

(ProQOL-5) were fairly uniform and did not result in differentiating between participants.

According to participant scores on the ProQOL-5, participants were at low risk for burnout and secondary traumatic stress. Additionally, they all scored in the average to high range on compassion satisfaction. These results suggest that all eight practitioners were satisfied with their jobs and were not experiencing burnout or compassion fatigue at the time of the interviews.

The APA Ethics Code (2010) Standard 2.06 (b) recommends limiting scope of practice, seeking consultation or supervision, and engaging in personal treatment. The rural clinicians I interviewed identified a number of barriers to engaging in these self-care activities. These included finances, time and distance, and lack of local resources. Consultation was reported to be primarily informal, and continuing education was often used as vacation as clinicians needed to travel to conferences. Time was identified as a barrier to engaging in some self-care activities, as many resources were located at a distance. Participants spoke of why personal therapy is not a reasonable recommendation because of the travel distance necessary to avoid a dual relationship. They also reported financial reasons for not being able to miss much work, and the cost of gas and car maintenance. Limiting scope of practice was similarly identified as a challenge related to the nature of rural practice. As a function of both financial needs and continuing to meet the needs of a community with limited resources, the commonly recommended strategy of reducing client load was identified as being of limited utility for rural practitioners.

Additionally, the study's participants identified self-care as being a way to model healthy behavior for clients. Because this self-care conceptualization was first uncovered in this study and may be a consequence of the lack of anonymity that practitioners experience in rural areas where they are known and observed by all, more research is needed to understand this concept. The impact of rural culture on clinicians and ways clinicians incorporate this belief into their

own self-care would be an area for future exploration. Finally, participants strongly recommended that an education on rural culture is necessary before rural practice. Training programs for mental health professionals would benefit from taking into account this recommendation for specific training on rural culture (see Harowski and colleagues (2006) for an outline of best practices for rural training, practice, and advocacy).

The current study provides a first step into obtaining a deeper understanding of the self-care practices of rural mental health professionals. Rural clinicians face a number of stressors such as dual roles and increased visibility. These stressors appeared to affect the choices available to the study's participants for self-care. They reported a number of barriers to traditional self-care recommendations that deserve further exploration. Self-care is a way to minimize distress and prevent impaired professional competency. As stated by Maslach and Goldberg (1998), one must help oneself before helping others. It is my hope that this research will lead to further understanding of the ways that rural clinicians can care for themselves and their clients.

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Appendix A: Participant Demographics

Participant	Sex	Highest Degree	Profession of Degree	Professional License
1	F	M.S.W.	Social Work	LCSW, CSAC
2	F	M.S.W.	Social Work	LCSW
3	F	M.S.W.	Social Work & Christian Education	LCSW
4	F	M.S.W.	Social Work	LCSW; LMSW
5	F	M.S.	Human Development/ Counseling	LPC
6	M	Psy.D.	Counseling Psychology	Licensed Psychologist
7	M	M.S.	Counseling	LPC, CSAC
8	F	M.S.W.	Social Work	LCSW

Three of the participants worked in integrated care settings, while the other five worked in private practice settings. Six of the participants identified theoretical orientation as either integrative or eclectic, with the other two reporting CBT or Existential as their primary orientations. This information is not included in the above table in order to protect the identities of the research participants.

Appendix B: Interview Themes

Research Question 1: What are the experiences of mental health practitioners in a rural area?

Challenges of rural practice

- *Being known within the community* (dual relationships, confidentiality and privacy, maintaining a positive reputation, high visibility within the community) - **6 participants**
- *Combating the stigma associated with mental health* - **4 (5 > prompting)³**
- *Poverty within the community* (lack of client resources, economy) - **6**
- *Lack of professional resources* (lack of local CEU opportunities, professional isolation) - **5**
- *Travel and transportation concerns makes it difficult for clients to reliably present for sessions* (geography, client transportation) - **7**

Benefits/ Opportunities of rural practice

- *Being known in the community* (being able to provide a local resource, getting referrals, reputation, being a part of the community) - **5 (6 >)**
- *Characteristics of rural communities and rural life* (nature, being a generalist, interprofessional collaboration) - **6**
- *Being near to family and family ties to the community* - **3 (4 >)**

Research Question 2: In what ways are rural clinicians currently caring for themselves?

