Building a Practice in Rural Settings: Special Considerations

Tracy J. Cohn
Sarah L. Hastings

Private practice in rural areas presents special challenges. Rural communities often hold more stigmatizing views about psychotherapy and have fewer economic resources, yet rates of mental health problems are comparable to those in metropolitan areas. Rural practice can be particularly rewarding for clinicians who can build collaborative networks, adjust to visibility, negotiate boundaries, and successfully integrate into the community. This article offers recommendations for mental health counselors on building a practice for branding, marketing, collaborating, and exercising self-care. It also discusses challenges associated with counseling in rural areas and gives suggestions for building a thriving practice.

Because rural areas across the United States and Canada struggle to attract and retain qualified mental health counselors, establishing a private practice in a rural setting can both meet a critical need in underserved areas and provide a rewarding, though challenging, career. When counselors consider rural practice, they must have realistic expectations about rural work and life, consider the cultural values permeating different rural communities, and understand the impact of geographic isolation on themselves as well as their clients.

Rural areas may be very different from one another in terms of geography, cultural heritage, ethnic makeup, and history, but certain factors shape the lives of all who live in rural areas in significant ways. These factors speak to a dimension of diversity often overlooked in the mental health literature, but it is essential that counselors working in rural settings understand them.

Rural residents often rely on tight-knit community relationships supported by kinship ties extending back generations (Curtain & Hargrove, 2010). The social support provided by family, and often by the church, leads to high levels of satisfaction among those who adhere to community standards (Childs & Melton, 1983), but the reliance on family and friends often means that outsiders are viewed with suspicion (Bradley, Werth, & Hastings, 2012). Gender roles in rural settings are often traditional, with cultural standards encouraging hetero-normative behaviors for both men and
women (Boswell, 1980; Campbell, Bell, & Finney, 2006; Salamon, 1992). Community standards also promote conservative traditional values and advocate self-sufficiency and hard work (Harowski, Turner, LeVine, Schank, & Leichter 2006; Helbok, Marinelli, & Walls, 2006).

Drawing on anecdotal and empirical support, this article discusses both the problems and the promises of rural practice. We provide recommendations for building a successful rural mental health practice in terms of branding, marketing, collaborating, and exercising self-care.

**CHALLENGES IN RURAL PRACTICE**

The prevalence rates of mental illness in rural areas are equivalent to those in metropolitan or urban centers (Robins & Regier, 1991; Wagenfeld, Murray, Mohatt, & DeBruyn, 1994), with approximately 20 million rural adults having experienced mental illness in the previous year (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). However, rural residents are more likely to die from suicide (Hirsch, 2006). Because they are also less likely to perceive a need for care (Rost, Fortney, Fischer, & Smith, 2002), they access care at lower rates than urban peers (Rost et al., 2002).

A number of structural barriers also inhibit access to care: lack of insurance, transportation, and available providers; poverty; and stigma. Poverty is particularly challenging. In urban areas, 12% of residents live below the poverty line; in rural areas that is true of 15% of residents (DeNavas-Walt, Proctor, & Smith, 2008). The federal Agency for Healthcare Research and Quality (AHRQ) under the U.S. Department of Health and Human Services (U. S. Department of Health and Human Services, Agency for Healthcare Research and Quality [HHS] 2006) reported that one in five individuals who are uninsured reside in rural areas. Rural residents are also more likely to be uninsured, belong to an ethnic or racial minority, and have less than a high school education (HHS, 2006).

Even if someone can afford treatment and perceives a need for care, there may not be a provider in the area or a provider who has openings. Some 65 million residents in the United States live in an area considered a professional shortage area (U.S. Department of Health and Human Services, Health Resources and Service, 2009); of the shortage areas, 85% are in rural areas (Bird, Dempsey, & Hartley, 2001). In the analysis by Bird, Dempsey and Hartley, there was no behavioral health worker in over 50% of the counties studied. Thus, the few providers in rural areas may be overwhelmed by the demand for services. It is also likely that when the Affordable Care Act is fully on line, both demand for and utilization of rural services will surge (U.S. Department of Health and Human Services, 2010), causing even more
overwhelming demand in rural areas. The cost of traveling to a provider is also a serious concern: while only 10% of urban residents travel more than 30 minutes to see a provider, 14% of rural residents must do so (HHS, 2006).

