Practicing Rural Psychotherapy: Complexity of Role and Boundary

Dianne L. Sterling

SUMMARY. The experience of practicing psychotherapy in a small community with a particular focus on complexity of role and boundary are discussed. It is a general assumption that personal data about the therapist is a variable which is under the control of the therapist. What is not usually considered is the relative lack of control that therapists in small communities possess over what is known about them. Also, the therapist is a member of the community, with a visible way of life.

There may be distinctive characteristics of small community practice which warrant particular consideration. Four areas of importance included: (1) The multiplicity of boundary issues that arise in rural practice; (2) The complexity of the role of therapist; (3) The ongoing nature of the therapy relationship; (4) The changed stance of the therapist as an adaptation to the rural community setting.

Practicing psychotherapy in an urban environment is experientially and qualitatively different than practicing in a small community environment. Having worked in the small community of Martha’s Vineyard for three years, I experienced a difference in role and boundary when I began practicing in the urban setting of Boston.

It is a general assumption that self-disclosure is a controllable variable by the therapist; that personal data about the therapist is

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something to be carefully and cautiously doled out according to therapeutic need and only in the service of facilitating the therapeutic process. What is not usually considered is the relative lack of control that therapists who work in small communities possess over what is known about them. The proximity and community communication channels provide ample opportunity for gathering information about a therapist.

In a small town, a therapist is a participant in the community. A therapist, like other residents, votes in town meetings, goes to the post office for mail collection, takes positions on community issues, and is seen in a variety of everyday and commonplace situations. Milton Mazer (1976), the first director of the mental health center on Martha’s Vineyard, described this in his book, People and Predicaments:

For on the island, no resident is perceived as a stranger, and he is assumed to share the common values and the common trials of life. The urban detachment that ensures a tolerable degree of social privacy is not found on the island. For better or worse, people either know about each other or know much about each other. (p. 23)

Another apt quote from Mazer (1976) further sums up this way of life:

It is not enough that people live close to one another to be members of a community, to partake in one of the essentials of community, they must interact with each other, both in amity and in conflict. (p. 25)

A therapist in a small community is not a disenfranchised person commuting to practice in another part of the city, unknown in vivo. Rather, a therapist is a real person with a visible way of life. While I worked at the community mental health center on Martha’s Vineyard, I was confronted with situations which involved interacting with present and past patients outside of my office on an almost daily basis. As illustration, the following vignettes highlight some of my experiences.

Ms. M. was a woman in her mid-thirties who referred herself for treatment due to chronic poor self esteem and depression. Her appointments with me were held at the end of the day, after which, I would attend an exercise class at a local health club. After a few months in treatment, Ms. M. became more concerned about her appearance. After one session, I wrote the case note and rushed to the health club locker room to change my clothes for class. She, too, had the same idea. Not only did I find her changing clothes beside me in the locker room, she also came to the same class.

Another patient, a 40 year old man, was struggling with sobriety and intimacy in his marriage. Since I had known his father-in-law socially, we discussed this connection prior to treatment to attempt to assess the effect it would have on his treatment. We discussed the tenets of confidentiality and agreed to proceed with the therapy. Several weeks later, I was invited to a small dinner party with not only my patient and his wife in attendance, but his father-in-law as well. We had to completely switch roles with context and push aside our therapeutic relationship, since no one knew that I saw him in another setting.

Daniel, an eighth grade boy, had a mother who was emotionally absent and inconsistent due to her manic-depressive illness. We met weekly at my office. One weekend day, I was gardening at home and he appeared, offering to help. He revealed that he often walked by my house to assure himself that I was there and informed me that he had found out quite a bit about me through one of my friend’s children, a friend of his.

I saw Mrs. W., a woman in her fifties, for about one year while she was finishing a Master’s degree in art therapy. She struggled with identity issues and questioned the path her life was taking. We successfully terminated therapy and three months later she was starting to do art therapy with children. I attended a school meeting for one of my child patients around this time and she was there on the recommendation of the guidance counselor to be part of the treatment team. Again, I had to accommodate a role and boundary shift. These are just a few examples of what it is like to be a therapist in a small community, finding ways to manage boundaries and live in the community while taking one’s role and responsibility into consideration.