Strategies for engaging in self-care

- *Maintaining a balance between personal and professional lives* (boundaries, setting priorities, maintaining a balance) - **7**
- *Maintaining a self-awareness of the need for self-care* - **5 (6 >)**
- *Professional strategies* (informal consultation, attending CEU courses) - **6 (8 >)**
- *Specific strategies* (i.e. pets, exercise, prayer, flexibility in schedule, eating right, relaxation, vacation, going out to lunch, reducing client load) - **8**
- *Utilizing available resources* (local gym, professional organization, medical checkups) - **4**
- *Utilizing ones support system* (family, friends, colleagues, professional organizations, church) - **8**

Consequences of not effectively engaging in self-care

- *There is a change in the clinician* (missing work, avoiding clients, relief at no-shows, getting sick, somatic complaints, irritability, stress, anxiety, minimal grooming) - **7**
- *The clinician is not as effective in session with clients* - **6**
- *There is a change within the client interaction* (possibly boundary crossings, countertransference, client inquiries into well-being of clinician, there may be a change in how clinician approaches the session) - **7**

Research Question 3: What are the barriers experienced by rural clinicians with relation to engagement in self-care?

- *Finances* (inability to afford activities for self-care; if not billing, not getting paid) - **4 (6 >)**
- *Lack of local CEU opportunities* - **3 (4 >)**
- *Time and time management make it difficult to engage in consistent self-care* - **5**

³ In this list the first number represents the number of participants who identified a theme during the initial interview. The second number in parentheses represents the total number of participants who endorsed the theme following prompting. E.g. 5 participants (6 > prompting)

- *Travel and distance* (resources are spread out, so there is a certain amount of time spend in the car traveling to and from activities) -5

Cross-Cutting Themes

- *Self-care is a way for the clinician to be a model of healthy behavior for clients* -3
- *Knowledge about the culture is recommended prior to engaging in rural practice* (being raised in a rural community; clinical experience being limited to rural practice; graduate education had a focus on rural practice) -8

New Themes Based on Prompting

Barriers to Self-Care

- *Personal therapy not being an option due to finances and lack of options (3 >)*
- *Reducing client load not a realistic option (4 >)*

Professional Strategies

- *Diversity of professional roles (3 >)*
- *Reducing client load as a strategy (3 >)*

Challenge of Rural

- *Lack of referral options (3 >)*

Appendix C: Demographic Questionnaire

I would like to start by asking about the community in which you practice.

1. What county do you practice in? _____

2. How large is the community in which you practice?
 - a. less than 5,000
 - b. 5,000 - 9,999
 - c. 10,000 - 14,999
 - d. 15,000 - 19,999
 - e. 20,000 or greater

3. How would you classify the community in which you practice?
 - a. rural
 - b. small town
 - c. suburban
 - d. metropolitan
 - e. large city
 - f. other _____

Now I am going to ask you some standard demographic questions

4. What is your age? _____
5. What is your sex? _____
6. What is your ethnicity? _____
7. What is your highest completed degree? _____
8. In what profession is your degree? _____
9. In what year did you receive your degree? _____
- In what year did you begin practicing
following receipt of your degree? _____

10. What professional licensure do you hold? _____

In which states? _____

What year did you receive your license
to practice independently? _____

11. How would you describe your theoretical
orientation? _____

*I want to shift gears again and ask questions about your current work setting and the work that
you do*

12. How would you describe your practice setting?
(independent, group, community, agency) _____

13. Could you describe your typical work week for me? _____

(Particularly things such the approximate hours spent
in activities such as face to face client hours,
administration, consultation, outreach, paperwork,
billing, types of clients, etc.)

14. What types of clients do you usually serve? _____
(e.g. depression, anxiety, psychosis, suicidal)

15. What type of social support system do you
have where you live and work? _____

16. Which if any professional organizations/
associations do you belong to? _____

Appendix D: Interview Protocol⁴

Thank you again for your willingness to participate in my dissertation research examining the self-care practices of rural clinicians. I will be asking you approximately 8 questions today and depending on how much you have to say I anticipate the interview taking approximately one hour.

- 1) You were invited to participate in this study because you are a mental health professional practicing in a rural area. I am interested in hearing your perspectives on the benefits and challenges of providing mental health services in a rural area.⁵
 - Benefits
 - Challenges
- 2) Do you believe that there is anything in particular that would have better prepared you for rural practice?
- 3) As we have discussed, I am specifically interested in the self-care practices of rural clinicians. What does self-care mean to you?
 - Are there any specific self-care strategies that you use, and would you describe them for me
 - Helpful or not?
- 4) How would you know when self-care is needed?
 - What happens if you do not engage in self-care?
 - Effects on you
 - Effects on clients
- 5) What resources are available to you as a practitioner to engage in self-care?
 - (if necessary) Are there other professionals around with whom you can engage in consultation and/or supervision?
 - (if necessary) Are there any support systems outside of your professional circle?
If so, in what ways do you use them?
- 6) Are there any barriers to you being able to engage in self-care?
 - (if necessary) how would you or do you overcome those?

