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Rural Clinicians' Perceived Ethical Dilemmas: Relationships with Clinician Well-Being and Burnout

Amithea M. Love

Antioch University - New England

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Rural Clinicians' Perceived Ethical Dilemmas:
Relationships with Clinician Well-Being and Burnout

By

Amithea M. Love

B.A., University of Hawaii-Hilo, 2005
M.S., Antioch University New England, 2010

DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of
Doctor of Psychology in the Department of Clinical Psychology
at Antioch University New England, 2015

Keene, New Hampshire



Department of Clinical Psychology

DISSERTATION COMMITTEE PAGE

The undersigned have examined the dissertation entitled:

**RURAL CLINICIANS' PERCEIVED ETHICAL DILEMMAS:
RELATIONSHIPS WITH CLINICIAN WELL-BEING AND BURNOUT**

presented on January 5, 2015

by

Amithea M. Love

Candidate for the degree of Doctor of Psychology
and hereby certify that it is accepted*.

Dissertation Committee Chairperson:
Gargi Roysircar-Sodowsky, PhD

Dissertation Committee members:
Gina Pasquale, PsyD
Daniel Lafleur, PhD

Accepted by the

Department of Clinical Psychology Chairperson
Kathi A. Borden, PhD

on **1/5/15**

* Signatures are on file with the Registrar's Office at Antioch University New England.

Dedication

To My Father, Christopher A. Rivera.

My gratitude for your unyielding loyalty throughout my life's journey defies measure or explanation. Your faith in me is a key ingredient in all of my triumphs.

You have always been my biggest fan and most steadfast support.

This paper is dedicated to you.

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Abstract

Mental health clinicians are bound by professional ethics codes that are intended to ensure beneficence toward clients. When clinicians reside in rural areas, ethical dilemmas result from the distinct nature of rural life and clinical practice. Despite extant literature on the ethical dilemmas of rural practice, little research has examined the effect of ethical dilemmas on the social-emotional functioning of clinicians. In response to this need, the study investigated the relationships of frequency of and discomfort from ethical dilemmas on clinician social-emotional functioning. Participants were rural and small town clinicians ($N = 60$) between ages 24-65 and primarily Caucasian (83.3%), from 19 states of the U.S., and one from Costa Rica. They responded to an online survey. Answer formats ranged from a Likert scale to open-ended statements to multiple choice options. Survey questions addressed demographic information; frequency and discomfort related to ethical dilemma types; decision-making strategies used; confidence in and stress relief from use of decision-making strategies; and frequency of service denial due to payment problems. The Friedman Well-Being Scale and Maslach Burnout Inventory were also included. Hypotheses predicted that frequency of encounters with ethical dilemmas and increased discomfort from ethical dilemmas would relate to lower well-being and higher burnout. Research questions were aimed at understanding the types and frequency of ethical dilemmas experienced by rural and small-town clinicians and decision-making strategies used. Differences between well-being and burnout scores of the study participants and participants of the normative studies for these measures were studied. Results indicated that frequency of and discomfort level from ethical dilemmas predicted the burnout dimension of Emotional Exhaustion. Dual role and clinician visibility dilemmas were most common. Most participants used a case-by-case, multiple-strategy approach for decision-making. Participants

reported confidence in decisions made and relief from stress by using decision-making strategies. T-tests indicated that study participants had a significantly lower well-being mean score than a normative college student sample, and significantly higher Personal Accomplishment than the MBI-HSS normative sample. The majority of participants indicated turning away clients due to client payment difficulties. These results, the study's limitations, and suggestions for future research are addressed.

Keywords: Rural mental health practice, clinician ethical dilemmas, burnout, well-being, ethical decision-making

Rural Clinicians' Perceived Ethical Dilemmas:
Relationships with Clinician Well-Being and Burnout

Chapter 1

The rural community presents a variety of ethical challenges to mental health clinicians due to its very nature (Bachtel, 1996; Hargrove, 1986), such as, its small population, isolation, and underdeveloped resources. Many ethical guidelines that are adhered to in the average town or city become challenging when clinicians reside and work in the same rural township as their clients (Hargrove, 1986; Schank & Skovholt, 2006). Of particular interest to the present study was the well-being of rural psychologists. The study examined the frequency, nature, and extent of ethical dilemmas of rural clinicians and their effects on clinician well-being and burnout.

In order to fully grasp ethical dilemmas faced by clinicians, one must, first, consider the general ethical guidelines (American Psychological Association [APA], 2002) for clinician behavior. Second, one must understand the nature of rural practice (Hargrove, 1986; Schank & Skovholt, 2006) and third, one must consider the unique challenges (Hargrove, 1986; Schank & Skovholt, 2006) that such a work environment presents to clinicians. In the section that follows, ethical dilemmas are defined and pertinent ethical regulations are delineated as these pertain to rural clinical practice. The concepts of well-being and burnout are also explained. Research questions are posed which guided the present research.

Ethical Dilemmas

In order to gain an understanding of the questions investigated in the current study, it is important to first define ethical dilemmas. According to Hill, Glaser, and Harden (1995), an ethical dilemma occurs when the therapist experiences a conflict, and when there is no definitive answer found in one's code of ethics which addresses the particular conflict at hand. It is also

noted that there isn't typically a correct choice in the case of an ethical decision: there is only usually one that feels somewhat better in comparison with alternatives (Hill et al., 1995).

Select Ethical Guidelines of the American Psychological Association

Psychologists are expected to comply with the ethics put forth in the Ethical Principles of Psychologists and Code of Conduct, delineated by the American Psychological Association (APA, 2002, 2010). Many of the ethical dilemmas of rural psychologists are the result of disparities between what is ethically expected and what is possible within rural practice. Ethical guidelines which are particularly problematic for rural psychologists include concerns for confidentiality, multiple relationships, and competence.

Confidentiality. Standard 4.01 of the ethics code (APA, 2002,) charges the clinician with maintaining the client's confidentiality. The psychologist is required to protect confidential information about the client. Part of confidentiality generally includes keeping the client's attendance in therapy confidential. In a small town this is not always feasible. As Werth, Hastings, and Riding-Malon (2010) noted, residents of rural towns may notice clients' cars are parked in front of the therapist's office, or see them walk in.

Dual roles. The APA ethics code (2002) defines multiple relationships (also known as dual roles and multiple roles) in three ways. Although a number of terms have been used to describe the phenomenon, the term dual roles is used throughout the dissertation. All of the definitions of dual roles first require that the psychologist be engaged in a professional capacity with the client. The first type of dual role occurs when the psychologist is engaged with the same client in another role, such as being a client's neighbor. The second type of dual role occurs when the psychologist holds a relationship with someone closely associated to the client, such as working in the same school as a client's uncle. Finally, the psychologist can engage in dual roles

by promising to engage in future relationships with either a client or someone with whom that client is closely associated (APA, 2002), such as playing on the village soccer team at the invitation of the client who coaches the team.

Non-sexual dual roles can take a variety of forms, which vary in complexity. The following types, compiled by Reamer (1998, as cited in Pugh, 2007), exemplify some of this variety. One might engage in a relationship, the sole aim of which is the attainment of benefits, such as material or financial goods and services, for example, purchasing groceries from a client's store. A professional may seek to meet the needs of a client through altruistic acts which move beyond the confines of one's therapeutic role, such as stopping to help a stranded client whose car has broken down. Finally, professionals and their clients (current or former) may come into contact through happenstance, such as meeting at the grocery store or standing in line behind a client at the movie theater (Reamer, 1998; as cited in Pugh, 2007).

Dual roles, while inevitable in some respects, are proscribed when such relationships pose a risk to therapist objectivity, potential helpfulness to clients, and clinical judgment (APA, 2002; Hargrove, 1986.). Dual roles are likewise forbidden when there is a possibility for harm or exploitation of the client as a result of the dual role (APA, 2002).

Many authors have asserted a rural clinician's increased likelihood of experiencing dual roles. Helbok, Marinelli, and Walls (2006) found that rural clinicians experience significantly more instances of dual roles than their urban and suburban counterparts. Helbok et al. also indicated that rural clinicians experienced increased likelihood of internal struggles as a result of dual role dilemmas. Even seemingly trivial encounters with a client out in the community are likely to cause clinicians to consider the ethical standards around dual roles and to reconsider their actions in order to ensure acting in the best interests of the client.

Competence. Standard 2.01 of the APA ethics code (2002) stipulates that psychologists engage only in professional activities within which they are competent. If alternative services are not available to the client, the psychologist may practice outside his or her area of competence in order to ensure that treatment is not denied to the client. However, in such a case, the clinician must make efforts to ensure that competence is gained through such means as research, additional training, or consultation. Sobel (1992) noted that a rural clinician is likely to be called upon to practice outside of his or her area of competence as the result of being the only clinician within one's geographic area. For example, consider a clinician who specializes in treating couples. If this clinician were the only mental health professional available and was asked to treat a 4-year-old child, the clinician would need to consider whether it would be ethically feasible to treat the child, or whether the child should be referred to the nearest clinician 100 miles away (and risk the child not receiving needed treatment).

Clinician Visibility

Visibility is a concern for psychologists in rural communities (Helbok et al., 2006). While not proscribed by the APA, it has been noted that there is an expectation that psychologists will behave consistently across social settings (Pugh, 2007). Pugh also noted that difficulty can arise when one attempts to behave consistently across social settings while also upholding professional distance in small or rural towns. For example, a clinician who is known for telling jokes among friends may feel uncomfortable doing so if a client is within earshot. Pugh further noted that living and working in a small or rural setting allows for one's clients to observe the therapist in a variety of roles, such as in church, in parent-teacher association meetings, etc. The disparity between the therapist's professional and interpersonal personas could challenge the client's view of the therapist's authenticity or integrity. This experience was also observed by

Helbok et al. who found that rural clinicians are more likely to experience greater visibility. Helbok et al. indicated that a rural client is likely to have more information about a clinician's personal life than the clinician appreciates and also that clinicians at times feel that there is little divide between their personal and professional lives and that they are, therefore, constantly in the role of therapist. Werth et al. (2010) asserted that visibility is a stressor for rural psychotherapists.

Ethical Decision-Making

The ethics code of the APA (2002) serves as a guideline for ethical decision-making practice (Barnett, Behnke, Rosenthal & Koocher, 2007). However, the ethics code does not provide solutions to ethical dilemmas. Additionally, it has been noted that practitioners who adhere rigidly to ethical standards when faced with dilemmas are likely to overlook the complex nature of ethical issues (Ridley, Liddle, Hill, & Lee, 2001). Barnett et al. further noted that clinicians intend to heed the general principles of the APA ethics code when facing ethical conundrums. The general principles put forth by APA include "Principle A: Beneficence and Non-maleficence; Principle B: Fidelity and Responsibility; Principle C: Integrity; Principle D: Justice; and Principle E: Respect for People's Rights and Dignity" (APA, 2002, p. 1). Furthermore, a number of models exist beyond the general principles of the APA, which serve to elucidate strategies for ethical decision-making practices.

For example, Barnett et al. (2007) suggested a number of steps when clinicians face an ethical dilemma. First, clinicians should consider a number of questions regarding the general principles of the APA (2002). Such questions include "Will doing this be helpful to my client?"; 'Will this action likely harm anyone?' and 'Have I allowed my judgment to become impaired as a result of inadequate attention to my own care or needs?'" (Barnett et al., 2007, p. 8). Barnett et

al. further noted that the clinician should consider laws, both state and local, as well as the policies of pertinent agencies when managing ethical dilemmas. Finally, they urged readers to consult with colleagues who are well-versed in the topic under scrutiny to gain insight of colleagues (Barnett et al., 2007).

How a clinician approaches decision-making when faced with an ethical dilemma is highly individual in nature. There are a number of decision-making models, which clinicians may utilize in responding to ethical dilemmas. A presentation of the various decision-making models is included in Chapter 2.

Rural Towns

Rural living presents a variety of unique challenges for clinicians due to a number of characteristics typical of rural locales. People in rural towns tend to hold a stigma against psychological help, which may deter people from utilizing mental health services. Rural residents tend toward strong ties to family and resistance to discussion of problems, particularly with mental health clinicians (Helbok, 2003). Rural community members tend toward a view of psychologists as outsiders. As a result, they are likely to refuse help (Schank & Skovholt, 2006). The psychologist, then, is faced with the task of earning the trust of the community. This is achieved by becoming an integral and active member of the community (Schank & Skovholt, 2006). While this helps to earn the trust of one's clients, it also increases the likelihood for dual role dilemmas.

Helbok (2003) noted that rural communities tend to have high poverty and unemployment rates and scarce resources. Because there are a limited number of businesses in rural areas, a therapist may be caught between doing business with his or her client, such as

purchasing groceries from the client's store or offending the townspeople by taking one's business out of the community (Schank & Skovholt, 2006).

Clinicians' Emotional and Psychological Status

Well-being. The APA Dictionary of Psychology (VandenBos, 2007) defined well-being as “a state of happiness, contentment, low levels of distress, overall good physical and mental health or outlook, or good quality of life.” (p. 996). More specifically, Ambler (2008) discussed the concept of mental health as being made up of components of subjective and functional well-being. Functional well-being refers to the degree to which an individual is functioning psychologically and socially (Ambler, 2008).

Subjective well-being. Much of the literature pertaining to well-being is aimed at exploring subjective well-being. Subjective well-being includes one's emotional well-being states, which are measured by the individual's account of positive and negative sentiments that one harbors about life experiences (Ambler, 2008). Subjective well-being also includes psychological well-being. According to Keyes (2003, as cited in Ambler, 2008) “Psychological well-being represents more private and personal criteria for evaluation— criteria that have been measured reliably and with validity by a six-dimensional scale that includes: ‘self-acceptance, positive relations with others, personal growth, purpose in life, environmental mastery, and autonomy’ ” (p. 4). Finally, Ambler indicated that subjective well-being also includes social well-being. Individuals possess social well-being when they feel a sense of belonging in their communities and believe they contribute meaningfully to society. Such individuals also accept society as it is, while also maintaining the ability to see society's potential for growth. They find social interaction meaningful and are able to comprehend it (Ambler, 2008).

Burnout. Maslach, Schaufeli, and Leiter (2001) denoted burnout as a syndrome which is psychological in nature, and which occurs as a reaction to longstanding interpersonal difficulties that the person experiences as a part of his or her job. Maslach et al. further noted that burnout engenders three components. First, the person experiences Emotional Exhaustion. The exhausted individual tends to feel excessively strained and feels devoid of resources, both physical and emotional in nature (Maslach et al., 2001). The second component of burnout is cynicism, which is also known as Depersonalization. Depersonalization is described as "...a negative, callous, or excessively detached response to various aspects of the job" (Maslach et al., 2001, p. 399). Finally, the worker who is experiencing burnout tends to feel ineffective and devoid of Personal Accomplishments (Maslach et al., 2001).

Burnout is associated with a number of job-related problems. Burned-out employees tend toward decreased productivity at work as well as decreased efficacy (Maslach et al., 2001). Such employees also tend to be less satisfied and less committed to their jobs (Maslach et al., 2001). When applied to a rural clinician, burnout is especially important, as the rural clinician may be the only or one of few mental health practitioners available in the community. If the rural practitioner experiences burnout, he or she may become less effective in clinical work and could potentially cause harm to clients. Additionally, if the rural clinician loses commitment to practicing, the rural clients may be left without easily accessible mental health services.

When an individual has little social support, this is strongly linked to the development of burnout (Maslach et al., 2001). Maslach et al. noted that receiving support from supervisors is an important factor in avoiding burnout. For the rural clinician, these factors are important. The rural clinician may have limited social support if he or she refrains from dual relationships in the community, and the clinician may also be isolated because of the absence of colleague with

whom to share experiences or seek guidance from. Additionally, the rural practitioner may not receive frequent or adequate supervision, as a result of being the only clinician in the community and surrounding environs.

Research Questions

The study intended to expand upon current understandings in the literature with the following research questions:

Question 1: What types of ethical dilemmas do rural clinicians strongly endorse?

Question 2: How frequently do rural clinicians experience ethical dilemmas?

Question 3: What types of decision-making do clinicians follow to address ethical dilemmas?

Question 4: What is the level of well-being of rural clinicians in the present study?

Question 5: What is the level of each burnout dimension (EE, DP, and PA) for the clinicians in the present study?

Question 6: How frequently does a client's inability to pay result in denial of mental health services by clinicians in the present study?

Summary

Mental health clinicians are charged with the task of helping their clients to heal. As a profession, it often seems that psychologists are expected to be "super human," always remaining objective, professional, and unflawed. For a rural clinician, it may be difficult to maintain clearly delineated boundaries between personal and professional identities because roles often merge in rural America, where the mayor is also a school teacher and one's psychologist may also serve on the Parent-Teacher Association.

Psychologists are entrusted with ensuring the well-being of their clients, but it is not always clear how a psychologist's well-being is to be maintained. In the business of caring for others, it is imperative that psychologists take care of themselves. When a psychologist is the only or one of few clinicians available to serve individuals in a small town and the surrounding environs, the inherent risk for psychologist burnout is of concern. It is hoped that by understanding rural clinicians' experiences, we may understand the extent to which the ethical guidelines, while meant to protect clients, may affect clinicians negatively. Likewise, a burnt-out or distressed psychologist may do harm to clients. It is hoped that the present study's findings and their implications will pave the way for further research to consider ways for psychologists to prevent or address effectively ethical dilemmas of rural mental health practice. Chapter 2 provides further information on topics briefly introduced in this chapter.

Chapter 2: A Review of the Literature

This chapter reviews the literature pertinent to the present study. Relevant topics include rural towns and the nature of rural living; ethical dilemmas of mental health practitioners, including dual relationships, confidentiality, professional competence, and therapist visibility; clinicians' ethical decision-making; and psychological burnout versus well-being.

Rural Practice

Characteristics of rural towns. Although rural towns tend to be heterogeneous in a number of ways, they typically share certain characteristics (Hargrove, 1986). The American Psychological Association (VandenBos, 2007) offered a definition of rural environments which denoted some of these characteristics. Rural environments were described by APA as:

An environment usually characterized by open land, sparse settlement, some distance from cities and towns, and an economy that is usually agriculturally based but may alternatively be based on other types of economic activity, such as logging, mining, oil and gas exploration, or tourism... (p. 808)

Hargrove (1986) stated that rural towns tend to have small populations and to have great distance between people and towns. Cohen (1993) corroborated Hargrove's assertion by noting that rural communities are far from larger cities and public transportation. Hargrove explained that this distance tends to encourage rural citizens to be self-reliant, while also depending on the help of close friends and family. Rural residents tend to be poorer than their urban counterparts and to achieve lower levels of education (Cohen, 1993). Cohen additionally noted that rural residents tend to have limited availability of services compared to their urban counterparts, including mental health and medical care.

Defining rural, for purpose of the present study. There is not a universally agreed-upon

definition of “rural,” and there are many aspects of rural environments which may or may not be applicable to a given study (Hart, Larson, & Lishner, 2005). Hart et al. suggested that researchers should decide what aspects of rural environments are most salient to the study at hand, and then define rural according to those aspects. For the purpose of the present study, the factors of population size and distance from large metropolitan areas were most salient. These aspects were most important because small population size and distance from resources possibly result in clinician visibility, dual roles, confidentiality concerns, and dilemmas regarding practicing outside one’s area of competence due to scarcity of resources. In addition, due to the present study’s need for 102 participants that practiced and resided in the same rural county, the likelihood of enough eligible participants responding would likely decrease significantly if population criteria were too restrictive. For the purpose of this study, the U.S. Census Bureau’s definition of rural towns as populations of 2,500 or less (U.S. Bureau of the Census, 1971, as cited in Murray & Keller, 1991) was thought to be too restrictive. Instead, the Office of Management and Budget’s (OMB, 2013) definition was more helpful. The OMB classified counties within urban areas of 50,000 people or more as metropolitan. The next category defined by the OMB is the micropolitan area, which has a population between 10,000 and 49,999 people. For the purpose of the present study, it was agreed by members of the dissertation committee, based on their personal experiences, that cities of 25,000 people often lend themselves to the types of ethical dilemmas addressed by the study, without being overly restrictive so as to preclude participation, and without including areas that were so large that the phenomenon intended for study would not be experienced by participants. As a result, the participation criteria for the study included those towns that would fit the U.S. Census bureau definition of 2,500

individuals or less, while also including individuals from micropolitan areas with a population up to 25,000.

