

Rural Culture is a Diversity Issue

Kay Slama, Ph.D., LP

Are people who live outside cities the same as those who live in cities? Just like urban residents, rural people live in houses, go to jobs, socialize, eat, and sleep. They have racial and ethnic diversity, like our cities, but otherwise, there aren't many differences, right? This article will attempt to make the case that there are some significant differences in factors that affect rural people's mental health, as well as in the manner in which we can most effectively provide mental health services to them. It is not only psychologists working in rural areas who need to attend to the differences, since rural people are often referred to urban areas for secondary and tertiary health care. If you work in a large medical center or a specialized psychology service, you are likely to assess and treat people from outside your city.

More intensely since the mid-1990s, awareness has been increasing that residents in rural areas of America are getting less help than urban citizens with their mental health issues. Many reasons are well-documented in the surgeon general's report (1999), the National Rural Health Association's paper on the subject (1999), the APA Committee on Rural Health's report (Mulder, *et al.*, 2000), and the recent APA book, *Rural Behavioral Health Care: An Interdisciplinary Guide*, edited by Beth Hudnall Stamm (2003), who spoke via telecommunication hookup at MPA's 2001 Annual Convention in Alexandria. These are excellent publications, and I recommend them to your attention. These sources document that mental disorders are at least as prevalent in rural areas as in urban areas, and "may be higher for substance abuse, depression, suicide, and traumatic stress" (Stamm, 2003). They also show that rural residents often receive a lower frequency of treatment, especially for people with the most serious mental illnesses and nursing home residents.

Many of the factors that create barriers to rural mental health services involve cultural diversity—cognitive and behavioral differences from the 80% of Americans who live in urban areas. Rural Americans have cultural differences that, like many other minority populations, make it hard for them to accept mental health services, as well as making it difficult for providers who are not aware of the cultural differences to serve ruralites appropriately. In this first article, I will describe some of these cultural differences. In the sec-

ond article, to be printed in the next *Minnesota Psychologist*, I will suggest ways in which mental health providers can modify their services to be more responsive and effective with people from rural cultures, as well as policies which will help us meet this goal.

What is Rural?

I'll make four preliminary points. First, as with cultures derived from ethnic and racial differences, people from rural America fall along a continuum of acculturation to mainstream culture, the degree to which they adhere to characteristically rural values, traditions, and customs, versus those of urban life. American mainstream culture pervades rural areas, particularly through the ubiquitous influence of our television, Internet, musical, and radio media. It is just as important to assess degree of acculturation in this population as it is when working with someone of any other culture. The points I make below about rural culture do not apply uniformly to the people who live in a rural area, and it is just as important not to stereotype rural people as it is to avoid stereotyping people from ethnically or racially based cultures.

Second, there are degrees of rurality, and I prefer to think of rurality as a continuum. In Minnesota, besides "The Metro Area," there are several large population centers in "Greater Minnesota" which meet the definition of Metropolitan Statistical Areas. Further along the continuum, there are quite a few smaller cities with 15,000-50,000 people, and many small towns of under 15,000 people in rural areas. Lastly, 33 of Minnesota's 87 counties meet the "frontier" criterion of <6 people/sq. mi. The further along this continuum people live, the more likely they are to internalize and reflect rural culture. One exception is that people with financial means adequate to afford lakefront property seem to have clustered in circles around many of Minnesota's lakes. Such rural residents often moved from, or otherwise have adopted values similar to, those of suburban Americans.

This helps make my third point: Rural areas are not homogeneous. It is critical to recognize that their traditions and customs vary from small town to small town, as well from farm to town. One of the principles of rural service provision is to know your cultural geography; each area's par-

Continued on page 10

ticular customs and traditions are a treasured part of how people from that place think and act.

Keep in mind that the differences noted in this article are, of necessity, generalizations. To the extent that mass media are homogenizing America, the differences may be shrinking. To the degree that the differences reflect facts of life for rural Americans, however, I do not expect them to decrease. The sources cited in my initial paragraph document that greater poverty, older populations, access difficulties, lack of privacy, and isolation are integral aspects of rural life. They produce the more strongly rural values listed by Wagenfeld (2003) as self-reliance, conservatism, a distrust of outsiders, religion, work orientation, emphasis on family, individualism, and fatalism. I'm going to attempt to present a feel for rural culture using three concepts that, while inevitably related, may have separate heuristic value: Conventional or conservative attitudes, isolation, and poverty.