In general, given the shortage of specialized providers, primary care physicians (PCPs) may be providing more mental health services in rural communities (Geller, 1999), which can be problematic. In general, PCPs have less training in mental health and are less likely to recognize psychiatric symptoms (Geller, 1999). Even if they do recognize symptoms, PCPs may be less likely to refer clients elsewhere for services.

Finally, stigma in accessing mental health services is a particular barrier in rural areas (Calloway, Fried, Johnson, & Morrissey, 1999). Because those living in rural areas often believe they have less anonymity and privacy than their urban counterparts, they may be hesitant to access care out of concern that their treatment provider might share information about their problems. This absence of trust may cause early termination (Caesar, 1997).

Although researchers have some understanding of potential barriers to treatment for clients, there is less understanding about barriers for treatment providers. In an attempt to understand what current providers see as challenges to practicing in a rural area, Hastings and Cohn (in press) surveyed rural practitioners. Participants voiced concern about the “fishbowl”—mental health providers are perceived as always being at work. At the grocery market or the movie theater, rural providers see themselves as being watched by their community. Hastings and Cohn argued that they experience role strain, in which individuals have different roles for different identities (Goode, 1960). That is, the counselor acts in the role of a mental health professional when serving as helper but may serve a different (and potentially competing) role as, for example, a parent. Campbell and Gordon (2003) noted that individuals are known within a social and historical context. Strain or role conflict begins when competing roles overlap. Participants in the Hastings and Cohn study (in press) evidenced that they experience tension or stress because residents know them as therapy providers but also as parents, members of community groups, or unhappy customers in the grocery.

In addition to role strain, Hastings and Cohn (in press) also noted that practitioners may struggle to build networks of self-care and support. Kee, Johnson, and Hunt (2002) remarked that rural practitioners who experienced burnout were likely to mention that they had limited social integration and peer attachment. As prior studies observed, a rural counselor is likely to be the only mental health provider in the area, which limits opportunities for consultation. Moreover, if there are multiple providers, it is quite possible that one has received services from the other, thus creating an intricate network of boundaries and boundary crossings that may raise ethical concerns. Werth, Hastings, and Riding-Malon (2010) have written extensively on eth-
ical challenges in rural areas; dual relationships are one of the issues cited most frequently (Werth et al., 2010).

Responding to individual cultural needs in rural communities is also a challenge. There may be competing demands between family members and for the provider related to multicultural experiences. For example, access to an airport large enough for international travel, ethnic grocery stores, minority communities, and religious or spiritual groups may be more limited in rural areas. These aspects of culture may affect providers as they work to experience and expand multicultural competence. Practitioners may also experience pressure to meet demands and requests to provide for their own family’s cultural needs. Many providers responded to these challenges through travel and accessing resources online (Hastings & Cohn, in press).

As noted earlier, rural communities are often defined by the emphasis on family ties and family histories (Cohn & Leake, 2012). Within rural communities, there is a strong push to know the historical legacy of members of the community. It is likely that residents who leave the community to pursue advanced training and education will be perceived as outsiders when they return. Those who relocate to a rural community may be perceived as outsiders because they lack familial connections. Termed the “who’s your daddy” phenomenon by Hastings and Cohn (in press), family name is central to social networking. Access to a rural clique may be permitted or denied based on family name and history. Those who enter a rural community to which they have no previous connection may struggle to be seen as legitimate members of the community. Some rural communities may reject outsiders totally, perceive them as threatening, or believe they have come to exploit community resources. This struggle has been common in Appalachian communities where businesses have moved in, stripped the environment, and left when natural resources have been consumed, leaving the communities without resources. Given the history of outsiders in rural areas, it is increasingly likely that providers will face challenges in integrating into the rural community.