Therapist mismatch with a community. Cohen (1993) noted that some characteristics of rural communities can be particularly difficult for a therapist. First, if the therapist possesses certain unique personal or demographic characteristics, he or she may have difficulty fitting into the community and may feel ostracized. For instance, if the therapist is younger than the rural residents, this can be problematic because rural residents may not take that person seriously (Cohen, 1993). The same can be said for women in professional roles, according to Cohen. It was also noted by Cohen that being of a race or culture which is unfamiliar to people in the town can lead to the therapist experiencing prejudice. Cohen emphasized that such prejudice is the result of lack of exposure to other cultures because rural residents have not yet had the opportunity to disprove erroneous beliefs.

Values differences between therapist and community. Many psychologists are trained in urban settings and hold values which are largely disparate from those held by individuals within the rural community (Schank & Skovholt, 2006). For example, psychologists' attitudes to such issues as domestic violence, racial bigotry, and substance abuse are likely to differ from those of many rural citizens (Kersting, 2003).

Therapist isolation. Therapists in rural towns may have difficulty finding a social network upon which to rely (Cohen, 1993). Cohen noted that people generally gravitate toward friendships with people who are similar to the individual in important ways, but therapists may have difficulty finding individuals within the town who are similar to them. Additionally, there is at times a mistrust or resentment by rural townspeople toward those with advanced education

(Kersting, 2003). As a result, many therapists may only find friends outside of the rural community, who may live much farther away (Cohen, 1993).

In addition to social isolation, Schank and Skovholt (2006) explained that rural therapists also tend to feel professionally isolated. If one is the only therapist for several miles, it can be difficult to cultivate consultation relationships with colleagues. Attaining supervision and continuing education also tends to be difficult when such resources are far from the therapist. Helbok (2003) explained that rural therapists can seek telephone supervision, but that this is not the same as having in-person interaction.

Rural mental health needs. Although the rural environment is often not a good match for many therapists, mental health workers are much needed in rural areas. It has been estimated that at least 15 million rural American citizens have significant mental health needs (Roberts, Battaglia, & Epstein, 1999). These include substance abuse, psychotic disorders, depression, anxiety, and trauma (Roberts et al., 1999). Furthermore, in recent years the suicide rate of rural citizens has surpassed that of their metropolitan counterparts (Roberts et al., 1999). However, obstacles to provision of rural mental health care may hinder the clinician's ability to deliver appropriate care to rural individuals, as well as the individual's ability to procure appropriate services for oneself (Roberts et al., 1999). Ethical dilemmas often threaten to impede the provision of services to rural clientele (Roberts et al., 1999).

Ethical Dilemmas

The rural clinician who resides and works in a small community is more likely to face certain ethical conundrums than his or her urban or metropolitan counterparts (Sobel, 1992). In order to successfully engage with the small community in which a clinician lives and practices, Sobel indicated that clinicians may need to make some compromises in regard to certain ethical

standards. Sobel made the important distinction that the rural clinician should not behave in an unethical manner, but instead must devise methods for navigating the various ethical shades of gray which result from living and practicing within one's small community. Similarly, Helbok (2003) noted that despite the existence of ethical conundrums in rural areas, the clinician should not use this fact to excuse unethical behaviors or forego adherence to the ethical standards.

In their review of the literature regarding mental health care and ethical issues in rural communities, Roberts et al. (1999) highlighted the importance of consultation around ethical conundrums. When faced with ethical dilemmas, some necessary skills for avoiding ethical mistakes include consulting with colleagues, collaborating with other professionals, and possibly referral (Roberts et al., 1999). However, the rural clinician may have difficulty utilizing these processes. Ethics committees may not be available in rural organizations, and when they are, the individuals involved are likely to struggle with the same ethical questions (Roberts et al., 1999). Roberts et al. also noted that experts on ethics are frequently not available in rural areas, and even if consultants are available, they may not have a clear understanding of the nuances of rural culture which complicate ethical decisions. Helbok (2003) similarly noted that rural communities are often isolated, and that such helpful practices as frequent and continuous supervision and consultation regarding ethical issues may not be readily available.

Ethical resources available for guidance are often urban-centric in their presentation of ethical issues, which can be problematic for the rural clinician struggling with ethical questions. Some rural clinicians may deem available resources un-helpful, which may lead them to devise their own set of procedures for managing ethical problems (Roberts et al., 1999). Such approaches may place the rural clinician and one's clients at risk. Not only might the clinician make erroneous ethical judgments, but the clinician may be misunderstood by others and

perceived to be unethical when deviating from the urban standards of ethical judgment (Roberts et al., 1999).

Dual roles. The issue of dual roles is addressed by standard 3.05 of the APA ethics code (2002), and is frequently discussed in the literature regarding ethical dilemmas in rural mental health practice. The APA ethics code indicated that dual role situations arise at times that may not have been foreseen or avoided, and offers some guidance, should this occur. At times, a psychologist may realize that a dual role situation has arrived unexpectedly that is likely to cause harm (APA, 2002). Should this occur, the APA noted that the psychologist should take “...reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the ethics code” (p. 6). At other times, circumstances may arise in which, by virtue of a legal or institutional requirement, the psychologist must take on numerous roles as part of legal proceedings (APA, 2002). In such cases, the psychologist is encouraged to be forthcoming regarding limits of confidentiality as well as role responsibilities. Such clarifications should take place at the outset of the professional relationship and as changes arise (APA, 2002).

In addition to the distance from other mental health professionals (Campbell & Gordon, 2003), there is also a tendency for rural residents to seek psychological services from someone they know. This can create dual role dilemmas. In rural communities, where outsiders are not trusted, becoming involved with one's community is helpful in building trust (Schank & Skovholt, 1997). As such, dual roles become difficult to avoid if one would like to build clientele. Also, because rural residents are suspicious of outsiders, they may prefer to be seen by a psychologist who has already earned the trust of the community rather than to see someone whom they do not know and therefore do not trust (Campbell & Gordon, 2003).

Ethical decision-making regarding dual roles can be complicated. Rural residents are likely to be related to each other in a variety of ways (Campbell & Gordon, 2003; Erickson, 2001), and the psychologist must consider the impact of all relationships with the client and his or her family members. A psychologist may be faced with seeing a child client who is in the same class at school as the psychologist's own child, and whose mother is the teller at the local bank. Careful consideration of the potential impact of all of these relationships would be important before moving forward. As Erickson indicated, the onus of making the appropriate decision regarding dual roles is upon the psychologist, not the client. Relationships can also be unpredictable and even those that are initially not expected to be harmful could change in unexpected ways, and the potential for harm could be created. The psychologist must take care of all dual roles to guard against potential harm (Erickson, 2001).

Confidentiality. Confidentiality is an ethical standard of the APA (2002) which is viewed as one of the important ingredients for gaining and maintaining the trust of one's client and allowing the client to be candid within the confines of therapy. APA ethical standard 4.01 dictated that the psychologist must take measures to protect confidential information of all clients, while also recognizing that at times confidentiality may be regulated by local laws and institutional rules. There are some instances in which a therapist must reveal confidential information, and in standard 4.02, the APA indicated that the client should be informed at the outset of treatment regarding the limits of confidentiality as well as intended uses of information gained through provision of psychological services. Even the fact that a client is receiving services is considered confidential information, and while the client is free to share information about his or her treatment, it is not acceptable for the psychologist to do so (Nagy, 2011). Rural

communities can pose some challenges to the maintenance of confidentiality for the rural clinician.

Because of the stigma of mental health problems for rural clients, confidentiality is often an area of concern (Helbok, 2003). Although the rural client and clinician may not reveal the client's use of mental health services, it is more likely in the rural community than urban settings that it may become common knowledge. Helbok noted that rural residents may be hesitant to engage in group therapy because they may know other group members quite well.

Support staff can also pose a threat to confidentiality in the rural community (Helbok, 2003; Sobel, 1992). Often the secretary or other administrative supports in rural clinics are longstanding members of the community and are likely to have ties to many individuals and families in the community (Helbok, 2003). Although psychologists and other mental health professionals generally undergo significant training regarding ethics, including confidentiality, support staff may not have a clear understanding of this and other ethical issues. In her practice, Sobel explained to all prospective employees the importance of confidentiality and potential ramifications of confidentiality breaches. She also maintained an ongoing discussion of confidentiality issues with her support staff in order to work through any potential or impending conflicts (Sobel, 1992).

The rural therapist must be particularly mindful of where he or she has learned information when engaging in conversations about town to avoid unintentionally revealing confidential information learned within the context of therapy. In a town where everyone knows everyone else, it can be easy to forget where one learned a particular piece of information (Helbok, 2003). For the everyday citizen, this may not be problematic. However, if a psychologist reveals something learned within the context of providing therapy, this constitutes a

breach of confidentiality. As such, even the simple act of engaging in small talk in daily interactions may lead the rural psychologist to question his or her ethical behaviors.

An additional dilemma centered on the principle of confidentiality occurs when the expectations of referral sources regarding sharing of information are disparate from the ethical principles followed by psychologists (Helbok, 2003). Referral sources may expect that the rural psychologist will keep them apprised of the client's progress, though ethical principles for psychologists do not permit such communication without the informed consent of the client (Helbok, 2003). The dilemma occurs because the psychologist risks alienating the referral sources and potential loss of referrals (Helbok, 2003). Helbok noted that it is unrealistic for the psychologist to expect to come into a community and change the way things are done, but that he or she cannot simply ignore the ethical standards. He or she cannot change either system, which places the psychologist in a double bind. When the psychologist is first becoming a part of the community and is not fully accepted, he or she may face rejection if attempting to educate other professionals regarding confidentiality of the therapist-client relationship (Helbok, 2003).

Professional competence. The APA (2002) dictated ethical standards in regard to maintenance of and practice within the boundaries of one's competence, which can prove a challenge for the rural psychologist. Standard 2.01(a) of the APA ethics code stipulated that psychologists should practice only with populations and in areas for which they have gained appropriate competence through "...education, training, supervised experience, consultation, study, or professional experience" (APA, 2002, p. 4). In the case that a psychologist is asked to see a client for whom no other treatment is available, the APA noted in standard 2.01(d) that clinicians may provide services to ensure that treatment is not denied. However, the clinician

must make efforts to gain the needed competence through such avenues as literature reviews, consultation, or other such methods.

Rural psychologists may need to practice as generalists, rather than focusing their skills in one specific area of practice (Helbok, 2003; Kersting, 2003). Kersting noted that the rural psychologist may be the sole such individual within 50 or 100 miles. The rural clinician is likely to be called upon to provide a variety of services for an array of problems (Helbok, 2003). Even if trained and practicing as a generalist, the rural clinician may be faced with the decision of whether to provide treatment which may be at the outer limits of his or her competence (Helbok, 2003; Schank & Skovholt, 2006). However, if a more appropriate clinician is not available for many miles, turning away the client may result in no treatment at all. In their review of the literature, Roberts et al. (1999) noted that the rural clinician has great responsibility and an increased need for support from specialists in the field. However, training and supervision for rural psychologists are often less available to rural clinicians than to their urban counterparts (Roberts et al., 1999). To further complicate matters, appropriate training to gain competence may only be available a great distance away (Schank & Skovholt, 2006).

When a rural psychologist is professionally isolated, there is increased likelihood for errors in judgment. As Helbok (2003) noted, urban practice tends to come with built-in supports such as peer and supervisor relationships. These relationships generally include professional feedback and learning opportunities, which are, at times, lacking in the rural clinician's experience (Helbok, 2003). Without the feedback of others, the rural clinician may tend to rationalize ethically problematic behavior and practice outside his or her areas of competence, without fully realizing that he or she is doing so (Helbok, 2003).

A further complication of the matter of competence lies in the fact that competence is not clearly defined within the APA (2002) ethics code, as noted by Helbok (2003). The APA ethics code did not specify how many clients or how many years of training a clinician must have with a certain type of issue or treatment in order to be deemed competent. The APA's definition of the term in the APA Dictionary of Psychology (VandenBos, 2007), does not lend much clarity to this issue; it defines competence, in part, as "one's developed repertoire of skills, especially as it is applied to a task or set of tasks..." (p. 204). Though the definition is further elaborated, the elaboration does not serve to quantify or elucidate how one might know when he or she has reached the appropriate level of competence. Thus, the issue of professional competence is not entirely clear to begin with, which is likely to result in varied interpretations of the principle by various practitioners and to contribute to the ambiguity of ethical conundrums.

An additional issue related to competence regards promotion of individuals to leadership positions. Kersting (2003) noted that rural psychologists may be promoted to leadership or administrative positions early on in their careers. Such a promotion may be anxiety-provoking for the novice psychologist, who may not feel adequately prepared to take on such a role, but who may be the only or one of few individuals in the area to meet qualification criteria.

Some potential solutions to competence issues were presented by Schank and Skovholt (2006). First, clinicians at times utilize distance learning resources such as webinars, internet searches, and telephone consultation to gain knowledge and support when they are unable to gain the necessary expertise through continuing education or other such learning opportunities (Schank & Skovholt, 2006). Second, the clinician may inform the client at the outset of treatment of existing hesitations regarding treatment of the client and reserve the option of possibly transferring the client's services, should the present treatment not appear helpful. Such clinicians

would utilize their general therapy skills to treat the client while also attempting to learn more about the client's specific presenting difficulties and other matters for which the clinician does not feel appropriately prepared (Schank & Skovholt, 2006). Schank and Skovholt also note that in some rural areas, mental health resources are increasing somewhat, and that clinicians may have the opportunity to refer clients to other nearby professionals. Additionally, clinicians may consider consultation with nearby colleagues, and some clients may indeed prove willing to drive great distances to procure the most appropriate mental health care available (Schank & Skovholt, 2006).

Clinician visibility. It has been noted that clinician visibility can be problematic to the therapeutic relationship (Helbok, 2003; Schank & Skovholt, 2006). The therapist is a role model in the community and as a result he or she must be careful about personal behaviors (Helbok, 2003). Helbok explained that a clinician's behavior in public can lead to transference issues. In the rural community, it is not uncommon for residents to know a good deal about community members, including the therapist (Helbok, 2003; Schank & Skovholt, 2006). If the rural therapist is experiencing family problems, legal trouble, or other such difficulties, it is likely that the client will find out about these problems, which may affect the therapeutic relationship.

Rural clinicians can limit their transparency within the community by limiting their community involvement (Helbok, 2003). For example, the rural clinician can attend religious services in another community. However, when the rural clinician chooses to distance oneself from the community, it may be difficult for the clinician to gain the trust of the townspeople (Helbok, 2003). Without the trust of the townspeople, it may prove difficult for the rural clinician to build his or her business within the town and to feel welcomed and to be a part of the community.

Ethical Decision-Making

A number of models exist which are aimed at helping psychologists navigate ethical dilemmas skillfully (Nagy, 2011). There also exist some models (e.g., Gottlieb, 1993; Kitchener, 1988; Sonne, 2006; Younggren & Gottlieb, 2004) which focus on ethical decision-making about dual roles specifically. In the present section, select decision-making models are delineated, both those which are more general and those which apply to dual roles.

General models of ethical decision-making.

Deontology and teleology. Nagy (2011) delineated stances by which individuals can approach ethical decision-making. Deontology is a stance by which an individual acts in a particular manner which he or she believes to be morally correct in all circumstances. The individual does not contemplate specific circumstances or exceptions, but acts in the same manner for all situations. For example, a person acting from a deontological perspective, believing that multiple relationships are wrong, would not buy groceries from his or her client, even if it meant taking one's business out of the one's community and offending the town's citizens (including one's client).

On the contrary, teleology bases ethical decisions on actions that would achieve the greater good or bring happiness to most individuals. This perspective is focused on the results of one's actions (Nagy, 2011). When approaching an ethical decision from the teleological standpoint, one considers a specific situation and does not utilize a "one size fits all" approach to decisions.

Timing of ethical decision-making. Ridley et al. (2001) noted in their model of ethical decision-making that one's process depends upon whether the ethical problem simply has the potential to occur or whether the problem has already been experienced. Based upon the point of

entry, in the past or in the potential future, the actions that one must take vary as the clinician works through the ethical decision-making process.

Should a clinician face a potential ethical concern, he or she must first consider whether an ethical problem is going to occur based on the clinician's potential behavior. If the answer to this question is affirmative, then the clinician should begin the process of creative problem-solving. If an ethical problem would not be created by a clinician's potential behavior, then problem-solving would not be necessary (Ridley et al., 2001).

If an ethical problem is already taking place, Ridley et al. (2001) prescribed a different course of action. The first step is the same, in that the clinician must be sure that an ethical problem is indeed taking place. If so, the clinician must consider whether his or her actions were ethical. If the answer to this question is "yes," then no further process is needed. If a clinician deems his or her actions to be ethically flawed, the clinician should reflect upon the situation and then engage in creative problem-solving (Ridley et al., 2001).

Characteristics of a well-constructed decision-making process. Four components of effective decision-making models were delineated by Ridley et al. (2001). First, the decision-making process must be thorough. A thorough decision-making process should guide the clinician to consider all the pertinent elements of the dilemma so that a sound ethical decision can be made. Second, the model must be clear and logical (Ridley et al., 2001). That is, the decision-making process should be based upon sound and widely accepted knowledge, and should lead an individual to make a sound ethical decision, wherein it is clear how the individual reached a conclusion in the matter (Ridley et al., 2001). Third, the process must apply to the problems encountered by the clinician and be easy to follow. Finally, the process must include all stakeholders in resolving ethical dilemmas (Ridley et al., 2001). Ridley et al. noted that

decision-making strategies which do not include the above elements tend to lead one toward poor ethical choices.

Canadian Psychological Association 10-step decision-making process. Though the present research is generally concerned with ethical decision-making as it relates to the ethics code of the American Psychological Association, there is an ethical decision-making process presented in the Canadian Psychological Association's ([CPA], 2000) code of ethics, which can be helpful to clinicians who have identified an ethical problem (Nagy, 2011). The authors of the ethical code reminded readers that some ethical decisions are relatively easy to make due to clarity of relevant ethical principles and lack of conflict between standards. However, some ethical decisions are more difficult to make and may be stressful for the clinician, particularly when two or more ethical principles conflict (CPA, 2000).

The steps in the decision-making process were laid out by the CPA (2000) as a numbered list of steps which one should take when making an ethical decision. In the first few steps, the psychologist determines all of the people who may be affected by the ethical decision, as well as all pertinent ethical and other issues which are involved in the problem. This can include the rights of parties affected, as well as systemic or circumstantial factors which may contribute to the ethical problem (CPA, 2000). Next, the psychologist is asked to consider his or her personal motivations, such as biases or interests, which might affect the decision-making process. The following steps ask the psychologist to devise a number of different solutions to the dilemma, and to consider the short-term, chronic, and long-term potential benefits and inherent risks of each course of action. Such consideration should include attention to effects on all relevant parties, including the client and those close to him or her, and also one's co-workers, the practice of psychology as a whole and even society (CPA, 2000). Next, the psychologist selects a course

of action after careful consideration of ethical and values-based standards, and carries out the chosen course of action, while remaining cognizant of one's responsibility for the outcomes, both positive and negative, of the decision (CPA, 2000). The process does not end following the chosen action, however. The psychologist is responsible for managing negative consequences of the action, and should re-engage in the decision-making process when warranted (CPA, 2000). Finally, the psychologist should take action where appropriate to prevent future occurrence of similar ethical conundrums (CPA, 2000). In addition to the steps of the decision-making process, the authors note the importance of consultation in two ways. First, the psychologist should consult with person or persons who are likely to experience the effects of the decision (CPA, 2000). Second, the psychologist should consult with colleagues or other advisers who can contribute expertise or an objective viewpoint (CPA, 2000).