Conventional Attitudes

Independence and self-reliance are survival values when you live at distances from services and other people. These values are instilled in rural people so early that it is hard to modify them, especially for older people who have lived most of their lives without the Internet and cell phones. I suggest that these values have produced rather conservative ways of approaching life—when you depend so much on yourself, you become more careful and considered in your decisions.

Population density is, by definition, lower in rural areas. Fewer people living in an area often means that they are more likely to know each other, and they have fewer choices of other people with whom to associate. Thus, despite the isolation involved in rural living, there is also what I shall call a goldfish bowl effect, in which ruralites are aware that other people are very interested in their lives and in talking to others about them. This lack of anonymity or privacy results in certain conventional behavioral expectations, as well as pressure to conform to them.

There are several effects of this goldfish bowl phenomenon. One is that people are less open about aspects of themselves and their opinions that are not conventional, such as sexual orientation and religious or political beliefs. As just two examples, there are many gay and lesbian people in rural Minnesota who are living quiet, desperately unhappy married lives and have never told another person about their sexual orientation. Many pro-choice opinions have never been expressed because of the fear that doing so will result in severe censure and being ostracized from one's family and social groups.

Another goldfish bowl effect is the magnification of the usual degree of stigma concerning mental illness with which we are all, as mental health professionals, so familiar. For example, a panic attack can seem a great deal more threatening if one is convinced, with a greater degree of reason, that if anyone sees the panic attack, "everyone" will soon know about it. Unusual behavior rapidly becomes the subject of community-wide gossip, so rural people tend to worry a great deal about how their actions will be perceived, which can exacerbate generalized anxiety. For the same reason, people do not want to be seen going into a mental health center. Since people know the cars others drive, they do not even want their car to be seen in the mental health center parking lot. On the more positive side, some rural communities seem to "close ranks" around people with more easily understood disabilities, such as mental retardation, and go to some lengths to protect them. Although the stigma concerning mental illness may be gradually decreasing in rural areas, it remains greater than in urban areas.

The dual relationships involved in providing mental health services in a small community may also make people reluctant to consult a mental health professional. They feel awkward at the prospect of meeting their psychologist in the only local grocery store or at the few restaurants, churches, high school sports games, or community clubs. They may fear that if they greet the psychologist, people will somehow know that they have a mental health problem.

Other aspects of conventionality appear in the more traditional gender and generational role expectations in rural culture. When women or children want to change their roles in the perceived less rigid directions of mainstream culture, marital and family conflict result, and community pressures generally collude with the person(s) resisting change. I often see these processes involved in child or spouse abuse and in marital dissolution.

More conventionally-oriented clients often resist the new ways of looking at things that we encourage in psychotherapy. A proudly down-to-earth and practical rural tendency may make abstract ideas difficult to process. Respect for authority may discourage the self-advocacy role that I've found predicts good psychotherapy response. Indeed, more rurally-oriented clients often expect me, as therapist, to "fix" them, or at least make decisions for them that it would better for the client to make. Lastly, I've noticed that more rurally-oriented clients tend to adhere more closely to the value of self-abnegation; positive self-statements are perceived as boasting, and positive thoughts about oneself are equated with the sin of pride, or at least, being conceited. The result is that self-esteem work, for example with depressed people, can be quite difficult.

Continued on page 11

Isolation

Rural people, by definition, live in less populous areas. There are fewer services locally, and it is often quite a distance to opportunities and services that urban people take for granted. Our mental health services are a good example—with few exceptions, the map of Minnesota's Mental Health Professional Shortage Areas highlights all but the St. Cloud and Willmar to Twin Cities to Rochester corridor. This means that most mental health needs are taken to family practice physicians, ministers, family, friends, and bars. Such resources, while important, are often inadequate to deal fully with mental health problems.

Isolation and lack of privacy both create an ethic of keeping problems in the family. Unfortunately, when combined with the common family pattern of not expressing emotions and not talking about emotional problems, this isolates the individual psychologically and tends to exacerbate problems. It is generally more difficult for rural people to share problems and feelings with strangers, and mental health professionals are certainly strange. I see higher degrees of family enmeshment, often across the extended family, as well as greater multigenerational caregiving demands. Sometimes this gives the therapist greater freedom to act within the family structure, but it often constricts what clients think they can do to change.