⁴ The numbers and closed bullets represent the way in which I plan to ask the question, whereas the open bullets are more prompts for myself during the interview process for items which I ask if necessary based on the responses provided by the clinician.

⁵ Standard prompt if they start to go off topic – “This is all really good information, but I don’t know if I asked the question very clearly, I was really interested in “

- 7) Is there anything else that you want to add about self-care and rural practice that we have not discussed?
- 8) The literature mentions a variety of self-care strategies. Here is a list of some of those self-care strategies, some of which you have already mentioned. As you look at this list, do any of these strategies seem particularly beneficial or on the other hand are there those that don't seem particularly realistic or useful for you? (if necessary) Could you elaborate on those barriers?

Hand list of self-care strategies to participant on separate sheet

- Self-awareness/self-monitoring
 - Preserving balance between personal & professional lives (how?)
 - Relationship with spouse/ partner/ family
 - Personal therapy
 - Vacations
 - Medication
 - Reducing Client Load/ Limiting Scope of Work
 - Engage in Leisure Activities
 - Physical Exercise
 - Consultation/ Supervision (What type?)
 - Relaxation program
 - Diversity of professional roles
 - Continuing education
 - Spiritual beliefs/activities
 - Involvement in professional organizations
- 9) I really appreciate all the time you have taken in completing this interview. During the background review for my study, I learned that early detection of stress is a key component to effective self-care. I came across a measure that I would like to ask you to complete. I anticipate using the results to help me interpret the information that you provided me today. When you finish recording your answers, I can review the results with you if you are interested.

Appendix E: Letter Requesting Participation

Date:

Dear _____,

I am a student in the Doctor of Psychology (Psy.D.) program at Radford University and I am writing to request your assistance in the completion of my dissertation research study. The reason you are being contacted is that you are a mental health professional who works in a rural area and therefore have valuable knowledge about the unique issues that arise out of such work. The subject of my research is the self-care practices of clinicians in rural areas. My own work in rural communities has shown me some of the challenges of practicing in rural areas, and barriers to my own personal self-care. As such, I started to wonder about how rural practitioners are able to find that balance between meeting client needs and caring for themselves in an effort to prevent burnout, compassion fatigue, or possibly vicarious traumatization. I am therefore interested in learning about the “tips and tricks” for self-care and burnout prevention that rural practitioners may have developed for themselves as they navigate rural practice.

If you agree to participate in this research then I will interview you for about 60 minutes (depending on how much you have to say) regarding your experiences providing mental health services in rural areas while also caring for yourself, followed by a brief symptom survey. All information obtained related to the interview will be reported anonymously. If you are willing to be interviewed, I can meet with you at your office, Radford University, or another mutually agreeable location. I will contact you by telephone within the next week to answer any questions and ask about your willingness to participate. If you agree to participate when I contact you by phone, I will ask you some demographic questions at that time. This will help me determine if your experience fits the population I am studying. If you do meet these criteria then I hope that we can schedule an interview meeting during this phone call. Practitioners who agree to participate will be given the opportunity to attend a continuing education course with complimentary registration and CEU credit based upon the findings of the study.

This study has been approved by my dissertation committee and the Radford University Institutional Review Board. My advisor, Dr. Ruth Riding-Malon is available to answer questions you may have about the approval process.

Sincerely,

Jennifer Stroup, M.S.

Psy.D. Student

Radford University

Phone: XXX-XXX-XXXX

Email: jstroup2@radford.edu

Ruth Riding-Malon., Ph.D.

Assistant Professor of Psychology

Radford University

Phone: XXX-XXX-XXXX

Email: rridingmalon@radford.edu

Appendix F: Adult Informed Consent – Nonsurvey Research

Title of Research: Rural Mental Health Clinician Self-Care and Burnout Prevention: A Qualitative Study

Researcher(s): Jennifer Stroup, Ruth Riding-Malon, James Werth

We ask you to be in a research study that will explore the self-care practices for rural mental health professionals. Specifically, from this study we hope to learn about the ways in which you work to minimize symptoms of burnout and professional impairment. You were selected because you are a mental health practitioner in a rural area. If you choose to be in the study, you will be asked to participate in a semi-structured interview lasting approximately 60 to 90 minutes dependent on how much you have to say. The interview will be audiotaped to allow for transcription and analysis of the interview. The audio recordings will be deleted after transcription has been completed and verified for accuracy. All data will be presented anonymously in final form and will be in no way linked with you the participant. If you agree to participate, you will first be asked to confirm the demographic information that you provided over the phone, and then be asked a series of open ended questions. At the conclusion of the interview, you will be provided a brief survey instrument intended to provide you with information regarding your current stress levels.

This study has no more risk than you may find in daily life.