Feminist ethical decision-making model. The feminist model of ethical decision-making is rational and evaluative, while at the same time considering clinician's emotional resonances and intuition regarding the dilemma. The power differential that exists between client and therapist is considered, as well as cultural biases and values (Hill et al., 1995). Hill et al. delineated six distinct steps in their feminist decision-making model.

Step one: Recognition of the problem. Hill et al. (1995) indicated that the first step in the feminist model is to recognize a problem. The authors noted that recognition of the problem can occur in myriad ways. For example, the clinician may utilize his or her experience as a therapist as well as knowledge of the ethics code to recognize ethical problems (Hill et al. 1995). Alternatively, one's client or colleague may recognize that there is an ethical problem and inform the therapist. Hill et al. noted that the therapist's feelings of discomfort are often the first indications that there is an ethical dilemma. The clinician is also advised to be aware of any

elements of one's feelings which may complicate or hinder the decision-making process and to work through these (Hill et al., 1995).

Step two: Definition of the problem. In the second stage of the feminist decision-making model, the task is to delineate the conflict (Hill et al., 1995). During this stage, the clinician identifies the ethical principles and other standards (such as laws) that are involved in the conflict. The clinician also identifies important stakeholders at this point, who will be impacted by the decision, and whose best interests should be considered. The clinician is encouraged to involve the client in the process of working through the ethical dilemma, to the extent that such involvement is in the client's best interests (Hill et al., 1995).

The clinician at this stage also utilizes awareness of his or her emotional experience as a compass by which to understand the nature of the conflict. Also at this stage, the clinician considers the values and individual characteristics that he or she utilizes in defining the problem, and to consider the ways that these may differ from the client's view of the issue based on cultural or religious factors (Hill et al., 1995).

Step three: Consideration of solutions. In the third step of the feminist ethical decision-making model, the clinician devises a number of possible responses to the dilemma (Hill et al., 1995). At this stage, the clinician also considers the benefits and drawbacks of each solution, as related to ethical principles, particularly those principles concerned with minimizing harm and maximizing benefit (Hill et al., 1995). The authors noted that the clinician should also consider the practicality and level of wisdom inherent in each option (Hill et al., 1995). Hill et al. emphasized the importance of the clinician's emotional responses to each of the solutions as important data to be utilized when choosing a solution. Additionally, Hill et al. noted that it may be helpful to include the client when considering various solutions.

Step four: Selecting a course of action. In the fourth step of the feminist model, the clinician selects the best course of action among the solutions previously identified (Hill et al., 1995). The clinician is asked to give equal weight to both cognitive and affective factors, as each are seen by Hill et al. to carry great importance. The clinician is to consider whether the chosen solution fulfills the needs of all involved parties and can be readily implemented and tolerated by the clinician.

Step five: Reviewing the chosen course of action. Prior to implementing his or her solution, the clinician is asked to carefully consider the chosen solution (Hill et al., 1995). At this stage, the clinician is asked to carefully consider one's values and biases, and the roles which these may be playing in the clinician's selection of the chosen solution (Hill et al., 1995). Hill et al. noted that it is particularly imperative to consider one's biases and value differences when the clinician is different from the client in prominent ways. The clinician should remain mindful of the power which he or she holds in the situation, and should ask oneself whether a different clinician, who is more similar to the client, might choose a different course of action (Hill et al., 1995). Once the clinician has carefully considered the decision, he or she should then communicate the decision to the client, and when feasible, should seek understanding of the client's reaction to the decision (Hill et al., 1995).

Step six: Carrying out and evaluating the decision. The final step in the feminist decision making model is twofold (Hill et al., 1995). As the clinician carries out the chosen course of action, he or she is to remain cognizant of the consequences of this action. He or she should continue to consider whether the chosen course of action still makes sense, both affectively and cognitively (Hill et al., 1995.) Of particular importance in the evaluation process is the client's

reaction to the chosen course of action (Hill et al., 1995). When possible, clinicians should include the client in the evaluation process (Hill et al., 1995).

Models regarding dual roles.

Worst-case scenario. Nagy (2011) recommended a worst-case scenario approach when considering the addition of one or more roles beyond the professional relationship. The clinician is asked to consider the possible negative ramifications of engaging in the additional relationship, even when such ramifications have a low likelihood of occurring (Nagy, 2011). Remaining aware of the potential for harm to the client can help one avoid such harm. Nagy also noted that clinician must strive to strike a balance between the potentials for negative and positive consequences of one's action.

Kitchener's role-theory model for identifying problematic dual roles. Kitchener's (1988) model is based upon the idea that each role an individual takes on comes with inherent expectations about the ways in which one will act, as well as the duties which he or she must fulfill. When the therapist is engaged in more than one role with a client and the expectations around the roles conflict, that is when the potential for problematic dual roles develops (Kitchener, 1988).

Kitchener (1988) offered three guidelines which were intended to assist clinicians in identifying dual role relationships which are likely to result in harm to the client. The first guideline examines the compatibility of the expectations inherent in each of the roles that the clinician takes on (Gottlieb, 1993; Kitchener, 1988). Incompatibility of role expectations is positively correlated with risk of harm to the client. The less compatible the expectations of two roles are, the greater is the likelihood of harm (Kitchener, 1988). Next, Kitchener focused upon the obligations which come with each of the roles. When the obligations of the roles are

disparate, one is more likely to have a hindered capacity for objectivity and conflicted loyalties (Kitchener, 1988). Finally, Kitchener offered insight regarding power and prestige. As the power and prestige of the professional and the client diverge, the possibility of exploitation increases, and the potential for the client to remain objective in decision-making may be hindered (Kitchener, 1988). A client or other individual who is interacting with a psychologist or other mental health practitioner may place great weight upon the opinion of the clinician and may be hesitant to act against the advice of the clinician.

Gottlieb's three-factor model for ethical decision-making regarding dual roles. As an extension of Kitchener's (1988) work, Gottlieb (1993) developed a decision-making model for assisting the professional in decision-making when considering entering into a dual role. Gottlieb's model is intended for considering potential relationships in conjunction with the current professional relationship (Gottlieb, 1993). Gottlieb noted a number of advantages of the model, including the specific aim toward dual role dilemmas and the applicability to various dual role dilemmas, regardless of professional context. Additionally, Gottlieb's model is both specific enough to be practically applicable, and general enough to allow the clinician some flexibility in decision-making (Gottlieb, 1993). Gottlieb's model is based upon three factors believed to be imperative to ethical decision-making, and includes five steps which the professional must take during the decision-making process (Gottlieb, 1993; Nagy, 2011).

Gottlieb (1993) noted that the professional should base one's decision upon the dimensions of power, length of the relationship, and the nature and finality of termination (Gottlieb, 1993; Nagy, 2011). Power in this context refers to the amount of power which the psychologist has relative to that of the client (Gottlieb, 1993; Nagy, 2011). The power held by psychologists can vary greatly, depending on the roles which they are taking (Gottlieb, 1993).

For example, a psychologist presenting an in-service about childhood depression for the local Parent-Teacher Association is likely to wield less power than a psychologist acting as an expert witness in a child custody dispute. The second dimension considered by Gottlieb is the length of the relationship. This aspect is also related to the concept of power, as the amount of power held by the psychologist tends to increase as the duration of the relationship increases (Gottlieb, 1993; Nagy, 2011). The final aspect considered is the nature of termination of the professional relationship. This aspect refers to the likelihood that a professional and client will have continued professional contact (Gottlieb, 1993). Some professional relationships have clearly delineated endings, and it is relatively clear that further professional contact in that capacity will not occur. For example, when conducting an assessment, the psychologist is not likely to engage in further assessment of the same client once testing is complete and results have been shared with the client. However, other professional relationships, such as some individual therapy, are at times less certain in their endings. Gottlieb noted that the psychologist should assume that the consumer may return for services, when the client's feelings on this subject are not known. Gottlieb grouped each of the dimensions into three levels. In regard to power, the level can be low, mid-range, or high (Gottlieb, 1993). Regarding duration of the professional relationship, the continuum ranges from brief, to intermediate, and finally to long (Gottlieb, 1993). Finally, in regard to finality of termination, this can range from specific, to uncertain, to indefinite (Gottlieb, 1993). Gottlieb presented the continuum of the three dimensions in a diagram, with the least problematic levels on the left-hand side, the neutral levels in the middle, and the most problematic levels on the right.

Gottlieb's (1993) model contains five steps, which he illustrated with a decision tree. At each step, the professional answers a yes or no question about the situation being considered.

'Yes' answers result in discontinuation of the decision-making process, and consultation is recommended (Gottlieb, 1993). 'No' answers lead the professional to the next step in the decision tree (Gottlieb, 1993). At steps one and two, the clinician evaluates the current and potential relationships in terms of where they fall on each of the three dimensions from the clinician's best understanding of the client's perspective (Gottlieb, 1993). If two or three of the dimensions fall to the right of the diagram, the clinician should not consider a dual role with the client, as harm may be incurred (Gottlieb, 1993). In the event that the dimensions of the current relationship fall to the left, but the dimensions of the contemplated relationships fall to the right, it may be permissible for the clinician to move forward with the second relationship (Gottlieb, 1993). In the third step of Gottlieb's model, the professional evaluates both the current and contemplated relationships in terms of the level of compatibility between roles. Gottlieb noted that the professional should refrain from entering into the contemplated relationships if incompatibility between the two roles is high. If there is low incompatibility between the two relationships, the psychologist may continue to consider moving forward with the second relationship and may move further down the decision tree (Gottlieb, 1993).

The final steps of Gottlieb's (1993) decision-making model consist of inviting others into the decision-making process. In the fourth step, the clinician is required to consult with a colleague regarding the dual role dilemma (Gottlieb, 1993). The consultation should consider the relationship from the perspective of the consumer, with the goal of making a conservative decision (Gottlieb, 1993). When selecting a colleague with whom to consult on the matter, Gottlieb suggested that the clinician select an individual who has a clear understanding of the matter being considered and the client under consideration, as well as the clinician (Gottlieb, 1993). In the final step of Gottlieb's decision-making model, if the clinician is still considering

engaging in a dual role with the client, he or she should invite the client to take part in the decision-making process (Gottlieb, 1993). At this juncture, it is important that the clinician help the client to understand the dilemma at hand. Such an understanding should include potential consequences, a review of the decision-making model, and potential alternatives (Gottlieb, 1993). Gottlieb stressed the importance of ensuring that the client is capable of making an informed decision, with a clear understanding of the dilemma, appropriate time in which to make a decision, and a willingness to seriously consider the issues at hand. If the client is unwilling or unable to mindfully engage in the decision-making process, the additional relationship should be avoided (Gottlieb, 1993).

Younggren and Gottlieb's risk-management model for dual role decision-making.

Younggren and Gottlieb (2004) offered a number of questions which clinicians can ask themselves to assist them in decision-making around dual role dilemmas. The questions are focused on ensuring the well-being of the client, as well as risk-management, for both client and clinician (Younggren & Gottlieb, 2004). Younggren and Gottlieb's model pertains specifically to psychologists who are working with psychotherapy clients, not all of the myriad professional roles which a psychologist must embody. The authors noted that in general, due to the significant potential for harm, psychologists should avoid engaging in dual roles when possible, while also acknowledging that dual roles are inevitable at times (Younggren & Gottlieb, 2004). Younggren and Gottlieb also stressed the importance of consultation when making ethical decisions, as well as the importance of considering future consequences of one's actions, from the standpoint of outside observers.

Younggren and Gottlieb (2004) offered two sets of questions for the clinician to ask oneself when considering dual roles. The first set of questions is intended to assist the clinician

in deciding whether or not to move forward with a dual role (Younggren & Gottlieb, 2004). The second set of questions offers points of consideration for risk management when one has made the decision to enter into a dual role (Younggren & Gottlieb, 2004). In deciding whether to move forward with a dual role, the clinician must first determine whether an additional relationship is necessary (Younggren & Gottlieb, 2004). Younggren and Gottlieb recommended that dual roles should be avoided when possible because therapeutic relationships can be unpredictable. A clinician cannot always predict with accuracy the course that therapy work will take. Next, the clinician must consider the potential harm to the client which might result from engaging in a dual role (Younggren & Gottlieb, 2004). The authors reminded clinicians that it is the duty of the psychologist to anticipate potential risks of harm for the client and to take steps necessary to minimize and avoid such risk (Younggren & Gottlieb, 2004). In the event that harm is unlikely to result from the additional relationship, the clinician must ask oneself whether the client is likely to benefit from the additional relationship (Younggren & Gottlieb, 2004). The next question focused on the primary therapeutic relationship, as the clinician considers whether the contemplated relationship is likely to cause disruption to the therapy relationship (Younggren & Gottlieb, 2004). Younggren and Gottlieb noted that this process takes place prior to engaging in an additional relationship, but is also reassessed throughout the therapy relationship once the choice to engage has been made. The authors further noted that the client may have difficulty understanding the risk posed to the therapeutic alliance, so the clinician must be responsible for making sure that such risks are understood and considered by the client (Younggren & Gottlieb, 2004). Finally, the clinician must evaluate his or her capacity to objectively consider the dilemma (Younggren & Gottlieb, 2004). The authors indicated that critical self-evaluation,

consideration of one's motivations, and consultation with unbiased colleagues may be necessary (Younggren & Gottlieb, 2004).

Once the clinician has gone through the first set of questions and has decided to proceed with the additional relationship, he or she must then consider a number of risk-management questions (Younggren & Gottlieb, 2004). This step is necessary due to the risks posed by the additional relationship to the client, the therapeutic relationship, and the practitioner (Younggren & Gottlieb, 2004). Younggren and Gottlieb suggested that the clinician consider whether the decision-making process has been appropriately documented. Even if the clinician engaged thoughtfully in a decision-making process, this may not be evident in the case of an investigation if it is not documented in the client's record. The record one creates should clearly delineate the decision-making process, and it should be apparent to potential readers why the clinician reached the conclusion that he or she came to (Younggren & Gottlieb, 2004). Additionally the record should indicate that the decision-making process was oriented toward the well-being of the client (Younggren & Gottlieb, 2004). The clinician must also consider whether he or she engaged in the process of informed consent with the client, and that the client clearly understood the issues inherent in the dual relationship (Younggren & Gottlieb, 2004). Next, the clinician must consider whether the record reflects engagement in professional consultation as part of the decision-making process (Younggren & Gottlieb, 2004). The clinician should also consider whether the professional with whom one consulted on the matter is likely to be viewed by regulatory bodies as a credible source of consultation (Younggren & Gottlieb, 2004). A credible consultation source, the authors note, should have experience in the method of treatment as well as the pertinent aspects of ethical and legal regulations (Younggren & Gottlieb, 2004). The clinician must also be mindful of the roles that client diagnosis, additional client characteristics,

and the therapist's theoretical orientation play in the decision to engage in a dual role with the client (Younggren & Gottlieb, 2004).

Sonne's four-factor model of dual role decision-making. Sonne (2006) asserted that the spirit of dual role rules are oft misunderstood by clinicians, who erroneously equate dual roles with those unavoidable, incidental encounters with clients in daily life. On the contrary, Sonne noted that dual roles are those which consist of a deliberate, extended social interaction between the professional and client. The author hypothesized that clinicians experience discomfort when confronted with potential for dual roles because there is no simple litmus test or definitive method by which to decide right from wrong in these situations (Sonne, 2006). Sonne further noted that clinicians may neglect to carefully consider a course of action regarding dual role dilemmas and may instead engage in impetuous decision-making due to the controversial and confusing nature of the topic. When the clinician makes hasty decisions regarding dual roles, the client may not benefit and may, in fact, be harmed (Sonne, 2006). Additionally, the profession may become mired in hasty decision-making in this area, and unable to move forward toward clarity or to offer thorough and applicable decision-making models (Sonne, 2006).

In Sonne's (2006) model, the clinician was asked to consider a number of factors when faced with a decision of whether to engage in a dual role with a client. Sonne equated her model to a pilot's pre-flight checklist. The clinician is intended to work his or her way through the list of factors, considering each prior to making a decision. Sonne identified four elements which must be considered, each of which has a number of sub-categories which must be considered by the clinician (Sonne, 2006). The four elements identified by Sonne were: "Therapist factors, client factors, therapy relationship factors, and other relationship factors" (paragraph 9). The therapist factors to be considered reflect one's tendency toward various biases and viewpoints in

decision making, both as a person and as a professional. In regard to personal factors of the therapist, Sonne identified such factors as the psychologist's cultural background, gender, religious views, moral and ethical values, and personality traits. A number of factors related to the therapist's professional identity are also identified. Such factors include the specific type of therapist role, the psychologist's theoretical orientation, and years in practice (Nagy, 2011; Sonne, 2006). Like the therapist factors, the client factors to be considered also include such aspects as culture, gender, and religious identification. In addition to those factors, one must also consider psychological factors of the client which are likely to influence the client's ability to effectively navigate the dual roles. Such factors include the client's strengths and weaknesses in psychological and social development, as well as his or her personal history of boundary violations (Nagy, 2011; Sonne, 2006). Therapy relationship factors which can influence ethical decision making range from such basic factors as the setting in which the therapy takes place, such as clinic versus hospital, to the community in which the practice resides, such as rural towns versus large cities (Nagy, 2011; Sonne, 2006). Additional factors of the therapy relationship which must be considered are the balance of power, the length of the therapy relationship, and the client and therapist understandings of the nature of the therapy relationship (Nagy, 2011; Sonne, 2006). The final collection of factors to be considered in the decision-making process are those which relate to the secondary or additional relationship being considered (Nagy, 2011; Sonne, 2006). A number of the factors relate to the psychologist, such as his or her motivations for considering an additional relationship, as well as his or her emotional responses to the prospective relationship (Nagy, 2011; Sonne, 2006). Additional factors to be considered include the potential for harm and benefit, as they relate to the client and to outside parties, such as family members of the client, other clients, and staff, as well as the probability of conflict

between the roles of the therapy relationship and the additional relationship (Nagy, 2011; Sonne, 2006). Also, as with the primary relationship, the clinician must consider the setting and community of the potential relationship. Nagy (2011) recommended that clinicians utilize Sonne's four-factor model in conjunction with Younggren and Gottlieb's (2004) model, and suggested that doing so is likely to allow the clinician to form a more accurate estimation of the risk of harm to the client.

Well-Being and Burnout

Well-being. In addition to previously explored definitions, Rath and Harter (2010) offered an explanation of well-being as being influenced by five factors that distinguish between a life of suffering and a life of flourishing. Rath and Harter further explained that difficulties in any of the five well-being domains can detract from an individual's well-being and can negatively influence one's day-to-day life experience. Deficits in certain well-being factors can also affect the other factors, as many of the factors are interrelated. The first of the five factors is Career well-being, which encompasses an individual's satisfaction with the responsibilities that one engages in on a daily basis. It was noted (Rath & Harter, 2010) that a career does not always refer to a job for which someone is paid. Rather, a career can be any activity in which an individual takes part on a daily basis or for most of the week. Social well-being refers to the presence and strength of social relationships and love in an individual's life (Rath & Harter, 2010). Next, Rath and Harter describe Financial well-being, which pertains to the skill with which one manages his or her funds. Physical well-being refers to the state of one's health as well as the adequacy of one's energy which allows an individual to achieve his or her goals (Rath & Harter, 2010).

It has been argued by Rath and Harter (2010) that Career well-being has the greatest effect on an individual's overall well-being out of the five elements. Similarly, Warr (1999) asserted that job-specific well-being influences overall or context-free well-being. Rath and Harter noted the importance of finding meaning and enjoyment in one's career. They found that individuals who were actively disengaged at work showed a significant likelihood of developing depression. Factors that contribute to positive Career well-being include having a boss who is engaged and attentive and who focuses on an individual's strengths. An individual also experiences heightened Career well-being if one's areas of strength can be used to fulfill the duties of one's position. Additionally, having friendships in the work place, particularly a "best friend" can contribute to increased productivity and quality of work and can enhance an individual's Career well-being. Additionally, Warr asserted that the level of job demand impacts job-specific well-being. When an individual experiences either very low or very high levels of job demand, job-specific well-being decreases. However, when job demand is moderate, job-specific well-being is increased.

