Ethical Issues in Rural Counselling Practice

Janet A. Schank
Macalester College

Abstract

Counsellors in rural areas find themselves facing unique challenges in striving to practice ethically and meet the needs of clients and communities. These challenges include dealing with: (1) multiple relationships, (2) limits of competence and resources, (3) geographic or professional isolation, (4) community values and expectations, and (5) inter-agency relationships. These challenges lead rural counsellors to examine and question their daily practice and lives in an attempt to balance ethical codes with the realities of rural life. Further illumination of the issues, along with suggestions to minimize practice risk, can contribute to the ethical practice of counselling that is most appropriate to rural areas and small communities.

Résumé

Les conseillers des régions rurales se heurtent à des défis particuliers en essayant de satisfaire aux besoins des clients et des communautés tout en exerçant leur profession de façon éthique. Les défis comprennent: (1) les relations multiples, (2) les limites de compétence et de ressources, (3) l'isolement géographique ou professionnel, (4) les valeurs et les attentes de la population, et (5) les relations interinstitutions. Ces défis amènent les conseillers ruraux à faire leur examen de conscience sur les plans personnel et professionnel afin de trouver l'équilibre entre les codes d'éthique et les réalités de la vie rurale. Ce sont là des questions qu'il faut approfondir et assortir de recommandations afin de réduire au minimum le risque pour la profession et d'adapter le mieux possible le counseling aux régions rurales et aux petites communautés.

All counsellors face a variety of decisions as they strive to practice ethically in their work with clients, yet the issues related to ethical dilemmas and decision making are compounded for counsellors working in small communities and rural areas. Prevailing standards in training, ethical codes and regulations, which are usually developed in urban areas, are not so easily applied in rural and small-community practice. The "intricate web of professional-personal roles" (p. 23) described by Purtilo and Sorrell (1986) complicates professional boundary issues in rural areas.

Many mental health professionals will find themselves practicing in small communities and rural areas, although few have received training during graduate school or in subsequent continuing education on managing ethical dilemmas in small-community practice. Mental health professionals in rural areas usually know the content of ethical codes but often struggle in choosing how to apply those codes in the best interest of clients (Schank, 1994). Rules that seem straightforward and absolute are often subject to interpretation when the practitioner is faced with a "real life" dilemma (Woody, 1990). Unfortunately, codes of ethics do not specifically acknowledge conflicting obligations or offer instructions on how to weigh their relative importance when obligations do conflict.

The ambiguity inherent in ethical codes is inevitable, given the range of dilemmas that counsellors may confront. As a result, therapeutic decisions about ethical and values issues are often made intuitively and automatically. The counsellor draws upon an internalized ethical stance, grounded in both personal values and knowledge of formal codes. Woody (1990) acknowledges this reality, in recommending that mental health practitioners "reflect on the unique problem, weigh the various factors and risks, and make the 'best' decision possible, perhaps seeking consultation in doing so" (pp. 133-134). The uniqueness and complexity present in rural mental health practice means that, "Informal expectations and formal rules are more likely to come into conflict with each other in rural practice than they are in urban settings" (Rich, 1990, p. 33). Frequently, these professional codes and guidelines "tend to place the rural practitioner in opposition to prevailing rural community standards" (p. 17).

Even though several authors have recognized that counsellors must sometimes rely on less formal decision-making rules, there is still a consensus that formal ethical principles should be considered. Counsellors who possess a clear understanding of the relevant ethical principles will be more able, and more likely, to apply those principles to small-community situations that do not have clear-cut answers.

The reality is that mental health practitioners in these communities report applying both internal and formal, external standards as guides to their practice. At the same time, practitioners may know very little about how their decision-making compares to that of colleagues in similar circumstances. There have been few opportunities for practitioners, and professional organizations, to openly discuss and address the process that practioners go through in combining both of these standards as they strive toward ethical practice. In addition, rural mental health professionals have sometimes been reluctant to share their ethical struggles out of fear of sanction and criticism from their urban colleagues.

