# Ethics Issues and Training Needs of Mental Health Practitioners in a Rural Setting

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## Abstract

Through an exploratory survey of a representative sample (n = 316) of licensed and certified counseling and social work mental health professionals (N = 1,324) in one rural state, ethical issues and training needs were identified by the providers. The intended goal was to obtain direct feedback about ethical issues and ethical training needs from practitioners themselves who work in rural settings. Results identified three primary ethical issues: dual relationships, confidentiality, and competence; and three primary ethical training needs: boundaries, state rules and regulations, and supervision. The discussion examines in more detail the ethical issues and trainings needs and provides some recommendations for further research and investigation.

*Keywords*: social work practice, ethical dilemmas, ethics, continued education, rural practice

## 1. Introduction

Individuals enter the mental health counseling profession with a desire to help others (Jennings, Sovereign, Bottorff, Mussell, & Vye, 2005; Rønnestad & Skovholt, 2003); however, ethical issues continually arise in this work. Research has addressed a diversity of ethical challenges in

mental health work such as boundaries, supervision, gift giving and receiving, termination of services, confidentiality, multicultural awareness, and practitioner wellness (Borders, 2005; Brown & Trangsrud, 2008; Carney & McCarren, 2012; Cummins, Massey, & Jones, 2007; Frame & Williams, 2005; Glosoff & Pate, 2002; Lawson, 2007; Moleski & Kiselica, 2005; Pope & Keith-Spiegel, 2008; Trimberger, 2012; Vasquez, Bingham, & Barnett, 2008). Even though there are numerous ethical quandaries faced by mental health professionals, this research endeavor was designed to hear from rural practitioners themselves about their ethical challenges and training needs.

### 1.1 Ethical Decision Making Errors

Practitioners are human and can make poor ethical decisions. Strom-Gottfried (2003) examined types of ethical complaints made against the ethical codes of the National Association of Social Workers (NASW). Of 267 adjudicated cases, 107 involved sexual activity, 77 involved dual relationships, 70 involved other boundary violations, 55 involved failure to seek supervision, 41 involved failure to use accepted practice skills, 34 involved fraudulent behavior, and 33 involved premature termination. Other types of errors identified were failure to maintain records, discuss informed consent, and make referrals. In a survey conducted to assess ethical misconduct in a national sample of graduates from counseling training programs, Trigg and Robinson (2013) found the most frequent ethical violations were "practicing outside of the scope of one's training and experience and practicing while impaired due to substance use or mental health matters" (p. 28), violations of professional boundaries (both nonsexual and sexual), and breaches of confidentiality. Rural settings provide unique opportunities and challenges in ethical dilemmas and decision making.

### 1.2 Ethical Dilemmas in Rural Settings

Ethical dilemmas are intensified in rural settings with issues such as dual relationships, multiple roles, unique community standards, isolation, and lack of access to training and supervision (Casemore, 2009; Erickson, 2001; Nickel, 2004; Phillips & Baker, 1983; Schank & Skovholt, 1997). Providers in rural settings are often given cases for which they are not prepared, lack adequate supervision, and are expected to carry full caseloads (Lawson & Venart, 2005). These challenges, coupled with feeling isolated in rural settings, can lead to increases in ethical dilemmas. Cellucci and Vik (2001) identified a greater percentage of substance abuse clients in rural as compared to urban areas and their study suggested additional training was needed for psychologists working with substance abuse in rural settings. In a qualitative study of 43 school counselors, Lehr, Lehr, and Sumarah (2007) identified problems in rural settings including role conflicts, inconsistencies, and idiosyncratic choices in such ethical practices as confidentiality and informed consent.

### 1.3 Resources for Practitioners

Even with ethical challenges, there are resources for practitioners to utilize to help reduce ethical violations. Three of these resources include ethical codes, licensing boards, and continued education.

**Codes of ethics.** Ethical codes can assist with ethical quandaries, protect consumers, and clarify the standards of professional organizations (American Counseling Association [ACA], 2005; Corey, Corey, & Callanan, 2007; NASW, 2008; Ponton & Duba, 2009; Trimberger, 2012). Codes of ethics are available as guides for navigating the diverse world of ethics and are continually updated to reflect changes in societal norms and knowledge (Kaplan, Wade, Conteh, & Martz, 2011; Kocet, 2006; Walden, Herlihy, & Ashton, 2003).