Virtually no attention has been paid to the practice of psychother-
apy in a small community. Sundet and Mermelstein (1983) and Berry and Davis (1978) briefly address the difficulties in applying urban models to rural practice. Sundet and Mermelstein pointed out there are often "urban prejudices" in psychotherapy practice in small communities. They explained that, unlike in urban settings, there are no context-free interventions in rural settings because of the interdependence of the social systems and stated, "One may ponder the profound implications of the notion that the individual and the community both initiate and limit each other" (p. 33).

Though Sundet and Mermelstein (1983) did not discuss the experience of practicing in a rural area, they did discuss the role and boundary issues that confront a therapist in a small community:

A brief note about role convergence and boundary permeability is in order... In mapping the rural community, one must be aware not only of the multiple roles a person must play (e.g.; the deacon-physician-school board member who is prominent in the Republican party and is on the Savings and Loan board of directors and the CMHC advisory board) but of familial interconnections as well... Boundary permeability is another aspect of this multidimensionality of the rural community, where schematic definitions of social systems tend to blur... (p. 31)

Berry and Davis (1978) wrote about the problems that urban-trained mental health professionals encounter in their initial inability to be responsive to the culture of a rural area and stated, "The boundaries of a rural area are often diffuse; as an entity, it therefore differs socially and physically from urban catchment areas" (p. 674). They pointed out that urban professionals must learn to adapt to the culture and expect that it takes time to gain the trust of rural people. Berry and Davis also noted that special skills are demanded in a rural setting such as knowledge of rural politics and power structures, and the ability to develop informal patterns of communication with key community officials. In addition, they thought that mental health professionals should be generalists and have the capacity to work with a wide range of people and be able to use a number of different therapies and resources effectively and stated, "...the professional role in rural community mental health should be determined by the phenomena addressed, not by the imposition of the prevailing professional methodology or ideology" (p. 678).

Berry and Davis (1978) also briefly discussed the practical issues of managing visibility as well as the inevitable judgments that will be made about practitioners in rural practice:

Rural people are well informed on matters concerning the worker's life, such as marital status, family stability, drinking habits, where clothes are purchased and their cost, kind of car driven, recreational habits, religious participation, and residence. Rural mental health professionals must be concerned about their image in the community because local people will judge them on the basis of personal factors noted above and this judgment will color their response to the professional's services. (p. 677)

The above authors only addressed a few general issues about rural practice. Soreff and Hymonoff (1976), Ordway (1976), and Mazer (1976) more specifically discuss rural practice based on their own experiences. Ordway (1976) described his personal experiences in practicing psychodynamic psychotherapy in rural Maine and relates them to being in a confined academic setting:

Carrying out psychoanalysis in a small community is somewhat like practicing psychoanalysis in an intimate department of psychiatry in a closely knit medical center... once again because the analyst is a member of the same social group, he sees his acquaintances therapeutically and/or analytically. With these people, as well as his physician analysts, the analyst had to set ground rules about social avoidance familiar to many university departments. (p. 213)

Ordway believed that patients have difficulty in cutting off real-life relationships in order to experience the therapist transfentially. He thought that the easiest treatments were ones in which the patient commuted from outside of the community in which the ther-
apist lived and therefore knew less about the therapist.

Whereas Ordway described some of the dilemmas that a therapist is apt to encounter in rural practice, Soreff and Hymoff (1976) focus on the differences in rural psychotherapy from urban psychotherapy from both the patient's and therapist's perspective. They noted that there is often role confusion and a complexity of interactions resulting from personal contact outside of the therapeutic relationship, and that added information about the therapist affects treatment and changes anonymity. They stated:

The authors wish to emphasize that the decline in anonymity and increase in multiple roles is an inevitable consequence. As a result of these factors, the therapist will be considered by the patient as "more human," more as an individual, and as a multidimensional person. Likewise, the same phenomenon occurs by which the therapist appreciates the patient as "more human." Thus, one of the byproducts of these extra interactions is that the therapist is able to observe healthy aspects of the personality as well as the disruptive and pathologic as traditionally only seen by the psychotherapist in his office. (p. 667)