Social well-being affects a number of other areas of one's life (Rath & Harter, 2010). In addition to contributing to one's Career well-being, social relationships also affect our health. Our friends tend to influence our eating and exercise habits, as well as our tendency to engage in harmful behaviors, such as smoking. Having positive social relationships during stressful times helps individuals to cope effectively and time spent engaging in social activities tends to increase one's probability for enjoying his or her day (Rath & Harter, 2010).

Financial well-being is influenced by a number of factors, not simply the amount of money an individual has (Rath & Harter, 2010). Having enough money to provide for basic necessities, such as food and shelter, can be a concern for individuals, and this can be stressful.

Rath and Harter noted that individuals who provide for their expenses by setting up default systems, such as automatically depositing a certain percentage of one's paycheck into a savings or expense account, can avoid bill-related stress. Additionally, the way that an individual chooses to spend his or her money can influence well-being (Rath & Harter, 2010). The act of buying material things for oneself generally does not improve one's overall happiness or well-being. However, when an individual chooses to spend money on others or on an experience, such as a vacation, these acts do serve to improve one's well-being and satisfaction (Rath & Harter, 2010).

Physical well-being is made up of a number of contributing factors which can influence one's health and happiness. The food one eats and the amount of exercise one engages in influence physical health and energy levels as well as one's mood (Rath & Harter, 2010). The amount of sleep that an individual gets is also influential in a variety of ways. Individuals who do not get enough sleep are more susceptible to health problems (Rath & Harter, 2010). Additionally, lack of sleep can lead to irritability, while a good night's rest following a negative emotional experience can lead to a happier mood the next day.

Community well-being, like the other factors, is influenced by a number of components. At the most basic level of importance are certain fundamental aspects of the community. The quality of the air and water, as well as the safety of one's community can influence an individual's overall well-being (Rath & Harter, 2010). Beyond the basic elements, one then becomes concerned with such factors as the appropriateness of the community for one's personality and lifestyle (Rath & Harter, 2010). For example, such factors as accessibility to nature and exercise resources or availability of certain community programs can have an effect on an individual's satisfaction with his or her community. Rath and Harter also noted the

importance of becoming involved in one's community in a meaningful way, such as through social networks and service opportunities.

Subjective well-being was conceptualized by Cummins (2013) as a relatively stable feature, which maintains homeostasis through both internal and external buffering mechanisms. Diener and Lucas (1999) also noted the overall stability of subjective well-being. They asserted that subjective well-being is influenced by a number of factors, including overall health over the long term, patterns of interaction, and living conditions. However, Cummins also noted that significant stress can cause changes to an individual's subjective well-being.

A related term, applied to aspects of one's professional functioning, is called well-functioning, and is explained by Coster and Schwebel (1997) as "...The enduring quality in one's professional functioning over time and in the face of professional and personal stressors" (p. 5). Coster and Schwebel offered a simplified explanation of well-functioning, explaining that it can be conceptualized as the opposite of impairment.

Although many studies in the field have focused upon the negative effects of the helping professions (Linley & Joseph, 2007), some researchers have focused upon factors which contribute to the well-being of human services professionals. Linley and Joseph found a number of factors to be associated with positive effects for therapists. Therapists who reported receiving support in the form of personal therapy (either past or present) and professional supervision also reported greater experiences of personal growth than colleagues who did not receive such supports (Linley & Joseph, 2007). Coster and Schwebel (1997) also found that the supportive factors of supervision, receiving personal therapy, and having the support of peers and strong personal relationships outside of work were deemed important factors in the maintenance of well-functioning by psychologists. Additional factors deemed important by psychologists in

maintaining well-functioning included affiliation with a graduate department or school, as well as continuing education (Coster & Schwebel, 1997). Psychologists also reported that balance between professional and other activities, such as time with family and friends and recreational activities, was important for maintaining well-functioning (Coster & Schwebel, 1997)

Additionally, therapists who experienced strong therapeutic bonds with their clients and a strong sense of coherence were found to experience less negative changes than their counterparts and were less likely to experience burnout (Linley & Joseph, 2007).

The goal of Seligman's (2011) well-being theory includes increasing the amount of flourishing in one's life and in the world by using positive emotions, engagement, relationships, meaning-making, and achievement (PERMA). Positive emotions make up the subjective pleasant life, happiness, and life satisfaction. Engagement consists of a subjective state of flow with limited thoughts or feelings. Meaning-making refers to connectedness to something bigger than the self that is both subjective and objective. Accomplishment pertains to pursuing achievement for its own sake, even when it brings no meaning or emotions. Positive relationships involve the importance of other people and how they are necessary for all of the principles in positive psychology (Seligman, 2011).

Burnout. Burnout is a psychological condition which often occurs in therapists. The American Psychological Association (VandenBos, 2007) offered a clear explanation of burnout:

“n. physical, emotional, or mental exhaustion, especially in one's job or career, accompanied by decreased motivation, lowered performance, and negative attitudes towards oneself and others. It results from performing at a high level until stress and tension, especially from extreme and prolonged physical or mental exertion or an overburdening workload, take their toll...Burnout is most often observed in professionals

who work closely with people (e.g., social workers, teachers, correctional officers) in service-oriented vocations and experience high levels of stress. It can be particularly acute in therapists or counselors doing TRAUMA WORK, who feel overwhelmed by the cumulative secondary trauma of witnessing the effects..." (p. 140)

Maslach (2003) noted that burnout results from the experience of contending with chronic stress in the work environment and that it can result from a mismatch between the individual and the field of work. Burnout can result in the loss of the professional, when such a professional quits his or her job due to the stress or in diminished work quality in the burnt-out professional who stays on and continues working without addressing the burnout (Maslach & Goldberg, 1998). When one considers burnout in the case of the psychologist, either result would be detrimental to clients. If the psychologist were to quit, particularly in a rural area, the clients may have to go without services. If the psychologist were to stay on, but to perform with only a diminished capacity, the client is also likely to suffer as a result of receiving inadequate services. A number of themes were identified by Maslach and Goldberg as workplace or job components which set the stage for burnout to occur. First, the workplace is characterized by an imbalance between the demands on the clinician and the resources available to the individual to aid in meeting said demands (Maslach & Goldberg, 1998). Second, the stressors in the work environment are chronic, occurring over a long period of time without respite (Maslach & Goldberg, 1998). Finally, the workplace is characterized by conflict. The conflict can occur in many ways. There can be conflict between colleagues, between clients, or even between the various demands put upon the individual therapist (Maslach & Goldberg, 1998).

Conclusion

Rural towns tend to have a great need for psychological services, though there are a number of factors which render psychological practice in a rural town difficult. While psychologists are held to stringent ethical standards, a number of characteristics of rural towns render stringent adherence to the ethical standards somewhat confusing. As a result, ethical decision-making may prove difficult for the rural clinician. A number of ethical decision-making models exist, which range in intricacy from consideration of various factors to step-by-step decision-trees.

Well-being is a multi-faceted concept which is influenced by a wide variety of factors. An individual's environment, social supports, physical health, and finances all contribute to his or her overall functioning. Work-related well-being is especially important because individuals spend a good deal of their time in their place of work. In a related concept, burnout results from chronic stress and other negative factors of the work environment. Burnout can result in decreased productivity, hostility toward clients, and lowered efficacy.

The unique ethical conundrums encountered by the rural clinician are of particular interest to the present study as they relate to well-being and burnout. It is suspected that the stress of frequent ethical conundrums, lack of social and professional support, and other characteristics of rural practice may lead to lowered clinician well-being and, in turn, burnout. It is hoped that by exploring these relationships in the present study, we can gain further understanding of the rural psychologist's experience and begin to seek solutions.

Chapter 3: Method

Past research and theoretical writings have indicated that rural clinicians experience increased incidences of certain types of ethical dilemmas compared to their urban and suburban counterparts (Hargrove, 1986; Helbok, 2003; Helbok et al., 2003; Schank & Skovholt, 2006). In the present study, rural and small-town clinicians' experiences were examined pertaining to ethical dilemmas, well-being, and burnout. The following sections delineate the methodology of the study, such as instrumentation, procedures for recruitment, participant informed consent, confidential and anonymous data collection, sampling, research hypotheses, and design for data analyses.

Participants

One hundred and two participants were sought for the needed effect size for a multiple regression analysis. However, only 60 participants began the survey and among these, only 29 (48.33%) completed the survey in its entirety. Different subsample sizes were, therefore, utilized for analyses. Participation criteria required respondents (a) to be practicing psychotherapy in a rural or small town area with 25,000 residents or less and at least 45 minutes away from the nearest city of 50,000 people or more, (b) to be residing in the same county in which they practice, and (c) and to be holding graduate degrees in psychology or a closely related field.

Of the 60 participants that began the survey, 47 (78.3%) were female, 13 (21.7%) were male, 50 (83.3%) self-identified as White/Caucasian, while 3 participants self-identified as Asian and Hispanic/Latino (5.0% each), respectively. Two participants (3.3%) identified as Pacific Islander, while one participant each identified as Black/African American and Multiracial/Multiethnic (1.7 % each, respectively). Thirty-three participants (55.0%) held a doctoral degree, 23 (38.3%) a master's degree, and four (6.7%) held other qualifications (two

Educational Specialist degrees, one doctorate in progress, and one associate's degree).

Participants resided in 19 states of the United States and one other country. See Table 1 for participant demographics. Participants' age ranged from 24 to 65 (see Table 2). Except for the youngest age group (20-29 years of age), the age grouping were similar in size. Data on the age groups of participants are reported in Table 2.

Table 1

Participants' State of Residence

State	<i>n</i>	Percentage
Alabama	12	20.0%
Hawaii	8	13.3%
New Hampshire	7	11.7%
South Dakota	5	8.3%
Arizona	4	6.7%
Minnesota	4	6.7%
Texas	3	5.0%
Wisconsin	3	5.0%
Pennsylvania	2	3.3%
Vermont	2	3.3%
Colorado	1	1.7%
Maryland	1	1.7%
Missouri	1	1.7%
Montana	1	1.7%
Nebraska	1	1.7%
New Jersey	1	1.7%
Oregon	1	1.7%
Tennessee	1	1.7%
Washington	1	1.7%
Other (Specified Below)	1	1.7%
- Costa Rica		
Total	60	100.00%

Table 2

Participants' Age Groups

Age	N	Percentage
20-29	8	13.33
30-39	17	28.32
40-49	14	23.32
50-59	10	16.67
60-69	11	18.33

Measures

Parts 1-5 of a self-report questionnaire were author-developed. Part 1 presented participation criteria and the informed consent form. Part 2 collected demographic information on age, sex, race, level of education, and state of residence. Part 3 had seven questions about the respondent's community and practice, such as, the population size of the town where participant resided and worked, distance from the nearest therapist with the same expertise as the respondent, distance from the nearest large city, case load, utilization rate of scheduled clients, and frequency with which clients were denied services due to inability to pay.

Part 4 had nine questions that noted participants' frequency and degree of discomfort in relation to four types of ethical dilemmas: dual roles (sometimes called multiple roles or multiple relationships), client confidentiality, limits of therapist competence, and clinician visibility. Clinicians were asked to rate how often they experienced each of the dilemmas on a Likert scale from 0 to 4, with 0 meaning "never," and 4 meaning "12 or more times per year" (see the questionnaire in Appendix B). Participants were then asked to rate the degree of discomfort they experienced with ethical dilemmas. The discomfort items were answered on a Likert scale of 0 to 4, with 0 meaning "no discomfort" and 4 meaning "extreme discomfort" (see the questionnaire in Appendix B). Part 4 also included one open-ended question asking which roles participants were engaged in when they encountered ethical dilemmas.

Part 5 had seven questions that pertained to ethical decision-making strategies. This section of the survey contained brief summaries of decision-making models, with questions about respondents' endorsement of the various decision-making methods. Decision-making models which pertained only to dual role dilemmas were presented, as well as general models. Two questions covered the two topic areas of ethical practice:

- For general ethical decision-making models, participants chose between the Canadian Psychological Association's 10-step decision-making process (CPA, 2010), and the Feminist ethical decision-making model (Hill et al., 1995).
- For ethical decision-making models related to dual roles, participants were asked to choose between the Worst Case Scenario model (Nagy, 2011); the Role Theory model (Kitchener, 1988); the Three-factor model (Gottlieb, 1993); the Risk-Management model (Younggren & Gottlieb, 2004); and the Four-factor model (Sonne, 2006).

Part 5 also contained one open-ended question and one multiple choice question to elicit information on individual decision-making strategies. One additional question asked whether participants used case-by-case analysis to resolve ethical dilemmas or if they applied a universal rule to all ethical dilemmas. Two well-established instruments followed Parts 1-5 of the questionnaire, which are reviewed below.

The Friedman Well-Being Scale (Friedman, 1994). Part 6 of the questionnaire consisted of the Friedman Well-Being Scale (FWBS). The FWBS is a 20-item self-report measure which takes approximately two to three minutes to complete (Friedman, 1992). The FWBS produces a number of scores, including an over-all well-being score, known as the Friedman Well-Being Composite (FWBC) score. Additionally, there are subscale scores for Emotional Stability, Self-Esteem/Self-Confidence [present author's comment: self-esteem and

self-confidence are two different constructs, but which probably correlate when measured], Sociability, and Happiness (Friedman, 1994).

Each item consists of two adjectives which are antonyms (e.g., “tense” and “relaxed”), with a number line between them, ranging from 0-10, for example 0-1 (“Very Tense”) to 9-10 (“Very Relaxed”). The respondent then chooses the value which is most descriptive of him or her most of the time, as compared to peers of the same age and gender (Friedman, 1994).

Friedman (1994) has reported internal consistency reliability for the full FWBC scale and eight subscales studied in 5 studies with psychotherapy clients and college students, respectively. The internal consistency ranged between α .92 and α .98. . The highest alpha was for the combined Self-Confidence and Assertiveness subscales, ranging from α .90 to α .96. The lowest alpha was for the Steadiness subscale, from α .72 to α .89. (Friedman, 1994). Friedman also cited studies which showed acceptable split-half reliability (Friedman, 1994).

Friedman (1994) provided evidence of test-retest reliability. For the psychotherapy clients, test-retest reliability was α .85 at the 3rd week and α .81 at the 13th week. In a study of 95 college students over a four-week period, the test-retest reliability was α .73. Friedman noted that these test-retest alphas were impressive because well-being is a subjective state which tends toward change over time even without intervention.

External validity of the FWBS was shown by having married and cohabiting couples rate both themselves and their partners (Friedman, 1994). A correlation of $r = .61$ was found for the couples' ratings on the full measure. Convergent validity was shown with positive correlations between the FWBC and measures of similar concepts. For the psychotherapy patient group, a correlation of $r = .61$ was shown with the Bradburn Well-Being Scale (Friedman, 1994); a correlation of $r = .60$ with the Fordyce Well-Being Scale (Friedman, 1994); a correlation of r

=.59 with the Friedman Positive thoughts Scale; and a correlation of $r = .59$ with the Hudson Self-Esteem Scale (Friedman, 1994). For the college student population, correlations of .71, .69, and .60 were found between the Friedman Positive Thoughts subscale, Andrews Quality of Life Scale, and Fibel and Hale Expectancy of Success scale, respectively (Friedman, 1994).

Divergent validity was indicated between the FWBS and a number of scales measuring the opposite of well-being (Friedman, 1994). For both college and psychotherapy samples, there was an inverse correlation with the Beck Cognitive Depression measure, $r = -.54$ and $r = -.59$, respectively; the Beck Depression and Anxiety measure, $r = -.56$ and $r = -.52$, respectively; and the Beck Cognitive Anxiety measure, $r = -.42$ and $r = -.35$, respectively (Friedman, 1994). An additional study of adult psychotherapy patients showed 26 negative correlations between the FWBS and various measures that would be thought to be the opposite of well-being, further indicating divergent validity (Friedman, 1994). The largest negative correlation in that study was with the NEO-FFI-Neuroticism scale, $r = -.81$, while a moderate negative correlation was shown with Morey's PAI-Suicidal scale, $r = -.31$ (Friedman, 1994). For the present study, the composite Friedman well-being score was used for statistical analyses because of the study's small sample size.

Maslach Burnout Inventory, Third Edition, Human Services Survey (Maslach, Jackson, & Leiter, 2010). The final section of the survey comprised the Maslach Burnout Inventory, Third Edition, the Human Services Survey (HSS). The HSS version was administered because it is most appropriate for the psychology profession.

The MBI HSS is a 22-item, 7-point Likert self-report measure which assesses the frequency with which human service providers experience three main factors of burnout: Emotional Exhaustion, Depersonalization, and Personal Accomplishment (Maslach, Jackson, &

Leiter, 2010; Wright, 2005). Three subscales measure these dimensions. Emotional Exhaustion (EE) was defined by Maslach et al. as “feelings of being emotionally overextended and exhausted by one’s work” (p. 4). The Depersonalization (Dp) subscale assesses “...an unfeeling and impersonal response toward recipients of one’s service, care, treatment, or instruction” (p. 4). Finally, Personal Accomplishment (PA) is defined as “...feelings of competence and successful achievement in one’s work with people.” (p. 4). It is notable that the Personal Accomplishment subscale measures the presence of feelings of personal accomplishment, rather than decreased personal accomplishment, as is generally seen in the burnout syndrome (Maslach et al., 2010). The MBI-HSS does not produce an overall burnout score, but rather three separate scores on the three burnout dimensions. The MBI HSS was normed in part on mental health workers (Maslach et al., 2010; Wright, 2005).

Maslach et al. (2010) have reported acceptable internal consistency reliabilities: EE $\alpha = .90$, DP $\alpha = .79$, and PA $\alpha = .71$. A number of studies determined the test-retest reliability of the MBI-HSS with intervals ranging from two weeks to one year (Maslach et al., 2010). Test-retest reliability for the EE subscale ranged from $\alpha = .58$ to $\alpha = .82$; for DP from $\alpha = .54$ to $\alpha = .72$; and for PA from $\alpha = .57$ to $\alpha = .80$.

Maslach et al. (2010) investigated convergent validity in three ways: first, the correlation between MBI-HSS subscale scores and behavioral ratings by someone who knew the respondent well; second, correlation between MBI-HSS scores and job factors that are thought to lead to burnout, such as caseload; finally, correlations of MBI-HSS scores and scores on outcome measures, which measured factors related to burnout. Correlations generally ranged from low to moderate, with $p < .05$ significance level attained for the majority. However, Wright (2005) noted that despite being significant, only 20% of the correlations had a value greater than or

equal to .40, and 20.5% of the correlations were in the range of .31 to .38. The latter can be considered moderately low correlations, not signifying strong convergent validity (Anastasi & Urbina, 1997).

The strongest correlations were reported for a sample of mental health workers. The correlations between peer ratings of appearance of physical fatigue and respondent EE scores were moderately strong at $r = .42$ (Wright, 2005). Peer ratings of respondents' perceived emotional and physical fatigue had correlation with respondent scores on the DP scale at $r = .56$ and $r = .55$, respectively (Wright, 2005). Finally, scores of a sample of mental health workers, nurses, and social workers on DP showed a moderate negative correlation ($r = -.41$) with peer ratings of co-worker satisfaction and ($r = -.47$) with peer ratings of growth satisfaction, whose construct, however, was not defined (Wright, 2005); PA was found to be positively correlated with peer ratings in the same two areas mentioned above ($r = .40$ and $r = .41$, respectively). Considering the above multi-trait multi-method construct validation practice, the moderate convergent validity correlations are impressive (Anastasi & Urbina, 1997). Job satisfaction was found to have a moderately low negative correlation with EE and Dp ($r = -.23$, $p < .05$, and $r = -.22$, $p < .05$, respectively), suggestive of discriminant validity.

