The Ethical Frontier: Ethical Considerations for Frontier Counselors

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This paper explores the aspects of counseling significant to rural and frontier settings. It discusses the traditional attitudes of rural and frontier populations, the counselor's place in these communities, and ethical concerns that are significant to these areas of counseling. It also offers potential ways to address related ethical issues.

Working in small and rural communities presents counselors with challenges and experiences not necessarily or often encountered in larger population centers. The geographic constraints of the area itself, the culture and behavior of the client population, as well as the attitudes and skills of the counselor can combine to create significant difficulties in providing ethically competent mental health care. Even the term "rural" is difficult to define when attempting to describe the 16% (Nusca, 2011) of the total U.S. population, and the 20% (Trading Economics, 2011) of the Canadian population that live in "rural" settings. Rural in this usage is generally defined in regards to low population density, population size and distance from larger population centers. Although governmental agencies vary in their exact definition and identification of rural locations and populations in the United States, urban is generally defined as an area having more than 100 people per square mile, rural areas generally comprise open country and settlements with fewer than 2,500 residents and are defined as having between 99 and 6 people per square mile, and frontier is an area having less than 6 people per square mile (Bushy & Carty, 1994; Helbok, 2003). Much of Alaska, the central United States, and central Canada are primarily designated as frontier areas.

"Rural" and "frontier" become increasingly difficult to define when viewed through the perceptions of those living in these areas. Individual life-experiences and interpretations blend with considerations of distance between families and communities, self-sufficiency, access to resources, and support to and from the community to create a style of living centered on individual capacity and self-reliance, as well as increased community interdependence (Brownlee, 1996; Erickson, 2001). Small and rural community living, however, does tend to have some similarities across geographic areas including scarce resources, higher poverty rates, lack of access to employment opportunities, lack of higher formal education, higher illiteracy rates, limited health services, limited insurance coverage, higher rates of disability, greater environmental hazards, increased overall age-adjusted mortality, and fewer mental health resources (Helbok, 2003; Murray & Keller, 1991; Roberts, Battaglia, & Epstein, 1999; Wagenfeld, 1988; Wilcoxon, 1989). In addition to the concerns associated with rural living, frontier areas have to contend with even fewer mental health care resources due to populations spread over a large geographic area, reduced numbers of mental health care providers, limited access to crisis services, mental health services and general medical care, inaccessibility to remote geographic areas, and the increased hardship of living in isolated locations (Bushy & Carty, 1994; Roberts et al., 1999).

Alaska is illustrative of the difficulties of providing for mental health care needs and access to experienced practitioners in rural and frontier communities. Alaska is the largest state (656,424 square miles) with the lowest population density in the United States with 1.2 persons per square mile. Much of that population is concentrated in two metropolitan statistical areas that account for approximately 66% of the state's total estimated population (U.S. Census Bureau, 2012). In 2007, it had the highest suicide rate in the nation, with 21.8 suicides per 100,000 residents as compared to 11.5 suicides per

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100,000 for the rest of the U.S. For Alaska Natives, the suicide rate jumps to 35.1 per 100,000 people (State of Alaska Bureau of Vital Statistics, n.d.).

In 2006, a report on the prevalence of mental health concerns estimated that 4.6 percent (21,754) of Alaskan adults in households had a serious mental illness and that 7.2 percent (12,725) of Alaskan youth had a serious emotional disturbance. The estimates for adults only include those with a diagnosable disorder that had persisted for over one year and was associated with a significant impairment (State of Alaska, Health & Social Services, n.d.). In 2007, approximately 11.3 percent of the population (about 53,000) Alaskan adults (age 18 years or older) experienced serious psychological distress and 7.6 percent (about 36,000) had at least one major depressive episode (SAMHSA, 2009).

Community hospitals are important healthcare contact locations in rural and frontier areas. In 2011, Alaska community hospitals had only one community hospital bed for every 433 people. Outside the primary population areas of the state, this number increased to one bed for every 792 people. Only two psychiatric hospitals exist in Alaska and both of these are located in the municipality of Anchorage; outside of this area the state has no public psychiatric treatment options (U.S. Census Bureau, Health & Nutrition, 2012: U.S. Hospital Finder, 2011).