Mazer (1976) reiterated many of the points made above and made many more in his book, People and Predicaments. Mazer was the first and only therapist for many years on the island of Martha's Vineyard and wrote a book on his observations regarding the stresses of life on the island as well as his experiences in practicing there. He described the importance of relationships in a small community and the complexity of connections. He noted that privacy is difficult to achieve and that, "Thus, the maintenance of the therapeutic incognito long advocated by psychiatrists for both technical and therapeutic reasons is less possible in rural areas. Such changes have produced situations of stress for psychiatrists, the results of which have been likened to culture shock" (Mazer, 1976, p. 213).

Mazer (1976) made the interesting point that therapists in urban settings become accustomed to living and operating under the protection of a therapeutic incognito and that, "Maintenance of the incognito probably has another function which has rarely been mentioned; it protects the therapist from the anxiety inherent in any vital human experience" (p. 214). He further elaborated on therapeutic stance in a small community:

Even if the incognito is a desirable stance for the therapist, it is doubtful that it can be maintained in a small community. If the therapist is to live and work in the community, to participate in its social and political life, to have a spouse doing the same and children studying in its schools, that spouse can no longer retain the anonymity which such a stance requires. (p. 214)

He noted that a common concern for both therapist and patient is that a meeting on a social occasion is probable and each is afraid that he or she will not know how to behave under the new circumstances, which adds another role strain.

Mazer (1976) did add some positive aspects to the work—that a therapist has much more information about a patient and can observe the progress of former patients. He also added that the therapist is experienced more as a human being and stated:

Finally, the therapist in a small community finds that his customary entrenchment behind the facade of his profession and the distance that its prestigious position places between him and others may serve him poorly in his work. His many-faceted position constantly exposes him as a human being . . . (p. 226)

My own experiences and interviews with other rural practitioners suggest that there are distinctive characteristics of small community practice which warrant particular consideration. Discussion of the more notable and keenly experienced aspects of practicing psychotherapy in this context will be interspersed with direct quotes from several psychiatrists and psychologists in rural practice.

Four areas found to be of particular significance and noteworthiness were: (1) the multiplicity of boundary issues that arose in rural practice; (2) the complexity of the role of therapist; (3) the ongoing nature of the therapy relationship; and (4) the changed stance of the therapist as an adaptation to the small community setting.
THE INCREASED ATTENTION TO THERAPEUTIC BOUNDARIES

When I work with a client, I set some very basic things up with them. You must, living in a small community, set some protection for your client, not only yourself, but for your client. What you say may well be, you need to talk, that we both live in this community and that we may bump into each other at church or at the grocery market or socially at someone’s birthday party. We need to talk openly about what I may say and what you may say. For example, I tell clients they may know me as my husband’s wife, they may know me from the school community, they may know me in a lot of capacities. If they meet me on the street and they are with a friend, if they don’t want to say, ‘Hi, this is my psychotherapist,’ they need to know that I’m not particularly concerned. So, I say to them, you are more than welcome to say, ‘This is a friend of mine’. . . . For example, they know that I’m not going to be concerned as to how they introduce me but I also tell them that I will never allude to knowing them in a psychotherapeutic situation. (Dr. B)

. . . . You’re always running into someone on the street and it is something that’s usually addressed in the first session . . . In the part that’s different here is that I always address the idea that chances are we will run into one another at some other place. So you set up some guidelines. And what I usually say to people is that I leave it up to them whether they chose to acknowledge me . . . and like I said, I would even go so far as giving them control of the situation. If they want to come up and say hello, that’s fine. (Dr. C)

The establishment and maintenance of boundaries is a critical consideration which overarches all other aspects of small community practice. The often jarring realization of one’s visibility within the community, increased information about patients, and increased potential for informal contact with patients all lead to a heightened attention to boundary issues by rural practitioners. A possible reason for this is the unexpectedness and unpreparedness that a therapist may experience when initially faced with extratherapeutic con-

It can be argued that urban practitioners could inadvertently become myopic to the assumptions behind their actions, whereas rural practitioners become acutely aware that what they have learned is less applicable in a smaller setting, prompting the need to challenge old assumptions and create new premises. The rural therapist may, by necessity, be more sensitive and alert to confidentiality and boundary issues. Though boundaries and confidentiality are universal and important therapeutic issues, they become more obvious consideration in a less populated setting.

