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Rural psychologists' responses to multiple-role relationship ethical dilemmas and their perceptions of job burnout

by

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A dissertation submitted to the graduate faculty

in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Major: Psychology (Counseling Psychology)

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2007

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ABSTRACT

A national study of doctoral-level, licensed psychologists practicing in rural settings was conducted. The study had three main objectives: to assess the degree of challenge and trouble associated with variations in timing and type of unavoidable, multiple-role relationship dilemmas and the likelihood of engaging in therapy; to measure job burnout among a national sample of licensed, doctoral-level psychologists practicing in rural settings; and to examine potential predictors of job burnout. One hundred sixty participants completed and returned surveys yielding a 44% return rate. The survey consisted of three parts: a 14-item demographics section, seven items corresponding to one of six multiple-role relationship (MRR) ethical dilemma situations (vignette), and the 22-item Maslach's Burnout Inventory-Human Services Survey (MBI-HSS). Six ethical dilemma situations were included in this study to allow for the manipulation of the timing (pre, concurrent, and post) and type (professional and social) of the MRR.

Rural psychologists reported that the concurrent ethical dilemma situation was less troubling, in terms of therapist resources, than both the pre- and post-MRR dilemmas. The results also indicated that rural psychologists perceive professional MRR ethical dilemmas as more challenging and more troubling, in terms of out-of-therapy variables, than the social MRRs. In addition, negative correlations were found between the respondents' likelihood of engaging in (or continuing) a therapeutic relationship and the level of challenge and trouble reported in the given situations.

A comparison was made between the job burnout scores reported by this study's sample of respondents and those scores obtained by MBI-HSS normative sample of mental

health practitioners. This national sample of rural psychologists reported less job burnout than what was reported by the normative sample. The relationship between levels of burnout and the following variables were also examined: (1) frequency of experiencing multiple-role relationship dilemmas, (2) degree of challenge or intensity of usual multiple-role dilemmas, (3) accessibility of a referral source, (4) adequacy of opportunities for consultation, and (5) adequacy of opportunities for supervision. Frequency of multiple-role relationships, accessibility of referral sources, and adequacy of opportunities for consultation were found to be significant predictors of job burnout.

INTRODUCTION

Ethical thinking is not a matter of black and white categorization, but by definition is normative, rather than factual, in nature (Gladding et al., 2001, p. 3). Professional codes of ethics are meant to enhance, inform, expand, and improve members of the profession's ability to serve as effectively as possible those clients seeking their help (Zibert et al., 1998). However, most ethical codes are written ambiguously so that they are applicable across many diverse situations, thus opening the door for misinterpretation and ethical dilemma situations.

The most recent version of the American Psychological Association (APA, 2002) ethics document, "The Ethical Principles of Psychologists and Code of Conduct," reflects this ambiguity. It specifies that not all multiple-role relationships are unethical; yet states that psychologists should refrain from entering into multiple relationships that could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in working with the client, or that present a risk of exploitation or harm to the client. While multiple relationships that would not reasonably be expected to impair the psychologist's objectivity, competence, effectiveness or otherwise risk exploitation or harm are not unethical (APA, 2002), what constitutes these situations is not well-described.

The Ethics Code (2002) further suggests that the psychologist should take reasonable steps to resolve the situation if a potentially harmful multiple-relationship arises, but does not offer specific steps for resolution. The therapist is often left to his or her own professional judgment as to what the most ethical choice may be and what steps may be reasonable to resolve the dilemma.

At the present time, it is still unclear what rural psychologists find most troubling about multiple-role dilemmas and whether or not these challenges affect the psychologist's

decision to enter into or continue a therapeutic relationship that involves a dual-role with the client. Further, it is unknown whether aspects of multiple-role dilemmas are associated with job burnout. While both multiple-relationship dilemmas (Perkins et al., 1998) and burnout (Kee et al., 2002) have been shown to be prevalent among rural mental health practitioners, to date, no studies have examined these two constructs in the same study. Given the well-documented, negative consequences of job burnout, it is paramount for the rural psychologist to gain a better understanding of this construct. This is particularly important since the Code of Ethics (2002) expects psychologists to be aware of and manage factors that negatively influence their professional effectiveness (APA, 2002).

Rural Mental Health Practitioners

Research has shown that the delivery of mental health services in rural communities is frequently plagued with unique ethical challenges (Schank & Skovholt, 1997). Confidentiality and anonymity issues are often more profound in the rural setting than in an urban setting. Anonymity is not characteristic of rural life, which makes some people uncomfortable with seeking help and disclosing their personal mental health histories (Hartley et al., 1999). Efforts to assure a client complete confidentiality could be difficult given the intimate and often socially-connected nature of small communities.

According to the Center for Rural Mental Health Studies (School of Medicine University of Minnesota Duluth, 2000), rural residents are more likely to have inadequate health insurance coverage and have incomes below the poverty level. This presents not only a problem for clients accessing services, but also for the practitioner receiving adequate monetary reward for provided services. For these reasons bartering has been considered as a means to pay for treatment. Many liability insurance carriers interpret bartering

arrangements as business relationships and would decline to defend covered psychologists when bartering schemes become problematic (Koocher & Keith-Spiegel, 1998, p. 181). This creates a risk for those practitioners choosing to engage in bartering.

The belief systems of rural residents may also pose barriers to accessing mental health treatment (Wayman, 2000). Rural residents are more likely to downplay their symptoms and attempt to cope on their own rather than risk being "labeled" with a mental illness. When psychological problems develop, individuals are expected to deal with the problems within their families or by talking with a member of the clergy or the family physician (Campbell & Gordon, 2003). In Massachusetts, Sommers (1989) found that rural individuals were less likely to use mental health services than urban dwellers; however, rural people were more likely to use crisis intervention services.

Rural clients frequently come for therapy only when significant problems are apparent. This poses an additional problem due to a lack of a spectrum of services available in the rural setting. In urban settings, psychotherapists are able to specialize and are readily available to deliver the full range of services to clients; however, small town practice does not permit specialization (Sobel, 1984). Thus, it is likely that the urban therapist would choose to refer a potential client to any number nearby practitioners when a dual-role dilemma exists.

In a rural setting, few available practitioners and difficulties that clients experience in accessing other professionals due to geographic distance pose conflicts for the rural practitioner. Jennings (1992) suggests that withholding treatment and making referrals are not often viable options for the rural practitioner. Further, rural practitioners must be prepared as generalists in order to provide services to individuals from all age groups as well

as handle multiple presenting concerns. Thus, the need to provide generalist services may pose an ethical dilemma in handling clinical problems that are outside the scope of one's practice. While there are times when it is reasonable for psychologists to extend their areas of competence, it is a more frequent issue for the rural clinician (Hargrove, 1986).

Another ethical challenge of the rural psychologist is managing multiple-role relationships. Multiple-role relationships between psychologists and clients were found to have occurred significantly more often in rural areas than in urban areas (Borys & Pope, 1989; Horst, 1989). However, engaging in multiple relationships can be a risky practice. Dual relationships can erode and distort the professional nature of the therapeutic relationship. They may create conflicts of interest that compromise professional judgment or create situations where the therapist is engaged in meeting his or her own social, financial, or other personal needs, rather than putting the welfare of the client first.

Campbell and Gordon (2003) suggest that characteristics of rural communities and characteristics of psychologists who practice there may also promote the likelihood of multiple-role relationships. For example, rural inhabitants tend to remain in a particular community for years, even generations, thus, relational bonds are likely to be long-term. In addition, multiple levels of relationships are expected and seen as "normal." Rural residents expect to see each other at the store, gas station, church, doctor's office, and school. It is often because of such relationships (i.e., considerable personal knowledge about the psychologist) that clients seek treatment, which is often the opposite of what is commonly seen in urban settings (Jennings, 1992).

A number of common characteristics of rural psychologists may promote multiple-role relationships (Campbell & Gordon, 2003). For example, rural psychologists are

comfortable with a rural lifestyle and likely grew up in a rural environment. They are more likely to be aware of, and incorporate in their practice, the norms and expectations of small communities. Rural psychologists are likely to be visible members of service groups, churches, and other community organizations that facilitate active integration into the community. Finally, rural psychologists are often comfortable with a relatively high profile in the community and may demonstrate a higher tolerance for a blurring of personal and professional boundaries.

A qualitative study of psychologists who lived and practiced in rural areas identified dual relationships as the most frequent and complicated of all ethical dilemmas that they encountered in daily practice (Schank & Skovolt, 1997). Although there seems to be some consensus that dual-role relationships can be handled in an ethical manner by informed and attentive therapists (Brownlee, 1996; Haug, 1999; Horst, 1989), they still form the major bases of licensing disciplinary actions and financial losses in malpractice suits involving psychologists (Pope & Vasquez, 1998). Because of their frequency, ambiguity, and potential ramifications, the proposed study will focus specifically on multiple-role relationships.

Multiple Role Relationships

The American Psychological Association defines multiple relationship in the 2002 Ethical Principles of Psychologists and Code of Conduct (Standard 3.05) as occurring when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom they have the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person. The fact that the two roles are sequential

does not, in and of itself, mean that the two relationships do not constitute a dual relationship (Pope, 1991). Thus, multiple-role dilemmas may arise in three kinds of situations: (1) pre-therapy, when a request for therapy is made by a person with which the therapist has an existing out-of-therapy relationship, (2) concurrent with therapy, when an incidental relationship occurs during the course of therapy, and (3) a post-relationship/pre-therapy situation, when a person requests therapy after a previous outside-of-therapy relationship no longer exists.

All three types of multiple-role relationships were examined in the current study. Research indicated that harm and conflicts of interest are most likely to occur when roles are blended concurrently (Sonne, 1994). Thus, it was hypothesized that concurrent situations will be viewed as more challenging and troubling than either pre-therapeutic or post-relationship situations. In addition, the therapist has less control over decision-making in a concurrent dual-role situation which may also contribute to it being seen as more problematic.

It was hypothesized that a pre-therapy situation will be perceived as more challenging and troubling than a post-relationship/pre-therapy situation, since one of the potential outcomes of decision-making in a pre-therapy situation is a concurrent relationship. A post-relationship/pre-therapy situation would constitute a sequential dual-relationship and thus, is likely to be viewed as less problematic. This later situation is of interest in the proposed study since it has been reported that in some rural settings, it is because of dual relationships—considerable personal knowledge about the psychologist—that clients seek treatment, which is often the opposite from that commonly seen in urban settings (Jennings, 1992).

To describe the type of multiple-role relationships psychologists encounter in practice, Anderson and Kitchener (1996) conducted an exploratory study asking psychologists to describe up to three instances of a nonromantic, nonsexual relationship between psychologists and former clients. A total of 91 critical incidents or scenarios were described by the respondents and these were classified into eight categories: (1) personal or friendship, (2) social interactions and events, (3) business or financial, (4) collegial or professional, (5) supervisory or evaluative, (6) religious affiliation, (7) collegial and social, and (8) workplace. The first two categories, personal or friendship and social interactions and events, were most frequently represented with 18 incidents each. The next two categories, business or financial and collegial or professional, were the next most cited categories, each with 12 incidents.

Schank and Skovholt (1997) arrived at similar categorizations after interviewing 16 rural psychologists. They identified the following four multiple-relationship situations involving professional boundaries as most commonly problematic: (1) social relationships, (2) business and professional relationships, (3) overlapping relationships on members of psychologists' families, and (4) working with multiple members of a family or others in the community who have significant connections with current clients. This study described and included dilemma situations based on the two most commonly cited multiple-role types: professional and social. A vignette describing overlapping relationships on members of the psychologist's family, the third most common type of multiple-role dilemma, was created for this study, but was not included due to the pilot study indicating a need for major revisions.

Methods for Studying Ethical Decision-Making

Various methods have been used to study ethical decision-making. Early researchers (Pope & Vetter, 1992) used open-ended surveys asking participants to describe ethically challenging incidents that they had faced in the past year or two. Similarly, Anderson and Kitchener (1996) conducted an exploratory study to identify and describe common multiple-role situations encountered in practice. Lamb and Catanzaro (1998) had respondents rate a list of boundary crossings as to their appropriateness in practice. Salisbury and Kinnier (1996) had participants rank the importance of 21 counselor concerns involving posttermination relationships. More recent research (Reamer, 2003) has used contrived ethical situations (descriptive vignettes) to stimulate thinking about multiple-role relationships.

Ethical dilemmas represent one format for studying ethical issues and are used to gain a better understanding of ethical decision-making. Dilemmas can take a variety of forms but they typically involve the competing rights and responsibilities of therapists, clients, and institutions (Gladding et al., 2001, p. 4). To understand multiple-role entanglements, Pope and Vasquez (1998; p. 191) suggested that specific examples or vignettes that are typical of actual practice, rather than abstract definitions, should be used.

The vignette method was used to collect data in this study. Vignettes presented realistic examples that not only provide the respondent with a dilemma situation, but also the relevant information that's salient and credible in managing them. Furthermore, they provided a means for the experimenter to manipulate the stimulus materials that was presented to the respondents. The specific vignettes included in this study were contrived based on the literature and were tested experimentally for the purposes of this study.

Challenging Elements of Multiple-role Dilemmas

The appropriateness of blending nonsexual roles between psychologists and those with whom they work in a professional capacity continues to be the source of debate. Some mental health professionals criticize the concept of firm professional boundaries, asserting that they are harmful to the natural process of psychotherapy (Lazarus, 1994), whereas others contend that lax professional boundaries are often a precursor of exploitation, confusion, and loss of objectivity (Brown, 1994).

Characteristics of both the outside-of-therapy contact and the therapeutic contact were associated with varying degrees of challenge. For example, ongoing outside-of-therapy interactions with clients were viewed as more problematic than interactions in which the contact was brief and unplanned (Anderson & Kitchener, 1996). In the therapeutic relationship, it is considered most problematic when a large power discrepancy exists between the therapist and the client (Gottlieb, 1993). Power is lower when relationships are brief, such as in a single assessment session for referral, and increases as relationships continue, such as in long-term, insight-oriented psychotherapy.

Gottlieb (1993) also asserts that the clarity of termination, the likelihood that the therapist and the client will have further professional contact, is also a distinguishing factor between ethical and exploitive multiple-relationships. Deciding what constitutes termination of the professional relationship appears to lack consensus in the profession. For example, there was an even split between respondents as to whether or not post-termination friendships and personal relationships were ethically problematic (Anderson & Kitchener, 1996). Similarly, in a national survey of counselors' attitudes of dual-role relationships, most respondents (70%) believed that post-termination friendships were acceptable two years after

termination (Salisbury & Kinnier, 1996). In this same study, one-third of the respondents indicated that they had engaged in such friendships.