One of the most frequent of these dilemmas is the existence of multiple or overlapping relationships between counsellors, their clients, and others in the small communities in which the counsellors live and practice. These relationships may be either concurrent or consecutive (Sonne, 1994). The latest APA Code of Ethics (American Psychological Association, 1992) addressed the fact that dual or overlapping relationships are not inherently unethical and may not always be avoidable. The Canadian Guidance and Counselling Association Guidelines for Ethical Behaviour (Canadian Guidance and Counselling Association, 1989) also prohibit dual relationships unless no other alternative is available. A primary objective for rural and other small-community practitioners is to keep the needs of clients foremost and to be vigilant in situations that could impair the practitioner's objectivity.

Although multiple-relationship dilemmas may be the most frequently recognized as concerns in rural practice, several other arenas of difference can be identified: limits of competence and limited resources, geographic or professional isolation, community values and expectations, and inter-agency working relationships.

In each of these areas, rural practitioners have encountered the inherent limitations of their professional ethics codes. It would be a mistake, however, to conclude that unethical practice is the necessary result. Instead, these practitioners have succeeded in drawing attention to gaps in our professional codes and catalyzed discussions that will benefit practitioners in a range of settings.

Rural practitioners, in their struggle to make ethical decisions under challenging circumstances, have demonstrated that ethics must be more than simply adhering to standards or rote application of rules. Ethics should not be static but rather constantly examined and evolving in order to be most beneficial to clients and counsellors. To do otherwise would be what Pope and Vasquez (1991) identified as mindless rule following, a poor substitute for a more thoughtful and concerned approach. Rural mental health practitioners cannot avoid blending or overlapping roles without isolating themselves from the community and are also more likely to play multiple roles in a rural setting (Kitchener, 1988; Rich, 1990). This is much different from most urban settings, with "discrete, compartmentalized relationships" (Rich, 1990, p. 22).

Understanding the dilemmas of small-community practice is important not only for counsellors in these settings, but for their urban colleagues and for governmental and professional policy makers. In the following sections, a number of frequently encountered dilemmas are discussed in detail.

RURAL PRACTITIONERS: VOICES FROM THE FIELD

A study which involved face-to-face, on-site interviews with 16 Master's and PhD-level licensed psychologists in rural areas of Minnesota and Wisconsin provided rich information that illustrated the day-to-day reality of such dilemmas (Schank, 1994; Schank & Skovholt, 1997). Practitioners were interviewed at their job sites and responded to several open-ended questions, based on general themes that emerged from an extensive review of the literature on ethical dilemmas of rural mental health professionals. The most salient of these themes are addressed in the following sections: (1) multiple or overlapping relationships, (2) limits of competence and limited resources, (3) geographic or professional isolation, (4) community values and expectations, and (5) inter-agency working relationships. The generosity of the participants in providing their time and honest input is reflected in the quotations used in the discussion.

COMMON ETHICAL DILEMMAS

Multiple or Overlapping Relationships

While the continued importance of prohibiting dual sexual relationships should be a forgone conclusion in the ethical practice of psychology, nonsexual overlapping relationships are not a matter of "if" as much as "when" in small-community practice (Barnett & Yutrzenka, 1995). For example, counsellors in rural areas and other small communities frequently live in the communities in which they practice. As such, "social or other nonprofessional contacts outside a primary professional relationship are not only inevitable but imminent" (Faulkner & Faulkner, 1997). Professional contacts, such as patronizing local businesses, may occur between counsellors and current, past, or potential clients. As Keith-Speigel and Koocher (1985) stated, "It is most likely that psychologists will be judged culpable when a 'small-world hazard' was known in advance *and when alternatives were clearly available,* but the psychologists undertook a professional relationship anyway, and charges of exploitation, prejudice, or harm resulted'" (p. 274). Rural counsellors are also faced with the fact that sometimes "denying help to a potential client because of a preexisting relationship could mean that the person gets no help at all" (Smith & Fitzpatrick, 1995, p. 502).

