

The Rural Profile: A Concept Analysis

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Abstract

Purpose: It has been well-documented that rural communities experience poorer health outcomes than urban or suburban communities. The contribution of various structural and sociodemographic factors to this disparity has been well studied. However, research on the impact of the rural profile on health outcomes is understudied, in part because what it means to “be rural” has not been well defined nor operationalized.

Methods: Walker and Avant’s traditional concept analysis method was used

Findings: The rural profile was defined as the set of personal attitudes, beliefs and behaviors that are typically informed by the structural and demographic elements found in less densely populated areas. The attributes of the rural profile are self-reliance, close community and family ties, and an emphasis on place. Observable indicators for each of these attributes based on previously published research are discussed.

Conclusions: While conceptualizing the rural profile is challenging, it is imperative to define and operationalize this concept in order to better address the health needs of rural people and communities.

Keywords: Concept analysis, rural, health behavior, rural beliefs

The Rural Profile: A Concept Analysis

It is becoming increasingly clear that rural dwellers have distinct definitions of health. Their healthcare needs require approaches that differ significantly from urban and suburban populations. Subcultural values, norms, and beliefs play key roles in how rural people define health and from whom they seek advice and care. These values and beliefs, combined with the realities of rural living –such as weather, distance and isolation–markedly affect the practice of nursing in rural settings (Long & Weinert, 2018, p. 28).

The above excerpt indicates that nursing and other health professionals cannot dismiss the influence “being rural” has on health outcomes in rural populations. There is a large body of multidisciplinary research that has found rural people have worse health outcomes than their urban counterparts (Aggarwal et al., 2021; Cosby et al., 2019; Moy et al., 2017; Yaemsiri et al., 2019). Thomas et al. (2014) has highlighted how a lagging rural economy, lack of investment in rural areas, and geographic isolation have all contributed to health disparities. However, there is a lack of research on the role that the rural profile plays in these health outcomes. Part of the issue for this gap may be due to the difficulty of defining, operationalizing and measuring the concept.

Purpose and Method

The intent of this concept analysis is to uncover the attributes of the rural profile, determine how these attributes may impact health, and examine how the rural profile can be effectively operationalized. In doing so, nurse scientists and other rural health researchers will be able to better understand rural behavior and attitudes as they pertain to health care access and health outcomes.

Walker and Avant’s traditional approach guided this concept analysis. For the purposes of this analysis, the following steps were employed: select a concept; determine the aims or purposes

of analysis; identify all uses of the concept; determine the defining attributes; identify the antecedents and consequences; and define empirical referents.

Findings

Uses of Rural Profile

Rural as defined by the Oxford English dictionary is “relating to or characteristic of the countryside rather than the town” (Oxford English Dictionary, n.d.a.). The term has been both conceptually and operationally defined in a myriad of ways. *Profile* is defined as “a record of person’s psychological or behavioral characteristics, preferences, etc.” (Oxford English Dictionary, n.d.b.).

As a phrase, *rural profile* and its related terms of *rural values*, *rural attitudes*, and *rural identity* have been used in a variety of sociopolitical contexts to help explain differences that are observed along the urban-rural continuum. For example, there is a large body of literature examining how the rural profile or rural values impact politics and society at large (Lynch et al., 2018; Lyons & Utych, 2021; Nemerever & Rogers, 2021; Trujillo, 2022) as well as more discrete issues such as environmental conservation and sustainability (Bonnie et al., 2020; Brinkman & Hirsh, 2017; Diamond, 2021; Firlein, 2018), and educational attainment (Agger et al., 2018). This body of literature largely frames rural communities as struggling to exert their agency and influence in a society that is based on urban policy.

In nursing and other health disciplines, the rural profile has been overshadowed by a focus on how the structural elements of living in a rural area lead to health disparities (Anderson et al., 2015; Behrman et al., 2021; Hartley, 2004; Matthews et al., 2017; Moy et al., 2017). Traditionally, many health researchers have emphasized the modifiable risk factors (e.g. higher smoking rates,

lower physical activity rates) in rural communities, and invariably suggest the correlation between education, income, access challenges, and health outcomes. More recently, there has been a focus on the phenomenon of syndemics (Miller & Vasan, 2021), which are defined as “clusters of synergistic health problems precipitated by structural inequalities associated with poverty, racism, and other forms of social exclusion, displacement, exploitation, and oppression” (Miller & Vasan, 2021, p. 6). Regardless of the approach in public health, the primary rural discourse in the health disciplines has been deficit-based instead of acknowledging the unique strengths that come from identifying as being rural (Afifi et al., 2022; Bourke et al., 2010; Poulin et al., 2020; Simpson & McDonald, 2017).