ADVANTAGES OF RURAL PRACTICE

Nevertheless, clinicians living and working in rural areas cite numerous advantages to their rural lifestyles. In a survey examining the experiences of mental health counselors in central Appalachia (Hastings & Cohn, in press), counselors reported high rates of job satisfaction, citing their enjoyment of flexible careers in settings with pastoral views, clean air and water, and a slower pace of life. They described appreciating community ties established after years of practice with multiple generations of a family and the ability to build new areas of expertise to meet community demands.
Gifford, Koverola, and Rivkin (2010), who studied behavioral health providers in rural Alaska, found love of rural life to be a common theme among those who had practiced there for a long time. A slower pace, the beauty of the tundra, and freedom from stressors such as rush hour traffic enhanced their satisfaction. They also identified themes related to flexibility and reported adapting to the local seasonal schedules and making appointments with sensitivity to cultural and subsistence practices. Interestingly, a similar theme, and the one most often mentioned in the Hastings and Cohn (in press) study of Appalachia, was flexibility, freedom, and autonomy as positive aspects of rural practice. Thus, mental health counselors from these two very different regions highlighted this commonly appreciated facet of their rural practice.

Flexibility also manifests in defining the scope of practice in a small community, with a willingness to expand it as needed. One of us, for example, received a referral from a neurologist, who, after working with a patient over a period of years, determined the diagnosis was best conceptualized as conversion disorder. The client, though doubtful that a counselor could help, was willing to meet with her. The counselor consulted long-distance with clinicians who had expertise in conversion disorder, searched the literature, and worked with the client to achieve a favorable outcome. The neurologist has since sent several more referrals, knowing that the clinician now has skills that might help clients manage symptoms of chronic pain and discomfort. Because rural counselors must operate from a generalist perspective (Stamm, 2003), and because they may need to learn to treat a range of concerns, their practice is less likely to become routine or dull.

Some clinicians also find engagement with community contacts a positive aspect of their work. Within rural communities, there are many opportunities for meaningful collaboration with physicians, attorneys, and other professionals whose roles interface with the counselor’s. Clinicians described these collaborations as energizing in that they provide new perspectives, new challenges, and new opportunities for practice (Hastings & Cohn, in press). Educating these other professionals about elements of the counselor’s role, including confidentiality, is critical, but our experience is that many clinicians enjoy the opportunity to interact with those whose training is different. Similarly, many clinicians seem to enjoy their professional visibility and are proud to be identified as the counselor in town who is called upon in times of need to provide community education or offer expert opinions. Indeed, making a difference was one of the most common themes in the Hastings and Cohn (in press) survey. Whether with individual families or with the entire community in times of crisis, counselors play a vital role in alleviating suffering and providing support.
BUILDING A PRIVATE PRACTICE, LESSONS LEARNED

In our work not only in our own private practices but also in mentoring new professionals and students who would like to be in private practice, we have realized that many clinicians have similar visions. In general, new providers discuss their ideal location, the atmosphere of their office, and the many people they will help, though they often lack a real understanding of the marketing and business aspect of private practice. Based on numerous conversations with students and consultants, we have designed an approach that covers branding, collaborating, marketing, self-care, and professional involvement to help guide others as they build their ideal practices.

Branding

Branding, a term borrowed from business, encompasses both building the private practice and marketing it to potential clients. Branding has been called a company’s promise to customers about a product or service (Williams, 2008). In the case of private practice, the service might be, for instance, group therapy, marriage counseling, disability evaluations, educational assessments, or individual counseling.