In 2008, NASW updated their ethical codes for social workers. The NASW's codes support the mission of the social work profession to enhance the well-being of all humans; particularly empowering those who are vulnerable, oppressed, and living in poverty. The 2008 NASW *Code of Ethics* recognizes the importance of responding to diverse clients and to a variety of therapeutic settings, as well as providing a set of values, principles, and guidelines to ethical decision making (NASW,

2008). For example, the *NASW Code of Ethics* (2008) section 1.05c states that:

> Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability. (p. 9)

**Licensing boards**. In addition to using the codes when encountering an ethical issue, practitioners can also access their state licensing boards and professional associations' ethics committees (Chauvin & Remley, 1996; Neukrug, Milliken, & Walden, 2001). Professional boards hold ethical violation hearings to address conflicts, hear complaints, and enforce infractions to protect the public (Corey et al., 2007; Strom-Gottfried, 2003; Welfel, 2005). Boards can provide ethical decision making consultation for practitioners. Resources such as codes, state boards, and professional organizations are important components in the ethical risk management toolbox for all practitioners (Wheeler & Bertram, 2012). In addition to consultation, practitioners need to use ~~an~~ informed consent, documentation, and supervision (Borders, 2005; Wheeler & Bertram, 2012). Ultimately, it is each provider's responsibility to stay informed and current on the ethical standards of care, best practices, and codes; in part, this responsibility can be addressed through continued education.

**Continuing education.** Continued education is designed to assist practitioners in learning about the changes in codes, as well as to address ethical struggles throughout the counseling process (DePauw, 1986). Educating practitioners about the many complexities in ethical practices helps them be better prepared to respond effectively to ethical dilemmas (Carney & McCarren, 2012; Corey, Corey, & Callanan, 2005). Education can enhance both cognitive functioning and moral reasoning in mental health professionals (Sias, Lambie, & Foster, 2006) and social-cognitive maturity has been found to be related to higher measures of legal and ethical knowledge (Lambie, Hagedorn, & Ieva, 2010). Even though ethical training does appear to enhance competencies in mental health practitioners, ethical training programs and methods are not consistent across or within disciplines (Hill, 2004; Urofsky & Sowa, 2004)

## 1.4 Ethical Errors and Real-World Practice

In spite of access to resources, practitioners can become habituated, unaware, and even burned out in the day-to-day practices of clinical work (Lawson & Venart, 2005). Wheeler and Bertram (2012) described two types of habituation: 1. being *bounded ethicality,* when decisions are made in a setting with limited data, and 2. having *ethical fading,* when everyday operational events such as assigning a diagnosis can blind a practitioner from awareness of ethical implications. Everyday practice may have a lack of safety for practitioners to honestly discuss personal needs and wants, thus they may feel afraid to openly talk (Flynn & Black, 2011; Nelson, Barnes, Evans, & Triggiano, 2008; Warren & Douglas, 2012). In daily practice, factors such as the providers' personal traits, the job duties, and the agency's culture can influence ethical decision-making (Trimberger, 2012). Providers can compromise their ethical rigor when faced with multi-faceted ethical dilemmas. Of 188 substance abuse practitioners, Sias (2009) found that moral reasoning level scores were significantly lower in personal, authentic, and/or real-life decisions, when compared to hypothetical ethical dilemmas.

Questionable ethical decisions may reflect unique rules of diverse settings, such as a rural community, and may not be well understood or communicated in the professional literature (Flynn & Black, 2011). However, committing an ethical error does not mean a practitioner is on an inevitable slippery slope to where he/she is doomed to make more errors. Instead, a practitioner may be making a decision seemingly appropriate for the situation (Gottlieb & Younggren, 2009). All work settings and

specializations present unique ethical challenges (Calley, 2009; Linton, 2012; Shallcross, 2012). When ethical dilemmas do occur, there are social norms, competing values, and contextual conditions to consider such as the client's well-being, unique legal mandates, moral values, community standards, economic considerations, and business survival (Calley, 2009; Flynn & Black, 2011; Foster & Black, 2007; Guterman & Rudes, 2008). These competing priorities are exacerbated in rural settings by demands such as large caseloads, managed care, and on-call expectations (Lawson & Venart, 2005). Thus, the current researchers seek to better understand ethical issues and ~~ethics~~ ethical training needs within a rural setting.

