Professional Ethics in Rural Canadian Psychology:
Understanding the Experiences of Practising Psychologists

by

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Certificate of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgement is made in the dissertation. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

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Judi L. Malone
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ABSTRACT

The context and ethical challenges of rural psychological practice are not often explored. Existing literature suggests that ethical dilemmas typically arise in relation to overlapping relationships, community pressure, generalist practice, interdisciplinary collaboration, and professional development. This in-depth interpretive inquiry of professional ethics involved twenty rural psychologists from across Canada. The focus of the series of three interviews was an exploration of participant experiences with professional ethics. The main research question was, “what ethical issues arise for you as a practising rural psychologist?” A secondary focus was on ethical development and the current sociohistorical context for professional ethics. Hermeneutic phenomenology, a qualitative form of inquiry, was used for analysis and to present rich understandings that connect with prior research, highlight new considerations, and describe the phenomenon within the Canadian context. The findings begin with an account of dominant sociohistorical considerations for psychologists. Identified by participants, these were: competition and concern over the delivery of services, the influence of government, the prescriptive authority debate, rural-specific registration and mobility concerns, and insufficient professional advocacy. These dimensions set the national context of the participants’ experience. Thematic analysis of transcripts led to three themes that were central to understanding the phenomenon of professional ethics for participants. The first theme highlights the way that demographic and practice characteristics may instigate ethical issues. The second theme was a compendium of the five common ethical dilemmas as experienced by
rural Canadian psychologists. The third theme was an experiential exploration of ethical development through the ethical schema used by rural psychologists. While bound to its situational context and the participants’ ability to articulate ethical processes, this research allowed for a rich and dynamic study of the meaning of those experiences. This study identified the need to further an understanding of professional ethics in rural practice, fostered recommendations for the profession, and provided some tangible ideas for rural Canadian professional practice.
CHAPTER ONE

BEGINNING THE EXPLORATION

The beauty and solitude of towering spruce trees and rolling hills during routine, almost traffic-less commutes. The comfort of personal familiarity with those I meet at my child’s school, or local stores, or when receiving services. The acceptance and respect I receive as a professional in a small community. This balanced with the challenge and reward of piecing together a complicated beautiful puzzle – how to work as a psychologist in a rural area and how to balance the ethical complexities of that small community with the rewards and opportunities that I have had.

From my analytic journal, May 2009

1.1 Reflections of a Rural Psychologist

I began this research process with my own knowledge and experience as a rural psychologist, sitting in meetings and attending training seminars where I knew my practice was different than the practices of my urban colleagues. Ethics has always been my passion but when working collaboratively on ethics committees, and even in co-authoring national ethics guidelines (Church, Pettifor, & Malone, 2007), I would find myself struggling internally to place the issues into my own context of a rural setting. It almost seemed as though rural practice represented more than a different community -- perhaps a different culture -- within the practice of psychology. Provincial and national ethics discussions are so very different from the peer consultations or supervision sessions that I have had with rural practitioners where ethical dilemmas are worked through with an understanding of the context and the inherent difficulties that rural practice can present.

When I began to teach university courses on counselling, the concern about ethics in rural practice began to gel in my mind. I have taught at a rural campus. My students, who are local residents, questioned the textbooks and readings on ethics as they applied to rural settings. Who do you refer to when there is only one counsellor in town? If I cannot work with someone I know
personally, then how could I ever work with anyone from my community? My community does not need specialists in counselling – they need counsellors, period! The students had much to teach me and together there were wonderful opportunities to explore these kinds of issues critically.

As a practising rural psychologist, I would like to believe that rural psychologists (myself included) practice ethically within our context. Yet, I have experienced some isolation when discussing the complexities of my professional practice unless the discussion has taken place with a colleague familiar with the rural setting. I have often had the opportunity to work with respected and gifted urban peers. For me this can create a perception of inferiority when considering my own practise. A reasonable explanation is that this perception reflects an unacknowledged difference between urban and rural practice – an inability to compare practices without an understanding of their inherent differences. When I began to review the literature on psychology in rural practice, I found that it strengthened my resolve to better understand these differences by allowing me to better comprehend the complexities of psychology in rural practice. I began to articulate more clearly what my own experience had taught me and to realize that I had a need to contribute to the development of a knowledge base about psychology in rural practice. Given my interest and experience in the field of ethics and professional practice, exploring these within rural practice was a natural fit for me.

1.2 Phenomena for Inquiry

“In a rural setting, dual relationships are the norm. I chuckle when I read articles on ethics by city people, cautioning against dual relationships. In my world, multiple types of interactions are not only inevitable; they are desirable and helpful in the therapeutic process. They reduce history taking time for a new patient that the psychologist has known in another setting. They provide first-hand information about a patient's liabilities and assets”. (Fair, 2004, p.55)
What makes rural practice in psychology distinct? How do these differences complicate ethical practice? What practical wisdom exists to piece together this puzzle in rural settings? These are the questions that guided me as I began to define the phenomenon that I wanted to study. The place to begin was an extended review of what other rural psychologists and researchers have published in this area. Although conducting the literature review taught me a lot and gave me language to articulate ethical and rural practice issues, it demonstrated two significant limitations. First, I found far less research and theory specific to rural practice of psychology (and professional ethics for this setting) than I had expected. The second limitation from a Canadian perspective was that the majority of the literature was from Australian researchers and specific to their context. Despite the tremendous rural population in North America, I began to realize that knowledge and expertise in this area is sorely lacking.

I read the literature anticipating that I would learn from the wisdom of other rural psychologists. I was disappointed. I found information on how the setting is unique, why there are more ethical barriers, and even some recommendations about how these ethical barriers might be managed. Virtually all of the literature I reviewed imposed a quantitative frame on the issues which did not reveal much about the varied, rich, challenging, and rewarding rural practice that I know. It became clear to me that more research was needed to begin to fill this gap in knowledge.

From this background I began the design of this dissertation. My research had a practice-oriented purpose as I sought to better understand how rural psychologists practice ethically given the distinct complexities that they may face. As a researcher, I was concerned specifically with the rural practice of psychology within the Canadian context in the hope that this study might
contribute to a more informed understanding of this phenomenon. To do this, I explored the direct experiences of participants, reflected on my own experience, and analysed these experiences within the current social and historical context of psychology in rural Canada.

Wanting an understanding more than a comparison, I chose not to explore the experience of urban psychologists or that of other allied professionals. I do acknowledge that similar ethical concerns in rural practice may be experienced by social workers, nurses, teachers, counsellors, and those in religious ministries. I chose to focus this research on those professionals who are registered psychologists.

1.3 Research Approach

The purpose of this study was to investigate what ethical issues arise for practising rural Canadian psychologists and how they deal with those issues. Research has indicated that rural psychologists face unique ethical dilemmas and work in settings not normally covered in professional training (Ridgeway, 2005; Womontree, 2004). This research was an opportunity for an in-depth study of ethics in this specific practice setting. Schank and Skovholt (2006) said that, “the central dilemma for small community psychologists [is] how to practice at a high ethical level according to ethics codes, and how to also be an engaged member of the small community” (p. 5). The wealth of data shared by the participants in this study was another step in accumulating knowledge to facilitate an understanding of this phenomenon which may eventually inform policy, science, or clinical practice.

Seeking an in-depth understanding of this topic, I chose to use qualitative research methods. Qualitative research methodologies describe and explore phenomena in rich detail. Specifically, I used a hermeneutic phenomenological
(HP) research method. This method is situated within the constructivist-interpretive paradigm. It allowed me to explore and draw themes from the data, to analyse these in relation to existing literature, and to place this understanding within the current social context. This method also allowed me to consider my own influence on the data analysis. Essentially, I approached the phenomenon of rural practice ethics from a generalist position, without strong preconceived notions. I balanced that with my existing beliefs and the existing scientific knowledge in the area. The literature review assisted me in framing the research and clarifying behavioural and cognitive dimensions of the phenomenon. It was a difficult task to use this scholarly knowledge through each phase of the research process without becoming tied to any particular assumptions presented by that literature and with a conscious understanding of my own evolving contribution to the research findings (Haverkamp & Young, 2007).

The following three chapters represent the literature review. In chapter two, I review professional ethics for psychologists. In chapter three, I present an overview of rural practice. In chapter four, I integrate these concepts and present ethical issues for rural psychologists. Following the literature review, I provide a detailed elaboration of the methodology used to design and implement this inquiry. In the results and discussion sections I attempt to articulate my own role in understanding and co-constructing the meaning of the themes from the participants’ stories. I hope to add a bit more clarity to the puzzle that is professional ethics in rural Canadian psychology.
CHAPTER TWO

PROFESSIONAL ETHICS FOR PSYCHOLOGISTS

Consent can be less clear when working with individuals with developmental disabilities. I have had clients with legal guardians even though they live very independently and rarely see that guardian. Others have had no legal guardian and yet live in managed care arrangements and are not, in my professional opinion, able to provide truly informed consent for services. I find collateral contacts invaluable as part of the determination of ability to consent but I also struggle with this – each additional contact threatens confidentiality for a member of an already vulnerable population.

From my analytic journal, May 2009

As a registered psychologist, I need to determine how to best resolve ethical dilemmas. It is ultimately my responsibility, even if I rarely do this alone. Resolution is a learning process with abundant personal growth opportunities which I often enjoy. This reflects my love of moral philosophy and of the complexity of human nature – particularly as I have a tendency to cope through intellectualization of issues and logical evaluations. The study of ethics is a wonderful field for rational analysis as ethics provide a basis for both value judgments about how to act and for determining what behaviours are right or wrong (Eramo, 2002; Truscott & Crook, 2004). More specifically, codes of ethics for psychology provide an aspirational context for broad and complex professional interactions (Schank & Skovholt, 2006; Truscott & Crook, 2004). Psychologists are in the business of relationships and are continually immersed in the complexity of human interaction (Bauman, 1999). Understanding professional ethics for psychologists is like seeing the picture on the outside of a jigsaw puzzle box – it does not solve the puzzle for you but provides a sense of the gestalt needed to proceed and a reference point during the process. In this chapter, I will provide: 1) a brief introduction to ethics, 2) a review of the components of ethical
psychological practice, 3) some examples of relevant ethical decision making models, and 4) a brief overview of professional ethics for psychologists.

2.1 Ethics

In attempting to understand ethics, one can conceptualize either deontology or consequentialism. Deontology is the study of moral obligation. Through deontology, ethical behaviour is action motivated by, and in compliance with, one’s duty. It is therefore based on rules of practice and codes of conduct.

Consequentialism, or teleology, is more concerned with the end result of ethical decisions or the consequences of actions (Schank & Skovholt, 2006; Truscott & Crook, 2004). For psychologists, professional ethics codes guide practice in a discipline rife with ambiguity (Schank & Skovholt, 1997). The deontological approach is not entirely useful as it assumes consensus about how to behave ethically when this consensus may not exist. From a deontological model, codes of ethics for psychology provide excessive guidance in the form of rules and are not aspirational or responsive to situational complexities. From a teleological model, codes of ethics for psychology do not clarify what is actually good and therefore provide too little guidance (Truscott & Crook, 2004). While they contribute to our understanding of professional ethics for psychologists, neither deontology nor consequentialism sufficiently articulates the complexities of human interaction inherent in the practice of psychology.

Professional practice ethics clarify morality and are concerned with proper professional behaviour (Eramo, 2002; Fisher, Fried, & Masty, 2007; Morrissey & Symons, 2006). Professions like psychology are regulated to follow certain standards and also operate under a contract of trust with society that allows them to self-govern under legislated standards (CPA, 2000; Fisher et al., 2007). Current codes of ethics for psychology have increasing emphasis on social responsibility.
This responsibility extends beyond individual clients to the families, groups, communities, organizations, and societies that might also be impacted by psychological services (Fisher et al., 2007). This makes sense as the science of psychology itself is dependent on how individual and societal considerations interact (Kendler, 2005; O’Neill, 2005). Meara and Day (2003) have conceptualized this as a moral obligation owed to society by the field of psychology. In this way, formal ethical standards with aspirational principles extend beyond the professional and into our personal behaviour (Fisher et al., 2007; Pipes, Holstein, & Aguirre, 2005). This is often articulated as psychologists having a duty of care for other members of society that is greater than that which members of society may have towards each other (CPA, 2000; Kakkad, 2005; Meara & Day, 2003). This can foster anxiety as the philosopher Bauman argues that increases in our level of responsibility and duty of care mean progressively less clarity about how one should act (Bauman, 1998).

2.2 Psychology Ethics

“There are moments in every psychologist's professional life that are fraught with anxiety about what is to come. Sometimes it is best not to act, but rather to sit with our experience and explore what we can learn from our feelings. As situations evolve, it can also be helpful to remain mindful that we are not alone. We can collaborate with our colleagues as consultants. Often, it can be enormously valuable—and anxiety-reducing—to collaborate with our clients as well.”

(Behnke, 2008b, p.62)

The practical application of ethics to the profession of psychology is much like that beautiful picture on the outside of the jigsaw puzzle box – pleasing in its completeness but difficult to accomplish. Psychology encompasses an enormous breadth of activities and has a sprawling range of ethical considerations. For psychologists to practice ethically they need to be aware of requisite ethical reasoning, knowledgeable about ethical, professional, and legal issues, and skilled
at making ethically justifiable decisions (Schank & Skovholt, 1997; Truscott & Crook, 2004).

2.2.1 Components of Ethical Practice

There are numerous components that should collectively develop ethical practice skills for psychologists. These include training, ethics codes, ethical guidelines, decision making models, peer consultation, and ongoing professional development. All of these evolve through a developmental sequence. The first stage is normally professional training which commonly incorporates university curriculum and practicum or internship experience in professional ethics. Despite debate and lack of empirical validation on how to best teach ethics (Jones, 2008; Morrissey & Symons, 2006; Pettifor, Estay, & Paquet, 2002), ethical dilemmas remain a critical part of the training of psychology because they are often difficult to resolve, emotionally distressing, and may require time consuming deliberation (CPA, 2000; Houser et al., 2006). Professional training in this area should reflect the complexity inherent in making ethical decisions (Jones, 2008; Pope, 2003; Thompson & Fata, 1997; Wilson & Ranft, 1993). It should, at a minimum, include critical thinking, professional and personal reflection, and opportunities to develop requisite knowledge and experiential practice (Jones, 2008; Morrissey, 2005; Pettifor et al., 2002).

Another essential component is professional codes of ethics. Truscott and Crook (2004) provide a useful overview of professional codes of ethics for psychologists.

“First, codes of ethics for professionals are typically not pure ethics, but rather some combination of ethics, professional conduct, and legal standards. Second, no existing code of ethics perfectly possesses all three of these distinguishing features. Thus, professional psychologists are dealing with an imperfect system for guiding their decisions and conduct. Despite this imperfection, however, psychologists’ code of ethics can provide useful guidance for professional behaviour” (p.xix).
Professional codes of ethics for psychologists (which I will review in more detail later), differ from the codes of conduct developed by the various colleges or registration bodies that detail minimally acceptable behaviour. A resource meant to bridge the gap between codes of ethics and codes of conduct are ethical guidelines. These non-enforceable guidelines are specific to either specialty areas, special knowledge, or particular challenges that may occur in following an ethics code (Truscott & Crook, 2004). More direct guidance on how to resolve ethical dilemmas is provided by ethical decision making models which are meant to help psychologists outline and articulate a decision making process (Truscott & Crook, 2004). I will review several decision making models later in this chapter.

Another essential component of ethical psychological practice is peer consultation (Pipes, Blevins, & Kluck, 2008; Truscott & Crook, 2004). This is essential not just because psychology is a self-regulating profession (Truscott & Crook 2004) but also because peer consultation is effective. Pettifor, Estay, and Paquet (2002) found that peer interaction and discussion was a preferred method for ethical development. Zins and Murphy (2007) found that “the peer support group, which is characterized by the sharing of expertise and knowledge, the provision of mutual support, and joint problem solving among professional colleagues, has been advanced as a promising means of promoting professional growth and development” (p.175). In addition to peer consultation, psychologists in Canada, as well as other nations, are required to keep up to date through ongoing professional development by means of self-directed study and continuing education activities (CPA, 2000). The growing literature on professional ethics in psychology is only beginning to capture the complexity of ethical practice (Thompson & Fata, 1997). Ethics are also becoming an increasingly important
topic for continuing education across one’s professional career (Pettifor et al., 2002).

Each of these components (training, ethical codes and guidelines, decision making models, peer consultation, and ongoing professional development) collectively develop ethical practice. However, it is important to consider that the development of an internalized ethical stance takes time and follows a developmental sequence. Jones (2008) suggests that the progression from novice to expert can take 10 to 15 years and continues far beyond formal academic training. As an applied skill, this ongoing process requires long-term practical experience (Jones, 2008; Morrissey, 2005; Morrissey & Reddy, 2006; Truscott & Crook, 2004). This is perhaps because of the different strategies required for acquiring knowledge versus developing skills (Pettifor et al., 2002). Experience and training together are essential to the development of personal ethical judgment.

Research has shown that psychologists often make ethical decisions intuitively and automatically (Moleski & Kiselica, 2005; Schank & Skovholt, 1997). This is consistent with Bashe, Anderson, Handelsman, and Klevansky’s (2007) idea that, with experience, the complex process of ethical decision making requires progressively more personal judgment. Awareness of one’s own values, beliefs, and morality is an important aspect of this process. Ethical acculturation is more than a linear learning process of adopting a set of rules. Rather, many have suggested that the process also involves ongoing active reflection and balance of personal morality, knowledge, culture and context of practice, and codes of ethics (Barnett, Behnke, Rosenthal, & Koocher, 2007; Bashe et al., 2007). Morrissey and Reddy (2006) refer to this as developing and maintaining ethical mindedness. Research by Dewhurst (2006) indicated that psychologists
who are exemplars of ethical practice benefited from grounding their practice in competence, virtue, mindfulness (conscious ongoing awareness), and working within a supportive community of peers that inspire continuing ethical development. To explore professional ethics, I will review principles and values specific to psychological ethics and the Canadian Psychological Association’s Code of Ethics (CPA, 2000).

2.2.2 Principles and/or Values

To practice ethically, psychologists need relevant moral principles or values to anchor, guide, and evaluate their professional behaviour. Indeed, codes of ethics represent the core values of the profession (Truscott & Crook, 2004). These values serve to motivate psychologists to prefer one behaviour or outcome over another, but do not prescribe specific behaviours (Fry, 2005; Schank & Skovholt, 2006). In a recent study, Dewhurst (2006) found that psychologists nominated as exemplars of ethical practice reported having personal values of honesty, integrity, humility, and respectfulness towards clients and others. This is consistent with the review of Meara & Day (2003) who suggest that virtues are paramount to ethical development. The virtues that appear to support the principles of ethical psychology include autonomy, beneficence, nonmaleficience, fidelity, justice and prudence (Nelson, Pomerantz, Howard, & Bushy, 2007b; Truscott & Crook, 2004). Autonomy in psychology refers to respecting client’s right to self-determination (Truscott & Crook, 2004). Beneficence is concern for, and contribution towards, the well being of others. In psychology, this requires competence and putting the welfare of clients above personal gain (Meara & Day, 2003; Truscott & Crook, 2004). Nonmaleficience is not causing others harm. A requirement in psychology is confidentiality or the protection of information (Eramo, 2002; Truscott & Crook, 2004; Womontree, 2004). Fidelity in
psychological practice refers to faithfulness, loyalty, honesty, and trustworthiness and is represented by integrity (Levinson, 2002; Meara & Day, 2003; Truscott & Crook, 2004). Finally, core principles are justice (acting fairly) and prudence. Prudence emphasizes using good professional judgment to provide coherence in times of uncertainty and over the long-term (Meara & Day, 2003; Truscott & Crook, 2004). These values make up the aspirational foundation of codes of ethics for psychological practice. It is noteworthy that these values are important but very broad and socially-based beliefs. Agreement with these values is socially acceptable and professionally important but these mores, or cultural-bound values, risk being accepted without careful contemplation.

Codes of ethics assist psychologists in understanding and identifying with the rich history and professional culture of psychology (Bashe et al., 2007; Cottone, 2004; Schank & Skovholt, 2006). Ethics codes for psychological practice are not human rights statements, professional standards of behaviour, or rules of conduct. Rather, they are sets of articulated principles, values, and standards for ethical behaviour and attitudes within a profession (CPA, 2000; Pettifor, 2004; Truscott & Crook, 2004). These continually evolving codes attempt to strike a balance between being descriptive and prescriptive and often represent both deontological and teleological models in an attempt to balance these views. Ethical codes allow for professional regulation, professional development, and guidance in dealing with ethical concerns. A code of ethics also serves to distinguish a profession from an occupation and to create public trust, confidence, and awareness (Blickle, 2004; Moleski & Kiselica, 2005; Morrissey, 2005; Pipes et al., 2005). Professional registration boards are charged with responsibility for protecting the public and have investigation and adjudication processes for complaints. They promote ethical principles, values, and standards
of how to integrate codes of ethics into practice (Bashe et al., 2007; CPA, 2000; Truscott & Crook, 2004). As such, codes of ethics are resources for psychologists by setting standards for their behaviour and defining good practice. National codes of ethics attempt to also represent the culture and context of practice for that country. In this review, I will focus on the Code of Ethics for Psychologists used in Canada.

2.2.3 CPA Code of Ethics

The Canadian Psychological Association (CPA) recognizes its responsibility to help assure ethical behaviour and attitudes on the part of psychologists and requires that all psychologists in Canada accept and abide by the third edition of the *Canadian Code of Ethics for Psychologists* (CPA, 2000; Truscott & Crook, 2004). This code, collectively developed by many psychologists in Canada, has an internationally unique structure of core principles, standards, and an ethical decision-making system (Schank & Skovholt, 2006; Truscott & Crook, 2004). The CPA Code of Ethics is primarily a descriptive code which is based on four broad principles arranged in order of descending priority. These are, in order of significance: I -- Respect for the Dignity of Persons, II -- Responsible Caring, III -- Integrity in Relationships, and IV -- Responsibility to Society. The first principle, given the highest weighting, corresponds to autonomy and to justice. The second principle embodies beneficence and nonmaleficience. The third principle, given the third highest weight, embodies fidelity. Finally, the fourth principle corresponds to beneficence but includes aspects of social justice (CPA, 2000; Truscott & Crook, 2004).

Each of these overarching principles is followed by values statements which are then clarified with a set of specific ethical standards. The values statements are what the principle is based on and the standards demonstrate how
to apply the principle and are presented from minimum behavioural expectation to idealised but achievable expectations. For example, under the principle of “Respect for the Dignity of Persons”, the first values statement is for general respect. This is followed by four ethical standards beginning with the minimum behavioural standard to “demonstrate appropriate respect for the knowledge, insight, experience, and areas of expertise of others” (CPA, 2000, p.9). This set of standards ends with the idealised but achievable standard to “abstain from all forms of harassment, including sexual harassment” (CPA, 2000, p.9). These articulated principles, values, and standards apply to all psychologists whether they are scientists, practitioners, or scientist-practitioners in all roles related to the discipline of psychology in Canada (CPA, 2000). In Canada, psychologists register with the college or registration board appropriate to the province within which they practice. All of these registration boards, having the legislated responsibility to protect the public for that region, adhere to the CPA Code of Ethics for Psychologists.

2.3 Ethical Decision Making Models

The primary purpose of a code of ethics is to provide essential frameworks to assist psychologists in making consistent and objective choices when faced with ethical dilemmas (Hadjistavropoulos, Mally, Sharpe, Green, & Fuchs-Lacelle, 2002; Nelson & McPherson, 2004). Sinclair and Pettifor (2001), in their introduction to the companion manual to the Canadian Code, point out that “most of the time decisions come easily, but when there is conflict between principles or among different parties, decisions may be difficult” (introduction). The problem is that ethics codes cannot be specific to all situations, they make extensive use of modifiers such as “appropriate” and “feasible”, and they tend to represent a top-down or deductive approach to ethical decision-making (Fowers, 2005; Lutosky,
Codes of ethics cannot, and should not, cover every situation or circumstance. Rather, a code should offer guidance while leaving room for professional judgment and discretion (Barnett, 2007; Behnke, 2007; Morrissey & Symons, 2006; Truscott & Crook, 2004). Several authors have suggested that the regularity with which psychologists are confronted with ethical uncertainty is a sign that psychology is a challenging, nuanced, and important profession (Barnett et al., 2007; Behnke, 2007; Fowers, 2005). This necessitates an awareness that ethical issues will continue to evolve and new ethical issues are certain to arise.

Ethical decision making in psychology is complex not only because the issues are always evolving, but also because there are multiple influences in most ethical dilemmas and because ethical principles themselves can be in conflict. In considering the potential influences, psychologists are required to be sufficiently familiar with ethical codes, regulations, legal boundaries, case law, and professional consensus (Barnett, 2007). Many have also suggested that community consensus is required (Fisher et al., 2007; Zur, 2006). There are also many occasions when ethical principles may conflict and a deep and nuanced level of ethical reasoning is required (Barnett, 2007; Fowers, 2005; Truscott & Crook, 2004). Even experienced and knowledgeable psychologists may be unsure of how to proceed in some situations and which of the conflicting principles should be given the most weight (Barnett, 2007; Hadjistavropoulos et al., 2002). Informed decisions on what is the best solution to an ethical decision requires consideration of the context, critical thinking, reasoning, making thoughtful inferences and judgments, and problem solving (Arrigo, 2004; Fisher et al., 2007). This knowledge and critical evaluation are enhanced by peer consultation (Barnett, 2007; Mccullah, 2002; Pope, 2003; Zur, 2006).
When a psychologist can demonstrate that every reasonable effort was made to apply the principles of their code of ethics, even when resolution had to depend on their personal conscience, the psychologist would be deemed to have followed the code of ethics (CPA, 2000). From neurocognitive research, Reynolds (2006) has suggested that ethical decision making involves a reflexive pattern matching cycle and a higher order conscious reasoning cycle. This means that this process involves not only reasoned analysis but also intuition and retrospection. This is supported by research that indicates that psychologists look to formal codes of ethics for what they should do but that they look to personal values and practical considerations for what they will actually do (Schank & Skovholt, 2006; Schulz, 2004). Reasonable effort requires complex cognitive skills such as critical thinking, reasoning, making thoughtful inferences and judgments, and problem solving (Fisher et al., 2007) but is facilitated by a structured model for ethical decision making.

The complexity in ethical decisions requires a structured problem solving process. There are not guidelines for all situations and even when they are available it is prudent to use a procedural, hierarchical, or multidimensional ethical decision-making model which is explicit enough to bear public scrutiny (CPA, 2000; Lehr & Sumarah, 2004; Reynolds, 2006). A procedural model provides sequential steps to carefully evaluate ethical questions but is less useful for psychologists who are inexperienced or lack knowledge or skills in judgment. A hierarchical decision-making model requires moral reasoning followed by ethical reasoning and then reasoning based on specific key ethical principles. This tends to be quite abstract rather than specific for application. Multidimensional models of ethical decision-making provide a matrix of considerations including: moral principles and personal values, clinical and cultural factors, professional
codes of ethics, agency or employer policies, statutes, rules and regulations, and case law. Unfortunately, while these models go beyond others in considering context, they remain general and are like lists of salient considerations (Fowers, 2005). There is debate about which of the multiple models available for psychologists are best to use (Barnett, 2007; Fowers, 2005). The presence of so many ethical decision-making models suggests that there are many ways to legitimately interpret an ethics code (Dewhurst, 2006). For the purposes of this literature review, I will briefly review five ethical decision models.

2.3.1 Code-Specific Ethical Decision Making Models

The American Psychological Association Code of Ethics and the Australian Psychological Society Code of Ethics do not prescribe an ethical decision making process (APA, 2002a; APS, 2007a). Alternatively, the British Psychological Society and the Canadian Psychological Association prescribe similar ethical decision making processes that focus on structure, steps to take, and that apply to all professional activities (BPS, 2006; CPA, 2000). I will briefly review the latter of those two models. The Canadian Code of Ethics for Psychologists presents a comprehensive model for ethical decision making that requires that four principles are considered and balanced. When the main principles appear to be in conflict, they are to be considered with the priority weighting given even though the Code is clear that ethical conflicts are complex and that there is no firm weighting for principles. To paraphrase the CPA code, the recommended steps include: 1) identify who is potentially affected by the decision, 2) identify the ethically relevant issues and practices that are pertinent to the dilemma, 3) consider how issues specific to the psychologist (i.e., biases, stresses or self-interest) might affect the decision made, 4) design alternative courses of action, 5) identify the potential risks and benefits that are associated
with each course of action; 6) carefully select a course of action, 7) take action with a commitment to assume responsibility for the consequences, 8) evaluate the consequences of the selected action, 9) accept responsibility for the action taken and, if necessary, taking steps to correct any negative consequences that the action may have caused, and 10) take whatever appropriate action to prevent future occurrences of the dilemma (CPA, 2000; Truscott & Crook, 2004).

2.3.2 Moral Development

Psychology is now understood as value laden and moral relativity is one way to understand how psychologists make ethical decisions (Fowers, 2005; Williams & Levitt, 2007). Moral development models allow for life experience to become part of innovative ethical solutions that can be more sensitive to context (Fowers, 2005; Lutosky, 2005; Williams & Levitt, 2007). Psychologists under this model rely on their judgment to deliver ethical psychological services (Fowers, 2005; Lehr & Sumarah, 2004; Williams & Levitt, 2007). Moral development models require that psychologists balance the values of their clients, their own values and personal beliefs, and their professional ethical codes (Lutosky, 2005; Williams & Levitt, 2007). In her research, Essinger (2006) found that both rural and urban psychologists used the rationale of upholding their personal moral standards when uncertain about applying the ethics code. A moral development model may assist psychologists in reducing the stress of ethical problems (Dewhurst, 2006).

When I have worked in Aboriginal communities it had been common to be introduced to people as a “friend” of my clients. I do not correct clients or ask them to not introduce me in this way even thought the CPA Code asks that psychologists correct misinformation and seek to avoid or actively manage overlapping relationships. My understanding of Cree culture is that a friend is any
person with whom you have shared secrets. I balance that knowledge with a personal belief that this is not the same kind of “friendship” that I would have with a non-client. It is my personal judgment that the subtle difference between friendship in a non-professional context and these friendships is also understood by many in the Cree culture and does not represent a boundary violation. This judgment considers the three primary components of a moral development model (the client’s values, my own personal views, and my professional ethics code).

### 2.3.3 Social Constructivism

The social constructivism model of ethical decision-making puts far greater emphasis on the character of the psychologist. It is a professional responsibility to be an ethical person as well as an ethical psychologist. This extends to how the psychologist thinks, feels, and acts. The cognitions, affective reactions, and behaviour of an ethical psychologist are based on a high level of self-awareness, knowledge of key personal values and beliefs, emotional reaction to situations, and an ongoing awareness of the consequences of actions taken (Schulz, 2004). This model acknowledges that human interactions are inherently complex and that ethical decisions occur within complicated interdependent relationships (Bauman, 1999). The psychologist must be self-aware and reflexive but also must balance that with active awareness of the social whole. The actions of the psychologist will have an impact on the social context just as social context will impact the individual psychologist. Motivation and intention of behaviour need to be considered within this dual context (Cottone, 2004; Lehr & Sumarah, 2004; Wihak & Merali, 2007).

Psychologists use dialogue and their relationships to complement their personal awareness. This differs from moral development theory because of the emphasis on the social context. Moral rules are seen as being valid only in certain
contexts (Lehr & Sumarah, 2004). Ethical decisions are continually re-assessed with practical reasoning as knowledge about the situation is sought. There is much consultation with peers and consumers of the psychological service. This is an interpersonal process of negotiating, consensus building, and arbitrating to benefit from the collective wisdom of those involved (Lehr & Sumarah, 2004; Wihak & Merali, 2007). In rural practise, this consensus would involve other psychologists in rural practise and members of the community within which the psychologist practises. Recent research by Wihak and Merali (2007) found that participants in small Canadian communities “used social constructivism approach to manage confidentiality, negotiate boundaries, and redefine ethical practice to mirror community values” (p.169).

In the earlier example of being introduced as a “friend”, a social constructivism model would require that I consider the influence of my relationship with the larger Cree culture and the community within which I practice. For example, I have discussed this issue with peers who also work in Cree communities, and with Cree elders and trusted community members to gain an understanding of how this issue was perceived. From these interactions, I have come to understand that it would be a cultural and social faux-pas to correct someone who introduces me as a friend or to ask them not to do that. This might discount the quality of the work that we have done together.

2.3.4 Virtue Ethics

Virtue ethics go beyond moral development theory and social constructivism and provide more general guidance on the nature of being a psychologist (Barnett, 2007; Fowers, 2005; Fry, 2005; Meara & Day, 2003). Virtuous professional behaviour is expected by consumers of psychological services. As a result of this expectation, psychologists should embody moral
ideals and rely on these ideals to solve ethical dilemmas (Fry, 2005; Meara & Day, 2003). Virtue ethics rely on wisdom and mores and are applicable to psychological clients who may be culturally, racially, and socially diverse. This is because virtue ethics considers context and community to define what is virtuous (Fry, 2005; Meara & Day, 2003; Pipes et al., 2005). The focus of virtue ethics is on developing or inspiring the character traits that facilitate the development of ethical psychologists (Fowers, 2005; Fry, 2005; Meara & Day, 2003). This perspective normalizes the complexity of ethical dilemmas and helps psychologists focus more on acting well rather than on necessarily doing the right thing (Fowers, 2005; Schulz, 2004).

Key virtues appear to be benevolence, cultural sensitivity, and respectfulness (Fry, 2005; Meara & Day, 2003). Cultural sensitivity helps psychology stay relevant in increasingly diverse societies. Fry (2005) found that benevolence was a significant positive predictor of cultural sensitivity. Acknowledging diversity reduced the ethical dilemmas caused when cultural values compete with ethical values. Finally, a key component of respectfulness is an awareness of the power differential when providing services to consumers and a need to value the consumer (Fry, 2005; Meara & Day, 2003). Ethical sensitivity, moral capacity, and motivation to do what is good reflect the character of the psychologist (Fowers, 2005; Schulz, 2004). Virtue ethics appears to be practiced by those who are considered exemplars of ethical psychological service (Dewhurst, 2006).

Being introduced as a friend of a client in a Cree community can be used again to exemplify key aspects of virtue ethics. This particular community has less than 1 000 people and I have been working in the community for over 13 years. It is common knowledge that I am a psychologist and when someone
introduces me as a “friend” that means that they know me well. This is a community that, like many Aboriginal communities, has great distrust of non-Aboriginal professionals who are deemed to be “outsiders” and who do not understand or value the Cree culture. This is likely the result of years of oppression of Aboriginal people in Canada. I accept that it is appropriate to be introduced as a friend in that context and essential that I respect their culture and norms.

2.3.5 Relational Ethics

Relational ethics puts the emphasis on the psychologist’s role in professional relationships. Given the immediacy and complexity of professional practice, engagement in relationships is at the heart of ethical practice. Relational ethics builds on moral development theory but shifts attention to behaviour that occurs within the context of professional relationships. Given the mutual vulnerability inherent in client relationships, it is the professional’s responsibility to foster engagement and mutual respect. Key considerations of relational ethics, which include interdependency and sense of community, are an ideal fit for rural practice (Austin, 2006).

To be introduced as a “friend” in a Cree community speaks directly to the value of relationships. Relational ethics would require me to consider my level of engagement with this client and to respond to this introduction authentically. It is difficult to explain why I know this is not unethical. My long-standing experience in the community has fostered a form of embodied knowledge. I understand that discounting such an introduction could harm the professional relationship. It would represent a disengagement from the relationship and potentially malfeasance (Austin, 2006). In this community, the culture supports an interdependent environment.
2.4 Chapter Summary

Understanding a code of ethics is not enough to ensure ethical behaviour (Morrissey & Reddy, 2006). The sequence of developing ethical practice skills incorporates training, ethics codes and guidelines, decision making models, peer consultation, and ongoing professional development specific to ethics. Through the course of this development, and with sufficient practical experience, psychologists begin to develop their ethical stance and to use professional judgment and take personal responsibility for their decisions when faced with ethical dilemmas (Barnett, 2007; Behnke, 2007; Morrissey & Symons, 2006). The complex matrix of influences inherent in ethical decision making, and the likelihood that ethical principles will conflict, require the use of a structured model for ethical decision making. There are several such models, reflecting the complexity of professional ethics in psychology. An essential consideration for psychologists is to develop, articulate, and use a framework that will convey the complexities of the situation, the psychologist’s own values and beliefs, the needs and norms of the consumers of those services, and the overall social context. Psychologists need to go beyond the minimum prescribed by an ethics code for working within specific contexts (Fowers, 2005). Rural psychological practice is a specific context of practice and is considered in the following chapter.
CHAPTER THREE
RURAL PRACTICE

As children are wont to do, my youngest loves to have friends over to play – in particular if they are from our “neighbourhood” as we are in a very remote location. New neighbour children were soon invited over to swim on a hot summer day. I was in the pool myself when they arrived. The mother, a nurse, arrived dressed in formal business apparel. She apologized for her attire explaining that she had heard all about me and wanted to make a good impression – this while I am dripping wet, shaking her hand while reaching for a towel.