Therapists in small communities have to create their own rules and guidelines and develop their own means of managing these issues. The principles of practice learned in training are not always directly applicable to the small community context, and only serve as a rough foundation. Thus, for each therapist, the formation of guiding principles of boundaries and confidentiality is done in relative isolation.

Part of the sense of isolation that rural practitioners experience may be due to feeling disregarded and out of the mainstream. There may be isolation in the experience of having the principles of prevailing theories not fit with the realities of practice in a rural setting and one’s own inventions feeling somehow renegade and not confirmed, validated or respected.

Or to put it simply, for example, we have one swimming pool and I can remember being absolutely naked in a locker room and turning around to see one of my most difficult clients and having to say, ‘Oh, Hi,’ and it was amusing because she said, ‘Hi, Dr. B,’ not my first name, not just ‘Hi.’ And I was standing there in my towel and the lockers are too small to jump into but I can remember thinking, Oh, God, I want to just jump into this locker. (Dr. B)
Extratherapeutic contact is a given in small community setting and a component of treatment that cannot be ignored. It is an almost unavoidable daily occurrence in small community living and becomes a routine expectation by the psychotherapist. By contrast, in suburban or urban settings, extratherapeutic contact does occur, but with such infrequency as to make it a surprising and often unsettling event. Extratherapeutic contact becomes an expectable event for the rural practitioner for which some protective measures have to be made. It is useful to consider how keenly sensitive this contact could be to both parties. The patient reveals acutely personal and often painful information about him or herself to the therapist during a therapy session. The patient counts on the therapist to act professionally and preserve the confidentiality of the information given, as well as to tolerate the feelings generated in the session. Outside of the therapy session, the possibility is great that the patient will meet the therapist in a social situation, and the patient is aware that the therapist knows much personal information. The patient has to shift from the patient role to the demands of the particular social context, where the expectations are for greater interpersonal reciprocity. Back in the office, the patient is once again required to shift back to interpersonal non-reciprocity.

On the other side, the therapist is the recipient of the most minute details of the patient’s life. The therapist must also shift roles outside of the therapy situation, possessing much information about the patient, while being careful not to allow that to be known. Also, the therapist, as the recipient of information, must tolerate the possibility that extratherapeutic contact will provide the patient with the opportunity to gather information about the therapist which may color the response to the therapist. As Mazer (1976) pointed out, the “therapeutic incognito” of an urban environment can serve as a protective device for the therapist and offers a buffer from the anxiety inherent in any vital human experience. The rural therapist does not have this buffer, and, therefore must tolerate the lack of anonymity and increased exposure of being a fallible human being. The therapist as an individual is usually protected from the microscope lens; however, in rural practice, the lens can become focused in his or her direction.

The tenets of traditional practice are worth questioning. Current theory and practice are dominated by prototypical traditional perspectives which create a distance and hierarchy in the therapeutic relationship. The stance of the therapist, the “therapeutic incognito,” could be experienced by the patient as chilly and withholding. Yet patients who experience it as such, and therapists who challenge these tenets, could be easily pathologized within a traditional framework. Generally, regardless of theoretical persuasion, the therapist is usually a silent partner in the process of psychotherapy. The patient may wonder about the personal life of the therapist or what the therapist is really like, but will rarely probe. The therapist, if a shade less conservative in outlook, may opt to share some carefully considered disclosures or personal references with a patient. These are the unsaid but recognized rules of psychotherapy in most settings.