Small Communities

Small communities can be seen as each possessing their own cultural milieu with a shared context, set of perceptions and understandings and a view of "how we do things around here" (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010, p. 50). When rural and frontier issues are part of a small community, the communities' concerns magnify through the restrictions of geography and scarcity of resources and all of the previously noted ways that distinguish rural and frontier populations. Even so, rural and frontier communities have common threads with other small communities in their methods of subcultural self-identification. Each of them can be defined as much by external forces (such as geographic setting, population density, available natural and economic resources) as internal motivators (desire for small community interactions, dislike of big cities, desire for support from those with similar values and outlooks), but each also has a shared context that encourages successful adaptation *in that setting*, including an appreciation and support for the cultural norms and values endemic to each setting (Alegria et al., 2010). Therefore, the life context of the people who live in these communities, whether they are in a geographically isolated village in Alaska, a group of military families living in and around a military base, or an alternative lifestyle community living in a larger city, have much in common. Each of them is a part of a culture that shapes attitudes, behaviors and values as well as perceptions of what is accepted as "normal" in their community (Schank, Helbok, Haldeman, & Gallardo, 2010). This perception is frequently in contrast, or opposition, to the majority culture and is continually evolving through member interactions, reaction to the environment and perceived self-identity.

Rural and Frontier Attitudes and Behaviors

Self-reliance, which includes self-care behaviors, is a characteristic traditionally associated with rural residents. Historically, this reliance on self and kinship ties helped people to survive in remote, isolated, and difficult environments (Bushy & Carty, 1994) and created a hesitancy to seek services. Current potential mental health clients still tend to turn to familiar people, friends and family as a first level of support (Bushy & Carty, 1994; Helbok, 2003). These services are informal, heavily steeped in a shared history or culture, and frequently follow a tacit understanding of reciprocity among participants. This informal level of healthcare can be very beneficial in its promotion of healthy living and self-care behaviors, for example, in a family's care of a mentally ill family member or a community's support of a person with a disability or developmental issue. It also can be highly detrimental as it can hide that person's issue within the family or community and enable a person to take on or maintain a *sick role* or prevent a person from seeking or receiving mental health care that may improve their overall functioning (Bushy & Carty, 1994).

The second level of assistance includes community groups, church and religious groups, school services, community educational and outreach programs, and civic organizations. Group members (usually extended community members) often combine and/or contribute resources to provide assistance to individuals and families in need, particularly in times of emergency or crisis. This generally takes the form of volunteering time, services, and donating food, clothing, other non-monetary items, and financial contributions. It also can include taking in an individual or family who is lacking

housing or needs more comprehensive support (Bushy & Carty, 1994; Murray & Keller, 1991). The third level of support covers formal services such as community mental health and hospital/clinic services, medical doctors, governmental programs and services, and for-profit commercial service providers (Bushy & Carty, 1994). Financial remuneration is expected for the services provided and may potentially be based on a sliding scale or reduced fee schedule (Bushy & Carty, 1994; Murray & Keller, 1991).

That residents of rural and frontier areas tend to initially rely on the two informal levels of social support may in part be due to their self-reliant tendencies aggravated by geographic location and/or isolation, inability to access or qualify for services, inability to pay for services and lack of service providers. This also may be due to cultural traditions regarding the accepted traditional method of handling mental health issues (or if the concern is even acknowledged as a significant issue), a shared belief that outsiders are not to be trusted, resentment of outsiders coming to "rescue" them, and/or negative perceptions of the value of formal services in addressing the issue (Bushy & Carty, 1994; Erickson, 2001).

Acceptability of services by rural and frontier residents also is influenced by the behavior and approach of mental health professionals. A provider's attitude and training in relation to rural and frontier practice can be fundamental in relating to a specific environment and the people living there. If a service is offered with an understanding of the particular characteristics and needs of a population, and the provider has been accepted into the community, then the services may be viewed as a treatment option in the community structure. If, however, the provider has not been accepted as a trustable member of the community or exhibits attitudes and behaviors that are incongruent with local values, then locals needing assistance may not seek services, or may not accept services that are readily available and accessible (Bushy & Carty, 1994).