If you decide to be in this study you may benefit from being a part of it. Some benefits to you may be that all participants are being offered free registration and CEU credit to a continuing education workshop based on the results of this study that will be conducted in mid-2013.

You can choose not to be in this study. Your decision whether to participate will not affect your future relations with Radford University. If you decide to be in this study, you may choose not to answer certain questions or not to be involved in parts of this study. You may also choose to stop being in or withdraw from this study at any time without any penalty to you.

If you decide to be in this study, what you tell us will be kept private unless required by law to tell. The researcher is a mandated reporter and is therefore subject to a duty to report any incidents of abuse, neglect, or exploitation of children or elderly and incapacitated adults. The audiotapes of the interview will be transcribed as soon as possible and then erased once the transcripts have been verified for accuracy. Transcripts will be given a participant number and not linked with your name. All other data will also be given the same participant number and in no way linked with your name. All data is kept securely in a locked cabinet within a secure research lab. We will present the results of this study, but your name will not be linked in any way to what we present.

If at any time you want to withdraw from or stop being in this study, you may leave the study without penalty or loss of benefits by contacting Dr. Ruth Riding-Malon rridingmalon@radford.edu (XXX-XXX-XXXX) or Jennifer Stroup jstroup2@radford.edu (XXX-XXX-XXXX).

If you have questions now about this study, ask before you sign this form.

If you have any questions later, you may talk with Ruth Riding-Malon or Jennifer Stroup

This study was approved by the Radford University Committee for the Review of Human Subjects Research. If you have questions or concerns about your rights as a research subject or have complaints about this study, you should contact Dr. Dennis Grady, Dean, College of Graduate and Professional Studies, Radford University, dgrady4@radford.edu, 1-XXX-XXX-XXXX.

Being in this study is your choice and choosing whether or not to take part in this study will not affect any current or future relationship with Radford University

If all of your questions have been answered and you would like to take part in this study, then please sign below.

_____	_____
Date	Signature

I/We have explained the study to the person signing above, have allowed an opportunity for questions, and have answered all of his/her questions. I/We believe that the subject understands this information.

_____	_____
Signature of Researcher(s)	Date

Note: A signed copy of this form will be given to the subject for the subject's records.

Appendix G: Self-Care Strategies from the Literature

Please Review the following list and discuss whether any of the following strategies feel particularly useful or on the other hand would be unrealistic for you personally.

- Self-awareness/self-monitoring
- Preserving balance between personal & professional lives (how?)
- Relationship with spouse/ partner/ family
- Personal therapy
- Vacations
- Medication
- Reducing Client Load/ Limiting Scope of Work
- Engage in Leisure Activities
- Physical Exercise
- Consultation/ Supervision (What type?)
- Relaxation program
- Diversity of professional roles
- Continuing education
- Spiritual beliefs/activities
- Involvement in professional organizations

Appendix H: Follow-up Letter

Date

Dear

Thank you for taking the time to meet with me recently. I appreciated hearing about your thoughts and experience with engagement in self-care as a rural practitioner. The information that you provided was very helpful.

I hope to be able to summarize the findings of my interviews sometime in early 2013. As part of the research protocol, I will be sending you a copy of the results so that you can review them and give me feedback about how well you believe they reflect your experience as you described it to me.

Sincerely,

Jennifer Stroup, M.S.

Psy.D. Student

Radford University

Phone: XXX-XXX-XXXX

Email: jstroup2@radford.edu

Appendix I: Feedback Letter

Date

Dear

I have completed the preliminary analysis of my research and would appreciate feedback from you. I have included the analysis of the interviews that I conducted. This is a summary of all of the interviews so your exact experience may not be obvious.

I am interested in the degree to which you think the descriptions reflect your experience, as you described it to me. If your answers were unique then you will not find them here as I needed at least 3 participants to discuss an issue in order to include it in the analysis. Please let me know if you have any questions or concerns about how your material was included in the attached analysis. If you think it is accurate, please let me know that.

Because of time constraints, I would appreciate any feedback within two weeks. If I have not heard from you within that time then I will assume that you found the results to be representative of your experience. If you do have feedback please email me at jstroup2@radford.edu. If you prefer not to contact me directly then you can email my dissertation chair at rridingmalon@radford.edu.

Again I would like to express my appreciation to you. Your time and consideration has been greatly appreciated and has assisted in better understanding the self-care needs and practices of rural clinicians. I will send a separate letter with information regarding the exact date and time for the CE workshop when that has been scheduled should you decide to attend and utilize your no obligation free registration.

Sincerely,

Jennifer Stroup, M.S.
Psy.D. Student
Radford University
[Jstroup2@radford.edu](mailto:jstroup2@radford.edu)
(XXX) XXX-XXXX