

Dimensions of Diversity

Editor's Note: In September, 2003, the Minnesota Psychologist began a series of articles addressing the various aspects of diversity that impact our roles as psychologists. Through an ongoing section entitled: "Dimensions of Diversity," the Minnesota Psychologist features discussions on topics ranging from practice issues, training, education, to research and organizational/systems change. The primary purpose of the section is to give readers an opportunity to explore and expand issues of diversity in a manner that is cogent and integrated with all that we do. We know that our challenges as psychologists are many. Yet, we take pride in developing our profes-

sional competencies and seeking to be better educators, trainers, researchers, consultants and practitioners. We are aware that the exploration of diversity issues is important.

This issue features the second article by Katherine Slama, Ph.D., LP, on rural cultural competence.

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Toward Rural Cultural Competence

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The first article in this series (Slama, 2004) made the point that rural Americans have some cultural differences from urban Americans. Some of these differences affect attitudes toward mental health services and make it more difficult to use our services, as well as for us to deliver them.

It is important for all Minnesota psychologists to know something about rural culture. Rural people may move to urban areas, go to urban specialty providers for secondary or tertiary assessment or care, or drive to urban general service providers to avoid the privacy dilemmas they perceive in their own communities. Therefore it is important that all psychologists be able to assess the degree of rural acculturation of their clients. Since 25-40% of Minnesotans qualify as rural, depending on definition, it would be desirable for urban mental health providers to gain the general familiarity with rural subcultures that will let them provide psychological services to rural clients in a culturally competent manner.

This second article will suggest ways mental health providers can assess acculturation of rural clients, as well as tailor services to serve those clients appropriately. It will go on to discuss ways that rural mental health providers can best serve rural communities, and then proceed to describe policies that our profession might advocate to facilitate development of rural cultural competence and to serve more adequately the mental health needs of rural people.

Assessing Acculturation

A principle of providing services to people of any minority culture is to learn to assess the degree to which each

member of that culture is more or less acculturated to mainstream/urban American culture. This will determine the degree to which we tailor our services in each case. Unfortunately, I have been unable to locate any research indicating what factors might constitute such an assessment for rural Americans. Therefore I have examined my own practice and questioned other rural providers, and the following will, I hope, serve as a starting point for assessing acculturation of rural clients.

First, are **demographic factors**: It is my experience that people who live in rural areas, or are from such areas, are more likely to hold characteristically rural values, as described in my previous article, and act in ways more consistent with those values, if they: (a) are older, (b) have less higher education, (c) live on a farm or in a smaller town or have never lived in an urban area for any significant length of time, (d) have parents and grandparents living in rural areas, and (e) have not traveled often or far.

It is critical to know the cultural geography of the area one serves. Not only are there pockets of exceptions to general demographic indications, such as the circle around lakes mentioned in my previous article, but many small rural areas have differing values and customs that relate to the characteristics of initial settlers, which might be German in one town and Irish in the next, or Catholic in one town and Mennonite in the next. Degree of acculturation may involve assessing the importance of local customs to each client.

Second, are indications from a client's **presentation and body language**: More rurally oriented clients are even more

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likely than Minnesotans in general to comment on the weather or local events as we walk from waiting room to the office and to include what we might otherwise consider tangential events about family or friends in their summary of what brings them for services. They may be more likely to use upper Midwestern language variants, sometimes characterized as "speaking Minnesotan." Rural women are less likely to offer their hand to shake before a mental health professional does so, while rural men are more likely to wear a cap, sometimes even into the office. Rural men especially seem to like an extra foot of personal space, to sit with their arms crossed, and to make less consistent eye contact initially. Rather than necessarily indicating defensiveness, these nonverbal characteristics may just represent cultural norms.

Third, is some specific **terminology** that might indicate greater cultural rurality: This may be as obvious as more rural people referring to the noon meal as "dinner" and the evening meal as "supper." They more often give directions by saying to turn north or south than left or right, and by citing a landmark (Nelson's house, the school, the Catholic church) than a street name/number. Rural clients, especially women, may be more likely to use apologetic language forms ("I'm sorry, but...") when giving information outside what they consider expected.

More rurally oriented clients may have more difficulty describing their emotional reactions. They seem more open to including concepts from their religion when I ask whether they wish me to do so when relevant. While no different from urban clients in terms of intelligence and personality characteristics, they perceive their lives (often with good reason) as more circumscribed in terms of opportunities and pressures to conform.