Rural and Frontier Mental Health Services

The U.S. Department of Health and Human Services' Health Professional Shortage Areas, which are determined by the availability of mental health service providers in relation to population numbers for a defined area (HRSA, 2011), illustrates the lack of qualified mental health services and providers for rural and frontier populations. This lack of qualified mental health professionals translates directly to reduced services for a given area as well as professional practice concerns for those that provide services.

In the face of such scarcity, frontier mental health providers frequently assume multiple roles in order to function in a variety of situations. Counselors may take on many duties past their primary role as clinician including case manager, crisis intervention specialist, advocate for client services, and community outreach worker, just to name a few. This multiplicity of duties provides better generalized coverage for client care, but can place the counselor in the ethically dangerous position of potentially breaching client confidentiality, operating outside professional training and competence, managing multiple dual relationships and conflicting professional roles, limited or no professional support, and increased potential for professional burnout (Roberts et al., 1999; Schank, 1998; Werth, Hastings, & Riding-Malon, 2010).

Ethical Issues in Rural and Frontier Mental Health Services

Counselors frequently face serious ethical dilemmas as service delivery in rural and frontier communities presents them with ethical challenges distinctive to those environments (McDermott, 2007). These ethical dilemmas and potential violations are no less common in rural and frontier areas than in urban locations, but according to studies, are more difficult to resolve (Bolin, Mechler, Holcomb, & Williams, 2008) due to geographic and social isolation, scarce resources, limited population numbers, and the cultural expectations that characterize those communities (Roberts et al., 1999; Scopelliti et al., 2004).

These ethical issues are not limited to populations that are primarily defined or identified by geographic restrictions or population density. They also are particularly relevant to small communities that are identified by demographic variables such as age, race, culture, sexual orientation, disability, or spiritual orientation. Although there are some needs that are specific to certain populations, the determination of appropriate ethical practice guidelines also should include the needs and cultural values of other small community groups (Schank et al., 2010; Schank & Skovholt, 1997).

The needs and considerations of rural and frontier communities frequently cause professional codes and guidelines to be in opposition to prevailing small community standards and expectations (Schank, 1998). To address these concerns, rural and frontier clinicians may find it necessary to adopt a view of professional boundaries and ethical guidelines that places more importance on community values and professional roles in the community than on rules of behavior as defined by professional organizations.

Urban ethical orientation in mental health services. This necessity on the part of mental health providers is intensified by the fact that mental health training and much of the ethics literature and professional ethics codes appear to favor urban-based mental health practices. This could potentially lead to erroneous assumptions when it comes to distinguishing between ethical and unethical practices in small community environments (Helbok, 2003; Roberts et al., 1999; Werth et al., 2010).

Most mental health clinicians are trained at universities and colleges located in urban and suburban areas. Their practical experience takes place in urban and suburban clinical training sites that have adequate resources and readily available personnel. Later in their practice, clinicians tend to work within areas that have relatively easy access to referral resources at multiple levels of intervention (hospitals, psychiatric treatment centers, partial treatment and day treatment centers), public transportation, various community support and centers, self-help groups, and peer support including ongoing supervision and professional mentoring (Helbok, 2003; Schank et al., 2010). This exposure to training in an urban/suburban environment may not adequately prepare those clinicians that go forward to work with small community and rural populations and creates the general consensus in the literature that an urban model of mental health training and service delivery is inadequate to meet the needs of rural and frontier communities. With this in mind, mental health service providers often feel that ethics codes and other literature are so urban-biased that they are not helpful in a rural or frontier context (Helbok, 2003; Murray & Keller, 1991; Roberts et al., 1999; Schank, 1998; Werth et al., 2010).