Maslach et al. (2010) argued that the MBI-HSS scores reflect constructs which are different from other constructs which are assumed to be similar to burnout dimensions. For instance, a non-significant correlation was found between job satisfaction and PA ($r = .17$, $p > .0506$). Maslach et al. found no correlation between the subscales of the MBI and a measure of social desirability. Maslach et al. cited a study (Meier, 1984, as cited in Maslach et al., 2010) which found a moderate correlation between a total MBI burnout score and a number of depression measures. However, these results are somewhat suspect because the researcher

combined the three subscale scores of the MBI to create an overall burnout score, which is not the recommended use of the MBI subscale scores (Maslach et al., 2010). An additional study (Firth et al., 1987, as cited in Maslach et al., 2010) found some overlap between the construct of Professional Depression (a measure of work-related depression) and the MBI-HSS EE subscale. Contradicting Maslach and colleagues, other authors have called into question the concept of burnout, arguing that it is not separate from job stress, depression, anxiety, and anger (Krehbiel, 1985, & Scarfone, 1985 as cited in Maslach et al., 2010). However, Maslach et al. have maintained that burnout is indeed a separate concept, specifically due to the occurrence of the burnout syndrome within certain work settings, while depression is global in nature. Maslach and colleagues referred to a study (Leiter & Durup, 1994, as cited in Maslach et al., 2010) which provided evidence for burnout as a distinct syndrome, with its three subscales more closely related to each other than to scales of depression.

Though Maslach et al. (2010) did not cite studies which demonstrate the distinction between burnout and occupational stress, the authors did make a number of distinctions between the two constructs which would lead one to conclude that the two constructs are indeed separate though related. Maslach and colleagues noted that burnout differs from occupational stress because only certain types of jobs lead to burnout, while occupational stress can occur more generally (Maslach et al., 2010). The authors also noted that the specificity of the feelings involved in the burnout construct is further evidence of the concept's distinction (Maslach et al., 2010).

Procedures

Participants were asked to complete an online questionnaire anonymously through PsychData.com. Participants were recruited through online recruiting efforts. Each of the 50 state

psychological associations was contacted via email with the informed consent form and a link to the survey, requesting that the association forward the request to participants if possible. If associations responded with a proposal for alternative methods of recruitment (such as emailing members individually, posting a link to the survey on the association's website or Facebook page, etc.), that method was followed, as specified. Those that received the request were permitted to forward the informed consent and survey link to others. If no reply was received from an association and contact information for members was publicly posted, members of associations were contacted individually through email. In addition, participation requests were sent to counseling and school counseling associations, school psychology associations, and graduate programs in psychology and counseling.

Ethics and informed consent. In order to maintain ethical propriety and minimize risk to respondents, a number of steps were taken. First, the respondents were provided with the informed consent statement at the start of the online survey. They were also provided the author's contact information to seek clarification regarding the study and participation (see Appendix A for informed consent). The informed consent form explained the voluntary nature of participation and the risks and benefits inherent in participation. Anonymity was assured owing to the anonymous nature of the online survey. Computer IP addresses were not recorded. The anticipated professional use of a dissertation was also explained in the informed consent form.

Research Hypotheses and Questions

Hypotheses. Four research hypotheses were tested:

1. Higher scores on frequency of ethical dilemmas will relate to lower well-being scores of clinicians.

2. Higher scores on frequency of ethical dilemmas will relate to higher levels of burnout scores, as measured by the three dimensions of the MBI-HSS.
3. Higher levels of discomfort with ethical dilemmas will relate to lower well-being scores of clinicians.
4. Higher levels of discomfort with ethical dilemmas will relate to higher levels of burnout scores, as reflected by the three burnout scores of the MBI-HSS.

Questions. In addition to the above hypotheses, the study examined the following research questions:

Question 1: What types of ethical dilemmas do rural clinicians strongly endorse?

Question 2: How frequently do rural clinicians experience ethical dilemmas?

Question 3: What types of decision-making do clinicians follow to address ethical dilemmas?

Question 4: What is the level of well-being of rural clinicians in the present study?

Question 5: What is the level of each burnout dimension (EE, DP, and PA) for the clinicians in the present study?

Question 6: How frequently does a client's inability to pay result in denial of mental health services by clinicians in the present study?

Data Analyses

Hypothesis 1. The first hypothesis on the relationship between frequency scores on ethical dilemmas and level of well-being was tested by a Pearson Product Moment correlation analysis. Each respondent's Likert responses to the ethical dilemmas were summed to elicit a total ethical dilemma frequency score for that individual. Well-being was measured by the Friedman Well-being composite score for each respondent.

Hypothesis 2. The second hypothesis about the relationship between frequency scores on ethical dilemmas and level of burnout on each of the three MBI-HSS dimensions was first tested by Pearson Product Moment correlation analyses. Second, a simple regression analysis was conducted, with frequency scores on ethical dilemmas and degree of discomfort with ethical dilemmas as the predictor variables and Emotional Exhaustion as the criterion variable.

Hypothesis 3. The third hypothesis regarding the relationship between level of clinician discomfort with ethical dilemmas and well-being was examined through use of a Pearson Product Moment correlation analysis. Each respondent's Likert responses for each of the questions regarding level of discomfort experienced was summed to produce an overall discomfort score for each individual. Well-being was measured with the Friedman Well-Being composite score for each individual.

Hypothesis 4. The final hypothesis, regarding the relationship between level of clinician discomfort with ethical dilemmas and level of burnout experienced was tested utilizing similar procedures as with the previous three hypotheses. First, a Pearson Product Moment correlation analysis was carried out. Each respondent's level of discomfort total score was correlated with the respondent's score on each of the three MBI-HSS dimensions. Second, a simple regression analysis was carried out to analyze the predictive power of level of discomfort and frequency of ethical dilemmas for predicting EE, the criterion variable.

Research questions. Analyses for the research questions ranged from simple reporting of frequency data to t-test to thematic analysis of qualitative data. The analysis used for each research question is explained below.

Research questions 1 and 2. Research questions regarding which ethical dilemmas are most strongly endorsed and frequency of ethical dilemmas experienced were both analyzed as

frequency data. Total number of respondents that endorsed each type of dilemma was calculated and descriptive statistics (mean, median, mode, and standard deviation) for each type of ethical dilemma were calculated. In addition, frequency data were calculated in regard to the number of times per year that each of the ethical dilemmas was experienced by participants.

Research question 3. Ethical decision-making strategies used by participants were examined through frequency data from multiple choice questions about decision-making strategies. Percentages of respondents that used various strategies were calculated. In addition, respondent levels of self-confidence and stress relief were also calculated in the form of percentages of respondents that selected various levels of confidence and stress relief.

Narrative responses regarding decision-making strategies were analyzed through the use of thematic analysis, as described by Braun and Clarke (2006). Braun and Clarke presented a step-by step process for analyzing qualitative data which is flexible but which also provides clear steps for approaching the analysis process. Braun and Clarke's method consists of six steps, which entail becoming familiar with the data, coding responses, identifying and reviewing themes, further analysis and definition of themes, and reporting of the data. To become familiar with the data, this author gathered the narrative responses and read them several times, making note of initial ideas. Initial codes were then generated, and grouped into overall themes, which were reviewed and revised and re-named to reflect the overarching themes. Frequency data were then calculated for each of the themes, and the most frequently endorsed themes are reported in a frequency table. Narrative responses which served as particularly illustrative examples of some themes were also identified for inclusion in the results.

Research questions 4 and 5. For comparison of the well-being and burnout scores of the current sample with scores of previous samples, t-tests were used. The present author chose to

compare scores from the current study to the scores from the original normative samples, selecting comparison populations from the original FWBS and MBI-HSS studies which appeared most similar to the current population. For the FWBS, where the normative samples consisted of college students and mental health patients, the college sample was selected for comparison with the current sample. For the MBI-HSS, a sample of mental health workers was chosen for comparison due to similarity of professional roles. Tables were created comparing the means and standard deviations from the current and normative studies, and t-tests were run to show whether there were significant differences between the performances of the various samples on the measures of the study.

Research question 6. To understand the frequency with which participants in the study turned away clients due to inability to pay, frequency data were calculated in regard to the percentage of clinicians that turned away clients for payment issues. For those that indicated turning away clients at least some of the time, percentages of these participants were calculated and presented in a table.

Conclusion

The present study examined the relationship between frequency and level of distress of ethical dilemmas with rural and small-town clinicians' scores on measures of well-being and burnout. Ethical decision-making strategies were also examined. The presence of relationships was examined, as well as the directionality of those relationships.

Though much has been written regarding the increased encounters with ethical dilemmas by rural clinicians, the relationship between these encounters and well-being and burnout are as yet not clearly determined. The present study sought to clarify these relationships.

Chapter 4: Results

The purpose of the study was to understand the relationships between rural clinicians' experience with ethical dilemmas and their levels of well-being and burnout. Both quantitative and qualitative data were collected to respond to the study's research hypotheses and questions.

Quantitative Data

Internal consistency reliability. Cronbach's alpha was calculated to examine the reliability of several measures in the study's survey: frequency and level of distress of ethical dilemmas, the FWBS well-being full scale, and three subscales of the MBI-HSS, the professional burnout scale.

The Cronbach alpha for frequency of ethical dilemmas (four items) and level of distress of ethical dilemmas (four items) was $\alpha = .61$ and $\alpha = .66$, respectively. While moderately low, the Cronbach's alphas were acceptable, given the few items in each scale.

Cronbach's alpha for the FWBC was $\alpha = .92$, showing excellent internal consistency reliability and was similar to the alphas from the normative studies cited by Friedman (1994). Table 3 lists these alphas.

Table 3

Reliability of FWBC for Current Study and Normative Studies

Dimension	α Current Study	α Norm Study College Student Population	α Norm Study Psychotherapy Client Population 1	α Norm Study Psychotherapy Client Population 2	α Norm Study Psychotherapy Client Population 3
FWBC	.92	.92	.94	.98	.95

Note: Current study, $N = 29$; College student study $N = 105$; Psychotherapy client population 1 $N = 48$; Psychotherapy client population 2 $N = 22$; Psychotherapy client population 3 $N = 23$.

For the MBI-HSS, the Cronbach's alpha for Emotional Exhaustion was $\alpha = .91$, which is listed in Table 4 along with the α values for the normative studies on the measure (Maslach et al., 2010). For dimensions of Depersonalization and Personal Accomplishment, the Cronbach's alpha was $\alpha = .70$ and $\alpha = .76$, respectively. These values are provided along with alphas for DP and PA in a normative study cited by Maslach et al. The alphas for the present study were similar to those of the normative study.

Table 4

Reliability of MBI Dimensions for the Current Study and Normative Studies

Dimension	α Current Study	α Original Norms
Emotional Exhaustion	.91	.90
Depersonalization	.70	.79
Personal Accomplishment	.76	.71

Note. Original normative alphas are from the Maslach Burnout Inventory Manual (Maslach et al., 2010).

Tests of research hypotheses.

Hypothesis 1. Higher scores on frequency of ethical dilemmas will relate to lower well-being scores of clinicians. This hypothesis about an inverse relationship between frequency of ethical dilemmas and the FWBC full score was not supported by a Pearson correlation analysis. The correlation was low ($r = .10$, $p = .60$), suggesting very little relationship.

Hypothesis 2. Greater frequency of ethical dilemmas will relate to higher levels of burnout scores, as measured by the three dimensions of the MBI-HSS. This hypothesis that frequency of ethical dilemma encounters would be correlated with the three dimensions of burnout was partially confirmed. The correlation with Depersonalization was not significant ($r = -.05$, $p = .82$). In fact, the correlation was close to 0, suggesting the absence of a relationship. The correlation with Personal Accomplishment, though in the expected direction, was also not significant ($r = -.23$, $p = .24$). The correlation with Emotional Exhaustion was significant ($r = .40$, $p = .03$), suggesting a moderate correlation.

The three MBI-HSS subscales had non-significant moderate to low inter-scale correlations. The three subscales showed their relative independence from each other, as suggested by Maslach et al. (2010).

Table 5

Pearson Correlations among Frequency of Ethical Dilemmas, Emotional Exhaustion, Depersonalization, and Personal Accomplishment

	EE	DP	PA	Frequency
EE	1.00			
DP	.32	1.00		
PA	-.34	-.16	1.00	
Frequency	.40*	-.05	-.23	1.00

Note. $N=29$. EE = Emotional Exhaustion; DP = Depersonalization; PA= Personal Accomplishment; Frequency = Frequency of ethical dilemmas encountered.

* $p<.05$

Hypothesis 3. Higher levels of discomfort regarding ethical dilemmas encountered will relate to lower well-being scores of clinicians. This hypothesis on the relationship between the level of distress experienced and well-being, while in the expected negative direction, showed a low non-significant correlation ($r = -.11, p = .56$).

Hypothesis 4. Greater levels of discomfort experienced regarding ethical dilemmas encountered will relate to higher levels of burnout score, as reflected by the three burnout scores of the MBI-HSS. Depersonalization and Personal Accomplishment were not significantly correlated to level of distress experienced. The Depersonalization measure's correlation was low and not significant ($r = .20, p = .30$), but in the expected positive direction. Similarly, the correlation between level of distress and Personal Accomplishment, though in the expected negative direction ($r = -.11, p = .59$), was low and not significant. A significant correlation, however, was found for Emotional Exhaustion ($r = .38, p = .04$) with level of discomfort regarding ethical dilemmas.

Table 6

Pearson Correlations Among Level of Clinician Discomfort, Emotional Exhaustion, Depersonalization, and Personal Accomplishment.

	EE	DP	PA	Discomfort
EE	1.00			
DP	.32	1.00		
PA	-.34	-.16	1.00	
Discomfort	.38*	.20	-.11	1.00

Note. $N = 29$. EE = Emotional Exhaustion; DP = Depersonalization; PA = Personal Accomplishment; Discomfort = level of clinician discomfort.

* $p < .05$

Additional analysis for hypotheses 2 and 4. A simple linear multiple regression analysis was conducted to determine whether frequency and level of distress of ethical dilemmas predicted EE. Both frequency and level of distress significantly predicted EE, $R^2 = .28$, $F(2, 28) = 5.15$, $p = .01$. See table 7 for regression results.

Table 7

Summary of Multiple Regression Analysis of Frequency of Ethical Dilemmas and Level of Discomfort as Predictor Variables with Emotional Exhaustion as the Criterion Variable

	β	B	Std. Error of Beta	<i>t</i>	<i>p</i>
(Constant)		-.75	.86	-.88	.39
Frequency	.38	.14	.06	2.25*	.03
Discomfort	.36	.12	.06	2.15*	.04

Note. * $p < .05$. Criterion Variable = Emotional Exhaustion

Research Questions

Research questions 1 and 2. Frequency data were used to answer the research questions 1 and 2, which asked which ethical dilemmas were most strongly endorsed by respondents and how frequently respondents experienced ethical dilemmas. The ethical dilemma most often endorsed was dual role dilemmas. Of the 39 individuals who responded to the question, 38 (97 %) individuals indicated experiencing dual role dilemmas at least some of the time. Therapist visibility dilemmas were endorsed by 36 (92.3%) of respondents. Dilemmas related to limits of therapist competence were endorsed less often, with 31 of the 39 respondents (79.5%) endorsing this type of dilemma. The least endorsed type of dilemma was maintaining client confidentiality, with 30 (76.9%) of respondents reporting this type of dilemma. However, three-fourths of the sample endorsed the above-mentioned problems of rural practice. See Table 8.

The vast majority of the participants (97%) reported dual role dilemmas. See Table 10. Among these, 17 respondents (43.6%) experienced dual role dilemmas between 1 and 4 times per year; 11 participants experienced such dilemmas 12 or more times per year (28.2%); 7 respondents experienced such dilemmas 5 to 8 times per year (17.9%), and 3 participants 9-11 times per year (7.7%). Only 1 respondent (2.6%) indicated no encounters with dual role dilemmas.

Frequency of confidentiality dilemmas are reported in Table 11. Confidentiality dilemmas were most often experienced by respondents between 1 and 4 times per year ($N = 20$, 51.3%). This frequency was followed by those who never experienced confidentiality dilemmas ($N = 9$, 23.1%). Third came those that experienced such dilemmas between 5 and 8 times per year ($N = 4$, 10.3%). Those who endorsed such dilemmas 9 to 11 times per year, and those that experienced these dilemmas 12 or more times per year were each endorsed by the same number of respondents ($N = 3$, 7.7%).

Respondents most often indicated experiencing dilemmas of therapist competence between 1 and 4 times per year ($N = 19$, 48.7%). This was followed in frequency by those respondents who never experienced dilemmas related to therapist competence ($N = 8$, 20.5%). Individuals who experienced competence dilemmas between 5 and 8 times per year followed ($N = 7$, 17.9%). Four respondents (10.3%) indicated experiencing competence dilemmas 9 to 11 times per year, with only one respondent (2.6%) experiencing these dilemmas 12 or more times annually. Complete data pertaining to competence problems can be found in Table 12.

Data on dilemmas pertaining to therapist visibility are reported in Table 13. These dilemmas were experienced by 14 respondents (35.9%) between 1 and 4 times annually. This was followed by those individuals who experienced such dilemmas 12 or more times per year ($N = 10$, 25.6%). Third were those individuals who experienced such dilemmas between 5 and 8 times per year ($N = 8$, 20.5%), followed by those who experienced these dilemmas 9 to 11 times per year ($N = 4$, 10.3%). Three individuals (7.7%) indicated never experiencing visibility dilemmas.

Table 8

Frequency of Respondent Experiences of Ethical Dilemmas

Type of Ethical Dilemma	Number of Respondents That Endorsed This Type of Dilemma	Percentage of Respondents that Endorsed This Type of Dilemma
Dual Roles	38	97%
Therapist Visibility In Community	36	92.3%
Limits of Therapist Competence	31	79.5%
Maintaining Client Confidentiality	30	76.9%

Table 9

Descriptive Statistics for Each Type of Ethical Dilemma

Type of Ethical Dilemma	Mean	Median	Mode	Standard Deviation
Dual Roles	3.15	3	2	1.3
Therapist Visibility In Community	3.10	3	2	1.34
Limits of Therapist Competence	2.26	2	2	0.98
Maintaining Client Confidentiality	2.26	2	2	1.13

Note. $N = 39$. Descriptive statistics were based on the following values: 1: Never; 2: 1-4 times per year; 3: 5-8 times per year; 4: 9-11 times per year; 5: 12 or more times per year.

Table 10

Frequency of Respondent Encounters with Dual Role Dilemmas

Frequency	<i>N</i>	Percentage
Never	1	2.6%
1-4 Times Per Year	17	43.6%
5-8 Times Per Year	7	17.9%
9-11 Times Per Year	3	7.7%
12 or More Times Per Year	11	28.2%

Note. Total *N* = 39

Table 11

Frequency of Respondent Encounters with Confidentiality Dilemmas

Frequency	<i>N</i>	Percentage
Never	9	23.1%
1-4 Times Per Year	20	51.3%
5-8 Times Per Year	4	10.3%
9-11 Times Per Year	3	7.7%
12 or More Times Per Year	3	7.7%

Note. Total *N* = 39

Table 12

Frequency of Respondent Encounters with Therapist Competency Dilemmas

Frequency	<i>N</i>	Percentage
Never	8	20.5%
1-4 Times Per Year	19	48.7%
5-8 Times Per Year	7	17.9%
9-11 Times Per Year	4	10.3%
12 or More Times Per Year	1	2.6%

Note. Total *N* = 39

Table 13

Frequency of Respondent Encounters with Therapist Visibility Dilemmas

Frequency	<i>N</i>	Percentage
Never	3	7.7%
1-4 Times Per Year	14	35.9%
5-8 Times Per Year	8	20.5%
9-11 Times Per Year	4	10.3%
12 or More Times Per Year	10	25.6%

Note. Total *N* = 39

Research question 3. Data from a number of the survey questions served to elucidate the decision-making practices of participants. Strategies used were understood through multiple choice response formats and thematic analysis of narrative responses. The helpfulness of respondent decision-making strategies for alleviating distress related to ethical dilemmas and respondent confidence in decisions made through ethical decision-making practices were also examined.

