Smaller Is Not Always Simpler

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People are complex, and therapists find themselves directly in the midst of that chaos. While the media focuses on the difficulties of urban areas, therapists in rural areas may actually face more frequent ethical dilemmas and simultaneously have fewer resources to offer their clients. One of the most common and trickiest ethical quandaries that therapists in rural areas must navigate is the problem of dual relationships. The average person in rural communities knows a much greater percentage of the total population of the area than the average person in an urban setting. It is no surprise then, that therapists are likely to have contact with past, present, or potential clients in contexts other than their office. The scope of the dual relationship problem broadens when one more accurately includes not just the client but the client's close family and friends.

The easy response to dual relationships is to simply make referrals elsewhere; however, the smaller the community, the fewer the referral options. When one factors additional restrictions such as the client's insurance or financial limitations, scheduling concerns, entry requirements, and waiting lists, there are frequently no viable options left. The challenge further increases for families who have been "in the system" (social service agencies, healthcare professionals, government assistance programs, and religiously-affiliated organizations) for a couple of generations. These families have exhausted the limited resources already to the point that later generations may suffer under the weight of the negative label of their family ties. Working in a rural community, comments like, "Oh, great, another Smith – as if we didn't have enough going on already!" are frequently heard, even when that particular client is new. Thus, the gold standard of referring out is often not available.

Following are suggestions that improve chances of successfully navigating the unique difficulties of providing therapy in rural settings. Since referral sources are limited, treatment providers simply must make full use of professional networking opportunities. This includes events like regional meetings of professional associations (even those that are not the provider's specific area of expertise but are clearly related), continuing education workshops, serving on multi-disciplinary committees, and online networking sites such as LinkedIn, the local Chamber of Commerce or Small Business

Development, and specific problem focus groups like suicide prevention or substance abuse awareness. Therapists should actively build strong relationships with anyone who could potentially open referral doors for their clients.

Another important tool for therapists in these communities is the power of asking for what is needed. Resources like transportation, phone cards, or co-pay assistance often can be found if one will simply ask diligently until the need is met. This sometimes allows obstacles of referral options to be overcome. Therapists in rural settings must ask for help in another key way. They must have at least one peer (but two to three would be helpful) with whom they can regularly consult for peer supervision. An external professional perspective can help therapists unravel the ethical dilemmas as they start, so that the therapist makes the appropriate decision from the beginning and then carries that out consistently. The peer consultation provides new eyes looking for potential conflicts but also a resource for alternative options.

Finally, therapists in these settings must be especially diligent about ensuring their own healthy boundaries between their professional work and their personal lives. When approached in a professional capacity in what the therapist has defined as a personal setting, it is necessary to respectfully acknowledge a person's concerns and quickly redirect them to calling about it during office hours. Therapeutic rapport must be maintained or developed, but personal sanity cannot be ignored lest that becomes professional burnout. However, integrity is an equally vital aspect of the constant balance of healthy boundaries. Even in one's personal life, therapists should live out their professional ethical codes by doing no harm, being honest and fair, treating others with respect and dignity, and having only appropriate intimate relationships. While this is not unique to a rural setting, integrity failures are particularly magnified in smaller towns because there are greater chances of those flaws being exposed, and then the ripple effect of consequences is amplified.

I have personally experienced these complexities. One of the most difficult occurred when I inadvertently discovered that a current client was the birth parent of a child I taught in an extracurricular activity. My client had, several years ago, surrendered parental rights to an aunt and uncle because both biological parents were active substance abusers at that time. At my point of discovery, I had ongoing relationships with the child,

the child's legal guardian, and the child's biological parent. My client still had limited contact with the child through supervised visitation, so I fully discussed the dual relationship concerns in a therapy session. Everything seemed settled – until my client unexpectedly brought the child to a family event hosted by our agency held during a supervised visit. Then, the guardian became very angry that I had not asked her permission prior to allowing the child to attend, which of course I could not have done anyway because of confidentiality requirements. The guardian proceeded to alternately try to discuss my client's "terrible behavior" with me or to ask me for information or my opinion of my client at the extracurricular events. She eventually removed the child from the activity altogether. She said that she was afraid it would "confuse" the child to see me "condoning" the biological parent's behavior. My client became frustrated that yet again the child was being hurt because of past decisions made during active addiction. Due to the size of our community, no referral options were available for my client. We were able to process the frustration and regain appropriate therapeutic rapport, but only after a setback that had much more to do with the dual relationship issues of a small town than direct therapeutic problems. Another example occurred when a client left a gift at a wedding shower hosted by my church, which my client found out about from relatives who attend the same church. The client had largely resolved her therapeutic issues a few months prior, so we had tapered towards termination, but at our last visit, she still left the option open to return as necessary. In this case, I consulted with professional peers to sort out the pertinent ethical issues and decide on the most appropriate course of action. Finally, I have experienced numerous instances in which someone will call my personal phone number to discuss therapeutic issues, even though I do not give my personal phone number to clients. The explanation typically given is that someone I know in another context gave them the number. This has happened often enough that if a friend or acquaintance tells me that he is referring a new client to me, I give them a card and explicitly tell them to have the person call this number and ask them not to give out my personal phone number. When it does occur, I have to delicately, gently ask the person in the future to please call my business number for concerns of this nature.