These rules do not readily apply in a rural setting. Maybe it would be useful to examine and even question the rules that are so embedded with us and often taken for granted. Is it so unreasonable and potentially countertherapeutic for patients to want to know more about someone with whom they confide their most private thoughts and experiences? It is curious why therapists are taught to curtail questions directed to them. Being one’s self is not often discussed in the literature, though ways of making one’s self inscrutable can be readily found. Certainly, the amount of information known about a therapist appears related to the setting. Perhaps the amount of information made available should depend on the setting as well, since expectations may differ. A fresh look at the assumptions of practice may prove valuable.

It is possible that the residents of small communities become accustomed to increased and varied contact with other community residents and adapt to changes in role as a function of everyday life, unlike urban residents, who rarely encounter others in more than one role or setting. It becomes important in rural practice to differentiate the types of boundaries. Revelation is not exploitation. What one may reveal may shift and expand yet always continue to be bound by the task of therapy.

There are few training grounds or other settings where much consideration to therapeutic boundaries is required. Confidentiality guidelines broadly address therapeutic boundaries, but offer little
additional direction. Didactic training rarely covers these issues since they are often such background aspects to practicing psychotherapy in other settings.

Also boundaries become altered in a small community context. What could be considered inappropriate boundaries with patients in a larger setting may have less validity in a smaller one. Therapists in a rural setting are few in number and are participants in the community. Dilemmas arise on whom to treat and how to deal with the glut of information accessible about patients.

Rules observed in larger communities regarding patient referrals and avoidance of treating patients who are related or connected in some way are not easily achieved in rural settings.

Small community therapists sometimes accept referrals to treat people with whom they have had social relationships and treat people who have close relationships with each other. Often this is a result of being one of a few therapists within the community, which make referral difficult.

As mentioned earlier, perhaps success of treatment in a small community is not dependent on such strict boundaries as advocated in traditional practice. Again, it is interesting to speculate on the success of attempting a pure psychoanalytic treatment in a small community, since many of the tenets of this perspective are not easily followed in a rural context. Certainly transference becomes altered when there is so much available information about the therapist. The question becomes one of how much anonymity and distance in the therapeutic relationship are critical to successful psychodynamic treatment in any context.

The interconnectedness of community residents and the information flow in a community with a small population is another aspect of rural practice that is a departure from the experience of therapists in larger settings. A psychotherapist may be provided with access to a wealth of information about his or her patients both directly and indirectly. Diplomatic ways of devising boundaries to modulate information and preserve confidentiality become necessary. Again, rural therapists are confronted with ethical problems not typically encountered in other settings and, therefore, may have to create their own guidelines. It appears that guidelines set on this issue become an individual decision. It can be speculated that this poses a continuous demand on the rural therapist to be attentive to the many facets of the psychotherapeutic situation.

At the same time I suppose that some of my training has hindered me particularly because there's a certain amount of discomfort involved in learning which rules to follow and which ones to bend a little bit in this particular setting. There is nothing in my training that helps me deal with a patient arriving at a staff party that I'd been invited to, as the boyfriend of a staff member. There's nothing in my training that tells me about that at all, except in the vaguest sense where I've been told to keep my distance. There's nothing in my training that really told me how to accommodate to such an odd situation, how to integrate the notion that this personal contact outside the therapy setting along with the ongoing therapy. That is something that has to come, in a large part, from one's self and judgement. (Dr. D)

Rules for rural practice are transmutable and complex, dependent on each individual situation. Overall, there is a resonance to the dilemmas that confront rural therapists. Their task is an ongoing process of continuously evaluating and determining the appropriateness of their actions. Berry and Davis (1978) aptly captured this in their statement, "...the professional role in rural community mental health should be determined by the phenomena addressed, not by the imposition of the prevailing methodology or ideology" (p. 678).