From my analytic journal, August 2008

3.1 Small Communities and Definitions of Rurality

The experience with the new neighbour did not surprise me as a member of a rural community. I have thought a lot about the needs and characteristics of small communities, such as my own, and am aware that familiarity is often an important part of relationships. Small communities can be defined by culture, professional experience, geographical separation, and of course, rurality. In most small communities, providers of psychological services will experience overlapping relationships and difficulties in separating formal and informal community participation (Coakes, 2002; Schank & Skovholt, 2006). Although the issues identified for small communities are not exclusive to rural communities, this literature review will focus on needs, practice considerations, and sensitivities specific to only rural communities. This is particularly prudent in Canada as about 20% of the population is rural (Barbopoulos & Clark, 2003; Bray, Enright, & Easling, 2004; Harowski, Turner, LeVine, Schank, & Leichter, 2006). In reviewing the literature on rural communities, I discovered common themes in the literature from Canada, the United States of America, and Australia. As the Canadian literature appears to be more limited in focus, this chapter will review rural communities and people, their health considerations, and psychology
in rural practice using information from all three of these countries. I then review specific considerations for psychology in rural Canadian practice.

I begin with the daunting task of defining rurality. The multidimensional concept of rurality has not yet been adequately defined to the requirements of all users and may never be (Muula, 2007; Philo, Parr, & Burns, 2003; Stamm, Lambert, Piland, & Speck, 2007). Armstrong (2008) makes the point that “only when definitions are clear can the role of rurality in relation to mental health and well-being truly be understood and lead to meaningful community-based intervention” (p.7). Rural areas tend to be defined as areas that are not urban (Stamm et al., 2007), by population size (Zapf, 2001), or by remoteness (Charlebois, 2006; Muula, 2007). Many authors have called for more adequate descriptors (Armstrong, 2008; Bowman & Kulig, 2008; du Plessis, Beshiri, Bollman, & Clemenson., 2001; Harowski et al., 2006; Jameson & Blank, 2007; Judd, 2006; Kemp Brill, 2003; Letvak, 2002; Murray, Judd, Jackson, Fraser, Komiti, Hodgins, Pattison, Humphreys, & Robins, 2004). The difficulty in conceptualizing rural lies in part in the increasing diversity and ongoing economic and social changes in rural areas (Barbopoulos & Clark, 2003; Jameson & Blank, 2007; Harowski et al., 2006). What is needed is an adequate definition that captures the diverse characteristics of rurality. This would foster research and program development, ensure that the needs of rural people are not missed or marginalized, and validate research in rural practice. Research has suggested that such a definition should incorporate key characteristics such as: access to health care, services, and amenities (Muula, 2007; Stamm et al., 2007; Zapf, 2001), the distinct rural lifestyle or culture (Armstrong, 2008; du Plessis et al., 2001; Harowski et al., 2006; Letvak, 2002), geographic disparity from urban centres (du Plessis et al., 2001; Harowski et al., 2006; Letvak, 2002), and any distinct
socioeconomic concerns (Jackson, Judd, Komiti, Fraser, Murray, Robins, Pattison, & Wearing, 2007; Jameson & Blank, 2007; Judd, 2006; Murray et al., 2004).

Multiple considerations such as these imply that a common definition would indeed be difficult to achieve. Perhaps this is why there are no consistent government or agency definitions in Canada (du Plessis et al., 2001). The Ministry of Rural Affairs’ (2000) definition includes locations where more than half of the people live in communities with a population density less than 150 people per square kilometre. For medical issues, the Canadian government uses the General Practice Rural Index which indexes rurality according to: remoteness from the closest advanced referral centre, remoteness from the closest basic referral centres, drawing population or size of service area, number of general physicians and specialists, and presence of an acute care hospital. This definition is not as useful outside of a medical application due to its specificity (Muula, 2007). The CPA supported defining rural communities as those with less than 25 000 people that are at least 50 kilometres from a larger urban area (Bazana, 1999). The commuting distance in this definition concerns me as 50 kilometres is something easily considered a commuting zone or even suburb of an urban area. Finally, Statistics Canada has recommended that the definition of rural depends on the characteristics one is examining, such as economic or social variables, but advises using defined benchmarks. The suggested benchmarks are those living in communities of less than 10 000 people that are also outside of the commuting zone of an urban centre (du Plessis et al., 2001). They do not define what a commuting zone might be.

For the purpose of this research, I wanted an opportunity to further clarify psychology in rural practice. I agree that variables such as population size,
isolation, economic activity, and social systems are important determinants of rurality (Stamm et al., 2007; Zapf, 2001). Given the complexities of understanding these communities, I wanted to consider what psychologists themselves would define as rural. Rather than beginning with a static definition of rural, I incorporated two processes for participant selection. First, I accepted participants who self-identified as “rural” knowing that they would be more intimately familiar with the distinct variables of the communities that they serve. A second process I used, as a flexible benchmark, was selecting participants from communities of less than 10,000 people that are also outside of the commuting zone of an urban centre, as recommended by Statistics Canada (du Plessis et al., 2001). Consideration of what defines rurality is also covered later in more detail as this became one of the themes from the data of this study.

3.2 Rural Communities and People

There is so much diversity among rural settings and people that characterising these communities is difficult. This means studying a group with great heterogeneity. The “geographic diversity in Canada accounts somewhat for these distinctions, as evidenced by coastal towns and fishing villages of the east and west coasts, rural farming and lumbering communities, rolling prairie lands, and northern isolated communities set on the tundra and Cambrian shield” (Moffit et al., 2009, p. 1156). That said, distinct concerns and characteristics of rural people have been proposed. Research has shown that the prevailing idea of idyllic stress-free rural life is an urban myth (Barbopoulos & Clark, 2003; McCabe & Macnee, 2002; Pong, 2007; Zapf, 2001). In fact, Jameson and Blank (2007) have suggested that rural people be considered a vulnerable group of people. International and national changes in economies, politics, and ecology have created disadvantages for rural people (Cheers, 2001; Pong, 2007), increasing
their needs and decreasing their ability to serve their community members (Jameson & Blank, 2007; Heflinger & Christens, 2006). Recent research by Sanderson (2004), for example, found that rural Canadian farmers appeared to be losing hope in farming. Key forces in shaping rural communities have been geographic isolation, social and economic factors, rapid changes to rural areas, and the culture of rural people. Isolation creates significant service disparity for rural communities (Barbopoulos & Clark, 2003; Harowski et al., 2006; Philo et al., 2003), yet being isolated does not protect rural communities from the impact of national and world events (Cheers, 2001). Rural communities experience more economic hardship and report higher levels of unemployment or underemployment than their urban counterparts (Barbopoulos & Clark, 2003; Gale & Deprez, 2003; Jameson & Blank, 2007; Judd, Cooper, Fraser, & Davis, 2006b; Philo et al., 2003; Shepard, 2004; Stamm et al., 2007). There is more poverty among rural people than inner-city residents, especially for women and children (Harowski et al., 2006; Meyer & Lobao, 2003). Poverty has been shown to increase the likelihood of mental distress for rural people (Pong, 2007; Stamm et al., 2007; Thorngren, 2003). Certainly, this appears to imply that there are distinct concerns for rural people. However, in many of the studies I reviewed, it was difficult to tell how rural and urban groups were matched and how variables were controlled. Many of the articles appeared to be well informed opinion of cultural analysis. Others appeared to compare rural and urban characteristics.

In considering common characteristics, it has been implied that rural communities and their psychological service needs have been changing (Barbopoulos & Clark, 2003; Heflinger & Christens, 2006; McCabe & Macnee, 2002). In addition to their geographical diversity, rural populations are becoming more diverse. Numbers of aging rural residents are growing, younger rural
residents are migrating to urban centres (Barbopoulos & Clark, 2003; Gale & Deprez, 2003; Jameson & Blank, 2007; Harowski et al., 2006), and there are increasing numbers of immigrants and refugees to rural areas (Bonifacio, 2007; Hargrove, 2007; Harowski et al., 2006). In some areas, community dynamics are being further altered by an influx of employment-mobile urban families seeking rural lifestyles (Hargrove, 2007). Given this diversity, the notion of a homogeneous “rural culture” has been questioned. Yet, the literature consistently suggests that psychologists be sensitive to traits considered common in rural populations. These include stoicism, conservativism, interconnection with others, and being from marginalized groups (Barbopoulos & Clark, 2003; Gale & Deprez, 2003; Harowski et al., 2006; Jameson & Blank, 2007; Judd et al., 2006b; Letvak, 2002; Roufeil & Lipzker, 2007; Shepard, 2004; Thorngren, 2003). The risk in this “sensitivity” is that rural people are aggregated into one group and defined only by their difference from urban populations. This could foster stereotypes that do not consider variability.

One example is the stigma concerning mental disorders in Canada (Cohen, 2009a). This is presumed to be worse in rural areas due to socially influenced or collective attitudes towards mental illness in rural communities (Boyd, Hayes, Sewell, Caldwell, Kemp, Harvie, Aisbett, & Nurse, 2008; Jackson et al., 2007; Letvak, 2002). Some literature has suggested that rural residents report higher levels of pride, independence, and stoic behaviour (Griffiths & Christensen, 2007; Harowski et al., 2006; Judd, Jackson, Komiti, Murray, Fraser, Grieve, & Gomez, 2006a; Sanderson, 2004; Stamm et al., 2007; Thorngren, 2003). However, I did not find any causal empirical evidence to suggest that this translates directly into mental health stigma. However, research has shown that rural people tend to be less aware of mental health issues and seek help less often (Caldwell, Jorm, Knox,
Braddock, Dear, & Britt, 2004; Jackson et al., 2007; Stamm et al., 2007; Thorngren, 2003). What accounts for this paucity in mental health awareness and help-seeking is not readily apparent.

One explanation is the perception that these communities are “closer knit” and therefore are less responsive to labelling mental health issues and see individual concerns as community considerations. If this is true, then perhaps there are social functions to the stigma against help-seeking in rural areas that foster a greater emphasis on family, individualism, and fatalism (Barbopoulos & Clark, 2003; Boyd et al., 2008; Harowski et al., 2006; Jackson et al., 2007; Jameson & Blank, 2007; Murray, Judd, Jackson, Fraser, Komiti, Hodgins, Pattison, Humphreys, & Robins, 2005; Thorngren, 2003). Further, rural communities have a vibrancy that contributes to the safety net of rural people. This helps people to connect and endure in trying times, giving people hope, and building successful communities (Harowski et al., 2006; Schank & Skovholt, 2006; Vella-Brodrick, Judd, Scannett, & Burney, 2006). Perceptions of rural health needs may underestimate the beneficial impact of informal community services, greater community involvement, and the capacity that derives from collective values (Boyd et al., 2008; Sanderson, 2004; Thorngren, 2003; Vella-Brodrick et al., 2006).

There are other features of rural communities that may negatively impact mental health. Enhanced social connectedness may foster a “goldfish bowl phenomenon” as community members expect to know more about each other which decreases privacy and increases community pressure (Barbopoulos & Clark, 2003; Harowski et al., 2006; Shepard, 2004; Thorngren, 2003). There can be a sense of isolation created by limited access to services and resources, social relationships, and increased difficulties in accessing services and necessities.
Characteristics are difficult to empirically validate but two characteristics of rural communities were studied more thoroughly. In a comparative study in Australia, remoteness of communities was associated with increased reports of psychological distress (Vella-Brodrick et al., 2006). The second consideration from Canada was that Aboriginal people (who live predominantly in rural areas) have very high rates of serious mental health concerns. Aboriginal Canadians are culturally marginalized and profoundly socially disadvantaged which makes them more sensitive to economic problems and the inadequate and inequitable mental health services in rural areas (Barbopoulos & Clark, 2003; Romanow & Marchildon, 2003). There are distinct mental health issues in rural areas but an inconclusive understanding of the characteristics of rural communities and people.

### 3.3 Challenges and Opportunities in Rural Practice

Psychology in rural practice is the study and practice of psychology that is primarily concerned with rural communities and people (APS, 2004b; Barbopoulos & Clark, 2003; Schank & Skovholt, 2006). The current state of rural mental health has practical challenges and advantages for psychologists (APS, 2004b; Barbopoulos & Clark, 2003; Gale & Deprez, 2003; Schank & Skovholt, 2006; Thorngren, 2003). Primary challenges are related to geographic barriers, lifestyle constraints, limited privacy, and higher risks of burnout (Barbopoulos & Clark, 2003; Gale & Deprez, 2003; Perkins, Larsen, Lyle, & Burns, 2007; Stamm et al., 2007). Rural psychologists may find that they serve a larger population, have more disadvantaged clients, and are more likely to work in professional isolation than their colleagues in urban practice (APS, 2004b; Fair, 2004). Despite these challenges, rural psychological practice can be rewarding. Perkins, Larsen,
Lyle, and Burns (2007) found that those who remain in rural practice report high levels of satisfaction with the job, lifestyle, and environment. Enhanced career, professional, and employment opportunities benefit the psychologists and the communities they serve. It has been found that those who work in rural settings do so by choice and the distinct professional challenges and lifestyle advantages may be strong incentives (Casey, 2007; Charlebois, 2006; Dimogiannis, 2000; Schank & Skovholt, 2006). Rural psychologists may experience intrinsic rewards related to impact they can have for rural communities and people (Dollard, Biswas, & Lynch, 2004). These psychologists may also get professional challenge from working as generalists with a variety of client needs, building multi-layered relationships and connections, and having a contextual and multifaceted view of their clients (APS, 2004b; Casey, 2007; Schank & Skovholt, 2006). Rural psychologists experience more community involvement and acceptance (Casey, 2007; Schank & Skovholt, 2006). They are afforded more professional opportunities to be educators, to offer professional development, to assist with community development, and to be involved in evaluation and research (Barbopoulos & Clark, 2003).

The available literature on rural mental health paints a bleaker picture than I had expected. The literature indicates that rural people are more likely to suffer from stress and mental health concerns like depression, suicide, and substance abuse (Bray et al., 2004; DeLeon, Wakefield, & Hagglund, 2003; Harowski et al., 2006; Stamm et al., 2007). The available research appeared to validate these mental health disparities (Fiske, Garz, & Hannell, 2005; Hoolahan, Kelly, Stain, & Killen, 2006; Thorngren, 2003) and demonstrated that up to a third of the rural population may have moderate to high levels of psychological distress (Campbell, Manoff, & Caffery, 2006a; Gale & Deprez, 2003; Kilkkinen, Kao-Philpot, O'Neil,
Philpot, Reddy, Bunker, & Dunbar, 2007). There are some difficulties in taking this at face value. The studies I reviewed did not use a consistent definition of rural, making it difficult to compare groups in making such statements. Also, researchers have questioned whether some of these results tease-out differences between culture and rurality (Judd et al., 2006b). The existence of supportive community factors should also be taken into consideration (Vella-Brodrick et al., 2006) as that can impact perceptions of stress and distress.

Research does indicate that rural mental health concerns are more likely to be undetected and untreated (Barbopoulos & Clark, 2003; Findlay & Sheehan, 2004). It is proposed that rural people tend to underestimate the prevalence of mental health problems and, when they do have concerns, tend to seek assistance from their general medical physician (Bartlett, Travers, Cartwright, & Smith, 2006; Gale & Deprez, 2003). Rural physicians do not detect mental health concerns as often nor do they provide as much psychotropic treatment or referral to professional mental health services as their urban counterparts (Harowski et al., 2006; Jameson & Blank, 2007). If this is the case, it has to be difficult to empirically validate mental health needs.

There are distinct rural considerations that impact access to health care. Rural people tend to be widely geographically dispersed and culturally diverse (Gale & Deprez, 2003; Roufeil & Lipzker, 2007). Proposed barriers to service access include the distance to services (DeLeon et al., 2003; Findlay & Sheehan, 2004; Gale & Deprez, 2003; Perkins et al., 2007) which may be further hampered by lack of supportive services like public transportation (DeLeon et al., 2003; Gale & Deprez, 2003; Harowski et al., 2006; Turpin, Bartlett, Kavanagh, & Gallois, 2007). It has also been proposed that rural people are less likely to access available professional mental health services and some of the literature has
indicated that this may be due to concerns about anonymity and confidentiality (DeLeon et al., 2003; Harowski et al., 2006; Jameson & Blank, 2007; Schank & Skovholt, 2006). This concern, however, does not appear to be empirically supported and is likely conjecture based on what is known about mental health stigma. Other research has demonstrated that rural people are less likely to access available professional mental health services as a result of a general lack of awareness about mental health (Bartlett et al., 2006; Findlay & Sheehan, 2004; Roufeil & Lipzker, 2007; Thorngren, 2003). I would suggest that inappropriate funding is more likely an issue at play than rural characteristics. Professional mental health services are less accessible in rural areas, particularly psychological services (Barbopoulos & Clark, 2003; Bowman & Kulig, 2008; Roufeil & Lipzker, 2007; Findlay & Sheehan, 2004), and are underfunded compared to other health services (Campbell, Kearns, & Patchin, 2006b; Gale & Deprez, 2003; O’Kane & Tsey, 2004; Turpin et al., 2007). This likely reduces literacy about mental health issues and heightens difficulties in accessing services. Insufficient funding may reflect urban-centric policies which are not responsive to the rural context (Benson, 2003; DeLeon et al., 2003; Harowski et al., 2006; Jameson & Blank, 2007; Nelson & McPherson, 2004).

Barriers can also be opportunities. Acute needs and low provider numbers have fostered several creative programs and ideas for mental health service delivery and adaptation in rural areas (DeLeon et al., 2003; Gale & Deprez, 2003; Roufeil & Lipzker, 2007; Schopp Demiris, & Glueckauf., 2006). Recognizing the need to reduce mental health stigma, rural prevention programs have targeted stoicism and self-reliance in an effort to increase mental health literacy (Findlay & Sheehan, 2004; Griffiths & Christensen, 2007; Judd et al., 2006a; Letvak, 2002; Wrigley, Jackson, Judd, & Komiti, 2005). Telehealth and the internet have
also created unique opportunities. Using this technology, psychologists may be able to provide services at a distance, lessening some of the barriers of travel and visibility (DeLeon et al., 2003; Jameson & Blank, 2007; Schopp et al., 2006; Stamm et al., 2007).

An idea considered crucial in rural areas is developing interdisciplinary rural mental health teams to provide services more tailored to the rural area and to reflect the collective dimension of rural life (Boyd et al., 2008; Gale & Deprez, 2003). It has been proposed that these teams consist of physicians and allied health professionals (DeLeon et al., 2003; Gale & Deprez, 2003; Jameson & Blank, 2007). Others suggest that these teams include specialty mental health providers, primary care providers, community agencies, school systems, clergy, consumers, and other key stakeholders (Harowski et al., 2006; Heflinger & Christens, 2006). While there have been some favourable pilot projects where such teams have been established (Lewis, 2001), these often require outside resources to succeed (Griffiths & Christensen, 2007; Hourihan & Kelly, 2006). Given the limited number of all health professions in rural areas, I would question the ease with which these teams might be created. While local teams would be most responsive to the community, effective teams require time for communication and for ongoing training to work collaboratively. Personally, I experience frustration in my struggle to work collaboratively with my peers in health and allied health. This is because each person’s workload, including my own, is so high that we rarely get time for any collaborative work. Rather than develop new interdisciplinary teams, another approach is to further develop existing community resources and to increase collaboration between local community helpers. Many studies have shown that this improves psychological treatment outcomes and increases mental health awareness (Dimogiannis, 2000;
Hodgins, Murray, Donoghue, Judd, & Petts, 2004; Judd, Davis, Hodgins, Scopelliti, Agin, & Hulbert, 2004). These kinds of initiatives would likely require substantial funding and time to become established.

3.4 Rural Psychology Practice in Canada

Rural practice issues are germane to Canadian psychology due to the immense geography and rural and remote dispersion of the population. In Canada, 90% of the land mass is considered rural and remote and, by some definitions, approximately 20% of Canadians live in small and rural dispersed communities (Barbopoulos & Clark, 2003; CIHI, 2006; McIlwraith & Dyck, 2002; Nigro & Uhlemann, 2004; Romanow & Marchildon, 2003; United Nations, 2005). Rural Canada is being transformed by the costs of transporting goods and transferring information, the migration of rural youth to urban areas, and the increasing numbers of elderly residents and immigrants in rural communities (Beshiri, 2004; Bollman, 2007; Pong, 2007).

Rural Canadians represent a diverse group with many common experiences. They vary with respect to cultural, ethnic, and religious composition (McIlwraith & Dyck, 2002). Rural Canadians report a strong sense of community belonging (CIHI, 2006). Compared to urban Canadians, they experience poorer socio-economic conditions and report lower educational attainment -- even for the youth (Alasia & Rothwell, 2003; CIHI, 2006; Pong, 2007; Shepard, 2004). Unemployment is higher in rural and remote areas, especially for women, and even for immigrants with university education (Beshiri, 2004; McIlwraith & Dyck, 2002). Existing employment tends to be resource-based which is economically riskier and physically more dangerous (McIlwraith & Dyck, 2002; Shepard, 2004). Also, Aboriginal Canadians, who live primarily in rural areas, are a considerably disadvantaged minority group, who tend to be isolated from
services and have higher rates of unemployment (Bollman, 2007; McIlwraith & Dyck, 2002; Romanow & Marchildon, 2004). Rural Canadians have less favourable health status than their urban counterparts (CIHI, 2006; Mitura & Bollman, 2003; Pong, 2007; Romanow & Marchildon, 2003). They have higher mortality rates, shorter life expectancies, and exhibit less-healthy behaviours such as poorer diets, higher rates of smoking, lower levels of physical activity, and higher rates of obesity (CIHI, 2006; McIlwraith & Dyck, 2002; Mitura & Bollman, 2003; Pong, 2007). Interestingly, rural Canadians have lower rates of cancer than their urban counterparts (CIHI, 2006; Romanow & Marchildon, 2003). Unfortunately, they do have a higher prevalence of circulatory diseases, arthritis/rheumatism, injuries, and long term disabilities (CIHI, 2006; McIlwraith & Dyck, 2002; Mitura & Bollman, 2003).

One needs to consider this information carefully given the difficulties in defining what is rural or urban and when considering how variables were controlled in the various studies. Ongoing research on rural mental health trends should use an agreed definition of rural to inform accurate, flexible policy making and to note changes over time. Overall, the discourse evident in the health literature implies that rural Canadians face a relatively poor mental health status compared to their urban counterparts. This is despite the protective and supportive factors inherent in rural and small communities.

The health and mental health needs of rural Canadians are coupled with less service availability. There are typical rural service issues such as lack of childcare and public transportation but more significantly, health care tends to be less accessible (McIlwraith & Dyck, 2002; Mitura & Bollman, 2003; Pong, 2007). The population dispersion makes it expensive and difficult to provide health care services and there are also significant shortages of health and mental health
Many rural Canadians cannot access psychological treatment. Alternatively, they access less appropriate, but more available, services through medical, legal, or other public services (McIlwraith & Dyck, 2002). This is likely due to a combination of negative community attitudes towards mental health treatment combined with the marginalization of psychology within the Canadian healthcare system (CPA, 2007; Hunsley & Crabb, 2004; McIlwraith & Dyck, 2002; Romanow, 2006). Canada is the only G8 country without a developed national mental health strategy which is one of the more urgently required reforms to the Canadian health system (Arnett, Nicholson, and Breault, 2004; CPA, 2007; Mikhail & Tasca, 2004; Romanow & Marchildon, 2004).

There is not sufficient rural mental health practice research in Canada to adequately assess these issues. This hampers the ability of psychologists in rural practice to provide empirically validated services, equitable treatment and services, or solutions to complex rural issues (Barbopoulos & Clark, 2003). I could find only a few examples of government departments, university initiatives, and academic literature specific to mental health issues in rural and remote Canada. Most of these focus on health in general rather than psychology specifically. From 1998-2002, there was a federally funded program to provide basic socioeconomic information and analysis to researchers and policy makers called “The Rural and Small Town Canada Analysis Bulletin”. The last bulletin based on that funding was posted in 2006 (Government of Canada, 2008). In 2004, six federal government departments and agencies sponsored a research forum called, “The Dialogue on Northern Research”. This meeting was established to facilitate networking, awareness, and collaboration and focused specifically on northern research (Graham & Bonneville, 2004). The only
ongoing effort in this area appears to be the Canadian Rural Information Service which posits itself as a clearinghouse for information relevant to rural Canada. It is mainly a way to access information on community development, funding opportunities, and services for rural youth (CRIS, 2008).

The academic community in Canada appears to have the most significant investment in health research in rural and remote Canada. Most noteworthy are developments from the University of Saskatchewan, the University of Northern British Colombia, and Laurentian University. The University of Saskatchewan had the “Canada Rural and Remote Health Studies” (CRRHS) program. It was grant funded from 2000-2005 to develop networks among rural and remote health researchers and to facilitate knowledge translation (University of Saskatchewan, 2008a). This program now houses the “Canadian Rural Health Research Society” (CRHRS) which was established “to facilitate research and knowledge translation aimed at understanding and promoting the health of people living in rural and remote Canada” (University of Saskatchewan, 2008b, para3). Although very promising, recent research by Biggs (2007) found that the CRHRS has had declining membership since it was established in 1999 and that most rural researchers are not familiar with the organization. The University of Northern British Columbia has an institute called, “The British Columbia Rural and Remote Health Research Institute” (BCRRHRI) which was founded in 2000. This is the only BC research institute that is dedicated to rural health issues with the goal of working towards improving the health of people in rural, remote, and northern populations (UNBC, 2008). Unfortunately, the focus is almost exclusively on British Colombia. Laurentian University hosts what it calls the “Centre for Rural and Northern Health Research” (CRaNHR). This program was established in 1992 with a broad research interdisciplinary mandate for health
research and includes Lakehead University’s “Northern Health Human Resources Research Centre” (Laurentian University, 2008). The mandate for CRaNHR sounds nationally promising but, upon closer review, the research appears to be solely based on rural Ontario and focuses on the work of researchers at Laurentian University, Lakehead University, and the health care community in Ontario.

A promising development for academic literature on this subject is the development of a North American section of the Australian peer-reviewed journal, *Rural and Remote Health*. The academic and research infrastructure in Australia is well developed and this peer reviewed journal (which is available online to facilitate access) has published many of the major contributions to the field of rural and remote health. The inaugural North American issue in May 2008 may mark the beginning of a forum for rural health researchers, clinicians and educators to explore the rural dimension specific to Canadian culture (Bowman & Kulig, 2008).

3.4.1 Current State of Psychology Practice in Rural Canada

Although mental disorders are more prevalent in rural and remote Canada, there is a shortage of mental health professionals in these areas (Barbopoulos & Clark, 2003; McIlwraith & Dyck, 2002). In particular, the ratio of psychologists to population is four times higher in urban areas in Canada (Bazana, 1999; Romanow & Marchildon, 2003) and there are significant issues with recruitment and retention in rural areas (Goodwin, 2004; McIlwraith & Dyck, 2002; McIlwraith, Dyck, Holms, Carlson, & Prober, 2005). Rural psychologists in Canada tend to be less experienced than their urban counterparts (Barbopoulos & Clark, 2003). One reason may be because most Canadian psychology students receive no formal training or exposure to rural practice considerations (Barbopoulos & Clark, 2003; Goodwin, 2004; McIlwraith et al., 2005). This is
despite a recent Royal Commission in Canada which indicated a distinct need for the further development of rural and remote psychological services (Romanow & Marchildon, 2003) and despite market demands.

There have been calls to develop programs and services to address this shortage. Most focus on the redevelopment of the health care system to include psychologists in services ranging from primary-care to prevention. Although there is empirical evidence supporting the efficacy of psychological treatments in health care, there have been no significant changes to include psychologists (Hunsley & Crabb, 2004; Romanow & Marchildon, 2004; Romanow & Marchildon, 2003). I could only find four examples of actual developments to address health psychology services in rural Canada. The Government of Saskatchewan’s Rural and Remote Memory clinic is designed to be a one-stop interprofessional service that includes clinical psychologists to improve dementia care in rural and remote areas of the province through the use of telehealth services (Crossley, Morgan, Lanting, Bello-Haas, & Kirk et al., 2008). The Department of Clinical Health Psychology of the Faculty of Medicine of the University of Manitoba has had a doctoral internship program in Rural and Northern Community-Based Psychology since 1999. This model, which includes a community-based generalist training model, is supplemented by telehealth supervision and rotating placements in rural and more urban areas. To date, there have been 20 participants as interns (Dyck, Cornock, Gibson, & Carlson., 2008; McIlwraith et al., 2005). The government of the province of Saskatchewan created nine programs within a rural model of integrated service delivery (Linzmayer, 2003). Finally, there is the Section for Rural and Northern Psychology, a voluntary member group of the CPA, meant to establish
networking opportunities, distribute information, and recruit students and psychologists interested in rural practice (Dyck, 2006).

3.5 Chapter Summary

Perhaps the most significant consideration when reviewing the literature on psychology in rural practice in Canada is that there is no common definition of rurality. While the available discourse tends to present a bleak picture of rural health it also indicates that there are complex and nuanced aspects of rural practice. It is important to balance an understanding of the commonalities of rural people with recognition of the diversity and variation within rural communities and peoples. The health of rural Canadians involves complex environmental, cultural, social, and psychological factors. There are challenges related to distance, fewer colleagues and allied health professionals, and limited training, research, and professional infrastructure in rural practice. The social networks and values of rural communities position the practising psychologist within a cultural system that may be vastly different from urban settings. Reflecting back on Chapter Two: Professional Ethics for Psychologists, I remind the reader of the need for psychologists to consider the content and context of dilemmas in their ethical decision-making. Psychology in rural practice presents a specific context. This may increase their responsibility, increasing their anxieties about ethical decision making (Bauman, 1998) and fostering the need for rural psychologists to have a mature and reflective understanding of ethics and professional practice. The next chapter will review the required ethical and decision-making acumen among rural psychologists.
CHAPTER FOUR

ETHICAL ISSUES FOR RURAL PSYCHOLOGISTS

Early in our marriage, my husband and I would shop together locally. Unfamiliar with rural life, he thought I knew everyone. He was puzzled about why I rarely introduced him or explained where I knew people from. He came to realize that a large number of community residents are acquaintances, extended family, colleagues, or clients (present or past). Once, under the assumption that my spouse knew details of my work, one of his students revealed details of a horrific childhood trauma. After that he decided that it didn’t matter how I knew people. It was easier to assume everyone was a client, and it was often faster to shop alone!

From my analytic journal, May 2008

Overlapping relationships, community pressure, generalist practice, interdisciplinary collaboration, and professional development and support are aspects of rural practice that may be more prevalent. When they are, they pose risks by complicating professional practice and the resolution of related ethical issues. These issues are acknowledged and discussed in the professional literature and in some cases supported by empirical data. Collectively, this material underscores the need for rural psychologists to have good decision making skills and exercise sound professional judgement in order to negotiate ethical issues and dilemmas.

4.1 Overlapping Relationships and Objectivity

It was heart-wrenching to hear that my stalwart but gentle child had been bullied at school for several weeks. My request for a meeting with the school was immediately granted and the teachers handled the situation efficiently and respectfully. I was surprised to hear another parent suggest that they had not received such an intervention. Would things have gone so smoothly for me if I was not the local psychologist who had other professional relationships with many of these teachers?

From my analytic journal, January 2009

An overlapping relationship (often called dual or multiple relationships) occurs when a psychologist enters into a second, non-professional relationship or role with a client. This may occur before, during, or after the professional relationship and may arise either by choice or by chance (Gripton & Valentich,
Boundaries are the psychological spaces between people in relationships. Overlapping relationships increase the probability of boundary crossings and boundary violations and it is important to distinguish between these two concepts.

Boundary crossings are benign overlapping relationships. They are more common in environments where the psychologist lives in close proximity to clients and may move in the same social circles. Boundary crossings are often unavoidable in rural practice and can be considered a normal and healthy part of rural living (Haydar, 2007; Scopelliti et al., 2006; Yonge & Grundy, 2006; Zur, 2006). Boundary crossings include appropriate self-disclosure, home and community visits to clients, or other minor deviations from a strict professional role. In boundary crossings, the psychologist is not standoffish but continues to perceive all non-office or non-professional relationship as potentially risky (Zur, 2006). Boundary violations, on the other hand, impair judgement and objectivity and have clear potential to be exploitative and harmful to the client, the professional relationship, and the profession of psychology. Treating members of one’s own family, close friends, or others with whom one has a significant non-sexualized relationship are boundary violations as are behaviours with clients such as touching, excessive self-disclosure, or involvement in sexual relationships. Boundary violations are never acceptable (APS, 2004a; Haydar, 2007; Nelson, Lushkov, Pomerantz, Weeks, 2007a; Scopelliti et al., 2006).

Discriminating between a boundary crossing and a boundary violation occurs on a case-by-case basis and is dependent on context, such as the cultural background and theoretical orientation of the client and psychologist (APS, 2004a; Endacott, Wood, Judd, Hulbert, Thomas, & Grigg, 2006; Lamb et al., 2004; Haydar, 2007; Lamb, Catanzaro, Moorman, 2004; Moleski & Kiselica, 2005; Truscott & Crook, 2004).
Understanding the difference between boundary crossings and boundary violations is complex, even when they appear harmless. Each requires due diligence and ongoing risk-benefit analysis (Barbopoulos & Clark, 2003; Charlebois, 2006; Moleski & Kiselica, 2005; Zur, 2006).

Psychologists in urban practice may find it easier to maintain clear professional boundaries because they live in a less-embedded environment. Compared to rural psychologists, they may enjoy greater anonymity, neutrality, and objectivity, which facilitate boundary separation. Such boundaries are more difficult to maintain in rural practice. In rural communities, roles and relationships overlap and can blur professional and social relationships (Scopelliti et al., 2006; Womontree, 2005; Younggren & Gottlieb, 2004). Non-professional contacts are commonplace because of the many roles people play in rural areas (Campbell & Gordon, 2003; Helbok, Marinelli, & Walls, 2006; Schank & Skovholt, 2006). Overlapping relationships become the normalized standard of care in rural practice because of the increased likelihood of family or friendship ties, chance encounters, co-involvement in community activities, and community norms that support overlapping relationships (Campbell & Gordon, 2003; Gripton & Valentich, 2004; Helbok et al., 2006; Zur, 2006).

Compelling psychologists to avoid overlapping relationships does not consider the necessary or therapeutic nature of some of these relationships (Austin, Bergum, Nuttgens, & Peternelj-Taylor, 2005; Helbok, 2003; Yonge & Grundy, 2006; Younggren & Gottlieb, 2004). Some authors suggest that effectively managed overlapping relationships may increase the effectiveness of rural psychological services (Moleski & Kiselica, 2005; Scopelliti et al., 2006; Yonge & Grundy, 2006; Younggren & Gottlieb, 2004). Behnke (2008b) has suggested that “finding oneself in a multiple relationship is not necessarily a sign
that one has engaged in unethical behaviour. It may rather be a sign that one is fully engaged in the life of a community” (p.62). This can enhance understanding of community needs and community members and can heighten the unique bonds between psychologists and clients (Johnson, Ralph, & Johnson, 2005; Scopelliti et al., 2006).

Often what rural people want and need is not impersonal clinical expertise but a strong friend to walk beside them through their pain and confusion, to share knowledge that will give hope, to identify with them yet demonstrate how to move out of their self-defeating behaviors and cognitive limitations. (Fair, 2004, p.57)

It also speaks to the artificiality of boundaries in therapeutic practice. A boundary is merely a metaphor for conceptualizing ethical issues. In reality, these relationships are one component of a complex series of interactions within the professional relationship (Austin et al., 2005).

4.1.2 Overlapping Relationships and Codes of Ethics

Typically, ethics codes state that overlapping relationships are not unethical if they do not exploit clients or impair objectivity. However, most ethics codes assert that psychologists are to refrain from overlapping relationships (Haydar, 2007; Johnson et al., 2005; Truscott & Crook, 2004; Yonge & Grundy, 2006). The principle of nonmaleficence requires that psychologists avoid behaviours or practises that could cause harm. Overlapping relationships between professionals and clients are not equal as the professional has more power than the client. Psychologists are more aware of boundary issues and clients are less able to negotiate boundary expectations (Moleski & Kiselica, 2005; Truscott & Crook, 2004). Avoiding overlapping relationships, when possible, is one way of fostering client autonomy.

The Canadian Code of Ethics for Psychologists (CPA, 2000) states that
overlapping relationships are to be avoided and when unavoidable are to be
strictly managed as they could harm the client or result in the delivery of inferior
services (Truscott & Crook, 2004; Yonge & Grundy, 2006). This applies to both
the personal and professional behaviour of Canadian psychologists (Pipes et al.,
*Integrity in Relationships*. Relevant behavioural standards of this principle require
psychologists to avoid overlapping relationships that may cause a conflict of
interest (behavioural standard III.33) and to develop and use safeguards when in
unavoidable overlapping relationships (behavioural standards III.34 and III.35).
Specifically, psychologists must manage any unavoidable overlapping
relationships through supervision, consultation, or third party consent (CPA,
2000; Yonge & Grundy, 2006).