Rural areas have fewer kinds of social and activity options. When trying to assist a reclusive client in forming a social support network, one realizes that social outlets in more rural areas are generally limited to family, school sports, church, work, and bars. There may also be a senior citizens center and one or two community clubs. Seldom is there a health club, and organized child care and youth activities are less common than in urban areas. With fewer options, ruralites, especially teens, are more likely to engage in sex and drug activities. Rural areas have more teen parents, venereal disease, alcohol and illicit drug use, and smokers at most age levels than urban areas (Mulder, 2000; Stamm, 2003), all factors associated with poorer physical and mental health.

Rural Poverty

I don't believe you can work in psychology without becoming aware of the pervasive effects of poverty on a person's mental health and ability to obtain and use mental health services. The median income of rural Minnesotans is significantly lower than that of urban Minnesotans, and many more rural families live in poverty. Poor ruralites suffer the same disadvantages that other poor Americans suffer. In addition, poor rural residents have less access to city-style services, such as transportation to mental health and other services, or even access to pay phones to make

appointments. They are less likely to have health insurance and, due to the shame involved in not being self-sufficient, are often reluctant to access Medical Assistance. They may believe, often with reason, that others will know if they ask county social services to fund their mental health treatment.

Another mental health services access factor derives from the higher proportion of small businesses in rural areas, such as farms or family establishments. This has two repercussions. First, many family members provide unpaid labor for such businesses, so they don't receive benefits, such as social security or medical insurance. Second, medical insurance is so costly for small businesses that it is often out of reach, or only catastrophic insurance is feasible. These factors combine with a higher proportion of rural jobs in areas such as tourism, retail, fast food, and so on, where health insurance may not be customarily provided. Thus, the proportion of rural people who can finance mental health services is lower. The result is that by the time such people access mental health services, they are likely to be much more ill than if they had come to us earlier.

Rural areas often have fewer and less diverse employment opportunities, and the ones that exist are often part-time. This means that rural residents are more likely to have multiple jobs that pay less and have fewer benefits. It also means that children move away, fragmenting the family unit that is so important to rural people. This leaves behind an older population, with more dependence on Medicare, resulting in lower average reimbursement for rural healthcare services, which makes provision of healthcare more difficult in rural areas.

Conclusion

People living in rural areas, to the degree that they are less acculturated to mainstream America, constitute a culture, or at least a subculture, of which it is important to be aware when providing mental health services to them. It is important to note that, increasingly, various racial and ethnic minorities are moving into rural Minnesota. Native Americans have always been more populous in rural areas. Such minorities usually must contend with the compounded difficulties of both rural and ethnic/racial diversity status. The same is true of GLBT people (Beard, 2002).

In the second article in this series, I will suggest ways in which mental health providers can assess acculturation, modify services to be more appropriate to more rural-oriented clients, and serve rural communities in other ways. I will also describe policies that I believe are needed to serve the mental health needs of rural people.

Continued on page 13

Rural Culture is a Diversity..., continued from page 11

REFERENCES

- 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>
- Beard, K. W. (2002). Introduction to the special edition: Issues for gay, lesbian, bisexual, and transexual rural residents. *Journal of Rural Community Psychology*. Retrieved November 16, 2003, from <http://www.marshall.edu/jrcp/JRCP%20Intro%20GLBT/introduction.htm>
- National Rural Health Association. (1999). *Mental health in rural America*. Retrieved November 16, 2003, from <http://www.nrharal.org/dc/issuepapers/ipaper14.html>
- Stamm, B. H. (Ed.). (2003). *Rural behavioral health care: An interdisciplinary Guide*. Washington, DC: American Psychological Association. Executive summary retrieved November 16, 2003, from <http://www.isu.edu/~bhstamm/pdf/RBHC%20handout.PDF>
- U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Retrieved November 16, 2003, from <http://www.surgeongeneral.gov/library/mentalhealth/chapter1/Sec8>
- Wagonfeld, M. O. (2003). A snapshot of rural and frontier America. In B. H. Stamm (Ed.), *Rural behavioral health care: An interdisciplinary Guide*. Washington, DC: American Psychological Association.

Editor's Note: Katherine M. (Kay) Slama, Ph.D., LP, currently serves three frontier counties in western Minnesota, two of which have no resident licensed psychologist. She is a past president of the Minnesota Rural Health Association, and is the representative from the MPA Rural Division to the MPA Governing Council.