The reality of overlapping social relationships. Simultaneous or overlapping social relationships can occur in a variety of settings: church, parties and social gatherings, cultural activities, school events, and volunteer activities. The following quotes are illustrative of these overlapping social roles:

> One of the things we have done in our church for the last 6 years is that we have taken a group of kids to Colorado skiing as part of the youth program. I feel some kind of tension about that sometimes. For example, one of my clients happened to be on the ski trip 3 or 4 years ago. Well, I thought, "Okay, we don't do anything socially with this family." But I don't think those pressures are so unusual. It's just that you have to keep those dual relationships clear in your mind.
>
> I am single. One of my big fears is that I'll meet someone [that I want to date], and they'll say, "You don't remember, but 9 years ago I came with my husband for one interview."

Many mental health professionals choose to talk directly with clients about the likelihood that they will encounter each other outside of therapy. This open discussion helps to clarifiy the overlapping relationship and the importance of clients and counsellors staying in appropriate roles:

> The critical issue is just being very careful to keep them separated. I have some clients who—one, in particular, was aware of that issue. She felt very strongly that when our paths crossed, she wanted to be treated like anyone else in the community. She expressed it as, "I don't want to be treated any differently by you than I would be my dentist, my doctor, or my accountant."

The reality of overlapping business or professional relationships. In a small community, it is likely that mental health professionals will encounter their clients in business situations. In fact, in many small communities, counsellors may be seen even more as outsiders if they choose to take all of their trade to business people outside of town. It appears that degree of involvement is the primary factor to consider in such overlapping relationships. For example, it may be nearly impossible to avoid business interactions with clients in local stores, but it would be very unwise to enter into a business partnership with a client or a client's family (Schank & Skovholt, 1997):

> This family that I was working with—it just so happens that the father in that family was a contractor who was working on my house. The way I handled that dilemma was to talk to him about the problems we would have . . . I basically just tried to keep on two different hats. I don't really know what the alternative is, especially when there are so few providers available.

The effects of overlapping relationships on members of the practitioner's own family. Although identified only once (Jennings, 1992) in an extensive literature review, 12 of 16 psychologists interviewed talked about the significant impact that their professional practice had on their families (Schank, 1994; Schank & Skovholt, 1997). For example, children and spouses who are clients may be unwittingly invited to the homes of counsellors, or social involvements may be limited without being able to offer explanations. Several practitioners talked directly to clients and engaged in mutual problem solving about overlap in their lives. They also spoke with their family members about ". . . how to deal with teasing and questioning, self-disclosure from clients, and inadvertently knowing confidential information . . ." (Schank & Skovholt, 1997) about the psychologist's work:

> I had a [client] who had problems and just came in a couple of times. . . . I don't think he ever really dealt with too much. I suppose about 6 months later he took out my daughter. . . . My daughter now [has stopped seeing him]. I'm glad she figured it out—it was kind of a relief. . . . If they are having a rough time in the relationship, they will hopefully tell you why they are having a rough time so you can focus on that. I could see it being an issue where you don't know the individual but do know the family, the cousins, uncle, or something like that.

Working with more than one family member as clients or with others who have friendships with individual clients. Limited counselling resources within rural areas make it highly likely that counsellors will see clients with connections to other clients. When other referral options are not available, practitioners find themselves making difficult decisions about how to balance the intersections of relationships. Sometimes they do not even know about these intersections until well into the therapeutic relationship with the overlapping clients:

> [A client's] daughter is also a client of mine. Her daughter is getting married. After quite a while, it came to me that the people who are going to be her

daughter's in-laws are also clients. That would be okay if it would be just information. But one of this woman's presenting concerns is issues she has with her daughter's future mother-in-law, who is a very [disturbed] person.

Limits of Competence and Limited Resources

Rural practitioners are sometimes put in a position of deciding how far they can stretch their own levels of competence in attempting to best meet the needs of their clients and yet still practice within the guidelines of the profession (Canadian Guidance and Counselling Association, 1989). Many may practice in areas where continuing education opportunities are only available at some geographical distance. Others may have adequate background as a generalist but limited experience with specific presenting problems. While some counsellors work in agencies that employ staff with a range of competencies and interests, others find themselves searching for ways to extrapolate from their own backgrounds or quickly learn more about a specific client's own presenting problem:

> I have practiced outside the scope of my license a million times since I have been here because I sometimes feel like something is better than nothing. You know, it is tough to kind of say that and to be up front with that. But there is so little available in communities like this that whatever you may know is helpful.
>
> If there is no [other] resource, my feeling is that we [should] do the best we can. We can be up front with the client on our level of expertise and experience. I was also working in a system where I have to see them, or no one else would take them. It wasn't even a matter of referring.