Before beginning branding, practitioners may wish to do some strategic planning, think deeply about the risks associated with starting a practice, and identify personal strengths and liabilities. The method usually used to refine a branding strategy is SWOT analysis, which assesses strengths, weaknesses, opportunities, and threats (Williamson, Cooke, Jenkins, & Moreton, 2003). For example, some counselors are particularly good at managing clients with intense anger or labile mood. Others are willing to take greater risks of dual relationships. Identifying strengths like these guides development of the practice and will help define or refine the branding strategy. As for weaknesses, some counselors are unwilling or would prefer not to take calls after hours, which would be a problem for clients who need after-hours services. Some who have little experience with psychotropic medications may not be well positioned to collaborate with inpatient psychiatric facilities. Identifying weaknesses can help practitioners understand where to direct energy in either shaping to whom the practice is marketed or identifying opportunities for professional growth.

Recognizing opportunities is the third component of SWOT analysis. For example, as the population ages, there is increasing opportunity for counselors to provide geriatric and hospice-related care. Finally, environmental threats must be assessed. Understanding the threats to the practice can help a counselor understand how opportunities may overcome threats. Examples of threats that private practitioners may encounter in rural settings include increased competition for clients, economic instability when the area is
dependent on a single major employer, or limited public transportation that may imply a need for multiple offices.

To introduce the notion of branding to students and new professionals in workshops, one of us asks participants to engage in guided imagery about what they want in their ideal practice. He encourages a liberal interpretation. Some focus on furnishing or aesthetics, such as wanting to practice in a converted old home where clients are welcome to bring animals. Others focus on services, such as providing disability evaluations to lawyers or serving as a medical expert for the court. As participants visualize their services, they are encouraged to think of adjectives that reflect their practice—empathic, focused, refined, goal-driven, calm. Each adjective begins to represent an aspect of practice that will help to brand the therapy being offered.

The challenge with branding is that although a rural practitioner may be interested in offering a particular type of therapy—say, group therapy in a converted Victorian house for women in postpartum depression (a valuable and highly branded therapy)—not all brands are marketable in rural areas. It is important for practitioners to analyze the other brands in the market. Although branding begins by brainstorming adjectives to describe the practice, the second step is identifying community needs. Informal consultations with primary care physicians who serve an identified market, consumers of resources related to that market (e.g., medication salespeople, who can informally offer useful information about community resources), and other constituents in the community can provide valuable information about service voids.

In addition to identifying community needs and strengths, it is important to take into account the needs of the provider. Since rural practitioners may be vulnerable to burnout, it is important for them to identify their must-haves and must-not-haves. Must-haves represent aspects of clinical practice the practitioner needs not just to make money but also to have a sense of self and identity. Must-nots are those aspects of practice that are likely to cause distress or depress job satisfaction, either temporarily or permanently. Although some must-nots can be identified in advance through guided imagery reflecting on past affective experiences in clinical practice, some may arise as the practice is being built. For instance, a counselor starting a new practice might consider accepting every client who comes through the door, but that can be problematic. Not only is it more likely to cause emotional strain because the counselor may be practicing on the fringe of his or her competence, it may damage the long-term success of the practice by taking away resources (time and energy) that could be spent on nurturing the practice. Although practitioners are usually trained as generalists, this does not mean that each can competently provide services to every client. Practicing in a rural area where there are few referral options may mean that providers must in some cases
practice on the fringe of their expertise, but weighing the risks and benefits to the client, exploring options for consultation, and pursuing continuing education will help them to resolve these dilemmas.

It is important to think carefully not only about what client to accept but also what client to refuse. For example, individuals on temporary leave from work due to violence, those in domestic courts because of battery, students with substance abuse problems entering treatment simply to get a note of support from the provider—by causing too much strain on the counselor, any of these may damage the practice. To protect the integrity of the service and protect the quality of the brand, it is important to reflect on the must-haves and must-nots in order to understand the market.

Besides identifying the market, counselors in private practice must take time to think about what skills they want to use and what their strengths are. Influenced by the literature on vocational counseling, we believe that most practitioners will be happiest in environments that match their personality, skills, and abilities (Bolles, 2013). Thus, we encourage counselors to reflect on the skills that bring nourishment to their professional selves. For instance, for a practitioner who enjoys and is talented in it, group work may be an essential clinical service.