Gottleib (1994) asserts that one must ethically assume that the client always has the right to renew the professional relationship in the future regardless of the amount of time elapsed or contact in the interim. However, he also suggests that social relationships with some types of ex-clients may be acceptable. Long-term clients or those who have difficulties that are likely to recur are best served by remaining available as an objective professional contact. This ambiguity is likely to produce dilemmas for the rural practitioner.

Managing Multiple-role dilemmas

Various methods have been proposed in the literature for managing multiple-role dilemma situations, from a minimal level of using the ethical code to a more comprehensive method of adopting a decision-making model. Referring to the ethical codes and standards is a necessary, but not sufficient, condition for ethical decision-making (Barnett & Yutrzenka, 1995). Haug (1999) recommends staying abreast of ethics and referring to them often, as well as, utilizing proactive informed consent procedures that include how out-of-therapy meetings might be handled. These disclosures should be in writing accompanied with the client's signature. Schank & Skovholt (1997) suggest that an ongoing discussion of clear expectations and boundaries strengthens the therapist-client relationship.

It is also recommended that therapists build supportive professional networks to reduce professional isolation and increase accountability (Haug, 1999). The conscience pursuit of ongoing supervision and peer consultation is crucial for recognizing biases, blindspots, or misjudgments and for practicing ethically. Whenever a dual relationship with a client exists, the literature suggests that practitioners seek consultation and/or supervision

throughout the therapeutic relationship. On-going consultation and supervision are vital to ensure continued therapist objectivity and the prevention of harm to the client.

Additional safeguards have been offered in the literature for dealing with multiple-role relationship dilemmas. Pearson and Piazza (1997) recommended not only consultation with peers but, also, with ethics committees. This is one way to defend against the tendency to justify behavior when there is a desire to engage in dual relationships and a belief that there will be gain. Catalano (1997) highly recommended that every interaction that occurs between the therapist and client outside of the therapeutic setting be addressed in subsequent sessions.

Two ethical decision-making models (Kitchener, 1988; Gottleib, 1993) practitioners may use for guidance in handling dual-role relationship issues are frequently referred to in the literature. Although described as “models” by the authors, they are actually atheoretical approaches designed to assist in conceptualizing and minimizing potential harms to the client. They offer the practitioner a conceptual framework for generating alternative actions when faced with an ethical dilemma situation.

Kitchener’s (1988) ethical decision-making model described three guidelines to use in the decision-making process. To assess the potential for harm in multiple relationships the therapist must examine the (1) incompatibility of role expectations, (2) divergence of role obligations, and (3) power and prestige differences between the therapist and the client. As these variables increase, so does the potential for harm.

Gottleib (1993) developed another ethical decision-making model for managing multiple-role situations. It includes assessing the power differential between the therapist and the client, but adds two additional components: (1) duration of the relationship, and (2)

clarity of termination. When little power differential exists between therapist and client, therapeutic contact is brief, and there is little potential for an ongoing relationship, there is less risk of harm from multiple roles. Gottlieb recommended assessing both the current relationship and the anticipated relationship along these dimensions as well as obtaining consultation when confronted with the possibility of multiple roles.

In a qualitative study, rural psychologists reported that they used their own comfort level as well as the type and severity of the client's presenting problem as criteria in deciding whether or not to enter into a therapeutic relationship with a client where a dual roles exist (Schank & Skovolt, 1997). Psychologists have also reported that the amount of outside contact did not influence decision-making as much as the degree to which the out-of-therapy relationship allowed them and their client to remain in their appropriate roles (Horst, 1989). This ambiguity as to how multiple-role relationships should best be managed may produce dilemmas for the practitioner.

It is likely that the lack of consensus associated with understanding and managing multiple-role relationships may foster job burnout in rural psychologists. Job demands such as role ambiguity and role conflict have consistently shown a moderate to high correlation with burnout (Maslach et al., 2001). Role conflict occurs when conflicting demands at the job have to be met, whereas role ambiguity occurs when there is a lack of adequate information to do the job well; both of which are present in managing multiple-role dilemmas. For example, role conflict occurs when a potential client seeks services with a provider with whom a dual-role exists; and, the client is unable or unwilling to seek services from another provider at a distance. Role ambiguity is apparent in the profession's lack of consensus regarding the acceptance and manageability of multiple-role relationships.

Job Burnout

One of the earliest definitions of job burnout was described by Freudenberger (1975) as a state of fatigue or frustration brought about by the individual's devotion to a cause or way of life that failed to meet expectations. The definition most widely used in research today (Schaufeli et al., 1993) refers to job burnout as a prolonged response to chronic emotional and interpersonal stressors on the job. This definition is based on the three-dimensional theoretical model of emotional exhaustion, depersonalization, and lack of personal accomplishment developed by Maslach and Jackson (1981) to conceptualize burnout (See Appendix A). Emotional exhaustion refers to feelings of being emotionally overextended and depleted of one's emotional resources. Depersonalization refers to a negative, callous, or excessively detached response to other people, who are usually the recipients of one's service or care. Reduced personal accomplishment refers to a decline in one's feelings of competence and successful achievement in one's work.

Burnout has been assessed through direct observations, interviews, and self-report methods. The use of self-report questionnaires have become popular because of their efficient, inexpensive, and anonymity benefits. Although a number of questionnaires have been developed to assess burnout, the Maslach Burnout Inventory (MBI) is almost universally used as the instrument to assess burnout (Schaufeli & Enzmann, 1998). The MBI test authors describe burnout as a three-dimensional syndrome that is characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment.

There are a number of competing theories to explain the possible causes of burnout among mental health professionals; however, a multidimensional theory of the causality of burnout is most widely accepted (Maslach, 1998). A multidimensional theory provides a

better understanding of burnout than does any kind of unidimensional ‘stress’ approach, because it more clearly recognizes the complexity of the phenomenon and its location within a situational context.

Possible causes of burnout can be classified into personality characteristics, work-related attitudes, and work and organizational characteristics (Schaufeli & Enzmann, 1998). The various personality characteristics that have been examined are hardiness, locus of control, coping style, self-esteem, neuroticism, extroversion, and Type A behavior. The work related attitude most often linked with burnout has been, high or unrealistic expectations. Work and organizational characteristics have been divided into four groups: job-related stressors, client-related stressors, social support, and factors that determine self-regulation of work activities. The first two groups can be considered job demands, whereas the latter two are resources.

The empirical research on contributing factors has found that situational variables, such as work overload, role conflict, and role ambiguity are more predictive of burnout than are personal ones such as personality, locus of control, and coping styles (Maslach, 1998). Although clear evidence exists for a positive relationship between lack of social support and burnout, correlations between support and burnout are less strong than for job demands and burnout. In a meta-analysis conducted by Lee and Ashforth (1996), support from supervisors explained, on average, 14% of the variance of emotional exhaustion, 6% of depersonalization, and 2% of personal accomplishment. The job demands of workload and time pressure were found to explain about 25-50% of the variance of burnout (Lee & Ashforth, 1996).

In addition, demographic variables such as age and gender have been correlated with burnout. Age has been most consistently related to burnout (Schaufeli & Enzmann, 1998). Burnout has been observed more often among younger employees than among those aged over 30 or 40 years. The MBI manual (Maslach et al., 1996) shows the decline of burnout symptoms with growing age or work experience for all three dimensions. However, these results should be interpreted cautiously because of the problem of survival bias; those who burnout early in their careers are likely to quit their jobs, leaving behind those who exhibit lower levels of burnout.

Gender has not been a strong predictor of burnout because of its inconsistent relationship with burnout. Some studies show that burnout occurs more often among women than among men, some show higher scores for men, and others find no overall differences (Maslach et al., 2001). However, women tend to score slightly higher on Emotional Exhaustion, whereas men score higher on Depersonalization and Personal Accomplishment (Cordes & Dougherty, 1993; Schaufeli & Enzmann, 1998).

In Maslach and colleagues' (1996) earlier conceptualization of burnout, both job demands and a lack of key resources were viewed as important antecedents of burnout. Work overload and personal conflict were the major demands, while the lack of resources such as control coping, social support, skill use, autonomy, and decision involvement were especially critical. See Appendix A for a diagram of Maslach's Theoretical Model of Burnout.

Recently, the multidimensional theory of burnout has been expanded to view the construct of burnout as one end of the continuum in the relationship people establish with their jobs (Maslach et al., 2001). As a syndrome of exhaustion, cynicism, and ineffectiveness,

it stands in contrast to the energetic, involved, and effective state of engagement with work. Thus, job engagement is defined in terms of the same three dimensions as burnout, but at the positive end of those dimensions rather than the negative (Maslach et al., 2001).

This expanded multidimensional model is also located in Appendix A. It illustrates that the greater the gap, or mismatch, between the person and their job, the greater the likelihood of burnout. More specifically, six areas have been identified in which mismatch can take place: workload, control, reward, community, fairness, and values. Each area of mismatch has a distinct relationship with burnout and engagement.

Four of these six areas seem to be highly relevant to the rural practitioner: workload, control, reward, and community. One area that has been shown to contribute to burnout that is likely to differ between rural and urban psychologists is workload. A mismatch between a person and workload occurs when one perceives the workload as too much, too complex, too urgent, or just too awful (Leiter & Maslach, 2005). A caseload consisting of more severely disturbed clients has been found to contribute to therapists' lower job satisfaction (Pine & Maslach, 1978), higher levels of stress from maintaining the therapeutic relationship, and more professional doubt and personal depletion (Hellman & Morrison, 1987). Shelton and Frank (1995) reported that rural residents rely more heavily on crisis services than their urban counterparts, often delaying their access to mental health care services until their needs are extremely significant. Thus, working with severely disturbed clients may be an ongoing reality impacting rural psychologists' workload.

Client load has frequently been shown to be correlated with burnout. Several studies have supported a significant positive relationship between client load and emotional exhaustion and depersonalization (Friensen & Sarros, 1989; Maslach & Jackson, 1981;

Rogers & Dodson, 1987). It is likely that rural psychologists, being the only local provider, may seek to keep up with the demand and take on clients beyond the point of a reasonable caseload, particularly when turning away a client would result in no services for the client.

The second area is a lack of control, which occurs when people have little power over the work they do or the clients they accept. When confronted with a dilemma of whether to serve or refuse treatment of a client where a multiple relationship exists, the practitioner may perceive a lack of control. This is particularly challenging when competent referral sources are located a great distance from the client. A further complication would be the knowledge that the client is not likely to access the needed therapy services at a distance. These factors are likely to reduce the rural psychologist's perceptions of control.

The third factor impacting burnout is a mismatch of reward, which refers to a lack of motivation, gratification, fulfillment, appreciation, self-worth, self-esteem, even love (Leiter & Maslach, 2005). Money is always an issue as there never seems to be enough. It becomes a mismatch when inadequacy of pay causes a hardship and/or when being aware that others in similar positions are being compensated more handsomely. This may be particularly relevant to the rural practitioner whose pool of potential clients is smaller and the chances of preexisting, concurrent, or subsequent relationships with clients significantly greater. Frequently turning away clients in which a dual-role exists may pose a financial hardship for the rural therapist.

The forth aspect of burnout that is relevant to the rural mental health provider is the workplace community. Community refers to the culture that permeates the environment in which one works (Leiter & Maslach, 2005). Breakdown in community occurs when people lose a sense of positive connection with others in the workplace and can occur in jobs that

isolate people from each other. Practicing in a small community where there are no or only one or two other therapists, put the psychologist at greater risk for professional isolation (Kee et al., 2002). Furthermore, professional isolation limits the immediate availability of peer consultation and supervision which are recommended in the literature for managing multiple-role relationship situations.

The remaining two areas (fairness and values) of job-person fit that contribute to burnout are less likely to be unique to the rural psychologist. Fairness refers to justice in the workplace, often involving decisions about schedules, tasks, and promotions. To the degree that these decisions seem arbitrary, disrespectful, or unfair would represent the mismatch between a person and his/her job. The final area, values, refers to the extent that one experiences connection or disconnect with the beliefs of the organization and that the organization believes in the worker. For example, to what degree does the organization and worker match on the importance, meaningfulness, and ethically acceptableness of the work.

Burnout has been the focus of years of research. A meta-analysis (Lee & Ashforth, 1996) of the results from 61 of 77 research-based studies done with the MBI from 1982-1994, summarized the correlates of emotional exhaustion, depersonalization, and personal accomplishment. Further, the variables that correlated with burnout were grouped into the broad categories of demands and resources. Maslach (1982) suggested that researchers should identify and include demands and resources perceived by their study participants to be the most relevant for their work context.

Two demands, perceived workload and time pressure, have been found to be strongly and consistently related to burnout, particularly the exhaustion dimension (Maslach et al., 2001). Two job resources, social support and decision-making control, seem to be pertinent

to this study. There is a consistent and strong body of evidence that a lack of social support is linked to burnout (Maslach, et al., 2001; Kee, 2002) and that people who have little control in decision-making exhibit higher levels of burnout (Maslach, et al., 2001).

Lee and Ashforth (1996) found that the three dimensions—emotional exhaustion, depersonalization, and personal accomplishment—were differentially associated with behavioral and attitudinal correlates. Emotional exhaustion and depersonalization were strongly associated with turnover intentions and organizational commitment, but only weakly associated with control coping. Personal accomplishment was strongly related to control coping.

Job burnout was chosen for this study not only because of its association with characteristics typical of rural psychology practice but, also, because it has been identified in the literature as a negative outcome with serious consequences for human service professionals. The consequences of burnout can be costly for the individual worker and everyone affected by that person. These frequently include job withdrawal, decreased job commitment, job dissatisfaction, interpersonal problems, and absenteeism (Turnipseed, 1994). These costs imply a deterioration in the quality of care or services provided to clients. Burnout is also linked to personal dysfunction, primarily in terms of impaired physical and mental health (Glass & McKnight, 1996). There is also some evidence for increased substance abuse as well as marital and family conflicts (Maslach, 1998).

Prevalence and Impact

Determining prevalence of burnout is not easy, because a measure that discriminates between burned-out cases and non-cases is not available (Schaufeli & Enzmann, 1998). There are provisional, clinically-validated cut-off points for the Dutch version of the Maslach

Burnout Inventory. Based on these cut-offs it is estimated that, depending on the dimension, between 3% and 16% of the Dutch human service professionals suffer from severe clinical burnout (Schaufeli & Van Dierendonck, 1995).