The Canadian Code proscribes overlapping relationships generally, but
acknowledges exceptions that must be carefully considered and managed. A
similar structure is taken in other national codes (for example, the American
Psychological Association, the Australian Psychological Society, and the British
Psychological Society). This is also evident in the recent *Universal Declaration of
Ethical Principles for Psychologists*. In the Declaration, a relevant value is stated
in principle I, *Respect for the Dignity of Persons and Peoples*. This principle
requires psychologists to accept the value of “protection of confidentiality of
personal information, as culturally defined and relevant for individuals, families,
groups, and communities” (IUPS/IAAP, 2008, p.2). For rural psychologists this
would mean using diligence and engaging in risk-benefit analysis to protect
confidentiality in benign and culturally appropriate overlapping relationships.
Principle III, *Integrity*, includes “recognizing, monitoring, and managing potential
biases, multiple relationships, and other conflicts of interest that could result in
harm and exploitation of persons and peoples” (IUPS/IAAP, 2008, p.3). Principle III also acknowledges that “cultural differences exist regarding appropriate professional boundaries, multiple relationships, and conflicts of interest” (IUPS/IAAP, 2008, p.3).

4.2 Community Pressure and Integrity

Pulling out of town I notice flashing RCMP lights in my rear-view mirror. I slow down and pull over to let them pass but they slow down and pull over too. They are stopping me! My first reaction is to be appalled – I often work collaboratively with the RCMP. Surely they wouldn’t stop me?! Then I catch myself and make a mental note to not behave as though I expect favouritism. That turns out to be the least of my worries. As I sit and wait for the officer to do his routine check I notice the people passing by and know that they notice me. It is not just embarrassing but it doesn’t look very professional of me!

From my analytic journal, November 2008

In psychology, pressure is commonly defined as “the emotional experience of feeling compelled to respond to someone’s wishes or to external forces” (Reber & Reber, 2001, p. 560). Community pressure is common in rural communities which can be considered to be embedded environments. To provide competent and successful services, rural psychologists must be familiar with the specific values and culture of the area in which they practise and subsequent community expectations (APS, 2004b; Helbok, 2003; Jameson & Blank, 2007; McDonald, Harris, & Leesurier, 2005; Thorngren, 2003; Womontree, 2005).

Community expectations are a significant consideration for rural psychologists (Endacott et al., 2006; Schank & Skovholt, 2006; Womontree, 2004) particularly as ethical action always takes place within a community and impacts more than just the psychologist and client (Austin, 2007). There is often an assumption that rural psychologists will take the role of expert and leader in community development (Gale & Deprez, 2003; Schank & Skovholt, 2006; Womontree, 2005). This may pressure a rural psychologist to work in a
community psychology role or to work beyond the limits of their competence. Competency issues are discussed in more detail under “Generalist Practice”. The increased visibility of rural psychologists also causes pressure based on reputation, appearance, or behavioural expectations (Gale & Deprez, 2003; Schank & Skovholt, 2006; Womontree, 2005). Rural psychologists are often expected to relate to community members at a social as well as a professional level. This may influence the ability of the psychologist to secure trust from key members of the rural social network, many of whom will have considerable knowledge about the psychologist’s personal life (APS, 2004b; Helbok, 2003; Schank & Skovholt, 1997). Lack of anonymity may foster trust but lack of privacy increases pressure for the psychologist (APS, 2004b; Helbok, 2003; Peterson, 2002). Visibility also impacts the confidentiality of clients as community members are likely to be aware of who is using psychological services. Support staff may be familiar with clients and other agencies may openly share information about clients with the psychologist (Helbok, 2003; Helbok et al., 2006). Charlebois (2006) found that distinctions needed to be made between confidentiality, anonymity, and privacy for rural clients. She suggests that only confidentiality can justifiably be offered to the client in a rural area. Essinger (2006) found rural communities often expect that psychologists will share information. In rural communities personal information is more readily available (and is often offered to psychologists) through common informal-sharing networks or gossip (Fisher, 2008; Green & Mason, 2002; Helbok, 2003; Kemp Brill, 2003). These networks are often part of the protective community fabric and the expectations to share confidential information without consent is unlikely to be seen as a harmful act (APS, 2004b; Schank & Skovholt, 2006; Womontree, 2005). There may also be expectations that psychologists provide
practical and tangible services which may compel the psychologist to focus more on services that result in concrete problem solving rather than services aimed at self-actualization (Schank & Skovholt, 2006).

Community pressure is dependent on the context or culture of the rural community in which the psychologist practises and may become more pronounced as the community size decreases or when community isolation increases (Endacott et al., 2006; Helbok, 2003; Scopelliti et al., 2006). In qualitative interviews, Schank and Skovholt (1997) found that 16 rural psychologists in the United States expressed anxiety in relation to perceived community pressure. This is consistent with Bauman’s (1998) suggestion that increased unspoken responsibility fosters anxiety. In a recent mail-out survey comparing the practises of over 400 rural and urban psychologists, Helbok et al. (2006) found that rural psychologists reported more community pressure, primarily in the form of multiple relationships. Interestingly, these rural psychologists also reported fewer ethical dilemmas related to this increased pressure.

4.2.1 Community Pressure and Codes of Ethics

The virtue of integrity is implicit in most codes of ethics (Haydar, 2007; Truscott & Crook, 2004; Yonge & Grundy, 2006). Integrity in relationships is a particularly salient issue in the cultural context of embedded environments where overlapping relationships are more common. The Canadian Code of Ethics for Psychologists (CPA, 2000) directs psychologists to monitor the need and cultural appropriateness of disclosure, to act in the best interest of community members, and to foster public trust in the discipline of psychology. These standards are outlined in the Code’s third principle, Integrity in Relationships. Ethically, rural psychologists need to balance both client and community needs (Schank &
Skovholt, 2006) Sinclair and Pettifor (2001) warn that “failures to meet expectations of integrity…have provided the basis for a large number of complaints against psychologists. Such failures can undermine scientific progress and public trust in psychology” (p.72).

The *Universal Declaration of Ethical Principles for Psychologists* states that it is important to acknowledge and respect the way that different communities and cultures respect the dignity of persons and peoples (IUPS/IAAP, 2008). This is certain to impact how integrity is perceived and sociocultural expectations for the psychologist. When community norms exert pressure on roles and expectations, rural psychologists must be careful to balance client and community needs.

Community pressure can pose risks to client confidentiality. The implied or explicit promise of the psychologist to keep client information private is central to the professional psychological relationship and the perception of integrity (Truscott & Crook, 2004). In the CPA Code, confidentiality and privacy are central ethical standards within the principle of *Respect for the Dignity of Persons* (CPA, 2000). Although community considerations are essential, this Code clarifies that the psychologist’s greatest responsibility is to their clients (Sinclair & Pettifor, 2001). This can be difficult when the psychologist has less ability to control disclosure of personal information. Increased visibility in rural practice means that the rural psychologist may unintentionally have more information about a client then that client consented to release. Similarly, the psychologist may be less able to control confidential client information (such as attendance at a therapy session) because of visibility.

Cultural competence is a focus in the CPA Code’s *Responsibility to Society*. In this principle, psychologists are to be responsible to the communities
in which they live and work and to acknowledge the need and value of the social structures in these communities (CPA, 2000). They are required to convey respect for prevailing community norms and recognize how societal expectations may impact their practice (Sinclair & Pettifor, 2001). This can be particularly difficult when community pressure undermines the integrity of rural psychologists or when visibility impacts client confidentiality. The *Universal Declaration of Ethical Principles for Psychologists* (IUPS/IAAP, 2008) also requires that psychologists provide services appropriate to cultural context. This Declaration states that “specific standards of conduct will vary across cultures, and must occur locally or regionally in order to ensure their relevance to local or regional cultures, customs, beliefs, and laws” (p.1). This implies the need for standards of conduct specific to communities in which psychological practice occurs.

4.3 Generalist Practice and Competency

The lack of local resources for people affected by cancer was an ongoing frustration — free psychological services are only available at the cancer hospital nearly 300 kilometres away and not an option for most people. When at a meeting with some of the psychologists from this department, I talked to them about the lack of referral resources for our area. The next thing I knew I was attending training and getting consultation from our provincial oncology services. As the one psychologist put it — “we can’t provide services to rural areas but we will help you to do it”. Not exactly what I had been looking for and not an area I had any previous training in.

From my analytic journal, March 2009

Rural practice conditions (such as lack of referral resources) often necessitate a generalist approach (APS, 2004b; Harowski et al., 2006; Helbok, 2003; Sawyer, Gale, & Lambert, 2006). Indeed, Dimogiannis (2000) found that most psychologists in rural practice define their practice as generalist in nature. This common practice consideration is reflected in the rural practice doctoral internship in Manitoba where “consistent with generalist rural practice, interns and residents provide consultation, assessment and treatment (individual, family,
and group) services to a broad patient base that ranges with respect to age, ethnicity, culture, and presenting concerns” (Dyck et al., 2008, p.244). Specialization is impractical as rural service needs require practitioners to be multi-skilled in dealing with diverse populations (Barbopoulos & Clark, 2003; McIlwraith et al., 2005; Perkins et al., 2007). They also deal with a greater range of illnesses and conditions (Essinger, 2006; Gale & Deprez, 2003; Hourihan & Kelly, 2006), and higher levels of co-morbid substance abuse (O’Kane & Tsey, 2004; Roufeil & Lipzker, 2007).

Generalist practice can contribute to greater job satisfaction but also fosters ethical issues. It has been suggested that a diverse general practice can cause concerns about competence, scope of practice, and appropriate training. It may also challenge the confidence of the psychologist (Hays, 2006; Helbok, 2003; McIlwraith et al., 2005). Unfortunately, professional training specific to generalist practice in rural settings is rare. This is despite the need for rural psychologists to be prepared to provide consultation, outreach, community assessment, program development, and evaluations. Rural psychologists are also likely to work with rural health care systems and to collaborate on interdisciplinary teams (Harowski et al., 2006; Helbok, 2003; McIlwraith et al., 2005).

Rural psychologists face the dilemma of providing needed services that may not exist without their efforts. Yet, the quality of such services may be compromised if they work outside their area of training (Kersting, 2003; Nelson et al., 2007b). Rural psychologists must decide whether to cover needs themselves, refuse treatment (considering the ramifications for the client), provide limited service, or provide service outside their area of competence (Schank & Skovholt, 2006). The scarcity of rural mental health resources may pressure
psychologists to work as generalists, often beyond the limits of their education (Barbopoulos & Clark, 2003; Gale & Deprez, 2003; Turchik, Karpenko, Hammers, & McNamara, 2007). In addition to the lack of alternative professionals, there is often limited access to specialists. The primary challenge is to provide optimal care, often with a minimum of resources, without violating the competency principle of ethics codes (Essinger, 2006; Helbok, 2003; Schank & Skovholt, 2006; Womontree, 2005).

The Australian Psychological Society noted that limited competence is one of four most commonly cited ethical issues for rural and remote practitioners (APS, 2004b). Psychologists working in rural areas with limited services often work with clients or issues beyond their level of expertise and with limited professional consultation much like rural general medical physicians (Gale & Deprez, 2003; Hays, 2006; Smith, 2003; Stamm et al., 2007). In the Manitoba program mentioned earlier, the supervisors role model ways to deal with limits of competence. Common supervisory discussions involve dealing with pressure to provide services, self-awareness about limits of competence, and identifying when additional supervision or consultation is required (Dyck et al., 2008).

4.3.1 Generalist Practice and Codes of Ethics

Competence is one of the cornerstones of professional practice and the reason that many clients choose to seek the services of a psychologist. However, most ethical codes do not clearly define competence (Helbok, 2003). Generally, competence is considered to be a multidimensional concept comprised of knowledge, skills, judgement, and diligence in the provision of professional services (Truscott & Crook, 2004). Even when trained as generalists, it is not possible to be competent in the provision of all psychological services to all client groups. Psychologists in rural practice need to assess their competencies within
the context of community and client needs, professional expectations for specialization and competency, and ethical standards (Schank & Skovholt, 2006).

The Canadian Code of Ethics for Psychologists (CPA, 2000) clarifies the values of competence and self knowledge and states that, “psychologists would offer or carry out (without supervision) only those activities for which they have established their competence to carry them out to the benefit of others” (CPA, 2000, p16). Other considerations for generalist practice are contained in the Universal Declaration of Ethical Principles for Psychologists. Here, one of the four foundational principles is titled “Competent Caring for the Well-Being of Persons and Peoples” (IUPS/IAAP, 2008, p.3).

4.4 Interdisciplinary Collaboration and Confidentiality

4.4 Interdisciplinary Collaboration and Confidentiality

I often work with addiction counsellors. One of these counsellors has no formal education or professional registration but is gifted in relationships and quite charismatic. Countless times she has betrayed the confidentiality of clients and established enmeshed boundaries. I have reviewed my concerns with her, her supervisor, and within clinical consultation team meetings. There are times when I feel a sense of transference – almost anger towards her repeated behaviour. I am cognizant that I have to be careful not to damage our professional relationship particularly if I want to impact her professional development.

From my analytic journal, February 2009

There are many forms of collaboration in professional practice. The literature refers to interagency relationships, multidisciplinary teams, transdisciplinary work, and interdisciplinary collaboration. Interagency relationships refer to work between agencies that may involve professionals of varying disciplines (Schank, 1997). Interagency relationships imply that collaborations are only with other professionals or agencies. In multidisciplinary teams, members cooperatively provide discipline-specific contributions. Cooperative processes, such as those in multidisciplinary teams, are not sufficient as no discipline is rurally-focussed. Transdisciplinary work means collaborative
work that evolves beyond discipline-specific contributions (Austin, Park, & Goble, 2008). Transdisciplinary collaboration exceeds the level of integration that is typical in rural collaborations. Interdisciplinary collaboration is “the deliberate pooling and exchange of information and knowledge that crosses traditional disciplinary boundaries” (Crossley et al., 2008, p.231). Interdisciplinary collaborations are useful for addressing complex, multi-faceted problems and goals and for achieving common ground (Austin et al., 2008; Van Vliet, 2009). These best describes the professional interactions common for rural psychologists as interdisciplinary collaborations are an effective way of providing for an integrated community response (Bock & Campbell, 2005; Donoghue, Hodgins, Judd, Scopelliti, Grigg, Komiti, & Murray, 2004).

Unfortunately, psychologists in rural practice are rarely trained in working collaboratively with professional and paraprofessional community supports (Bock & Campbell, 2005; McDonald et al., 2005; Turchik et al., 2007). Effective collaborations with health care professionals, teachers, and social workers may facilitate referrals (Benson, 2003; Jackson et al., 2007; Schank & Skovholt, 2006; Turchik et al., 2007). These collaborations may also increase the services available to rural community members in otherwise underserved areas (Barbopoulos & Clark, 2003; Linzmayer, 2003; Sawyer et al., 2006; Stamm et al., 2007). For the rural health professional, collaboration can help prevent burnout, work overload, and a sense of isolation (APS, 2004b; Helbok, 2003; McIlwraith & Dyck, 2002). Valuable resources in rural settings may include naturally-occurring community supports such as those in families, schools, churches, and community groups (Bock & Campbell, 2005; Schank & Skovholt, 2006; Turchik et al., 2007). Indeed, McDonald et al. (2005) found that many psychologists in rural practice do use natural support systems to reduce isolation for themselves.
and their clients and to provide for more holistic and informed crisis intervention (Bock & Campbell, 2005; McDonald et al., 2005; Smith, 2003).

Along with its benefits, interdisciplinary collaboration fosters concerns. These include an enhanced risk of blurred roles resulting in compromised client confidentiality (Helbok, 2003; Helbok et al., 2006; Schank & Skovholt, 2006; Womontree, 2005). The more casual sharing of information in rural areas may mean that colleagues and co-workers discuss cases openly without consent or expect this of psychologists. In these settings, even general discussions can be misinterpreted as being about specific clients (Schank & Skovholt, 2006). Psychologists in rural practice who decline to share confidential information, or who challenge the behaviour of other professionals, may alienate themselves and lose referral sources (Helbok, 2003; Kersting, 2003; Schank & Skovholt, 2006).

In reviewing rural mental health, Sawyer et al. (2006) reported that interdisciplinary collaboration is often hindered by insufficient communication, professional specialization, and a poor integration of mental health and primary health care.

4.4.1 Interdisciplinary Collaboration and Codes of Ethics

Confidentiality is another fundamental component of professional psychology. It is a foundation of codes of ethics in psychology and is only limited in extreme circumstances such as dangerousness. Breaches of confidentiality can undermine the professional relationship and cause harm. Psychologists must ensure that client information is not revealed to anyone without consent except in a few conditions that relate to likelihood of harm (Truscott & Crook, 2004). Although it can be a foreign concept in highly interconnected small communities (Wihak & Merali, 2007), confidentiality plays a vital role in the provision of
psychological services and breaking confidentiality may increase the stigma around seeking psychological services (Helbok, 2003).

In the *Canadian Code of Ethics for Psychologists* (CPA, 2000), *Respect for the Dignity of Persons* acknowledges that each person has the right to decide who has access to his or her private information. This primary principle requires psychologists to be careful not to relay confidential and potentially confidential information that was obtained in a professional relationship. Psychologists should clarify what measures will be taken to protect confidentially and only share confidential information with informed consent or in a manner that the persons involved cannot be identified (CPA, 2000). These considerations need to be balanced with the local rural culture and expectations and the need for collegial respect. Psychologists working with other agencies or supports are limited in their ability to affect the behaviour of those persons. Although Canadian psychologists must “encourage others, in a manner consistent with this Code, to respect the dignity of persons” (CPA, 2000, p. 14), Sinclair and Pettifor (2001) remind psychologists to demonstrate humility and respect and avoid being dictatorial. The ability of psychologists to influence agencies or community processes is complex and requires nuanced ethical decision making. The second principle, *Responsible Caring*, speaks to how breaches of confidentiality risk damaging the client and the professional relationship (Truscott & Crook, 2004). Psychologists are required to be acutely aware of the need for discretion as information (recorded, collected, and shared) can be misinterpreted or misused by others to the detriment of clients (CPA, 2000). Considerations for rural practice may mean enhanced levels of informed consent to protect client privacy within interdisciplinary collaborations. Finally, principle IV, *Responsibility to Society*, speaks to respect for the society in which psychologists work. Psychologists
require an ability to work effectively with others. They may require training to
develop the requisite skills for appropriate and effective collaborative work. This
includes the need to respect other professionals. Psychologists must respect
naturally occurring support systems and avoid unnecessary disruptions to these
groups. This means developing the necessary skills to balance ethical standards
with prevailing community mores through collaborative relationships (CPA,
2000). This presents a considerable balancing act in rural practice.

The Universal Declaration of Ethical Principles for Psychologists
(IUPS/IAAP, 2008) has several relevant issues that can be considered in relation
to interdisciplinary collaborations. They key standards of confidentiality and
privacy is enunciated under Principle I, Respect for the Dignity of Persons and
Peoples (IUPS/IAAP, 2008). This goes on to state in Principle III, Integrity, that
“complete openness and disclosure of information must be balanced with other
ethical considerations, including the need to protect the safety of confidentiality
of persons and peoples, and the need to respect cultural expectations”
(IUPS/IAAP, 2008, p.3). Rural psychologists need to assist their clients in
determining the extent of consent to release information in situations where there
will be interdisciplinary collaboration.

4.5 Professional Development and Support

There is a small group of psychologists in rural practice who regularly
attend the national convention. I have noticed a great sense of
camaraderie amongst this group. Perhaps it is similarities in personality
but more likely for me it is having that rare feeling of collaboration with
people who are familiar with my context. It is another form of small
community.

From my analytic journal, June 2008

Although psychologists require ongoing professional development and
support, particularly in ethics (Morrissey & Symons, 2006), rural-specific
professional development is not common. The literature suggests that there is
insufficient professional psychology training or placements specific to rural practice (Barbopoulos & Clark, 2003; Jameson & Blank, 2007; Stamm et al., 2007). The field of psychology tends to be urban-centric and psychologists in rural practice rate their undergraduate and postgraduate professional training in psychology as only somewhat adequate for rural practice (Jameson & Blank, 2007; Harowski et al., 2006; McIlwraith & Dyck, 2002). Specifically, they reported receiving insufficient training in the area of ethics (Roufeil & Lipzker, 2007; Schank & Skovholt, 2006). In a quantitative comparison, Dimogiannis (2000) found that rural psychologists rated their training as less adequate for the nature of their practice than urban psychologists.

Another consideration is the availability of consultation and supervision for those in rural practice. Regular peer consultation and clinical supervision is essential for good practice and maintaining competence (Schank & Skovholt, 2006; Truscott & Crook, 2004), particularly for those who work in relative isolation (APS, 2004b; Helbok, 2003; McIlwraith & Dyck, 2002; Sawyer et al., 2006; Schank & Skovholt, 2006). In qualitative interviews, Charlebois (2006) found that Canadian rural counsellors wished they had more access to peer consultation. In a comparative survey, Womontree (2005) found that psychologists in rural American practice reported less satisfaction with the availability of consultation and support when compared to their urban counterparts. Options for supervision and consultation are often limited by geographical, environmental, and economic difficulties (Schank & Skovholt, 2006; Wood, Miller, & Hargrove, 2005).

There are also concerns related to appropriate ongoing professional development. Continuing education, additional training, and retraining are important ways to stay professionally current. Johnson, Brems, Warner, and
Roberts (2006) found that psychologists in rural practice had great interest in continuing professional education on ethics, particularly the management of clients with special issues. Unfortunately, qualitative (Charlebois, 2006) and quantitative (Womontree, 2005) studies of rural practitioners confirm that they have fewer opportunities for continuing education and find participating in professional development more difficult. In her quantitative study of psychologists in rural practice, Womontree (2005) found three primary barriers to professional development. The first was a lack of financial support for the increased costs of accessing classroom training, workshops, conferences, and internet support. The second was geographical barriers to centres of higher learning or other resources. The third was a dearth in resources, training, or professional development that specifically addressed the concerns of psychologists in rural practice.

Finally, psychologists in rural practice often deal with personal and professional isolation (APS, 2004b; Barbopoulos & Clark, 2003; Schank & Skovholt, 2006; Jameson & Blank, 2007). Professional isolation results in fewer opportunities to consult on difficult cases, engage in collaborative work, or conduct research. This can result in a decreased sense of accomplishment and fewer opportunities for intellectual stimulation, collegial support, and sharing of ideas (Barbopoulos & Clark, 2003; Helbok et al., 2006; Jameson & Blank, 2007; Schank & Skovholt, 2006). This is compounded by the fact that most psychologists in rural practice work individually in private practice causing further isolation (Dimogiannis, 2000). The limited access to peers for supervision and consultation can undermine competency. In the absence of collegial feedback, rural psychologists may rationalize non-traditional practices, be less aware of unethical behaviour, and compromise standards due to isolation (Helbok, 2003;
Weigel & Baker, 2002). It is more difficult for rural psychologists to become involved in professional organizations as they may feel misunderstood or disempowered by their urban counterparts (Schank & Skovholt, 2006). Personal isolation can result from feeling isolated from cultural or medical resources (Schank & Skovholt, 2006; Womontree, 2005).

Perceived or actual isolation can impact recruitment, retention, and turnover of psychologists in rural practice (Helbok et al., 2006). An extreme manifestation of isolation can be compassion fatigue or burnout. This may present as emotional exhaustion, loss of purpose and energy, depersonalization or cynical attitudes, and loss of a sense of personal accomplishment (DeStefano Clark, & Potter, 2005; Helbok et al., 2006). Rural practice poses increased risk for burnout (APS, 2004b; DeStefano et al., 2005; Helbok, 2003; Kee, Johnson, & Hunt, 2002), particularly when there are high workloads (DeStefano et al., 2005; Schank & Skovholt, 2006). Other risk factors for burnout include difficulties setting limits (Gardiner, Sexton, Durbridge, & Garrard, 2005; Smith, 2003), significant travel (Kee et al., 2002; Schank & Skovholt, 2006; Schopp et al., 2006), and lack of resources and support (DeStefano et al., 2005; Schopp et al., 2006). Psychologists in rural practice are also at risk for burnout related to community pressure (Helbok et al., 2006; Jameson & Blank, 2007; Schank & Skovholt, 2006) and a need to adapt to the local culture (Smith, 2003; Wihak & Merali, 2007).

4.5.1 Professional Development and Codes of Ethics

Diligent psychologists continually attend to their skills and professional judgement so that their competence is not compromised (Helbok, 2003; Morrissey & Reddy, 2006; Truscott & Crook, 2004). Indeed, many jurisdictions require continuing professional development. The Canadian Code of Ethics for
Psychologists (CPA, 2000) holds psychologists responsible for developing and maintaining professional skills and for routinely assessing and discussing ethical issues with peers or senior colleagues. The principle of Responsible Caring requires psychologists to stay up to date on knowledge and research in the field, and to be aware of practice risks. This includes reading, peer consultation, and professional development activities. Behavioural standard II.12 specifically requires that psychologists address potential burnout and engage in self-care as a way to prevent impaired judgement. An overall expectation for currency is part of the principle of Integrity in Relationships which requires maintenance of competence in their area of specialization and a commitment to maintaining the standards of the discipline (CPA, 2000).

The Universal Declaration of Ethical Principles for Psychologists (IUPS/IAAP, 2008) has several relevant considerations specific to professional development. Principle II, Competent Caring for the Well-Being of Persons and Peoples, refers to “developing and maintaining competence” (IUPS/IAAP, 2008, p.3). This speaks to both training and ongoing professional development. Under principle III, Professional and Scientific Responsibilities to Society, relevant values include “the discipline’s responsibility to adequately train its members in their ethical responsibilities and required competencies” (IUPS/IAAP, 2008, p.4). Finally, under that same principle, the Declaration underscores “the discipline’s responsibility to develop its ethical awareness and sensitivity and to be as self-correcting as possible” (IUPS/IAAP, 2008, p.4). Consultation, supervision, and engagement (as opposed to isolation and burnout) are essential for maintaining ethical awareness and sensitivity.
4.6 Key Studies

The concepts and findings of this study were contextualized by detailed consideration of some of the empirical studies reviewed in this chapter. This section is a critical review of those studies for understanding the phenomenon of professional ethics for practising rural psychologists.

Comparative studies that I reviewed indicated that there are differences between rural and urban practice when considering professional ethics. Helbok, Marinelli, and Walls (2006) surveyed 447 rural and urban psychologists on ethical practices. They defined rural psychologists as those practising in communities of less than 20,000 people. In their results, rural respondents reported engaging in a statistically significant number of multiple relationship behaviours compared to urban respondents. Of the 34 multiple relationship activities listed, rural respondents indicated that they regularly engage in 19 of these behaviours compared to nine for the urban respondents. Similar statistically significant results were reported for behaviours that increased the psychologist’s visibility and that might create difficulties for maintaining confidentiality. It is meaningful that, despite the limits of self-report data from this mail-out survey, the rural respondents in the study did not endorse items indicative of burnout or of concerns over competence. For her doctoral dissertation, Kemp Brill (2003) also conducted a quantitative study comparing the practices of rural and urban psychologists. She defined rural psychologists as those practising in communities of less than 2500 people. She surveyed an equal number of urban and rural respondents (96 participants in total) from 50 states. The survey asked participants to rate the frequency in which they engaged in behaviours considered ethically questionable. They were then asked to rate how acceptable they considered those behaviours. Analyses of variance indicated no statistically
significant difference between urban and rural psychologists on any of the variables. In another comparative study, Johnson, Brems, Warner, and Roberts (2006) examined desire for continuing education in ethics. They surveyed 164 psychologists and 228 mental health counsellors from both rural and urban areas, defining rural as communities with less than 15,000 people. Participants rated how helpful they would consider continuing education on various topics in professional ethics. This research did not support the hypothesis that rural practitioners would prefer more training in these areas but instead found no significant difference between the groups.

Other quantitative studies on professional ethics focused exclusively on rural practice. In her doctoral dissertation, Lutosky (2005) surveyed 91 rural psychologists comparing their level of moral reasoning with how they rated various dual relationship scenarios. She used Kohlberg’s theory to represent moral reasoning and defined rural psychologists as those who live and practice in the same community of less than 10,000 people. Her results were not significant and did not support the hypothesis that those with higher levels of moral reasoning more easily identified conflict of interest dilemmas. Her study acknowledged some qualitative data but this was not analysed. Womontree’s (2004) doctoral dissertation involved a survey of 56 rural mental health care providers from Illinois and Missouri. She defined rural as communities with less than 18,000 people and indicated that participants included social workers, psychiatrists, and psychologists (apparently only two). This self-report survey reviewed the frequency with which participants experienced dual roles, competency concerns, feelings of isolation, community pressure, and interagency relationships in relation to their demographics. Respondents rated how often they engaged in 22 different behaviours from “always” to “no opportunity”. Responses
were compared to demographic information to explore which variables in rural practice increase the likelihood of experiencing ethical dilemmas. The only significant finding was that psychologists with three or more children had an increased likelihood of experiencing ethical dilemmas.

Schank’s (1994) qualitative dissertation was particularly relevant in the development of this study. She explored the experience of ethical dilemmas by practising rural psychologists in Minnesota and Wisconsin. Schank defined rural communities as those that were at least 50 miles from a major metropolitan area. Sixteen participants answered open-ended questions on seven ethical dilemmas which were: dilemmas involving professional boundaries; limited resources and limits of competence; community values and expectations; inter-agency issues: working with other community agencies, groups, and professionals; involving peer helpers and other alternatives to traditional treatment methods; and burnout. Analysis of convergent and divergent themes detailed participant experiences in each of these areas. She also found that the participants struggled to apply their code of ethics to these situations. Charlebois’ (2006) Master’s thesis was the only Canadian study I found. She interviewed three counsellors on 15 open-ended questions to explore their experiences of practising in a remote and isolated community. Participants needed to have lived and worked in the same community for at least five years. Participants’ responses indicated that they used professional and personal ethics, established clear boundaries, and desired more opportunities for professional development. Professional ethics was described through the use of formal ethics codes and protocols in addition to ongoing professional development. Personal ethics were described as values and focus on self care. The results of these qualitative studies support the need for a more in depth understanding.
None of these studies explored exclusively the experience of rural psychologists in Canada. In these studies, operational definitions of rural ranged from communities of 2500 to under 20,000 people or by distance from an urban centre. Selection and sample sizes ranged from three to over 400 participants and represented as little as one community or as many as fifty states. For me, these studies illuminated the differences between rural and urban practice. They also demonstrated contradictory findings about whether or not rural psychologists experience more ethical dilemmas because of those differences. The non-comparative studies confirmed the experience of ethical dilemmas for rural psychologists and the struggle to resolve these dilemmas. Those rural-only studies did not study how these dilemmas were resolved in actual practice.

4.6.1 My Research Goals and Questions

The literature reviews five primary rural-specific considerations that are relevant to professional ethics for psychologists. Rural psychologists are more likely to experience overlapping relationships which may mean an enhanced need to use diligence and engage in risk-benefit analysis to ensure nonmaleficence. Community pressure may increase visibility and expectations posing confidentiality and integrity concerns. Practice conditions may necessitate a generalist practice, which can task competency, or interdisciplinary collaboration which poses additional confidentiality concerns. Finally, the lack of rural-specific professional training and development can hinder rural psychologists’ self-awareness and competency.

Several empirical studies have begun to explore the phenomenon of professional ethics for rural practice with mixed results. Rural psychologists are more likely to experience overlapping relationships (Helbok et al., 2006) but may not engage in more unethical behaviour (Kemp Brill, 2003) and may not have any
greater desire for ethical training than their urban counterparts (Johnson et al., 2006). The results of rural-specific studies exploring overlapping relationships and the ability to identify conflict of interest dilemmas were limited (Lutosky, 2005; Womontree, 2004) but qualitative studies by Schank (1994) and Charlebois (2006) have begun to highlight struggles inherent in applying codes of ethics in rural practice. The empirical studies reviewed employed vastly different operational definitions of rural (from 2 500 to 20 000 people) and none were specific to the experience of rural psychologists in Canada or how dilemmas were resolved in actual practice. However, they did underscore the need for rural psychologists to have good decision making skills and to exercise sound professional judgement in order to negotiate ethical issues and dilemmas.

Even experienced and knowledgeable psychologists may be unsure of how to proceed in some situations. Understanding a code of ethics is not enough to ensure ethical behaviour, particularly in specific contexts. Rural practice, although rural is poorly defined in the literature, represents a distinct community of practice which may include specific ethical practice considerations. Having insufficient scholarly understanding of professional ethics for rural practice hampers the ability of rural psychologists. This is particularly germane in Canada where approximately 20% of Canadians live in small and rural dispersed communities. Personally, I suspected a high level of practical wisdom among rural psychologists. The literature did support the idea that rural psychologists may have developed implicit knowledge to assist them in practising ethically within the constraints of rural practice (Schank & Skovholt, 2006). This knowledge, if it can be made explicit, would be an important resource to psychologists in rural practice, those in training, and urban psychologists who may work with rural clients or within small communities. A better understanding
of professional ethics in rural practice could better protect rural clients, educate
the public about psychology in rural practice, and provide rural psychologists
with ways to implement ethical values in everyday practice (Behnke, 2004; Womontree, 2005). One way to gain this understanding is to explore the
experience of ethics for practising rural psychologists using qualitative
methodology. Although there may well be specific ethical challenges for rural
psychologists the available research is limited, particularly within the Canadian
context. This research focussed on ethical issues experienced by practising rural
psychologists in Canada. The global research question used in this study was,
“What ethical issues arise for you as a practising rural psychologist and how do
you deal with these?” I had several goals for this research. I wished to explore
professional ethics in rural Canadian practice through actual experiences. I
wanted to see if there were patterns of commonalities in the way that rural
psychologists understood and dealt with ethical challenges. Finally, I wanted to
increase the research and literature available on ethical rural practice. As an
insider-researcher, I also hoped to seek out the practical wisdom of practising
rural psychologists in Canada.
CHAPTER FIVE
METHODOLOGY

One of the participants in this study was a colleague from graduate school. Although we had lost contact for over a decade we reconnected easily during our research relationship. I was struck after the interview at how much deeper and richer that particular interview was. Even with a thousand kilometres and a decade between us perhaps it was the relationship that made the difference. As psychologists in rural practice in the same province and being from the same alma mater perhaps we are our own form of small community.

From my analytic journal, December 2008

5.1 Qualitative Research

Knowing what I wanted to study, I needed to select an appropriate research process. As a psychologist, relationships are the crux of my work. As a person-in-relation, they are significant to my identity. Qualitative research was a natural fit as it documents the subjective experiences of people and can reflect on the complexity of psychological phenomena (Morse, 2006; Ponterotto, 2005; Silverstein, Auerbach, & Levant, 2006).

Measured against methods that use formal hypothetico-deductive methods, it is more difficult to ascertain the beginning of a qualitative research project. Preliminary activities include note taking, scribbling, diary writing, and observation-making done long before the researcher has any inkling that these would turn into formal research projects. (Blackstone, Given, Lévy, McGinn, O’Neill, Pals, van den Hoonoord, Griener, Poff, Rice, & De Groote, 2006, para 3)

My goals were consistent with the qualitative research priorities of understanding meaning and process (Haverkamp, 2005; Haverkamp & Young, 2007; Morrow, 2007).

This process began without predefined hypotheses but with a specific research question to be explored (Kral & Kidd, 2002; O’Neill, 2002; Polkinghorne, 2005; Silverstein et al., 2006). My question was “what ethical issues arise for practising psychologists in rural practice and how do they deal with these?” Typical of qualitative exploration, my data sources were varied and the goal was to plumb the depth, not breadth, of available information to describe
the richness of this phenomenon (Haverkamp & Young, 2007; Kidd, 2002; O’Neill, 2002; Polkinghorne, 2005). Qualitative research is well suited to the study of complex processes such as ethics and professional practice (Denzin & Lincoln, 2005; Ponterotto, 2002; Rennie et al., 2002; Silverstein et al., 2006). There are a wide range of qualitative methods and procedures. To foster transferability of results, it is important to spell out the philosophical underpinnings and the methodological elements of the paradigm selected and to detail the research method used and the role of the investigator. These provided the conceptual foundation for this research.

5.2 Constructivist-Interpretive Paradigm

I selected the constructivist-interpretive paradigm (also called the C-I paradigm, constructivism, or interpretivism) for several reasons. I agree with the ontology of constructivism which posits that reality is subjective and can only be understood within sociohistorical context (Denzin & Lincoln, 2005; Ponterotto, 2002; Rennie, 2002). I agree that we only learn about the subjective reality of others when we are able to empathise with them and see their reality as complex. I concur with the epistemology that meaning is co-constructed. I also support the axiology that my values will influence the research process (Denzin & Lincoln, 2005; Morrow, 2007; Ponterotto, 2005). To make this research appealing, I used a personalized rhetorical style. I used emotive prose to reflect my own subjectivity but relied extensively on the voices of the participants (Denzin & Lincoln, 2005; Morrow, 2007; Ponterotto & Grieger, 2007). This research was discovery-oriented in nature but was also inductive as it was built from the data that I collected. It was intended to generate hypotheses and ideas for practice (Ponterotto, 2002). Finally, this was transactional research that used the research relationship to create a conscious understanding of experience (Morrow, 2007; Ponterotto,
5.3 Research Design – Hermeneutic Phenomenology

It is important to be specific in detailing the research method chosen from the overarching paradigm. I chose hermeneutic phenomenology which is a research method commonly used for studying applied aspects of psychology and one that provides evidence of integrity and trustworthiness (Creswell, Hanson, Clark Plano, & Morales, 2007; Denzin & Lincoln, 2005; Ponterotto, 2002; Rennie et al., 2002; van Manen, 2002). Phenomenological and hermeneutic principles are an elaboration of the C-I paradigm that guided my research approach.