Current ethical codes do not adequately address ethical concerns in rural settings. It is important to understand that while there may be significant differences between the ethical considerations of urban, rural and frontier mental health practices, this does not mean that ethical codes have no applicability in rural and frontier clinical settings; to the contrary, potential ethical concerns should be closely monitored precisely *because* of the inherent ethical dangers that come with working as a clinician in such areas (Helbok, 2003). The fact that such situations *will* occur in rural and frontier clinical settings and *will* influence mental health services encourages the need to develop and expand the ethical codes and ethical decision-making processes (Schank et al., 2010) to include an understanding that rural and frontier mental healthcare decision-making is "colored and shaded by values, beliefs, emotions, competencies, and resources" (Cook & Hoas, 2008, p. 52). It is only by understanding and working with this *coloring and shading,* that mental health providers can develop awareness and skills needed to work effectively in rural and frontier communities. To do this, rural and frontier clinicians must do more than simply adhere to standards or rote application of rules, they must understand why those rules exist, at what point those rules may be a detriment to the development of clinical relationships, and what may constitute a severe enough ethical issue in regards to both ethical codes and community values to warrant concern. Rural and frontier clinicians need to understand that "ethics should not be static but rather constantly examined and evolving in order to be the most beneficial to clients and counselors" (Schank, 1998, p. 272).

Confidentiality

The limitations in both human and material resources in frontier areas can cause many seemingly obvious and standard professional practices to take on significant ethical aspects and primary among these is confidentiality. With fewer mental health professionals in a given area, fewer support mechanisms and services, and geographically large and sparsely populated areas, confidentiality can be more difficult to ensure in rural and frontier practice; while on the other hand a strict adherence to confidentiality can negatively impact important collaborative relationships in smaller communities (Scopelliti et al., 2004).

The close confines and small populations of many frontier areas and towns lend themselves to personal business being known by many people in the community and each person potentially being aware of many others' behaviors (Helbok, 2003; Roberts et al., 1999). It is in this regard that confidentiality is difficult to control as the size of the community lends itself to many people knowing who is seeking and/or getting treatment at any time. The members of the community tend

to collectively know those who are having difficulties with mental health, personal or addiction concerns. The stigma of receiving mental health services, particularly when the potential client knows that the community is aware of their actions, can cause many to avoid needed professional assistance. This is only compounded when the office or support staffs of a mental health service are longtime members of the community and are familiar with the client, or may even be related to the client. Potential clients may be reluctant to engage in services where they may personally know others, such as in group counseling or outpatient addictions settings (Helbok, 2003; Solomon, Hiesbergr, & Winer, 1981). Office and support staffs, themselves not having to meet the ethical requirements of professional licensure, may be more apt to share confidential client information between themselves, friends and family members. This sharing of information between community members is a concern on a professional level as the lack of professional referral sources may mean involving people, groups and organizations that may not share a counselor's view of confidentiality. These referral sources may include community, church, and volunteer organizations, and these organizations and their associated paraprofessionals may create confidentiality concerns for clients through the informal sharing of information which is common in small communities.

This sharing of confidential information across professional lines also is significant in the relations of the counselor to the broader array of professional services and agencies that may interact with their clientele. Law enforcement, medical, educational and social service professionals may expect the rural and frontier counselor to freely share information the counselor considers confidential to the client. Without an appropriate informed consent or release of information the counselor is obligated to not share any personal or treatment information, or to even tell if the client is receiving services. This ethical stance can be damaging to a counselor's professional practice as it can distance them from the local professional community, reduce future client referrals and strain relations with other health and service professionals (Helbok, 2003; Solomon et al., 1981; Stockman, 1990). Hargrove (1986) maintained that confidentiality must be preserved unless there is consent to release information, or if there is a clear and present danger. At the same time, the counselor needs to be responsive to community standards and attempt to work in the best interests of their client even when most rural clients assume that information will be shared without their consent (Elkin & Boyer, 1987; Helbok, 2003). In frontier settings, it may be difficult to balance ethical obligations with community expectations, but the counselor can be the best agent of change in these situations by taking steps to educate referral sources and local professional organizations on the importance of confidentiality in counseling services and how confidentiality can reduce the client's fear of being stigmatized. Counselors also should take steps beyond the development of a comprehensive informed consent to discuss with clients the professional requirements of confidentiality and promote clarity regarding what information will be shared and in what circumstances (Helbok, 2003).