Mental health professionals in rural areas experience pressures, both from within themselves and from their communities, to try to be everything to everyone in order to meet what sometimes seem like overwhelming needs. Some quickly educate themselves by using internet resources and other methods of distance learning or by reading books and journal articles in an attempt to learn along the way. Others inform clients from the beginning if their presenting problems are not within the practitioners' areas of expertise but suggest they try working together, with the understanding that the clients would be referred if it later seemed more appropriate. They may focus on general skills that they would use with any clients as they learn more about a specific area of concern, while also trying to recognize their own limitations.

Geographic or Professional Isolation

Geographical distance is sometimes an issue, both for clients and for practitioners, and can have a major impact on how and where a client receives services:

> I don't think people who don't live in small towns understand that a lot of people don't even have telephones. A great many of them don't have cars, and there is no public transportation. They often will schedule appointments around a dozen

other things that they are doing in town, like shopping, dentist, and visiting Aunt Mary, because they don't have gas to get here or they don't have a car and they have to piggyback with somebody who is coming in. If you say, "I want you to go see one of my colleagues out in ________" or wherever, that might as well be Africa because they can't get there.

Others talk about the hardship clients face in having to drive many miles to get to counselling resources or specialized services, particularly if the clients are low income and assigned to a specific mental health center or hospital to receive services. When hospitalization is required, it is frequently many miles away from the client's home and family support.

Mental health professionals also struggle with geographical distance themselves as they try to maintain consultation groups and collegial relationships across many miles. Although some counsellors welcome trips to urban areas to pursue educational opportunities, the distance, time, and expense involved pose a hardship for others, as does arranging coverage for clients while they are out of town. The lack of specialists and specialized services is also an issue for some practitioners, although the push toward specialization within the profession can be a source of ambivalence for those currently practicing as generalists.

Community Values and Expectations

Since mental health professionals are trained almost exclusively in urban areas, there may be some significant differences between their values and those of rural residents. Abortion, sexual orientation, religious issues, culture, and ethnicity may be only a few of the areas of difference. Clients in rural communities may also tend to come to therapy with very specific problems, often postponing any sort of therapeutic contact until or unless the problem is very serious in nature:

I think there is much less of wanting to do it to enhance your life. In rural areas you don't have that much of a leisure class, so most people aren't into personal growth. When I first moved here, I talked with a psychologist down in ________, and he made a comment that has always stayed with me. He thinks that people in this area—and I think this would be true of any rural area—have a real high tolerance for pain. They really have to be in crisis or they have to really have hit bottom before they come in.

The informal communication network in small towns also carries information on mental health professionals' personal and professional behaviour, especially it if diverges from community norms and expectations:

We would go to the local steak house, and I would have a beer or something. I would hear from patients that, "Oh, so-and-so saw you with a beer." You might lose some patients because of that.

Successes and failures are more visible, and pressure to react in certain ways may come into play:

This other psychologist we hired has only been here for 3 months. This is the first time he has ever lived in a small town. . . . The first thing that happened when he

got here is that he had a real sticky child abuse case that involved a local dignitary. He had no desire to start off on the wrong foot with somebody who was in a position of power in the community. He ended up, after a lot of discussion, referring that person out of town because he felt it would be just too difficult. . . . Things that you do with clients spread like wild fire. Everybody knows everybody. . . . If you do a good job, they will be knocking down your doors; if you do something wrong, you're in trouble.

Requests for participation in community events, organizations, committees, task forces, and educational activities may leave some rural practitioners feeling overwhelmed or burned out:

Everybody wants you to do something—be part of their club, serve on the board of directors. They want me to give talks all the time. . . . There are a lot of demands that are separate from actually providing services. You kind of have to balance. . . . My wife and I have had a lot of discussions about trying to find that line. . . . So I try to weigh every request with the potential value of it. . . . But it does seem like you just can't hide.