Identifying personal needs is essential to clinical work in rural areas. Some rural providers with whom we work are willing to see clients only three to four days a week because they want to maximize weekends for travel. Others are cautious in screening new clients to maintain a manageable caseload of individuals with severe mental illness. This enables them to balance their professional responsibilities with family demands. Texts such as What Color Is Your Parachute? (2013) by Richard Bolles offer thoughtful ways of identifying skills that practitioners value and want to use in clinical practice.

Counselors entering private practice are often surprised at the cost of running a business. Clients also express surprise at the cost of an hourly session. However, counselors and clients rarely pause to reflect on the financial and emotional costs of private practice. Although counselors can often identify the larger costs of running a practice, such as liability insurance, rent, computer, printer, phone, specialized software, and the supplies various devices require, rarely do they consider such costs as continuing education, licensure fees, property insurance, costs for billing insurers, legal consultations, travel to multiple offices, local, state, and federal self-employment taxes, accountant or attorney fees, costs for assessments and tests, or benefits such as retirement savings or medical coverage.

As they reflect on the skills, needs, costs, and benefits of private practice, counselors are encouraged to consider a menu rather than a buffet approach to services. That is to say, practitioners in rural areas may want to advertise brief, time-limited, focused sessions, exploring one aspect or component
of health functioning. For instance, the practitioner may want to offer two sessions on better sleep skills for new parents; three sessions to evaluate and provide feedback on self-compassion related to food; or a week-long, one-hour-a-day session on curbing stress. Because rural practice requires counselors to be flexible in their thinking about the work, we encourage them to also be flexible about how they package services. Moving away from the traditional 45/50-minute hour may also reduce the stigma associated with accessing care.

**Collaborating**

Collaborating with community partners is important for success in private practice. Medical providers, clergy, business leaders, and elected officials are a useful source of referrals for the private practitioner as well as a network of assistance to clients. When one of us began a private practice in a town of 12,000, another professional in the building recommended that she join the town Chamber of Commerce. The relatively small investment in an annual membership fee provided her with a well-publicized ribbon-cutting ceremony for her office, which included free coverage in the local newspaper that prompted several referrals. The counselor joined a Chamber committee charged with planning a wellness fair, which helped establish relationships with other community health care providers and was another opportunity to market her practice. Serving on the committee expanded her professional network and helped get the word out about her new practice.

Religious leaders are another source of referrals for rural private practitioners. Religion is often central to rural communities. While some religious leaders may prefer to counsel members of their congregations themselves, many appreciate the opportunity to refer members to the new clinician. In fact, several members of the clergy mentioned that the demands of leading a congregation often make it impossible to provide long-term counseling to individuals and couples who need it. They said that while their training included some coursework on spiritual counseling, they felt overwhelmed when someone’s needs went beyond their training. Being able to establish boundaries between services they could provide and those that needed to be provided by someone else helped these clergy clarify their roles and offer assistance in the form of referrals for more complex situations.

The local librarian may be a somewhat unexpected collaborator. Counselors may recommend books, DVDs, or other materials to clients. The local library may have some of those on hand or may be willing to add others to its collection. The librarian may appreciate the counselor identifying good resources for patrons. In one library, this collaboration prompted the staff to maintain a rotating display of materials related to positive mental health, wellness, parenting, and self-care. The counselor was invited to give
workshops on related topics and lead a book discussion for an adult summer reading program.

**Marketing**

Beyond collaborative relationships formed in the community, additional marketing and network strategies will emerge from the work on branding. How and where to target marketing will emerge from understanding the product and identifying the consumer. In general, there are three areas of marketing: print media, social media, and online presence. Where rural areas have lower rates of computer use and Internet connectivity than urban areas (Rainie, Reddy, & Bell, 2004), the printed telephone directory may be a primary source of information. It may be useful for counselors to review under which headings in the directory most mental health providers place their names (e.g., mental health, therapist, counselor, psychologist). Clients with limited exposure to the domain of mental health may not be aware of the differences between clinical and psychiatric services. Although it might seem advantageous to be the only provider in one category, there may be a reason others chose different categories. Once a brand has been refined and the target client identified, counselors may want to research publications in related fields. Those interested in the mind-body connection might, for instance, post an advertisement at the local gym or community recreation center. One practitioner with whom the authors worked offered a yoga class once a month to attract clients. This helped the community access a service, yoga, that otherwise might not have been available and helped introduce the clinician to potential clients.