Boundaries of Competence

A counselor's boundaries of competence are defined as the "education, training, supervised experience, state and national professional credentials, and appropriate professional experience" (ACA Code of Ethics, C.2.a, 2005) that qualifies a counselor to work with a particular client, population, or mental health area. In rural or frontier areas the determination of professional boundaries of competence can be difficult to achieve (Helbok, 2003). As rural and frontier clinicians are called upon to serve a diverse range of client issues, they tend to work as generalists rather than specialists in order to provide the highest quality of service to the most clients within a given area (Werth et al., 2010). Within a small community they may be asked to address many issues including adjustment concerns, addictions, mental illness, trauma, crisis, marital issues, career development, developmental and learning issues, life-changing circumstances and/or end-of-life concerns. These concerns can surface in any of the situations that a frontier counselor may find themselves in including community outreach, educational training, professional consultation and individual or group counseling settings (Werth et al., 2010).

When such a situation arises it is the duty of the counselor to determine if the concerns of the potential client fall within or without their professional competence while also considering the availability of appropriate referrals and professional services that may be better suited to address this issue, the geographic availability of such referrals, if such exists, and the ability, resources and inclination of the client to access such services. The counselor may choose to deny a client services on the grounds of non-maleficence; namely, that by working outside their areas of experience they risk more potential harm to the client than they would by violating their boundaries of competence. On the other hand, the counselor may choose to uphold the principle of beneficence in regards to client care with the opinion that a potentially inappropriate

treatment would be less harmful than no treatment, or when there are no reasonably available referral options (Remley & Herlihy, 2009). Both of these options can be untenable when judging the value of a person's mental stability and ability to function against an ethical code that does not take into account the realities of small community life. In that regard, each of these options serves to highlight the position that determinations of boundaries of competence in frontier areas need to include an awareness of the needs of the community.

In areas where members of close-knit communities traditionally depend on each other in the face of adverse living conditions, and the problematic behavior of even a single person can disrupt a family and through that a community, it is imperative to be aware of the interdependence and needs of small communities. With this in mind, when a frontier counselor is faced with a client concern that they do not feel wholly qualified to treat, they may choose to work with the client knowing that referral services are too far removed or inaccessible and that professional action may be construed as a violation of competence on the part of the counselor, but also that working with the client may serve to maintain the client's best functioning in the community, thus supporting the continued well-being of the community itself (Werth et al., 2010). In contrast, a counselor could deny services to a client based on the counselor's perception of their own professional abilities in regards to a particular client concern. The counselor could then seek to augment the boundaries of competence through supervision, mentoring and continuing education, expanding understanding until more comfort working with a particular concern or population was achieved. This assumes, of course, that adequate supervision and continuing education opportunities are available and that the counselor is able to access these services. In this manner, the frontier counselor is in the same predicament as their clients with geographic location and distance determining availability of resources. While technologies (Internet, audio/visual conferencing, telephone) do create greater potential access to necessary resources, the reality of frontier life is that many areas do not have Internet or phone access, or have very limited access heavily dependent on weather conditions and other factors relating to location and available technical resources. While most licensing boards allow some continuing education units (CEU's) to be obtained through distance means (Zur, 2006) and some allow distance supervision for licensure (McAdams & Wyatt, 2010), the actuality of frontier counseling frequently makes it difficult to readily obtain licensure CEU's, timely mentoring, and collaborative resources when needed.

Multiple Relationships and Conflicting Professional Roles

"A dual relationship would be considered to exist when, in addition to the professional role and relationship, there exists a further meaningful relationship with clear role expectations and obligations, such as employer, friend, family member, or business partner" (Brownlee, 1996, p. 498). These dual and multiple relationships are the most pervasive ethical concern facing rural and frontier counselors and are the most complicated of all the ethical dilemmas encountered in daily professional practice (Helbok, 2003; McDermott, 2007; Scopelliti et al., 2004; Werth et al., 2010; Zur, 2006).