## 2. Purpose of the Study

The purpose of this exploratory study was to identify self-reported ethical challenges and ethical training needs of a sample of clinical practitioners who were licensed or certified under the same board in one rural state. The licensing board was a composite board combining both counseling and social work mental health professionals and substance abuse providers.

## 3. Methodology

The two research authors who created the surveys and categories, have practiced in rural mental health settings for 23 years and 10 years, respectively. They relied on their experience in counseling in rural areas to create a simple survey seeking information about the challenges practitioners face. The survey was mailed to every fully licensed or certified mental health and social work practitioner in the state at the time of the study, which included a total of 1,324 professionals.

The entire state was considered "rural/frontier" except for two counties. More specifically, 74% of the counties had fewer than six residents per square mile and therefore, by definition, were considered "frontier" at the time of this study. An additional factor important for understanding the unique aspects of this setting was that the entire state was designated as a shortage area for mental health care; consequently, both counselors and social workers provided similar mental health services and were both overseen by the same licensing board (Wyoming Department of Health-Office of Rural and Frontier Health Division, *n.d.*).

Although there are differing rules and regulations across states regarding ethics training requirements for counseling professionals (Wheeler & Bertram, 2012), the state in which this study occurred aligned its licensing and certification requirements with national standards through its work with the American Association of State Counseling Boards (AASCB) (2012). Participants who were licensed were required to meet the minimum of a master's degree level of education, supervised experience, and examination requirements, which allowed them to provide independent practice. The licensed professionals included: Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Addictions Therapist (LAT). Participants who were certified were required to obtain a bachelor's degree or bachelor's degree equivalent and were allowed to provide services only under clinical supervision of a qualified licensed professional. The certified professionals included: Certified Addictions Practitioner (CAP), Certified Social Worker (CSW), Certified Mental Health Worker (CMHW), and Certified Addictions Practitioner Assistant (CAPA). At the time of this study, all licensed and certified professionals were regulated by the same board, must have renewed their credentials every two years, and were required to complete at least three contact hours of continuing education in professional ethics every two years.

The procedures for the study were approved by the university's Institutional Review Board. One mailing of the survey was sent to every counselor and social worker licensed or certified by the state (N = 1,324); this included an introductory letter with an explanation of the

study, an informed consent statement, the survey, and a stamped and addressed return envelope. There were no incentives offered to participate in the study. The participants were asked to complete a brief demographic questionnaire and respond to two questions:

1. The most difficult professional ethical dilemma or situation I have encountered in the last two years has been:______
2. Two primary ethical trainings I would find to be most helpful in my practice are: *self-care, boundaries, rules and regulations, malpractice, supervision, professional competency, risk management, end of life, suicide, duty to warn, confidentiality, diagnosis, spirituality, multicultural topics,* and *other*.`

Although this was an exploratory study, the survey responses were analyzed with IBM SPSS version 19 to determine the descriptive statistics, frequencies, and relationships.

## 4. Results

There were 1,324 surveys mailed with approximately 155 returned non-deliverable. Of the remaining 1,169 mental health providers presumed to be contacted by mail, 316 (27%) responded to the survey. Because the response rate was significant, a non-response bias was not considered to be a significant limitation of the survey results (Alreck & Settle, 2004). Mail was used in lieu of e-mail to personalize the survey and because access to email is not consistently available in some rural areas. According to the original data provided by the board, distribution results of the survey sample (see Table 1) closely approximated the current distribution of licensing and certification in the state; thus, this was considered a representative sample.