Research in the United States has demonstrated that significant levels of burnout exist in the helping professions. Farber and Heifetz (1982) investigated prevalence of burnout in mental health professionals via two-hour semistructured interviews with a heterogeneous group of sixty psychotherapists. The interviews focused on the therapists' experiences of work and their perceptions regarding the effects of the psychotherapeutic role. Interview responses were coded and frequency counts to each question were made. They found burnout, defined as reported "overt disillusionment with the therapeutic enterprise" and "the need to defend against feelings of disillusionment," in 71% of the psychologists, 43% of the psychiatrists, and 73% of the social workers interviewed (Farber & Heifetz, 1982).

In a later study (Ackerley et al., 1988), it was found that in a national sample of licensed psychologists, more than one-third of the respondents reported experiencing high levels of emotional exhaustion and depersonalization. When comparing the mean levels of emotional exhaustion, depersonalization, and personal accomplishment for the sample of licensed psychologists with those of mental health workers in the normative sample from Maslach's Burnout Inventory manual, scores on all three subscales were significantly higher. In regard to emotional exhaustion, 32.7% were in the moderate burnout range and 39.9% were in high burnout range. Concerning depersonalization, 24.7% were in the moderate burnout range and 34.3% were in the high burnout range. With regard to personal accomplishment, 3.8% were in the moderate burnout range and 0.9% was in the high burnout range.

In an investigation of the impact of clients' mental illness on social workers' job satisfaction and burnout, Acker (1999) found that high involvement with clients with severe mental illness was positively correlated with burnout. Furthermore, adequate support was associated significantly with lower scores on the emotional exhaustion scale.

While the prevalence of burnout in many human service professions has been established, the research on burnout in particular groups has been limited. Maslach (1993) suggested that studies on burnout should focus on specific work settings. To date there has been only one known study assessing burnout in rural mental health settings. Kee and colleagues (2002) found that a large proportion (65%) of master's level rural mental health therapists reported moderate levels, or greater, of burnout and that adequate social support on the job was negatively associated with burnout.

Thus, both the prevalence and potential negative impact of burnout make it an important construct for further study. A better understanding of how rural psychologists perceive multiple-role relationship situations was sought. Specifically, what aspects of the multiple-role dilemma situations did they find most troubling. In addition, what characteristics of rural practice (frequent and challenging multiple-role encounters, inaccessible referral sources, inadequate opportunities for consultation and supervision) predicted job burnout.

Purpose of the Study

The current study had four objectives. The two primary objectives were to measure the extent to which rural psychologists view the multiple-role dilemma situations (vignettes) as ethically challenging and troubling, and secondarily to assess their likelihood of engaging in (or continuing) a therapeutic relationship in the given situations.

A third objective of the study was to measure the level of job burnout perceived by Ph.D.-licensed psychologists practicing in rural settings, as this has not been previously assessed on a national level. The final and fourth objective was to examine potential predictors of burnout among rural psychologists. The predictor variables that were examined are psychologists' perceptions of their: frequency of experiencing multiple-role relationship dilemmas, degree of challenge that multiple-role dilemmas present, accessibility of a referral sources, adequacy of opportunities for consultation, and adequacy of opportunities for supervision.

METHOD

Participants

Participants were selected from American Psychological Association (APA) members who indicated that they were Ph.D. or Psy.D., licensed psychologists having a zip code on their membership application that corresponded with a 100% rural setting (0% urban). Rural classification was based on the following U.S. Bureau of the Census definitions (2000). A rural setting consists of all territory, population, and housing units located outside of an Urbanized Area (UA) or an Urban Cluster (UC). The Census Bureau delineates UA and UC boundaries to encompass densely settled territory, which consists of: (1) core census block groups or blocks that have a population density of at least 1,000 people per square mile and (2) surrounding census blocks that have an overall density of at least 500 people per square mile. Thus, "rural," as used in this study, include those communities that are considered 100% rural and (0% urban).

The member's address on their APA membership form was used to select rural members. The American Psychological Association Office of Research randomly selected

400 participants, from a total of 721 practitioners meeting the above criteria, for inclusion in this study.

Mailing labels were purchased from APA's Office of Research and the 400 rural psychologists were each sent a survey packet by US mail. However, 39 (9.8%) of the potential participants communicated via phone, email, and US mail that their APA mailing address was their rural residence address, and that they commuted to an urban area to practice. In addition, one person indicated that he/she was an administrator and not a practicing psychologist. Thus, 40 persons were eliminated from the initial sample of 400 for not meeting the sample description for this study. Thus, the adjusted sample consisted of 360 potential participants. Using a projected 50% return rate, it was calculated that this sample size would be sufficient in terms of power to detect moderate differences at the .05 alpha level (Cohen, 1992).

Procedures

Mailing labels for the random sample of rural psychologists were purchased from the American Psychological Association (APA). Each of the 400 potential respondents was sent a packet containing a cover letter introducing the project, an informed consent form, and a 4-page survey which included a demographic section, one version of the multiple-role relationship vignette with corresponding questions, and the Maslach Burnout Inventory-Human Services Survey (MBI-HSS). A sample packet is located in Appendix B. In addition, a self-addressed, stamped return envelope was included. Follow-up reminders were sent 10 days following the initial mailing to participants who had not responded. To ensure the highest possible return rate, complete packets were mailed 3 weeks after the initial mailing to the remaining non-respondents.

Initial packets were coded so that when completed surveys were received, participants' names were removed from the follow-up mailing lists. The codes were removed to maintain participants' confidentiality. Upon receipt of the completed surveys, the instruments were scored and all valid data was entered into SPSS-14 spreadsheet format and analyzed.

Completion and return of the survey constituted informed consent for participation in the study. This study was reviewed and approved by the Iowa State University Research Review Board (IRB approval number 06-122; 4/12/06). It was determined to meet all applicable ethical and institutional criteria for the protection and welfare of human participants.

Instrument

The instrument designed for this study was a 4-page survey (see Appendix B) consisting of three parts: demographic information, ethical dilemma vignette, and job burnout inventory. It consisted of 43 items (14 demographic questions, 7 ethical dilemma questions, and 22 job burnout items). It was estimated to take approximately 15-30 minutes to complete.

Demographic Information

The demographic information collected was: participants' gender, age, ethnicity, length of time practicing as a doctoral-level psychologist, type of primary work setting, and if they were full-time or part-time practitioners. Participants were asked if they reside in the community in which they practice and how much they enjoy practicing in a rural area. Respondents' perceptions of their professional support were assessed by asking them to indicate the degree of adequacy they experience with their current opportunities for

consultation and supervision. Inquiries as to psychologists' current mode and frequency of consultation and supervision were also included. See survey in Appendix B.

Job Burnout Measure

The Maslach Burnout Inventory-Human Services Survey (MBI-HSS) was selected for this study to measure job burnout because it is by far the most widely used instrument to assess burnout: over 90% of the journal articles and dissertations have used the MBI (Schaufeli et al., 2001). The instrument was introduced in the early 1980's (Maslach & Jackson, 1981), the second edition of the test manual was published 5 years later (Maslach & Jackson, 1986), and the third and most recent edition was published in 1996 (Maslach et al, 1996). The instrument is copyright protected and cannot be included in this manuscript. A copy of the MBI-HSS can be purchased from CPP, Inc., Mountain View, California.

The MBI-HSS is a 22-item, self-report survey with three factor derived subscales: Emotional Exhaustion (9 items), Depersonalization (5 items), and Personal Accomplishment (8 items). Items are scored on a seven-point rating scale with fixed anchors that range from 'never' to 'everyday', thus, the frequency with which the respondents experience feelings related to each subscale is assessed. Instead of one composite burnout score, a score for each subscale is computed. The instrument takes approximately seven minutes to complete.

Psychometric Properties

Internal consistencies of the three MBI-HSS scales are satisfactory with alpha values ranging from .70 to .90 (Maslach et al., 1996). Lee and Ashforth (1996) analyzed 47 studies that included nearly 10,000 respondents and computed overall reliability coefficients for each subscale that were well within the range of the test manual: emotional exhaustion (.86), depersonalization (.76), and personal accomplishment (.77).

MBI scores seem to be somewhat stable over time. According to the test manual, test-retest coefficients for the subscales of the MBI-HSS were: .60 for Depersonalization, .80 for Personal Accomplishment, and to .82 for Emotional Exhaustion, for a sample of graduate students in social welfare and administrators in a health agency ($n = 53$), the two test sessions were separated by an interval of two to four weeks. Although these coefficients range from low to moderately high, all are significant beyond the .001 level (Maslach et al., 1996).

Other studies have been conducted to examine the test-retest reliability on the MBI-HSS (Jackson, Schwab, & Schuler, 1986; Lee & Ashforth, 1993; Leiter, 1990; and Leiter & Durup, 1996). Results have consistently shown that values do not differ greatly across short periods of up to 1 month and only drop slightly when longer periods of up to 1 year are considered (Maslach et al, 1996). This stability is consistent with the MBI-HSS's purpose of measuring an enduring state. Consistently, Emotional Exhaustion appears to be the most stable burnout dimension, whereas Depersonalization is the least stable dimension.

Results on the construct validity of the MBI-HSS are numerous and are generally quite positive. Structural analyses contrasting models of burnout (Lee & Ashforth, 1993; Leiter, 1993) have generally found support for assigning a central, but not exclusive, role to Emotional Exhaustion. Exhaustion appears to be the MBI-HSS subscale that is most responsive to the organizational environment and social interactions that characterize human service work. It mediates the environment's relationship with Depersonalization, the occurrence of which is closely tied to Emotional Exhaustion. In contrast, Personal Accomplishment is less closely related to exhaustion in structural models. In fact, it may be that diminished Personal Accomplishment develops in parallel with exhaustion without any major causal links between the two (Leiter, 1993).

Convergent validity was demonstrated in several ways. First, an individual's MBI-HSS scores were correlated with behavioral ratings made independently by a person who knew the individual well. Second, MBI-HSS scores were correlated with the presence of certain job characteristics that were expected to contribute to experienced burnout. Third, MBI-HSS scores were correlated with measures of various outcomes that had been hypothesized to be related to burnout. All three sets of correlations provided substantial evidence for the validity of the MBI-HSS (Maslach et al., 1996). Studies indicate that, for the most part, the MBI-HSS scales measure the same construct as do other burnout instruments such as the Burnout Measure (BM) and the Staff Burnout Scale for Health Professionals (SBS-HP) (Schaufeli et al., 1993, p. 209).

Investigations that assess the discriminant validity of the MBI-HSS in relation to other constructs that might be expected to be confounded with burnout offer additional evidence of the validity of the MBI-HSS. For example, it would be expected that the experience of burnout would have some relationship to lowered feelings of job satisfaction, but they should not be so highly correlated as to suggest that they were the same thing. A comparison of subjects' scores on the MBI-HSS and the Job Descriptive Survey, a measure of general job satisfaction, provided this support. Job satisfaction had a moderately negative correlation with both Emotional Exhaustion ($r = -.23$, $p < .05$) and Depersonalization ($r = -.22$, $p < .02$), as well as a slightly positive correlation with Personal Accomplishment ($r = .17$, $p < .06$).

Although there are important distinctions between burnout and depression, their differentiation has been the focus of much research. Depression is a global clinical syndrome pervading every aspect of a person's life, whereas burnout describes a crisis in one's

relationship with work and is more a quality of the social environment of work. This theoretical distinction has been empirically tested utilizing a confirmatory factor analysis of scores on the MBI and several measures of depression and found that the subscales for burnout and for depression loaded on separate second-order factors (Leiter & Durup, 1994). This study confirmed burnout as a complex, three-factor syndrome, each component was more closely tied to one another than to any aspect of depression.

The MBI as an individual assessment tool lacks clinically validated cut-off points. The MBI-manual presents arbitrary statistical classifications of burnout levels (Maslach et al., 1996, p. 6). Scores are considered high if they correspond with those in the upper third of the normative distribution, average if they match those in the middle third, and low if they correspond with those in the lower third of the normative distribution.

Due to the limited knowledge about the relationships between the three factors of burnout, the scores for each subscale are considered separately and are not combined into a single total score. Thus, for this study three scores are computed for each respondent and compared to norms based on large samples of workers. Each score can then be coded as low, average, or high by using the numerical cutoff points listed on the scoring key. However, neither the coding nor the original numerical scores should be used for diagnostic purposes as there is insufficient research on the pattern(s) of scores as indicators of individual dysfunction or the need for intervention.

It might be argued that scores on the MBI-HSS may be subject to distortion by social desirability since many of the items describe feelings that don’t conform to professional ideals. To test this notion, 40 graduate students in social welfare were asked to complete both the MBI-HSS and the Crowne-Marlowe (1964) Social Desirability Scale. None of the MBI-

HSS subscales was significantly correlated with the Social Desirability Scale at the .05 level; thus, the results indicated that reported burnout is not influenced by a social desirability response set (Maslach et al., 1996). According to the manual, the MBI-HSS should be presented as a survey of job-related attitudes and not be linked to burnout in any way.

Ethical Dilemma Vignettes

A total of nine vignettes (see appendix C) illustrating three levels (pre-, concurrent, and post-relationships) of three different multiple-role relationship situations were created by the author for the purposes of this study. The vignettes were created based on those multiple-role relationship situations that the literature on rural practitioners cited most frequently: professional, social, and overlapping relationships of members of psychologists' families (Anderson & Kitchener, 1996; Schank & Skovholt, 1997). However, only six vignettes were used in this study; see pilot study results for explanation. The six vignettes were similar in length, ranging from 226 words to 302 words.

The vignettes were created to illustrate the ambiguousness of multiple-role relationships common in rural practice. The vignettes also reflected the unavoidability of the multiple-role relationship which is common in rural settings. Variables that remained constant across each version of the vignettes were: (a) type of outside-of-therapy contact with the client, (b) amount of time spent with the client outside of therapy, (c) type and severity of the client's problem, (d) potential duration of therapeutic contact with the client, (e) unavoidability of therapeutic contact (no local referral sources and the unlikelihood of the client pursuing another therapy provider), (f) gender of therapist was not stated, and (g) gender of client was not stated.

As displayed in Appendix C, vignettes 1A, 1B, and 1C described a professional relationship involving the psychologist serving on a local school board with the (potential) client. Vignettes 2A, 2B, and 2C described a social situation where the therapist and (potential) client are in the same couple's golf league. Vignettes 3A, 3B, and 3C illustrated an overlapping relationship with the psychologist's family member, in that the therapist's client or potential client is the special education teacher of the therapist's child. Vignettes 3A, 3B, and 3C were not used in this study because of pilot study feedback indicating a lack of similarity and the low likeliness of encountering dilemmas such as those described in Vignettes 3A, 3B, and 3C.