Tailoring Direct Client Services

To the degree that a client is less acculturated to urban culture and adheres more closely to the values and behavior of rural culture, I would suggest the following procedures, although I could not locate research that validates them.

Despite the emphasis in some brief therapy models on jumping directly into a review of therapy-related events or homework, it seems to me that it is particularly important to rural people that a therapist take a few minutes to help them transition into therapy, generally by talking about the weather, crops, status of local sports teams, or other local events. This seems to help them feel more comfortable and function better in therapy sessions, with the shared experiences facilitating a clinical joining, so that the time investment is worth the result. Likewise, I begin the transition out of therapy a bit earlier, perhaps by reference to similar topics, right after the summary of what aspects of therapy they'll work on during the time between sessions. This acknowledgement

of both clients' and therapist's solid relationship to the community and its events seems to validate the general interaction experience of more rurally oriented people. Similarly, offering coffee or other treats is part and parcel of making the rural client feel welcome, much like what would happen if you were in their home.

Rural mental health professionals learn to set boundaries somewhat differently with more rurally oriented people. Their tendency to defer to authority makes it even more important that therapists be aware of their own values and beliefs and avoid expressing them to clients without clearly identifying them as one's own values and noting that other values may be just as valid. Some rural clients become distressed in the face of therapy techniques aimed at leading them to explore and choose their own best options, when they expect therapists to make clear recommendations ("You're the doctor!"). It may be effective to use strategic suggestions for such clients early in therapy until they learn to trust themselves more. It is important that the therapist explain clearly why it is not appropriate for others to make personal decisions for clients. The most recent revision of the APA ethics code shows APA's efforts to be sensitive to the boundary issues of rural psychologists.

Self-disclosure is a highly valuable tool in working with rural clients. Therapists may discuss their children, experiences growing up, rather mundane daily experiences, cognitive distortions, etc. as a model for explaining dynamics to clients. Such personal stories seem to make clients feel more willing to talk about their own difficulties, an activity their culture has made hard for them. Of note, the need to appear morally virtuous in rural communities sometimes raises the social desirability scales of personality tests, and it is important to take that into account to some degree when interpreting the results from the test of a very rurally oriented client.

Given rural clients' greater concern about confidentiality, I take greater measures to reassure them on this topic. For example, I note in the first session's orientation that, since I am mainly known as a psychologist in two of the communities in which I work, I would, if we meet in public places, let them take the lead in deciding whether to initiate a greeting or not, and I would not feel hurt in any way if they choose not to do so. I clarify what will happen if they call our crisis line, as well as how our office staff would respond if someone should call us to talk about them. I understand and deal with rural clients' reluctance to participate in therapy groups due to their confidentiality issues.

When clients may know me from some joint activity, it's often not desirable, given the dearth of other nearby mental health professionals, to refuse service and refer. In such

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cases, I openly discuss the shared activity, and we decide how to interact in that setting. Many of my clients know each other, so it's very important for me to keep what I know from one client separate from what I have learned from another client. This can be particularly difficult when information from one conflicts with information from another. Peer consultation with other rural psychologists is especially important in dealing with such situations. Helbok (2003) has an interesting discussion of rural ethical issues. He notes that rural mental health practitioners need to be more sensitive and flexible concerning some ethical issues, and he recommends a number of decision-making models that might be of assistance when ethical dilemmas arise.

The practical or concrete nature of culturally rural people often makes more abstract therapies difficult with them, and I may work in a more behavioral manner with such people, conceptualizing therapy as learning self-management skills. To satisfy their practical nature and assist conceptualization, I may use more examples than with other clients, attempting to customize each example carefully to each person. If their concrete nature leads more rural clients to focus more on medications as the solution to their problems, when research would indicate psychotherapy instead or as well, I try to describe clearly how learning the skills I'm proposing is likely to be useful to them. I find that they often respond very well to clear descriptions of disorders and therapies in a psychoeducational mode.