THE COMPLEX ROLE OF THE RURAL THERAPIST

... You usually don't share intimate parts of your life with people you may be dealing with as clients, however, I've also found that some of the strength that makes you the therapist you might be has to come from who you really are and you end up processing that. (Dr. B)

People look to them [therapists] as role models for managing their lives and that may not be fair. We all have problems and stuff. The flip side is that it is a small community and there are
by ratio many mental health professionals. You do come to
own a role that extends beyond your working hours. This role
is typified in the type of model you are for people you are
counseling or who are aware that you are counseling others
about how to deal effectively with problems, how to handle
things and how to live reasonably within a community. — I re-
ally believe in role modeling as far as people changing. — That
occurs in a small community, that I know from experience
rarely occurs in a larger city, just because you’re in more con-
tact physically with these folk, that’s a plus for them. (Dr. F)

The big difference in rural psychotherapy is model behavior.
You’d better not plan on doing rural therapy unless your life is
in order and by that I mean, you can have you own issues,
whatever they are, you could be getting divorced, you can go
through whatever you’re dealing with but you must be honest
with yourself because they’ll just know it. I mean, if you’re
very basic with yourself, you’re fine. (Dr. B)

The role as psychotherapist became both expanded and contin-
uous in a small community setting. This role is a 24 hour a day
experience with often no clear distinctions between one’s profes-
sional and personal life. Information about the therapist is readily
accessible.

One of the aspects of the complexity of role is the sense that one
becomes a “role model in living” in a small community. Rural
psychotherapists are utilized beyond their professional role to pro-
vide examples of modeling behavior. The psychotherapist becomes
a model to the whole community system and not just to individual
patients. The psychotherapist is a known and visible community
member, whose personal life is unavoidably more subject to scrut-
inny. This creates a demand on therapists to be accountable in their
actions and to be congruent with what they say and do both in and
out of the therapy office and live in a healthy manner to provide
positive modeling behavior. One’s life may be examined as an ex-
ample for dealing effectively with common problems.

This role modeling may be further-reaching than one’s practice
and could be considered akin to a clergy role, where a psychother-
apist is expected to behave in a manner that befits his or her practice.

Like a vicar or parish pastor, the rural therapist is expected to hold
confidential material and be trusted as a confidante. It can be argued
that part of the role of both rural therapist and minister requires
being willing and open to having his or her life on view. Both are
expected to be active community participants and to be “on call” as
necessary. It can be speculated that people use both as role models
and prototypes of “good enough” human beings, to borrow a Win-
cottian term.

It is interesting to consider what it means to be a role model. It is
not the role of therapist that becomes exemplary. Rather, the ther-
apist becomes a role model as a human being. How a therapist is and
behaves is always paramount—the therapist can be observed in and
out of the therapy office. In a rural setting, it can be speculated, a ther-
apist can never forget himself or herself as a professional. Ther-
apists must always be aware of how they are presenting themselves
both in and out of the psychotherapy context. The therapist be-
comes aware that his or her life provides an example and that psy-
chotherapy practice purports a value and a goal for being and be-
having. It becomes a necessity to be true to one’s self. A therapist is
“never off the job” because of the awareness that his or her self-
presentation accentuates the practice of psychotherapy as a model-
ing process.

Perhaps this self-awareness and self-consciousness becomes syn-
tonic over time. Consequently, self-monitoring may turn into an
automatic and tolerable process. There may be a continuous intensi-
fied emphasis upon the observing ego functions of the therapist.
Certainly, in my own experience in rural practice I was both aware
yet habituated to being aware. On the surface, this appears to have
the potential to create tremendous pressure on the psychotherapist
to act in a superhuman way and be a vicissitude of rural practice.
However, there is the increased opportunity to renounce an ideal-
ized and unrealizable image for a fully human and imperfect one.
Thus, the therapist can become less invested in looking perfect and
“all-knowing” and attempt a healthy integration of doing the work
of psychotherapy and being human.

The notion of the therapist being a role model may have some
interesting implications for practice. Should we, as therapists, con-
sider ourselves role models? Is this far too burdensome to consider
or should we be able to adhere to a standard of reasonable mental health and code of conduct which we could be comfortable about being on view? There is, of course, a morality to this that many theories tend to either not acknowledge or try to distill from their perspectives. There are many implications to acknowledging our moral positions within our role as therapists. In rural practice, what occurs outside of the therapy office becomes important in adjunct to what happens within in it. In a rural context, it is possible that our decisions and behaviors become more public, thus, our morality becomes more public as well. It is possible that a rural context demands more attendance to one’s behavior and person.