Perceived problems with multiple relationships in counseling. The relationships themselves are, of course, not the problem. The ethical concerns begin to arise when the boundaries of a therapeutic relationship become unclear through multiple relationships to the extent that the potential of client dependency, feelings of entitlement to special favors, and financial, emotional, or sexual exploitation can more readily occur (Nickel, 2004). That is why the traditional view of managing multiple relationships has been to avoid them (Ebert, 1997; Faulkner & Faulkner, 1997; Stockman, 1990) and in general, the ethical codes of mental health professional organizations have discouraged multiple relationships in an effort to avoid exploiting the trust and dependency of clients (Erickson, 2001).

In the American Counseling Association's (ACA, 2005) ethics code, for example, counselors are encouraged to avoid all non-professional interactions or relationships with "clients, former clients, their romantic partners, or their family members…except when the interaction is potentially beneficial to the client" (A.5.c). If there is a potential benefit for a current or former client the counselor:

> must document in case records, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. (A.5.d.)

This may be a reasonable course of action when the counselor has the justifiable belief that he or she can move around in an environment without the immediate concern of interacting with a current or former client (Schank & Skovholt, 1997). But when the constraints of geography, availability of mental health services, population density, and the distinct

characteristics and expectations of frontier communities and their inhabitants are taken into account it is a much more sensible assumption on the part of the frontier counselor that non-professional contact with a client, former client, their romantic partners, or their family members is not only inevitable but imminent (Faulkner & Faulkner, 1997; Schank et al., 2010). It is this inevitable imminence that lies at the heart of the disparity between current ethical guidelines and practical mental health provision to rural and frontier populations.

While there are some clearly delineated ethical violations that apply across professions and work environments, such as sexual or romantic counselor-client relationships, the complexity of social values and human relationships makes it impossible to define clear directives for engaging in nonsexual multiple relationships, particularly for those who practice in rural and frontier communities (Faulkner & Faulkner, 1997; Nickel, 2004; Pope & Vetter, 1992). With these considerations in mind, the idea that all dual relationships are unethical "would seem to be unnecessarily restrictive and unrealistic in a rural context" (Brownlee, 1996, p. 500).

Place of multiple relationships in frontier counseling. Unfortunately for the frontier counselor, the very social structure of frontier life fosters multiple interdependent relationships between people as a way of adapting to the realities of living in remote, and sometimes harsh and dangerous environments. The smaller and more remote a community is, the greater the interdependence between its members in regards to life necessities such as food, water and shelter, as well other needs including health issues, education and companionship (Roberts et al., 1999). In frontier areas, the likelihood of multiple relationships between community members is even greater due to scant resources and professional services, reduced population density, and the fact that many of the community members will have family relations between them as well. As Roberts et al. (1999) stated, "in these naturally 'enmeshed' communities, there are few options for relationships other than overlapping ones" (p. 499). Multiple relationships between members are seen as normal and reflect expected and traditional cultural and social norms (Campbell & Gordon, 2003). They expect to interact with each other in significant social and personal endeavors so their social norms have more flexible and permeable boundaries (Nickel, 2004) than might be encountered in less interdependent and socially interwoven populations.

Utility of multiple relationships in frontier counseling. It is into this world of highly interconnected social and familial relationships that the frontier counselor strives to be accepted and trusted. Faced on the one side with the idea of the ethical *slippery slope*, where relatively minor ethical infractions tend to lead to more severe violations (Faulkner & Faulkner, 1997), and on the other with a populace that expects, and in many cases demands social and interpersonal interactions, the frontier counselor must find ways to be embraced by the people that make up their communities (Schank & Skovholt, 2006). The most secure route to this acceptance is through involvement with the community as this promotes familiarity which may lessen suspicion and increase approachability (Campbell & Gordon, 2003), thereby fostering community approval and trust (Horst, 1989; Schank et al., 2010).