**Self-care**

Any discussion of building a successful private practice should take into account clinician self-care. Mental health counseling involves so many stressors that burnout is a real concern (Shapiro, Brown, & Biegel, 2007; Tziporah & Pace, 2006). Since a rural practitioner is more likely to be working in isolation, have fewer after-hours resources for clients in crisis, and may be more likely to experience role strain, self-care is especially critical to both professional competence and personal well-being. Eating a balanced diet, getting enough sleep, and exercising regularly are generally recognized as the foundation of positive emotional and physical health, yet many mental health professionals admit they are better at advocating such lifestyle basics than doing them (DeAngelis, 2002). Beyond attending to physical needs, engaging in social and leisure practices not associated with work, such as vacationing and spending time with family and friends, is usually recognized as a component of effective self-care (Volz, 2000).
Self-care in a rural setting may look a bit different from self-care in a metropolitan area. For example, physical activity may be harder to access in rural areas because of long distances to gyms and exercise classes or fewer sidewalks, walking trails, and parks. Thus, counselors may need to be creative in finding ways to be physically active at home or on the job, taking breaks during the day to reduce sitting time, and building in exercise on weekends. They have to think beyond the social and cultural outlets common in metropolitan areas, such as restaurants, museums, and concerts. They will also need to utilize other self-care strategies, such as diversifying work activities, engaging in positive self-talk, maintaining a balance between personal and professional identities, spending time with family, tuning into spirituality, and asserting control, when possible, over work duties (Stevanovic & Rupert, 2004).

Self-care also includes the ability to navigate culturally appropriate boundaries with community members and between work and personal roles. While a great deal has been written about this topic (see Werth et al., 2010), it must be mentioned in any discussion about maintaining competence and preventing burnout. Setting boundaries has been identified as one factor associated with long-term retention of rural mental health counselors (Gifford et al., 2010). In tight-knit rural communities, where counselors often feel they live in that fishbowl, establishing satisfying boundaries, while often complex to navigate, helps them manage the multiple demands associated with being a visible member of the community.

**Professional Involvement**

Professional involvement can also be a means of maintaining one's identity despite a demanding job. If a counselor is one of only a few providers in the area, building coalitions of support with other providers may be difficult. Staying connected to national or regional professional organizations can help. Professional associations like the National Association for Rural Mental Health and the Special Interest Group (SIG) of the Society of Counseling Psychology, a division of the American Psychological Association (APA), offer members opportunities to interact online or at conferences or through specialized programming within larger conferences, in addition to print communication. The ideas and discussions on listservs remind many isolated professionals that colleagues, though geographically distant, share many of the same concerns and are often willing to provide suggestions when asked. Professional journals dedicated to rural practice can also help practitioners feel more connected to their colleagues. *The Journal of Rural Community Psychology*, the *Journal of Rural Mental Health*, and *Contemporary Rural Social Work* are all available online free of charge.
Both of us are in practice consultation groups, which meet about once a month to discuss difficult cases, exchange resources, and share support. Clinicians far distant from colleagues could make use of telehealth opportunities to consult through conference calls, Skype, or other emerging technologies. Rural practitioners who access telehealth to communicate with peers have been found to increase their comfort and competence in using the technology over time (Hilty, Yellowlees, & Nesbitt, 2006). As relationships are established with other providers, counselors expand their collaboration, become more likely to consult about treatment planning, and have positive evaluations of this means of communication (D’Souza, 2000; Hilty, Luo, Morache, Marcelo, & Nesbitt, 2002; Hilty, Yellowlees, & Nisbitt, 2006).