The pattern rural clients have often learned of not expressing emotion may also present difficulties in applying many therapy modalities. After validating the reasons for such learning, it may be useful to take some time to help clients learn an emotion vocabulary and give emotional expression exercises to practice between sessions. Some rural clients, more often men, may be so uncomfortable with such work that they can't tolerate it, and it may be more effective to stay with more behavioral therapies, as recommended by Levant & Habben (2003). If a client objects to self-esteem strategies, expressing fear of becoming or being thought conceited, the therapist might differentiate between boasting to others and learning to be realistic with oneself about one's positive aspects and abilities.

A general reluctance to express emotion may create greater somatization in rural people, as one of the few relatively acceptable ways, especially for women, to manifest distress. I believe that we serve such people best if we work closely with physicians, informally educating them in identifying such patients and referring them. We then need to learn, and teach clients, methods from behavioral medicine, such as the various pain management technologies. It is my observation that somatizing clients respond best to therapy if it relates to the reason for referral and is directed at their primary physical complaints. The trust in a therapist

that builds during this process may later allow them to work in more traditional psychotherapy.

It strikes me that flexible mental health providers probably implement many of these suggestions to some degree with all their clients, rural or urban. I have simply tried to point out some measures I believe are even more important with people with more rural attitudes and values. Perhaps one of the best ways to gain competencies in rural culture is to take time to network and talk with rural therapists in detail about their rural clients and services.

Since rural mental health practitioners are distributed more scarcely, it is more important for them to have more general competencies, much like family practitioners in medical practice. Rural communities need generalists who can treat both children and adults. Geropsychology skills are important as well, due to the higher proportion of older citizens in rural areas. Rural settings need psychologists who can treat people in jails, general hospitals and emergency rooms, group homes for people with mental health and developmental disabilities, and nursing homes. With all the ethnic and racial diversity of people moving into rural areas (seven languages at one food processing plant in my area), and usually without other local mental health providers more experienced with such cultures to whom we can refer, we must ensure that we ourselves become knowledgeable about those cultures (NRHA, 1999).

Thus it is extremely important for rural psychologists to continue our education past our internships, gaining broad competencies. This is ironic, given the difficulties that rural practitioners experience accessing continuing education, which tends to be held in more urban areas, raising overall costs due to more travel and overnight time. A good consultation network with our colleagues with specialties other than our own is also critical. Lastly, although most rural areas sadly lack good language translation resources, it is critical for us to identify these resources that exist, since the usual translators, clients' children, are generally not suitable as translators for the adult and personal material involved in their parents' therapy. I'm looking forward to the supplemental issue of *The Journal of Rural Health* on health and mental health issues concerning minorities and multicultural populations living in rural areas, expected in June 2004.

Our Role in Rural Communities

Although most mental health providers in rural areas are trained solely in clinical work, we usually find ourselves getting involved in community psychology as well, using our expertise to assist our communities in facilitating the mental health of citizens and in preventing mental illness. Many of us serve more than one community and thus become, in effect, multi-community citizens, taking part in the development of several communities. Our literature suggests that

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this is an important role. Rural people are deeply embedded in social and cultural systems that we must understand, enter, and use to help them most effectively.

Community collaboration begins with our clinical work. One of the most common recommendations in the rural mental health practice literature is to provide mental health services in highly collaborative ways. In particular, we are encouraged to co-locate, or otherwise work closely, with rural medical practitioners (Lambert, *et al.*, 1996; National Rural Health Association, 1999; Sears, 2003; APA, 2003; Mulder, 2003). The family practitioner is seen by many rural residents in the same light as the pastor, as an extension of one's family. There is also the benefit of instant credibility with a client if "Doc Jones" says the client should see you.

Physicians are increasingly coming to understand that ready access to mental health consultation for themselves and services for their patients lets them provide better services and makes it likely that the patients will obtain and use mental health services. In return, psychologists in collaborative settings can more easily consult and refer their clients for medication assessments, as well as for the medical assessments that can rule out medical causes of mental illness symptoms. Location of mental health services in the same building with other services also obviates the rural resident's concern about being seen using that building. The case for location of children's clinical services in schools is similar to that for locating mental health services in medical settings (Nordal, *et al.*, 2003).

Perhaps even more than urban mental health providers, rural providers find it important to link clients to other services to build assistance and support networks. Even in my most rural community, I find myself, directly or by suggestions to clients, referring to the hospice and its grief counselor, the domestic violence advocate, county social services, pastors, school counselors, legal services, vocational rehabilitation, AA, GA, the mental health support group, public health, home health, extension services, the senior citizens center, pharmacists, chiropractors, optometrists, nutritionists, physical therapists, and occupational therapists. Often clients are already using such resources, so I can coordinate what we do.