Mistrust and stereotypes of psychology may come from lack of exposure to the profession in some rural communities:

Especially among older people. [Here in this small town] just two weeks ago [someone] was introducing me to this very nice lady, and she slipped and said, "Oh, you're that . . ." and I said, "The head shrinker. . . ." She laughed and said, "We need people like you here, too." But I could tell that wasn't really what she thinks. I guess that is probably true in the cities as well, but it is just absorbed as part of the community. You are not really targeted like you are here.

Paradoxically, maintaining confidentiality contributes to some of that mistrust. Residents of rural areas are used to knowing about and sharing information regarding the health and well-being of others:

I was seeing a woman . . . who had lost her job, had major health problems, and was in a real transition stage in her life. Her brother called and wondered how she was doing, and I couldn't tell him anything. I think that is very typical. Here is somebody really well-intended, yet I could not share anything with him. He was very put off by it. . . . In general, people open up more about what is happening if it is a medical problem. . . . It is very much a healthy sort of thing—"What can we do to help?" But that does play into times where confidentiality gets pushed.

Community values and expectations may become especially salient for non-Native counsellors who are working with Native people, particularly in rural and remote areas. Historical mistrust and previous negative experiences may lead Native people to view non-Native counsellors with skepticism. In addition, non-Native counsellors need to examine their own assumptions and beliefs about Native culture. Differing values and expectations between counsellors and Native clients and communities are issues that must be addressed and acknowledged if non-Native counsellors are to work successfully with Native people. Native clients "may hold quite different beliefs about the etiology of their problems and the manner in which change can be accomplished" (Manson & Trimble, 1982).

The linkage of traditional Native community approaches to healing, connections to traditional community and kinship support systems, information about specific tribal societies and how they influence the individual and family (Gurnoe & Nelson, 1989), understanding of holistic viewpoints and alternative explanations for being "out of balance" with the natural world (Heinrich, Corbine, & Thomas, 1990; Thomason, 1991), knowledge of and experiences within specific Native cultures, respect for extended family relationships, and belief in the strength of a collective rather than individualistic orientation may serve non-Native counsellors well in their goal of working successfully within the Native community (LaFromboise, 1988). Since "new solutions to problems or new ways to see old problems become possible through interconnectedness with the community" (p. 392), non-Native counsellors would do well to keep in mind the importance of avoiding imposing their biases on Native clients or attempting to shape "the behavior of the client in a direction that conflicts with Indian cultural life-style orientations and preferences" (p. 392). Native clients may be comfortable integrating both traditional Native and conventional psychological approaches if non-Native counsellors offer informed respect to Native healing approaches.

Inter-Agency Working Relationships

Visibility and the local "grapevine" make it hard for mental health practitioners to openly challenge the competence of other professionals. Even with counsellors' commitment to confidentiality, others involved in a conflict may end up talking freely about a situation. Thus, any questioning of others' skills and intentions may become fodder for informal discussions and information-sharing, especially in rural areas where professionals are widely known to the community. Some counsellors face the dilemma of hearing about poor quality, but not blatantly unethical, treatment of clients by other practitioners. Counsellors may handle these situations by helping clients make informed choices as to plans of treatment, talking directly to the practitioner to share concerns, and not referring to questionable providers. There may also be dilemmas over clear ethical violations by other mental health practitioners, including misrepresentation, failure to report abuse, and misuse and misinterpretation of psychological tests. Questions of competence may also come up around dealing with social service agencies and local schools, particularly systemic concerns around who defines and responds to client needs. However, in small communities, confronting other professionals and pushing for adherence to ethical standards could have lasting implications. Others who have been challenged may refuse to work with or refer to counsellors who have raised questions about their professional

behaviour, and counsellors who confront other professionals may come to be seen as troublemakers.

Conflicts and questions about the competence of local physicians may remain out of the public eye, for the most part, because of the possible consequences of openly challenging the prestigious reputation of the small-town doctor. There may be no other physicians for miles around, so rural mental health practitioners may be left with a dilemma of choosing what is in the best interest of clients. Is it better to downplay those conflicts in the interest of a harmonious working relationship with local physicians, or are the concerns so egregious that the working relationship cannot continue and may even become the topic of public discussion among the members of the rural community?