Despite the reference to a unique rural profile in the literature, *rural* is still predominantly tied to geographic place and the use of various government geographic designations (Bennett et al., 2019; Brown & Schafft, 2019; Ratcliffe et al., 2016). The United States Census Bureau, the United States Department of Agriculture–Economic Research Services, and the Office of Management and Budget all classify rural slightly differently (Fahs & Rouhana, 2021). While widely used, these operational designations can be discordant with people’s own identification of “being rural” (Onega et al., 2020).

Mao et al. (2015) described how place-based measures of rurality lead to an ecological fallacy. In other words, while health behavior outcomes (e.g. diet, physical activity, monitoring blood sugar) are measured at the individual level, place-based rural designations cannot practically be smaller than a census tract. Yet any associations between these individual outcomes and rurality must be aggregated at the level of place (e.g., county, zip code, etc.) and therefore, by definition, cannot infer individual experiences.

Bennett et al. (2019) recognized that these current classification systems are flawed, and argued that not only are the inconsistencies in defining rural confusing, but they may bias interpretation of research findings. Bennett and colleagues suggested the necessity of incorporating elements of the natural environment and local residents' perceptions of rurality when operationalizing *rural*. However, operationalization of the term cannot occur until what it means to “be rural” is defined.

While rural researchers recognize that the structural and demographic characteristics of living in rural places (e.g. older populations, lack of anonymity, limited resources, economic decline) inform the rural profile (Brown & Schafft, 2019; Cheesmond et al., 2019; Keller & Owens, 2020; Molinari & Guo, 2018; Oser et al., 2022; Ulrich-Schad & Duncan, 2018), more research is needed to address how the rural profile itself can influence health outcomes. Therefore, for this concept analysis, the rural profile is defined as a set of personal attitudes, beliefs and behaviors that are typically informed by the structural and demographic elements found in less densely populated areas.

Defining Attributes

Researchers who study rural populations, regardless of the discipline, consistently described the vast heterogeneity of rural populations (Afifi et al., 2022; Brown & Schafft, 2019; Farmer et al., 2012; Simpson & McDonald, 2017) and therefore defining the rural profile is challenging. However, self-reliance, an emphasis on close community relationships, and a recognition of the value of place were constructs that were nearly ubiquitous in the rural literature.

Self-reliance, as a construct, is related to hardiness, independence, resilience and individualism (Bacsu et al., 2017; Bernacchi et al., 2021; Collins et al. 2009, Keller & Owens,

2020; Kuntz et al., 2018; Wagnild & Torma, 2018). Numerous studies have explored the concept of self-reliance in rural communities and have identified it as one of the factors that contributes to the differences in health seeking behaviors between rural and urban populations (DeGuzman et al., 2022; Starcher et al., 2017), particularly mental health seeking behaviors (Fennell et al., 2018). Self-reliance has been characterized as a learned skill that emphasizes autonomous decision making and independence (Lee et al., 2022). According to the updated rural nursing theory, the concept of self-reliance pertains to the ability to maintain health without seeking help from others (Lee & McDonagh, 2022).

Close community relationships includes recognizing the importance of both family and social networks and incorporates the ideas of neighborliness and reciprocity (Bonnie et al., 2020; Keller & Owens, 2020; Maclaren, 2018; Phillips & McLeroy, 2004; Skrocki et al., 2022). Simpson and McDonald (2017) described community as one of three values that must be considered when thinking about the ethics of rural health care. Rural communities are tightly knit often because there are fewer opportunities for relationships, and a smaller choice of friends and social networks. Maclaren (2018) described how rural populations are shaped by and shape the rural communities in which they live. Rural areas should not be dichotomized based on population densities or distances to the nearest metropolitan area. Rather, they have to be put into context so that the cultural, socioeconomic, and sociopolitical factors which construct health experiences can be understood (Poulin et al., 2020).

This idea of understanding how people interact with the space in which they live is also connected to the third construct of the rural profile, which is an emphasis on place. Simpson and McDonald (2017) referred to three understandings of attachment to place: affective, cognitive, and

behavioral. The affective, or emotional attachment understanding, is evident in the rural literature. While many rural areas' economies are no longer extraction based, the connection to place and specifically the land as it was traditionally used, was a strong theme in the literature. There is a sense of nostalgia for the "heritage of what used to be" (Ulrich-Schad & Duncan, 2018, p. 76). In a study by Bonnie et al (2020), 60% of rural respondents strongly agreed that where they live is an important part of their identity. At a cognitive level, individuals often incorporate thoughts of the place into their identity and the way in which health care decisions are made can be influenced by this value of place (Simpson & McDonald, 2017).