Rural libraries can assist by providing books that psychologists use for bibliotherapy, as well as the only Internet services that many clients can afford, and we can give librarians the names of the books that we most commonly recommend to clients. We can refer to the local Chamber of Commerce for the lists of clubs clients might join and of volunteer opportunities. We can work with staff of nursing homes and residential facilities for people with mental illnesses and developmental disabilities. When serving a rural community, it is important to meet with all of the people

who provide any of these services, so that we can understand how they can serve our clients, as well as give them a sense of our services. Bartenders and local police and sheriff department personnel may be just as important. There may not be the specificity or variety of resources available in an urban area, but is critical to network with the resources that do exist in each rural community.

In rural areas, it is even more important than elsewhere that psychologists wear the many hats that reflect the multiple arenas in which we are trained and work. We can share our mental health expertise and knowledge through a wide variety of teaching activities, ranging from formal college courses through public school community education courses, as well as through consulting to businesses and talks to local clubs and congregations. This is not to minimize individual contact, for example with a bartender who asks what to do when a patron talks about suicide.

Our training and experience with community residents uniquely fit us to collaborate in giving impetus and direction to efforts to improve the social, health, and even economic aspects of our areas. It is important for us to advocate for activities for both youth and adults that provide alternatives to substance use, gambling, and unwise sexual activity, wherever those alternatives can be located in communities. This often means teaming with local business and government leaders, churches, social services, and ad hoc groups in a wide range of community development activities. Our input might be critical, for example, in helping county commissioners realize the impact of family violence when they say, "We don't have that kind of thing out here!" or in helping a faith congregation reach a consensus on making services friendly to members who might be GLBT.

Policy Considerations

Stamm (Benson, 2003) has used the term "urbancentrism," which she defines as "a tendency for psychologists and other professionals, as well as the general public, to pay more attention to the problems of cities and suburbs than to those of rural areas." Due to the particular geography of Minnesota, I've often heard "metrocentrism" used in the same way. Nordal (2003) notes that "Legislators need to know that national policies are often based only on urban models and do not provide an accurate picture of rural areas." He suggests that "...models of funding and care must take rural factors into account." I'd add that it is not just national legislators, but people located in all layers and branches of government, as well as in non-governmental organizations and professional associations, who might do well to take heed of such factors. Please note that the recommendations below, unless referenced, arise out of my own opinion, experience, and communication with other rural mental health professionals.

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MPA

Let's start with our own organization, the Minnesota Psychological Association (MPA). One of its newest actions has been to encourage members to include our cultural competencies in the MPA directory. This can help in a number of ways. Members with rural cultural competencies can note them, and when we rural psychologists refer for specialty evaluations and other services, we will know which colleagues are more likely to treat our clients sensitively and competently. When urban psychologists without rural cultural competencies find that their new client falls toward the rural end of the acculturation continuum, they will be able to look in the directory to find an appropriate consultant. When we rural psychologists see a client of a culture unfamiliar to us, we will be able to find colleagues with whom we can consult until we obtain the training for that competency.

It would also be helpful for consulting on therapy issues if MPA's competency list could include some general client and therapy categories in which members are willing to consult, much like the one developed by Minnesota Women in Psychology (MWP). Another helpful step would be for MPA to encourage some entrepreneur to form an organization of translators, preferably with good general mental health vocabularies, who would provide that service with our clients and us by phone, so we wouldn't have to pay translator travel costs, as well as their service fees.

Next, MPA's various committees, task forces, and divisions could make it easier for rural members to participate, since only such regular participation will advance the singularly rural issues that will attract and serve rural members and help them serve their rural clients. I applaud the divisions with active listservs, as well as the listserv for members in general. However, many MPA bodies hold meetings on weekday mornings or evenings, so MPA members from farther than about an hour away would have to take time off work for travel, as well as pay extra meal and room costs, to attend. No wonder so few members from rural areas serve on our committees or belong to MPA divisions, and so feel rather disenfranchised within MPA! The MPA office now tries to find metro members who will host members from Greater Minnesota overnight, and I have had wonderful experiences with this service, but I suspect that many rural members have eschewed it, perhaps due partly to the rural value of self-reliance.