Phenomenology, like psychology, seeks an understanding of human experience (Creswell et al., 2007; Kendler, 2005). Phenomenology has a complex philosophical heritage (Holstein & Gubrium, 2005; Kendler, 2005; van Manen, 2002). Edmond Husserl (1859-1938) was one of the primary philosophers concerned with the experiential components of knowledge and perception (Denzin & Lincoln, 2005; Holstein & Gubrium, 2005; Wertz, 2005) and of describing the conscious components of this subjective reality (Creswell et al., 2007; Kendler, 2005). Phenomenology has given rise to many theories that continue to influence psychology such as existentialism, poststructuralist, postmodernism, and feminism (van Manen, 2002; Wertz, 2005). Personally, I identify as an existential-feminist psychologist. Within research, phenomenology is the study of lived experiences understood through reflection and social interaction. Phenomenological research does not dehumanize research participants or attempt to simplify the complexity and subjectivity of their experience (Kendler, 2005; van Manen, 2002; Wertz, 2005). Phenomenological methods are methodical, systematic, and critical (Wertz, 2005). They employ
several sources such as texts, participants, and personal knowledge (van Manen, 2002; Wertz, 2005).

Hermeneutics relates to the interpretation of meaning. A hermeneutic approach seeks to interpret data within sociohistorical context, through deep reflection, and taking account of prior understanding and prejudice (Denzin & Lincoln, 2005; van Manen, 2002). Heidegger’s philosophical understanding of hermeneutics is particularly well suited to psychology and applied practices. Heidegger describes hermeneutics as a personal process born of interpretation (van Manen, 2002).

Hermeneutic phenomenology (HP) involves contextualizing the phenomenon under study so that it is represented in the way that it is experienced. This is to reflect the multi-layered and multidimensional elements inherent in all phenomena (Hein & Austin, 2001; Strong, Pyle, deVries, Johnston, Foskett, 2008). Employing the principles and techniques of hermeneutic phenomenology assisted me to uncover embedded meanings from highly interactive interviews. HP provided a specific framework for interpreting data within sociohistorical context and managing my influence (Laverty, 2003; van Manen, 2002).

5.3.2 Methodological Steps of Hermeneutic Phenomenology

The hermeneutic circle begins with an exploration of the participants’ context. The next aspect explores the essence of the participants’ experience through analysis of latent or implicit themes from the entire data set. Then there is an exploration of manifest or explicit themes from the research questions. The final part of the hermeneutic circle is returning to latent or implicit themes. There were several key HP activities employed during this process. I attempted to suspend scientific assumptions through epochs, to summarize experiences through statements of textural and structural descriptions, and to triangulate the results of
various sources (Creswell et al., 2007; Wertz, 2005; van Manen, 2002). Epochs, or research bracketing, involves acknowledging, describing, and suspending researcher assumptions (Holstein & Gubrium, 2005; van Manen, 2002; Wertz, 2005). This process began with reflection and then a literature review. During the interviews and initial analysis, I used the epoch of research bracketing by attempting to put aside what I had learned from the literature review. This was also so that I could be congruent and fully present with the participants during the interviews (Cheatham, D’Andrea, Ivey, Ivey, Pederson, Rigazio-DiGilio, Simek-Morgan, & Sue et al., 2002; Nelson-Jones, 2002; Toporek, 2001). I also employed the epoch of phenomenological psychological reduction. This involved bracketing my own triggers during the literature review and interviews by acknowledging them, noting them in my analytic journal, and by exploring how these triggers might be affecting my interviewing. I later reviewed and incorporated journal data into the analyses in order to honour the intersubjective experience of the phenomenon (Wertz, 2005).

5.4 Researcher-as-Instrument

To review researcher-as-instrument considerations is to elaborate on the above process, specifically the potential impact of the researcher’s social location in relation to potential bias. To paraphrase the Canadian Code of Ethics for Psychologists, science but not scientists, can be viewed as value-free and impartial (CPA, 2000). Cognitive theory tells us that, “all of us are as unaware of our blind spots as fish are unaware of the water they swim in, but those who swim in the waters of privilege have a particular motivation to remain oblivious” (Tavris & Aronson, 2007, p.43). Knowing that I could not have been fully objective or neutral, I wish to elaborate on social location. I intentionally used my own experiences in understanding and interpreting my research question and the
related data (Haverkamp & Young, 2007; Morse, 2006; Ponterotto, 2002; Silverstein et al., 2006; Suzucki et al., 2007). My experiences lead to my interest and passion for research in this area. These experiences have validated and informed my own personal and professional growth. They have impacted my data creation and presentation (Yeh & Inman, 2007).

5.4.2 Social Location

In sharing my social location, I seek to increase the trustworthiness and transparency of this study. I was born and raised in the rural community where I now have a psychology practice. I have worked in rural human services throughout my career and my first two degrees were in psychology. I have been a registered psychologist in Alberta since 1999. I am a member of eleven professional associations and have an active role with many of these groups. My community, St. Paul, has 6000 residents and a trading area of 18 000 people including several Aboriginal communities. St. Paul is over 200 kilometres from a major urban centre and is economically dependent on farming, petroleum, and commercial trading. There are currently only four psychologists across the greater region of over 40 000 people.

In the literature, my psychology practice would be described as rural generalist practice. I teach university and deliver professional development workshops. I work in two therapy clinics, do research, and act as a consultant to agencies and for community development. When I teach on-campus in my own community, I am continually challenged to offer material in a culturally appropriate manner that also speaks to issues inherent in small communities. As a therapist, in my St. Paul clinic, my clients are predominantly middle-class Caucasian clients. I use modalities such as existential therapy, feminist therapy, cognitive-behavioural therapy, and EMDR. Clients are of all ages and issues
range from children coping with separation to professionals with existential angst to insurance related referrals of people with disabilities. My clients represent the cultural range of the community and some travel from as far as 150 kilometres away. I also travel 100 kilometres to provide therapy and community development services to an Aboriginal community where the people are predominantly of the Cree culture and live with dire socioeconomic circumstances. There I work within a triage model with Aboriginal professionals in a federally funded health centre. Typical presenting issues include trauma, addictions, legal involvement, violence, poverty, and the ongoing effects of colonization. In this setting, I am also active in consultations with community professionals, workshop and training, and public speaking.

My primary interest is in the area of ethics. It was in my university ethics courses that I found the best merge between my joint love of philosophy and psychology. Philosophy has taught me to respect complexity and how to use logic without losing sight of “the big picture”. Perhaps it is from living in a rural area that I had, from early in my career, an awareness of the importance of boundaries and an understanding of the far reaching implications of actions. Working in a rural community, I have often heard many sides of stories and issues and have benefited from seeing the complexity in so many situations. Over the years, I have also had the honour of being mentored by Jean Pettifor, who is often referred to as the grandmother of Canadian psychology ethics. Jean has co-authored the Canadian Code of Ethics for Psychologists (CPA, 2000) and many of the CPA’s ethical guidelines. I am active with several national groups that consider professional ethics in psychology. Interestingly, I found that even the experts in the field of ethics in Canada do not seem to have much knowledge or interest in rural practice considerations.
I have experienced critical incidents in the development of my own ethical awareness. Sadly, I see evidence of ongoing oppression of Aboriginal people in our area. Having developed an awareness of the social and cultural oppression and colonization of the Canadian Aboriginal people, I have become more aware of the ongoing social racism that occurs, even by professionals and professions. Well intentioned professionals, who are not suitably aware of cultural differences and history, have provided woefully inadequate or unprofessional services to local Aboriginal communities. Another significant incident involved co-leading a professional mediation with a local psychologist accused of sexual inappropriateness with clients. This involved practice advisors from the provincial registration body but did not involve formal client complaints. The clients involved became my clients. Although I may have wanted formal complaints to be lodged, that was not the clients’ wishes. I hope that the mediation resulted in the psychologist becoming more aware and practising in an ethically more appropriate manner. I will never know as that individual moved away shortly after the mediation.

Finally, there have been several times that I have consulted with peers and practice advisors on ethical dilemmas that I have had to manage myself. I had a situation where a client lodged a complaint with a third party payer about a termination of services that I had initiated. I found this to be a nerve-racking experience but one that had many personal growth opportunities. I cannot imagine not having close relationships with peers in rural practice with whom to consult on ethical issues. These have often been my most stimulating and rewarding collaborations and have contributed to my personal and professional growth.

In addition to these personal and professional experiences, I wish to share some of my qualitative research experience. Training and experience in my first
degree was from a positivist or quantitative paradigm and it was this model that I used for research in my Master’s degree. It was not until my professional practice that I was able to apply qualitative research concepts that I studied during my Master’s degree. First, I worked collaboratively with another researcher on a qualitative community needs assessment. Later, with the engaged mentorship of Nancy Parker, the director of a university research department, I was the primary researcher evaluating the university counselling services department. During this mixed-methods study, results were triangulated from surveys, literature reviews, a program review, and focus groups. I found qualitative research rewarding and enjoyed the tangible outcomes from those processes. When a fellow psychologist discussed her qualitative dissertation on ethics, the idea for this current research project crystallized for me. I have benefited from her ongoing mentorship during this research study.

In summary, reflecting on this personal history made me aware and sensitive to key aspects of my worldview. I value relationships and the relational nature of qualitative research. I value knowledge and learning. Also, I believe in equality and social justice. These experiences, values, and beliefs, have shaped my interests in professional ethics and rural psychological practice.

5.5 Participants

Institutional ethics approval for this study was provided by the Ethics in Human Research Committee of Charles Sturt University and that letter is contained in Appendix E. In this study, I followed Polkinghorne’s (2005) four steps for selecting participants. First, I generated a potential pool. This pool was members of the Canadian Psychological Association’s Northern and Rural Interest group, provincial rural psycho-social oncology groups, and through word-of-mouth contacts. Purposeful advertising was done on three occasions though
group list serves. I am a member of these groups and first sought the support of
list moderators. The initial email contained basic information about the research
project and goals and asked interested volunteers to contact me for more
information. Those who made contact were sent information and consent forms.

I had many volunteers who were not deemed suitable for this study. Those
volunteers tended to be psychologists who lived and worked in urban centres but
occasionally commuted to rural communities for work. Volunteers who were no
longer working as rural psychologists were also excluded. Purposely selecting
participants from the pool of volunteers was the second step in participant
selection. Wanting breadth in perspective, I sought participants from a variety of
national settings and with a range of rural practice types. I also selected
participants with range in their duration of experience and different levels of
training. In the third step, I began the interviews. Ongoing participant selection
was based on the likelihood of uncovering data that would confirm or disconfirm
results. Throughout the process, emails were used to share information about the
study and for scheduling. This accommodated vast geographical distances
between the researcher and participants and served as an effective way to send
and receive information.

Rather than beginning with a static definition of rural, I incorporated two
processes for participant selection. First, I accepted participants who self-
identified as “rural” knowing that they would be more intimately familiar with the
distinct variables of the communities that they serve. A second process I used, as
a flexible benchmark, was selecting participants from communities of less than 10,000 people that are also outside of the commuting zone of an urban centre, as
recommended by Statistics Canada (du Plessis et al., 2001). That flexible
benchmark assisted my decision to accept participants from semi-urban (less than
40 000 people) but geographically isolated communities who self-defined as rural and described their communities as geographically isolated and having service limitations more consistent with smaller rural communities.

Twenty rural psychologists participated in this study over a seven month period from June 2008 to January 2009. Participants came from eight regions of Canada with two from the North West Territories, one from British Colombia, four from Alberta, three from Saskatchewan, three from Manitoba, four from Ontario, two from Nova Scotia, and one from Newfoundland and Labrador. Participants represented various areas of interest or specialization. Four were school psychologists, seven were clinical psychologists, two were forensic psychologists, and seven were counselling psychologists. Four indicated that their work was specialized and 16 said that it was general practice. Half of the participants worked in private practice and the other half was divided between school-based practice and work within health care. Only one worked for a community agency. Most participants provided therapy or counselling, assessments or diagnostic services, and consultations. Many were involved in teaching, training, or supervision and only a few were involved in research, forensic work, program administration, or public education.

Participants also represented a considerable range in their years of experience and community of practice. Two had been registered as a psychologist for over 20 years, three for ten to 15 years, nine for five to ten years, two for less than five years, and three were either provisionally registered or had been registered for less than one year. Half of the participants reported having PhDs and the other half were registered at the Master’s level. Most participants worked with a large age range of clients and lived and worked in rural communities. The size of community within which participants worked was less easy to determine.
Most of the participants worked in communities of less than 10,000 people but may have worked in up to 10 communities varying in size from 500 to 40,000 people. The larger communities, served by four of the participants, were determined to be either northern or remote and were therefore relevant to study.

In order to situate my selection, the following is a brief description of each research participant to demonstrate salient characteristics of their life-world contexts and to assist in determining transferability to the reader’s own context. In these descriptions several terms are used which I will define briefly here. For the purposes of this study “semi-urban” means an urban community of up to 40,000 people that was considered to be geographically isolated. For those participants who lived in a rural or semi-urban community, “works in other rural communities” means that the participant did not work in the community in which they resided. Years of experience psychology in rural, northern, or isolated communities refers to the number of years of experience that participants had working in a professional capacity in the helping professions in non-urban communities.

The four male participants

Donald – PhD psychologist registered for 8 years with over 20 years experience in psychology and in rural, northern, or isolated communities; in private practice doing generalist practice (therapy, teaching, assessments, research, consultations, forensic assessments) with clients of all ages; travels full time to over 20 different communities ranging in size from 400 – 16,000 residents; lives in a semi-urban environment but works exclusively in rural settings.

Albert – Master’s level psychologist registered for 11 years with over 30 years experience in psychology and over 20 years experience in rural, northern, or isolated communities; in private practice doing generalist practice (counselling, therapy, program development, consultation, assessments) with adult only clients; travels half of the time to over 20 different communities ranging in size from 500 to 15,000; lives in a semi-urban environment but works exclusively in rural settings.
Ken – PhD psychologist registered for 27 years with 29 years experience in psychology and over 20 years experience in rural, northern, or isolated communities; in specialized private practice (functional assessments, developmental assessments, public education, training, consultation) with clients of all ages; travels full time to 15 different communities ranging in size from 2000 to 5000 residents; lives in a semi-urban environment but works exclusively in rural settings.

Bryon – Master’s level psychologist registered for seven years with 19 years experience in psychology and lifelong experience in rural, northern, or isolated communities; in school-based specialized practice (testing, assessments, diagnosis, consultation, clinical supervision, administration, university instruction, research) with clients who are primary school aged youth; travels one-third of the time and works in communities ranging in size from 5000 to 10 000 residents; lives and works in the same rural community that is a service centre for other communities.

The 16 female participants

Sandra – Master’s level psychologist registered for five years with ten years experience in psychology and over 30 years experience in rural, northern, or isolated communities; in school-based specialized practice (assessments and consultations) with clients who are primary school aged youth; travels full-time and works in communities ranging in size from 500 to 10 000 residents; lives in a rural community and works in other rural communities.

Virginia – Master’s level psychologist registered for over 20 years with over 20 years experience in psychology and in rural, northern, or isolated communities; in a multi-disciplinary health centre in generalist practice (therapy, consultation, workshops, prevention, committees) with youth and families; lives and works in the same rural community of 24 000 people that is a service centre for 50 000 people.

Jeanne – PhD psychologist who is provisionally registered with less than two years experience in rural, northern, or isolated communities; in a community children’s agency in generalist practice (assessments and consultations) with clients who are 18 months to 18 years old and collaterally with adults; travels half of the time and works in 14 communities ranging in size from 900 to 6 500 residents; lives in a semi-urban community and works exclusively in rural communities.

Mary -- PhD psychologist registered for seven years with lifelong experience in rural, northern, or isolated communities; in private generalist practice within a health centre (counselling, therapy, program development, consultation, assessments, supervision) with clients who are adolescents and adults; lives and works in the same rural community that is a service centre for 10 000 people.

Carole – Master’s level psychologist registered for nine years with over 30 years experience in rural, northern, or isolated communities; on a
multi-disciplinary team for a health centre (therapy, consultations, assessments) with clients who are youth and collaterally with adults; travels half-time and works in three communities ranging in size from 10 000 to 20 000 residents; lives and works one of those communities.

Debbie – PhD psychologist, provisionally registered, with less than two years experience in rural, northern, or isolated communities; in private specialized practice (therapy, counselling, assessment, supervision, consultation all specific to injury and chronic pain) with adults; travels full-time and works in several communities ranging in size from 2000 to 6 000 residents; lives in a semi-urban community and works in her own community and in rural communities.

Barbara – PhD psychologist registered for eleven years with over ten years experience in rural, northern, or isolated communities; generalist practice for a health authority (health care administration; supervision, psychological assessments, consultation, program development, group therapy, therapy, teaching) with clients of all ages; travels some of the time, provides some telephone services and works in six communities ranging in size from 2 000 to 10 000 residents; lives in a rural community and works in other rural communities.

Doreen – Master’s level psychologist registered for five years with lifelong experience in rural, northern, or isolated communities; in private generalist practice (counselling, therapy, consultation, teaching) with clients of all ages; travels some times, provides some telephone services, works in one community of 2000 people that is a service centre for another 4000 people; lives and works in the same rural community.

Brenda – PhD psychologist registered for six years with eight years experience in the field of psychology and five years experience in rural, northern, or isolated communities; generalist practice in a health centre (therapy, consultations, assessments) with clients of all ages; travels full-time to six different communities ranging in size from 5000 to 40 000 people; lives in a semi-urban but works predominantly in one rural community.

Moriah – PhD psychologist registered for just a few months with two years experience in psychology but lifelong experience in rural, northern, or isolated communities; in generalist practice for a health authority with a multi-disciplinary team (health care administration; supervision, psychological assessments, consultation, program development, group therapy, therapy, teaching) with clients of all ages; lives and works in the same rural community of 10 000 that is a service centre for another 10 000 people.

Connie – Master’s level psychologist registered for nine years with 19 years experience in psychology and lifelong experience in rural, northern, or isolated communities; in private generalist practice (counselling, therapy, consultation, teaching) with adolescents and adults; travels some times, provides some telephone services, lives and works in the same rural
community and travels to work in two other communities all of which range from 500 to 10 000 people.

*Lorna* – Master’s level psychologist (two master’s degrees) registered for four years with seven years experience in psychology and lifelong experience in rural, northern, or isolated communities; a school psychologist (testing, assessments, diagnosis, consultation) with clients who are school aged children and collaterally with adults; lives in a rural community and travels full-time to up to ten other rural communities ranging in size from 3600 to 10 000 people.

*Esther* – PhD psychologist registered for eight years with 20 years experience in psychology and 14 years experience in rural, northern, or isolated communities; in private generalist practice (child and family assessments, legal assessments, counselling, consulting, teaching, research, academic writing) with youth and collaterally with adults; lives and works in the same rural community of 800 people but clients travel from outside communities.

*Eleanor* – PhD psychologist registered for 14 years with 25 years experience in psychology and six years experience in rural, northern, or isolated communities; in private generalist practice (therapy, consultations, assessments) with adolescents and adults; works in two rural communities of 10 000 to 20 000 people and lives in one of those communities.

*Joanne* – Master’s level psychologist registered for seven years with nine years experience in psychology and lifelong experience in rural, northern, or isolated communities; in generalist private practice (counselling, therapy, assessments) with clients over the age of five; travels sometimes serving communities of 500 to 15 000 people, provides some telephone service, and works in her own rural community.

*Janet* – Master’s level psychologist (two master’s degrees) registered for nine years with eleven years experience in psychology and lifelong experience in rural, northern, or isolated communities; a school psychologist in generalist practice (diagnosis, counselling, therapy, consultation, crisis intervention, clinical supervision, assessment, professional development training) with school aged clients and collaterally with adults; travels full-time and lives and works in one of the rural communities that she works in; the overall service area has 10 000 people.

Each participant completed a series of three interviews based on Polkinghorne’s (2005) model which is described in more detail later. Total interview time per participant lasted from 34 minutes to over two hours (median length 76 minutes). This is more than the single half hour interview with 3-10
participants typical in North American phenomenological studies (Haverkamp & Young, 2007; Morrow, 2007; Ponterotto, 2005; Suzucki et al., 2007; Wertz, 2005). Most interviews (15) were conducted by telephone, although in-person interviews (5) were used whenever possible. Although telephone interviews have barriers like decreased nonverbal communication and increased levels of anonymity (Suzucki et al., 2007), they can also be an effective research tool (G. Tyson, personal communication, December 13, 2007) and are commonly used to overcome geographical distances (Peräkylä, 2005). I found that telephone interviews not only increased the potential participant pool but also resulted in better articulated communication. The telephone interviews transcribed easier and maintained more of their original meaning when in written form than in-person interviews. The in-person interviews were more dependent on my visual observations and memory of non-verbal communication. After each interview, I employed standard procedures of memoing reflections, emotional quality, and interpersonal interaction (Haverkamp & Young, 2007; Ponterotto, 2002; Silverstein et al., 2006; Suzucki et al., 2007).

The interviews were flexible like natural conversations; replete with questions and listening. However, there was structure to these negotiated texts as I used a semi-structured format typical of phenomenological research (Kendler, 2005; Wertz, 2005). I developed research interview skills through ongoing supervision. Although I had experience with telephone therapy sessions, case conferences, consultations, and teleconferences, I needed to familiarize myself with telephone interviewing for research interviews. I did this through a mock interview with my supervisor and a telephone role-play of the interview with a peer. My research questions and format were initially based on my review of the literature but were subject to ongoing revision based on supervision and
experience with the actual interviews. The questions were open-ended to facilitate participant discovery but employed C-I style prompts to target the meaning or processes that the participants experienced (Haverkamp & Young, 2007; Ponterotto, 2002; Silverstein et al., 2006; Williams & Levitt, 2007). These were requests like, “tell me more about that”, or “can we explore that more?” to construct, deepen, elaborate, expand, develop, or explore their answer (Haverkamp & Young, 2007). The difficulty in the interviews was the abstract nature of ethics. Experiencing this phenomenon is a more complex process than using language to describe it. I asked participants to recall experiences and then tell their story which was sometimes articulated for the first time.

I modelled my set of three interviews on Polkinghorne’s (2005) assertions that this will enhance relationship development, data collected, and my own understanding as the researcher. The initial screening interview was to: get acquainted, develop rapport, provide information, answer questions, and collect demographic data in a less formal collaborative research structure (Fontana & Frey, 2005; Suzucki et al., 2007). The second interview was more focused and explored professional ethics in rural practice in depth through the use of a global research question (What ethical issues arise for you as a practising rural psychologist and how do you deal with those?) and specific research prompts asking more specific and intimate questions (Creswell et al., 2007; Fontana & Frey, 2005; Suzucki et al., 2007; Wertz, 2005; Williams & Levitt, 2007). The prompts sought experiences in known ethical issues, ethical development, and their perception of the social context for ethics in rural practice in Canada. The complete interview protocol is contained in Appendix C. Throughout, I asked for concrete details and examples which is a common variation to the phenomenological method (Wertz, 2005). The third interview, or participant
check, occurred anywhere from two to six weeks after the core research interviews. Some participants chose to review transcripts prior to this third interview and others preferred a verbal overview of the core research interview to begin this final interview. The participant checks helped me verify the content of the core research interviews and were meant to empower the participants in their role as co-constructors of the meaning from their recorded experiences.

Consistent with other researchers, I chose to include these in the data analysis as participants often clarified points, raised new ideas, or elaborated on relevant information during the participant checks (Polkinghorne, 2005; Ponterotto, 2002; Silverstein et al., 2006; Suzucki et al., 2007).

All interviews were recorded using a portable audio recorder. Only one participant expressed some misgivings about being recorded but consented once confidentiality and file storage concerns were explained to their satisfaction. During one of the initial interviews the recorder failed to work. After explaining this, that participant agreed to confirm key demographic information by email.

5.5.2 Researcher Roles and Relationships

I attempted to create a dialectic communication style and to portray feelings of respect for the participants. My goal was to foster a sense of participatory partnership. In the interviews, I used many of the Rogerian counselling skills that I use in my practice. I endeavoured to be present and focussed so that I could be open to both confirming and disconfirming experiences. I often found myself identifying with the participants but I remained empathetic so that I would not let over-identification interfere with their ability to tell their story (Denzin & Lincoln, 2005; Knapik, 2006; Morrow, 2007). Also, once my expert role allowed me entry into their private lived-worlds, I strove to relinquish this role so that the participants became the experts in their
experiences. Based on guidelines in the literature, I did not share my findings to
date or “answers” from the literature and was respectful when participants sought
to challenge my role or research process (Polkinghorne, 2005; Suzucki et al.,
2007). In one instance, a participant questioned the validity of qualitative
methodology. Rather than defend this form of research, I thanked that participant
for agreeing to participate given their views.

There are several ethical best practices that need to be considered for
qualitative research (Haverkamp, 2005; Suzuki, Ahluwalia, Kwong Arora, &
Mattis, 2007). Sensitivity of the subject matter and overlapping relationships were
the most salient ethical considerations for this study. As a registered psychologist,
I have a duty to report serious ethical violations that pose risk of harm. Assuming
a fiduciary role, I clarified all questions to ensure informed consent to participate
and to withdraw at any time during the process. Each time I confirmed consent, I
reminded participants of their right to suspend recording and to make comments
“off-the record”. None asked to do this, although one participant did hesitate
when providing permission to audiotape the interview. All volunteers were sent
the consent and information forms contained in Appendices A and B. These forms
were attached to a friendly and inviting email to encourage participation despite
the warning that I would be required to report serious ethical violations revealed
in the interviews. I remained cognizant of my training as a therapist and the
potential of my supportive and nonjudgmental stance to cause participants to self-
disclose more than might be in their best interest. This was a concern as I asked
about their ethical (and perhaps not-so-ethical) experiences. I am grateful that
there were no disclosures of ongoing risk of harm from unethical behaviour.

The second specific consideration was overlapping relationships. Rural
psychologists represent a small community of practice in Canada. I met some of
the participants at a national convention. Here, I used a similar protocol to meeting clients in my own community. I was friendly and this was not insincere. This was balanced with their needs for privacy and confidentiality. I let participants approach me first and I reacted as I would with any other colleague. One of the participants was assigned to work on a national committee with me. When this happened, I reviewed the multistage decision making model of the CPA Code of Ethics (CPA, 2000). Finding this model too general for this situation, I turned to recommendations in the literature from Haverkamp (2005). I acknowledged the relational nature of this research by considering her interests and rights as well as my own. I acknowledged my subjectivity by considering how I might influence our collaborative work and sought her reaction to our joint work. I also consulted a peer who suggested working on a different area of the national committee to limit direct interaction with the participant. My peer reminded me that researchers are also participants in some ways and that I was responsible for my character and choices in both relationships with the participant.

More general ethical research practices were privacy and research ethics approval. Asking for detailed stories of experiences and needing to incorporate thick descriptions into the reported results made it difficult for me to ensure full confidentiality. I discussed this quandary with several of the participants and made it a regular discussion topic with my supervisor and in peer consultation. Participants were assigned pseudonyms and geographic details were left out of participant descriptions.

5.6 Sources of Data

I constructed, rather than collected, data through interviews, observations, and documents (Polkinghorne, 2005; Silverstein et al., 2006; Suzucki et al., 2007;
van Manen, 2002). Generating interview data of sufficient breadth and depth took time and skill unless participants had high levels of meta-cognitive awareness and were naturally articulate. Key documents were the transcriptions, my analytic journal, my research memos, and the literature review. The literature review was used to prepare the study and during data analysis (Polkinghorne, 2005; Wertz, 2005; van Manen, 2002).

5.7 Data Analysis

Interviews were transcribed verbatim for reading and re-reading during analysis. I transcribed the first three interviews and then outsourced the remaining transcriptions to a legal transcriptionist. From these, I collected a wealth of rich data (over 700 pages in transcripts from 20 participants). I hope that this represents saturation. I am cognizant that I stopped collecting data once I determined that I had a sufficient amount that included disconfirming evidence. I found support for this decision in the literature. Not only did I confirm that it can be very difficult to ascertain when saturation is indeed achieved (Blackstone et al., 2006; Morrow, 2005; Polkinghorne, 2005; Wertz, 2005), but Morrow (2007) indicated that true redundancy can never be achieved because of the richness and complexity of the data and analysis. Hein and Austin (2001), in their review of hermeneutic phenomenology, put this more succinctly as, “there can be no saturation point, no final analysis: The inquiry is circular” (p.9).

Data analysis was initiated early in the data collection and was no small task. As Olsen and Given (2003) have said, “researchers have one very important consideration in common: what to do with the reams of data collected during a research project?” (p. 129). I sought to make sense of it all by using systematic processes to help me to interpret broad meaning. I acknowledge that multiple meanings and interpretations are possible and so I did not seek to unearth a single
“truth” or to verify my literature review findings (Ponterotto, 2005). Consistent with hermeneutic phenomenological research, I relied primarily on data immersion and thematic identification and analysis (Creswell et al., 2007; Knapik, 2006; Yeh & Inman, 2007).

Throughout the interviews and analysis of the texts I sought discrepant findings or disconfirming evidence. I did this to combat confirmatory bias, to ensure that I did not end up with an overly simplistic interpretation of the data. Discrepant analysis was also done to challenge my own preconceived notions. Supervision and peer consultation helped me to clarify significance in participants’ stories, re-examine my analysis, and to consider more depth in my analysis (Morrow, 2005; Polkinghorne, 2005; Yeh & Inman, 2007).

5.7.1 Subjectivity and Personal Impact

Interviewing psychologists in rural practice in Canada when I am one myself makes me an insider-researcher. When I consider cognitive theory, I note that I may have experienced subtle forms of cognitive dissonance. “Cognitive dissonance is a motivating state of affairs. Just as hunger impels a person to eat, so does dissonance impel a person to change his opinions or his behaviour” (Leon Festinger as cited in Weiten, 2004, p.669). In this study, I expected to find that psychologists in rural areas practise ethically and that belief may have biased my research questions, what I listened for, and what I remembered. I hope that my awareness of cognitive dissonance balanced these risks. It was helpful that I used a self-reflective journal. Although initially sceptical about the value of routinely documenting insights, my “analytic journal” soon became a favourite process. This journal contained information about my preconceptions, insights, and reflections which helped me to name themes and deconstruct realities (Morrow, 2005; Silverstein et al., 2006; Yeh & Inman, 2007).
I took steps to remain aware of my subjectivity while focussing on the impact it might have on my intersubjectivity with the research participants. I found that participant stories validated practices and beliefs that I have, and made me question some of my own practices. I reflected on these through the use of hermeneutic phenomenological epochs (memoing, bracketing, journaling, and writing) and through the constructivist-interpretive processes of using participant checks and consulting with my supervisor (Wertz, 2005; Williams & Levitt, 2007; Yeh & Inman, 2007). My desk was often covered in small labelled sheets that I would file and re-file as the process continued. This helped me clarify which ideas came directly from the data (grounded in the data) and which were my own decisions and theoretical ideas during the analysis. The memos became another form of textual data for hermeneutic analysis and were attached to transcripts for that purpose and to help me continually refine the interview protocol (Kral & Kidd, 2002; Polkinghorne, 2005; Williams & Levitt, 2007).

I hope that these efforts at managing personal impact were enough. Lord Molson, British politician 1903-1991, said, “I will look at any additional evidence to confirm the opinion to which I have already come” (as cited in Tavris & Aronson, 2007, p.17). That was my risk during this process. As a researcher, I was both an insider and an outsider to the groups that I studied. I attempted to be vigilant with my reflexivity. As Tavris and Aronson (2007) have warned, “introspection alone will not help our vision, because it will simply confirm our self-justifying beliefs that we personally cannot be co-opted or corrupted” (p. 44). My reflexivity was enhanced through supervision and peer consultations and by openly asking participants for guidance and corrections in their final interviews. This feedback was helpful, frustrating, and growth promoting.

5.7.2 Thematic Analysis
Thematic analysis of psychological research is poorly demarcated in the literature (Braun & Clarke, 2006; Given & Olson, 2003; Olson & Given, 2003) so I wish to clarify the methods that I used. The thematic analysis in this study required data immersion. Data immersion is a circular and fluid process of alternating between inductive and deductive interpretation done by reading and re-reading the data while writing about the process. I continued this until I could see clear relationships among themes and until I had a deeper understanding of the core ideas (Morrow, 2005; Peräkylä, 2005; Silverstein et al., 2006). Through data immersion I achieved clarity and was able to describe primary essences or thematic meanings (Yeh & Inman, 2007).

The procedures used represented concepts from hermeneutic phenomenology that was consistent with Braun and Clarke’s (2006) model of thematic analysis for qualitative research in psychology. First, I read transcripts and listened to the audiotapes of these interviews in their entirety several times to gain an overall sense of the participants’ experiences. Typical to HP research, repeated statements were identified with close attention paid to the words chosen and how these were expressed (Hein & Austin, 2001). These reflections were noted in my analytic journal. Second, I coded concepts that appeared to repeat in the data like “advocacy” and “a sense of professional disconnect”. Third, I searched for potential themes by collating those codes in ways that might capture the intended meaning of the participants. Potential themes at this stage were “professional or client advocacy” and “lack of professional validation”. I then carefully selected data that fit within each potential theme.

The fourth step was to review the potential themes by creating a thematic map. In addition to detailed listings of themes and subthemes, visual schematics were created and re-created as the themes evolved from being concrete to those
that more closely represented the central essence of the theme. I reflected on these new themes, the available literature, and my own experiences as a rural psychologist. The more central themes were then validated through another review of the interview audiotapes and transcripts. This time each interview was compared to the entire data set looking for similar instances as well as discrepant findings. This review helped to identify complex, multidimensional perspectives of the phenomenon of the experience of professional ethics in rural practice.

The fifth and final phase involved defining and naming the themes. Each theme was carefully analysed by itself and revised in consideration of the whole of the data to ensure clarity within the theme and across the overall findings. The descriptions of these themes were meant to clearly state the experience of the participants and so included supporting quotations of rich text. Putting the themes into words meant writing and rewriting the descriptions and seeking out what this might mean within the existing literature. The goal was to be true to the participants’ experiences but to go beyond that by highlighting an intersubjective understanding of the meaning of those experiences (Hein & Austin, 2001).

5.7.3 The Hermeneutic Circle

A hermeneutic circle of interpretation is used in HP research for understanding complex phenomena. Parts of a phenomenon (like the themes of this study) cannot be objectively comprehended by themselves and require an understanding of the whole phenomenon. This circle necessarily includes a review of sociohistorical context and results require reference to relevant literature and the personal context, or biases, of the researcher (Given, 2008). Placing this analysis within sociohistorical context is a common variation to HP research (Wertz, 2005). I began this hermeneutic circle with an exploration of the participants’ current social context from their perspective as recommended by
Lynch (2000). The next aspect of the hermeneutic circle explored the essence of the experience of professional ethics for practising rural psychologists in Canada. This was based on the latent or implicit themes from the data analysis and is fundamental to phenomenological research. I then explored the manifest or explicit themes related specifically to the research questions. This allowed for a link to be established to the existing literature. The hermeneutic circle concluded with a return to the latent or implicit themes. Presenting results within the hermeneutic circle allows the reader to better place results and helps fuse key aspects of the results (Capurro, 2000; Wertz, 2005; van Manen, 2002).

5.8 Standards of Trustworthiness

In this study, I strove to integrate constructivist-interpretive and phenomenological standards of trustworthiness. In presenting this research, I have sought to include social validity by sharing information about myself, participants, the process, and by using thick descriptions. I secured adequate data through purposeful and varied sampling, a well articulated interview strategy, and through the difficult task of determining saturation (Christians, 2005; Denzin & Lincoln, 2005; Williams & Levitt, 2007). I sought out disconfirming evidence and conducted discrepant case analysis. For triangulation I used various data sources to capture and respect multiple perspectives, to achieve multidimensionality to the data set, and to reduce the risk of chance associations in the interpretation (Denzin & Lincoln, 2005; Guba & Lincoln, 2005; Polkinghorne, 2005). Finally, my supervisor was consulted as an external reference. His assistance allowed me to interrogate and refine my ability to faithfully identify and communicate the themes while honouring the various intersubjective sources.
CHAPTER SIX

RELEVANT PROFESSIONAL STRUGGLES

I edit a column on the history of psychology for a provincial newsletter. A recent review of the 1960s in psychology was a popular article. There were many favourable comments on how the stories about psychology during that era made sense in light of provincial, national, and international events.

From my analytic journal, July 2009

Within a hermeneutic circle of interpretation, contextual issues are reviewed to provide a foundation for understanding the complex phenomenon of professional ethics in rural practice. This chapter represents the beginning of the hermeneutic circle with an exploration of the participants’ current social context from their perspective and in relation to the literature. This information was sometimes provided spontaneously by participants. When it was not, they were prompted with, “what current factors in Canadian psychology make ethics relevant to rural psychologists?” The sociohistorical features elaborated on in this chapter are meant to contextualize the results and assist the reader in determining transferability. Based on the participants’ stories, these relevant features were indicative of professional struggles and how these impacted their experience of professional ethics in rural practice. Key sociohistorical considerations were: (a) competition and concern over the delivery of services, (b) the influence of government, (c) the prescriptive authority debate, (d) rural-specific registration and mobility concerns, and (e) insufficient professional advocacy.

6.1 Competition

The first sociohistorical consideration was a sense of competition. The Canadian Psychological Association defines psychology as a profession that “studies how we think, feel and behave from a scientific viewpoint and applies this knowledge to help people understand, explain and change their behaviour”
Services that are psychological in nature are not delivered exclusively by psychologists and participants raised concern about non-psychologists offering substandard services. They discussed this within the context of insufficient public awareness. Participant stories reflected concern about how competition to provide services may affect rural communities, their clients, and may also affect the profession of psychology.