Longstanding political and financial connections regarding referrals to and from local social services, community mental health centers, schools, and private practitioners may affect a rural counsellor's ability to best meet the needs of clients. As an example, some agencies may not refer to other professionals because of past conflicts or business agreements, which may have nothing to do with a particular counsellor or be completely unrelated to current practice. There may also be pressures to share confidential information with additional interested parties such as attorneys, social workers, probation officers, and school personnel.

IMPLICATIONS FOR PRACTICE

The issues addressed in this article are salient not just for rural counsellors, but for counsellors who practice in a variety of small communities—communities of color, small college, gay/lesbian/bisexual/transgender, military, or disability. Yet, few of us received any training on practicing within small communities. A broader discussion and coalition across small communities would be an important step in drawing attention to the relevant ethical issues and might also facilitate discussion in which risk of censure or misunderstanding is minimized. The inclusion of small-community practice in counsellor training programs and relevant continuing education opportunities, along with attention as to how to weigh importance when conflicting obligations occur, are other ways to elevate the importance of ethical practice.

Although the cautions for entering into dual relationships are for the benefit of clients, rather than to protect ourselves from censure (Herlihy & Corey, 1992), they also pose risks for the mental health professional. From this perspectice, there are several steps that mental health professionals can take to minimize practice risk:

1. *Recognize that ethics codes or standards are necessary but not sufficient.* Codes cannot cover every dilemma that counsellors will face, especially within the complexity of rural practice. We must be able to apply regulations but also make ethical decisions based on daily challenges. Counsellors must be knowledgeable regarding relevant standards but must also be able to take those guidelines

and apply them to counselling situations that are usually not as clear-cut as examples which are provided for or developed by urban colleagues.

2. *Know relevant codes, regulations, and laws.* Although it is a cliche, ignorance of the law is no excuse. Keep up to date with professional standards and provincial or national laws.
3. *Obtain informed consent.* Talk with clients directly about the plan of treatment and any ethical dilemmas that are involved for you as a counsellor. Be sure that your case notes indicate the process of informed consent, along with documentation of any dual relationship or limits of competence. Describe relevant consultations with other mental health professionals.
4. *Involve prospective clients in decision making.* Discuss with clients the implications of any overlapping social or business relationships, along with any concerns that you might have about where you will need to enhance your own professional background in order to work with them most effectively. Give information about other options available to them and work together to decide whether you can enter into a counselling relationship. Document all of this in your case notes.
5. *Talk directly with clients about the likelihood of out-of-therapy contact.* Instead of waiting for that uncomfortable moment out in the community, discuss the likelihood of out-of-therapy contacts openly at the beginning of therapy and reopen the issue as needed throughout the course of counselling (Barnett & Yutrzenka, 1995). Also, set clear limits with clients about the inappropriateness of discussing therapy when you meet each other in social or business settings.
6. *Consider type and severity of presenting problems.* When deciding whether to see clients with whom you have overlapping relationships or limited competence, consider how their own problems may complicate the situation. For example, accepting a client who is presenting with problems of depression or anxiety may be different than seeing a client with a borderline personality disorder or with paranoia. Of course, in some remote settings, such decisions are a moot point. There may be no other referral options available, or a client may be assigned to a particular agency as a service provider.
7. *Set clear expectations.* Be immediately clear about the boundaries of the professional relationship and ways that personal interaction could be affected. Discuss with clients what expectations they may have of you in the varying roles that you might play in the community. Any discrepancies between client expectations and the ability of the counsellor to meet these expectations should be clearly addressed.
8. *Set clear boundaries, both within yourself and with clients.* Any behaviour that might be construed as a boundary violation should be justified by sound clinical reasoning. Err on the side of caution, and heed Roll and Millen's (1981) call to "rigidify" in dealing with other parameters of therapy (fees, cancellations of sessions, time limits, etc.). Be clear with yourself as to what your limits are, and communicate that clearly to clients.
9. *Be especially aware of issues of confidentiality.* In a small community even general discussions can be misinterpreted as being about specific clients. Discuss the limits of confidentiality with clients at the beginning of counselling and address the difference between confidentiality and privacy. Be sure that clients and others in the community understand that you cannot discuss the content of your counselling sessions with others or even verify that you may or

not be seeing a particular individual. However, you cannot guarantee that clients will not be seen coming or going from your office.