**Table 1:** ***Demographic Information***

| Demographic | Number reporting | Percent of total |
|---|---|---|
| ***Gender*** | | |
| Male | 87 | 27.5% |
| Female | 229 | 72.5% |
| ***Race/ethnicity*** | | |
| Caucasian | 294 | 93% |
| African American | 0 | 0% |
| Hispanic | 3 | 1% |
| Native American | 4 | 1% |
| Biracial | 3 | 1% |
| Other/no response | 12 | 4% |
| ***Years of Practice*** | M = 12.49 | SD 8.8 |
| ***Licensing Breakdown*** | | |
| MSW | 93 | 29% |
| LPC | 148 | 47% |
| LAT | 10 | 3% |
| LMFT | 14 | 4% |
| CMHW | 10 | 3% |
| CAP | 8 | 3% |
| Multiple Licenses/other | 33 | 10% |

**Table 1: *Demographic Information, continued***

| Demographic | Number reporting | Percent of total |
|---|---|---|
| ***Place of Service*** | | |
| Community agency | 98 | 31% |
| School | 44 | 14% |
| Private | 60 | 19% |
| Hospital | 23 | 7% |
| Residential | 19 | 6% |
| Other<br>Multiple Settings | 35<br>37 | 11%<br>12% |

*Note.* Based on a sample of n = 316. MSW-Masters in Social Work, LPC-Licensed Professional Counselor, LAT-Licensed Addictions Counselor, LMFT-Licensed Marriage and Family Counselor, CMHW-Certified Mental Health Worker, CAP-Certified Addictions Professional

## 5. Ethical Issues

The survey began with open-ended questions intended to identify two ethical issues experienced by the participants in the previous two years. Most participants responded with two or three words; a few responded with lengthier responses describing the ethical issues they had faced. Two of the research authors analyzed each of the 316 surveys and developed categories and coding rules for the responses (Popping, 2010). The researchers followed the procedure described by List (2003), in which the raters spent sufficient time together to sort out problems and come to an agreement on the meaning of the open-ended responses. Fourteen categories were identified: isolation, caseload, burnout, impairment, supervision, confidentiality, dual relationships, competence, diagnosis, peer impairment, professional silence, duty to warn, suicide, and mandatory reporting. Thus, every response was coded into one of the categories and there were no other possibilities mentioned in the first question response. A third rater, who was trained in the meanings of the categories, independently rated half of the surveys in order to substantiate inter-rater reliability (Johnson & Christensen, 2012). The correlation between raters was .78 and the ratings were deemed reliable. There were a limited number of stories and comments provided by the respondents.

The top three issues identified by the first question (see Table 2) were *dual relationships* (19%), *competence* (19%), and *confidentiality* (17%). Concerning dual relationships, one respondent said, "Seeing clients in a small town [is a difficult ethical challenge because it is] where I also have to do business with the same people. No other choices." Two additional findings regarding ethical dilemmas encountered were *professional silence* and *supervision* representing 10% and 9%, respectively. Professional silence refers to the fear of discussion of ethical issues in oneself or others. Binomial tests for categorical variables were run to compare the number of mentions of ethical dilemmas to the expected number, given all possibilities were equal. In a one-sample binomial test, *dual relationships* ($z = 11.46$, $p<0.0001$), *competence* ($z = 10.92$, $p<0.0001$), *confidentiality* ($z = 9.84$, $p<0.0001$), *professional silence* ($z = 3.37$, $p = 0.0004$), and *supervision* ($z = 2.47$, $p = 0.0068$) were significantly higher than the expected value. The supervision variable included one notable comment identifying a difficulty with "a counseling supervisee with a substance problem and a mood disorder that was severe."

**Table 2:** ***Self-Identified Ethical Issues***

| Issue | Number reporting | Percent of total |
|---|---|---|
| Dual relationships | 99 | 19% |
| Professional competency | 96 | 19% |
| Confidentiality issues | 90 | 17% |
| Professional silence | 54 | 10% |
| Supervision | 49 | 9% |
| Duty to warn issues | 30 | 6% |
| Peer impairment | 29 | 5% |
| Mandatory reporting | 27 | 5% |
| Isolation | 22 | 4% |
| Suicide issues | 19 | 4% |
| Impairment | 16 | 3% |
| Diagnosis issues | 14 | 3% |
| Caseload | 10 | 2% |
| Burn out | 6 | 1% |

*Note.* Based on a sample of n = 316 who identified one or more most difficult professional ethical dilemmas or situation issues. There were 531 identifications in the responses.