Antecedents and Consequences

Antecedents to the rural profile include having lived experience within a rural community (either directly or vicariously), and feeling as if one belongs in that community (Brown & Schafft, 2019). Belonging is necessary because it facilitates the embodiment of place.

Consequences are the outcomes of the concept (Walker & Avant, 2019). If a person has a strong rural profile that person typically has substantial social capital (Brown & Schafft, 2019; Mayer & Buttler-Nelson, 2018; Phillips & McLeroy, 2004) as well as substantial mistrust or distrust of outsiders and newcomers (Bernacchi et al., 2021; Bonnie et al., 2020, Brown & Schafft, 2019; Lee et al., 2018). Both of these consequences are related to the traditional "deficit discourse" of rurality. Rural individuals can often feel as if they are not worthy, or are treated as second class citizens. This phenomenon is true for medical practitioners as well. There is an implicit bias that if a practitioner is working in a rural environment, it means the practitioner was not skilled enough to work in an urban environment and therefore the quality of care will be lower in rural areas (Simpson & McDonald, 2017). The implication of these consequences is that individuals with a

strong rural profile may not seek health care through formal avenues as readily as others (Skrocki et al., 2022). When they do seek health care, it is often for acute matters, or matters pertaining to their children, and there is not an emphasis on preventive care (Earle-Richardson et al., 2015; Mize & Rose, 2019).

Empirical Referents

The last step of Walker and Avant's concept analysis method is identifying the empirical referents. These are observable indicators whereby one "can recognize or measure the defining characteristics or attribute" (Walker & Avant, 2019, p. 180). Most of the literature describing the rural profile or similar terms is qualitative in nature. The attributes are named, but they are not typically operationalized. However, there are a few studies that have attempted to define indicators for various attributes of the rural profile.

Mansfield et al. (2005) developed the barriers to help-seeking scale which contains a "need for control and self-reliance" subscale. Items on this scale that are useful observable indicators for the attribute of self-reliance include: "I would think less of myself for needing help"; "I'd feel better about myself knowing I didn't need help from others"; "I do not want to appear weaker than my peers"; and "I like to make my own decisions and not be too influenced by others." Paskett and colleagues (2020) developed indicators for identifying with community in their study on rural Appalachian communities. Useful observable indicators for the concept of community cohesion include: "I know most of the people who live around me," "I feel a sense of loyalty to my community," "I feel a sense of connection with other people in my community." Other indicators for the construct of community and family cohesion come from Oser et al. (2022) where the authors described the development and validation of a rural identity scale. Indicators that could be

used include: “I have weekly dinners with my extended family,” “I go to family reunions,” “everyone knows one another’s business in my county,” “I feel a sense of belonging with people who live in my county,” “family is very important to people in my county,” and “I exchange goods or services with my neighbors.” The rural identity scale also includes observable indicators for the attribute of place and tradition that is affiliated with place. These indicators include: “I grew up learning about my county’s history,” “either my immediate family or I work in land-related production and/or extraction industries,” and “people born in my county tend to stay here.” Thus, in recent years, there has been some movement towards operationalizing attributes of the rural profile, although a comprehensive instrument for assessing the rural profile has yet to be developed.

Conclusion

For this concept analysis, the rural profile is defined as a set of personal attitudes, beliefs and behaviors that are typically informed by the structural and demographic elements found in less densely populated areas. Antecedents to the rural profile include having the lived experience of being in a rural place, and feeling as if one belongs in that rural place. The attributes include self-reliance, a closeness to family and community, and a strong emphasis on place. The consequences of having a strong rural profile include increased social capital and also a general distrust of newcomers and outsiders. These consequences may lead to unique health seeking behaviors among rural populations. Empirical referents or observable indicators of these attributes were identified.

There are many opportunities to further explore this concept, due to the heterogeneity of rural populations and the complexity of unraveling the rural profile from the geographic and socioeconomic influences of health. Future work could be focused on developing and validating

instruments to quantitatively measure the rural profile. Recognizing that “being rural” leads to a different understanding of health, it is also necessary to collaborate with rural populations to develop best practices and policies within the healthcare arena for these communities. This analysis should be considered a starting point. As Farmer so eloquently stated, culture or identity becomes ‘the elephant in the room’ – fundamental to health, but ‘too difficult’ to explore” (Farmer, 2012, p. 246). It is imperative that nurse scientists and other rural health researchers continue to address this elephant in the room so that the appropriate provision of health care and health promotion interventions can be offered in rural communities.

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