10. *Maintain a hierarchy of values.* Clients' needs should always come first, and decisions should be made on that basis. When the role of counsellor conflicts with another social or professional role then the alternate role, not the therapist role, should suffer (Roll & Millen, 1981).
11. *Know yourself.* Understand who you are, monitor your personal and professional needs, and be aware of how you may influence the lives of others. Work on your own blindspots, weaknesses, and prejudices (Barnett & Yutrzenka, 1995).
12. *Participate in ongoing consultation and discussion.* Build networks and resources, attend conferences and workshops, and consult with others who can help you identify weakness or rationalizations. Seek immediate consultation when entering into an overlapping relationship or practicing outside your competency level and continue that consultation throughout the relationship. Reflect on and discuss conflicts and dilemmas that arise.
13. *Continue to educate yourself.* Remain current on professional issues and relevant research literature. Participate in self-study and other more formal educational opportunities.
14. *Know when to stop.* There is a greater chance in overlapping relationships that the counselling contract may become unclear. Refer or terminate too early, rather than keep a client in counselling too long (Roll & Millen, 1981), especially when the fine line between personal and professional relationship starts to blurr within counselling sessions.

CONCLUSION

The issues raised in this article and in the daily practice of small-community counselling remind us that certainties are rare in the counselling profession. Further attention in graduate training, research, and continuing education are important methods of illuminating the importance of dealing with ethical dilemmas and concerns in small-community practice. Hearing directly from rural counsellors is the essential factor in accurately addressing relevant issues.

Open discussions on the dilemmas of rural mental health practitioners need to be encouraged and supported. Without such discussion, there is a potential danger that rural and small-community practitioners may become more isolated, resulting in restricted input and an increased likelihood that self-protective barriers will be set up that prevent feedback.

An important next step is to broaden those discussions to include others who practice in small communities—communities of color, gay/lesbian/bisexual/transgender communities, small colleges, military bases, disability communities, and other "small communities" which can occur even within the supposed anonymity of urban areas. By joining together across communities, practitioners can gain support for the difficulties which are a part of practicing ethically in small-community settings.

The paradox of awareness and fluidity of boundaries, particularly in dual or overlapping relationships, leads to a constant examination and refinement of ethical codes in rural and small-community practice. Counsellors usually *know* the content of ethical codes and laws, but they often struggle in having to *choose* how to best apply those codes and rules in the best interest of clients. Rules that seem absolute are often subject to interpretation when the practitioner is faced with a dilemma (Woods, 1990). Unfortunately, codes of ethics do not yet acknowledge conflicting obligations or offer instructions on how to weigh importance when obligations do conflict. In reporting the results of a national survey of ethical dilemmas encountered by members of the American Psychological Association, Pope and Vetter (1992) called for ethical principles which "must address clearly and realistically the situations of those who practice in small towns, rural communities, and other remote locales" (p. 400).

An open discussion of urban/rural differences needs to take place in an atmosphere of mutual respect, free of recriminations and the fear of retribution. The needs of both rural and urban clients deserve consideration and discussion when counsellors adapt guidelines for fair, ethical practice. Since many urban counsellors may find themselves practicing in small communities within a larger urban setting, a true collaboration between rural and urban practitioners can be mutually beneficial and informative.

In addition, a reexamination of the advantages of the practice of counselling in rural areas and small communities is warranted. If managed professionally and ethically, overlapping relationships in a rural setting may, in fact, be advantageous to both counsellor and client. While this and most other articles in the professional literature focus on the problems and dilemmas inherent in rural and small-community practice, the picture presented by many rural mental health practitioners is much more multi-faceted. The lifestyle, opportunities, and sense of personal control keep rural counsellors within the fabric of small-community life. More attention can be paid to the positive and life-enhancing qualities of rural practice to offset the gloomy picture set forth in some of the literature and to counter the negative stereotypes possible held by urban-based counsellors. Ultimately, it is our clients who will benefit most from our increased awareness and availability.