Most individuals (86.67 %) reported use of a case-by case approach when managing ethical dilemmas. When describing personal decision-making strategies, most individuals surveyed (66.67%) indicated the use of multiple strategies when engaging in decision-making practices.

Strategies used for ethical decision-making were understood through thematic analysis of narrative descriptions of strategies, as well as a review of multiple choice selection of strategies from a given list. See Tables 14 and 15 for the respective findings. In responses elicited by the multiple choice format, respondents tended to select mainly from the given choices, with only one individual choosing “other.” Respondents to the multiple choice questions tended toward more agreement among responses, while the themes that were identified in thematic analysis of narrative responses elicited more variation.

There was generally agreement across question type regarding the most popular decision-making strategies, with some variation. The most popular strategies indicated on the multiple choice question were Review of Ethical Laws and Guidelines (93.3%) and Consultation (90.0%). In thematic analysis, one of the two most popular decision-making themes was “Consulting with people, professional associations, or ethical guidelines” (50.00%). One thematic category was a melding of the two most popular multiple choice strategies, which indicated overall agreement across questions. Discussing ethical dilemmas with clients was also a strategy which was echoed in both a multiple choice question (80.0%) and the thematic analysis of narratives (36.67%). The strategy was perhaps best exemplified by the following narrative response provided by an anonymous survey participant: “...Then I choose a response (or two possible responses if appropriate) and talk candidly with the client about the ethical issue. I ask many questions to judge the client’s comfort level and the clinical impact of the potential ethical issues (e.g., multiple roles scenario).”

There were a number of strategies which were delineated in the narrative responses, which were not represented by the options in the multiple choice question. One strategy which appeared frequently in narrative responses (50.00%) was “Emphasis on reducing the likelihood of harm or other negative outcomes.” This sentiment is perhaps best exemplified by the following narrative response offered by one of the survey respondents: “Do no harm. If a decision I make could harm the client in any way, I will do my best to find another path.” A second strategy which was prevalent in narrative responses (36.67%) is “Consideration of various factors.” This theme encompasses those responses which included considering factors of the dilemma such as power differentials, cultural factors, and ethical obligations to various parties. A third strategy which was noted by a number of participants (23.33%) is the tactic of

avoiding dual roles whenever possible. Narrative responses which included this theme ranged from somewhat extreme responses such as “Avoid additional relationships period” to responses which indicated a best effort to avoid additional relationships, with the understanding that some are unavoidable. Responses that exemplify this approach included the following: “...I avoid dual relationships as much as possible and inform clients of the possibility of us running into each other (sic) in town and encourage them about our being able to talk about it.” Another example: “...However, I avoid taking on new clients who have an active outside relationship with me. Most of the time the dual relationship issues happen after I have established care with someone or after treatment has finished. I talk to patients at the beginning of therapy about confidentiality and dual relationships (and it’s in my consent form) and how they would like me to greet (or not greet) them in public. Many times we pretend we know each other from the community as I regularly see patients at gatherings or in the community. When an unavoidable dual relationship emerges, I discuss the potential impact with the patient and ask them how they would like me to handle it. However, at times the procedure feels extremely stigmatizing...”

Overall, participants indicated that their methods of ethical decision-making were helpful in reducing stress related to ethical dilemmas, and that they were confident in the decisions they made when utilizing their chosen decision-making strategies (See Table 17). The majority of respondents indicated that their decision-making methods were either very helpful (33.3%) or extremely helpful (33.3%) in alleviating stress from ethical dilemmas. Seven respondents (23.3%) indicated that their methods were moderately helpful in alleviating stress, while three individuals (10.0%) only found their strategies to be slightly helpful. None of the respondents indicated that their decision-making strategies were not helpful at all.

In regard to confidence in appropriateness of decisions, responses were generally

positive. All respondents to the question indicated confidence levels in the moderately confident, very confident, and extremely confident categories (23.3%, 33.3% and 43.3%, respectively).

When asked to choose from pre-existing models which best reflected the participant's personal decision-making style, there were some notable trends in the data. See Tables 20 and 21 for complete data. When choosing a model for general ethical decision-making, there were two choices to select from. Slightly more participants chose the Canadian Psychological Association 10-Step model (56.7%), while the remainder chose the Feminist Ethical Decision-Making Model (43.3%). Regarding models which pertained specifically to ethical decision-making regarding dual-role dilemmas, participants were provided with five models to select from. The most popular strategies selected by participants were the Worst Case Scenario strategy and the Risk Management model (30% each). The other models were less popular, with Gottlieb's Three-Factor model in third place (16.7%), followed by Sonne's Four-Factor model (13.3%), and finally the Role Theory model (10.0%).

Table 14

Themes Identified Through Thematic Analysis of Respondents' Narrative Descriptions of Their Ethical Decision-Making Strategy, by Frequency of Appearance

Theme	<i>N</i>	Percentage of Responses Which Included This Theme
Considering or reducing likelihood of harm or negative outcomes	15	50.00%
Consulting people, professional associations, or ethical guidelines	15	50.00%
Consideration of various factors	12	40.0%
Discussing ethical dilemmas with the client	11	36.67%
Avoiding Dual Roles	7	23.33%
Evaluating on the outcome of the decision	3	10.0%
Documentation of decision-making process	2	6.67%

Note. Total *N* for narrative responses = 30.

Table 15

Strategies Used by Respondents When Faced With Ethical Dilemmas, as Indicated Through Multiple Choice Format

Strategy	<i>N</i>	Percentage of Respondents Who Selected This Approach
Review of Ethical Laws and Guidelines	28	93.3%
Consultation	27	90.0%
Discussing the Issue With the Client	24	80.0%
Intuition	7	23.3%
Attending to Emotional Reactions	4	13.3%
Utilization of a Specific Decision-Making Model	2	6.7%
Other: Please Specify	1	3.3%
- Response: "Discussing issue with patient or others directly involved (e.g., other therapist, intern, etc.)"		

Note. Participants were asked to indicate the three responses most often used when engaged in ethical decision-making. Of the total participants who responded to the question ($N = 30$), 26 chose three strategies as directed, 3 respondents chose more than three strategies, and 1 participant chose less than three strategies.

Table 16

Respondent Identification with Given Models for Ethical Decision-Making Related to Dual-Role Dilemmas

Model Most Similar To Personal Decision-Making Style	<i>N</i>	Percentage of Respondents Who Selected This Model
Worst Case Scenario	9	30.0%
Risk-Management Model	9	30.0%
Gottlieb's Three-Factor Model	5	16.7%
Sonne's Four-Factor Model	4	13.3%
Role Theory Model	3	10.0%

Note. Total *N* = 30

Table 17

Respondents' Reported Confidence in Appropriateness of Decision Following Use of Ethical Decision-Making Method

Level of Confidence	<i>N</i>	Percentage of Respondents Who Indicated This Level of Confidence
Extremely Confident (76-100% confident that appropriate choice was made)	13	43.3%
Very Confident (51-75% confident that appropriate choice was made)	10	33.3%
Moderately Confident (26-50% confident that appropriate choice was made)	7	23.3%
Slightly Confident (25% or less confident that an appropriate choice was made)	0	0.0%
Not at all confident	0	0.0%

Note. Total *N* = 30

Research question 4. This question, which examined the level of well-being of participants in the present study compared to levels of well-being reported for the normative study on the Friedman Well-Being Scale, indicated a significant difference. The participants of the current study had an FWBC composite mean which was significantly lower than that of the college students from the normative study, with a large effect size (-0.85). See Table 18 for the t-test results.

Table 18

T-test Comparing Current Study's FWBC Central Tendency Result With that of the Original Normative Study, Assuming Equal Variances

Study	Mean	Standard Deviation	<i>N</i>	<i>t</i>	<i>p</i>	Cohen's <i>d</i>
Love, 2015 (Current Study)	53.88	8.60	29			
Minnesota College Student Study (no date) used by Friedman (1994) for normative data. *	63.04	12.56	105	-3.70	<.01	-0.85

Note. * Indicates data reported in the Friedman Well-Being Scale Manual (Friedman, 1994)

Research question 5. There were mixed results regarding similarities and differences between the current study's scores and the normative scores (Maslach et al., 2010) for the three dimensions of the MBI-HSS. Table 19 shows the t-test results.

T-test analysis examining the means on the dimensions of EE and DP from the current study and those of the normative sample showed no significant difference. T-test analysis comparing the current sample's mean score and the normative sample's mean score for the PA dimension showed a significant difference. The PA mean score of the current study's participants was significantly higher than the PA score in the normative study, with a large effect size ($d = 1.80$).

Table 19

T-test Comparing Current Study's Emotional Exhaustion, Depersonalization, and Personal Accomplishment Central Tendency Results with those of the Normative Study, Assuming Equal Variances.

Study	Mean	Standard Deviation	<i>N</i>	<i>t</i>	<i>p</i>	Cohen's <i>d</i>
EE Dimension:						
Love, 2015 (Current Study)	17.07	11.03	29			
Normative Study Data for Mental Health Practitioners *	16.89	8.90	730	0.11	0.92	0.02
DP Dimension:						
Love, 2015 (Current Study)	4.52	4.51	29			
Normative Study Data for Mental Health Practitioners*	5.72	4.62	730	-1.37	0.17	-0.26
PA Dimension:						
Love, 2015 (Current Study)	41.90	5.87	29			
Normative Study Data for Mental Health Practitioner *	30.87	6.37	730	9.17	<.01	1.80

Note. * Indicates data from the Maslach Burnout Inventory Manual (Maslach et al., 2010). EE = Emotional Exhaustion; DP = Depersonalization; PA = Personal Accomplishment.

Research question 6. In regard to the question of the frequency with which clients' inability to pay results in termination of services, the majority of respondents ($N = 26$, 60.5%) indicated that they turn away clients at least some of the time each year. Of the total individuals that responded to the question ($N = 43$), 12 individuals (27.9%) indicated terminating or turning away between 1 and 5 clients per year. There were 6 respondents (14.0%) who turned away between 6 and 10 clients annually, while 5 (11.6%) turned away 16 or more clients annually. The least endorsed category was 11-15 clients per year ($N = 3$, 7.0%). In contrast, 17 individuals

(39.5%) indicated that they never turned away clients or prematurely terminate services due to the client's inability to pay.

Summary

The study examined the experiences of rural and small-town clinicians as these pertained to encounters with ethical dilemmas, decision-making strategies, and levels of clinician well-being and burnout. Both quantitative and qualitative analyses served to answer four research hypotheses and six research questions which directed the present study. Despite the small number of participants (60 total participants began the study, and 29 participants completed the full survey), a few significant results and meaningful qualitative themes were found.

Significant findings.

Predicting Emotional Exhaustion, a burnout factor. Significant correlations were found between frequency of ethical dilemmas encountered and the MBI dimension of EE, as well as between level of discomfort related to ethical dilemmas and EE. A simple regression analysis indicated that EE can be predicted when frequency of ethical dilemmas and/or level of discomfort related to ethical dilemmas are known.

Ethical dilemmas strongly endorsed. Participants indicated that two of four ethical dilemma types were experienced by the most participants. The most frequently endorsed dilemma type was that of dual roles. Therapist visibility dilemmas were the second most endorsed dilemma type.

Decision-making strategies utilized by participants. Data collected indicated a number of trends regarding the decision-making strategies of participants in the study. The majority indicated that they utilized a case-by-case approach when engaged in ethical decision-making,

rather than applying one rule to all situations. In addition, the majority of respondents utilized multiple strategies when addressing ethical dilemmas.

Ethical decision-making strategies most frequently endorsed by participants included consultation, reviewing ethical laws and guidelines, and discussing the ethical issue with the client. A strong emphasis was placed upon reducing the likelihood of harm or risk to the client by a number of participants. A number of participants also emphasized avoiding dual roles whenever possible.

Helpfulness of decision-making strategies. Participants indicated that their decision-making strategies were helpful in two ways. Decision-making strategies were attributed with alleviating stress related to ethical dilemmas by the majority of respondents who completed the survey. In addition, all respondents who completed the survey indicated that they felt at least moderately confident in the appropriateness of the decision made following use of the decision-making strategy.

Well-Being and burnout dimensions of study participants compared with normative samples. When compared with participants in the original normative studies for the MBI-HSS and the FWBS, participants of the present study varied in similarity with the normative samples. In regard to the FWBS normative study with a college student sample, participants in the current study showed significantly lower scores than the normative sample, indicating a large effect size. When compared with the MBI-HSS normative study sample with mental health practitioners, the levels of EE and DP were largely similar. However, mean PA scores of participants in the current study were significantly higher than mean scores of participants in the normative study, indicating a large effect size.

Denial of mental health treatment due to financial constraints. Regarding the

frequency with which participants turned away clients or denied services due to a client's inability to pay, the frequencies varied. It is notable that the majority of participants indicated that they turned away clients or discontinued services at least some of the time annually due to a client's inability to pay.

In Chapter 5, the study's results are discussed and limitations of the study are presented. In addition, suggestions for future research are proposed.

Chapter 5: Discussion

The study investigated the experiences of rural and small town mental health practitioners' experiences with ethical dilemmas, decision-making strategies, and levels of well-being and burnout. A combination of quantitative and qualitative data enriched understanding of participant self-reports. This chapter examines significant findings in light of the literature reviewed in Chapters 1 and 2. Limitations of the study are considered, and avenues for future research are delineated.

Internal Consistency Reliabilities

Author-created measures on frequency and level of discomfort with ethical dilemmas yielded moderately low, though acceptable reliability. Internal consistency reliability of the Friedman Well-Being Composite score was excellent. Reliability of the three dimensions of burnout measured by the Maslach Burnout Inventory, Human Services Survey varied; Emotional Exhaustion (EE) yielded excellent reliability, while Depersonalization (DP) and Personal Accomplishment (PA) yielded good reliabilities.

Significant Findings

Frequency and level of discomfort of ethical dilemmas as predictive of EE. EE is a sense of exhaustion characterized by professionals feeling that they are devoid of resources and unable to cope with challenges (Maslach et al., 2001). The findings that frequency and level of discomfort with ethical dilemmas predicted EE supported two of the study's research hypotheses. As noted by Helbok et al. (2006), rural clinicians are likely to experience internal conflicts resulting from encounters with ethical dilemmas. Though Helbok et al. specifically referred to dual role dilemmas, other types of ethical dilemmas likely also result in internal conflicts as clinicians attempts to resolve them.

As clinicians encounter various dilemmas as a part of rural practice and living, they likely reflect on these dilemmas by using known information to make appropriate decisions. Participants largely endorsed a case-by-case approach to address ethical dilemmas rather than using a standard template application of the APA Ethical Principles. Owing to this process of analyzing ethical dilemmas contextually on a case-by-case basis, it is not surprising that as encounters with dilemmas increased in frequency, the likelihood for EE likewise increased. Given Maslach and Goldberg's (1998) conceptualization of EE as "...the basic stress dimension of burnout." (p. 64), it makes sense that the level of discomfort caused by ethical dilemmas would predict EE. As rural clinicians experience increased distress over ethical dilemmas and increased EE, we may consider this experience as a possible early sign of increased rates of burnout later on (Maslach & Leiter, 2008).

Dual role and visibility dilemmas most frequently reported. Dual role dilemmas were most commonly endorsed by participants. There is a large amount of literature on this topic, and numerous decision-making models solely address this type of dilemma. The high frequency of reported dual role dilemmas was not surprising, given what the literature informs about the culture of rural towns and their inhabitants. The distance from large cities and limited availability of services (Cohen, 1993), paired with distrust of outsiders (Schank & Skovholt, 1997), increase the likelihood that rural residents will seek services from those they know. As a rural clinician seeks acceptance from the community, engagement with the town's people is critical. However, this community involvement increases the likelihood for dual role dilemmas.

Visibility was the second most frequent type of dilemma. Although the literature clearly supports the notion that rural clinicians are more readily visible than their counterparts in other areas (Helbok, 2006; Pugh, 2007) and the experience of resultant stress (Werth et al., 2010), this

finding was surprising because dilemmas of competence and confidentiality were endorsed less frequently than visibility. APA (2002) provides mandatory principles about therapist competence and confidentiality, but does not even suggest guidelines for managing clinician visibility. It is possible that this absence of guidelines around visibility contributes to therapist discomfort around visibility dilemmas. APA generally offers some guidelines for determining when an issue is problematic and when it is not. With no such guidance from APA or other governing bodies about clinician visibility, the responsibility for professional behavior rests solely upon an individual clinician. Clinician visibility is markedly different from the other dilemma types measured in the study. While dual roles, competence issues, and, to a lesser degree, confidentiality concerns, can be planned for and steps can carefully be considered before acting, these types of prevention are not true for visibility concerns. While the rural clinician can certainly reduce the likelihood of visibility concerns by going out of town for religious services, etc., it would be nearly impossible to plan for all instances of visibility. Visibility issues generally arise unexpectedly and are often beyond the control of the clinician, which likely exacerbate the negative feelings around this type of concern.

The nature of dual role and visibility dilemmas in rural communities, coupled with their frequency compared to that of other dilemmas, are cause for concern for potential clinician burnout. Maslach et al. (2001) said that the likelihood of burnout is higher for individuals who do not have an active role in decision-making. Although the participants delineated decision-making strategies for ethical dilemmas, it is notable that visibility and dual-role dilemmas are at times beyond the control of the clinician. For example, a clinician's child may be in the same class at school as the clinician's child client, or the clinician and client may both be invited to the same social gathering. Likewise, the clinician may have little control over which aspects of his or her

life are observed by community members and perhaps known to clients. Maslach et al. also indicated that role conflict on the job is related to burnout. When a clinician lives and works in the same small community, it is possible that resulting role conflicts for the clinician may lead to the clinician's burnout.

Decision-making methods. The decision-making methods most frequently endorsed by participants was consultation, followed by discussing the issue with the client, reviewing ethical standards, laws, and guidelines, focusing on harm reduction, and considering various other factors (e.g., potential benefits to client, other resources available to the client, etc.). These strategies are largely supported by the literature on ethical decision-making (cf. Hill et al., 1995) and may indicate appropriate decision-making by clinicians in the study.

Consultation. Consultation is recommended as an important step in ethical decision-making (Gottlieb, 1993; Roberts et al., 1999), and is included in a number of decision-making models (CPA, 2000; Gottlieb, 1993; Younggren & Gottlieb, 2004). Participants frequently cited consultation as a method used for ethical decision-making. This is a positive action that reduces the likelihood of clinicians making errors in judgment due to lack of feedback or subsequent rationalization of unethical behaviors when a clinician acts in isolation. However, clinicians must remain mindful of selecting appropriate colleagues for consultation. Gottlieb indicated that a consultant's understanding of a client's issues and familiarity with pertinent ethical issues are imperative. Younggren and Gottlieb noted that a consultant should have experience in the treatment methodology that is being used, as well as an understanding of relevant ethical and legal issues. In a rural area, where availability of services is often sparse, it is likely that consultative colleagues may only be available at a distance or by phone. Clinicians may be tempted to engage in consultation with whoever is available, which may not result in appropriate

feedback or insights.

Discussing the dilemma with the client. Participants often cited having a discussion with the client as a form of resolving ethical dilemmas. The inclusion of the client in the decision-making process is a recommended part of many decision-making models (CPA, 2000; Gottlieb, 1993; Hill et al., 1995; Ridley et al., 2001). Clinicians are, conversely, cautioned about including clients in the decision-making process. First, Erickson (2001) emphasized that the responsibility for making an ethical choice lies not with the client, but with the clinician. As a result, the clinician must determine what he or she believes is the most ethical course of action, even if this is not in agreement with the client's wishes. In addition, the power differential inherent in the therapist–client relationship may impact the client's capacity for objective decision-making (Kitchener, 1988); for instance, the client may want to please the clinician, be negativistic toward the clinician, be avoidant, or experience additional stress. As a result, it is important for the clinician to remain cognizant of the clinical implications when engaging the client in decision-making.

Reviewing ethical laws and guidelines. Clinicians often referred to ethical guidelines and laws when attempting to address ethical dilemmas. This demonstrated a desire in clinicians to abide by the ethical and legal expectations of the field. However, Barnett et al. (2002) noted that the APA ethics code serves as a set of guidelines for ethical practice but does not provide solutions to dilemmas.