The timing of the occurrence of the dual-role relationship (pre-therapy, concurrent with therapy, and post-relationship/pre-therapy) was manipulated across each type of vignette. Thus, each vignette has three levels representing the time of the multiple-role relationship occurrence. Version A (1A, 2A, and 3A) of each vignette represented situations in which the extra-therapy contact existed prior to considerations of a therapeutic relationship that would necessitate a pre-dual role relationship decision. Version B (1B, 2B, and 3B) of each vignette described situations where, during the course of therapy, an outside-of-therapy relationship occurred, and Version C (1C, 2C, and 3C) of each vignette indicated that a post-relationship, but pre-therapy contact existed. Vignettes are located in Appendix C.

Participants responded to seven Likert-type questions following the vignette (see survey in Appendix B). First, they indicated the degree to which they perceive the situation to be ethically challenging. Secondly, they indicated the degree to which they would take the person on as a client, or continue the therapeutic relationship with the client. Similarly, participants were asked to rate how likely they were to continue their outside-of-therapy

contact with the client. Respondents also rated the degree that each aspect of the situation was troubling: (a) type of outside-of-therapy contact with the client, (b) amount of outside-of-therapy contact with the client, (c) client's presenting problem, (d) duration of the potential therapeutic contact with the client, (e) lack of local referral sources, (f) unlikelihood of the client pursuing another therapeutic option, and (g) clarity of guidelines in the literature for managing ethical dilemmas.

Respondents were then asked to respond to three items regarding the multiple-role relationship dilemmas they face in their own practice. First, they specified the frequency of multiple-role relationship dilemmas that they encounter. Next, they indicated the degree of challenge encountered by the multiple-role dilemmas they typically experience. Lastly, they rated the accessibility of the nearest referral source that they consider most of the time.

Pilot Study

The nine vignettes were pilot tested using a local sample of 13 mental health practitioners (return rate—42%) to gain feedback as to their clarity and realism. Each vignette was rated by three or four respondents across a number of areas (similar, realistic, clear, frequency of encountering, ethical challenge, and comfort level) using a six-point Likert-type range (see Appendix D for the pilot study survey). Respondents were asked to indicate how similar the vignettes were to situations they have encountered in their practice. Participants also rated how realistic and clear they found the vignettes. In addition, respondents rated the frequency in which they encountered similar situations. Participants were asked to rate the degree to which they perceived the situation to be ethically challenging, as well as their comfort level with taking the client on as part of their caseload. Participants were asked further to provide feedback or comments, to improve the vignettes.

Finally, an optional question was included that asked respondents to describe the most ethically challenging situation they had encountered in their practice in the last year.

The means and standard deviations were calculated for each vignette across the six items on the pilot survey. Responses to the two open-ended questions asking for feedback or comments regarding the vignettes and a description of their most ethically challenging experience were listed in narrative format (see Appendix D for the summary of results).

According to the mean responses to the question regarding similarity to those situations encountered in practice, six of the nine vignettes were rated as slightly to moderately similar. Three vignettes (1B—current client becomes a school board member, 2C—person whom you've previously engaged in a couple's golf/social league is requesting therapy, and 3C—child's previous teacher requests therapy) were rated as slightly dissimilar.

Seven of the nine vignettes were rated as being moderately to very realistic. Two vignettes (2B—a current client gets involved in the same golf and 3C—child's previous teacher requests therapy) were rated as slightly realistic. All nine vignettes were indicated as being moderately to very clear.

Responses to the frequency of encountering similar situations as described in the vignettes were more varied. According to mean responses, participants indicated that they encounter situations similar to four of the vignettes on a slightly to moderately frequent basis, whereas most respondents reported that they encounter situations as described in five of the vignettes (1B—school board member with current client, 2C—person whom you've previously engaged in a couple's golf/social league is requesting therapy, 3A—child's current teacher is requesting therapy, 3B—child's teacher is current client, 3C—child's previous teacher is requesting therapy) on a moderately to slightly infrequent basis.

Generally, the respondents perceived the dilemmas to be challenging. Respondents' mean scores indicated that eight of the nine situations were perceived to be moderately to very ethically challenging. One vignette (3C—child's previous teacher is requesting therapy) was rated as slightly challenging.

For six of the nine vignettes, mean ratings indicated that respondents were very to moderately uncomfortable in taking the client on as part of their caseload. In two situations (1A—a school board member is requesting therapy, 3C—child's previous teacher is requesting therapy), respondents were slightly uncomfortable taking the potential client on as part of their caseload. In another situation (1C—person whom you've previously served with on the school board is requesting therapy) respondents were slightly comfortable taking the client on as part of their caseload.

The only feedback offered towards improving the vignettes were directed at vignettes 2C (person whom you've previously engaged in a couple's golf/social league is requesting therapy) and 3B (child's teacher is current client). One respondent indicated that 2C (person whom you've previously engaged in a couple's golf/social league is requesting therapy) was only slightly challenging because according to the Code of Ethics, the therapist must quit the golf league if he/she were to take the person on as a client. To incorporate this feedback, an additional question was added to the survey asking respondents how likely they would be to end or disengage from the out-of-therapy contact with the (potential) client.

According to the feedback on 3B (child's teacher is current client), one respondent questioned whether the client was agreeable to a continuing therapeutic relationship, given that the client was now the teacher of the therapist's child. Clearly, the client's perception of the situation and his/her best interests are important in the decision-making process. Thus, to

acknowledge this factor that was pointed out by a respondent, vignettes 1B (school board member with current client), 2B (couple's golf/social league with a current client), and 3B (child's teacher is current client) were modified to include a comment on the agreeableness of the client to continue the multiple- role situation.

Based on these results, six of the nine vignettes appeared adequate as written and were included in the proposed study, after making the two minor modifications mentioned above. Vignettes 3A, 3B, and 3C appeared to need additional study and major revisions, and thus were excluded from the present study. All three levels of Vignette 3 were rated by respondents as being encountered infrequently and the 3C vignette was rated by mental health practitioners as dissimilar to those they encounter, and only slightly realistic and slightly challenging.

Study Design

The participants were randomly assigned to one of the six vignette situations; thus, the study used a 2 x 3 between subjects design for analysis. There were two types of MRR dilemma situations (1 = professional and 2 = social) and three levels of timing in which the MRR dilemma occurred (A = pre-therapy, B = concurrent with therapy, and C = post-outside-of-therapy contact, pre-therapy) illustrated by the six vignettes. See appendix C for a depiction of the 2 x 3 design.

Research Hypotheses and Associated Analyses

Hypothesis 1

It was predicted that psychologists' ratings of challenge and trouble, the degree to which respondents perceived elements of the therapeutic relationship to be problematic, would vary significantly across the three versions of the vignettes (pre-therapy, concurrent

with therapy, and post-relationship/pre-therapy). More specifically, it was predicted that the order of the ratings or degree of problem, from greatest to least, would be that the concurrent situation would be viewed as the most problematic as it illustrated a situation in which the therapist has the least amount of control over in terms of decision-making and occurred without any prior notice. Further, the concurrent role produced a situation that directly conflicts with the APA ethical code prohibiting the abandonment of clients. It also was predicted that the pre-therapy situation would be viewed as intermediately problematic, as the decision to accept the person as a client would then result in a concurrent situation requiring ethical management.

The post-relationship dilemma was predicted to be the least problematic, as there seems to be more openness or willingness to accept relationships with clients' post therapeutic termination (Salisbury & Kinnier, 1996). This hypothesis was tested by examining the independent variable of timing of the ethical dilemma, with three levels: pre-therapy (vignettes 1A and 2A), concurrent with therapy (vignettes 1B and 2B), and post-relationship/pre-therapy (vignettes 1C and 2C). The dependent variables (DVs) were the degree of challenge (item 1) and total level of trouble (average total score of items 4a–4f) produced by the timing of the ethical dilemma situation.

Hypothesis 2

Hypothesis 2 examined whether there were differences between the two types of dual relationship dilemmas, professional versus social. Two, two tail t-tests with p-values of .05 were conducted to determine if the two types (professional and social) of dual-relationship dilemmas differed in how challenging (item 1) and troubling (averaged total score of items 4a–4f) they were perceived by rural psychologists. The independent variable (IV) was the

type of dual-relationship dilemma, with two levels: professional (vignettes 1A, 1B, and 1C) and social (vignettes 2A, 2B, and 2C). The two DVs were the degree of challenge (item 1) and level of total trouble (average total score of items 4a–4f) perceived by the type of ethical dilemma situation.

Hypothesis 3

It was predicted that negative correlations would exist between the extent the vignette was perceived as challenging (item 1) and the psychologists' likelihood of engaging in (or continuing) a therapeutic relationship. In addition, the correlations between perceived trouble, problematic aspects of a relationship (averaged total score of items 4a–4f), and the psychologists' likelihood of engaging in (or continuing) a therapeutic relationship also was predicted to be negative. Psychologists who reported that the vignettes were highly challenging or troubling would be less likely to engage in or continue a therapeutic relationship. To test these hypotheses two separate correlations were estimated. One correlation was estimated between the degree of challenge perceived by the MRR dilemmas and the likelihood of engaging in or continuing a therapeutic relationship. Another correlation was estimated between the total level of trouble perceived by the MRR situations and the likelihood of engaging in or continuing a therapeutic relationship.

Hypothesis 4

To assess the degree of job burnout among these rural respondents, the scores on each of the three MBI-HSS subscales: Emotional Exhaustion (EE), Depersonalization (Dp), and Personal Accomplishment (PA) were summed for each respondent, and all of the participants' scores were aggregated. Means and standard deviations for each of the three scales were computed for the entire group of respondents. These scores then were compared

to the normative sample scores in the MBI-HSS manual, in order to compare this sample of psychologists with the burnout indices reported by mental health workers in general.

Hypothesis 5

Five variables were used to predict job burnout. Three separate criterion variables, each of the respective Maslach Burnout Inventory subscale scores, EE, Dp, and PA. Five predictor variables were employed: (1) frequency of multiple-role relationships in one's practice (item 5), (2) degree of challenge presented by multiple-role relationships faced in one's practice (item 6), (3) accessibility of a referral source (item 7), (4) adequacy of opportunities for consultation (item 6 from demographic section), and (5) adequacy of opportunities for supervision (item 9 from demographic section). Three separate multiple regressions using the five predictor variables were estimated, each focusing on one of the three criterion variables.

Descriptive Statistics

Descriptive statistics were used to summarize the occurrence of job burnout among Ph.D. licensed psychologists practicing in rural settings. Any significant variations of burnout with demographic variables were reported. The most frequently used mode of consultation and supervision as well as the preferred mode of consultation and supervision among the sample of respondents were summarized. Finally, the participants' perceptions of the adequacy of their opportunities for consultation and supervision were described.

RESULTS

Upon receipt of the completed surveys, the instruments were scored and all valid data were entered into SPSS-14 spreadsheet and analyzed. From the pool of 360 potential participants, 160 completed surveys were returned, yielding a 44% response rate. No cases

were deleted prior to the analyses as a result of missing data. One survey was partially completed, but was included in the analyses because the demographic data and the MBI were completed. The following analyses were performed using the data provided by the total number of respondents (n = 160). Inter-item correlations were estimated among all items that were not vignette-specific. The correlation matrix is shown in Appendix E.

Power analyses indicated that the sample size for power of .80 was sufficient for testing all of the hypotheses, except for the first. To detect a medium effect size (d = .50) among three groups using an ANOVA, Cohen (1992) suggested that each group should have at least 52 observations. Testing the first hypothesis, one of the three groups, post-MRR, had 43 respondents, falling short of the recommended amount. Thus, not finding significant results could be due to a small sample size.

The demographic composition of the final sample was as follows. There were 89 females (55.6%) and 71 males (44.4%). Seventy-two participants (45%) were within the age range of 51 and 60, thirty-eight (23.8%) were over 60, thirty-seven (23.1%) were between 41 and 50, and 13 (8.1%) were between 30 and 40 years of age. The ethnic delineation of the sample was 1 (.6%) African American, 1 (.6%) Asian/Pacific Islander, 0 (0%) Latino(a)/Hispanic, 2 (1.3%) American Indian/Alaska Native, and 156 (97.5%) White.

Experienced practitioners comprised the largest number of respondents, with 68 (42.5%) having between 11 and 20 years of doctoral-level practice and 56 (35.0%) reporting 21 or more years of practice at the doctoral level. Thirty-two (20.0%) respondents indicated between 5 and 10 years of professional practice, while 3 (1.9%) reported practicing less than 5 years at the doctoral-level. Multiple practice settings were represented in the sample: 75

(46.9%) Independent Solo, 30 (18.8%) Independent Group, 28 (17.5%) Other, 16 (10%) Hospital or Inpatient, and 9 (5.6) Community Mental Health Center.

Most participants (98, 61.3%) reported that they resided within the community in which they practice, while 62 (38.8%) indicated that they did not reside in the community where they practiced. The majority of respondents (108, 67.5%) were full-time practitioners, whereas 52 (32.5%) reported working less than 40 hours per week. Most participants enjoy practicing in a rural area; 107 (66.9%) reported that they very much enjoy, 37 (23.1%) responded that they moderately enjoy, and 9 (5.6%) indicated that they slightly enjoy practicing in a rural area. Only a few respondents indicated that they did not enjoy practicing in a rural area: 3 (1.9%) slightly don't enjoy, 1 (0.6%) moderately don't enjoy, and 2 (1.3%) don't at all enjoy.

Representativeness of Respondents by Time of Response and Geographic Region

While the desired response rate goal was not achieved, statistical analyses were conducted to ascertain whether respondents were substantially different from non-respondents on important dependent variables. Three separate one-way ANOVAs were estimated to determine if there were significant differences among the respondents on the three main dependent variables (EE, DP, and PA) across the three response times. It was hypothesized that if respondents did not differ across the three response times with respect to the main DVs in the study, it would be more likely that respondents were randomly selected from the population of interest. Table 1 displays the means and standard deviations for the three job burnout dependent variables for each time of response.