## 6. Ethical Training Needs

The second item asked the participants to select two ethical trainings from a pre-determined list of 15 options, which they considered might be most helpful for their practice. These were ranked by frequencies of responses. Although the respondents were asked to choose two trainings, 40 of the respondents chose more than two, with one respondent checking all of the training topics that were listed. The top three ethics trainings selected were *boundaries* (12%), *rules and regulations* (12%), and *supervision* (10%). One respondent stated, "I think in our state it is more difficult to maintain professional boundaries because of the closeness of our communities. For instance, in my neighborhood I am surrounded by former clients as neighbors." In a one-sample binomial test, *boundaries* ($z = 5.85$, $p<0.0001$), *rules and regulations* ($z = 5.06$, $p<0.0001$), and *supervision* ($z = 3.17$, $p = 0.0008$) were found to be highly significant; the percentages of these options were much higher than would be expected if all trainings were equally valued. In addition, there were four issues that were second-place in percentages, including *professional competency* ($z = 1.91$, $p = 0.0281$), *self-care* ($z = 1.75$, $p = 0.0401$), *duty to warn* (not significant), and *risk management* (not significant), and each issue representing about 8% (see Table 3). Self-care was particularly concerning to one respondent who indicated, "Burn out and quality treatment" need to be addressed.

**Table 3:** ***Self-Identified Ethical Training Needs***

| Issue | Number reporting | Percent of total |
|---|---|---|
| Boundaries | 85 | 12% |
| Rules/Regulations | 80 | 12% |
| Supervision issues | 68 | 10% |
| Professional competency | 60 | 8% |
| Self-care | 59 | 8% |
| Duty to warn issues | 57 | 8% |

**Table 3: *Self-Identified Ethical Training Needs, continued***

| Issue | Number reporting | Percent of total |
|---|---|---|
| Risk management | 57 | 8% |
| Confidentiality issues | 50 | 7% |
| Diagnosis | 43 | 6% |
| Spirituality | 35 | 5% |
| Malpractice | 34 | 5% |
| Suicide issues | 33 | 5% |
| End of life | 26 | 4% |
| Multicultural topics | 19 | 3% |

*Note.* Based on a sample of n = 316 who identified their top two needs for training. There were 710 training needs identified in the responses.

Statistical analysis was used to look for relationships between demographics, issues, and training needs in order to identify if there might be any tentative connections. Because these were categorical responses, chi square analysis was used to look for significance. When ethical issues and training needs were analyzed together with Pearson chi-squared analysis, a few significant relationships were found. These findings were not the primary focus of the study; however, they are included to add additional perspectives. Fifty-two percent of those who indicated that *dual relationships* were an ethical issue chose *boundaries* training ($\chi^2$ (1) = 22.57, p< .0005). For example, one respondent reported problems with "reporting unethical conduct by my spouse" as an example of the difficulty with boundaries. Forty five per cent of those who reported professional *competency* as an ethical issue requested *competency* training ($\chi^2$ (1) = 7.49, p = .006). Additionally, there was a significant correlation between the issue of boundaries and the issue of self-care ($\phi$ =.15, p =.008), indicating a small relationship.

Based on the demographics, using frequency and chi-square analysis, some statistical relationships were found in the desired trainings and demographics, including years of licensing and practice and type of credential. Regarding years licensed, 22% of those licensed less than 10 years requested training in *self-care* and 16% of those licensed more than 10 years chose *self-care*. Those who had been licensed longer were more likely to request *duty to warn* (19%) and *risk management* (22%) training than those licensed less than 10 years (17% and 19%, respectively). The difference in *risk management* among different years of licensing was found to be statistically significant ($\chi^2$ (1) = 6.00, p = .049) with the Pearson chi-square test of independence. Those who have been licensed longer listed *risk management* training more frequently than those who were more newly licensed. Likewise, *malpractice training* was strongly indicated by those who have been serving for more years ($\chi^2$(1) = 8.76, p = .003, odds ratio = .069); for every additional year of practice, the odds of a counselor requesting *malpractice training* goes up by 7%. On the other hand, for every year of service, the odds of a request for *confidentiality training* decreased by 5% ($\chi^2$ (1) = 6.51, p = .011, odds ratio = -.046). Licensing area also showed that addictions specialists were more likely to indicate a preference for *self-care* training; indeed, the results of Pearson chi-square ($\chi^2$ (6) = 20.76, p = .002) indicated that the choice of *self-care* training was dependent on the licensing area. Training responses were tallied in demographic groups and analyzed with Pearson chi-square analysis. Gender was found to be independent of the top five training preferences, meaning there was no relationship between genders and training requests. Ethnicity was not tested due to

the limited numbers of practitioners who were not Caucasian. Finally, the results showed no significant relationships between the setting of services and choices of training.