Focus on evaluating and reducing harm to the client. Participants indicated reduction of harm as a key consideration in ethical decision-making. They strove to practice Principal A of the APA ethics code (2002), which focuses upon promoting benefit and avoiding harm to a client. This observance is important because a clinician's poor choices can have a profound

negative impact on a client. Clinicians must also remain mindful of the importance of reducing harm to their own well-being and emotional state. If a clinician is not well or is experiencing burnout, the therapeutic work may become compromised and, thus, harm the client.

Consideration of various factors. Participants' consideration of various factors in ethical dilemmas is promising, suggesting recognition by them of the complexities of ethical decision-making. There are numerous gray areas inherent in rural mental health practice, and one must be cognizant of nuances at play and consider them in making a decision (e.g., Risks, benefits, alternative responses, nature of the dilemma, etc.).

Respondent relief from stress and confidence associated with decision-making strategies. At first consideration, it may appear promising that clinicians in the study reported relief in stress and development of confidence from decisions that resulted from their use of strategies. The social and professional isolation of rural clinicians (Helbok, 2003; Schank & Skovholt, 2006) may preclude appropriate collegial feedback and consultation. It is noted that confidence in one's decision, if achieved in the absence of feedback from colleagues, may not be indicative of sound decisions.

Brown et al.'s research (2011) indicated that when an individual has previously established moral propriety, he or she is more likely to rationalize immoral behaviors in ambiguous situations. In the case of the rural clinician who has joined a professional association and pledged adherence to that association's ethical code of practice, this can amount to a person establishing one's moral credentials. As argued in the present study, ethical dilemmas are ambiguous in nature. Thus, when faced with an ethical dilemma, it is likely that poor decisions, when made in isolation, can be easily rationalized by the clinician. Thus, survey participants' confidence in their decisions might have either reflected confidence because an appropriate

choice was made, or might have been an effect of rationalization or poor clinical judgment.

Gottlieb, Handelsman, and Knapp (2013) noted that distress around ethical dilemmas can hinder one's capacity for appropriate decision-making. Gottlieb et al. indicated that cognitive processes are hindered when one is distressed. It is possible that the distressed clinician, in the absence of appropriate consultation, will act hastily, or view the problem too simplistically (Gottlieb et al., 2013). It may be helpful for clinicians to assess their level of distress around an ethical dilemma, and to seek consultation if their level of distress is moderate. However, it is also possible that as distress increases, a clinician's capacity for objectively assessing one's own level of distress is hindered.

Significantly lower overall well-being (FWBC) of study participants when compared to college student normative sample. When compared with college students, the participants had significantly lower FWBC scores. With consideration of the social advantages and activities afforded to college students in comparison to the social isolation of rural practitioners (Cohen, 1993), it is hypothesized that social support might be responsible for the differences in FWBC scores. Although some college students can be socially isolated, there are many opportunities for college students to form social ties. In addition to interest clubs and academic and sports activities, the concentration of individuals on a campus can improve the likelihood of social ties through proximity. In addition, the college environment is generally predictable and organized, while career experiences, particularly those of mental health workers, can be unpredictable and stressful.

Other resources available to college students may outweigh the resources available to rural mental health practitioners. Most college campuses provide student counseling centers, where college students can seek mental health services as needed. Because rural areas have

sparse availability of such services (Cohen, 1993), a rural clinician may have a more difficult time resolving personal mental health issues. Linley and Joseph (2007) found personal therapy to be important for therapist growth. The lack of access to personal therapy services could be problematic for clinician well-being.

Rural therapists can be socially isolated for a number of reasons. These may include demographic characteristics of the therapist, such as age, sex, and cultural characteristics, when these vary from the dominant characteristics of the rural community (Cohen, 1993). There may be values differences between the therapist and the rural community (Schank & Skovholt, 2006); the therapist may be liberal, while the rural community may be conservative and traditional. Rural communities' distrust of outsiders (Schank & Skovholt, 2006) and of higher education (Kersting, 2003) are likely to leave the rural clinician feeling like a stranger. Social well-being can affect other areas of an individual's well-being, such as career and health (Rath & Harter, 2010). As explained by Rath and Harter, it is important for individuals to develop meaningful community involvement. Notably, some narrative responses from clinicians of the study indicated social isolation, even when the question at hand was not probing for it.

Significantly higher Personal Accomplishment of study participants when compared to mental health practitioner normative sample. PA refers to feelings of effectiveness in one's work, and is generally low in individuals who are experiencing burnout (Maslach et al., 2001). The higher PA mean score of the study participants compared to that of the normative sample in the MBI-HSS instrument development study may indicate a positive aspect in rural and small-town mental health practice. It is notable that the original normative data were first available in the first edition of the Maslach Burnout inventory manual, which was published in 1981 (Maslach et al., 2010). This normative sample of 730 mental health workers was made up

of psychologists, counselors, psychiatrists, psychotherapists, and staff from mental hospitals (Maslach et al., 2010). Wright (2005), in her review of the Maslach Burnout Inventory, noted that the demographics of the overall sample (not just mental health workers) consisted of approximately 60% females. The present study of rural clinicians consisted of approximately 78% females. Although the specific demographic data for the mental health practitioner normative group were not accessible to the author of the present study, one could speculate that the difference in distribution of males vs. females between the studies may have contributed to the difference in Personal Accomplishment scores of the respective samples. It is also not known what percentage of the normative sample of mental health practitioners practiced in rural areas. In addition, it has been more than 30 years since the normative study was conducted. In that time, research and understanding of self-care and well-being, like many areas of mental health research since the 1980's, has expanded significantly. As a result, the differences in PA scores may be a reflection of society's increased understanding of self, self-improvement, self-empowerment, and self-discovery of personal strengths and achievements.

Although being the only or one of few mental health practitioners in a small isolated community may result in stressors and ethical challenges, there is also an opportunity for the clinician to be highly valued. Roberts et al. (1999) indicated that the mental health needs of rural residents are great. For the rural clinician, helping those with significant needs but few opportunities for getting help can lead to feelings of accomplishment. In addition, the visibility that can sometimes be problematic for therapeutic work can also serve as a positive factor. In larger urban and suburban areas, it is unlikely that practitioners will see clients outside of the office. A clinician in a rural setting, however, would be more apt to encounter clients functioning in their community, which may allow clinicians to observe the positive effects of mental health

treatment. When one considers these positive aspects of rural practice, it is not surprising that PA in rural clinicians was higher than in the normative sample.

Clients turned away due to inability to pay. The finding that the majority of respondents turned away clients due to their inability to pay for treatment at least some of the time may be cause for concern. As Cohen (1993) noted, rural residents tend toward higher levels of poverty and experience a scarcity of services in their areas. Rural mental health needs are great, and suicide rates in rural areas have surpassed those of metropolitan populations (Roberts et al., 1999). On the other hand, it is unreasonable to expect rural mental health clinicians to go without compensation. It is important that solutions to this treatment barrier, (i.e., lack of access), be sought in order to decrease the likelihood that rural clients go without needed services due to their inability to pay.

Limitations of the Study

Sample size. The study's small sample size is a particularly salient limitation. Despite significant recruitment efforts, only 60 individuals participated in the study. This number was below the projected sample of 102 participants. As such, participant diversity and the ability to detect even small effect sizes were limited. The online survey method was perhaps partially responsible for the low response rate. Web-based surveys have been shown to yield 11% less responses than other methods, such as mail surveys (Manfreda, Bosnjak, Berzelak, & Vehovar, 2008); so the low response rate was not surprising. In addition, a number of the organizations contacted indicated that their members had expressed feeling inundated by requests for participation in online surveys. With the advent of internet communication and the decrease in personal communications and hard copy mailings, it may be easy to dismiss online survey requests, which occur often. Other medium may elicit more consideration from potential

respondents, such as in-person or short telephone surveys.

Difficulty recruiting participants due to organizational policies contributed to the small sample size. Many of the organizations that replied to the recruitment request indicated that their respective organizations had a policy that prohibited the forwarding of survey requests to members. This professional policy reduced the recruitment pool. In addition, the narrow participation criteria (e.g., practicing in a community of 25,000 or less) limited the number of individuals who could participate in the study; however, these criteria were necessary to ensure that the intended population and phenomena were studied.

The survey required commitment on the part of the respondent, as it required reading, as well as short essays by the participant. It is likely that there was some non-response bias, in the sense that burnt-out clinicians, suffering from Emotional Exhaustion and low Personal Accomplishment, may not have had the energy to complete the survey or may have been too overwhelmed with work tasks to participate.

Participant drop-out. A significant factor which affected the results was participant drop-out. Of the 60 individuals who began the study, 31 individuals (51.67%) dropped out prior to completing the study. The survey did not include a participant feedback section, so reasons for drop-out are largely unknown. However, examination of drop-out points and completion time were considered in attempting to understand the reasons for drop-out.

Time commitment. Active time spent on the survey varied widely among participants. Some individuals spent less than one minute on the survey prior to dropping out, while one individual took over 9 hours to complete the survey, indicating that perhaps he or she left the survey open for completion later in the day. Of the 29 individuals who completed the survey, 23 (79.31%) completed the survey in 30 minutes or less, which was the time estimated in the

informed consent. There were six individuals (20.69%) who completed the survey, but took longer than the estimated 30 minutes to do so. However, time spent is not thought to be the reason for drop-out because most individuals who completed the survey did so within the estimated time. Only one of the individuals who did not complete the survey had taken more than the estimated survey completion time at the time of drop-out.

Drop-out points. Individuals dropped out of the survey at three distinct points: (a) question 6, (b) question 22, and (c) question 13. In addition, one individual discontinued the survey at question 29. As a result, it is likely that the content or task required from the survey at the three drop-out points might have been responsible for participant drop-out.

Most of the individuals (54.84% or 17 out of 31) who did not complete the survey dropped out at question 6: "What is the population size of the community in which you practice?" It is possible that individuals who did not notice the section of the informed consent which pertained to population size then re-examined the participation criteria when they reached this question and did not continue due to ineligibility. It is also possible that individuals who did not complete this question did not wish to expend the effort to look up population size data.

Several individuals dropped out of the study at question 22, which required reading descriptive paragraphs of ethical decision-making models and selecting the model which was most similar to the participant's own decision-making method. There were nine individuals (29.03%) who dropped out at this point. It is notable that this question marked a significant shift in the survey format. Prior to question 22, all questions consisted of multiple choice or open-ended responses. It is possible that participants were simply unwilling to engage in more complex thinking and, thus, dropped out of the study.

Finally, four participants (12.90%) dropped out without completing question 13, which

pertained to frequency of encounters with dual role dilemmas. It is possible that individuals were unsure how many dual role dilemmas they encountered or they felt distress when thinking about dual role dilemmas and opted to discontinue at that time.

One individual (3.23%) dropped out at question 29, which was the first question of the Friedman Well-Being Scale section of the survey. It is difficult to determine why the individual stopped participating because there was no open-ended question asking why individuals did not complete the survey.

Demographics. It is not appropriate to attempt to apply the results of the study to the general population due to the highly specific nature of the population surveyed. In addition, data are not readily available on demographics of rural psychologists in the United States. The demographics of participants from the current sample were examined in comparison to demographic data of APA members (APA Center for Workforce Studies, 2011). APA demographic data were chosen for comparison because it is expected that members of the APA hold similar professional roles and adhere to the same ethical principles as the rural clinicians surveyed for the present study.

The study's sample and APA members were similar in that women, Caucasians, and doctoral level individuals outnumbered men, individuals of racial and ethnic minority, and those with other degrees. However, distribution within gender and racial and ethnic categories varied between the study's sample and APA members. The present study consisted of 78.3 % females and 21.7% males, compared to 57% and 43%, respectively, for APA members. Caucasian Americans comprised 83.3% of the study's sample, while racial or ethnic minority participants made up 16.7%. In the comparison group of APA members, Caucasian and racial and ethnic minorities represent 90% and 10% of individuals, respectively.

Suggestions for Future Research

Creating operational definitions of rural. Varying definitions of *rural* led to difficulty determining appropriate inclusion and exclusion criteria for the study. Although the literature is rich with exploration of rural experiences, there is little agreement on a concrete definition of the term “rural” in psychology. It would be helpful to future research on rural psychology if a widely agreed upon definition could be determined. It would likely be helpful for developers of such a definition to consider various factors, including population size, availability of resources, rural culture and values, etc.

Examining various well-being factors of rural clinicians. It was beyond the scope of the present study to examine rural clinicians' well-being in depth. However, it may be helpful for future research to focus on this aspect of the rural clinician's mental health. There are numerous facets of well-being, such as Career, Social, Financial, Community, and Physical well-being (Rath & Harter, 2010). Additional research focused on the functioning of rural clinicians in relation to each of the well-being facets described by Rath and Harter may pave the way for the development of specific interventions focused on enhancing rural clinicians' well-being in needed areas.

Exploring differences in well-being between rural and urban clinicians. The present study focused solely on clinicians in micropolitan areas. It is not yet known whether there are significant differences in the well-being of clinicians in rural areas when compared to their urban counterparts. Future researchers may consider exploring this aspect to determine whether interventions aimed at increasing the well-being of rural clinicians may be warranted.

Examining appropriateness of decisions based on various strategies. Although Hill et al. (1995) asserted that there is generally not a correct choice in ethical dilemmas, only one that

feels better to the decision-maker, it is certainly possible to make poor choices in clinical practice. The variety of ethical decision-making strategies available to clinicians allows flexibility in decision-making. One particular area of paucity is the effectiveness of various decision-making strategies. While it is likely that a number of strategies can lead to appropriate decision-making, it is not clear whether some strategies are more effective than others. It is also possible that some strategies, such as, proceeding with a decision without consulting colleagues, may lead to poor decision-making. It would be helpful for research to focus on the effectiveness of various decision-making methods.

The effects of therapist visibility on treatment and efficacy. Perhaps the most surprising finding was the frequency and distress related to visibility dilemmas. Although the APA (2002) does not proscribe visibility as an ethical issue, it may be beneficial for researchers to study the effects of therapist visibility on treatment and outcomes.

Engaging burned-out clinicians in research. It is likely that individuals who are experiencing burnout do not feel capable of participating in research on the subject. In order to fully understand the rural clinician's experience of burnout and to seek solutions, it will be important to obtain insight from clinicians experiencing burnout. Future research may focus on ways for increasing the engagement of clinicians who are experiencing burnout. For instance, there are clinicians who seek therapy for themselves. Clinics could collect anonymous data from clinician-clients to inform healthcare policy on the needs of clinicians. This data collection could occur at the systems level. Or clinicians who provide therapy to clinicians could be asked to report anonymously and confidentially on their general observations of their clinician clientele. Supervision textbooks could carry vignettes from supervisors who have supervised burned out early career professionals. The APA website could also carry an online survey like that of the

present study to assess anonymously and confidentially the well-being of its members who are practicing licensed psychologists. The results of such a survey may influence changes in the next revision of the APA Code of Ethics or, at least, in the formation of an APA Presidential Task Force to deliberate on the well-being of rural psychologists and produce a report on their deliberations and recommendations.

Examining payment alternatives. One particularly concerning finding is that many participants turned away clients at least some of the time due to non-payment of fees. This is particularly concerning because in rural areas, mental health needs are high and services are often scarce. Researchers and practitioners would benefit from determining solutions to the financial cause of low access.

Conclusion

Although this study was limited by a number of factors, important relationships were discovered in rural and small town mental health practice and burnout factors. The present study was unique in its focus on the well-being of mental health clinician in rural communities. Most of the literature to date simply examines the types and prevalence of rural ethical dilemmas but not on potential effects clinicians experience as a result (cf. Cohen, 1993; Hargrove, 1986; Helbok, 2003; Schank & Skovholt, 2006). The ethical principles of psychologists (APA, 2002) implore clinicians to avoid harm to the client. This standard may become compromised if rural practitioners are unable to care for themselves due to simply practicing in a rural area. Moreover, ethical decision-making, in general, may be compromised due to a lack of resources (e.g., colleagues in close proximity, visibility concerns). The findings of the study indicate that further examination of rural clinician well-being, burnout, and decision-making methods is needed. Factors that contribute to practitioner burnout in rural areas must be given attention to provide

prevention and resources in contrast to providing a booklet of the APA code of ethics that psychologists follow at the individual level. In order to address some of these concerns, it may be helpful for rural mental health networks to be developed. These networks could provide access to consultation by those familiar with the struggles of rural mental health practice. Also, APA could develop specific guidelines for ethical rural practice as a supplement to the universal ethics code. In addition by inviting input from rural clinicians, specific decision-making models could be developed for the unique challenges of rural practice.

This small study, while limited in scope, served to elucidate some of the concerns encountered by rural mental health practitioners. If the well-being of rural and small-town clinicians is emphasized, and burnout is prevented, rural and small town mental health care recipients are also likely to benefit, as practitioner morale, retention, vitality, and effectiveness would likely be improved.

References

- Ambler, V. M. (2008). Who flourishes? The criteria of complete mental health. In S. J. Lopez (Ed.), *Positive psychology: Exploring the best in people* (pp. 1-20). Westport, CT: Praeger Publishers.
- American Psychological Association (2002). Ethical principles of psychologists and code of conduct. Washington, DC: American Psychological Association.
- American Psychological Association (2010). 2010 amendments to the 2002 "Ethical principles of psychologists and code of conduct." *American Psychologist*, 65, 493.
- American Psychological Association Center for Workforce Studies (2011). *Current major field of APA members by membership status*. Retrieved July 13, 2014 from <http://www.apa.org/ads/about/ad-demographics.pdf>
- Anastasi, A. A., & Urbina, S. (1997). *Psychological Testing* (7th ed.). Upper Saddle River, New Jersey: Prentice Hall.
- Bachtel, E. G. (1996). *Out in the country: A phenomenological exploration of the therapist's experience of small town practice* (Doctoral dissertation, Massachusetts School of Professional Psychology). Retrieved from <http://www.proquest.com>
- Barnett, J. E., Behnke, S. H., Rosenthal, S. L., and Koocher, G. P. (2007). In case of ethical dilemma, break glass: Commentary on ethical decision making in practice. *Professional Psychology: Research and Practice*, 38, 7-12.
- Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research In Psychology*, 3, 77-101.

- Brown, R. P., Tamborski, M., Wang, X., Barnes, C. D., Mumford, M. D., Connelly, S., and Devenport, L. D. (2011). Moral credentialing and the rationalization of misconduct. *Ethics & Behavior, 21*, 1-12. doi:10.1080/10508422.2011.537566.
- Campbell, C. D., and Gordon, M. C. (2003). Acknowledging the inevitable: Understanding multiple relationships in rural practice. *Professional Psychology: Research and Practice, 34*, 430-434. doi:10.1037/0735-7028.34.4.430
- Canadian Psychological Association. (2000). *Canadian code of ethics for psychologists* (3rd. ed.). Retrieved from <http://www.cpa.ca/cpsite/userfiles/Documents/Canadian%20Code%20of%20Ethics%20for%20psycho.pdf>
- Cohen, D. (1993). Occupational hazards of the rural psychologist. *Psychotherapy in Private Practice, 10*, 13-35.
- Coster, J. S., & Schwebel, M. (1997). Well-functioning in professional psychologists. *Professional Psychology: Research and Practice, 28*, 5-13.
- Cummins, R. A. (2013). Positive psychology and subjective well-being homeostasis: A critical examination of congruence. In A. Efklides and D. Moraitou (Eds.), *A Positive Psychology Perspective on Quality of Life* (pp. 67-86). Social Indicators Research Series, 51. doi: 10.1007/978-94-007/978-94-007-4963-4_5
- Diener, E., & Lucas, R.E. (1999). Personality and subjective well-being. In D. Kahneman, E. Diener, & N. Schwarz (Eds.), *Well-being: The foundations of hedonic psychology* (pp. 213-229). New York, NY: Russell Sage Foundation.
- Erickson, S. H. (2001). Multiple relationships in rural counseling. *The Family Journal: Counseling and Therapy for Couples and Families, 9*, 302-304.