Table 1. Means and Standard Deviations of EE, DP, and PA by Time of Response

MBI-HSS Scales	Response Time 1	Response Time 2	Response Time 3
Emotional Exhaustion (EE)			
M	17.08	17.68	14.58
SD	8.66	9.45	8.48
Depersonalization (DP)			
M	3.91	4.65	3.27
SD	3.19	3.97	2.90
Personal Accomplishment (PA)			
M	42.06	41.25	41.45
SD	4.67	7.47	4.17

The three one-way ANOVAs for each of the respective dependent variables indicated the following: EE $F(2, 157) = 1.28$, $p < .28$; DP $F(2, 157) = 1.56$, $p < .21$; and PA $F(2, 157) = .36$, $p < .70$. The analyses yielded non-significant results, indicating that participants' emotional exhaustion, depersonalization, and personal accomplishment responses did not differ significantly by time of response. Therefore, more confidence can be placed on the likelihood that there were not substantial differences between those who responded to the survey and the population of interest, in terms of their reported job burnout.

Similarly, five one-way ANOVAs were conducted to determine if there were any significant differences among the participants across the three response times on the five predictor variables used in this study to predict job burnout. The means and standard deviations are shown in Table 2. Four of the five analyses were non-significant. Challenge of MRR in Own Practice $F(2, 155) = 1.15$, $p < .32$, $\eta^2 = .02$, Accessibility of Referral Sources in Own Practice $F(2,156) = 2.21$, $p = .11$, $\eta^2 = .03$, Adequacy of Opportunities for Consultation $F(2, 157) = .968$, $p < .38$, $\eta^2 = .01$, and Adequacy of Opportunities for Supervision $F(2, 157) = .517$, $p < .60$, $\eta^2 = .01$. One analysis yielded significant results: Frequency of MRR in Own Practice $F(2, 155) = 8.01$, $p = .001$, $\eta^2 = .09$.

Table 2. Means and Standard Deviations of Predictor Variables by Time of Response

Predictor Variables	Response Time 1	Response Time 2	Response Time 3
Challenge of MRR in Own Practice			
M	4.00	4.03	3.66
SD	1.10	1.23	1.31
Frequency of MRR in Own Practice			
M	2.92**	3.75**	2.63**
SD	1.30	1.37	1.16
Accessibility of Referral Sources in Own Practice			
M	4.78	4.20	4.66
SD	1.31	1.60	1.64
Adequacy of Opportunities for Consultation			
M	4.80	4.43	4.61
SD	1.41	1.43	1.60
Adequacy of Opportunities for Supervision			
M	3.66	3.43	3.27
SD	1.92	1.88	2.16

** $p < .01$

The non-significant results indicated that participants reported similar responses on four of the five predictor variables across the three waves of data collection. Again, more confidence can be placed on the likelihood that those who responded to the survey adequately represent the population of interest, in terms of these items. Due to the significant differences in reported frequency of MRR dilemmas encountered in one's practice by time of participation, some caution should be exercised when interpreting results based on this item. Participants in the second response time reported encountering significantly more frequent MRR in their practice than did participants responding in times one and three.

The sample of rural psychologists used in this study reflected the geographical makeup of the general population, according to the APA's Research Department. To ensure adequate geographical representativeness of the sample, a chi-square analysis was conduced

to determine if there was a statistical difference between respondents and nonrespondents in geographical region represented. The results were significant: χ^2 (9, 365) = 5.46, p = .02, indicating a disproportional response rate. As can be seen from Table 3**,** two geographic regions were underrepresented, South Atlantic (26%) and Mountain (26%), while one area was overrepresented West North Central (72%).

Table 3. Representativeness of Sample by Geographical Region

Region	Sent	Received	Percent Received by Region
New England	86	42	49%
CT	6		
ME	26		
MA	13		
NH	20		
RI	1		
VT	20		
Middle Atlantic	55	21	38%
NJ	6		
NY	24		
PA	25		
East North Central	53	29	55%
IL	3		
IN	9		
MI	17		
OH	13		
WI	11		
West North Central	25	18	72%
IA	1		
KS	4		
MN	6		
MO	7		
NE	3		
ND	2		
SD	2		

Table 3. Representativeness of Sample by Geographical Region (Continued)

Region	Sent	Received	Percent Received by Region
South Atlantic	47	12	26%
DE	0		
DC	0		
FL	3		
GA	10		
MD	0		
NC	10		
SC	1		
VA	22		
WV	2		
East South Central	10	3	30%
AL	1		
KY	1		
MS	2		
TN	6		
West South Central	16	6	38%
AR	2		
LA	2		
OK	4		
TX	8		
Mountain	35	9	26%
AZ	5		
CO	11		
ID	1		
WY	6		
Pacific	33	15	45%
AK	2		
CA	20		
HI	2		
OR	5		
WA	4		
Unknown		5	
Totals	360	160	44%

Roughly equal numbers of participants were obtained for each of the six vignettes (see Table 4). A total of 360 potential participants were sent a survey including one of the six vignette situations. The six vignette conditions were divided evenly among the sample, thus 60 surveys representing each vignette situation were sent to potential respondents. A chi-square analysis was conducted to determine if there was a statistical difference between number of vignettes sent and number of vignettes returned for each of the six conditions, in terms of representativeness of the vignettes sampled. The results were not significant (χ^2 (5, 360) = .164, p = .085). Thus, responses to each vignette situation were adequately represented by the respondents in the study.

Table 4. Representativeness of Sample by Vignette

Vignette	Number Expected	Number Received	Percent Received
1A	60	32	53
1B	60	26	43
1C	60	18	30
2A	60	31	52
2B	60	28	47
2C	60	24	40

Each participant was sent one randomly assigned vignette. 159 surveys were completed and included in this analysis. One survey was returned partially completed and was not included in this analysis.

Study Questions

The hypotheses of the study were addressed by the following questions:

1. Do rural psychologists report differences in the degree of challenge and trouble when presented with variations in the timing (pre, concurrent, and post) of a MRR dilemma?
2. Do rural psychologists report differences in the degree of challenge and trouble between two types (professional and social) of MRR dilemmas?

3. Are rural psychologists less likely to engage (or continue) in a therapeutic relationship where a highly challenging or troubling MRR dilemma exists?
4. Are respondents less likely to continue in their outside-of-therapy contact with a client when confronted with a highly challenging or troubling MRR dilemma?
5. How does this national sample of rural psychologists compare with the MBI's normative sample of mental health practitioners regarding job burnout?
6. Can the three different factors of burnout be predicted from the various conditions inherent in MRR dilemmas faced by rural practitioners?

Analyses Prior to Hypothesis Testing

It was intended, prior to data collection, that the seven troubling items would be summed to represent a single variable labeled "trouble." The standardized Cronbach's alpha was .69 for the seven-item scale. Inter-item correlations among the seven variables are shown in Table 5. One item, "Lack of Guidelines," was weakly related with the other items; however, deleting this item from the scale would improve the Cronbach's alpha only to .70. Thus, it was decided to include all seven items on the troubling scale.

Table 5. Correlations among the 7 Troubling Items

	2	3	4	5	6	7
1 Type of Outside Contact	.69	.22	.15	.34	.23	.15
2 Amount of Outside Contact		.12	.12	.30	.17	.20
3 Lack of Referral Sources			.16	.19	.55	.19
4 Client's Presenting Problem				.48	.28	.02
5 Amount of Therapy Contact					.21	.09
6 Unlikelihood of Other Provider						.16
7 Lack of Clear Guidelines						

To explore the factor structure of the correlation matrix resulting from the correlation of the seven troubling items, an exploratory principal components factor analysis with an oblimin rotation was conducted with the seven "troubling" items. In conjunction with

examination of scree plots, this initial factor analysis produced (based on eight iterations) three factors that met the Kaiser Normalization retention criterion of eigenvalues greater than 1.0. The first factor had an eigenvalue of 2.49, explaining 35.58% of the variance, Factor 2 had an eigenvalue of 1.29, explaining 18.4% of the variance, and Factor 3 had an eigenvalue of 1.15, explaining 16.41% of the variance. Thus, the cumulative variance accounted for by the three-factor solution was 70.39%. Based on item content, the three factors represented the following aspects of "trouble": Factor 1, out-of-therapy trouble (two items); Factor 2, therapist resources trouble (three items); and Factor 3, in-therapy trouble (two items). Factor loadings are reported in Table 6.

Table 6. Factor Loadings of the 7 "Troubling" items

	Out-of-Therapy Trouble	Therapist Resources Trouble	In-Therapy Trouble
Type of outside of therapy contact	**.88**	.26	.18
Amount of time involved with outside of therapy contact	**.91**	.18	.12
Lack of referral sources	.17	**.86**	.12
Client's presenting problem	.09	.23	**.85**
Amount of time involved in therapy	.40	.20	**.76**
Unlikelihood of client pursuing another provider	.18	**.83**	.27
Lack of clear guidelines for managing MRRs	.38	**.48**	.27

As can be seen from Table 7, these three factors are only mildly to moderately related, suggesting that these three variables represent qualitatively different aspects of the overall construct "trouble." Thus, it was decided to treat these three aspects of "troubling" as separate dependent variables in subsequent analyses.

Table 7. Correlations among the 3 "Troubling" factors

	Therapist Resources	In-Therapy
Out-of-Therapy Trouble	.309**	.250**
Therapist Resources Trouble		.256**
In-Therapy Trouble		

** Correlation is significant at the .01 level (2 tailed).

Hypothesis Testing

Variations in Perceived Challenge and Trouble by the Timing of MRR Dilemmas

The independent variable, timing of the MRR, had three levels (pre, concurrent, and post). Results are reported for each of the four dependent variables: degree of challenge, out-of-therapy trouble, therapist resources trouble, and in-therapy trouble. Means and standard deviations for the three troubling dependent variables are reported in Table 8.

A one-way ANOVA was estimated, to determine whether each of the dependent variables differed by the timing of a multiple-role relationship (pre, concurrent, and post). Thus, four separate ANOVA's were estimated, one with each dependent variable and the timing of the MRR (pre-therapy, concurrent with therapy, and post-relationship).

One of the four analyses indicated significant differences. A significant main effect occurred $F(2, 152) = 3.40$, $p = .036$, $\eta^2 = .04$, for level of Therapist Resources Trouble. As shown in Table 8, mean responses for Therapist Resources were significantly less troubling ($p < .05$) in the concurrent situation compared to the pre- and post-MRR conditions.

No significant differences were found for Out-of-therapy Trouble ($F(2, 154) = 1.57$, $p = .212$); In-therapy Trouble ($F(2, 154) = .35$, $p = .704$); and degree of challenge, ($F(2, 156) = 1.93$, $p = .149$), among the three different timings of MRR dilemmas. The means and standard deviations for the three troubling variables are reported in Table 8.

Table 8. Mean and Standard Deviations of Troubling Indices by Timing of MRR

Vignette Timing	Pre-MRR	Concurrent	Post
Out-of-therapy Trouble			
M	1.96	1.73	1.98
SD	.84	.82	.65
Therapist Resources Trouble			
M	1.84*	1.55*	1.88*
SD	.67	.73	.69
In-therapy Trouble			
M	.78	.65	.72
SD	.92	.65	.83

* $p < .05$

The means and standard deviations for degree of challenge are as follows. In the pre-MRR condition, the mean rating was 4.76 with standard deviation of 1.22. The concurrent mean rating was 4.30, with standard deviation of 1.31. In the post situation, the mean score was 4.56, with standard deviation of 1.26.

Variations in Perceived Challenge and Trouble by Type of MRR Dilemmas

The independent variable, type of MRR, had two levels (professional and social). Means and standard deviations are reported in Table 9 for the three troubling dependent variables: Out-of-Therapy Trouble, Therapists Resources Trouble, and In-Therapy Trouble. In addition, the means and standard deviations for a fourth essential variable, Challenge, are as follows. In the professional MRR dilemma situations, the mean score was 4.77 and the standard deviation was 1.18; the mean score of the social MRR dilemma situations was 4.34, with standard deviation of 1.33.

An independent samples *t*-test was utilized to examine whether the two types of multiple-role relationships (professional and social) differed in the levels of trouble and degree of challenge perceived by this sample of rural psychologists. Four separate *t*-tests, three for troubling items and one for ratings of challenge, were conducted, one for each of the

dependent variables. The analysis indicated significant results for two of the dependent variables: Level of Out-of-Therapy Trouble and Degree of Challenge. The mean responses for level of out-of-therapy trouble differed significantly ($t(155) = 2.23$, $p = .03$, Cohen's $d = .35$) between Professional and Social MRR dilemmas. Similarly, the means for degree of challenge differed significantly ($t(157) = 2.14$, $p = .03$, Cohen's $d = .34$) between the two groups. The Professional MRR dilemmas were significantly more challenging and more troubling in terms of out of therapy variables than were the Social MRR dilemmas. The means for the other two dependent variables, Therapists Resources Trouble and In-Therapy Trouble, did not differ significantly.

Table 9. Means and Standard Deviations for Troubling Indices by MRR Type

	Professional	Social
Out-of-Therapy Trouble		
M	2.03*	1.76*
SD	.76	.80
Therapists Resources Trouble		
M	1.76	1.75
SD	.71	.71
In-Therapy Trouble		
M	.78	.67
SD	.84	.79

* $p < .05$

Likelihood of Engaging in (Continuing) Therapy when a MRR Dilemma Exists

Four pairs of correlations were calculated between the variable likelihood of engaging (continuing) in therapy and the following variables: challenge, out-of-therapy trouble, therapist-resources trouble, and in-therapy trouble. The Pearson *r* statistic was used to estimate the linear relationships between the variables of interest.

Three of the four correlations were significant. Perceived challenge was significantly negatively correlated with the likelihood of engaging in treatment ($r = -.245$, $p = .002$). Two

of the three troubling indices were negatively correlated with the likelihood of engaging in treatment. Out-of-therapy trouble produced a statistically significant (r = -.379, p = .001) negative correlation with the likelihood of engaging in treatment, as did in-therapy trouble (r = -.241, p = .002). Therapist resources were not significantly correlated (r = -.019, p = .813) with the likelihood of engaging in treatment. Therefore, the more challenging the situation and troubling out-of-therapy and in-therapy variables were rated the less likely respondents were to engage or continue therapy with the (potential) client.

Likelihood of Continuing (Resuming) Outside-of-Therapy Contact when a MRR Exists

In addition, four pairs of correlations were calculated to determine whether challenge, out-of-therapy trouble, therapist-resources trouble, and in-therapy trouble were related to the likelihood of continuing a dual-role relationship. A Pearson r statistic was used to estimate the relationship between the variables of interest.