This approval may directly establish the counselor as a trusted resource regarding mental health concerns and allow the counselor to act as an advocate for the value of formal therapeutic services. It also may indirectly influence clinical effectiveness (Erickson, 2001; Scopelliti et al., 2004) as clients may mistrust a counselor who lives and operates outside of the community structure and isn't available on social or personal levels. As Nickel (2004) stated, "No matter how warm and caring they may be during therapy, rural mental health care providers cannot be effective if they hold themselves distant and aloof in other situations" (p. 19). On a personal level, this aloofness may not be advisable as the frontier counselor, and potentially his or her family, is living in the community and as such, personal survival may depend on interactions and relationships with community members. This inherent dual relationship works against the potential of avoiding multiple relationships as it is acceptance into the community that helps ensure communal and personal survival in many frontier and remote areas. However, the deeper a counselor is accepted into a community the greater the probability of developing non-sexual multiple relationships with clients and their families (Werth et al., 2010). This, consequently, could lead to professional ethical concerns for all of the reasons mentioned previously and potentially lead to gross ethical violations and/or impairment on the part of the counselor (Faulkner & Faulkner, 1997; Stockman, 1990). It should be noted, however, that not all multiple relationships *must* lead to ethical violations. While some rural clinicians establish and maintain strict professional boundaries, discouraging multiple relationships due to a belief that clinicians who work in rural environments must make personal sacrifices (Faulkner & Faulkner, 1997), others believe that multiple relationships may enhance a clinician's standing in the community (Schank et al., 2010) to the extent that chance meetings outside of therapy and routine social interactions are protected by the counselor's investment in the community and the

community's trust in the counselor (Faulkner & Faulkner, 1997).

This emotional investment of the counselor in the community can become a positive ethical force as "dual relationships and familiarity with patients…tend to decrease the probability of exploitation--not increase it--as the power differential in a more egalitarian relationship is reduced" (Scopelliti et al., 2004, p. 955). Due to the counselor's involvement in the community, the local clientele may choose the services of the frontier counselor *because* they may be seen as someone who would understand and have awareness of the client's concerns (Schank et al., 2010). Thus, the regard the counselor has for the community's overall welfare can act as a monitor "warning that distancing through anonymity and neutrality is not only likely to be counter-therapeutic, but also to increase the likelihood of exploitation" (Scopelliti et al., 2004, p. 955). This of course assumes that the counselor is diligently aware of their relations with clients and community members because, as Reamer (2003) states, such relations "can be ethically appropriate and, in fact, therapeutically helpful as long as the clinical dynamics are handled skillfully" (p. 128). Conversely, lack of awareness can lead rural clinicians to consider that because multiple relationships *can* be expected they are free to engage in any type of relationship and excuse it as a natural result (Werth et al., 2010).

Considerations for Frontier Counselors

Certainly there are no easy answers to the ethical dilemmas that working in frontier areas present. Limited by resources, bound by geography and distance, and confronted with issues that might seem tractable in more urbane environments, the awareness of a frontier counselor needs to be focused on many professional and ethical levels at any one time.

Define Clear Boundaries

Informed consent is paramount. Considering the potential for ethical violations in a frontier setting the counselor must clearly communicate to her or his clientele the parameters within which the counseling relationship can exist. This should include how the client wishes chance or social encounters with the counselor to be handled as well as how multiple relationships, to the extent that they can be pre-determined, should be addressed when they occur. In an environment where overlapping relationships are best viewed as a certainty the need for transparency in the client/counselor relationship is fundamental for a clinical relationship that can weather the ethical realities of frontier life.

The counselor also needs to consider her or his own professional boundaries and determine a level of comfort in regards to the potential ethical issues that shape frontier clinical practice. Clarifying one's own understanding of where boundaries of competence are can help the counselor determine when he or she is entering an area of uncertainty regarding providing services in which the counselor may not be fully conversant. In this regard the counselor also needs to come to terms with her or his own acceptable level of multiple relationships with clients. Understanding one's self-determined boundaries, be they ethical or personal, can help alert the counselor to behaviors that could lead to ethical violations.

Confidentiality. The counselor must communicate to the client the confidentiality issues that are common in frontier environments and establish an understanding of the counselor's ethical and legal obligations. Even when the client expects the counselor to share information about the client with other services or professionals in the area, it is the responsibility of the counselor to foster an understanding on the part of the client as to the extent and obligation of counselor/client confidentiality. As with other aspects of counseling, the frontier counselor should also be prepared to define their professional boundary of confidentiality when dealing with other professional services or agencies in the area. To the extent that they are able, it is a counselor's duty to protect their client's confidentiality, even in the face of a cultural value that shares information as part of communal survival.