- Firth, H., McKeown, P., McIntee, J., & Britton, P. (1987). Professional depression, “burnout” and personality in longstay nursing. *International Journal of Nursing Studies, 24*, 227-237.
- Friedman, P. H. (1994). *Friedman Well-Being Scale and professional manual: Sampler set: Manual, instrument, and scoring guide*. Retrieved from <http://www.mindgarden.com/products/fwbs.htm>
- Gottlieb, M. C. (1993). Avoiding exploitative dual relationships: A decision-making model. *Psychotherapy, 30*, 41-48.
- Gottlieb, M. C., Handelsman, M. M., and Knapp, S. (2013). A model for integrated ethics consultation. *Professional Psychology: Research and Practice, 44*, 307-313. doi: 10.1037/a0033541
- Hargrove, D. S. (1986). Ethical issues in rural mental health practice. *Professional Psychology: Research and Practice, 17*, 20-23.
- Hart, L. G., Larson, E. H., and Lishner, D. M. (2005). Rural definitions for health policy and research. *American Journal of Public Health, 95*, 1149-1155. doi: 10.2105/AJPH.2004.042432
- Helbok, C. M. (2003). The practice of psychology in rural communities: Potential ethical dilemmas. *Ethics and Behavior, 13*, 367-384.
- Helbok, C. M., Marinelli, R. P., & Walls, R. T. (2006). National survey of ethical practices across rural and urban communities. *Professional Psychology: Research and Practice, 37*, 36-44. doi: 10.1037/0735-7028.37.1.36

- Hill, M., Glaser, K., & Harden, J. (1995). A feminist model for ethical decision making. In E. J. Rave & C. C. Larsen (Eds.), *Ethical decision making in therapy: Feminist perspectives*. New York: The Guilford Press.
- Kersting, K. (2003, June). Teaching self-sufficiency for rural practice. *Monitor on Psychology*, 34(6). Retrieved from <http://www.apa.org/monitor/jun03/teaching.aspx>
- Keyes, C. L. M. (2003). Complete mental health: An agenda for the 21st century. In C. L. M. Keyes and J. Haidt (Eds.), *Flourishing: Positive psychology and the life well-lived* (pp. 293-312). Washington, DC: American Psychological Association.
- Kitchener, K. S. (1988). Dual role relationships: What makes them so problematic? *Journal of Counseling and Development*, 67, 217-221.
- Leiter, M. P., & Durup, J. (1994). The discriminant validity of burnout and depression: A confirmatory factor analytic study. *Anxiety, Stress, & Coping*, 7, 357-373.
- Linley, P. A., & Joseph, S. (2007). Therapy work and therapists' positive and negative well-being. *Journal of Social and Clinical Psychology*, 26, 385-403.
- Manfreda, K. L., Bosnjak, M., Berzelak, J., Haas, I., & Vehovar, V. (2008). Web surveys versus other survey modes. *International Journal of Market Research*, 50, 79-104. Accession number: 27996448
- Maslach, C. (2003). Job burnout: New directions in research and intervention. *Current Directions in Psychological Science*, 12, 189-192.
- Maslach, C., & Goldberg, J. (1998). Prevention of burnout: New perspectives. *Applied and Preventive Psychology*, 7, 63-74.
- Maslach, C., Jackson, S. E., & Leiter, M. P. (2010) *Maslach Burnout Inventory manual* (3rd ed.). Retrieved from <http://www.mindgarden.com/products/mbi.htm>

- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology, 52*, 397-422.
- Meier, S.T. (1984). The construct validity of burnout. *Journal of Occupational Psychology, 57*, 211-219.
- Murray, J. D., & Keller, P. A. (1991). Psychology and rural America: Current status and future directions. *American Psychologist, 46*, 220-231. doi: 10.1037//0003-066X.46.3.220
- Nagy, T. F. (2011). *Essential Ethics for Psychologists: A Primer for Understanding and Mastering Core Issues*. Washington, DC: American Psychological Association.
- Pugh, R. (2007). Dual relationships: Personal and professional boundaries in rural social work. *British Journal of Social Work, 37*, 1405-1423. doi: 10.1093/bjsw/bc1088
- Reamer F. G. (1998). *Ethical Standards in Social Work: A Critical Review of the NASW Code of Ethics*. Washington, DC: NASW Press
- Rath, T., & Harter, J. (2010). *Well Being: The Five Essential Elements*. New York: The Gallup Press.
- Ridley, C. R., Liddle, M. C., Hill, C. L., & Li, L. (2001). Ethical decision making in multicultural counseling. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling (second edition)*. Thousand Oaks, CA: Sage Publications.
- Roberts, L. W., Battaglia, J. M., & Epstein, R. S. (1999). Frontier ethics: Mental health care needs and ethical dilemmas in rural communities. *Psychiatric Services, 50*, 497-503.
- Schank, J. A., & Skovholt, T.M. (1997). Dual-relationship dilemmas of rural and small-community psychologists. *Professional Psychology: Research and Practice, 28*, 44-49.

- Schank, J. A., & Skovholt, T. M. (2006). Rural practice: Illuminating dilemmas in one kind of small community. In J. M. Schank & T. M. Skovholt (Auths.). *Ethical practice in small communities: Challenges and rewards for psychologists* (pp. 75-115). Washington, DC: American Psychological Association.
- Seligman, M. E. P. (2011). *Flourish: A visionary new understanding of happiness and well-being*. New York, NY: Free Press.
- Sobel, S. B. (1992). Small town practice of psychotherapy: Ethical and personal dilemmas. *Psychotherapy in Private Practice, 10*, 61-69.
- Sonne, J. L. (2006). Nonsexual multiple relationships: A practical decision-making model for clinicians. Retrieved from: <http://kspope.com/site/multiple-relationships.php>
- U. S. Office of Management and Budget (2013). *OMB bulletin no. 13-01, Revised delineations of metropolitan statistical areas, micropolitan statistical areas, and combined statistical areas, and guidance on uses of the delineations of these areas*. Retrieved from <http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf>
- U. S. Bureau of the Census (1971). *Census of population: 1970. General population characteristics* (Final report, PC 1-B23). Washington, DC: U.S. Government Printing Office.
- VandenBos, G. R. (Ed.). (2007). *APA dictionary of psychology*. Washington, DC: American Psychological Association.
- Warr, P. (1999). Well-being and the workplace. In D. Kahneman, E. Diener, & N. Schwarz (Eds.), *Well-being: The foundations of hedonic psychology* (pp. 392-412). New York, NY: Russell Sage Foundation.

Werth Jr., J. L., Hastings, S. L., & Riding-Malon, R. (2010). Ethical challenges of practicing in rural areas. *Journal of Clinical Psychology: In Session*, 66, 537-548. doi:

10.1002/jclp.20681.

Wright, C. R. (2005). Review of Maslach Burnout Inventory, Third Edition. In the sixteenth mental measurements yearbook. Retrieved from Ebsco Mental Measurements Yearbook database.

Younggren, J. N., & Gottlieb, M. C. (2004). Managing risk when contemplating multiple relationships. *Professional Psychology: Research and Practice*, 35, 255-260. doi:

10.1037/0735-7028.35.3.255

Appendix A: Informed Consent
Ethical Dilemmas of Clinicians in Rural Practice

My name is Amithea Love, and I am a doctoral student in Clinical Psychology at Antioch University, New England, in Keene, NH. I am completing a dissertation as part of my doctoral degree requirement, and am requesting your participation in my study. The study is aimed at understanding rural clinicians' experience of ethical dilemmas.

Anticipated Participation Experience

This study consists of an anonymous online survey that asks some demographic questions and about various types of ethical dilemmas. Additionally, the survey covers professional issues and psychological reactions. Completion of the survey should not take more than thirty minutes in all.

Participation Criteria

Criteria for participation include the following:

- 1) You presently practice as a therapist in a rural community or small town. A rural or small town community is defined as one which:
- Has a population of less than 25,000 residents.
- Is at least 45 minutes away from the nearest city of 50,000 people or more.**
- 2) You reside in the same county in which you practice.**
- 3) You hold a graduate degree in psychology or a closely related field.**

Uses of Collected Data

Should you choose to participate, the data collected will be published in my dissertation. While brief quotations will be presented in the text of the dissertation because of their meaningfulness, most narrative answers will be paraphrased or grouped into overall themes. This dissertation will be available for public viewing.

Confidentiality

Steps have been taken to ensure your privacy. Though demographic data will be collected, you will not be asked for your name or email address, and electronic identifiers (such as IP addresses of computers) will not be collected.

Potential Participation Benefits

By participating in this study, you will likely experience some benefits. By reflecting on your experience, you may gain further understanding of your functioning as a psychologist. The opportunity to tell about your experience may also prove cathartic,

providing relief. By participating, you will be providing valuable knowledge about the experience of rural psychologists for the academic and practitioner community.

Potential Participation Risks

During the course of the survey, you may experience difficult emotions as a result of recalling the ethical challenges of rural practice. Should these emotions become too intense or painful, you may choose to discontinue your participation. In addition, discussing your experiences with fellow practitioners or therapists may prove helpful in working through these difficult feelings.

Your Participation is Voluntary

As a volunteer, you have the right to discontinue participation at any time, with no consequence to you. Further, you have the right to decline answering any of the questions, with no consequence to you.

Should you have any questions about this project, please feel free to contact me, Amithea Love (alove@antioch.edu; XXX.XXX.XXXX), or my dissertation advisor Gargi Roysircar (groysircar@antioch.edu; XXX.XXX.XXXX). Should you have any questions or concerns regarding your rights as a research participant, please contact Katherine Clarke, Chair of the Human Research Committee at Antioch University New England, at 603.283.2162. Alternatively, you may contact Leatrice Oram, Acting Vice President of Academic Affairs, at 603.283.2128; Antioch University New England, 40 Avon Street, Keene, NH 03431

**** Consent Statement****

I have read and understood all the information contained above. I have addressed questions which I previously had with the researcher, and these have been appropriately answered. I understand the benefits and risks of participating in this study, and I have received a copy of this form in its entirety.

By completing the following survey you hereby consent to participate in the study.

Appendix B: Survey

Part One: Informed Consent

Ethical Dilemmas of Clinicians in Rural Practice

My name is Amithea Love, and I am a doctoral student in Clinical Psychology at Antioch University, New England, in Keene, NH. I am completing a dissertation as part of my doctoral degree requirement, and am requesting your participation in my study. The study is aimed at understanding rural clinicians' experience of ethical dilemmas.

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Should you choose to participate, the data collected will be published in my dissertation. While brief quotations will be presented in the text of the dissertation because of their meaningfulness, most narrative answers will be paraphrased or grouped into overall themes. This dissertation will be available for public viewing.

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**** Consent Statement****

I have read and understood all the information contained above. I have addressed questions which I previously had with the researcher, and these have been appropriately answered. I understand the benefits and risks of participating in this study, and I have received a copy of this form in its entirety.

*****By completing the following survey you hereby consent to participate in the study.*****

Part Two: Demographic Information:

- 1) What is your age?
- 2) Sex
 - Male
 - Female
 - Other
- 3) What race do you assign yourself?
 - American Indian/ Native American
 - Asian
 - Black/ African American
 - Hispanic/ Latino
 - White/ Caucasian
 - Pacific Islander
 - Multiracial/Multiethnic
- 4) What is your highest level of education?
 - Master's Degree
 - Doctoral Degree
 - Other (Please Specify _____)
- 5) In which state do you reside and practice?
 - Alabama
 - Alaska
 - Arizona
 - Arkansas
 - California
 - Colorado
 - Connecticut
 - Delaware
 - Florida
 - Georgia
 - Hawaii
 - Idaho
 - Illinois
 - Indiana
 - Iowa
 - Kansas
 - Kentucky
 - Louisiana
 - Maine
 - Maryland
 - Massachusetts
 - Michigan
 - Minnesota

- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Washington
- West Virginia
- Wisconsin
- Wyoming
- Other. Please Specify _____

Part Three: Information on your Community:

- 6) What is the population size of the community in which you practice?
- 7) What is the distance (in miles) of your community from the nearest city of 50,000 people or more?
- 8) How far away is the next nearest therapist to you who practices with the same types of clients or presenting issues as you (or what is your drive time)?
- _____
- 9) How many years have you been practicing therapy?
- _____
- 10) In an average week, what is the size of your caseload (#of clients, both those who show and those who do not)
- 11) In an average week, what is the show rate of your caseload (___ %)

Part Four: Number of Ethical Dilemmas Encountered:

On a scale of 0 to 4, with the numbers specifying the following:

0	1	2	3	4
Never	1-4 times per year	5-8 times per year	9-11 times per year	12 or more times per year

How many times do you experience ethical dilemmas related to:

12) Dual Roles (Sometimes referred to as “multiple relationships” or “multiple roles”):

- 0 (Never)
 1 (1-4 times per year)
 2 (5-8 times per year)
 3 (9-11 times per year)
 4 (12 or more times per year)

13) Maintaining Client Confidentiality

- 0 (Never)
 1 (1-4 times per year)
 2 (5-8 times per year)
 3 (9-11 times per year)
 4 (12 or more times per year)

14) Limits of Therapist Competence

- 0 (Never)
 1 (1-4 times per year)
 2 (5-8 times per year)
 3 (9-11 times per year)
 4 (12 or more times per year)

15) Therapist Visibility in the Community

- 0 (Never)
 1 (1-4 times per year)
 2 (5-8 times per year)
 3 (9-11 times per year)
 4 (12 or more times per year)

Part Five: Ethical Decision-Making

Please read the following descriptions of two ethical decision-making models for general ethical decision-making:

Canadian Psychological Association's 10-step Decision-Making Model (Canadian Psychological Association, 2010):

A step-by-step process through which one first identifies parties that will be affected by one's decision, as well as the ethical issues which are involved. One then considers personal biases and motivations which may influence his or her decision. The clinician then determines several potential courses of action, while also considering the risks and benefits of each potential action. After selecting a course of action based upon ethics and values, the individual carries out the chosen action. Following the action, the clinician takes responsibility for any negative consequences that result and re-engages the decision-making where appropriate. In this process, consultation is emphasized. The clinician is expected to consult with stakeholders likely to be affected by the decision, as well as professional colleagues.

Feminist Ethical Decision-Making Model (Hill, Glaser, & Harden, 1995): A step-by-step process which emphasizes the importance of the clinician's emotional and intuitive instincts regarding the dilemma. There is also focus on the power differential inherent in the therapy relationship, as well as the cultural biases and values which may influence the process.

The process begins with the clinician's recognition of the problem, followed by delineation of the problem. This includes consideration of ethical principles and laws at play, while also identifying stakeholders in the decision. The clinician utilizes his or her affective and intuitive responses to guide him or her in understanding the problem. The clinician also considers the values which he or she is using to define the problem, attending to ways in which these values may differ from those of stakeholders.

When considering solutions, the clinician determines a number of potential solutions and considers the risks and benefits of each. The clinician focuses on ensuring maximal benefit and minimum harm to the client, while also attending to the clinician's affective responses and including the client in the consideration of various solutions.

The clinician then selects and carefully reviews a solution, attending to cognitive and emotional factors, as well as the practicality of the solution. The clinician also attends to his or her values and biases and the role which these play in the process. The clinician also remains cognizant of the power which he or she holds in the relationship. The decision is then reviewed with the client and understanding is sought. Finally, the clinician carries out the chosen solution, always remaining cognizant of the consequences and re-evaluating the decision when affective and cognitive intuitions indicate.

16) When faced with an ethical dilemma in general, which of the models described above is most similar to your decision-making strategy?

The Canadian Psychological Association's 10-step Decision-Making model

The Feminist Ethical Decision-Making Model

Please read the following descriptions of ethical decision-making models which pertain specifically to ethical decision-making related to dual-role dilemmas:

Worst Case Scenario (Nagy, 2011): When considering additional roles beyond the

professional relationship, one considers negative consequences that could occur. Even if the negative consequence is unlikely to happen, the clinician remains aware of the risks and strives to avoid harm to the client.

Role Theory Model (Kitchener, 1988): This model is focused on the roles which an individual is taking on in the additional relationship. The clinician is first asked to consider the compatibility of the expectations for each of the roles the clinician will be holding. The clinician then considers the obligations that are inherent in each role. Finally, the clinician considers the power differential between the roles of the clinician and those of the client. When there is incompatibility in role expectations, disparities between the obligations of the roles, and a great power differential, the potential for harm to the client is greater.

Three-Factor Model (Gottlieb, 1993): An extension of Kitchener's Role Theory model, this model is a step-by-step decision-tree model. Consultation on the matter with both a colleague and the client are emphasized prior to engaging in an additional role with the client. In this model, the clinician assesses both the current relationship with the client as well as the potential additional relationship, considering a number of factors. These factors include the power differential between client and clinician, the length of the relationship, and the nature of the termination of the initial relationship, if it has been terminated. The clinician also examines the level of compatibility between the current and potential roles.

Risk-Management Model (Younggren & Gottlieb, 2004): This model pertains specifically to decision-making when contemplating taking on an additional relationship with a client when currently engaged with the client as his or her therapist. This model stresses that it is usually best to avoid additional relationships with clients when possible. The importance of obtaining consultation is also stressed. The clinician is asked to consider the future consequences of his or her actions as they would be viewed by outside observers.

This model is presented as two sets of questions which the clinician should ask him or herself. The first set of questions is aimed at helping the clinician decide whether to move forward with an additional relationship. The questions relate to the necessity of the additional relationship, the potential for harm to the client, the potential for the client to benefit from the additional relationship, and the likelihood that the additional relationship will disrupt the therapy relationship.

The second set of questions presented in this model relates to risk management once the clinician has made the decision to move forward with the additional relationship. The authors note that this step is necessary because additional relationships pose risks to the client, the therapeutic relationship, and the practitioner. Among the questions the clinician is asked to consider are whether the decision-making process has been appropriately documented, the documentation of informed consent processes, documentation of consultation, and credibility of consultation professionals.

Sonne's Four-Factor Model (Sonne, 2006): The model is intended as a checklist of things for the clinician to consider prior to deciding to engage in an additional relationship with a client. The model consists of four sets of factors for the clinician to consider. These factors are: therapist factors, client factors, factors of the therapy relationship, and factors of other relationships. The therapist factors are those aspects which may influence one's decision-making such as culture, religious beliefs, gender, etc. Professional identity factors are also considered in this area, such as theoretical orientation and years spent as a therapist. Client factors include similar aspects as the therapist factors, such as culture and religious orientation. However, the therapist also considers psychological factors of the client, such as psychological and social development as well as past history of boundary violations. Factors of the therapy relationship can also influence ethical decision-making. These factors include such matters as the therapy setting, the community, the length of the relationship, and the balance of power. Finally, the clinician should consider factors related to the additional relationship that he or she is considering engaging in. Such factors include the psychologist's motivations for wanting to engage in the additional relationship, emotional responses to the prospective relationship, the potential for harm and benefit, as well as the likelihood of conflict between the roles of the therapy relationship and the additional relationship.

17) When faced with an ethical dilemma related to dual roles, which one of the models described above is most similar to your decision-making strategy?

- Worst Case Scenario
- Role Theory Model
- Gottlieb's Three-Factor Model
- Risk-Management Model
- Sonne's Four-Factor Model

18) Please describe your personal ethical decision-making strategy (about 200 words):

19) Do you make ethical decisions on a case-by-case basis, or do you utilize the same rule in all situations?

- Case By Case
- Same Rules All Situations

20) When faced with an ethical dilemma, what strategies do you use to resolve it? Please indicate the three strategies which you utilize most frequently (examples: consultation with colleague, talking through the issue with the client, etc.?)

- Consultation
- Intuition
- Discussing the issue with the client
- Attending to emotional reactions
- Review of ethical laws and guidelines

- Utilization of a specific decision-making model
- Other (Please specify).

Note: Friedman Well-Being Scale and Maslach Burnout Inventory items were also included in the survey, but are not shown herein due to copyright limitations.