Three of the four analyses were significant. Perceived challenge was positively related to the likelihood of continuing the out-of-therapy role (r = .262, p = .001). Two of the three troubling indices were significantly and positively correlated with the likelihood of continuing the outside-of-therapy dual role (professional or social). Results indicated that out-of-therapy trouble was significantly correlated (r = .246, p = .002) with the likelihood of continuing the outside-of-therapy dual role. Therapist resources trouble also was significantly correlated (r = .171, p = .033) with the likelihood of continuing the outside-of-therapy dual role. In-therapy trouble was not significantly related (r = .104, p = .193) to the likelihood of continuing an outside-of-treatment dual-role.

Thus, the more challenging the situation, and troubling out-of-therapy aspects and therapist resources were viewed, the more likely the psychologist was to continue the professional or social activity that coincided with the (potential) client.

Comparison of Burnout with this Sample and MBI's Mental Health Normative Sample

The Maslach Burnout Inventory-Human Services Survey (Maslach, Jackson, & Leiter, 1996) was used as the measure of burnout. The total sample means and standard deviations for the three scales were: Emotional Exhaustion (*M* = 16.71, *SD* = 8.84), Depersonalization (*M* = 3.96, *SD* = 3.36) and Sense of Personal Accomplishment (*M* = 41.73, *SD* = 5.40). The current sample was delineated by risk level and dependent variable in Table 10, using the mental health normative sample cutoff scores to determine risk levels. According to the MBI categorization data for mental health workers (Maslach et al., 1996), this sample fell in the average or middle range on EE (average range = 14–20). Their scores on DP were in the lower third (low range = 4 or below). The respondents' scores on PA fell in the low range in terms of experienced burnout.

Overall, findings indicated that this study's participants reported similar levels of emotional exhaustion, lower levels of depersonalization, and higher levels of personal accomplishment than those reported by the normative sample of mental health practitioners. Thus, the current sample of rural psychologists appears to be at a relatively low risk for job burnout. As compared to a national sample of licensed psychologists (Ackerley et al., 1988), the current study's participants' responses to the job burnout inventory were more favorable in terms of Emotional Exhaustion and Depersonalization, and only slightly worse in terms of Personal Accomplishments. When compared to a more recent sample (Kee et al., 2002) of master's-level, rural practitioners from a Midwestern state, the current study's respondents

scored more favorably across all three dimensions of job burnout. Results shown in Table 10.

Table 10. Prevalence of Risk Levels Across Factors of Burnout

Type of Burnout	Risk Level	Current Study Frequency	Current Study Percent	Ackerley et al., 1988 Percent	Kee et al., 2002 Percent
Emotional Exhaustion	Low	64	41.3%	27.4%	30.7%
	Moderate	44	28.4%	32.7%	31.8%
	High	47	30.3%	39.9%	37.5%
Depersonalization	Low	98	63.2%	41.0%	50.5%
	Moderate	31	20.0%	24.7%	31.8%
	High	26	16.8%	34.3%	17.7%
Low Sense of Personal Accomplishment	Low	126	81.3%	95.3%	62.0%
	Moderate	22	14.2%	3.8%	31.3%
	High	7	4.5%	.9%	6.8%

Cut-off scores are based upon the MBI-HSS normative sample.

Predictors of Burnout

Three separate multiple regression analyses were conducted, one for each of the three MBI-HSS factor scores of burnout. Five variables were used as multiple regression predictors to determine their ability to predict job burnout. The predictors were: frequency of multiple-role relationships faced in one’s practice, degree of challenge of multiple-role relationships in one’s practice, accessibility of a referral source, adequacy of opportunities for consultation, and adequacy of opportunities for supervision. The three factor scores of burnout—Emotional Exhaustion, Depersonalization, and Personal Accomplishment—served as criterion variables. Results of the regression analyses are presented in Tables 11-13.

Table 11.
Summary of Multiple Regression Analysis for Variables Predicting Emotional Exhaustion

Predictors of Emotional Exhaustion	df	B	Std. Error	Beta	Sig.
Regression	5				.002**
Challenge of MRR	1	.539	.638	.072	.400
Frequency of MRR	1	1.242	.564	.191	.029*
Accessibility of Referral Sources	1	1.337	.485	.223	.007**
Adequacy of Supervision Oppor.	1	.098	.390	.022	.802
Adequacy-Consultation Oppor.	1	-1.393	.543	-.231	.011*
Constant		10.604	3.699		.005*
Residual	151				
Total	156				

Note. R^2 = .12; Adj. R^2 = .09. **$p < .01$, *$p < .05$.

Table 12.
Summary of Multiple Regression Analysis for Variables Predicting Depersonalization

Predictors of Depersonalization	df	B	Std. Error	Beta	Sig.
Regression	5				.369
Challenge of MRR	1	-.205	.257	-.072	.426
Frequency of MRR	1	.430	.227	.172	.060
Accessibility of Referral Sources	1	.328	.195	.142	.095
Adequacy of Supervision Oppor.	1	.016	.157	.009	.921
Adequacy-Consultation Oppor.	1	-.106	.218	-.046	.627
Constant		2.354	1.489		
Residual	151				
Total	156				

Note. R^2 = .035; Adj. R^2 = .003. **$p < .01$, *$p < .05$.

Table 13.
Summary of Multiple Regression Analysis for Variables Predicting Personal Accomp.

Predictors of Personal Accomplishments	df	B	Std. Error	Beta	Sig.
Regression	5				.041*
Challenge of MRR	1	.362	.405	.079	.373
Frequency of MRR	1	.393	.357	.098	.273
Accessibility of Referral Sources	1	-.242	.308	-.065	.433
Adequacy of Supervision Oppor.	1	-.389	.248	-.140	.118
Adequacy-Consultation Oppor.	1	1.015	.344	.272	.004**
Constant		36.880	2.345		
Residual	151				
Total	156				

Note. R^2 = .07; Adj. R^2 = .04. **$p < .01$, *$p < .05$.

All five predictor variables: challenge of MRR, frequency of MRR, accessibility of referral sources, adequacy of opportunities for supervision, adequacy of opportunities for consultation, were used to predict the three factors of job burnout (Emotional Exhaustion, Depersonalization, and Personal Accomplishments). Three variables—frequency of MRR, adequacy of opportunities for consultation, and accessibility of referral sources—entered the equation as significant predictors of Emotional Exhaustion accounting for 9% of the variance $F(5, 151) = 4.11$, $p = .002$; Adjusted $R^2 = .09$. None of the variables were significant predictors of Depersonalization. One variable, adequacy of opportunities for consultation, significantly predicted Personal Accomplishment, accounting for 4% of the variance ($F(5, 151) = 2.38$, $p = .004$; Adjusted $R^2 = .04$).

Description of Consultation and Supervision

Most respondents' (79%) reported that they have adequate opportunities for consultation, while only 21% responded that they have inadequate opportunities for consultation. Sixty-five percent of the participants reported that they engage in peer consultation between one and five hours per month. Twenty percent reported engaging in consultation with colleagues less than 1 hour per month. Nine percent indicated that they engage in consultation between six and ten hours per month; whereas, 6% reported consulting for more than ten hours per month.

Most participants (52%) indicated that they typically use face-to-face consultation, followed by 23% stating that they use phone consultation. Twenty-one percent of the respondents indicated multiple modes of consultation by reporting two or more of the options given. The least used methods of consultation were U.S. mail (1%) and email (3%).

More variability was noted with respondents' reported adequacy of opportunities for supervision. Eight percent of the respondents indicated that they did not need supervision because they were already licensed. Fifty-seven percent of the participants reported adequate opportunities for supervision; while 35% indicated inadequate opportunities for supervision.

Given respondents relatively high rates of inadequate opportunities for supervision, it makes sense that most participants (55%) indicated less than one hour of supervision per month and some (13%) reported that they received no supervision. Twenty-nine percent reported receiving between one and five hours of supervision per month, with only 3% indicating more than six hours per month.

The typical methods of supervision were similar to those reported for consultation. The majority of participants (52%) indicated that they use face-to-face supervision, followed by 19% reporting phone supervision and only 3% using email and 1% using U.S. mail.

DISCUSSION

This study was conducted to address five hypotheses. The results supported three of the five, while there was partial support for two hypotheses. The first two hypotheses, which examined the significance of the timing and type of multiple-role relationships on the level of trouble and challenge perceived, were partially supported. The third hypothesis was supported, indicating that levels of challenge and trouble in multiple-role ethical dilemmas were negatively related to the likelihood of engaging in or continuing a therapeutic relationship. Similarly, the levels of challenge and trouble in multiple-role relationship (MRR) ethical dilemmas were also related to the likelihood of continuing an outside-of-therapy relationship.

The fourth hypothesis was of an exploratory nature, and therefore provides the first known national dataset of rural psychologists' perceptions of job burnout. Results revealed that rural psychologists are not prone to job burnout simply as a function of their setting. This provides good news for those contemplating a rural psychology practice.

The results of the fifth hypothesis were of primary significance. Examining both job burnout and responses to multiple-role relationship ethical dilemmas in the same study permitted making some meaningful connections between these two variables. Findings indicated that components of job burnout were predicted by frequency of encountering multiple-role relationship dilemmas, adequacy of opportunities for consultation, and accessibility of referral sources. These results have direct implications for the rural psychologist.

Multiple-Role Relationships (MRR)

Based on the findings of the current study, multiple-role relationship (MRR) ethical dilemmas were clearly troubling and challenging for rural psychologists, even for this highly experienced group. However, out of the four dependent variables (challenge, in-therapy trouble, out-of-therapy trouble and therapist resources trouble) only therapist resources trouble differed significantly among the three MRR conditions. Thus, minimal evidence indicated that the timing (pre, concurrent, post) of MRR ethical dilemmas affected the degree of perceived trouble.

Contrary to prediction, results indicated that the concurrent MRRs were viewed as being significantly less troubling than either the pre- or post MRR conditions. Rural psychologists perceived the lack of local referral sources, the unlikelihood of the client pursuing another provider, and the lack of clear guidelines in the literature, to be the least

troubling in the concurrent MRR dilemma situations. In contrast, the other troubling indices involving items about the type of contact and amount of time spent outside of therapy with the client, as well as the client's presenting problem and the amount of potential time for therapy, did not differ among the three situations. Also, the degree of challenge did not vary among the three types of MRRs.

This finding may be influenced by the therapist's perceived degree of control or responsibility over the situation. In both the Pre- and the Post-MRR situations, the therapist was aware of the dilemma prior to agreeing to accept the client as part of his/her caseload. However, in the concurrent MRR scenarios the dual role was unplanned; the client later joined the professional or social group in which the therapist had already been participating. Perhaps this lessened the burden of responsibility for the therapist.

The literature indicated that in some rural settings, it is because of dual relationships—considerable personal knowledge about the psychologist—that clients seek treatment (Jennings, 1992). This situation was reflected in the post-MRR vignettes. Based on this study's results, post-MRR dilemmas produce high levels of challenge and trouble for rural psychologists.

Mental health professionals have also reported some acceptance for engaging in post-termination friendships (Salisbury & Kinnier, 1996). However, the current findings did not support that a similar situation (post-MRR) where formal outside of therapy contact with a potential client has ended, was less challenging and troubling than pre- and concurrent-MRR.

One clear difference between the concurrent and the pre- and post-MRR situations, is the fact that the client is already being seen in counseling in the concurrent situation, but not the other two scenarios. It seems likely that when a psychologist is faced with two competing

ethical dilemmas, such as, managing a multiple-role relationship and terminating therapy prior to the client's needs being met; that the psychologist would prioritize the client's need for services and justify the management of the MRR. Clearly, the potential for abandoning a client was more obvious in the concurrent situation than either the pre or the post.

The pre- and post-MRR situations would allow for the psychologist to implement ethical decision-making guidelines and weigh potential decision-making outcomes equally. According to ethical theory, when principles are in conflict, ethical action should emanate from what would produce the least amount of harm (Gladding et al., 2001). Thus, in concurrent dilemmas the established therapeutic relationship would likely be prioritized when weighing ethical decision-making options, making therapist resources trouble less problematic.

The hypothesis regarding the impact of the type of MRR (professional or social) on the degree of challenge and trouble was partially supported. Significant results were observed for two of the four dependent variables. Results showed that the degree of challenge and level of out-of-therapy trouble varied by the type of MRR, while both types of situations (professional and social) were equally troubling in terms of in-therapy trouble and therapist-resources trouble. Out-of-therapy trouble consisted of the amount of contact and the type of contact that the therapist had with the (potential) client, outside of the therapy relationship.

Professional MRR dilemmas were found to be significantly more challenging and troubling than social MRR situations. This finding could be due to the particular vignette situation used to depict the two types, school board member as professional dual role and couple's golf as a social role. However, it is likely that there is at least some dynamic

between these two situations that makes the professional dual role more challenging than the social dual role.

Ethical decision-making theory can be used to explain these results. According to one of Kitchener's (1988) guidelines, estimating the potential for divergence of obligation, aids in differentiating between problematic and less problematic aspects of a MRR dilemma. As the divergence between the obligations imposed by different roles increases, the potential for divided loyalties and loss of objectivity increases.

It is likely that the respondents viewed the potential for conflict between themselves and the client/potential client as being greater in the professional situation because of the perceived "role requirements" of the professional situation, which is likely to be more problematic than the social situation. For example, if the psychologist and the client had differing perspectives on a highly important school board issue this would be extremely difficult to manage or avoid while serving as an effective school board member. However, on a couple's golf league/social hour, the psychologist and client could arrange to avoid excessive contact or potential conflict by choosing to interact with other couples more frequently than with each other. The social MRR dilemmas appeared to produce less divergence between the obligations imposed by the different roles, than did the professional MRR dilemmas and therefore were found to be less challenging and troubling.

The third hypothesis was strongly supported by significant relationships found in three of the four correlations conducted. As predicted, psychologists who perceived high levels of in-therapy and out-of-therapy trouble produced by the MRR dilemma were less likely to engage in or continue treatment with the client/potential client. Similarly, psychologists who reported higher degrees of challenge associated with the MRR dilemma

also endorsed a lower likelihood of engaging the client in treatment. Oddly, therapist-resources trouble was not correlated with engaging the client/potential client in therapy.

The second part of the third hypothesis was to examine the relationships between likelihood of continuing the extra-therapy participation and degree of challenge and trouble perceived by the MRR situation. The results have lead to more questioning than understanding regarding the interpretable meaning of this hypothesis. In retrospect, the clarity of the question asking participants how likely they were to continue their extra-therapy participation (school board member or couple's golf league) with the (potential) client is questionable. This item was added to the survey after obtaining results from a participant in the pilot study. If this survey was to be used in future studies, it is recommended that the item in question be rewritten to incorporate information about whether or not the psychologist had agreed to accept the person as part of his/her caseload. In other words, this item is not meaningful unless prefaced or contingently related to the decision to engage in treatment with the person.