*I have seen some bad services offered – anyone can call themselves anything.*

DONALD

*You have to assume that there’s going be a certain percentage that have been tested incorrectly. We had a fellow not trained in neuropsychology. Master’s level - not even registered….who did (in his mind) a neuropsychological screening and said this person never has to be tested the rest of his life. And so, you have to be able to withdraw that type of information from the files in a way that allows some sort of integrity of the work that we’re actually doing….you have to be stewards to your own profession.*

KEN

Literature on the competency of allied health professions is sparse, particularly about their work in rural practice (Lin, Beattie, Spitz, & Ellis., 2009). The CPA acknowledges that there are a range of mental health practitioners who, “claim to treat mental health problems. Not all of them are well trained professionals in the mental health field” (CPA, 2009b, Para 2-3). In public advice, the CPA encourages consumers to seek regulated or licensed professionals to ensure that their psychological services are provided by someone who has met high training and practice standards (CPA, 2009b).

A specific area of concern was the provision of psychological services by general physicians. Participants’ stories reflected a perceived lack of psychological training for physicians and concerns about general physicians creating unfair competition.

*Private practitioners in psychology have the biggest competitor in the world, which is the provincial government. So, how do you even survive in private practice….if people can go drive an hour to a public clinic and get it for free? ….How many people are going to their GP for counselling? And the GPs are billing and are the GPs trained for that? You know, it’s a funded service….I have a lot of concerns about how mental health is actually being paid for and cared for in the main health system.*
I think that the way that [the province’s] health is going with -- in regards to having these primary health clinics that may involve psychologists....I just heard the minister of health speak about how psychologists are going to be welcomed into medical clinics. And so -- because doctors are doing things that they don’t need to be doing. We don’t have a shortage of doctors. We actually are just using them for the wrong things, right? We don’t need to send a depressed person to see a doctor.

LORNA

Literature on psychology in Canadian health care reflects these concerns nationally. A recent Royal Commission on national health care noted that psychotherapy is publically funded if provided by physicians. This commission also noted that psychologists have far more extensive training than physicians in this regard (Romanow & Marchildon, 2003). Many Canadians “go to their family physicians for psychological reasons, either forcing family physicians to provide services that they are not optimally equipped for, or more often leading family physicians to prescribe medications as a short-term solution to a problem” (Dobson, 2002, p.68). Westra, Eastwood, Bouffard, and Gerritson (2006) have warned that this competition may negatively affect psychology as a distinct profession.

The literature also speaks to how the profession of psychology may be fostering this competition to deliver psychological services. Rather than promoting general psychologist practitioners, as there are general physicians, psychologists specialize. This leaves general psychological practice to allied health professionals. Albert Bandura warned that:

It is feared that as we give away more and more psychology to disciplines lower on the food chain, there will be no core psychological discipline left…psychology is the integrative discipline best suited to advance understanding of human adaptation and change. It is the discipline that uniquely encompasses the complex interplay between intrapersonal, biological, interpersonal, and sociostructural determinants of human functioning.

(Bandura, 2001, p. 12)
Currently, the profession of psychology is not well integrated. Prominent Canadian psychologists have expressed concern that the profession has been lax to integrate new skills and knowledge across the profession of psychology. They advise that the profession needs to create a core discipline based on both research and practice in addition to development on specialities (Latham, 2003; Seijts & Lantham, 2003; Sternberg, 2004). Thomas Hadjistavropoulos, reflecting on his tenure as president of the Canadian Psychological Association, said “it is important for psychologists across Canada to work together and talk to each other, proud of their traditions in both science and practise” (2009, p.5). When they do not, or when there are insufficient psychologists, mental health needs will be met by other providers.

6.2 Government

*When I went through graduate school, there was very, very, little attention paid to the impact of the socio-political system on the discipline of psychology. And, I think psychologists have to step up to their knowledge about that….these big systems out there really affect how our discipline is able to work.*

ESTHER

This quote captures another consideration, namely, the influence of government on the provision of professional psychology. Many participants spoke to a desire for changes in health care funding systems.

*If somebody comes in for three days and they’re, you know, they’re tired or anxious or stressed, scores you get aren’t going to be useful….at one point there was this “closer to home” philosophy in [the province]….they wanted professionals to live in the communities or the service to be provided within the community.*

KEN

*There is this constant struggle….between the medical profession and the psychological profession….In one small community….there was a poster from the Canadian Medical Association advertising that if you wanted family counselling, go see your family doctor. What family doctors receive training in family counselling?*

ALBERT
The literature has provided consistent research demonstrating the efficacy of psychology and the medical cost-offset effect of psychological services. Psychologists, particularly clinical psychologists, have argued that they should be publically funded within health care (Dobson, 2002). Despite this, there is little public funding for psychology and it is not recognized as an essential part of any of the provincial health systems (Arnett et al., 2004; Dobson, 2002; Hunsley, 2003; Westra et al., 2006). There is a “continuing marginalization of mental health services and the dominance of political considerations over compelling scientific evidence for the impact of psychological services on health and recovery from illness” (Hunsley & Crabb, 2004, p. 233).

Other participants spoke to specific government funding initiatives like the national Aboriginal Healing Foundation (AHF, 2009). Special funding can support the delivery of psychological services and improve access. It does not ensure public awareness.

There’s the residential school stuff that’s important, particularly for rural psychology. I’m doing some of that work directly with survivors from residential schools. And, more so from generations after and how they’ve been impacted by parents who’ve attended residential schools.

CONNIE

There are times, particularly around this residential school stuff, there are people ...[who] are getting [mis] information.... “Ali, you went to residential school. You’re entitled to all of this money and, you know, you need to contact a lawyer. And if you contact a lawyer, you also have to contact a psychologist.” Which isn’t true. They don’t have to, it’s a choice.

JOANNE

The Aboriginal Healing Foundation is a federal initiative that provides specific funding to assist Aboriginal Canadians in their healing in relation to trauma experienced as a result of the residential school system. Psychologists are one of several approved providers of mental health service for this program (Aboriginal Healing Foundation, 2009). Aboriginal Canadians tend to live in rural and remote
communities (Romanow & Marchildon, 2003) and so rural Canadian psychologists are likely to experience the greatest service demands related to this program.

6.3 The Prescriptive Authority Debate

The third sociohistorical consideration was the prescriptive authority debate for psychologists. Many of the participants spoke about prescription drug privileges.

_I think prescriptions, right, would come in there. Because, that’s broadening the scope of practice and creating...a slightly different view of what psychology is. A very different view potentially._

MORIAH

Westra et al. (2006) advised that, “whether to pursue prescriptive authority is a critically important and controversial issue currently facing psychology” (p. 77). Perhaps this is why participants shared support, opposition, and caution in reviewing prescription drug privileges in their reflections. Some participants spoke of being prepared to integrate psychotropic medication to enhance their services to clients.

_I’d probably know more about psychoactive medication for children than the family physician would but they’re the ones that can monitor it....I work with the young woman who has early psychosis who was struggling with the medication. She had to wait three months to see [the psychiatrist], right?! If I had the authority to change that and try something -- because I see her every two weeks. You know, so she suffered....there’s a human suffering cost of waiting sometimes. So prescriptive authority, I think, is an interesting debate about where it’s going and I’d like to see us move forward with that if possible. Because, you know, nurse practitioners can prescribe. Surely we’re trained as much._

VIRGINIA

_Having to know so much about the medical aspect of it -- the drug interactions -- Well, we cannot prescribe anything. We can’t even diagnose ADHD, let alone prescribe anything. But the, ah, hours and hours of studying..._

SANDRA
Some Canadian psychologists have argued for these privileges, spoke of the benefits to consumers and the field of psychology, and argued that this move is necessary (Nussbaum, 2001; Westra et al., 2006). Given the shortage of psychiatrists, prescription privileges may be particularly relevant for those who work with underserved populations like “children, the elderly, the chronically mentally ill, and rural areas” (Westra et al., 2006, p. 78). Prescription privileges could be particularly relevant for psychologists in rural practice (Harowski et al., 2006). Research by St. Pierre and Melnyk (2004) indicated support for prescription privileges among clinical psychology interns. They said that, “few people felt that prescribing was theoretically or philosophically opposed to the field of psychology or that it would compromise psychological service delivery” (p. 284).

Although the idea was supported by some of the participants in this study, others denied interest or expressed concern about prescription drug privileges.

_We struggle with the medical model. Some psychologists want to be able to prescribe medications and that. I don’t. I’m not interested._

_ALBERT_

_The competency piece is really quite huge and I think -- especially depending on who you’re dealing with and the incidents of co-occurring medical/physical issues -- the interaction effects....It scares me and I don’t want to go down that path for my career. Can’t imagine the liability insurance._

_MORIAH_

_I know the big push to have psychologists – psychologists to be able to prescribe medications. Yeah, like I’m curious. I mean, I certainly wouldn’t feel in a position to ever to be able to do that without a whole lot of extra training. But I think, you know, sometimes the doctors in general practice maybe don’t have any better ability to make that decision than a psychologist would._

_DOREEN_

The literature on prescription drug privileges reflects this tempered optimism.

Such a change to the practice of psychology raises a myriad of issues.
Prescription privileges could fundamentally alter the course of training and delivery of psychology. In fact, the overhaul to the profession could be so great that “training and regulating prescriptive authority would be more expensive than utilizing currently available medically trained professionals” (Westra et al., 2006, p. 78). Further, given the rising Medicare costs of prescription drugs, applied psychological services have been suggested as an alternative to psychotropic treatments (Romanow & Marchildon, 2003; Westra et al., 2006).

6.4 Registration and Mobility

Professional registration and mobility within the country comprise the fourth sociohistorical consideration for this study. There was particular tension expressed by participants in consideration of level of registration. Many of the participants with PhDs expressed concern that Master’s level psychologists represented the profession with substandard qualifications or posed unfair competition in the field.

“We’ve limited [our meetings] to PhD registered psychologists....because we don’t see that a lot of the folks, that are now getting the registration through the Master’s level, have the training for it....This particular meeting is for our own professional development.”

KEN

There are a lot more Master’s level psychologists out there and they don’t pay them as much. So they’re cheaper, more -- there are more of them available. So, doctoral level psychologists are viewed as being, sort of, more expensive and, “why do we need that if we have these other people who are also licensed and we don’t have to pay them as much”. .... It’s not that the Master’s level people are somehow less qualified. But, there are differences between doctoral level psychologists and Master’s level psychologists and it’s just sort of a festering issue in the profession that nobody really wants to talk about.

ESTHER

Some of the participants who were registered with Master’s degrees also spoke to the level-of-training debate. Usually, these stories reflected concern about requiring PhD level training given the shortage of psychologists in rural practice.

“I see it going back to the age-old dispute between -- no offence [laughs] -- between Doctor’s and Master’s level and that I think sometimes [pause].
Like for instance, in [this province], it is very difficult to get registered. And, I understand the importance of the job and that being a psychologist is a very critical job, but my God, it is tough to get registered. And school divisions are being pressured to hire only registered psychologists....I think we’re going to end up having a shortage. Well, we already do have a shortage.

SANDRA

There is a growing shortage of psychologists in Canada (Bieling, 2009). There is also debate in the literature about registration at the PhD versus Master’s level of training in professional psychology (Pettifor, 2004). Registration as a psychologist is done provincially in Canada and specific processes vary across provinces. My initial search of provincial registration bodies indicated that most required a PhD for registration. I was surprised that half of the participants in this study, all of whom were registered to practise the profession as a “psychologist” in their province, had only a Master’s degree. I learned that several provinces allow psychologists to register with a Master’s degree despite proposed changes or preferences for PhD level training.

Differences in level of registration are a primary issue impacting mobility of psychologists beyond provincial boundaries. Some participants suggested a nation-wide PhD level registration to facilitate better mobility.

You know, there’s lots of – lot’s more discussion of trying to have more permeable provincial boundaries so people can have reciprocity and practice different places. But in order for that to happen we all need to be on the same page. And so as a profession [requiring PhDs] is one way to do that.

MORIAH

Other participants disagreed and suggested competency-based national credentials.

I was involved in the development of the Mutual Recognition Agreement as a representative of [our region]. And, I still hear -- and it sort of saddens me in many ways -- the focus of education and training based on degree. When what we had attempted to do in the MRA is develop some core knowledge and skills. Identify those things. And I think we did. And, did quite a good job. But regulatory bodies continue to focus and maybe
even, and even the CPA because they only accredit doctoral programs rather than accrediting programs that are presenting the core value, or the core knowledge and skills.

**ALBERT**

The mutual recognition debate…. It’s not working…. There are lots of psychologists who still get stuck on degree versus competency. So, I think that makes it hard because it makes people who are in rural…. for some rural communities it’d be very hard to have a PhD [psychologist].

**JOANNE**

Informed opinion among psychologists on this issue is likely confounded by their own level of registration. As Canadian professional psychology evolves and diversifies, it is experiencing increased professional mobility (Pettifor et al., 2002). As registered health professionals, psychologists are only licensed to practise in the province in which they have secured registration. There has been recognition of the need to facilitate mobility across the country. Despite the suggestion that, “a framework now exists for the full mobility and interprovincial recognition of psychologists” (Dobson, 2002, p.68), mobility remains limited.

**6.5 Advocacy**

The final sociohistorical consideration is advocacy for psychology. Participant stories revealed the need to advocate for the sake of consumers of psychological services and for the profession itself. Participants’ stories spoke of public awareness as being crucial to psychology. They indicated that efforts to reduce the stigma of mental illness directly impacted their practice.

*I think there’s just lots of press around just mental health and mental wellness and stigma and all sorts of things that I do think play into ethical issues as well. I think a lot of that is intertwined. I think it’s just the general press in the field that’s, ah, emphasizing ethics.*

**BARBARA**

Accountability, lawsuits, recognition of, you know, mental illness as not as stigmatized as it used to be, I guess. You know, more acceptance of mental illness so it enables I suppose, psychologist’s recognition in the community.

**JANET**
Many also noted how advocacy could strengthen the profession by increasing its accountability and enhancing its reputation.

_Psychology has to stand up and lobby for itself and educate the public about itself and talk about these other service models._

_ESTHER_

_I think there’s increasing education by psychology as a profession and also like consumers who want to know more about who they’re working with. About how titles, like therapists and psychologists are used and what that means for credentials. Which I think is a good thing._

_MORIAH_

_People don’t really know what psychologists are. And, we don’t do a good job at promoting ourselves. You know, everybody knows what a chiropractor is and a massage therapist and, you know – And, everybody knows how to access money to get that. [Chuckles] We need to be better at this._

_LORNA_

The need for advocacy is frequently articulated in the literature. Some authors have spoken to the marginalization of psychology within the Canadian healthcare system (CPA, 2007; Hunsley & Crabb, 2004; McIlwraith & Dyck, 2002; Mikhail & Tasca, 2004; Romanow, 2006). Canada is the only G8 country without a developed national mental health strategy, an urgently required reform (Arnett et al., 2004; CPA, 2007; McIlwraith & Dyck, 2002; Mikhail & Tasca, 2004; Romanow & Marchildon, 2004). There have been calls, in the literature, for, “(a) continuing efforts to educate policymakers, the media, and Canadians about the value of psychological services and (b) active involvement from psychologists in efforts to develop new models of primary health care in Canada” (Hunsley & Crabb, 2004, p.233).

Not surprisingly, many participants spoke of the need to advocate specifically for psychology in rural practice. They acknowledged fledgling efforts in this area tempered with concern about the need for greater awareness and development. Many participants mentioned and spoke favourably of the _Rural and Northern Psychology_ section of the CPA.
I seem to recall there being quite a lot of information at the um, Canadian Psych Association Conference this year about rural psychology. And I’ve been, I suppose, loosely connected with the rural section of CPA for, I think, two years now. So, I’m always interested to kind of keep a close connection with that system about what’s going on. I think [the chair] does a really great job of disseminating information to us.

JEANNE

It’s nice to know that there is a network of rural psychologists out there in Canada even if I’m not able to, you know, speak with them face-to-face regularly.

MARY

I think the increased profile of rural and northern psychology is certainly helping....that’s certainly the intent of that. And, also to have a group of rural and northern psychologists that can consult with one another about these types of things when they do come up.

BARBARA

There was also commentary about the few northern and rural psychology programs in Canada. These included courses that are available at Lakehead University and the post-doctoral internship in northern and rural psychology offered at the University of Manitoba. For some, this training piqued or validated their interest in practicing psychology in rural Canada.

We actually had a course in community and rural psychology. And, doing the job I’m in, it helped. There’s different service models -- some of them -- and that way there might be some more research out there on rural psychology.

DEBBIE

People can get into rural practice without having had – and I think many people do get into rural practice without having had -- any specific training in it....one of the things that has been helpful to me has been having a year’s training doing a post-doc in rural psychology. To be able to begin going through some of this process under supervision.

MARY

The available literature appears to agree with the need to advocate for psychology. In particular, there was literature specific to the need to advocate for the rural practice of psychology. This advocacy may be more difficult because of a significant shortage of rural practitioners. Twenty percent of the Canadian population is rural which should be sufficient justification for at least an academic focus on rural issues in the profession (Brannen & Johnson-Emberely, 2006; Romanow & Marchildon, 2003). Although I found a wealth of Australian
research and literature, I found few academic articles from Canada. When searching databases with the key term “Canadian psychology” and then searching with the key terms “Canadian psychology” with the Boolean “and” for “rural”, the latter search had far fewer hits. The percentage of articles that with both search terms was six percent and thirteen percent of the number of searches for “Canadian psychology” alone for Google Scholar and PsycInfo, respectively. There were no hits with the two terms in either Sage or PsycEXTRA.

6.6 The Sociohistorical Context

All psychological phenomena should be understood and interpreted within their sociohistorical context (Hadjistavropoulos, 2009; Sternberg, 2004, p. 282). In this study, the participants specifically identified several relevant professional struggles. These contextual considerations provide the reader with a foundation to consider the exploration of the phenomenon of professional ethics in rural psychological practice that follows in the next chapter. Competition concerns highlight the potential vulnerability of the field of applied psychology. This concern suggests a need to foster more emphasis on general psychological practice. Another concern was how dependent psychology can be on government funding models and decisions. The prescriptive authority debate for psychologists appears to be controversial as cautious optimism is balanced with opposition to psychopharmacology gaining excessive prominence in the field. The debate about level of registration was seen to affect more than just mobility of psychologists in Canada. Inconsistencies in provincial registration processes may directly affect the availability of rural psychologists. The final key consideration was the need for advocacy to increase public awareness, decrease the stigma of mental illness, and develop Canadian psychology.
CHAPTER SEVEN
RESULTS

What a wealth of information I collected over the course of a few years. There were times when the meaning of the data seemed to be losing clarity despite of, or because of, all the data collected. One restless night, after yet another day of writing and contemplation, I awoke from a fitful dream. I suddenly realized with great clarity some of the themes (not a technique that I had read in any methodological review). Finally, themes began to make sense. I got up to write. After that it became clearer with the days. This was not because of artificially forcing the process but because of an awareness that was arising spontaneously from having so much familiarity with the material.

From my analytic journal, July 2009

Hermeneutic phenomenological (HP) research results are similar to the end product of a psychological clinical assessment. The results of a psychological assessment are always more than just the scores of psychometric tests. In this study the results were similarly much more than simply summarising interview responses. Balanced recommendations in assessments require reflection on the details and gestalt of the information. HP processes require a balance between the whole data set and links and contradictions within that set (Holloway & Jefferson, 2000b). Finally, in a clinical assessment, a holistic client-centred framework is used to foster client development. In this study, participant-focus was used to provide insight and to empower the participants.

This chapter illuminates and explores the results of this study from the perspective of the participants, practising rural Canadian psychologists. The three major themes of the study were: (a) connecting rural practice characteristics and professional ethics, (b) ethical dilemmas as experienced in the Canadian context, and (c) ethical schema for rural psychologists. These themes explore the phenomenon in a way that represents one of many possible perspectives of the data (Denzin & Lincoln, 2005). All thematic interpretations are based on a triangulation of the participant stories, the literature review, and my own
reflexivity. My use of rich text in quoting the participants is to foster transferability and to begin to share their stories.

7.1 Connecting Rural Practice Characteristics and Professional Ethics

The first theme which emerged from the data underscores the context of rural professional practice. This theme establishes the practice characteristics that contextualized the participants’ experiences of professional ethics and fostered the conditions which may make certain ethical issues more prevalent, complicated, or even less easily resolved than in urban practice. In the initial interview, participants were asked, “why were you interested in participating in this study?”

In response to that query, and often in commentary on ethical dilemmas, participants spoke of the need to better understand rural professional practice in order to understand professional ethics in that setting. Several participants spoke to the urban-centric nature of the profession.

*I am a rural psychologist and so often things seem to be geared towards urban situations and ah, urban settings, that it’s nice to kind of have some attention paid to the rural areas…the rural practices. And, they are different than urban practices.*

*SANDRA*

*I think there’s too much of an urban focus in psychology. And, I think there’s not enough research about rural issues and there’s not really a strong enough voice in general, I think, from rural psychologists.*

*ESTHER*

There were concerns about accessing appropriate formal training, research, and literature.

*There’s not enough people that are interested in rural practice. And they don’t have enough training in the area with the exception of the University of Manitoba program that has the rural rotation. There’s very few places where you can get that.*

*BRENDA*

*When I have gone to literature for different things, it tends to be a lot of stuff on just sort of a dual relationship and that sort of things. So, the ethical side of things that may not be particularly sort of treatment focused, or even solution focused…How do we do it that’s in a way that’s appropriate….I would be curious to see how other people handle it.*

*DEBBIE*
Perhaps rural professional practice is not clearly understood because of the urban-centric nature of psychology and many other professions in Canada (Misener, MacLeod, Banks, Morton, Vogt, & Bentham, 2008). Despite one fifth of our population living in rural areas, Canada is considered to be an urbanized country (Barbopoulos & Clark, 2003; Bray et al., 2004; Harowski et al., 2006; MacLeod, Misener, Banks, Morton, Vogt, & Bentham, 2008). Most Canadian psychology students receive no formal training or exposure to rural practice considerations (Barbopoulos & Clark, 2003; Goodwin, 2004; McIlwraith et al., 2005) and “current training models in graduate psychology are out of touch with the practice demands of rural psychologists” (Harowski et al., 2006, p.158). Jones (2008) indicated that, “educational institutions within Australia have an ethical obligation to ensure that they train psychology students to be good at what they do” (p. 45). Given the fact that one-fifth of our population is rural, this obligation likely extends to educational institutions in Canada. My personal bias is that there is an often unacknowledged difference between urban and rural practice. My academic training was in urban centres and based on urban models of service delivery. Rural issues were never mentioned. Fortunately, most of my internships and practica were in rural settings with rural supervision helping me to bridge that divide, particularly when encountering ethical issues that were complicated by the conditions of rural practice. Doctoral studies have been a welcome opportunity to develop my rural-specific scholarly knowledge. Ethical issues can be more prevalent, complicated, or perhaps even less easily resolved in certain contexts. Although the underlying ethical issues may be similar between rural and urban settings they may well manifest in different ways in rural communities. The ethical issues identified in this study may be fundamentally common but they take
on different complexions and complexities in rural settings which beget a better understanding of rural professional practice in psychology.

7.1.1 Characteristics of Rural Practice

Participant stories revealed four adaptations of professional practice norms in order to accommodate geographic barriers and resource limitations in rural practice. Some adaptations were made specifically to mediate geographic barriers.

In this study, five of the twenty participants spoke of telephone services as a regular means of dealing with geographic distances.

We did telephone counselling to employees who were living in the remote communities outside of [isolated urban community]. And then sometimes, they, if they were traveling to [that community] for other reasons we could set up appointments with them while they were in town..... I did a fair bit of work on the telephone....You know I hate to admit that I just sort of did it naturally....the way in which I addressed issues of consent on a face to face basis -- I just sort of transferred to the telephone.... Maybe I was not emphasizing or not speaking to a particular part of consent sufficiently.

ALBERT

In this quote, Albert describes how telephone services may mean increased access but may also increase ethical dilemmas for the psychologist. Another way to mediate geographic barriers was travel. Most of the participants (15) travelled to varying degrees in their clinical role. Seven of these participants travelled full-time to provide services. They shared stories about ethical concerns in relation to transporting and storing files. The primary concern tended to be client confidentiality.

You can’t leave your files behind which actually increases the risk for privacy breaches because you’re carrying people’s files around and you’re also carrying psychological tests around. And, you have to watch these very carefully so even if you, you know, have to drive a hundred miles out to a place and you stop for a coffee on the way back, what are you going to do?

ESTHER

The second adaptation, related to travel, was to practice in non-normative practice settings. Travel often meant work in borrowed office space.
The majority of the communities that I go to, um, we have kind of sister agencies that we work with so I’m able to use their space. And, they too would be considered a community agency funded by the government. Sometimes I’m in school. Sometimes I’m in daycares. Sometimes I’m in clients’ homes. Yeah, wherever they are, I go.

JEANNE

Generally it’s Ministry offices. Although, one of our programs that we work with, we have actual contractors within different communities and sometimes we use their facilities. It’s not as difficult as you might think it is, you know.

KEN

Many of the participants spoke to the benefits of shared office spaces for increasing communication or being more accessible to the community. Several participants commented on the benefits of housing their practice within a community medical clinic.

And the nice thing is, because I’m in a [medical] clinic, nobody can be identified. Which is one of the parts of rural practice, right? They don’t know whether somebody’s seen for a toenail or whether they’re seeing me….I let them know that [their file is] going to be seen by their family physicians and the lab technician so, how do we want to do that? And in that case, I will also take the physician aside and say, “This is....” I mean it’s not that I’m neglecting anything in the notes, but I’ll only write enough, right?....unless it’s a safety issue then I have to put it in.

BRENDA

Brenda’s quote shares not only the benefit but one of the salient risks of shared office space, namely confidentiality. Another concern was securing client files and psychological materials.

I left my briefcase with some working files in a locked office and left for lunch and felt that a locked office was secure enough -- that nobody would be getting into it because the office itself is also closed over lunch.....after lunch...someone -- another worker -- had returned early and had let a client into that office space not realizing that my briefcase was in there.

JEANNE

The other variation to typical professional practice was to provide services in the client’s home. This setting has potential risks for both clients and psychologists. Like telephone services, this setting may also increase ethical risks.

Sometimes there’s like about a billion people in this little tiny house. So, trying to have this gentleman’s counselling with him in his living room and was really – someone could be walking through the room every ten minutes -- every five minutes....sometimes if you’re getting into something
a little more personal he will kind of shut down at that point and not want to talk about it if his kids are walking through the room. Which is certainly understandable. So, that can be a bit of a challenge.

DEBBIE

Practice within a client’s home can also pose risks for the psychologist or their reputation.

It’s a bit of a challenge for you to explain to some psychologists who always work in very traditional settings that you actually walk in and see people in their living rooms. That kind of blows their minds sometimes [chuckles]. You know, because we’re always told in terms of avoiding any spectre of inappropriate. To do things very much by the book but any - in rural practice is not really feasible. So, sometimes I have to see people in their homes and if that’s not appropriate, I’ll see someone in like the coffee shop or something.

DEBBIE

However, appropriate service delivery in such settings may reduce risk of client harm by minimizing the chance of exploitation of the client or perception of same for the psychologist.

We videotape everything…. One is protection when I’m doing young women or things like that [alone with the client] Yeah. The other one is quality control. I look at every tape that I do so that I can look back and say, “Am I doing that correctly?”...Because you can wander off in terms of timing and all kinds of things. And the other one is to ensure that I’ve picked up on the behavioural aspect within the environment of the individual.

KEN

These settings can also increase the ability to provide enhanced assessment and service delivery.

About 10 or 12 times a year we’ll actually be assessing right in somebody’s home. Because that’s the best venue to get the data that we want.

KEN

You can actually use it to your advantage....Actually fills in the clinical picture a little bit in a way that you wouldn’t get if they were just coming to your office....Another gentleman shows me how he’s rearranged his barn so that he can, you know, show how he can accomplish the tasks....So, I can really see how that’s going and what he’s doing with that when I’m at his home. Or, he could describe that if he’s in my office. But it wouldn’t have the same richness to it.

DEBBIE
The third adaptation to urban-centric practice was tailoring service delivery to the needs of rural consumers. Participants in this study revealed an awareness of the impact of rural norms for conducting assessments.

And I use my differential diagnostics to really tailor interventions, right? ....you may only see them once or twice....when the person comes in, it needs to be done efficiently, correctly, and based on a really good history....it's the rural context but also the community context....you really tailor the intervention because it's absolutely critical in the rural communities.

BRENDA

Participants also expressed a desire for rurally-relevant assessment protocols.

You sometimes will see an individual only once and we have cut our battery down so that -- particularly if we’re dealing with....persons with mental handicaps -- that we need to have a battery that’s short enough, that’s comprehensive enough so that we get as much information as though they were actually in our office in [the city].

KEN

Some of the clients who I work with are Aboriginal children, and very few of the tests that I use have normative data on Aboriginal children....my assessments are not always standardized....I think I run into it more frequently because the settings that I’m in and the communities are sometimes less ideal than people frequently run into

JEANNE

Others described practice conditions that did not have any established protocols.

Several participants described arrangements with the federal government to provide short-term intensive psychological services for clients with significant geographical barriers to service access.

They travel in to see me....lots of them are coming from the small northern communities....for a week at a time [because they are so very isolated]. So it’s not, yeah, it’s not typical therapy, right? So, I’ll see them for four or five days in a row and then I won’t see them again for a month or so. And, then they come back in for another sort of intensive week of counselling.

JOANNE

I have read the books on intermittent therapy and stuff like that. And, short term brief enhancements. But, they are talking about people in urban settings. There is none to the way that the feds have set things up. Like they would to bring in a client out for 3 or 4 days for what they call “intensive” [work] and then fly them out — there is no model for that kind of practice.

DONALD

These specific practice scenarios both force and require variations to normative standards for assessment and treatment in rural practice. Consequently, the rural
practitioner may need to adopt innovative practices that are not supported by the conservative evidence-based literature. This can raise a variety of ethical issues.

Finally, participant stories indicated that social justice was important in the provision of ethical services to rural people and communities. Their stories revealed a need to advocate for socially appropriate services which could, at times, mean systemic interventions to deliver appropriate services.

*Doing things in a non-traditional way, a way that I wouldn’t have necessarily pictured my job as a psychologist….dealing with the resources that you have in rural areas where psychiatric facilities aren’t as accessible. And, trying to do what we can to make it work for a client in his community rather than having to make him come into a busy urban area….making recommendations that might be sort of outside the typical scope of what we would call treatments….It is a bit of a fight sometimes….Just trying to convince them that these people are entitled to the same treatment as people who happen to live in an urban area.*

*DEBBIE*

*Over the course of the time….we were able to convince them….to actually have what we call a mental health clinic on site….There’ve been deaths there. Not by accident. Somebody had a heart attack and died in their room and so interestingly enough, they really hadn’t set up provisions for coping with those kinds of situations. So they really didn’t see themselves as a community. And over time we helped them to kind of gather their wits around that.*

*ALBERT*

Participants spoke to their responsibility to advocate for rural communities and peoples.

*I really believe it’s important for us to work in ways that facilitate higher level changes or broader changes more at the population level. Whether that means looking at different ways of delivering services or helping regions with needs assessments around mental health issues, and those kinds of things. So, I think it impacts, I guess the greatest number of people when you’re the only psychologist in a very large region. I think it’s important to look for those opportunities and involve ourselves in them to the extent that it’s possible.*

*BARBARA*

*I love living in the north. It’s home. I love the people. And, it was really important to me -- I had many opportunities growing up and so it was really important to me to be able to give back when I finished. And, I knew of all the social problems, really. And so, I just wanted to be able to try to make a difference.*

*JOANNE*

Participants also shared stories of advocacy efforts directed at poverty in rural areas.
It’s not a rich area where I live. And, a lot of people don’t have a lot of money. And so, ethically, that was a bit of a dilemma as to what to set my rates at. Because, if I set my rates as the same as the city, I felt like there was a lot of people who wouldn’t be able to afford that.

ELEANOR

There are the poverty issues that we experience here in terms of the people that we work with, whether it is literacy issues, whether it is access to a physician. Or, that we are hours away from certain services… I don’t think it is given the credit it deserves. You always have to fight the issue. You always have to make a special point. It is never taken as a given.

CAROLE

The rural practitioner may need to be aware of systemic processes in rural communities, the impact of poverty, and how their professional role can impact these social conditions. This can also raise ethical issues.

I found no literature that reflected the first three adaptations of professional practice norms to accommodate rural practice considerations. This appears to be an area where more study is required. I lament this lack of discussion in the literature as it creates a certain vulnerability and professional isolation for rural psychologists. My personal bias is that practice accommodations are often required yet may leave rural psychologists vulnerable because of the atypical nature of such practices. In over a decade of practice in a rural setting, I have provided psychological services by telephone and travelled to mediate geographic barriers. For years I carried two heavy briefcases during my travels. Not only was this physically difficult (particularly at 30 degrees below zero in heavy snow) but I often encountered situations where I wished I had brought still other resources. Sharing office space with secured storage helped but this was only in one community. I have also conducted home visits when required to provide optimal conditions for the provision of services. I was initially somewhat naïve when working in clients’ homes but soon developed protocols to ensure protective factors for both the client and myself. I have also had to tailor
assessments to the needs of rural consumers, particularly as I often work with Aboriginal people.

The fourth adaptation or consideration, social justice, was represented in the literature and is more frequently being considered in Canadian psychology (Cohen, 2009b; Pope & Arthur, 2009). Why was there a social justice focus in this study? Maybe it was because rural Canadians do experience poorer socio-economic conditions and have less favourable health status than their urban counterparts (CIHI, 2006; Pong, 2007; Romanow & Marchildon, 2003) which speaks to the nature of the practice in these settings. Indeed, “social care is embedded in place, by which we mean the social relations that determine who provides what are closely connected with the physically bounded settings of meaning and interaction in which these activities and relations occur” (Hanlon, Halseth, Clasby, & Pow, 2007, p. 466). If this is true, then rural practice itself may foster such views or, alternatively, attract the kind of psychologist who has social advocacy as an area of focus. Recent research has indicated that rural practitioners are likely to participate in social advocacy for their communities (Boydell, Stasiulis, Barwick, Greenberg, & Pong, 2008; Greenhill, Mildenhall, & Rosenthal, 2009; Larson and Jones, 2009). There is more need for such advocacy for the economically disadvantaged (Pope & Arthur, 2009, p. 62) which, unfortunately, means many of Canada’s rural people. My own practice reflects a bias towards social advocacy. I usually have a long wait list for my private practice that has a standard hourly rate. Despite this, I always ensure that a certain percentage of my caseload is reserved for a heavily subsidized community program. I am also committed to providing services to a local Aboriginal community that has considerable poverty, a 70 percent unemployment rate, and much more difficult working conditions. I am often asked why I continue to
accept this challenging contract but for me it is difficult to begin to even articulate my sense of responsibility in this regard.

7.1.2 Initiating a Shared Definition

In this section, I take the view that it is useful to articulate a definition of rural professional practice in psychology that draws attention to the links between practice parameters and professional ethics. This study used the Statistics Canada benchmark of location and community size but also used participant self-definition as criteria for determining who is a rural psychologist. This followed a structure similar to that used by Kulig, Andrews, Stewart, Pitblado, MacLeod, Bentham, D’Arcy, Morgan, Forbes, Reus, and Smith (2008) who surveyed Canadian nurses from rural and remote locations. In both studies, the selection criteria fostered, rather than provided, definitions of rural practice. In their research with rural and remote Canadian nurses, Kulig et al. (2008) determined that a definition of rural was more than a static description. They determined that it was a series of content domains that described dimensions of rurality from the perspective of the interviewee. The results of this study supported a similar need to define rural practice in its complexity. A proposed description of rural professional practice in psychology for Canada was constructed from considering the demographics of the participants, their reactions to defining rural, and what they considered to be common features of rural practice.

The demographics of the participants in this study are telling as they represent important elements of the context of practising rural Canadian psychologists. The twenty participants represented a noteworthy range of psychological practices that included private practice, school-based practice, and work in health care, or a community agency, mainly in a type of generalist practice.
When you’re in a rural area sometimes you’re all that’s it and you have to be able to deal with whatever the problem is. So you have to be a generalist otherwise if you get too specialized it can be a problem for your business and a problem for people who are depending on you....in the kind of work that I do I have to be prepared to deal with all ages and all kinds of circumstances.

ESTHER

I’m the only PhD level psychologist for a health region which covers geographically most of northern [province]. And so it covers age range and presenting problems. Basically, you name it; we get it walking through the door. And it’s both in-patient and out-patient.

MORIAH

Most participants (14) provided therapy or counselling, assessments or diagnostic services, and consultations. Many (12) were involved in teaching, training, or supervision. Only a few (less than 4 in each category) were involved in research, forensic work, program administration, or public education. Most (18) participants worked with a large age range of clients.

The final demographic consideration was the size and nature of the rural communities in which participants practised. This was not easily determined as most participants did not limit their work to one community.

Donald

There is no answer to "size of community in which you work"....I travel to some communities with less than 400 population and have flown into others with populations of about 500 - 2000 - I have driven 7hrs to meet with clients because there is no air connection....people are very spread out.