THE ONGOING NATURE OF THE THERAPY RELATIONSHIP

It just seems to be more of a complete picture that I would see the kids at school, meet their parents who would go to the supermarket, at some point talk to the parent, or see the kid or something... I mean so you would actually see, really get into the part of their lives that you wouldn’t if you lived in one place and worked in another... It felt to my advantage to know much more about how these people were living and it was to their advantage to see me as not just an outsider but someone who was living with them, a real person. (Dr. C)

There’s a negative side to all this personal stuff, but there’s also a positive side. You know people and you really form relationships with people, these are relationships that really extend beyond the therapy room. These are people you see in the grocery store, shopping for your kid’s clothes, I mean you see them in bars, you see them everywhere and the therapy—not the same intense way that it occurs in the office—but the therapy goes on continuously and people change for the better under those circumstances, that’s been a real plus.

I’ve seen direct therapeutic gains to my clients in this setting that I never saw in a larger city. I really think they get better, they tend to have more contact with the therapist, if only by phone or in just knowing the therapist merges with other community members and there’s a sense that I just don’t see this person and I pay how ever many dollars an hour and then they’re gone and that’s it. You know, it’s like, I wonder if that hour really existed... there is something unreal between the hour you spend and then you go out into the city and do your thing. Its like two totally different worlds. That doesn’t happen here. I like this much better... the personal advantage of being in a small town is real attractive to me. (Dr. F)

In urban practice, the results of psychotherapy can remain intangible. The therapist rarely has a chance to see a patient utilize the gains made in treatment. Consequently, the urban practitioner may never really know if the therapy was truly successful. In a rural setting, she or he is more likely to see the results of treatment and even to have the patient acknowledge this to the therapist after termination. The rural practitioner can experience himself or herself as making a difference. A heightened sense of personal efficacy and impact can occur. It is perhaps this aspect of practice that makes the difficulties of working in this setting worthwhile. It can be tremendously reinforcing and rewarding to experience making a positive difference in the lives of others. This may contribute to the increased generativity of the therapist over time as well as a deep experience of personal and professional satisfaction.

A richer involvement can be derived from a practice when one can see the tangible results of one’s work and effort. Just as the therapist is visible, patients can be seen in the milieu in which they live and not just in the therapy office. Patients also experience multiple interactions with the therapist outside of the office. Soreff and Hymoff (1976) made the observation that, “Thus, one of the by-products of these extra interactions is that the therapist is able to observe healthy aspects of the personality as well as the destructive and pathologic as traditionally only seen by the psychotherapist in his office” (p. 667).

Therapists gain a fuller understanding of their patients because of this increased knowledge about their life situations. The therapeutic process extends outside of the therapy office. Because of the increased exposure on both sides, psychotherapy becomes somewhat more of a reciprocal exchange.
THE CHANGED STANCE OF THE THERAPIST

It's an extremely odd experience, as compared with being a therapist in the city, such as Boston or Cambridge. There are a number of differences, certainly one is that therapy seems to be practiced somewhat differently in a rural area. People seem to approach therapy from a somewhat looser standpoint. That can be good and that can be bad, but I think that clinicians tend to be a little less rigorous in application of therapeutic principles no matter what their theoretical orientation is... They might come in approaching therapy in a fairly rigorous fashion and theoretical principles tend to loosen up over time. People tend to just insert more of themselves in the therapy. (Dr. D)

In current practice, there exists a myth of the ideal therapist. The ideal therapist is a lofty being who distills personal characteristics out of the office and bestows enlightening interpretations to the patient in an antiseptically neutral atmosphere. This stance is mythologized and perpetuated publicly—supervisors pass on the tradition to clinical trainees and lecturers and authors tell tales of magnificently curative interventions by god-like creatures called psychotherapists (often themselves). The value is on the finely-honed persona, not the human-ness of the psychotherapist.