## 7. Discussion

This study provides a descriptive picture of self-reported ethical situations and the desired ethical trainings from a representative sample of mental health and substance abuse practitioners, licensed or certified, under one board in one rural state. There were three notable self-reported ethical issues: *dual relationships*, *competence*, and *confidentiality* (see Table 2). Overall, the findings closely reflect the findings of both Strom-Gottfried (2003) and Trigg and Robinson (2013), where practitioners and/or boards reported ethical violations in competence (including impairment and using accepted practice skills), boundaries (dual relationships), and confidentiality. The results from our study also reflect research findings on ethical issues faced by counseling practitioners in both specialty practices and rural settings where dual relationships, confidentiality, and competence are identified (Cellucci & Vik, 2001; Erickson, 2001; Lehr et al., 2007; Nickel, 2004).

Dual relationships and boundary issues are complex, and permeate the social work and counseling professions (Nickel, 2004; Pope & Keith-Spiegel, 2008; Strom-Gottfried, 2003; Trimberger, 2012). There are many issues around boundaries in rural practices such as responding to crisis referral and discovering the client is an acquaintance, being a community soccer coach with some players being clients, or being a member of an agency board and some of the clients use the service. Rural professionals need to carefully include boundary delineations in their informed consents, identify strategies to avoid boundary crossings when possible, and include boundary issues in supervision and consultation work (Pope & Keith-Spiegel, 2008).

In general, research demonstrates that competency and confidentiality are fairly common ethical challenges (Lehr et al., 2007; Wheeler & Bertram, 2012); our study is consistent with these findings. Particularly in rural settings, practitioners are required to work in areas in which they have not been trained due to a shortage of both workforce and relevant training opportunities. The first author remembers practice in a rural setting during one day in which the client load included a truant teenager, a schizophrenic adult, an emergency suicide attempt, a sex offender, and a young adult who had been sexually abused. The issue of competence to respond effectively to these diverse client issues was an ethical wonderment; yet, the requirement to work with diverse issues is a reality in rural settings.

In addition, issues of confidentially in rural settings can be difficult due to the challenges of boundaries and low workforce. For example, an individual may work as a counselor on Friday; however, on Saturday this same person may be coaching a football team with a child who is a client. Confidentiality must be maintained but can be difficult in such situations. Another example can occur, when the teacher of a small rural school informally asks the counselor how a particular student is doing, yet the counselor cannot respond. Sometimes a low workforce means providers serve in several roles, such as a practitioner teaching part-time, thus confidentiality is a constant ethical standard that is tested.

Although *professional silence* and *supervision* represented a smaller number of ethical problems identified, they were ranked in the top five issues (see Table 2). Professional silence could be similar to "professional mistrust" (p. 466) as reported by Flynn and Black (2001) in their qualitative survey of 25 counseling professionals. Professional silence can result from fear and shame and lead to an absence of dialogue; thus, silence can unwittingly contribute to unintended ethical infractions that may be avoided if discussed (Warren & Douglas, 2012; Welfel, 2005). It would be helpful to explore and define what professional silence means for the participants. In a similar manner, it would be interesting to identify if professional silence is addressed in supervision. Do counselors

openly dialogue with their supervisors about their ethical dilemmas? How might the supervisory relationship address professional silence? Supervision can be a challenge for ethical practice in rural settings due to a lack of available resources (Erickson, 2001); however, supervision is critical for ethical practice at any stage of practitioner development (Borders, 2005; Lawson & Venart, 2005; Nelson et al., 2008; Rønnestad & Skovholt, 2003; Wheeler & Bertram, 2012).

The results of this study suggest that rural mental health and substance abuse providers identify *dual relationships*, *competence*, *confidentiality*, *professional silence*, and *supervision* as primary ethical issues they faced in the previous two years. Based on these results, *all* five areas may need to be infused into rural based ethical training and supervision. In addition, through validating these challenges, rural providers may be more open to recognize these ethical issues as problems and proactively enhance dialogue, compassion, supervision, and relevant ethical training (Warren & Douglas, 2012; Welfel, 2005).