Professional Awareness

The journey from analyzing ethical case studies in training situations to personal involvement in potential ethical violations can be very short for the new frontier counselor (Schank & Skovholt, 2006). Counselors new to the frontier

perspective need to find qualified supervision to help them establish their understanding of ethical decision-making in ethically challenging environments. This may include investigating state licensure regulations on distance supervision (via phone, Internet, etc.) to expand the supervision and mentorship possibilities. The counselor, new or experienced, should also strive to find supervision and peer-consultation that has experience in rural and frontier communities to better support an informed awareness of the necessities and realities of frontier life.

"Acts of everyday living are self-disclosures" (Schank et al., 2010, p. 503) and the frontier counselor needs to be aware of their behavior on professional, social, and personal levels. As so much of frontier counseling is inter-relational this self-attention is significant as it can help foster an awareness of the ethical aspects of many facets of frontier counseling practices and alert the counselor to potential ethical concerns in the making. When concerns are identified it is then incumbent on the counselor to determine the nature and extent of the issue and take action when necessary. The nature of that action is dependent on the role the counselor has created for themselves in the community, the needs of the client and the community and the potential actions that can be taken within cultural and ethical guidelines.

Cultural Awareness

With their own traditions and attitudes frontier communities are very much their own small community cultures with self-determined ways of behaving and interrelating. For the frontier counselor to be accepted into the community it is necessary for the counselor to understand the values the community is built upon and work to honor and foster those values through professional practices. While many of the cultural behaviors of a frontier community may seem at odds with professional counseling ethical practices, a merging of the two is possible with vigilance and understanding. It is not for the counselor to enter a frontier community and require that they follow a professional ethic designed on a divergent cultural model by a dissimilar people; rather, it is for the counselor to appreciate that an ethical code is based on accepted cultural and behavior ideals and that it is the counselor's obligation to serve those ideals within the boundaries of accepted professional codes of ethics. Understanding the community needs and values in terms of desired ideals and expected behaviors will help the counselor to better become a part of, and serve the community as an involved and invested member.

Future Investigation Directions for Frontier Ethics

As the work of rural and frontier counselors impacts a significant percentage of the U.S. population and that population experiences a higher lack of mental health provisions than urban clients, it is in our best interest to better understand the needs and practices of rural and frontier counselors so that we can then provide better services to rural and frontier communities. Primarily, research needs to explore the practices of small community, rural, and frontier counselors which should include case studies of how clinicians approach and handle clinical issues. This investigation into counselor practices needs to focus on the ethical decision-making processes that counselors employ when managing the ethical concerns that are prevalent in these communities. It also needs to analyze the products of these processes in light of the professional counseling code of ethics to better determine at what level, if at all, rural and frontier counselors are experiencing ethical crossings or violations in their professional practices. Next, we need to gain an understanding of the extent to which counselor educators recognize and understand small community settings and their effect on counseling in such areas. This would include the training that may exist in counselor education regarding the preparation of counselors to work with small community, rural, and frontier populations and should include counseling program curriculum, professional development courses and continuing education opportunities. Understanding what counselors are being taught in relation to these populations will help to determine if their training is adequate and appropriate to the needs of these communities.

Conclusion

This paper seeks to illustrate the point that the ambiguity that makes a code of ethics a flexible set of guidelines of professional behavior also creates difficulties when the situations they caution against are an inherent part of the social fabric of the world that the counselor works within, particularly that of a rural or frontier community. It is clear that many ethical issues cannot be avoided when working with frontier communities and must be integrated into professional

practice with due consideration. Counselors in these areas need to be conscientious in examining their relationships with clients and community members. This examination should lead to clear communication with clients on potential ethical issues and help define the roles and boundaries of the client and the counselor. It also requires the counselor to remain vigilant against potential boundary violations and to take action whenever an issue arises (Helbok, 2003; Kitchner, 1988; Remley & Herlihy, 2009).

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