Kudos to the committees that have tried to find ways to use telephone hookups during committee meetings in an effort to include "outstate" members. Those hookups need to be tested and confirmed before the meeting site is selected; the main site needs to use a good quality speakerphone, and committee members at the main site need to be sensitive to the members present by phone, finding a way to be the same distance from the speakerphone and avoid

sudden loud exclamations to make the volume of each comfortable to the listener, identifying themselves before each contribution, and speaking clearly. Internet hookups might also be explored for this purpose, and e-mail can certainly be used to transmit agendas and handouts prior to meetings.

Some of the same points might be made with respect to MPA's provision of continuing education opportunities as those below related to educational institutions. Lastly, MPA members active with APA can encourage a strong APA Office of Rural Health, whose activities seem to have fallen off somewhat since Gil Hill's leadership of it ended.

Educational Institutions

There are a number of steps that Minnesota's institutions of higher education can take to assist mental health professionals in gaining rural cultural competency. Nearly a decade ago, APA (1995) suggested a curriculum to train mental health providers for rural service, so I won't go into that area here. What I'll do instead is to recommend that universities train all kinds of human services providers at all academic levels, from two-year chemical dependency programs to post-doctoral education and internships, in the general issues involved in rural culture and rural service provision. I'd also recommend exposing at least a certain percent of students to rural clients in practica and internships. Some services, such as psychotherapy, require supervision time that rural psychologists may have even more difficulty than urban ones providing, since it takes away from critical client service hours in much smaller settings; it would be important to take this into account in academic funding considerations. Training programs would do well to collaborate with rural providers in programs such as the Minnesota Consortium for Advanced Rural Psychology Training in Northwest Minnesota.

One easy way to ensure rural cultural competencies is to recruit students from rural areas. This works best if they are students of traditional college age who don't already have jobs and families living in the rural areas, since they can move to the university. However, many of our most valuable potential colleagues are non-traditional students with established lives in rural areas, such as a family farm or small business. For these trainees, we need innovative programs that, without losing quality, reward previous mental health experience and allow much training to occur on weekends or by internet or telecommunications in various distance education models. It should be obvious that the same is true in providing continuing education to rural providers. It appears that eventually it will be important for universities to provide the psychopharmacology training that may be more important to rural areas due to their greater shortage of psychiatrists (Sammons, 2003), and that the format of

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such training will need to be friendly to already-established psychologists.

Universities are uniquely situated to facilitate research, but because most graduate mental health training institutions are located in urban areas, researchers have not conducted much study into many issues in rural mental health, often just assuming that research conducted with urban populations applies equally to rural people. This is where collaboration is greatly needed, and I urge research psychologists to seek out rural colleagues in developing and investigating research questions related to rural issues. In doing so, it will be important to remember to share funding, since non-university psychologists generally have full-time jobs which schedule them up so fully that they may need some funding to break time free to do the research in which many of them are highly interested. Sometimes paid part-time ancillary or research positions are useful in this respect.

Government

Both as individual citizens and through MPA, psychologists can advocate for policies appropriate to rural people's mental health needs and their provision. As I write this in January 2004, I note that the federal Substance Abuse and Mental Health Services Administration made rural mental health one of its 2003 priorities. Likewise, the HHS National Advisory Committee on Rural Health and Human Services designated mental health as one of its two main foci for 2003, and its report on the subject is due in February 2004 (Benson, 2003). It will be important for us to urge governmental units to implement the recommendations we believe will be useful to our clients and the practice of rural psychology.

At the federal level, funding in research on rural mental health would be a priority. Another would be changing Medicare to fund clinical services equally across states, rather than its current higher per capita funding of more urban states, despite the proportionally greater aging populations in most states with higher rural populations. Many would like to see Medicare fund telehealth for mental health services more appropriately, as well as fund psychologist prescription medication services. Finally, higher funding of national educational loan forgiveness programs for psychologists employed in rural settings would be desirable.

At the state level, I believe MPA should advocate for funds to support development of the health care alliances that show promise in making health insurance affordable for the farms and small businesses so characteristic of rural areas. We should also support state loan forgiveness programs for psychologists employed in rural settings and state authorization of psychology prescription privileges. Medical Assistance should take account of rural issues. Perhaps the most blatant examples of its barriers are the ten days between

regular sessions (rural psychologists are often only in a particular location one day per week) and the lower funding of many services in rural areas of the state. We need the kinds of cost research that documents the higher costs of recruiting mental health professionals to rural areas, as well as their travel and other costs that are higher in rural areas.