DONALD

I work in the whole of the northern half of [the province]. The entire north.

KEN

The communities served by the participants also varied in size. The larger communities, served by four of the participants, were determined to be either northern or remote and were therefore relevant to study.

ALBERT

It's still isolated because there's a ferry you have to take to get across....[and] for about six weeks -- depending on weather -- you couldn't drive out and stuff had to either get helicoptered or flown over the river....however you define rural and it goes with things that could be considered -- there is an element of isolation just by physical....by the road system. It's the end of the road essentially.
There is 3 municipalities that are in that [region] and that would be another 20,000. So, it is a fairly big area but, you know, it is 3 hours away from a city and some describe it as, “at the end of the earth” because [laughs] you leave our home town and you are in the ocean….sometimes those roads can be pretty bad so – you know, there is an isolation factor.

CAROLE

Only four of the participants did not indicate a sense of personal or professional isolation.

It is moderately isolated. And it’s more isolated in the winter. It’s only an hour and a half from [the urban centre but travel] can be hazardous….the communities around it can be quite isolated.

BRENDA

Northern for sure. I don’t think of it as being very small but I come from a very small farming community, so, you know, it’s all relative…like you’re looking at a seven to eight hour drive to [the urban centre]. Um, four hour drive to [town], which would be, you know, the next sort of – or the next sizable community. And it is quite isolated. Like in between, in between those two places I mentioned, there’s not much.

MORIAH

Many of these demographics are consistent with the literature review in Chapter Three: Rural Practice. This included the tendency to be in generalist practice, the need to work with diverse age groups, and the requirement to find ways to bridge geographical barriers to service provision (Barbopoulos & Clark, 2003; Schopp et al., 2006). Practice descriptions reflected the limited resources common in rural areas (Gale & Deprez, 2003; Perkins et al., 2007).

My personal biases come from being demographically similar to the participants. I work as a psychologist in generalist practice and travel about half of the time to surrounding communities. I have provided telephone-based services to help mediate geographical barriers for clients. I am registered at the Master’s level and have lifelong experience in a rural community. My own practice is in a community of 6,000 over 200 kilometres from an urban centre. Finally, I do not consider my practice to be isolated, particularly in relation to some of the participant stories.
The contested nature of rurality arose spontaneously during most of the interviews. Most of the participants had their own idea of what rural professional practice entailed, yet none shared any clearly articulated definition. Many had concerns about having sufficiently stringent criteria to determine rurality, particularly in consideration of size and location variables.

When I taught my course on rural and community psychology, I was normally boggled at how people are trying to define things. How do you define rural? The definitions just aren’t there....there’s a criteria of the isolation of the practitioner [and the community]. And the limited resources available, yeah. I mean, there’s certainly a heck of a lot of difference between someone in [town name] which is, you know, a two hour flight north of here, not connected by roads and somebody in a small town just outside of [the city].

DONALD
I am sorry but you know what? At 50 kilometres I can come in to town and get a Starbucks in the morning if I wanted to. Do you want to know what my definition is? It is that I cannot get a Starbucks in the day. [Both laugh] Like when I am not in driving distance of a Starbucks – now I am talking rural. And, Tim Hortons just doesn’t cut it, sorry.

CAROLE
Others expressed a need to distinguish between psychologists who live in a rural setting and those who commute from an urban location to a rural community.

Rural psychologists who live in their community of practice work in embedded environments (Haydar, 2007; Moleski & Kiselica, 2005; Scopelliti et al., 2006; Yonge & Grundy, 2006). Participants appeared to be cognizant of the social and contextual differences between rural and urban Canada and how residential location may impact professional experience.

I wouldn’t really define that as rural psychology. If somebody lives in a rural setting and travels around that setting or has people come in to them in that setting, that’s one thing. But to live in the urban area and drive out, I wouldn’t really -- I don’t think I would define that as rural. That’s a type of rural service but I don’t think it comes with the same issues as being a rural psychologist.

ESTHER
The rurally-based psychologist is often expected to live up to assumptions made through active informal communication networks and needs to gain the trust of community members and leaders by being in a professional role at all times.
within the community (Behnke, 2008a; Helbok, 2003; Schank & Skovholt, 2006; Scopelliti et al., 2006). There is also a balancing act between client and community needs that likely heightens the cultural and contextual dimensions inherent in rural practice (Roberts, Warner, & Hammond, 2005; Roberts, Battaglia, & Epstein, 1999).

The literature, like the participants in this study, does not coalesce around a standard definition of rural practice in psychology. Definitions that do exist focus on population and distance. In empirical studies used to inform this research, operational definitions ranged from communities of 2500 to under 20 000 people or by distance such as 50 kilometres from an urban centre. The defining characteristics of rurality became an issue in a study of medical students in the United Kingdom. In that study, “what is rural?” became an unintended theme of the research (Deaville, Wynn-Jones, Hays, Coventry, McKinley, & Randall-Smith, 2009). Indeed, the authors concluded that degree of rurality, or what is rural, “will mean different things to different people, depending on their background” (Deaville et al., 2009, p.1165).

My personal bias is that a better articulated definition of rural professional practice in psychology is needed but will be difficult to achieve. Interviewing rural psychologists from across the country, I was struck by the variability in rural cultures and communities. This was most clear to me on the day I conducted a telephone interview from a cabin in Newfoundland, on the east coast of Canada, and the participant was a psychologist working off the west coast in British Columbia. How can you compare such diverse rural communities and come up with a suitable definition? Can there really be engaged discussion on professional ethics in such a poorly defined context?
7.1.3 Summary of Rural Practice Considerations

Interpretation of this theme is based on intersubjectivity, an understanding of shared meaning that is socially and historically contextualized (Hein & Austin, 2001). Rural professional practice in psychology in Canada has distinct characteristics and occurs without an articulated definition. Given the importance of practice characteristics for understanding professional ethics, I have proposed a definition of rural Canadian professional practice in psychology based on the multifaceted picture evident in the findings of this study. To conceptualise this in an accessible way, I turned to a model from my own training and practice and one commonly understood and used by many Canadian psychologists – the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV).

The current DSM-IV is considered the standard classification system for mental disorders. It is based on a comprehensive literature review and is used by a wide range of mental health professionals including researchers, practitioners, and policy makers (APA, 1994). The introduction to this manual gives a good overview of the DSM-IV.

The utility and credibility of DSM-IV require that it focus on its clinical, research, and educational purposes and be supported by an extensive empirical foundation. Our highest priority has been to provide a helpful guide to clinical practice. We hoped to make the DSM-IV practical and useful for clinicians by striving for brevity of criteria sets, clarity of language, and explicit statements of the constructs embodied in the diagnostic criteria. An additional goal was to facilitate research and improve communication … An official nomenclature must be applicable in a wide diversity of contexts. (APA, 1994, p. xv).

That description seemed ideal for guiding a definition of rural professional practice in Canada. I acknowledge limitations to the DSM-IV structure. Many psychologists are not supportive of diagnosis and the DSM-IV has been criticised on several counts. There are concerns that it is insufficient to support scientific progress and less objective than it claims to be. However, the structure itself is
useful. It provides definitional clarity and structure. DSM-IV descriptions list alternative terms in parentheses and includes specifiers. This structure implies that key features or criteria co-occur and manifest in various ways. This allows for variation of criteria to meet the conditions of the definition (APA, 1994). A proposed definition within that model is presented in Table 7.1 and was grounded primarily in participant information.
Table 7.1

*Proposed Definition of Rural Canadian Professional Practice in Psychology*

<table>
<thead>
<tr>
<th>Rural Canadian Professional Practice in Psychology</th>
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<tr>
<td>(professional practice of psychology in northern,</td>
</tr>
<tr>
<td>rural, or remote locations of Canada)</td>
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Conditions in (a), (b), (c), and (d) must be present

a. Professional practice of psychology in a community where at least two of the following are present:

1. *Size* – The population of the community is less than 15,000 people. Communities of 15,000 to 40,000 people may be considered if they also meet the remoteness and resources criteria.

2. *Remoteness* – the community is outside the commuting zone of an urban centre by at least 150 kilometres. Alternatively, community residents are required to access an urban centre for health services but there is no public transportation to that centre or travel can be hazardous during inclement weather.

3. *Resources* – The government of Canada considers the community to have insufficient access to health care, mental health services, or amenities for the service demand. Alternatively, Statistics Canada lists the community as one currently experiencing socioeconomic distress.

b. Professional practice is general and provided for a wide range of presenting problems as community needs do not support specialisation. This can be due to insufficient health care services, a small population base, or lack of suitable alternate community resources.

c. Adaptation of professional practice norms is often required to accommodate geographical barriers and resource limitations. These may include: telephone services, travel to provide services, or specific assessment and treatment modifications.

d. Ethical issues arise in relation to (a), (b), and (c).

The first two criteria in the required subset (a) that define the community size and remoteness were based on the analysis of the participant demographics. The third criterion in subset (a), resources, represents a common feature of rurality in the literature (Muula, 2007; Stamm et al., 2007; Vella-Brodrick et al., 2006; Zapf, 2006).
Statistics Canada provides regional socioeconomic context ratings in publications such as their *Rural and Small Town Canada Analysis Bulletin*. An example is the article, “Mapping the Socioeconomic Diversity of Rural Canada” available in that publication (Alasia, 2004). The second requirement, (b), reflects the findings of this study and the assertion from the literature that generalist practice is common in rural practice (APS, 2004b; Harowski et al., 2006; Helbok, 2003; Sawyer et al., 2006). The third requirement, (c), reflects some of the adaptations that arose specifically from this study. When applying the proposed definition in Table 7.1 to the demographics of the participants in this study, most of the participants meet all of the criteria. The only possible exception is four participants who provided more specialized services. The final requirement, (d), highlights how ethical dilemmas may manifest differently in rural settings because of those preceding conditions used to define rural Canadian professional practice in psychology.

### 7.2 Ethical Dilemmas in the Rural Canadian Context

A common variation in thematic analysis, particularly for HP research, is to move between latent or implicit themes and manifest or explicit explorations of responses to key research questions (Braun & Clarke, 2006, Laverty, 2003; van Manen, 2002). This second manifest theme is an exploration of the experience of the five primary ethical dilemmas in the Canadian context. When not spontaneously addressed, participants were prompted about their experiences with: overlapping relationships, community pressure, generalist practice, interdisciplinary collaboration, and professional development and support. These results extend the existing literature on the existence of these ethical challenges and provide insight into how they may be conceptualized in rural practice (Lin et
al., 2009; Womontree, 2005). Participants in this study provided a wealth of information and experiences for each of the five dilemmas.

*I think in rural private practice those ethics come up so often they’re in your face. It’s hard for you to not be aware of them.*

CONNIE

*I think rural practitioners probably come up against ethical dilemmas more often, in a more striking way just because of the closeness of the community.*

MARY

As Connie and Mary indicate, there were many stories to tell.

7.2.1 Overlapping Relationships

Most of the participants indicated that they were routinely faced with unavoidable overlapping relationships.

*It’s really hard to get away from dual relationships in rural areas.*

BRYON

*It’s hard to think of specific examples because living in a small town, you just – you’re confronted with it every day. So, I mean, always, you know, seeing people who I’m involved with professionally. I mean, when I leave the school we are involved in other ways. On committees, or at the grocery store, or whatever.*

SANDRA

Rural practice reflects work in an embedded environment where, as Sandra indicated, professional and personal roles can overlap considerably. Some of these boundary struggles impacted family members.

*Last year she got an invitation for a birthday party from – and it was with a family that I had, you know, previously worked with, right….I took her to the party….but I know there was some people that, you know, when the invitations come…. we’ll be busy that day. [Laughs]*

DOREEN

*He [my husband] actually said to me, “I wish I hadn’t known that. I don’t care if people are going to see psychologists for whatever, you know, concerns they’re dealing with. But it’s just a little awkward to know that the psychologist that they saw was you and that you know all this stuff about them and now you’re seeing them in a different setting.”*

MARY

Participants also told of times when their professional role overlapped with friendships. Sometimes, they developed friendships or unintended acquaintances with previous clients or those close to them.
It was about a year or a year and a half after that [this person] and I really started getting to be friends. And so, trying to figure out how to manage that -- knowing that I know all of this stuff about her husband.

MARY

I mean there were a few clients who did become friends. I wouldn’t consider them close, personal, intimate friends. But, they would be people like, that we would socialize with.

ALBERT

Other participants reflected on dilemmas that arose when friends became clients or had connections to clients.

My...friend [turns out to be] the aunt of my client, but my [other] girlfriend has now also heard this whole thing. So, another layer, which brings me to, how do you deal with those pieces?

CAROLE

I’ve also had people who are, maybe not good friends of mine but acquaintances of mine who have called ....I have taken them on, but as I’ve realized over the years, that’s just bad, really, right? It makes for awkward moments at BBQs or things like that. And so, I have learned not to do that.

JOANNE

As Joanne indicates, clearer boundaries help with avoidable overlapping relationships.

Several of the participants indicated ethical dilemmas in relation to colleagues. At times, prior clients could become colleagues.

One of the nurses was a client of mine....And, then I realized that I was going to that community and that particular nurse was working there. And again, I -- the client takes the lead. The client wondered if she [could] come and talk to me.

ALBERT

I taught at the local university – that person [previous client] was in my class, OK? Subsequent to that, they then decided to go to grad school to become a psychologist .... and if you think that is good, here is the next part. They graduate. They apply to a recent opening. The only one who gets an interview -- in my department!....We then had to make sure her file isn’t in the department, right.

CAROLE

Other times, current colleagues became clients because of a lack of alternative services.

When you’re it within that community, and you’re providing service to an area and you’re also working within an agency and with folks, then, you know, there’s all kinds of dual relationships with, um, with the human services director of the health centre, you know. And, her and her family
have come in to see me and some folks from -- who run different programs and their families.

CONNIE

There may be a local worker who wants to refer their kid – And, they are colleagues. And, the choice is to take the high ground and say, “I can’t do dual relationships” and then the kid gets no service whatsoever.

DONALD

Many rural psychologists have little choice about engaging in overlapping relationships (Johnson et al., 2005; Younggren & Gottlieb, 2004). Rural psychologists may be expected to provide services to, or receive services from, other local professionals within the community or even within the agency in which the psychologist works (Staal & King, 2000).

Similar struggles appeared to occur when the psychologist’s professional role overlapped with community relationships. Participants spoke of unplanned community involvement with previous clients.

I wanted to play broomball and so I joined this team and there she was. And, I could, um -- of course they were doing introductions around and I could tell the horror-stricken look on her face. And so, I just say, “Hi, it’s nice to meet you” and just pretended like I didn’t know her from anywhere else.

JOANNE

My concern, quite honestly, is often how clients feel about that. How uncomfortable it can make them feel. And, you know, I sometimes wonder if they are concerned that our knowledge about them in therapy might impact our, I don’t know, respect for them in another role...or about us sharing information about them in, you know, what goes on in therapy in this other setting even though we just talked to them about confidentiality.

BARBARA

These participants focussed on potential client impact. Research indicates that psychologists in rural practice tend to frame their ethical decision-making around the best interests of their clients (Endacott et al., 2006; Ridgeway, 2005).

Other stories reflected the struggle to balance information received through informal information sharing networks in overlapping relationships.

It makes it socially difficult to go to certain places I think, you know because you could run into parents of clients doing inappropriate things. So, if I went to a pub on a Saturday night with the family or with some friends and I saw the parent getting really drunk and making out with somebody that I knew wasn’t their partner, then that presents an issue.
My main issue is a familiarity with the family...Knowing some of the clients and their families too well...that might kind of slant, perhaps, the way it makes some of my recommendations. Or, it just makes it awkward when you have to talk to parents about ability levels that might be low or something.

The ethical dilemmas resulting from overlapping relationships are considered to be the most challenging for psychologists (Moleski & Kiselica, 2005; Ridgeway, 2005) and are intensified in isolated communities (Roberts et al., 2005). The following scenarios demonstrate the challenge of appropriately managing information sources.

I had to be extra careful to not, you know, say, “Oh yeah, I heard that.” But, then it was helpful in terms of what lines or questioning. But yeah, I had to be really cautious to not, you know, have one person’s information spilled from one person to the next, you know. Who I got what from.

You have family reputations you know so, somebody will come in and I’ll be assigned to somebody and I’ll know their family history....you know, you try very hard to be aware of your own issue – but also what their thoughts and perceptions are.

Having prior knowledge is more common in rural practice (Barbopoulos & Clark, 2003; Nigro & Uhlemann, 2004). It is important for the psychologist to resist undue influence of informally acquired client information and to protect clients from gossip and innuendo (Behnke, 2008a; Endacott et al., 2006; Essinger, 2006; Womontree, 2005).

How did the participants manage the ethical dilemmas inherent in overlapping relationships? Most spoke of handling these relationships with particular caution.

I do typically deal with those kinds of situations by consulting colleagues....I still do think those things through quite carefully and I know when I have discussions with other professionals outside of psychology...[we] are often kind of teased about being very anal about things. Because, I think we really do try and think things through very carefully.
Consultation is beneficial for managing overlapping relationships. Consultation can provide an additional perspective, can highlight contextual issues, and can decrease the isolation possible in rural practice (Behnke, 2004; Endacott et al., 2006; Schank & Skovholt, 1997). Another common response was to establish clear boundaries.

*I have just always been able to make really clear boundaries and I don’t – I just draw the line and I -- It’s not a big problem for me [as part of my personality] -- I just see it fairly clear in my head that work is work and socializing is socializing and they don’t mix.*

SANDRA

Clear and reasonable expectations and boundaries strengthen professional relationships, especially in situations where out-of-therapy contact cannot be closely controlled. Research by Haydar (2007) indicated that psychologists in rural practice attempt to minimize these risks by developing progressively more strict boundaries, particularly with family and friends. Participants also told of having creative arrangements with colleagues or through technology.

*We’ve been fortunate in being able to identify alternate services so the psychologist does not have to provide those but the client still gets services. So sometimes, for example, that might mean providing therapy services through video-conferencing. So, one of the psychologists in the other region would do that.*

BARBARA

*We could look at doing something at a distance with telehealth with another psychologist if necessary.*

MORIAH

Some of the participants also provided an alternative view of overlapping relationships. They spoke to the benefits and normative nature of overlapping relationships in rural practice. There could be value in having prior information about a client.

*It’s so helpful to see their different perspectives…..And, even knowing kind of the history of various families and, you know, traumas from 20 years ago.*

DOREEN

*I think the empathy is that much greater if you know things. You know, it seems unethical that you would know things. I guess it’s the nature of the
Also, in rural practice it can seem artificial to try to control unavoidable overlapping relationships.

_Psychology has created an image of the psychologist that might not be human.... as human beings, we all have relationships and, those relationships touch each other.... And, at every moment of every day we have to make choices about how we live those relationships....there isn’t such a thing as a psychologist who’s not a person. That’s an artificial academic distinction in our minds that doesn’t really exist...we also have to recognize that we have to be not only, you know, respect the dignity of people but we have to respect the dignity of ourselves. That, we are not robots and we are not open and closed shops. We do not open our doors at 9:00 a.m. and close them at 5:00 p.m. and stop being psychologists or turn on or off being people. That’s a silly way to think of ethics._

_Esther_

_I see psychology as trading in relationships. I’m trading in the sense of, you know, it’s my trade. Um hmm. Well, and you know, I think relationships are food for the soul._

_Eleanor_

Psychologists seeking to make good ethical decisions about overlapping relationships must effectively balance personal and professional role conflicts in ways that are acceptable to the community that they serve (Schank & Skovholt, 1997). Psychologists in rural practice need to explore how, not if, they can manage overlapping relationships (Moleski & Kiselica, 2005; Scopelliti et al., 2006).

7.2.2 Community Pressure

Most of the participants experienced community pressure. Some had concerns about how they were perceived by the community.

_Most people say, “So where do you live?” and that sort of stuff. And, I would say, “Oh, I live in [this] road in the normal people part not the rich people part”....I’m honest. Honest and open with it because....I don’t want them to think that I’m judging them._

_Virginia_

_Your house, your home. You are being evaluated. You are constantly being judged....and needing to fit it. If you are in an area that has poverty, then you don’t want to be driving a really fancy car....How do you want to be seen by your neighbours in small town?_
One such perception was of the rural psychologist as a role model.

She thanked me and said, “I just think you are the best mother.” And so, you know if they’re saying that to you they’re watching how you parent. I say to my kids, “Look, everybody’s watching you so behave yourselves.” [Both laugh]

ELEANOR

Psychologists are expected to live up to assumptions arising from informal communication networks. They need to gain trust of community members and leaders by being in a professional role at all times within the community (APS, 2004b; Schank & Skovholt, 2006; Womontree, 2005). Another pressure is the need to be seen as an integrated community member.

It is important that you are part of that community. You can’t just be -- you can’t live separate from your community. You can’t in those small communities! You have to be a part of it – to appear to be accepted

CAROLE

If there’s a death in our family then clients show up out of respect. But, if there’s a death in their family we struggle with whether or not to go, out of respect. Sort of that whole -- again that’s just such an integral part of the community yet in a different relationship.

VIRGINIA

Cultural dimensions, like expectations of community involvement, can intensify ethical issues (Roberts et al., 1999). The suggestion that rural psychologists keep an extremely low profile in the community is likely to contradict culturally relevant practice (Behnke, 2008a; Bishop, 2005; Helbok, 2003).

Participants also spoke to ethical dilemmas in relation to community expectations. A common issue was pressure to provide more services than possible.

That’s something I feel a lot when I do go into the schools. Um, so, I may be there doing an assessment on two of their kids and they tell me, you know, we really need you to see like 10 kids. How can we make that happen?

JEANNE

There’s increasing demand from more of an administrative side of things to, you know, give the psychologist perspective on, you know, this measure or this committee. “How do we go about doing this?” And, ” would you join the ethics committee? And, the continuing quality assurance committee?”

MORIAH
Participants also commented on pressure to provide services without a professional relationship.

*What kind of remuneration is involved and things like that? There’s a very large pressure also in, I don’t know if it’s true in all communities, in my community there’s a large pressure to do a lot of things for free.*

ESTHER

*People approaching me, who know what I do, and asking for advice. Yeah. I don’t know how I could forget this because it’s a bit of a bane of my existence.... I’ve been hit up numerous times. Yeah, because the ethical dilemma for me isn’t me being hit up. That’s just awkwardness. But it’s, what do I say? And, how accountable am I in those situations?*

ELEANOR

These issues are common among rural practitioners who often need to balance community expectations with their own needs and with client needs (Roberts et al., 2005).

Another common issue was about increased visibility in rural areas. Sometimes called, “living in a fishbowl”, this visibility impacts clients and psychologists.

*The smaller your community gets, the higher the risk....visibility. And then questions start being asked. Mary comes in and, “Oh, Mary, I saw you were in the office the other day talking to [the psychologist]”*

ALBERT

*Sometimes you'll drive out to a home and someone will say, “Hello, what are you doing here?” [Chuckles] And, you know, and then you're walking in with, you know, a brief case or something and it's obvious that you're there to see someone. You know, you're an official type person and -- you know, nosey neighbours.*

DEBBIE

Client confidentiality can also be compromised by psychologists’ family members who may not understand professional issues related to confidentiality.

*People will say, “Hi” to me and my mother’s very nosey. And she’s lived in the [region] a long time and so she’s always like, “How do you know that person?” And I make stuff up, really. It’s what I do. I make stuff up. I lie. I lie to my mother so that she doesn’t sort of know where I know people from....I mean I have also said to mother, “You need to stop asking me how I know people” right? I mean I have explained it to her but at that same time, she’s my mom. She just does what she wants to do.*

JOANNE
These kinds of social visibility and lack of anonymity can create barriers for rural clients (Barbopoulos & Clark, 2003; Helbok et al., 2006; Zur, 2006). Participants also had concerns about their own privacy.

*Your increased visibility and lack of anonymity as a professional. Even in social situations...people see you when you're grocery shopping. They see you if you're out at a bonspiel. They see you if you're at a bar, you know....People just are more likely to know you than you are to know them.*

**MORIAH**

*My natural tendency is to want to be as private as possible and I’m learning to let go of some of that and relaxing. Not relaxing my ethical standards but relaxing that if a client happens to see me grocery shopping on a Saturday and I’m not looking my most professional, it’s OK. And, being able to live with that...reputation is so huge. You know word of mouth in rural areas is far more important than, you know, what degrees you have on your wall in many cases.*

**MARY**

This kind of pressure can result in anxiety for the rural psychologist. In recent research, Haydar (2007) found that psychologists in rural practice disagree about their ability to compartmentalize their professional and personal roles.

*On one level I was feeling resentful because, you know, it's my daughter’s basketball game. I was there to watch it. On another level I felt very badly for this woman.....some people look upon us as, or they look upon the title, and they bestow or project a certain reverence or some people irreverence. That was an awkward situation for me.*

**ELEANOR**

*I’m much more aware of what I’m saying. Um, I think I’m more careful about how much personal information I’m sharing with my friend...I’m just not being as forthcoming with information with my friend about my own personal life and situations than I probably would be if my client wasn’t sitting behind me.*

**BARBARA**

Behnke (2008a) suggests that “psychologists must be able to integrate their personal and professional lives” (p.45). The participant stories indicated that this can be difficult in embedded environments.

Participants shared many valuable ideas for managing ethical dilemmas related to community pressure. One idea was working within a triage model.

*We have an intake person -- whose job it is to interview people. Absolutely knows which questions to ask and part of that intake process -- It’s very useful and she does ah, crisis assessments as well....And then a triage*
team sits down and sort of says, this is probably what’s going to be helpful for this family.

VIRGINIA

By the time I get the referral there’s a real need and that they’ve tried some other things before just turning to the Ed Psych and saying, “Here, find out what’s wrong and fix it.”

SANDRA

Triage models help psychologists to deal with demand by having cases prioritised and it allows for shared decision making on handling caseloads. Other participants set clear boundaries with community agencies.

I think part of it is trying to carve out my definition, my role, my job description and do that in a way that makes sense so I can set up some boundaries to both be able to tell people what I do and what I don’t do which has a self protection mechanism. Because I’m clearly not going to be able to address all the need.

MORIAH

I try to be really strict about….the setting of the boundaries before I get to the community about which clients are going to rise to the top circuit or prioritization scheme.

JEANNE

This is done in a respectful and supportive way. Bradley (as cited in Kersting, 2003) indicated that she overcame community pressure with simple friendliness and approaching community members in comforting ways. Other participants indicated that they specifically established clear boundaries with clients.

When you establish boundaries that are nice and firm and but kind, most people are very respectful of it and it’s never really been an issue in [town]. I’ve been living there for seven years since….my number’s in the phone book. We’re the only [surname] in the phone book -- And I’ve had only one parent call.

VIRGINIA

Charlebois (2006) found that creating boundaries was vital to well-being and self-care for counsellors in a remote northern community. Participants in this study were also careful to carve out private time, often by keeping their personal telephone number private.

I would never give my home phone number out. And I think that’s because of the size of the community….Like, it’s just not that big. And, I just think I would be crossing a boundary there. Like for myself, my own personal boundary. Because, I think I would get inundated with phone calls at home.

JOANNE
We actually have our phone number listed under a — I guess you’d say, “A nom de plume”….I wouldn’t want to have my phone number listed. And, you know, part of me thinks that’s so selfish but I’m going, “no, no, no, that’s fine.”

ELEANOR

I said to my husband, “you need to read this paper that I’ve just written on rural ethics because you need to understand the quandaries that I am getting into”….but I had to train my parents, “you cannot give out my home phone number – you cannot give it out”. Because they will call my mom and dad and -- see mom and dad, wanting to be helpful – small, rural – “Oh, here is her number” – no questions no hesitation. I got my mother trained fairly quickly. My father was a whole other issue [laughs].

CAROLE

Most of the participants also adopted procedures for managing client privacy during chance community encounters. Often these were discussed early in the professional relationship.

I address with people, typically as part of my routine introduction in our first appointment, that we live in a small community and it’s quite likely that we will cross paths, you know, in the mall or at some event or whatever. And, I tell people I will leave it up to them as to whether or not they would like to greet me.

MARY

If we happen to run into each other just know that it’s up to you whether or not you want to say ‘hello’. We’re not going to sit down and have a big conversation but I’d understand it if you’re with someone and don’t want to explain who I am or how you know me. I’m not going to take it personally.

MORIAH

Typically the client was given control by having a choice about directing that interaction. These ideas fit with Helbok’s (2003) suggestion to be open with clients about community pressure.

Despite the challenges of community pressure, there are benefits to working in embedded environments. Some of the participants indicated that visibility normalized the participant and enhanced their practice.

I was actually at a farm supper….I am sitting at a table and at the next table over I see someone who is a former client of mine who is there with her husband and they’re a farming family….I think in some ways it can be very helpful for people that are married to farmers and I have an understanding about some of the pressures and some of the lifestyle that goes along with farming.

MARY
The best benefit would be is that you get to see what happens with the kids. You get to kind of follow them through to graduation just because you’re in the communities…. And you get to, you know, know what happens – good or bad…. It’s a more personal kind of – adds a little personal dimension to the job.

SANDRA

Others framed community pressure as opportunities to contribute to community development.

Someone called me up to ask me if I would provide an evening of talk about children’s mental health. But, you know, for me that’s community -- it’s my contribution to community. I didn’t really feel pressured. Like, I felt like if I wanted to have said no, I would have. No, I felt like it was an opportunity to give back to my community.

ELEANOR

Indeed, “psychologists become ‘participant/observers’ in the local culture, which allows the psychologist to view the reciprocal influence of the psychologist on the community and the community on the psychologist” (Behnke, 2008a, p.45).

7.2.3 Generalist Practice

The third dilemma concerning generalist practice was common among the participants. Most felt the need to provide a full and diverse range of services when they perceived there to be few available alternatives.

As much as I love the variety of my work, I do feel often that I am pulled to provide services in areas in which I am minimally trained….Where else are they going to go if they can’t come to see me? What will I do?

MARY

You know what the problem is -- and this is directly to do with rural -- is that there are no people to refer to. And lots of the kids I see need very – they need people with expertise…. And, that’s not available here. So, I see that as being something that I’m trained to do and I want to do but it’s just a matter of, how do I do it ethically?

LORNA

Lack of alternative services has been shown to foster or intensify ethical dilemmas for rural psychologists (Roberts et al., 1999; Roberts et al., 2005). Even when there are alternative community resources, there might be issues that prompt dilemmas for rural psychologists.

The hospital up there didn’t want to see anybody who wanted to kill themselves. Even if they did admit somebody, they would leave them alone all day….so then you’re trapped. Like, if you can’t refer, you’re probably
better off doing something than nothing and just trying to be really conscious of what, you know, of what you’re doing.

**BRYON**

The biggest thing in our area of people, I’d have to say, is, ah, transportation. Getting to the appointment. We don’t have a public transit system so if people don’t have a car -- if they’re poor -- or if they’re the working poor or they just can’t afford gas.

**VIRGINIA**

Rural psychologists may have a moral responsibility to provide some creative and flexible services beyond their scope of training. This may be questionable ethical practice in urban settings but a defensible ethical stance when working with isolated rural clients. Helbok et al. (2006) hypothesized that American rural psychologists would experience difficulty maintaining their competency in generalist practice. In their recent self-report survey this hypothesis was not supported. That finding differed from the experience of participants in this study. Here, participants acknowledged concerns about practising outside their scope of practice and about balancing competency with client welfare when there are limited services.

*It’s kind of a fine line, too, between being asked to provide more and more services and also provide services that are outside your limit of competence. ... I felt some pressure to do things that I don’t feel I have competence to do.*

**BARBARA**

I always feel like I never know enough. I’m never caught up with all the many areas in which I practice that I would like to feel more on top of things. So that’s one real challenge as a generalist ... I’m always excited and interested in new learning opportunities and with that comes that pressure and the guilt that maybe I don’t know enough.

**MARY**

Generalist practice considerations are rarely part of formal training and so this can cause considerable adjustment and ethical angst for the rural psychologist (Helbok, 2003; Kersting, 2003; McIlwraith et al., 2005; Roufeil & Lipzker, 2007).

How then did participants manage generalist practice? Many said that self-awareness was integral to setting personal and professional limits.

*You can’t be like Atlas and carry the world on your shoulders, eh? And, you have limited resources and limited personal energy and time. So, you*
do have to make some -- a lot of -- decisions about what you can and can’t carry.

ESTHER

Indeed, rural psychologists must be intimately aware of their own comfort levels, their strengths and weaknesses, and how far outside their area of expertise they may be practising (Helbok, 2003; Yonge & Grundy, 2006). They also need to articulate those limits to others.

I just remind them of the services they have and those are the most appropriate professionals to be doing those types of assessments. So, I do try to keep my boundaries because I think if you let it, you could really be inundated by a variety of requests where there’s actually other services already set up in place to respond to those requests.

BARRBARA

The pressure to practice broadly prompted some participants to seek consultation and supervision specific to generalist practice.

Initially it was a bit scary and but I think with time and practise it -- I’ve relaxed into that role. The other piece is having some supports out there that I can rely on and talk to and debrief with and collaborate and get ideas from. So, that’s really a big support for me. Having those few people that I trust and can count on.

CONNIE

Some of my issue now is more, how do I rein in people who I’ve seen kind of going beyond [their competence]? I see them in the same situations….I really encourage those people to be discussing those kind of cases….and to formalize their treatment plan.

BRYON

Participants in this study also provided an alternative view of generalist practice. Some suggested that the real issues stem from psychology’s urbanization.

Urban psychologists have, what I think is, the amazing luxury of having a very narrow practice….I have contacted the [provincial] college several times recommending a wording change to the ethics code -- they should say that it depends on where you practice and the lesser of evils in offering a service….the lesser of evils’ clause.

DONALD

Here, Donald is referring to the requirement that psychologists do not practice outside their scope of training. Others indicated that generalist practice was one of the benefits of rural practice – that they enjoyed the variety and challenge.
You know, it’s funny, I think it’s the quality – there’s a quality that attracts – that rural and northern psychologists have, I think, that attracts us to these positions. And, part of it is that we have interests in so many things.

BARBARA

That would bore me to tears. But, to each his own. “Fill your boots!”[laughs]. That wouldn’t be for me. And, that is my personality style (and I know that) I would get bored silly if I was only seeing one – you know, one type of disorder. So it keeps me very much on my toes….That is why I like my job as much as I do.

CAROLE

Recall that psychologists stay in rural practice by choice (Dimogiannis, 2000) and that rural practice may be characterized by groups of highly skilled and committed clinicians willing to go beyond the call for their communities (Greenhill et al., 2009).

7.2.4 Interdisciplinary Collaboration

Most psychologists are not trained in interdisciplinary collaboration yet rural practice often involves such collaborations (Greenhill et al., 2009). These collaborations may involve work with other professionals or naturally occurring community supports (Bock & Campbell, 2005; Crossley et al., 2008; Donoghue et al., 2004). Most of the participants in this study indicated that they regularly experienced interdisciplinary collaborations. A common ethical dilemma in these relationships was the need to advocate for the distinct role of psychology.

They don’t know the practice of psychology necessarily….They want to get involved in….what’s developmental. And they don’t necessarily have the training.

LORNA

I think the bigger issue is they’re very poorly integrated. Not necessarily valued and not partnered with….there’s a fair amount of conflict….turf wars between professions….Why do we need these psychologists if we can have all this work done by social workers and psychiatric nurses?

ESTHER

Lorna and Esther were describing the need to clarify and advocate for their own roles as psychologists. Other dilemmas arose because of different expectations of professionalism.

I stopped sending them to mental health because they didn’t understand the reports….I showed them how in my report there was -- you know, I
always do a behaviour assessment. It’s really indicative of where the needs are [but the recommendations are disregarded].

LORNA

He came down with an interpreter…I don’t know the interpreter. I don’t hire the interpreter. He chose the interpreter….this gentleman kept saying, “So, I told the story. Are we done?” ….later the interpreter said, “I kept telling him to talk more about it because it was just really bad.” And I thought, “Who’s agenda is this?”

JOANNE

I guess the most vexing problem for me is when a worker doesn’t seem to have a clue what they are doing. I don’t think that paraprofessionals….seem to have an understanding of the limits of what they know and don’t know….I can empathize with them having difficulties -- It’s not frustrating; it’s pretty sad actually. You know, organizations need to recruit staff, they aren’t able to recruit staff, and the ministry doesn’t require them to recruit competent people.

DONALD

Rural psychologists make more use of naturally occurring community resources (Dimogiannis, 2000; Helbok et al., 2006). Paraprofessionals may lack necessary knowledge complicating these collaborations which may be ineffective (Adams, Xu, Dong, Fortney, and Rost, 2006).

Most of the participants spoke to difficulties in maintaining confidentiality in interdisciplinary collaborations. There can be pressure to share confidential information.

The communities and individuals, in terms of other health care professionals, other agency, agencies not always understanding our need to maintain confidentiality. And, again working in certain communities where information sharing is perhaps more freely than I’m comfortable with. And so dealing with that and trying to deal with it in a way where the other professionals are understanding and you don’t impact your relationships with them.

BARRBARA

There’s also a push sometimes for disclosing, you know, confidential information that may come up in sessions between myself and the client and sort of just wanting to know more than -- I feel there’s almost an obli -- you know, a push for me to disclose more than I’m willing to disclose.