References

American Psychological Association (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47*, 1597-1611.

Barnett, J. E., & Yutrzenka, B. A. (1995). Nonsexual dual relationships in professional practice, with special applications to rural and military communities. *Independent Practitioner, 14*, 243-48.

Canadian Guidance and Counselling Association (1989). *Guidelines for ethical behaviour.* Ottawa: Author.

Faulkner, K. K., & Faulkner, T. A. (1997). Managing multiple relationships in rural communities: Neutrality and boundary violations. *Clinical Psychology: Science and Practice, 4,* 225-34.

Gurnoe, S., & Nelson, J. (1989). In *Collaboration; the key: A model curriculum on Indian child welfare* (pp. 63-85). Tempe, AZ: Arizona State University School of Social Work.

Heinrich, R. K., Corbine, J. L., & Thomas, K. R. (1990). Counseling Native Americans. *Journal of Counseling & Development, 69,* 128-33.

Herlihy, B., & Corey, G. (1992). *Dual relationships in counseling.* Alexandria, VA: American Association for Counseling and Development.

Jennings, F. L. (1992). Ethics of rural practice. *Psychotherapy in Private Practice, 10,* 85-104.

Keith-Spiegel, P., & Koocher, G. P. (1985). *Ethics in psychology.* New York: Random House.

Kitchener, K. S. (1988). Dual role relationships: What makes them so problematic? *Journal of Counseling & Development, 67,* 217-21.

LaFromboise, T. D. (1988). American Indian mental health policy. *American Psychologist, 43,* 388-97.

Manson, S. M., & Trimble, J. E. (1982). American Indian and Alaska Native communities. In L. R. Snowden (Ed.). *Reaching the underserved* (pp. 143-73). Beverly Hills, CA: Sage.

Pope, K. S., & Vasquez, M. J. (1991). *Ethics in psychotherapy and counseling.* San Francisco: Jossey-Bass Publishers.

Pope, K. S., & Vetter, V. A. (1992). Ethical dilemmas encountered by members of the American Psychological Association: A national survey. *American Psychologist, 47,* 397-411.

Purtilo, R., & Sorrell, J. (1986). The ethical dilemmas of a rural physician. *Hastings Center Report, 16,* 24-28.

Rich, R. O. (1990). The American rural metaphor: Myths and realities in rural practice. *Human Services in the Rural Environment, 14,* 31-34.

Roll, S., & Millen, L. (1981). A guide to violating an injunction in psychotherapy: On seeing acquaintances as patients. *Psychotherapy: Theory, Research and Practice, 18,* 179-87.

Schank, J. A. (1994). *Ethical dilemmas of rural and small-community psychologists.* Unpublished doctoral dissertation, University of Minnesota, Minneapolis, MN.

Schank, J. A., & Skovholt, T. M. (1997). Dual relationship dilemmas of rural and small-community psychologists. *Professional Psychology: Research and Practice, 28,* 44-49.

Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional Psychology: Research and Practice, 26,* 499-506.

Sonne, J. L. (1994). Multiple relationships: Does the new ethics code answer the right questions? *Professional Psychology: Research and Practice, 25,* 336-43.

Thomason, T. C. (1991). Counseling Native Americans: An introduction for non-Native American counselors. *Journal of Counseling & Development, 69,* 321-27.

Woody, J. D. (1990). Resolving ethical concerns in clinical practice: Toward a pragmatic model. *Journal of Marital and Family Therapy, 16,* 133-50.

About the Author

Janet Schank, Ph.D., is the Associate Director of Health Services—Counseling at Macalester College, St. Paul, Minnesota, USA. Her current interests are in the areas of small-community counselling ethics and multicultural counselling skills.

Address correspondence to: Janet Schank, Macalester College Health Services, 1600 Grand Avenue, St. Paul, MN, USA 55105. FAX 651/696-6687. e-mail: schank@macalester.edu.