Thus, if therapists publicly acknowledge that they self-disclose at times or present more of themselves as individuals in the therapeutic encounter, they may experience shame and the stigma of inappropriateness. Certainly, this is not the stuff in which myths are made. Self-acceptance and comfortableness as a human being do not fit this model. Instead, the model fosters the keeping of secrets. Stiver (1985) made the comment that much is unknown about what really occurs behind closed doors. She related a story about a clinician leaving training and terminating a treatment relationship. This clinician gave her patient permission to keep in touch with her and let her know how she was doing. When she revealed this to her supervisor, she was severely chastised and told that she was being seductive and inappropriate. In turn, the clinician was terminating with her own therapist, who told her to keep in touch. The clinician was baffled and realized that what is usually taught about practice is not a full picture of what often occurs.

Rural practitioners break the perpetration of this myth. They seem to engender a brave new frontier spirit which values the person before the clinician. The myth does not hold, since they are far away from the realm of supervisors and renowned theoreticians. Possibly, because they consider their experiences as unique and incomparable, they are willing to share their outlooks on practice. Though the rural therapist has deviated from accepted premises of practice, direct results of the patient's progress are evidenced. Perhaps rural therapists avoid feeling ashamed since they find that what they do has positive results.

Early on I made decisions somehow out of sheer panic of having to encounter patients. This was something I had never experienced before because I rarely encountered patients in my personal life in Cambridge or Boston and I would just somehow try to accommodate the situation and maintain as much distance as I could. I think that was my primary objective, that I would not show much of myself. I think over a period of time that it probably evolved to perhaps showing a bit more of myself and in a more relaxed way. (Dr. D)

There is an increased overlap in the therapist's professional and personal life, increased visibility and the expectation of some openness about one's self with patients. Perhaps because of this, the context supports and demands a changed stance and way of being that departs from the experience of practicing in urban settings. It can be postulated that visibility and being known as a "real person" affects and shapes how psychotherapy is practiced. It is interesting to consider the possibility that the "real relationship" may actually help fuel the impetus for change instead of being a lesser element in therapy as it is usually considered.

Mazer (1976) noted that therapists may experience "culture shock" in a rural setting due to the lack of anonymity and the impossibility of maintaining a distanced stance from patients. He added that the therapist is experienced more as a human being without a professional facade. The small community setting may de-
mand some extra thought to be applied to familiar ways of practicing psychotherapy. Some form of transformation is needed—a process of assimilation and accommodation that moved one to let go of the notions and values that did not fit or work in the rural setting. There is a progression from an initial attempt to guard against self disclosure or attempting to modulate how much is known about the therapist, to gradual increase in comfort level with these issues. The alternative of attempting to maintain a less flexible stance and control visibility would require such considerable constriction of activity as to make this an undesirable option.

This adjustment and alteration may have the advantage of facilitating the development of one's personal style in the therapy. Initially, therapists described being acutely aware of their role and how they appeared to patients. Adaptation occurs, not by dropping the role, but by somehow incorporating the role into one's continuous sense of self and melding personal style with theoretical orientation and self acceptance. This can be contrasted to what informs a therapist in urban psychotherapy practice. In an urban setting, a therapist can construct and base his or her role on theoretical models or supervisory models. It can be surmised that in a rural setting, the therapist cannot rely on these models, because neither are wholly relevant. The rural therapist is required to improvise rules and standards that are more reflective of his or her personality and style. The role becomes an intrinsic part of the rural therapist's self concept, which can not be left behind at the office.

Allowing more of one's personality to emerge with patients, including using self disclosure and allowing for some access to one's personal life may possibly contribute to therapeutic gains. This seems to support that the person of the therapist cannot be excluded from the therapeutic experience in small communities. In fact, one's strength as a therapist seems to depend on who one is as a person. A rural therapist is perhaps as much a teacher, teaching by example, as a facilitator. A possible conclusion is that an increased use of self becomes appropriate and effective practice in small community practice. It is interesting to consider if these findings could be applied in other settings as well.


**BIBLIOGRAPHY**