The most notable ethics trainings selected by rural mental health and substance abuse providers were *boundaries*, *state rules and regulations*, and *supervision* (see Table 3). Boundaries are often identified as ethical challenges (Moleski & Kiselica, 2005; Nickel, 2004; Strom-Gottfried, 2003; Trimberger, 2012). The fact that boundaries were identified as a training need is supported in the research on boundary problems in counseling situations (Carney & McCarren, 2012; Moleski & Kiselica, 2005; Nickel, 2004; Pope & Keith-Spiegel, 2008; Trigg & Robinson, 2013; Trimberger, 2012). Shank and Skovholt (1997) reported that psychotherapists knew applicable ethics codes; however, they were unsure of how to apply these codes within the rural environment. Specifically, several participants described attending worship services with clients, which can result in dual relationships. Because there were some apparent relationships between ethical issues and training needs, these results may suggest that providers do proactively recognize ethical challenges and prevention is possible (Welfel, 2005). Ethical challenges do not have to be a predestined slippery slope (Gottlieb & Younggren, 2009); instead, they can inform training needs.

There were additional and speculative observations from our survey results. Respondents who had been in practice for less than 10 years more often requested training in *self-care, boundaries*, and *confidentiality*. Perhaps this reflects a type of self-interest (Flynn & Black, 2011) which may be more evident in newer practitioners. The complexities of confidentiality (Glosoff & Pate, 2002; Lehr et al., 2007) may be more confounding for newer practitioners. In this study, practitioners who had been licensed for a longer time period (more than 10 years), listed *risk management* and *malpractice* training more frequently. Perhaps years of practice bring forward complexities in counseling such as changes in state rules, duty to warn, and risk management. Prolific experience as a practitioner undoubtedly brings forth challenging cases where training in *risk management* and *malpractice* could be useful at addressing precarious or dangerous situations. Longer term practitioners can become lax and thus be more vulnerable to making ethical errors (Jennings et al., 2005).

To interpret the meaning of the finding that as length of service increased, the desire for *malpractice* training increased, and *confidentiality* decreased is speculative. Researchers will want to conduct more detailed interviews in order to identify the meanings of practitioners of all levels of experience. Although research suggests that longer-term practitioners may be more vulnerable to ethical infractions than those newer to the field (Jennings et al., 2005), perhaps those who have extensive field experience may recognize how practice-related issues are constantly changing and updates in rules and risk management procedures are needed.

Another speculative finding is that training programs need to consider specializations and years in practice when designing training. Although this study found no significant results regarding the employment setting and gender of

respondents being related to their training needs; findings did indicate that there was preference for *self-care* training among addictions professionals. Perhaps this finding reflects some of the difficult issues faced by professionals working in addictions (Cellucci & Vik, 2001). Training needs to reflect specialized needs.

Although survey results can inform researchers of where research is needed, the absence of information can also be informative. The request for training in *multicultural topics* was the lowest requested priority. This area of awareness could be a missing part of ethics training and/or awareness in this rural state; and could be related to the lack of ethnic diversity that may be represented in some rural/frontier states. Though the representation of ethnic diversity may be lacking in many rural states, the lived experiences of people of diversity reflects marginalization. That is, persons of different color, race, ethnicity, religion, sexual orientation, disability status, etc., may remain unrecognized, thus disempowered to address issues that are paramount to their well-being and personhood. Diversity in ethics is infused throughout providers' codes (Kocet, 2006: NASW, 2008) and is an important part of ethical competencies (Frame & Williams, 2005); however, multiculturalism was not identified in this study as a training priority. Possibly, multicultural awareness and competency is lacking in some rural settings.

## 8. Limitations

There are limitations in this study. The endeavor was exploratory and intended to set the stage for further research. The survey included only two questions: one was open-ended and the other incorporated a selection bank, which creates more room for interpretation error. Results may only be applicable to rural settings; they may be biased due to self-reporting, social desirability and possible researcher bias; and there were limited numbers of minorities in the state. Without further feedback, to understand the wording used, such as professional silence and multicultural, the findings can only be speculative. This, of course, is true for the other self-identified ethical issues that are discussed.