The results indicated that the more challenging and troubling in terms of out-of-therapy and therapist-resources the MRR dilemmas were perceived, the more likely to continue their extra-therapy contact, either professional or social, with the client or potential client. One highly plausible explanation for these results would be that because the dilemma was perceived has highly problematic, the therapist was not planning on taking the potential client on as part of his/her caseload, and thus reported a greater likelihood of continuing extra-therapy contact with the client. However, this wouldn't be the case for the concurrent situations where the client has already been seen by the therapist for ten sessions with the prediction of ten more.

Because the vignette did not specify whether or not the psychologist was planning on accepting the person as part of his/her caseload, there were too many confounding explanations. The results could mean that the psychologists who reported a low likelihood of continuing the extra-therapy contact did so even when they found the MRR situations to be highly challenging, because they did not intend to see the person in therapy. It also could mean that the psychologist accepted the individual as a client and also chose to opt out of the extra-therapy contact with the client rather than continue to address the problems that may arise because of such a relationship. It may mean that for those rural psychologists in this study who reported a higher likelihood of continuing their dual-role that they have a greater tolerance for and more experience in navigating around the problematic aspects of dual-role relationships.

Job Burnout

With respect to job burnout, the results indicated that rural psychologists report relatively low levels of job burnout compared to the normative sample of mental health workers. Along the three dimension of job burnout, approximately 30% of the sample of rural psychologists reported high levels of Emotional Exhaustion, 17% endorsed high levels of depersonalization, and only 3% reported high levels of low personal accomplishment. These findings indicated slightly lower levels of job burnout than those reported by Kee and colleagues (2002) in a study of rural mental health practitioners from a midwestern state.

This finding may be in part due to self-selection, those practitioners who are satisfied with their job stay and those who are dissatisfied leave. Given the high levels of experience and mean age of the current sample, it is likely that this study surveyed the self-selected job survivors or the more satisfied. This same reasoning could explain the sample's reported

high levels of enjoyment of practicing in a rural area, those who were enjoying their practice continued and those who were not enjoying practicing in a rural area, left.

Other job factors could account for the participants' high level of job engagement or low level of job burnout in this study. Having a high client caseload has been strongly and consistently related to burnout, particularly the exhaustion dimension (Maslach et al., 2001). Since 32% of the sample reported working part-time, perhaps they have more manageable caseloads and less time pressure, thus, lower levels of job burnout.

Having greater control in decision-making is also likely to have had an impact on this sample's reported job burnout. Given that burnout tends to be higher for people who have little participation in decision making (Maslach et al., 2001) and the majority of respondents (66%) in this study reported being in independent practice, it is likely that they are heavily involved in decision-making and less prone to job burnout. Lastly, the participants in this study seem to be less affected by scarcity of resources which negatively impacts burnout. Overall, most respondents indicated adequate opportunities for consultation and supervision, as well as, accessible and appropriate referral sources.

The present study also investigated whether aspects of multiple-role relationship ethical dilemmas predicted job burnout among rural psychologists. As predicted, three variables—frequency of MRR dilemmas, accessibility of referral sources, and adequacy of opportunities for consultation—were significant predictors of Emotional Exhaustion. None of the five variables significantly predicted Depersonalization. One variable, opportunities for consultation, predicted personal accomplishment.

The finding that depersonalization was not predicted by any of the variables was likely due to the low level of burnout or high level of job engagement of the current sample,

combined with the conceptualization of depersonalization being a later occurring factor in the experience of burnout, as shown in Appendix A. Theoretically, burnout is a cluster of three constructs and only emotional exhaustion was in average range, whereas the other two were in the low risk range. The theory indicates that exhaustion and diminished accomplishment and efficacy co-occur in the early stages of job burnout, and then sequentially create cynicism and depersonalization. This sample reported high levels of personal accomplishment and average levels of exhaustion, and therefore was not likely to experience depersonalization as its precursors (high emotional exhaustion and low personal accomplishments) were absent.

As expected, opportunities for consultation predicted both emotional exhaustion and personal accomplishment. This finding is similar to those reported by Kee and colleagues (2002). They found that rural mental health practitioners' deficiency of coworker support was negatively related with each of the three dimensions of burnout (Kee et al., 2002).

The robust relationship between the adequacy of consultation, one form of coworker support, and job burnout has significant implications for the rural psychologist, mainly, the importance of establishing a strong consultative network. Leiter and Maslach (2005) suggested that one way to banish job burnout caused by lack of peer connectedness is to join with fellow workers and build a system of mutual support by connecting with and organizing a support group of people doing similar activities.

Surprisingly, the degree of challenge associated with MRR ethical dilemmas encountered in one's practice did not predict burnout. There are likely various moderators affecting the relationship between degree of challenge of MRR and job burnout. Some of which may include the means and effectiveness for coping with MRR dilemmas, as well as

the decision as to whether or not to accept the potential client as part of one's caseload. For example, the rural psychologist may choose not to accept an individual for counseling when he or she perceives the situation as more challenging that he/she can manage, thus reducing the risk for job burnout. Also, it is likely that the respondents in this study were a highly experienced group of rural psychologists and have effect methods for managing MRR dilemmas when they are encountered making them more tolerant of challenging and troubling MRRs and less prone to job burnout.

Adequacy of opportunities for supervision did not predict burnout. This may be due to some confusion with the definition of this construct, as a number of respondents inserted comments in response to these items. For example, many participants reported "NA" (not applicable) or that they no longer needed supervision on the surveys. Some respondents inserted the word "peer" in front of supervision. Others made comments inquiring about the difference between consultation and supervision. The author intended for supervision to apply to a wide range of both formal and informal activities.

Strengths and Limitations of the Study

This study was the first to examine job burnout and multiple-role relationships among rural psychologists. Moreover, it was based on a representative, yet small, national sample of rural psychologists which permits some generalizability of the results. The study was unique in that it focused exclusively on rural psychologists, thus contributing to the knowledge on job burnout among rural practitioners. Further, these real-world, highly experienced, practitioners reacted to the ethical dilemma situations matching what they encounter in the real world.

In addition to the quantitative results, there were qualitative indices of the importance of the topic to rural practitioners, as indicated by spontaneous comments made by respondents. For example, one participant reported these comments, “Wonderful to see you researching this area. Survey hits the nail on the head for my situation. Mainstream APA specialty standards, practice guidelines, and training are disconnected from reality for rural providers.” Another respondent wrote these comments, “I work in the town I grew up in, so I know the multi-generational chapters of many people’s presenting issues. Multi-role relationships abound.” Another participant comment, “These issues are a constant, continuing, daily part of rural psychology.”

One limitation of this study is that it relied solely on a self-report method of data collection which increases the potential for over- or under-reporting information. The participants represented a sophisticated group and may have guessed correctly the content being assessed and therefore, the data may have been affected by social desirability. When psychologists are responding to questions about ethical dilemma situations in the abstract, as when answering a survey, they may be more idealistic about how psychologists ought to act. However, when directly involved in an ethical dilemma, psychologists might favorably distort situations and justify a different set of actions. Although participants were assured confidentiality, it is possible that they either over- or under-reported their level of burnout on the MBI. Future studies might utilize qualitative methods to enquire about how rural psychologists cope with unavoidable MRR dilemmas.

This study was limited in scope to examine two types of MRR dilemmas (professional and social) and three dimensions in the timing of a MRR dilemma (pre, concurrent, and post). Further, there was only one scenario represented for each of the two

types of MRR dilemma (professional-school board vignettes and social-golf vignettes). Thus, the vignette situations may have seemed more artificial to some respondents who identify less with these particular situations.

Overall, relatively minimal variation in the job burnout factors was explained by the predictor variables in the study. The variables involved may not have captured the most salient predictors of job burnout. This was a preliminary, exploratory study and it is likely that there is a combination of predictor variables that were not tapped into by this study.

Implications for Future Research

To enhance responses, future researchers could consider including a measure of social desirability when assessing responses to ethical dilemma situations. However, Maslach et al. (1996) reported that the scores on the MBI-HSS are resistant to distortion by a social desirability response set based on results showing that for a group of 40 graduate students in social welfare, scores on MBI-HSS and the Social Desirability Scale (Crowne-Marlowe, 1964) were not significantly correlated ($p > .05$). Response rates also may expand by employing phone contact with a structured interview format, rather than mail only contact.

Although partial support was found for differences in perceived challenge and trouble across the manipulations of timing and type of MRR ethical dilemmas, future research may benefit from exploring in more detail the specific aspects of MRR dilemmas that produced such results. Future studies are needed to examine whether the finding that professional situations were more challenging than social situations by expanding to other variations of professional and social situations. This may shed some light onto what particular aspects of professional situations tend to be more challenging than social situations.

Similarly, future research could examine what particular aspects of the concurrent MRR dilemmas contribute to their lower level of perceived trouble. Replication of this finding with larger sample sizes would also be warranted before making any strong conclusions based on the current results. Also, other types of MRR dilemmas could be examined, such as a MRR where the client has an overlapping relationship with the therapist's family member.

Although significant connections were found between job burnout and the adequacy of opportunities for consultation, accessibility of referral sources, and frequency of MRRs, only a small proportion of job burnout was explained by the predictor variables. This study's predictor variables, while conceptually relevant, may not have included a complete domain of predictors. Other situational variables that may account for some variance in job burnout should be examined in future research. For example, the present study did not include the number of clients or the proportion of problematic clients reported by practitioners. Both of these variables have been shown to predict job burnout (Maslach et al., 2001).

Future studies that examine the impact of manipulating predictors of job burnout as potential prevent efforts or effective treatment options for job burnout would be of interest. Based on this study's findings, such interventions would likely include building a professional social support network, reducing the frequency of one's MRRs, and expanding one's accessibility of referral sources. Thus, evaluating the impact of an intervention directed at one of these targets could prove invaluable to those suffering from job burnout.

Clinical Implications

This study suggested that it might be fruitful for a rural psychologist to engage in a number of activities that may protect oneself from possible job burnout. It seems that

building a professional network with other mental health care providers that would offer opportunities for consultation and potential referral sources would have the most impact. In today's world, the latest in technology could play a major role in improving the adequacy of opportunities for peer consultation, reducing the frequency of multiple-role relationship dilemmas and expanding the accessibility of referral sources.

Policy implications are also indicated by these results. Participants in this study represented older, satisfied individuals. As these individuals approach retirement, it will be necessary to recruit new psychologists to rural areas. This may become problematic if new recruits are dissatisfied with the rural setting and more prone to job burnout. Another policy implication alluded to in this study, is the need for pertinent ethical guidelines regarding multiple-role relationships that are unique to the rural practitioner.

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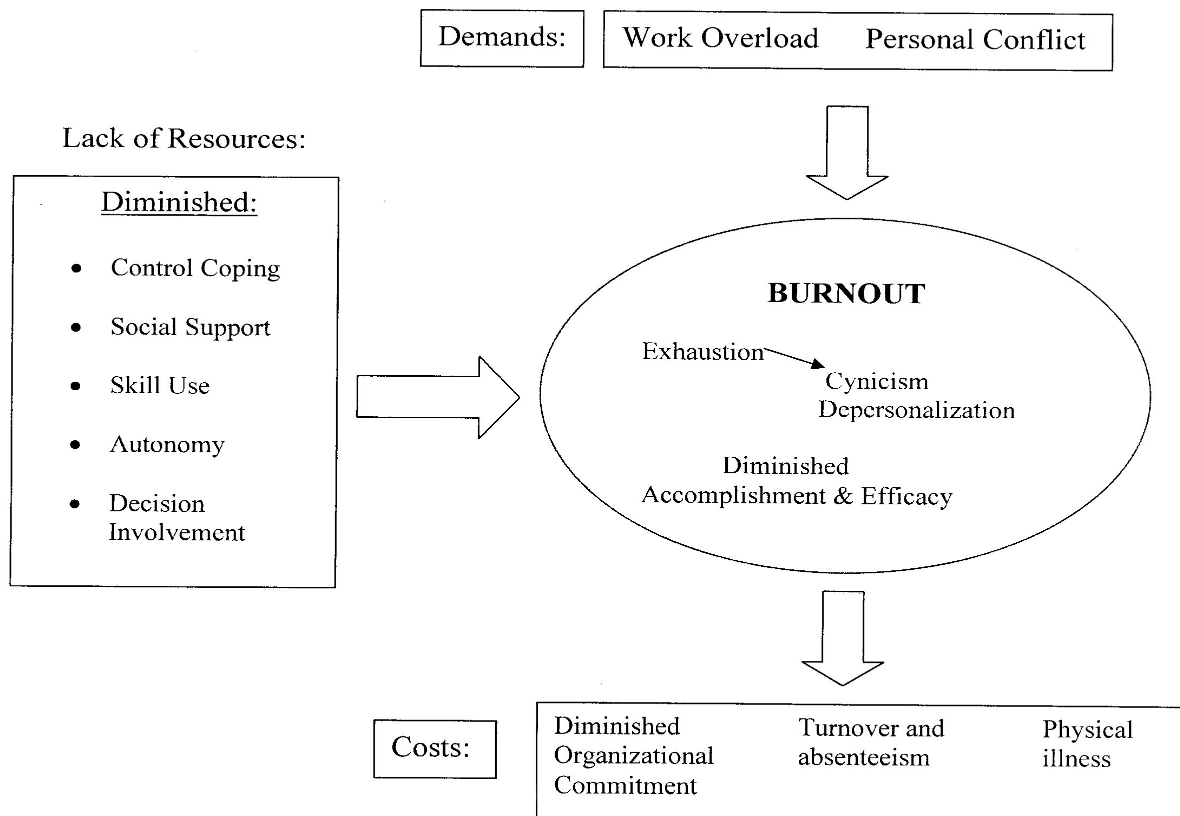
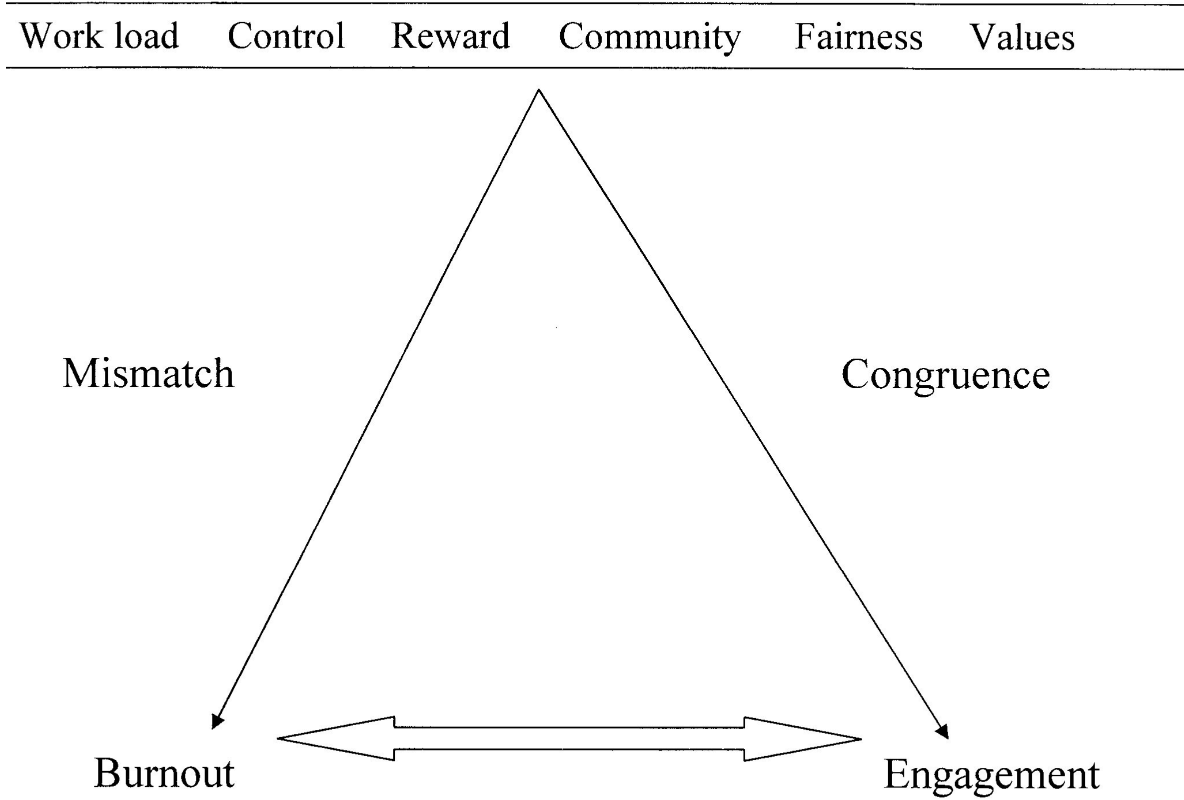
APPENDIX