CONNIE

Maintaining client confidentiality is a common challenge (Roberts et al., 1999; Roberts et al., 2005), particularly in communities where this is a foreign concept. Wihak and Merali’s (2007) study of remote practitioners found that confidentiality “posed unfamiliar challenges in the highly interconnected, small
communities where they lived and worked” (Wihak & Merali, 2007, p.176). This can create a sense of obligation to colleagues from other professions.

> It’s a bit tough with physicians. Yeah, because they just think that you should be able to talk to them about any of their patients, right.... That’s a bit delicate because they can, I find, take offence.

> Before, there was this sense within me about really wanting to be helpful and to maybe share information that would help in their understanding of the person. And, kind of this tug of war inside me about wanting to and knowing that, you know, that I couldn’t do that or that how much that would damage their relationship between myself and the person I was seeing.

Such transactional stressors likely reflect the psychologist’s overall involvement in the informal information-sharing network common among rural referral networks (Barbopoulos & Clark, 2003; Helbok et al., 2006; Zur, 2006). There is a need to balance exposure risks for clients and the psychologist’s relationships with community partners (Endacott et al., 2006; Essinger, 2006).

How then did participants manage the ethical dilemmas experienced in relation to interdisciplinary collaboration? The main strategy appeared to be establishing strong and clear boundaries.

> If we have recommended to -- this is one of the cases where we recommend that the person do 24 hour visual supervision and the government agency says we’ll give him four hours a week, we back right out. We’ll have nothing to do with this any longer because what you’re doing is abuse. And, we’ll say that in the reports. And, we’ll say that the person at risk of dying under this level of support. So, we don’t have any hesitation to provide that type of information

> Some education around what would a psychologist be doing in this setting and why is this important and how does it fit with what other professionals are doing and how can we work together in an inter-professional team recognizing each other’s real strengths that we bring to the table, both professionally and personally and respecting boundaries between the disciplines.

Participant stories indicated a need to set these boundaries respectfully.

> Communicating up front in the beginning about the limits of confidentiality and about what can and cannot be shared. Experience. Talking with counsellors and addiction workers and social workers about
what is -- about what, you know, information I will and won’t share in the beginning so that they know up front.  

CONNIE

I just try and explain the reasons behind that and try to impress upon them how in particular that’s very important in small communities because people often are concerned about information being shared….I do try and empathize with them and get their need for the information, that I can understand, you know, why they would be interested in this information.  

BARTBARA

The need to be clear on the roles and responsibilities of each team member is common in effective interdisciplinary collaborations (Greenhill et al., 2009; Sawyer et al., 2006). Many participant stories reflected the need to develop effective working relationships.

I think a key to effective rural practice is developing collaborative relationships with an agency so that you can, um, manage when people step over the line accidentally. Most of the time it’s accidental.  

VIRGINIA

Usually when that happens I go, “hey, I have an ethical issue here that we need to balance”. And, they are open to that, and I don’t find that really challenging…that I could say is probably one of my least challenging areas – because I have those connections with the people there, or know them.  

CAROLE

Rural psychologists need to be skilled in interdisciplinary intervention. Training in this area has been recommended for Canadian clinical psychologists (Crossley et al., 2008, p.231). McIlwraith et al., (2005) have incorporated interdisciplinary collaboration considerations into their rural psychology training program. Also, Meyer, Hamel-Lambert, Tice, Safran, Bolon, & Rose-Grippa (2005) found this kind of training enhances the recruitment and retention of rural providers.

Other participants provided alternative views of interdisciplinary collaborations. Such relationships can enhance the rural psychologist’s work.

When I first started my job I thought that case managers were going to kind of get in the way of what I do. But, I actually value them so much now that I think I would be limited if I didn’t have them. So, I have completely switched views on that because they do connect me to the community.  

JEANNE

There have been a couple of occasions when I’ve been asked to be the direct clinical supervisor of someone from a different discipline. Which can be a very interesting and very rewarding experience….there are
different ways of doing things and that they can be very valuable and important even though they differ than what our supervisors might have encouraged us to do as psychologists.

BARBARA

Greenhill et al. (2009) found that many rural practitioners genuinely enjoy interdisciplinary work even when not trained in collaborative models. Teamwork can assist the rural practitioner to deliver more effective services (Bock & Campbell, 2005; Smith, 2003).

7.2.5 Professional Development and Support

The final area, professional development and support, also posed ethical dilemmas for most of the participants. A common issue was lack of training in rural practice.

I think many people do get into rural practice without having had any specific training in it. But I think that the training beyond just being a generalist -- that identifies issues whether it’s ethical issues or professional issues that are specific to rural or northern practice -- I think that training is really helpful....I’ve always been interested in the variety and the generalist kind of practice that’s available in a rural area. But I just didn’t know that there was a rural field out there.

MARY

Rural practice characteristics make ethical dilemmas more complex (Thorngren, 2003) which implies the need for specific training and support in this area (Johnson et al., 2006). Roberts et al. (2005) found that rural mental health clinicians lacked sufficient training in ethical dilemmas for their practice setting. In this study, none of the participants had received formal training specific to rural psychology. A few of the participants had some exposure to rural practice issues in their doctoral studies.

I had no intention whatsoever of going into rural practice....it was through doing my practicum and interacting with the psychologists in that program -- that worked in rural psychology -- that really fuelled my interest. And, by the time I was going to internship, looking for internship sites, I had decided that that was the area that I wanted to practice in.

BARBARA

This example illuminates the documented benefits of having had professional training and exposure to a rural role (Dimogiannis, 2000; Eley, Hindmarsh, &
Participants also detailed difficulties in accessing suitable consultation and supervision.

_If I have an ethical dilemma, you know, sometimes you need a psychological perspective. And, as much as I respect my social workers, they don’t have the same code of ethics. They don’t have the same….if I have an ethical dilemma, I need to say, “So what do you think CPA… Where would this fit under? What do you think we’d do?”_

VIRGINIA

_You know they say….“Oh, just call us anytime”. But, if you hear back from them within six months you are doing really well. And, if they do call back, they frequently say, “Who are you?” and, “I don’t have time for you”_.

CAROLE

Insufficient access to ethical consultation is considered common in rural practice (Roberts et al., 2005) and may intensify ethical dilemmas (Roberts et al., 1999). Similarly, there were concerns about being able to supervise others in rural practice.

_If there’s a dearth of psychologists in the region, then if the psychologists who are qualified to supervise leave and you hire new people, where are you going to get your supervision from? A hundred miles away? Or, another region? Or, where?_

ESTHER

Limited access to supervision and consultation can increase risks of rationalization, lower awareness of boundaries of competence and unethical behaviour, and can increase feelings of isolation (Cottone, 2004; Weigel & Baker, 2002; Womontree, 2005).

Accessibility of appropriate ongoing professional development was another issue shared by most of the participants. One type of barrier was geographic distance.

_This is the Canadian prairies. Travel in the middle of winter can be a real issue._

ESTHER
There have been things I’ve missed out on because I do live so far from the main centre in [the province] that it’s just not possible to take the extra time that it takes to travel there or the extra money or -- can’t do everything. I still do need to pick and choose, so -- just the sheer distance.

MORIAH

Geographic barriers to professional development often increased the associated time commitment and expense.

It would be much easier for me to take the courses that I’m interested in if I was closer. Because it means time away from family. It means, you know, travel time. It means more expense. More difficult, yeah. Usually, what I want is not available near home. So I need to travel.

CONNIE

If they are in private practice, they are going to have to give up that day’s salary. Plus travel time, plus accommodations, plus meals, and then you have – and, if you are in public practice – the hospital isn’t going to support me and give me a day off to go up there. They aren’t going to do that. Are you kidding?!

CAROLE

This fits with Womontree’s (2005) findings that two of the three primary barriers to professional development were lack of financial support for the inherent increased costs and geographical barriers to access. The third primary barrier was the lack of resources and professional development that addressed concerns of rural practice. This was also mirrored in this study.

A lot of it would be, you know, more specialized things. So, if I wanted to nab something about borderline personality disorder or any other number of specialist or kind of more focused topics, it’s easy enough for me to get those. How much am I getting in terms of rural or generalist? That’s something I would say, you know, that’s really lacking.

MARY

I’d never been looking for anything specifically for rural, so that piece I guess would be a challenge because I don’t come across any of that.... You know, there has been a couple of workshops or talks that are focused more, maybe, on working within organizations or within multi-disciplinary teams which I think would apply nicely to a more rural practice but unexclusively.

MORIAH

When professional development was accessed it was rarely specific to rural practice.

A final professional development and support issue was a sense of isolation for many of the participants.
I think so many rural or northern psychologists operate in isolation for the most part. And I know for myself, I do bits of reading here and there about rural issues, ethical dilemmas that might be different in rural practice. But, I don’t have a network of rural psychologists right here in my community to be able to discuss these things with.

MARY

Right now our interaction with others is -- yeah, that’s not great. You do -- I do -- feel isolated at times. Physically, because we are physically isolated in [this part of the province] and yeah, not a lot of contact with other psychologists.

SANDRA

The literature indicates that isolation is related to risks of burnout. In this study only one of the participant stories indicated experiences which could have created burnout.

I was supervising three, well two interns and a post doc student that year. I was supervising two new staff members up north. I was doing some individual treatments. I was still doing my assessments and consultations, doing public education, and was involved in – as a consultant -- on several program evaluation projects in the region. And ended up really feeling like I wasn’t doing a particularly good job of anything. Which certainly doesn’t feel good....I wish I could have been self aware a little sooner.

BARBARA

Rural practice in psychology does pose increased risk for burnout due to the high workloads, difficulties setting limits, community pressures, and a lack of resources and support (APS, 2004b; DeStefano et al., 2005; Gardiner et al., 2005; Kee et al., 2002). Why then were there not more participant stories related to burnout? Interestingly, research has indicated that rural psychologists do not indicate more burnout. Instead, rural practitioners have been found to experience high levels of personal achievement and empathy for their clients (Helbok et al., 2006; Schank & Skovholt, 2006).

How then did participants manage their needs for professional development and support? Many did so through consultations with networks of geographically separated peers.

I felt quite comfortable approaching people that I felt comfortable with and had built relationships with throughout graduate school. So, I think it
was a necessary thing I had to do. Not necessarily complicated because I knew all the people.

JEANNE

I have a network of people who I would talk to. They’re not always in the province. Some people are sort of mentors from when I was training -- still on internship. For certain specialized issues, I might call them and ask them what they thought about a case....that’s my personal network....there’s nothing really that I know about that’s formal to link people up with each other. I think there should be. It’s not a bad idea.

ESTHER

The CPA’s Rural and Northern Section was established, in part, to assist in the development of such networks (Biggs, 2007). These consultative networks may also include professionals other than psychologists who understand rural practice (Helbok, 2003; Schank & Skovholt, 2006).

Also [colleagues in the city] that I phone every so often for support and help with all kinds of things. That’s helpful too. So, I have that plus other folks in similar kinds of professions. Social workers, people to provide supports to -- I’m thinking maternal health care, other counsellors.

CONNIE

Some participants spoke of using technology for consultation and professional development.

I remember when the internet first got started there was the group -- I think it’s still a group -- the Global School Psychologist Network. And it was quite nice. It was, um, because it had quite a bit more rural kind of focus to it. But I guess I felt more comfortable, you know, kind of reading what other people were experiencing. And I felt comfortable sharing, you know, and asking some questions.

BRYON

I do most of mine by internet. There’s tonnes of stuff that’s available. That’s not been a problem....I will probably be taking a 30 credit hour internet course in the fall.

KEN

The importance of staying involved in professional development activities despite the barriers is becoming easier through expanded use of technology (Sawyer et al., 2006; Weigel & Baker, 2002; Wood et al., 2005). Technology can reduce professional isolation and improve access to consultation and continuing professional development but is not a panacea to these difficulties (Jameson & Blank, 2007; Meyer, et al., 2005; Nigro & Uhlemann, 2004). Also, communication technologies are not always easy to use (APS, 2005; McIlwraith
Not all participants had issues with professional development and support. Some spoke about having access to appropriate consultation.

Because I am connected to the [a university] I’ve got lots of options for consultation or the possibility of someone, you know, coming up here and actually seeing clients. So, that gives me a little more backup than maybe someone who’s in, say, private practice.

MORIAH

I was always fortunate to have a peer group around me….we consciously made an effort to meet. To have what we called peer supervision. Peer support. Peer consult, I think is what we called it. And so, at least once a month we would set aside an hour and a half or two hours and whoever was available could come…. Peer consult was just as important to me as a learning experience as coming to a major conference or attending a specific workshop.

ALBERT

This kind of support assists psychologists to identify issues, challenges psychologists to examine and learn from ethical challenges, and builds community among colleagues. Similarly, a few participants spoke to having beneficial supervisory arrangements.

My primary supervisor actually is in a unique position because he practises in both [the city] and [the rural region] right now. So, he has many years of experience that he brings to it practicing in [the rural region]. And then, my secondary supervisor was actually within my position with my agency, probably five years ago. So, she’s very familiar with the kind of the company I work for, the processes that we go through, and the resources that we do have in place. Yes, I think I’m very fortunate.

JEANNE

Also, some participants did not perceive access to professional development as a difficulty.

Not that we have an unlimited budget but we have people that understand that we have to, you know, we want you to keep up with the latest research and your testing skills and whatever and well, you have to go, you go.

SANDRA

I think that’s completely due to the program that I’m employed with. They do have funds available to send us to – typically I’ve had funds to go to two major conferences in the year. And I am close enough to [the city] that I can access some of the continuing ed. opportunities through there as well.

BARBARA
7.2.6 Summary of Ethical Dilemmas

This second theme was an account of the five common ethical dilemmas as experienced by rural Canadian psychologists. Overlapping relationships can occur with family, friends, and colleagues. They arise during client interactions or from broader community involvement. Such relationships can lead to ethical dilemmas from unanticipated interactions and from providing the psychologist with outside information about clients. Overlapping relationships can be managed cautiously through clear boundaries, and can enhance services by increasing the psychologist’s knowledge base and developing community relationships.

Community pressure can create difficult expectations for the rural psychologist and can raise personal visibility. This means a need to balance personal and professional roles. This pressure can be managed through triaged services, clear boundaries, protecting private time, and having clients direct chance encounters. Community pressure, or working in an embedded environment, can be beneficial as it can normalize the psychologist’s role, enhance their practice, and allow rural psychologists to contribute to community development.

The ethical dilemmas inherent in generalist practice are intensified when there are fewer accessible alternative services. This can cause angst for the rural psychologist. Such dilemmas can be managed through self-awareness which is enhanced by consultation and supervision and by articulating limits. The main benefits of generalist practice are providing needed services to clients who might otherwise not have services and having variety and challenge in the professional role.

Interdisciplinary collaboration may require psychologists to advocate for the role of psychology, manage differing levels of professionalism, and develop
particular protocols to maintain confidentiality within such collaborations. These collaborations can be managed by respectfully setting clear boundaries and building effective relationships. Interdisciplinary collaborations can assist rural psychologists to provide more effective services and reduce the isolation of rural practice.

Finally, rural psychologists experience difficulties in acquiring appropriate training, consultation and supervision, and professional development. This may increase isolation and burnout risks which, in turn, can diminish competency. Professional development issues can be managed with creative solutions that include fostering long-distance collegial networks, consulting with other professionals familiar with rural practice, and using technology to mediate distance for consultation and for professional development.

7.3 Ethical Schema for Rural Psychologists

These results have moved progressively closer to the crux of the experience of professional ethics in rural practice. Understanding the specific context of rural professional practice contextualized the participants’ experiences of professional ethics, particularly of the five common ethical dilemmas. Those first two themes explored the national context, the rural context, and specific ethical issues. This final theme goes beyond those findings by exploring fundamental aspects of the internal ethical stance of the participants.

This third theme is an experiential exploration of ethical development through the ethical schema, or conceptual frameworks, used by rural psychologists. This latent or implicit theme represents a deeper, more personal facet of how the participants dealt with ethical issues. The three components of this final theme are: the participants’ fundamental commitment to professional
ethics, the role of critical incidents in their ethical development, and the elusiveness of ethical reflexivity.

7.3.1 Commitment to Professional Ethics

The participants in this study demonstrated a fundamental commitment to professional ethics. This commitment was evidenced in participant responses to the question, “what motivates you to practice ethically?” Motivation was articulated from a range of conceptualizations about ethics and along the full continuum from intrinsic to extrinsic motivations.

Several participants responded to the question from a deontological perspective.

*Ethics allows you to order the -- or to kind of frame the work that you actually do.... The ethics is my rule. They tell me what I can do and what I can’t do and that is, when you’re into this nebulous aspect of psychology that sometimes is a good anchor.*

KEN

*I would probably tend to be overly cautious, end up doing something and finding out that it’s, you know, it was less dire consequences than I might have thought. But I tend to enter into things quite slowly and guardedly....I think it gives me something to refer back to. Because of the framework or a guideline to guide some of my actions and decision*

MORIAH

Responses like these were indicative of ethics as moral obligation (Schank & Skovholt, 2006; Truscott & Crook, 2004). This is common to deontology where ethical behaviour is action motivated by, and in compliance with, one’s duty and is therefore based on rules of practice and codes of conduct (Schank & Skovholt, 2006; Truscott & Crook, 2004).

Other responses focussed more on the consequences of actions.

*At some level, the College is my motivation for, you know, keeping my ethical hat on because, you know, I have a professional reputation to uphold. And, you know, I wouldn’t want to, kind of have any black marks against me if you will.*

JEANNE
Maybe I’m sick. I have some kind of black and white personality….I must have learned over time that it really pays to follow the process….And besides, I don’t want to lose my license or something [laugh] .... I think I need to be really careful, follow the rules, and, um, do no harm.

LORNA

Well, I don’t want to hurt anybody. I don’t want to harm anybody by not doing good work and I want to -- then the ethics are there to protect people from me. So, being very aware of how....we’re in a tremendous position of power. Especially in a small community.

VIRGINIA

These kinds of responses could be conceptualized as being from teleology or consequentialism as the participants appeared to be more concerned with the end result of ethical decisions (Schank & Skovholt, 2006; Truscott & Crook, 2004). Alternatively, these representations of nonmaleficience may reflect a deontological albeit conditional duty. Either way, neither the deontological approach, which assumes consensus about how to behave ethically, nor the consequential or teleological approach, which provides too little guidance, speaks sufficiently to the complexities of professional ethics in rural practice. Indeed, many participant stories did not neatly fit into either way of viewing ethics.

Some of the participant responses suggested social constructivism. The following examples appear to have considered the social whole and demonstrated a focus on character and professional responsibility.

It’s what’s best for the profession. You know you want to be, you want others to see the work that you do as valuable and ethical and, you know, on the up and up. So I think it’s best for the client, best for the profession and lets me sleep well at night. [Both chuckle] It’s just the right thing to do I think.

DEBBIE

I want to be excellent about my practice. And I think the difference between somebody who does excellent work versus, you know, good work – like, you know, good stuff -- is the ethics....it’s really important that they get good service. Because the rural areas, it’s hard to recruit, right? So, they may be taking on people that may not have an investment in the community or are just going there during the training years, you know, that kind of stuff. But if you have a commitment to that you’re not -- and you follow the ethical practices you can do so much more in less time. They are vulnerable because they don’t have access to choice.

BRENDA
I really feel a strong commitment to high quality client care and practice in a way where you minimize a likelihood of harm. But I think really, that’s what it comes down to. And, I remember reading an article years ago -- I wish I would still have it -- where an argument was made why we should actually kind of loosen our ethics to some degree in rural areas around confidentiality and such because we need to respond to the culture of the community....And I remember thinking quite the opposite. That I think we really do need to be very careful in these small communities.

BARBARA

Social constructivism extends to how the psychologist thinks, feels, and acts and considers the interaction between their decisions and the social whole in which they work (Cottone, 2004; Lehr & Sumarah, 2004; Wihak & Merali, 2007). This fits with research by Wihak and Merali (2007) and Charlebois (2006) who found that their participants tended to use social constructivism to manage ethical dilemmas.

Participant responses were also indicative of virtue ethics as they spoke to the nature of being a psychologist.

It’s important for me to be a good example...I need those ethics to guide me ....Plus, it feels like my life’s work so it feels more important....No, it’s -- it’s a spiritual commitment or a gift almost that I’ve taken on or accepted and that I really believe that -- I really believe in my work and that I want to give it my all...It’s much deeper than that.

CONNIE

Some of that comes from my spiritual background. And my philosophy about humanity and why we’re here and my own personal ethical beliefs about people treating each other with dignity and responsibility. In other words, I had those values before I read them in the CPA Ethical Code...Yeah, that’s about who I am. That’s not about who I am as a psychologist. Yeah, and I think -- I don’t think-- I think if I were not a psychologist, if I were something else, for a job, I don’t think my values would be any different.

ESTHER

These responses, focussed on benevolence, were consistent with virtue ethics and using wisdom and moral ideals to act well and deal with the expected complexity of ethical dilemmas (Barnett, 2007; Fowers, 2005; Fry, 2005; Meara & Day, 2003).
Finally, Albert reflected the complex notion of relational ethics when he spoke about the role of his values in the professional relationship for all concerned.

I studied theology many years ago. And, not that I’m a theologian by any means, but I have an interest in spirituality and so I think my fundamental value system is one of acting respectfully. And, I think that was also reinforced in the work that I did in [my region] in working with Aboriginal people in that region and with elders. That they also help me to learn the importance of respect in relationships and respect -- an importance of respect in relation to the land, to the animals, to the water, to the whole environment….It resonated with me in terms of my fundamental value system.

ALBERT

Here, Albert noted the importance of his relationship with clients and the community. From the perspective of relational ethics, particularly for work within a culture of interdependency, this is essential to be fully engaged in the relationship and to avoid malfeasance or harm (Austin, 2006). What was consistent across the stories was a fundamental commitment to professional ethics by the participants in the study.

7.3.2 Critical Incidents and Ethical Development

The second aspect of ethical schema was the impact of critical incidents on the ethical development of the participants. Ethical practice and the development of an internalized ethical stance is complex (Jones, 2008). An important component of this process can be the experience of critical incidents. Critical incidents are situations where the response of the psychologist could have a significant impact on the psychologist, the client, or the profession. These are incidents that are stressful and challenge decision-making (Clarke, 2008; Cope & Watts, 2000; Preskill, 2006).

Participants were asked “have you ever experienced a critical incident that helped you to develop your judgement as an ethical rural psychologist?” Not all were able to provide a response and few responded immediately. A participants
Connie articulated the potential personal and professional growth opportunities in the experience of critical incidents.

"I think it's those kinds of experiences that, you know, kind of really, really provided -- I mean with the experience behind the training in school. So, it's one thing to read and to have someone lecture about the importance of this or that, but it's -- for me anyway -- a whole different experience to have those actual experiences and to feel what it feels like. And to see and care about the people that you're working with... And so, I think it touched in me, the seriousness of the work."

CONNIE

Most of the participants indicated that they had experienced critical incidents but many delayed giving a response until the final interview. Perhaps this reflects the deeper level of reflexivity required to recall and describe such incidents. The critical incidents shared by the participants reflected a variety of often unanticipated practice situations.

Several participants described critical incidents related to having insufficient connection with the rural community within which they practised.

"I didn't feel that I had strong connections to the local resources there for suicide prevention and intervention -- partly because I was fairly new to the position but partly also because I wasn't based in that community so it involved me maybe asking more questions....I felt uneasy that weekend going home."

JEANNE

When a psychologist in insufficiently aware of local resources and needs how can they adequately assess issues and provide appropriate services? Rural psychologists require community knowledge to adequately negotiate ethical issues and dilemmas in these settings. The CPA Code requires psychologists to be responsible to the communities in which they live and work (CPA, 2000).

Experiences like Jeanne’s, above, underscore the need to understand and develop connections within the local culture as a key aspect of developing and maintaining competence for rural practice.
Competence was also tested in participant experiences of critical incidents specific to nonmaleficience.

*It was really at that time, really out of my scope. And, she would come in at different times in really different ways.... And I really had a tough time figuring out; first of all, what to make of all of it and how to help her.... I would perpetuate that by going into the content and the detail of a lot of the trauma that she’s gone through. And it was very helpful for me to sit in on sessions with the psychiatrist that came to the area and watch him work with her and me being able to have someone to talk to about, you know, what was going on and how. What I was doing was not therapeutic and not helpful.*

**CONNIE**

This incident, shared by Connie, highlights how working outside the limits of one’s competence may put the welfare of clients at risk. Although not a rural-specific critical incident, the scarcity of rural mental health resources may fuel a pressure to provide a large range of services. Although such services may not exist otherwise, rural settings also mean that relevant professional consultation options are also likely limited. When psychologists work outside their area of expertise they also risk harm to their own confidence and to the profession overall. Competence is one of the cornerstones of professional practice and the reason that many clients choose to seek the services of a psychologist.

Critical incidents can be learning experiences, particularly when explored through consultation and supervision (Cope & Watts, 2000). Some participants shared stories of learning to change practices because of the experience, or near experience, of critical incidents.

*I think I got better with the consent stuff because at the beginning I kind of took it for granted. Like, there was no forms. I would still do my little introduction, verbal introduction but I didn’t have anything on paper. And then, as -- again as I got more experience and the issue became more critical, then it became more formal. And it makes sense, you know, we can operate -- I generally operate on good faith.... But we also know that even in professional relationships, partnerships, professional partnerships, you have to put stuff down on paper. And it’s not about that I don’t trust you. It’s just good business practice. So kind of in the same*
way I learned that, I learned that on a business sense, I also learned that with, in working with clients.

Here, Albert speaks of his maturing awareness of the need for more formal consent processes, for his sake and to the benefit of his clients. Informal community and professional participation can be common in rural areas (Coakes, 2002; Schank & Skovholt, 2006). Community norms must be balanced with the potential for such relationships to become or appear exploitative or harmful to the client, the professional relationship, or the profession of psychology. In this example, Albert’s ethical schema appears to have changed with his experience, evolving through critical thinking, and professional and personal reflection.

Some of the most telling stories of critical incidents involved boundaries in rural practice. The mere potential of a boundary violation, coupled with a desire for nonmaleficence, can lead to personal and professional growth. These could be boundaries with colleagues.

*Early on in the counselling profession there were probably -- there were boundary issues that helped me to learn to be much clearer about that by the time I was licensed as a psychologist. Not, you know -- didn’t fall in love with a client, but it was far more challenging....Far more challenging to keep the professional relationship as a colleague. This was not a client. So this would be more of a colleague-to-colleague relationship or the professional relationship....It did help me to be stronger as I got wiser and older and more experienced.*

Here, Albert remembers an incident that is complex in its implications for interdisciplinary collaboration and professional boundaries. The differentiation between boundary crossings and boundary violations may be more clear for relationships with clients but what about relationships with other professionals, particularly when there few other professionals in the community? Rural psychologists are likely to enhance service provision and combat isolation through collaboration (Bock & Campbell, 2005; Schank & Skovholt, 2006; Turchik et al., 2007) but roles within such relationships are likely to be blurred
(Helbok et al., 2006; Schank & Skovholt, 2006). When a psychologist also enters into non-professional relationship or role, particularly an intimate role, with a professional colleague these boundaries are likely to blur even further. Other boundary experiences involved clients. Ideally, awareness of a boundary issue prevents unethical behaviour.

I just made a decision and talked to her about it and worked towards termination and transitioning her to somebody else. And that’s what we did. Follow your gut – that there’s a reason. If there’s a red flag there, there’s a reason for the red flag. You have to pay attention to that. Yeah. You have to pay attention to it. And you know even a few years later that client contacted me again and still wanted to come back. Which I thought, “this is not healthy”. It didn’t feel good to me either.

ESTHER

I became so involved in my commitment to her and, and helping her to get well that my boundaries became kind of blurry and loose. And um, I remember making myself so available by phone or by appointments or for crisis and um, I just became so consumed and drained by the whole relationship and, you know, at some point realized that I definitely wasn’t helpful to her and wasn’t helpful to myself….that’s when I reeled in my boundaries and, um, and in doing so I think I did that too abruptly and what happened was, she fired me….I think that what happened was I lost sight of her responsibility in getting herself well and I felt that I took too much on myself.

CONNIE

Esther and Connie appear to have considered their level of engagement with the client and the potential to harm the professional relationship. Such stories speak to the complex interpersonal relationships that psychologists may have with their clients and their responsibility in negotiating such processes. These reflections appeared to be consistent with concepts of relational ethics as their stories reflected the personal facet involved in how such incidents might be processedHere, the emphasis is on their role and behaviour and the mutual vulnerability inherent in such professional relationships (Austin, 2006).

Some critical incidents can result in fundamental higher-level learning (Cope & Watts, 2000) and can support the development of new practices.

It was a very awkward situation….I certainly did some thinking about whether or not I should accept that referral but I think I was much more of
the mind set, “Well, you know, there really aren’t any other options so I really should do it.” And I think, after having that experience I think I’ve just looked for other options perhaps to a greater extent than I perhaps did at that time.

BARBARA

Here, Barbara reflects on the process in ways that continued to inform her practice. Critical incidents can impact ethical awareness and ongoing ethical development leading to the development of a more mature understanding of ethics. The experience of critical incidents can foster reflection and higher order learning (Clarke, 2008; Preskill, 2006), particularly when there are opportunities for consultation and supervision on these issues (Cope & Watts, 2000). These experiences highlight how the path to ethical development is not always straightforward.

7.3.3 The Elusiveness of Ethical Reflexivity

The third component of this final theme is the elusive nature of ethical reflexivity. Reflexivity is “self-awareness and agency within that self-awareness” (Rennie, 2004, p. 182). Ethical reflexivity is an awareness and objective understanding of personal ethical processes. Participants may not have been able to express ethical reflexivity simply because they did not have sufficient experience articulating their experiences of professional ethics. This is often a difficult process without sufficient consultation and feedback.

_I know for myself, I do bits of reading here and there about rural issues, ethical dilemmas that might be different in rural practice. But, I don’t have a network of rural psychologists right here in my community to be able to discuss these things with._

MARY

Recall from Chapter Two: Professional Ethics for Psychologists, that peer consultation and supervision are critical for ethical development (Pettifor et al., 2002; Zins & Murphy, 2007). Even when these forms of feedback are available, it can be difficult for those less comfortable with constructive criticism to take a detached position from their own actions (Lynch, 2000). This reflexive
objectification is the ability to step back and objectively assess what we have done with critical evaluation.

Participation in this study provided an opportunity for participants to discuss ethical issues in rural practice.

Well, I mean it’s pretty timely for me, right? Because when I read your proposal I thought, “Whoa man I know a lot about that” right?….there’s very few school psychologists anywhere and then on top of it being in rural areas. It’s kind of interesting to talk about it with people who know what it is. That’s for sure.

LORNA

I would really love to read the research because it -- it would be very interesting for me to see what other psychologists have said and um, it might be -- it might be validating for me to see what other psychologists have said about their experiences.

ESTHER

Recall that Johnson et al. (2006) found that rural psychologists had great interest in continuing professional education on ethics, particularly the management of special issues. As an insider-researcher, the participants may have felt that I understood the special ethical dilemmas they had experienced. This meant a welcome opportunity to reflect on professional ethics in rural practice.

Oh, it’s a pleasure! It really is, and I mean I think I’d be surprised if you haven’t heard from other people….even just participating in a study helps you -- helps me reflect a bit on what I’m doing and where I’m going.

ELEANOR

It was good, you know. It made me think about some things that, ah, you know, sometimes you don’t reflect on very often and it’s good actually. It just brings to the forefront and makes me look and say, “Yeah, you know what, I’m actually pretty happy with how I’m doing the things that I’m doing.” There are some challenges being in a small community and isolated community but I think for the most part...

JOANNE

I think that is one of the benefits of participating in something like this. It really does get to reflect on your practice and in ways that maybe we don’t always do on a regular basis. But, it certainly does get you to reflect on your practice and the decisions you’ve made and why you’ve made them and what’s worked out well and maybe what’s worked out less well and things like that so...

BARBARA

It’s really been helpful already to be an interviewee to process this stuff. Because, you know, I don’t hang out with other rural psychologists.

ELEANOR
Participation may have also meant an opportunity to contribute to a greater understanding of the abstract nature of professional ethics.

*I knew this is a kind of big picture kind of an activity because it’s not very often you sit down and talk about ethics and think about ethics. You know, you have your little dilemmas, like I said the other day, but it’s hard to come back and think about the big picture.*

**BRYON**

*By giving voice to the information that you’re going to gather in the course of your research, um, as you say -- I believe it will be helpful whether it’s new people or whether it’s people mid-career or even in their senior career, allows all of us to think about. So, for the more senior or experienced professional to actually think, “OK, so that’s what I was doing.” It’s kind of like going to a workshop and in a certain sense, it’s nothing new but all of a sudden there are words to describe what it is that you’re doing and -- it’s the language though, that now I have a language to say what I’m doing.*

**ALBERT**

There can be a sense of validation from being able to reflect on the gestalt of such an abstract process. This study provided an opportunity for participants to voice stories about their experience of ethics. These stories give language to the meaning of their experiences and reflection fosters ethical development. My own bias is that I have certainly benefited, personally and professionally, from being the researcher in this study. I have reflected greatly on my own practice, the stories shared by the participants, and I believe that this has taken my own ethical development to the next level.

A barrier to researching ethical reflexivity is the abstract nature of ethics itself. It is difficult to articulate professional ethics because reflexivity is an internal process. Ethical dilemmas and situations are discussed by practitioners in consultations but actual resolution processes are left to individual judgement. Indeed, most ethical issues do not require formal consultation but are handled on-the-job as part of routine processes that may not get selective reflection. Sometimes, participant responses revealed sophisticated levels of ethical reflexivity which is difficult to capture in quotations of rich text. These more
nuanced understandings were revealed through shifts in the discussion and
intersubjective clarity about internal processes.

*It’s a whole different experience to have those actual experiences and to feel what it feels like. And to see and care about the people that you’re working with and how, if you don’t know what it is or knowing that you can cause harm. And so, I think it touched in me, the seriousness of the work and made me realize how important that framework is in this process....[I am] much more able now to, you know, recognize, or to notice what goes on inside of me.*

CONNIE

Articulations like this example from Connie were rare but beg the question about
the necessity of reflexivity for wisdom and good practice. Some theories suggest
that reflexivity is a crucial skill while others suggest that it is merely a system
property (Lynch, 2000). Expecting such reflexivity from the research participants
may have been unrealistic. Consider, “the capacity for critical reflection as a rare
individual attribute….reflexive self-criticism is ‘constructive’ in the sense that, in
the long run, it is believed to enhance rather than undermine the positive status of
the knowledge that survives such criticism” (Lynch, 2000, p. 30).

Also, as a researcher, I may not have had the necessary skills to drill down
to this level with participants.

*It’s amazing that we can talk for 30 or 40 minutes, or whatever it was, and it seems to just barely skim the surface of the richness that is involved in rural practice. So, when we were talking about ethical dilemmas or different examples of challenges or dilemmas, it -- you know, we had quite an in-depth discussion -- and yet it seems to be just barely scratching the surface of everything that is involved.*

MARY

Mary’s comment may have reflected my interview style or her own inability to
articulate her ethical experiences. Experiences occur before reflection and are
then communicated through language which is never able to fully or directly
capture and convey the full meaning of the experience (Hein & Austin, 2001).
McCarron and Smythe (2009) remind researchers that “we need to appreciate that
the meanings expressed by our participants tend to be highly concrete, richly contextual and often do not fit the parameters of our abstract concepts” (p.15).

It is the error of researchers to “assume that the people with whom they work know what they think and feel and are willing and able to communicate it” (Holloway & Jefferson, 2000a). This may be because participants represent ‘defended subjects’ with conscious or unconscious response biases. In this study, participants may have wanted to present a positive image of their practices. Lynch (2000) suggests that this is done impulsively and that ‘knee-jerk reflexivity’ represents habitual instantaneous responses rather than conscious, deliberate, and chosen reflections. In semi-structured interviews and analysis it is assumed that there will be coherent and transparent meanings from the interview. Holloway and Jefferson (2000a) suggest that this is unlikely and that subjects cannot always provide rational, unitary accounts. They suggest that participants will unconsciously provide defended results, particularly when anxious.

It was, I guess, it was more anxiety in me wondering, “Oh my God, what are they going to ask me?” But now that it’s done and over with too bad that I never did it earlier because I probably would have encouraged other people to participate.

JANET

I’ve talked about examples with other [professionals] that I work with here at the clinic. I don’t want them to come across a piece of research and they think, “Just a minute. That’s my husband that’s being referred to in that example”....I was assuming that you would be working hard at protecting people’s privacy but I just thought, oh that’s the only thing that I wanted to ask about.

MARY

Janet and Mary are speaking to some of the anxiety that may have been present for participants. Stories were being shared as research participants not within a professional consultation. Research relationships come with an inherent power differential that can foster anxiety (Lynch, 2000). This can lead participants to unconsciously conceal deeply personal and private mechanisms. To do this they may provide contradictory or defensive statements in discussions regarding
private ethical processes. To penetrate such defences, Holloway and Jefferson (2001) suggest psychoanalytic analysis of such responses. However, “psychoanalytic interpretive strategies require much more grounding than is usually available from conventional interview texts” (Frosh & Emerson, 2005, p. 307) and may increase bias and decrease objectivity (Frosh & Emerson, 2005). The choice to not consider the concept of defended subjects is not likely to have negatively affected this analysis.

One does not need to accept the notion of the defended subject to accept that many interviewees adopt a strategy of intellectualising, of ‘managing’ painfully confusing emotional experiences through words which offer (apparently) the comfort of comprehension and the prospect of control.