## 9. Implications and Future Research

The significant positive relationship found between training in *boundaries* and *self-care* could reflect the importance of counselor wellness (Lawson, 2007; Lawson & Venart, 2005), and may suggest that wellness is related to boundary problems. A future study could explore how ethical practices, such as maintaining ~~healthy~~ wellness could influence boundary decision making in rural communities. Further, identification of ethical practices that positively influence the experience of wellness could lead to the creation of helpful continuing education training for those practicing within rural environments.

The fact that some longer-serving respondents in our study requested less training in *boundaries* and *self-care* and more in *state rules, duty to warn*, and *risk management*, could reflect the importance of offering training ~~fitting~~ that corresponds to the stages and needs of any professional (Jennings et al., 2005; Rønnestad & Skovholt, 2003). The *supervision* training request may suggest that additional supervision and supervision competency are important ethical needs for counselors in rural settings. Competence in supervision is critical for the wellness of counseling professionals (Borders, 2005). Future qualitative analyses could help clarify what specific supervision training is desired of participants.

Another observation from the findings is that providers identified *competence* as an ethical issue and *supervision* as a desired ethical training. A potential area of research could investigate more in detail to identify the areas of practice in which counseling practitioners need additional training. For example, these results reflect those of Cellucci and Vik (2001) who reported that rural psychologists believed their graduate training was inadequate for substance abuse work.

Future researchers would do well to examine issues of diversity training within the rural setting. The areas of multicultural competencies need to be further investigated in rural settings given that many clients, such as clients of color, the gay and lesbian population, and other minority groups, will seek services in rural settings. These clients

may encounter discrimination if additional training and awareness are not provided. Perhaps, qualitative interviews that explore practitioners' level of comfort and confidence in knowledge when working with minority clients would allow researchers to better understand the specific diversity training needs.

Additional research is needed to more clearly identify issues and needs in rural settings for counselors. It is important to replicate this study in other states. Perhaps a more standardized survey like the Ethical and Legal Issues in Counseling Questionnaire (ELICQ) developed by Lambie et al. (2010) could add a more rigorous quantitative measure. The ELICQ is a 50-item multiple choice instrument designed to measure ethical and legal knowledge (Lambie et al., 2010). As mentioned earlier, narrative feedback from practitioners can add depth to the findings. Given that "Thank you!" was written at the end of many of the survey pages may suggest that providers appreciated the opportunity to share concerns about ethical issues and training needs.

One last thought is that this study may lead to discussions about how to best provide ethics education in social work and counseling related training programs, especially, with practitioners who intend to work within the rural setting after graduation. It might be helpful to consider infusing ethics education throughout the curriculum, rather than having a stand-alone ethics course. The NASW *Code of Ethics* does not directly mention how to teach ethics education within a social work program, but the *Code of Ethics* does set guidelines for how a social work educator should interact with students (NASW, 2008). Because there is not consistency in ethics education there is an ongoing debate in the counseling literature as to *how* to provide the most effective ethics education (infused/separate class, etc.) (Hill, 2004; Urofsky & Sowa, 2004). Further research in ethics education may enhance how to create consistency and best-practice ethics education to both students and practitioners. Possibly an exploratory survey of how ethics education is currently provided across social work and counseling related training programs could be a starting point.

## 10. Conclusion

This inquiry into what rural practitioners face ethically and need professionally might serve as a guide to select meaningful counseling ethics education for licensing boards and mental health professionals, as well as inspire future ethics studies. It is important to obtain direct feedback about what happens in practice within small-town settings. Research shows that rural providers are challenged with ethical dilemmas which may be distinct from issues more prevalent in urban areas (Casemore, 2009; Schank & Skovholt, 1997; Phillips & Baker, 1983). The results of this study may contribute to the enhancement of ethics training, provide insight into rural issues, and give voice to mental health and substance abuse providers in one state. This study may lead to discussions about how best to provide continuing education to rural practitioners. A preventative training approach may contribute to reductions in ethical errors and increase professionals' trust and dialogue (Warren & Douglas, 2012). Studies which encourage providers to share ethical issues need to be ongoing, and results need to create training and offer support for those who work in rural settings.

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