The state needs to support telehealth by ensuring that the technical infrastructure to support it reaches rural areas, by facilitating integration of the various telecommunication systems that have grown up in Minnesota so they can interact with each other, and by reimbursing for telehealth services. State officials need to realize that sending "state-operated services," such as crisis teams and paraprofessionals, out into rural areas the state employees don't know may not only provide poor services for the clients, but also disrupt the services already in place for people with severe mental illnesses. Lastly, we should advocate for the state Office of Rural Health and Primary Care to provide the same assistance to recruit and retain mental health professionals in underserved areas that it provides to communities for finding and keeping physicians.

Conclusion

This article has attempted to show how assessment of acculturation of rural people might occur, as well as a number of ways that mental health professionals might modify their services to best serve rural people and their communities. It concluded with ways that we can advocate for policies that will better serve rural Minnesotans and their providers. Since there is little literature or research on several of the areas I have covered, I would welcome observations and discussion from colleagues, perhaps in letters to the editor or on the rural listserv. It would be fascinating to undertake a research project to test the relative strength of various factors in developing a measure for rural acculturation. I'd be most interested in collaborative studies in this area, as well as in validating some of the practice factors I've suggested.

A question some might ask of rural mental health providers is why, if there are so many challenges in working in rural settings, we choose to do so. Perhaps the very values that seem to be more characteristic of rural people attract us to live and work in rural areas. Helbok (2003) mentions the satisfaction derived from having an impact on an entire community. For my part, I like the variety and challenges that rural work gives me, as well as the community involvement and relationships and the sense that my work is highly valued and valuable. Many of my clients have the commitment to drive significant distances to seek services, and I consider it an honor to be of use to people with that ethic of hard work and independence.

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REFERENCES

- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060-1073.
- American Psychological Association. (1995). *Caring for the rural community: An interdisciplinary curriculum*. Washington, D. C.: APA Office of Rural Health.
- Benson, E. (2003). Beyond "urbancentrism." *APA Monitor*. Retrieved November 21, 2003, from <http://www.apa.org/monitor/jun03/beyond.html>
- Helbok, C. M. (2003). The practice of psychology in rural communities: Potential ethical dilemmas. *Ethics & Behavior*, 13, 367-384.
- Lambert, D., Bird, D.C., Hartley, D., & Genova, N. (1996). *Integrating primary care and mental health services: Current practices in rural areas*. Kansas City: National Rural Health Association.
- Levant, R. F. & Habben, C. (2003). The new psychology of men: Application to rural men. In B.H. Stamm (Ed.), *Rural behavioral health care: An interdisciplinary guide*. Washington, DC: American Psychological Association.
- Mulder, P. L., Kenkel, M. B, Shellenberger, S., Constantine, M., Streiegel, R., Sears, S. F., et al. (2000). *Behavioral health care needs of rural women*. Washington, DC: American Psychological Association, Committee on Rural Health. Retrieved November 16, 2003, from <http://www.apa.org/rural/ruralwomen.pdf>
- National Rural Health Association. (1999). Mental health in rural America. Retrieved November 16, 2003, from <http://www.nrharural.org/dc/issuepapers/ipaper14.html>
- Nordal, K. C., Copans, S. A., & Stamm, B. H. (2003). Children and adolescents in rural and frontier areas. In B.H. Stamm (Ed.), *Rural behavioral health care: An interdisciplinary guide*. Washington, DC: American Psychological Association.
- Sammons, M. T. (2003). Nonphysician prescribers in rural settings: Unique roles and opportunities for enhanced mental health care. In B.H. Stamm (Ed.), *Rural behavioral health care: An interdisciplinary guide*. Washington, DC: American Psychological Association.
- Sears, S. F., Jr., Evans, G. D., & Kuper, B. D. (2003). Rural social service systems as behavioral health delivery systems. In B.H. Stamm (Ed.), *Rural behavioral health care: An interdisciplinary guide*. Washington, DC: American Psychological Association.
- Slama, K. M. (January, 2004). Rural culture is a diversity issue. *Minnesota Psychologist*, 9-13.

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