Holloway & Jefferson, 2000a, p. 33

This implies that efforts to reduce participant anxiety may promote ethical reflexivity or at least the ability to articulate such processes.

Although it is elusive to study, the information shared by the participants provides some insights into understanding and promoting ethical reflexivity. Abstract concepts and internal processes are difficult to articulate and such descriptions may not even represent ability or wisdom. Ethical reflexivity can be enhanced through efforts to reduce participant anxiety and by providing opportunities to begin to articulate these processes through consultation, supervision, or even research participation.

7.3.4 Summary of Ethical Schema

In summary, the interpretation of this final theme is that the crux of the experience of professional ethics for rural psychologists is their ethical schema. This ethical schema, which fosters ethical development, has three aspects.

The first aspect is a fundamental commitment to professional ethics. Participants in this study articulated motivations for ethical practice that ranged along the full continuum from intrinsic to extrinsic motivations and were not
uniformly consistent with deontological, teleological, social constructivist, virtue ethics, or relational ethics theories. This suggested a commitment to ongoing ethical development, regardless of the reason or motivation to practice ethically.

Another aspect is how critical incidents like inadequate community connection, insufficient awareness of competence, unclear client consent, or boundary struggles can contribute to higher-order learning about ethical processes. The experience of such critical incidents can facilitate a psychologists’ internalized ethical stance as they present potential personal and professional growth opportunities. In this study, such experiences appeared to foster reflection and higher order learning, particularly when there were opportunities for consultation and supervision on these issues.

Finally, reflection about an abstract concept like ethics can be difficult. Not only can such internal processes be hard to articulate, particularly with insufficient experience, but descriptions of such experiences may not even represent ability or wisdom. Finally, reflection about an abstract concept like ethics can be a struggle. Participants did indicate that this study was a welcome opportunity to discuss ethical issues in rural practice and perhaps to give language to the meaning of their experiences. Opportunities to articulate ethical processes, like consultation and empirical studies like this, may well support ethical awareness and further ethical reflexivity.
CHAPTER EIGHT
LIMITATIONS, IMPLICATIONS & CONCLUSIONS

During conference presentations this spring I was struck by how engaged the audience was during my presentations. Although I would like to believe it was my engaging review of my research to date, I am aware that it was the opportunity for discussion and reflection on professional ethics in rural practice.

From my analytic journal, June 2009

The results of this study were not definitive as “a single, saturated, and final comprehension of a phenomenon is not possible” (Strong et al., 2008, 122). However, exploring professional ethics in rural Canadian psychology through the experiences of practising psychologists was an opportunity for an in-depth phenomenological and interpretive examination of this issue. This chapter reviews the limitations, implications, and concluding thoughts for reviewing the results of this qualitative study.

The primary research question was, “what ethical issues arise for you as a practising rural psychologist and how do you deal with these?” explored through the actual practises of rural Canadian psychologists. The hermeneutic phenomenological research methods detailed in Chapter Five: Methodology considered my influence as an insider-researcher while seeking to understand meaning and processes from the perspective of the twenty participants. This study focused on the experience of professional ethics and on factors associated with those experiences and which might foster ethical development. Through the process of a hermeneutic circle, the socio-historical context of this study is presented through participant-focussed considerations. From there the major themes of this study are explored to reveal some of the meaning and processes in the experience of professional psychology ethics in rural Canadian practice.
8.1 Making Meaning from Shared Stories

Existing literature provided the context for this study. Chapter One: Beginning the Exploration reflected on the often unacknowledged difference between urban and rural practice in psychology. Chapter Three: Rural Practice reviewed rural practice highlighting the lack of a common definition of rural and some of the complex and nuanced aspects of rural practice. The professional and social milieus of rural communities position the practising psychologist within a context that may differ vastly from urban settings. This context, specifically the Canadian context, was explored in the results of this study. The first theme, Connecting Rural Practice Considerations and Professional Ethics, explored required adaptations of professional practice norms, the need to define this specific practice setting, and proposed a tentative definition of rural Canadian professional practice in psychology based on the complex picture presented by the findings. This elucidated the distinct practice considerations, consistent personal and professional characteristics, and the geographic realities of the participants that grounded their experiences of professional ethics.

Chapter Four: Ethical Issues for Rural Psychologists provided a foundation for considering the ethical issues and ethical decision-making acumen required for psychologists in rural practice. The literature spoke primarily to overlapping relationships, community pressure, generalist practice, interdisciplinary collaboration, and professional development and support issues. The second theme of the results explored those five primary ethical dilemmas in relation to the Canadian context. Participant responses to the research questions indicated that they did experience the ethical dilemmas in those areas. Further, they had ideas for managing these dilemmas and they demonstrated some of the benefits of rural practice in relation to these experiences.
The results culminated with the final theme, *Ethical Schema for Rural Psychologists*. Those results explored the crux of the experience of professional ethics in rural practice. Ethics, psychological ethics, and ethical decision making models for psychologists was reviewed in *Chapter Two: Professional Ethics for Psychology*. The results of the third theme of this study go further to highlight three aspects of the internal ethical stance of the participants which fostered their ethical development. These were: the participants’ fundamental commitment to professional ethics, the role of critical incidents in their ethical development, and the elusiveness of ethical reflexivity.

### 8.2 Limitations

Empirical research is a formal and systematic extension of psychology’s study of people (Holloway & Jefferson, 2000b). In this study I was not a passive observer and I could not present an objective reality of the findings. As a rural psychologist, I was an active agent seeking a greater understanding of the phenomenon by examining some of the pieces of this puzzle. HP research methods were used with a relatively large number of participants to foster a comprehensive understanding of the phenomenon. There are limitations to having chosen this path.

Generally speaking, the experiences of others cannot be fully understood. Self-report evidence can never be assumed to accurately reflect the whole of participants’ experiences (Polkinghorne, 2005). In attempting to simplify and articulate complex processes, these results represent an artificial way of knowing. Consider how, “research is only a more formalised and systematic way of knowing about people, but in the process it seems to have lost much of the subtlety and complexity that we use, often as a matter of course, in everyday knowing” (Holloway & Jefferson, 2000b, page 3). Also, asking participants to
engage in a reflective process may have changed their understanding of their experiences.

This study also had specific methodological limitations. As qualitative research, this study is bound to its situational context limiting the interpretations and how the results may generalize. As a registered psychologist, I forewarned participants of my obligations to report ethical transgression that could pose harm. I did not have to report any participants but this potential may have limited participant openness.

[laughs] I feel this great pressure to come up with something ....But I don’t remember a particular mistake or anything where I thought, “well now I really have to change that”. Perhaps, you know, 20 years ago, and it kind of faded  [laughs]

DONALD

Although I suspected some reserve during this discussion with Bob there was no way of knowing why he hesitated and reacted in this way. Perhaps he was limiting what he chose to share in this situation. As a doctoral student, I designed this research study, was the sole interviewer, and was responsible for the data analysis. Despite active supervision and consultation, having primary responsibility meant reduced objectivity. Multiple perspectives and working collaboratively with researchers with differing expertise may have fostered a different methodology or interpretation of the data (Fereday & Muir-Cochrane, 2006). In hindsight, deeper levels of understanding may have arisen if I had pursued certain issues, had more time, or had used alternate interview formats (e.g., a six-month follow-up).

Every qualitative study has some limitations inherent to the sample used. The participants in this study did meet the criteria set and were good informants. However, I was not able to do full justice to the contextual/social constructivist
goals of this study because essential aspects of that picture could not be explored within the constraints of this study.

The range of participants (years of experience, geographic location, level of training) likely had significant impact on their constructions of ethical professional practice. It is likely that the participant experiences of ethical challenges might have differed between those participants who originally come from rural communities and those who come from urban communities, those from semi-urban but isolated communities and those from smaller rural communities, or even those who practice in exclusively one community and those who practice in several communities. Analyses of these impacts were beyond the scope of analysis of this study but undoubtedly shaped the results. Although all of the participants were rural psychologists, the variation in personal and situational circumstances was not fully explored.

Further, the research questions used, “what ethical issues arise for practising psychologists in rural practice and how do they deal with these?” may have been insufficient to truly mine the ethical landscape of rural psychological practice in Canada. Missing from the research prompts used were questions that might have explored the participant’s knowledge of the CPA Code of Ethics, relevant professional literature on ethics, how they conceptualized the ethical decision making models that they used, or even how they might have changed their experiences. Alternatively, the prompts that I used may limited what a participant may have been willing to share.

*Because I just felt horrible. I thought, yeah, you know, are all of those details really necessary. And I think that’s something that we don’t really learn about, or I didn’t learn about when I was in training. And maybe the message was there, you know, think about what information you include, but boy was this ever a practical real-life example that brought it home to me how important it is what information is in a report and how different people’s responses can be in terms of what information goes out about them.*

MARY
Being in the client’s shoes in sending out that information. In looking at the information that you’ve sent out.

Yeah. So, yeah.

JUDI

MARY

Here, Mary is speaking about the significance of this critical incident and my clarification is more about her motivation. Following this she shifts from exploration to agreement. In other instances, participants brought up situations that could be rife with ethical dilemmas such as working in client homes.

Yeah. I mean, we, we’ll actually and probably about 10 or 12 times a year we’ll actually be assessing right in somebody’s home. Because that’s the best venue to get the data that we want.

KENNETH

OK. Yeah, when you are in someone’s home, what else do you put in place?

JUDI

Ah, just clear people out.

KENNETH

In this exchange with Kenneth, I failed to explore his perception of the inherent ethical risks in this situation. Such exchanges may well have limited the data set that I was able to achieve. Also, this study did not drill down sufficiently into some of the strategies that the participants used. Superficial descriptions such as, “setting clear boundaries” and “consult with colleagues” are limited in their usefulness if they are not unpacked. Although professionally acceptable terms for dealing with ethical dilemmas, they obscure, rather than reveal, the depth of strategies used in actual practice. Overall, it was difficult to analyse the participant’s ethical reflexivity. This may have had more to do with my abilities as a researcher than their abilities to articulate such experiences.

8.3 Implications of this Study

In balance, this study had several benefits. This research allowed for a rich and dynamic study of experiences and the meaning that participants made of those experiences. The descriptions of actual practices provided by the participants bridges a gap between research and professional practice. The
sociohistorical considerations allowed for a fuller and more robust understanding of results and of the transferability for professional psychological practice. Triangulation of the data deepened the complexity of the results allowing them to better represent the lived experiences of the participants. The emphasis on the co-creation of knowledge respectfully acknowledged the contributions of the participants and the authors cited in the literature review. The relational style used in the interviews and analysis served to better develop an understanding of ourselves, not just as professionals but as complex social beings.

The crux of research is its implications. This study has particular value and benefit. The findings validated prior research, highlighted new considerations, and described the phenomenon within the Canadian context. The results of this study add to the knowledge field, foster recommendations for practice, and had an impact on the participants.

The primary implication of this research was nicely articulated by Carole.

*If you live in an urban area – they do not understand the implications of what it is like to work in a rural area. And, I think, the more research that is out there – the more literature that is out there -- we might begin to make some headway. [Laughs ] I think we are making some – I want to make more.*

**CAROLE**

Generally, this research supported the need for a greater understanding of rural practice and professional ethics in that context. There is a need for rural-specific practice models, training, supports, and ethics guidelines. Canadian psychologists in rural practice may be particularly vulnerable to government and societal structures and to registration and mobility issues. Some of the adaptations of professional practice norms identified in this study, namely telephone services, travel-related issues, and atypical service settings were not in the available literature. Also, the benefits of rural practice are rarely explored.
There are practical implications for practicing rural psychologists. Current research and practice exists without agreed definitions of rurality or rural professional practice in psychology. This is particularly relevant in Canada where 20% of the population is rural. Canadian literature on rural practice is limited and Canadian psychology is urbanized. There are benefits to having thick descriptions of ethical dilemmas as they manifest in rural Canadian practice. Even when the underlying issues may have been consistent with international literature on practice, the excerpts of stories shared by the participants in this study represented Canadian accounts. Consider the following accounts by Carole and Donald about geography.

*I was just talking to someone from the city here, and she said, “geez it took us 6 weeks to get to [your community] because of the snow storms in January – we couldn’t get a meeting together”, and sometimes those roads can be pretty bad so...*

**CAROLE**

*Northwest [of this province] is two thirds of the land mass of [the province]. With, like 2% of the population of Canada....*

**DONALD**

Or, the following account from Joanne which speaks to the role Canadian psychologists may have in working with Aboriginal people.

*I think that with some of the residential school stuff happening [Government of Canada Aboriginal Healing Foundation]....there are people, particularly elders I’m finding....they are getting information....Like, “Ali, you went to residential school. You’re entitled to all of this money....you have to contact a psychologist.” Which isn’t true. They come in and then I think, “You know, these people have lived for 60, 70 years with this stuff. Is it really important to start sort of digging in and tearing it up and bringing those emotions to the forefront?” Something that I think about a lot, particularly again when they’re going back to these communities where there are not a lot of resources and lots of these elders....try to live more traditional lifestyles so they are more isolated. They may live out in camps instead of right in the community.*

**JOANNE**

Similar situations may well be quintessentially Canadian and, as such, useful for training and development of Canadian psychologists. Participants in this study shared the kind of adaptations they made and began to speak to how and why they
chose those strategies. While these may not always represent the best ethical decisions they remain useful accounts of actual practice. It is that element of rural practice that make adaptations necessary that could be used as a rationale or excuse for idiosyncratic variations to practice that are not justifiable. This risk is enhanced with insufficient awareness.

Finally, this study had implications for studying professional ethics. In this dissertation, I found it difficult to study ethical reflexivity because of the abstract nature of ethics, my research skills, or perhaps even because reflexivity may not be required to demonstrate wisdom and good practice. The results of this dissertation do support the idea that it is important to identify areas of professional thinking about rural ethical dilemmas that need further attention and development. Reflexivity may be most important as only one aspect in ethical decision making. Perhaps ethical development is a more logical focus of study. The ethical development of the participants in this study was impacted by rural-specific critical incidents which could serve to inform training and professional development in rural practice. The results of this study began to reveal an underlying schema used by the participants for their ethical decision making of your sample. This included a basic commitment to ethical practice, an awareness of ethical issues, the role of critical incidents in the developmental fine tuning of ethical decision making, and the centrality of “boundary setting” and “consultation” as mechanisms for resolving dilemmas.

8.4 Applications from this Study

The primary application from the results of this study is a possible framework for understanding the key factors that underlie ethical challenges in rural practice. These factors are highlighted in Table 7.1 Defining Rural Canadian Psychology. Rather than just representing a definition, it is a useful framework for
conceptualising professional ethics in rural Canadian psychology. This shared definition implies that it is characteristics of the community interacting with the generalist nature of practice and adaptations to the size and remoteness of the community that gives rise to ethical dilemmas.

The results of this study also foster several general recommendations for the profession. Canadian psychology should consider the development of “general practice psychology” to strengthen the profession in light of its divisiveness, in response to competition from allied professionals, and for rural practice. Although I do acknowledge that the Canadian Psychological Association’s standards for accreditation of doctoral programs is predicated on training generalists this does not mean that Ph.D. level psychologists in Canada are fully prepared for rural practice. As learned from the stories of many of the participants, only half had doctoral training which is not required for registration in all provinces. Further, shortages may mean that rural areas recruit psychologists with less training than in urban areas. Also, even a cursory review of the professional registration categories provincially, and interest groups nationally, there is no representation or articulation of “general practice” as a subset of practice of psychology in Canada.

Rural practitioners should be involved in the prescriptive authority debate. Communities in rural and remote areas may be more likely to seek psychologists with prescription privileges. Alternatively, this might further the shortage of psychologists in rural practice, particularly when considering the varying levels of training reported by the participants in this study. And, training for rural practice should include focus on: required adaptations of professional practice norms, community connection, generalist practice, interdisciplinary collaboration, limits to consent, boundary crossings, and ethical dilemmas common to rural practice. A
specific example of this is how participants in this study managed overlapping relationships. Although their stories spoke of using caution, consulting with peers, and clarifying boundaries, it was less clear how the participants put limits on their professional and non-professional relationships. Training that incorporates available models, like those for managing risks in overlapping relationships proposed by Younggren and Gottlieb (2004) might be particularly valuable for those in or training for rural practice. Such training could be conducted as participatory action research with rural psychologists in an effort to determine the practicality of such existing models and to explore the need for new protocols.

These results could hold benefit for the profession of psychology in Canada. The Australian Psychological Society has Guidelines for Psychological Practice in Rural and Remote Settings (APS, 2004b). No such guidelines exist for use in Canada despite our much larger geographical population distribution. Personally, I have always perceived a need for, and benefit from, the development of such guidelines for the Canadian context. Resources such as the results of this study, the existing Australian guidelines, and those Canadian psychologists who hold memberships in the Northern and Rural section of the Canadian Psychological Association could combine to begin that process.

The results also provided some tangible ideas for rural psychologists. The results contain some specific ideas for managing various ethical dilemmas in rural practice. General considerations for this are: set clear and reasonable expectations and boundaries; consult regularly with a community of peers that need not be bound by location; develop effective community relationships; use technology to decrease isolation and distance; develop contingency plans for common pressures; seek out creative alternatives for service provision; and engage in self-care. The results also provide alternative conceptualizations of typical rural practice.
conditions. There can be benefits from having prior information about clients in rural areas and limitations of trying to artificially control benign overlapping relationships. Visibility can serve to normalize the psychologist, enhance their professional practice, and allow for the privilege of being a participant observer in community development. There is variety and challenge in generalist practice. Finally, well-managed interdisciplinary services can mean more effective services and a more rewarding practice.

Research participation extends beyond the researcher and the field of study to impact participants, often in emancipatory ways (Wertz, 2005). Attempting to articulate their ethical reflexivity may have positively impacted the participants’ ethical awareness and development. Reflecting on the gestalt of an abstract process such as professional ethics can promote an understanding of personal behaviour. Results indicated that this study provided a sense of validation for participants. That may have also fostered a greater sense of community of practice.

8.5 Future Research Considerations

Jean Pettifor (2004) said that “there are many paths to follow in the creation of knowledge” (p.11). The results of this research created a foundation for further study. This study provides impetus for research to define rural professional practice in psychology. An adequate definition would capture the diverse characteristics of rurality and foster research and program development by providing a shared understanding of what is rural for psychologists. Qualitative studies could gather understanding about the meaning of rurality to develop potential definitions. Quantitative studies could test these theories, comparing definitions and measuring the responsiveness of psychologists to these definitions.
There is a need to develop specific protocols. This study highlighted several adaptations to professional practice norms not in the literature. The profession has an obligation to foster research and literature on actual practices. Qualitative studies could explore and understand practices like short-term intensive psychological interventions in response to geographic isolation, assessment and practice in non-typical environments (like clients’ homes), and the implications of travelling to provide services. Quantitative studies could test protocols and best practices for such services.

Replication is also important. This study was conducted when there was little empirical data about professional ethics in rural Canadian practice. A qualitative study was the most appropriate way to begin that process and similar studies would add to the knowledge field and begin to foster generalizability. Future studies could compare participant responses in consideration of their level of registrations, region, or type of practice. An interesting area would be to have both insider-researchers and outsider-researchers assess for differences and to allow for both emic and etic perspectives given the specific culture and yet diversity of rural communities. I suspect this might highlight any sub-cultural differences between psychologists who originally came from rural communities and those who came from urban settings. Finally, quantitative studies could seek to develop and test theories based on qualitative findings. Such theories include the results of this study and Schank and Skovholt’s (2006) proposed strategies to minimize the risk of ethical dilemmas in rural practice.

Ongoing research on professional ethics in rural practice has implications for professional practice and training. Further qualitative studies should also consider what citizens of rural communities expect of psychologists specific to ethical standards. This would make the findings of studies like this one more
sensitive to community mores and may ground such findings in a more social constructivist perspective. Jones (2008) indicated that, “educational institutions within Australia have an ethical obligation to ensure that they train psychology students to be good at what they do” (p. 45). Given the fact that one-fifth of our population is rural, this ethical obligation likely extends to educational institutions in Canada.

8.6 Concluding Thoughts

This concludes my dissertation but not the study of professional ethics in rural practice. I was originally inspired by Schank and Skovholt’s (2006) assertion that, “the central dilemma for small community psychologists [is] how to practice at a high ethical level according to ethics codes, and how to also be an engaged member of the small community” (p. 5). The wealth of data shared by the participants in this study was another step in accumulating knowledge to facilitate an understanding of this phenomenon which may eventually inform policy, science, or clinical practice. I have had personal and professional benefit as the researcher and trust this study will serve as informative and validating for many in the field. I present no simple picture of the essence of professional ethics in rural Canadian psychology. Again, “a single, saturated, and final comprehension of a phenomenon is not possible” (Strong et al., 2008, 122). However, this complex phenomenon is now a bit clearer. As the researcher, it was an honour to share in the stories of other practising rural psychologists. The results of this study will provide a place to begin further exploration and understanding. As with most qualitative research, there is no clear end to the process (Blackstone, 2006). The final words I leave to the wisdom of Denzin and Lincoln (2005) speaking of qualitative research who said, “And so we come to the end, which is only the starting point for a new beginning” (p. 1083).
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APPENDIX A: Information Sheet

I am a registered psychologist in a rural practice and I am currently studying with Charles Sturt University of Australia. This research study is for my doctoral dissertation. Charles Sturt University is a regional Australian university with particular interest in training and research for the health professions. The purpose of this study is to explore what ethical issues arise for practising rural psychologists. My name is Judi Malone and I am conducting this study under the supervision of Dr. Anthony Thompson. If you have any questions regarding this study, you may address them to me at judim@alabamascu.ca or by telephone at 780-645-8514 or to Anthony Thompson in Australia at athompson@csu.edu.au or by telephone at 011 61 02 6933 3277.

If you participate, you will be asked to complete a series of three audio taped interviews, by telephone or in person. The first interview is a brief introductory interview in which I will share more detail about the research goals, ask you for some demographic information, and plan the primary interview. The introductory interview should take approximately 15 minutes.

The 2nd interview is the primary research interview. Here I will ask you to share stories of your experiences with ethics in your rural practice setting. This interview will involve a few open-ended questions and I may ask you to elaborate on your answers. This interview should take about 30 – 45 minutes. The 3rd interview is for clarification and debriefing. Prior to this third interview I will send you a transcript of our discussions if you wish to review this. This final interview should take approximately 15 minutes.

You will be assigned a pseudonym that will be used during data analysis and for any possible publication of the results. All information obtained over the course of this study is strictly confidential and your anonymity will be protected to the fullest extent possible.

There are no known risks associated with your participation in this study. During the interviews if you disclose compelling and specific information about reportable unethical conduct (e.g., sexual abuse), I will be obliged to report this offense. You can withdraw at any time and you are encouraged to report your data excluded. Participation is completely voluntary.

If you have any questions regarding this study, you may address them to Judi Malone or to Anthony Thompson. Thank you for considering participation in our research.

Assoc Prof Anthony Thompson

Note: Charles Sturt University’s Ethics in Human Research Committee has approved this study. I understand that if I have any complaints about the ethical conduct of this project. I may contact the Committee through the Chair at:
Chair, Ethics in Human Research Committee, School of Social Sciences & Liberal Studies, Charles Sturt University, Panorama Avenue, Bathurst, NSW 2795 Australia
Phone: 011 61 (02) 6338 6077 (International) Fax: 011 61 (02) 6338 6001 (International)
Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

www.csu.edu.au

The Commonwealth Register of Institutions and Courses for Overseas Students (CRICOS) Provider Number is 00006A for Charles Sturt University and the Charles Sturt University Language Centre.
RURAL PSYCHOLOGY PRACTICE IN CANADA: 
ISSUES IN PROFESSIONAL ETHICS

This is a research project being conducted by Judi L. Malone under the supervision of Dr. Anthony Thompson. The purpose of this study is to explore what ethical issues arise for practising rural psychologists.

If you participate, you will be asked to complete a series of three interviews, by telephone or in person. The first interview is a brief introduction and overview and should take about 15 minutes. The second interview, which is the primary research interview, should take about 45 minutes. The final interview, for clarification and debriefing, should take about 15 minutes.

There are no known physical, psychological, economic, or social risks associated with your participation in this study. You can withdraw at any time and ask to have your data excluded from the study. Participation is completely voluntary. You are free to withdraw for any reason.

If you have any questions regarding this study, you may address them to Judi Malone at jolive@athabascau.ca or by telephone 780-645-8214 or Anthony Thompson in Australia at athompson@csu.edu.au or by telephone at 011 61 02 6933 3277.

Thank you for taking the time to participate in our research. In signing this consent you are agreeing to the following:

- The purpose of the research has been explained to me
- I have read and understood the information sheet given to me
- The potential risks associated with the research have been explained to me
- I understand that any information or personal details gathered in the course of this research about me are confidential and that neither my name nor any other identifying information will be used or published without my written permission
- I understand that interviews will be audio taped

Charles Sturt University’s Ethics in Human Research Committee has approved this study. I understand that if I have any complaints or concerns about this research I can contact:

Chair, Ethics in Human Research Committee 
School of Social Sciences & Liberal Studies, Charles Sturt University 
Panorama Avenue, Bathurst, NSW, 2795 Australia 
Phone: 011 61 (02) 6338 6077 (International) 
Fax: 011 61 (02) 6338 6001 (International)

Signed by: .................................................. Date: ..........................
APPENDIX C: Interview Protocol

Interview Protocol

Introductory Interview

This is Judi Malone, the doctoral student from Charles Sturt University. Thank you for agreeing to this first interview. It should take about 15 minutes. Is this still a good time for you?

Brief informal discussion

Thank you for sending in the completed consent form. I trust that you had an opportunity to review the information sheet about the study. Are you still interesting in proceeding with the interview? Remember, that you can withdraw from this or subsequent interviews at any time.

Review consent

Today I will be asking you questions in general about the nature of your rural psychology practice and your interest in participating in this study. Before we begin, I wanted to remind you that, after you agree, I will be audio-taping our interviews. You can ask me to suspend recording or tell me that you want to make comments “off-the record” at any time. Those comments will not be used in the analysis of the transcripts but might still influence me as the researcher. Also, you can end this or subsequent interviews at any time and, if you ever decide to withdraw from the study altogether, I will respect this wish. Participation is completely voluntary.

Do you have any questions about consent or participation before we begin?

Can I begin to audiotape our interview now?

Begin Audio Recording -- once consent is verbally confirmed

Introductory Interview Questions

I am a rural psychologist practising in St. Paul, Alberta. I have been a registered psychologist for 9 years. I am currently studying with Charles Sturt University This research study is for my doctoral dissertation. I wish to learn from the practical wisdom of rural psychologists.

[Participant] why were you interested in participating in this study?

I would like begin by knowing a bit more about you.

How many years have you been registered as a psychologist?

What is name of the community(s) that you work in?

What is the size of those community(s)?

I have a few more questions – is that alright?

Psychologists have many roles. They provide counselling and therapy, teach, conduct assessments or research, provide consultation or forensic assessment, or work in program development and administration.

Psychologists work with all age ranges and in a variety of settings.

What kinds of psychological services do you offer in your practice?

What age groups do you work with?

What kinds of settings do you work in?
Would you consider this to be general practice?

There will be 2 more interviews. The next one will be the main research interview and may take 30 to 35 minutes. The last one will be shorter, about 15 minutes again, and will be your chance to review and confirm the main points from your interviews. In the main research interview I will ask about your experiences with ethics in rural practice. I will ask for specific examples, stories, and experiences. There will be a few open-ended questions and I may ask you for more detail or specifics.

I have some final questions – do you want to continue?

[Participant], what do you expect it will be like to participate in these interviews?

Do you still want to participate in the main research interview?

---

**Primary Research Interview Protocol**

This is Judi Malone calling, the doctoral student from Charles Sturt University. Thank you for agreeing to continue with this study by participating with this second telephone interview. It should take 30 to 45 minutes. Is this still a good time for you?

**Brief informal discussion**

I trust that you some time to reflect on our last telephone call and the nature of this study. Are you still interesting in proceeding with the interview? Remember, that you can withdraw from this or subsequent interviews at any time.

**Review consent**

Today I will be asking you more specifically about ethics in your rural psychology practice. There will be time at the end of the interview for clarification and we will have a final interview where you can review my summary of this conversation. Before we begin, I wanted to remind you that, after you agree, I will be audio-taping our interviews. Again, you can ask me to suspend recording or tell me that you want to make comments “off-the-record” at any time. Those comments will not be used in the analysis of the transcripts but might still influence me as the researcher. Also, you can end this interview at any time and, if you ever decide to withdraw from the study altogether, I will respect this wish. Participation is completely voluntary.

Do you have any questions before we begin?

Can I begin to audiotape our interview now?

Begin Audio Recording -- once consent is verbally confirmed

**Primary Research Interview Questions**

During this interview I want to know about your experiences and knowledge in the way that you understand it. I will need you to give me examples and descriptions of your experiences. This will help me to walk in your shoes and begin to understand how you have experienced ethics as a rural psychologist.

“[Participant], what ethical issues arise for you as a practising rural psychologist?”
Prompts, as needed, to get descriptions of actual life experiences, with the following:

- Can you elaborate on that?
- Can you give me an example?
- Can you deepen my understanding of your experience?
- Can you develop your answer with more detail?
- Can we explore that more?

I have a few more questions – do you want to continue?

If there are not specific examples given in the following areas, use these specific prompts:

- Overlapping Relationships – What has been your experience with overlapping relationships?
- Community pressure -- What has been your experience with community pressure?
- Generalist practice -- What has been your experience with generalist practice?
- Dealing with other professions -- What has been your experience in dealing with other professions?
- Professional development -- What has been your experience with getting continuing education / professional development?

I have a few more questions – do you want to continue?

In the questions I asked, do you think there was any kind of ethical dilemma that I did not ask you about or that I should also know about?

[Participant], have you ever experienced a critical incident that helped you to improve your judgement or practice as an ethical rural psychologist?

What motivates you to be an ethical practitioner?

I one more question – do you want to continue?

What current factors in Canadian psychology make ethics relevant to rural psychologists? (Prompt for socio-historical context)

I want to thank you for sharing your personal experiences as a rural psychologist. You provided me with some very useful information about your experiences.

What did you think of our discussion today?

Do you have any questions for me?

I will contact you once I have prepared a summary of the information that you have shared with me. You can review that before we are in touch for a final interview or I will give you a verbal overview then. The final interview should only take about 15 minutes. Thank you, again, for your time and for being involved with this study.

**Final Interview Protocol**

This is Judi Malone calling, the doctoral student from Charles Sturt University. Thank you for agreeing to this final interview. It should take about 15 minutes. Is this still a good time for you?

Brief informal discussion
I trust that you some time to reflect on the summary that I sent you about our interviews OR Do you want me to review, briefly, the previous interviews? Are you still interesting in proceeding with this review? Remember, that you can withdraw from this study at any time. Participation is completely voluntary.

**Review consent**

*Today I will be asking for your impressions on my summary of the information that you have shared to date. This will be your opportunity to correct any misinterpretations or to provide more clarification. You also may have had some after thoughts or further examples that you may be willing to share. Before we begin, I wanted to remind you that, after you agree, I will be audio-taping this last interview as well. Again, you can ask me to suspend recording or tell me that you want to make comments “off-the record” at any time. Those comments will not be used in the analysis of the transcripts but might still influence me as the researcher.*

**Do you have any questions before we begin?**

**Can I begin to audiotape our interview now?**

*Begin Audio Recording* -- once consent is verbally confirmed

**Final Research Interview Questions**

*Discuss or provide summary*

*[Participant], is that summary accurate or are there any corrections needed?*

*Now that you have reviewed the summary, is there anything you would want to add to it that would help me to better understand your experiences? You are finished participating in this study. If you are interested, I can place your name on a confidential list to receive information about any report or publications about the research data. Thank you for your time and for being involved with this study.*
APPENDIX D

PARTICIPANT SUMMARIES

Brief participant summaries as presented in Chapter Five: Methodology. The following highlights global topics of the research interviews with each of those participants.

Albert
- Competition
- Prescription privileges
- Advocacy for rural peoples
- Validation from participation
- Ethical development
- Client who became friends
- Clients who became co-workers
- Visibility for clients
- Professional networks
- Levels of consent
- Relationships and respect

Barbara
- Advocacy for the profession
- Advocacy for rural communities and peoples
- Own confidentiality
- Colleagues who became clients
- Community involvement with clients
- Creative use of Technology
- Clear boundaries and limits
- Own privacy and visibility
- Pressure and benefits of generalist practice
- Redefining services
- Pressure and benefits of interdisciplinary relationships
- Maintaining professional development and support
- Self-care
- Benefits of participation

Brenda
- Value of appropriate training
- Client visibility and privacy
- Contextually appropriate services
- Social constructivism
- Pressure of generalist practice
- Benefits of participation

Bryon
- Benefit of participation
- Rural context
- Personal and professional roles
- Lack of alternative services
- Responsibility to profession
- Using technology

Carole
- What is rural?
- Advocacy for rural communities and people
- Professional & personal roles
- Own privacy and visibility
- Clients as colleagues
- Community relationships
- Barriers to professional development and support
- Barriers to supervision
- Self-care
- Responsibility to the profession
- Ethical development through training
- Benefits of research
Connie
- Government structures
- Reflexivity
- Rural context
- Colleagues as clients
- Professional networks
- Community relationships
- Geographic isolation
- Virtue in personal and professional roles
- Ethical development
- Boundaries
- Validation from participation

Debbie
- Benefits of training
- Need for rural specific training
- Advocacy for rural people
- Client privacy and confidentiality
- Atypical service settings for rural needs
- Social constructionism and ethics
- Benefits of participation

Donald
- Concerns about paraprofessional services
- What is rural? Concerns over definitions
- Atypical service provision for rural needs
- Caution in all professional roles
- Lack of alternative services
- Competence as a “lesser of evils”
- Community-responsive services
- Insignificance of rural psychology
- Interest in participation

Doreen
- Prescriptive authority
- Family and overlapping relationships
- Benefits and pressures of overlapping relationships
- Atypical service settings for rural areas
- Moral development
- Ethical development
- Benefits of participation

Eleanor
- Advocacy for rural people
- Validation and ethical development from participation
- Overlapping relationships and family
- Isolation
- Personal and professional roles
- Community development
- Professional networks
- Professional obligation

Esther
- Competition
- Advocacy for the profession
- Socio-political systems
- Defining rural
- Urbancentricism
- Community involvement and relationships
- Validation of research
- Personal and professional roles
- Benefits and struggles of overlapping relationships
- Community pressure
- Responsibility to community
- Supervision barriers
- Personal and professional virtue
Janet
- Advocacy for the profession
- Concerns for own privacy
- Caution with participation
- Rural context
- Difficulties with and benefits of overlapping relationships
- Benefits of participation

Jeanne
- Professional networks
- Rural context
- Benefit of participation
- Community networks and pressure
- Boundaries
- Interdisciplinary pressure and benefits
- Ethical development
- Travel as a unique ethical concern
- Consequences

Joanne
- Need for public awareness
- Competency versus credentials
- Atypical service issues
- Advocacy for rural communities and peoples
- Fiends as clients
- Community involvement with clients
- Personal and professional roles
- Lack of alternative services
- Interagency concerns
- Contextually appropriate services
- Moral reasoning
- Overlapping client relationships
- Validation from participation

Ken
- Competition
- Advocacy for the profession
- Social structures
- Level of registration
- Rural context
- Clear boundaries in all professional relationships
- Creative training and support
- Atypical service delivery
- Duty and obligation
- Professional Responsibility

Lorna
- Competition
- Social structures
- Advocacy for the Profession
- Lack of alternative services
- Difficulty interdisciplinary relationships
- Moral obligation
- Validation from participation

Mary
- Validation from participation
- Ethical development through training
- Own privacy and confidentiality
- Rurality
- Personal and professional roles
- Clients as fired
- Colleagues as clients
- Client privacy
- Benefits of visibility
- Pressures of generalist practice
- Isolation
- Moral development
- Responsibility to the profession
Moriah
- Prescriptive authority
- Levels of registration
- Advocacy for the profession
- Consequences of actions
- Moral obligations
- Technology to mediate barriers
- Client privacy and confidentiality
- Own privacy and confidentiality
- Setting boundaries
- Challenges and benefits of generalist practice
- Limits to professional development

Sandra
- Benefits of prescriptive authority
- Levels of registration
- Urban-centric profession
- Challenges and benefits of overlapping relationships

Virginia
- Triaged services
- Client privacy
- Isolation
- Participation as collaboration
- Support of prescription privileges
- Family as clients
- Prior information on clients
- Own visibility and privacy
- Balancing personal and professional roles
- Benefits of triage
- Setting boundaries
- Assessing need
- Time pressures
- Building community relationships
- Lack of consultative support
- The need to know community context
- Consequences of actions
- Validation from participation
Memo

To: Judi Malone
From: David Bull, Chair, SSLS Ethics Committee
CC: Associate Professor Anthony Thompson
Date: March 16, 2010
Re: Ethics Application 2008/05

Dear Judi,

The Committee has considered your ethics application and has approved it. We would ask you to consider two points.

- You should consider filing your list of participants’ pseudonyms separately from your data so that it would be difficult for anyone but yourself to bring the two pieces of information together, thus enhancing anonymity.

- In your information sheet and consent form, you only provide half of Tony Thompson’s phone number. The full number is: 6933277.

David Bull