GETTING THE RIGHT REFERRALS

The use of the word “right” is intentional. To obtain the right referrals, counselors need to evaluate their referral streams. In other words, the question must be, “Where am I likely to get clients?” Many therapists look to primary care doctors and psychiatrists as sources of referrals. However, as the data support, in rural areas psychiatrists are likely to be few (Holzer, Goldsmith, & Ciarlo, 1998), and primary care doctors may want to provide counseling themselves. Obtaining the right referrals is often the result of educating a referral source. For example, dentists are a valuable source of referrals for those interested in working with clients with anxiety. Lunch-time roundtables for dental clinics on recognizing the signs of anxiety can highlight professional expertise and also heighten the awareness of dental staff to direct referrals. In addition to anxiety-related concerns, dentists are often the first to note signs of dental wear and decay as a result of disordered eating. Talking with the staff about how to discuss symptoms with patients and how to facilitate a smooth referral are important. Lawyers and clergy in rural communities are also valuable referral agents, but they, too, require education. For instance, they may not understand what it means to be bipolar, so using diagnostic labels would not be helpful. However, pointing out the outcome from therapy can help referral sources keep you in mind. For example, “finding a better way to manage anger” or “communication skills” help referral sources understand what counseling offers.

BARTERING

Within the mental health professions the practice of bartering has a complex history. Ethical guidelines published by the American Mental Health Counselors Association (AMHCA, 2010), the American Psychological Association (APA, 2002), and the American Counseling Association (ACA, 2005) all provide guidance about bartering, though earlier editions of some
ethics codes cautioned against or forbade the practice altogether (Treloar, 2010). Our anecdotal experience suggests that barter requests are relatively rare, yet counselors who work with underserved populations and those who reside in rural areas may be more likely to encounter them.

Bartering casts counselor and client into a dual relationship, which can result in client exploitation and complicate delivery of mental health services. What happens, for example, if the counselor is unhappy with the quality of the client's bartered goods (e.g., canned vegetables) or services (yard work)? Suppose the client does not adequately clear debris from the counselor's property as agreed? It may be that the dangers associated with ethical pitfalls are less problematic for counselors whose clients barter goods rather than services (Knapp & VandeCreek, 2008). To reduce ethical risks, Woody (1998) advised that counselors document any bartering arrangements in writing as an agreement to be signed by both parties. Counselors should minimize bartering and, when possible, only agree to accept goods but not services. The value of the goods should be determined objectively by an outside source. If the counselor notices that bartering is having an adverse effect on the therapeutic process, the agreement should be terminated (Woody, 1998).

FINANCIAL CHALLENGES

Not only are many residents in rural areas uninsured, but a significant additional proportion who receive government-sponsored insurance are underinsured. Despite a number of legislative and government initiatives (e.g., the Health Service Corps through U.S. Health and Human Services and the Affordable Care Act) to address the reimbursement gap between private and public insurance, in general government reimbursement rates are considerably lower than private. Private practitioners must therefore first decide if they will accept government-sponsored insurance. They must then decide if they will accept clients pro bono or on a sliding fee scale. Note that some insurance companies argue that accepting pro bono clients violates the terms of their contracts with providers. Because the insurance company wants to get the best service for the lowest price, a counselor willing to provide services to some clients at no cost or on a sliding scale, those companies argue, should offer all services at no cost or on a sliding scale. Although we understand the sensibility associated with a sliding scale and pro bono services, we generally argue that it is more reasonable to charge a flat fee that clients pay as they can rather than risk the complications of litigation or accusations of insurance fraud.
CONCLUSION

Private practice in rural areas can be challenging because of complex boundary and ethical issues, relatively strict gender roles, an emphasis on family and kinship bonds, and closed networks. However, there are strengths and opportunities for those who choose to enter rural practice, among them the physical beauty of the surroundings and the opportunity to practice as the "expert." This article could not describe all the advantages and disadvantages of rural practice; there are few other resources for guiding counselors considering rural practice. It is our hope that other scholars will respond to the increasing need for understanding the complex and subtle interaction between rural culture and clinical practice.

REFERENCES