Appendix A: Model of Burnout




Six Areas of Job-Person Fit:
Work load
Control
Reward
Community
Fairness
Values
Mismatch
Congruence
Burnout
Engagement

Appendix B: Survey Materials

Rural Psychologists' Perceptions
Department of Psychology, Iowa State University, W112 Lagomarcino Hall, Ames, IA 50011-3180

May, 2006

Dear Rural Psychologist,

I am Deb McDermott, a Ph.D. Counseling Psychology candidate at Iowa State University. I have worked as a mental health practitioner for 11 years serving rural communities in Iowa. My continued interest in rural mental health has prompted me to conduct research in this area. This is a research study designed to collect rural psychologists' perceptions of their job. You are being invited to participate in this study because you are part of a national sample of psychologists with rural addresses. Your input as a practicing rural psychologist is vitally important to this project, particularly in light of the fact that there are so few rural psychologists in the field.

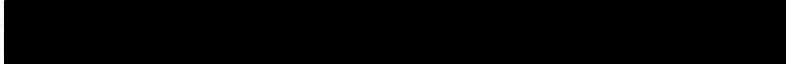
Enclosed are an informed consent form, a brief, anonymous survey and a postage-paid, return envelope. Please review the enclosed survey and take your time in deciding if you would like to participate. Return of the survey will constitute informed consent for participation. It should take about 10-15 minutes to complete the 2-page, confidential survey. You will be asked to complete items about your attitudes toward your current job and you will be asked to respond to a clinical vignette situation. Please take just a few minutes to respond. The aggregate responses are valuable to advancing the knowledge of rural mental health practices.

An identification number appears on the survey to assist me with planned follow-up mailings. Upon my receipt of your survey, this identification code will be removed and your survey will be compiled with others and there will be no way to identify your survey. Only the code list will be kept with the surveys for verification. The participant list will be kept in a different location. Thus, responses will be confidential. All original records will be kept in a locked filing cabinet and only Deb McDermott, researcher, and her supervisor Dr. Norman Scott, will have access to these records. If the results are published, they will be conveyed in aggregate form and remain anonymous. Otherwise, the original surveys and the compilation of data will be retained for 5 years before being destroyed.

Please feel free to ask questions at any time during this study. For further information about the study contact Deb McDermott at (641) 755-3611, debmcd@iastate.edu or Dr. Norman Scott at (515) 294-1509, nascott@iastate.edu. This research project has been IRB approved (IRB approval ID #06-122).

Thank you in advance for your consideration and support! Please return the 2-page survey in the enclosed envelope. Please note the informed consent document.

Sincerely,



Deb McDermott, Ed. S.	Norman A. Scott, Ph. D.
Ph.D. Candidate Counseling Psychology	Associate Professor of Psychology
Iowa State University	Iowa State University

INFORMED CONSENT DOCUMENT

Title of Study: Rural Psychologists' Perceptions of Multiple-role Relationship Situations & their Jobs
Investigators: Deb McDermott, Ed. S., Principal Investigator
Norman Scott, Ph.D., Faculty Supervisor

This is a research study. Please take your time in deciding if you would like to participate.

DESCRIPTION OF STUDY
The purpose of this study is to collect information about rural psychologists' perceptions of multiple-role relationship dilemmas and of their job. You are being invited to participate in this study because you have been identified as a rural psychologist.

DESCRIPTION OF PROCEDURES
Your participation is voluntary. If you agree to participate in this study, your participation will take about 15 minutes. You are being asked to complete a 3-part survey consisting of: a demographics section, a section inquiring about your attitudes towards your current job and a section asking you to respond to a vignette describing a multiple-role relationship situation. You may skip any question that you do not wish to answer or that makes you feel uncomfortable.

RISKS
There are no foreseeable risks associated with participating in this study. Nonetheless, you should feel free to not answer any questions about which you feel uncomfortable.

BENEFITS
While there is no direct benefit to you by participating in this study, it is hoped that the information gained in this study will benefit the profession by providing valuable information about rural psychologists' perceptions of their job and their current responses to multiple-role relationship situations.

COSTS AND COMPENSATION
You will not have any costs from participating in this study and will not be compensated for participating in this study. For your convenience, a postage-paid return envelop is provided for return of the survey.

PARTICIPANT RIGHTS
Your participation in this study is completely voluntary and you may refuse to participate.

CONFIDENTIALITY
To ensure confidentiality the following measures will be taken: Participants will be assigned a unique code which will be used on forms instead of names. This code will assist the researcher to identify potential participants for follow-up reminders and the mailing of additional surveys. The participant list will be kept in a different location from the surveys. The code will be kept with the surveys. All records will be kept in a locked filing cabinet. Access to the data from this study will be restricted to the principal investigator and supervisor. The data will be retained for 5 years before being destroyed. If the results are published, your identity will remain confidential. By completing and returning the survey in the enclosed postage-paid envelope, you will have given your consent for participation.

QUESTIONS OR PROBLEMS
You are encouraged to ask questions at any time during this study. For further information about the study contact Deb McDermott at (641) 755-3611, debmcd@iastate.edu or Dr. Norman Scott at (515) 294-1509, nascott@iastate.edu. If you have any questions about the rights of research subjects or research-related injury, please contact Ginny Austin, IRB Administrator, (515) 294-4566, austingr@iastate.edu, or Diane Ament, Research Compliance Officer (515) 294-3115, dament@iastate.edu.

Demographic Information

Gender: ☐ Male ☐ Female

Age: ☐ Under 30 yrs. ☐ 30-40 yrs. ☐ 41-50 yrs. ☐ 51-60 yrs. ☐ Over 60 yrs.

Ethnicity (Check all that apply): ☐ African American ☐ Asian or Pacific Islander
☐ Latino(a)/Hispanic ☐ American Indian/Alaska Native ☐ White

Number of years as a practicing doctoral-level psychologist:
☐ Less than 5 years ☐ 5-10 years ☐ 11-20 years ☐ 21 or more years

Type of practice: (check the one that best describes the majority of your time)
☐ Independent Solo ☐ Community Mental Health Center ☐ Other, specify: ______________
☐ Independent Group ☐ Hospital or other In-patient Setting

Do you reside in the community in which you practice? ☐Yes ☐ No

I consider myself a: ☐ Full-time practitioner ☐ Part-time practitioner (_____ hours/week)

How much do you enjoy practicing in a rural area?
☐ Don't at all Enjoy ☐ Moderately Don't Enjoy ☐ Slightly Don't Enjoy ☐ Slightly Enjoy ☐ Moderately Enjoy ☐ Very Much Enjoy

To what extent do you have opportunities for consultation with other mental health professionals?
☐Very Inadequate ☐Moderately Inadequate ☐Slightly Inadequate ☐Slightly Adequate ☐Moderately Adequate ☐Very Adequate

Usual mode of current consultation:
☐ Face-to-face ☐ Email ☐ Phone ☐ Mail ☐ Other (ie, video)

How frequently do you consult (formally & informally) with colleagues on cases per month?
☐ Less than 1 hour ☐ 1 – 5 hours ☐ 6 – 10 hours ☐ More than 10 hours

To what extent do you have opportunities for supervision of your clinical work?
☐ Very Inadequate ☐ Moderately Inadequate ☐Slightly Inadequate ☐Slightly Adequate ☐Moderately Adequate ☐Very Adequate

Usual mode of current supervision:
☐ Face-to-face ☐ Email ☐ Phone ☐ Mail ☐ Other (ie, video)

How frequently do you receive supervision per month?
☐ Less than 1 hour ☐ 1 – 5 hours ☐ 6 – 10 hours ☐ More than 10 hours

(PLEASE TURN OVER)

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Contact Information:

Consulting Psychologists Press
3803 E. Bayshore Road
P.O. Box 10096
Palo Alto, CA 94303
Telephone: (800) 624-1765, fax (415) 969-8608

Vignette 1A

Instructions: Please read the situation described below and imagine yourself as Dr. L. What do you think about this situation? How would you respond if this happened to you? Keep these questions in mind as you read the vignette below.

Dr. L has been a member of the local school board for three years along with S. They both enjoy their roles and are assets to the school district and community. Dr. L was approached by S at Dr. L's practice for counseling services regarding depressive symptoms. After discussing S's concerns, it seems likely, but not guaranteed, that S will require 20 bi-weekly sessions to address depression.

Dr. L is the only mental health provider in the community and the nearest referral source is approximately one-hour away. S reports that, due to work, family and transportation constraints, utilizing a service provider at that distance isn't feasible and would not be pursued. Dr. L's current schedule allows for these services and the needs appear to be within Dr. L's scope of practice.

As visible persons in a small community, Dr. L and S have contact with each other a couple of times per week, generally greeting each other and having minimal conversations about the weather or some community function. Once a month, Dr. L and S spend approximately two hours together as members of the local school board. A couple of times per year, additional meetings are called for special purposes. A variety of issues are discussed at the school board meetings. Dr. L and S agree on many issues; however, there are times when S and Dr. L do not agree.

As Dr. L, indicate the degree to which you perceive this situation to be ethically challenging? (Circle One)

Very Unchallenging	Moderately Unchallenging	Slightly Unchallenging	Slightly Challenging	Moderately Challenging	Very Challenging

Imagine yourself as Dr. L., how likely are you to engage in a therapeutic relationship with S? (Circle One)

Definitely Not Likely	Moderately Not Likely	Slightly Not Likely	Slightly Likely	Moderately Likely	Definitely Likely

Imagine yourself as Dr. L., how likely are you to discontinue your position on the school board? (Circle One)

Definitely Not Likely	Moderately Not Likely	Slightly Not Likely	Slightly Likely	Moderately Likely	Definitely Likely

(PLEASE TURN OVER)

As Dr. L, how troubling are the following aspects of the situation in deciding whether to engage in a therapeutic relationship with S. Write the corresponding number in the line next to each item:

0 = Not Troubling 1 = Slightly Troubling 2 = Moderately Troubling 3 = Highly Troubling

_______ Type of outside of therapy contact with S.
_______ Amount of time spent with S in the outside of therapy contact.
_______ Client's presenting problem.
_______ Amount of potential therapy contact.
_______ Lack of local referral sources.
_______ Unlikelihood of the client pursuing another provider.
_______ Lack of clear guidelines in the literature for managing such dilemmas.

In your own practice, how challenging are the multiple-role relationship dilemmas you encounter? (Circle One)

Very Unchallenging	Moderately Unchallenging	Slightly Unchallenging	Slightly Challenging	Moderately Challenging	Very Challenging

In your own practice, how often do you personally experience multiple-role relationship dilemmas? (Circle One)

Never Annually Monthly Bi-weekly Weekly Daily

In your own practice, how accessible is the nearest mental health practitioner that you would consider as an appropriate referral source most of the time, when needed? (Circle One)

Very Inaccessible	**Moderately Inaccessible**	**Slightly Inaccessible**	**Slightly Accessible**	**Moderately Accessible**	**Very Accessible**

Thank you for completing and returning this survey!

Dear Rural Psychologist,

This is a follow-up request to the survey we sent ten days ago asking for your assistance with a research project about psychologists practicing in a rural area. We were inquiring about your responses to a multiple-role relationship ethical dilemma situation and to questions about your job.

If you have already returned the survey to us, we sincerely thank you for your assistance. If you have not returned the survey, it would be greatly appreciated if you could take about 10 minutes to complete and return the survey. Your response is extremely valuable so that we can obtain the most accurate and complete information possible on rural psychologists practicing in the United States.

Again, thank you for responding to this survey! As we stated before, all responses will be kept strictly confidential. No names will ever be associated with completed surveys.

Sincerely,

Deb McDermott, Ed. S.
Ph.D. Candidate Counseling Psychology
Iowa State University

Norman A. Scott, Ph. D.
Associate Professor of Psychology
Iowa State University

Appendix C: Vignettes

VIGNETTE CLASSIFICATION SYSTEM

	A Pre-therapy	B Concurrent	C Post-relationship/pre-therapy
1 Professional	School Board Potential Client	School Board Current Client	Prior School Board Potential Client
2 Social	Couple's Golf League Potential Client	Couple's Golf League Current Client	Prior Couple's Golf League Potential Client
3 Overlapping With Family Member	Child's Teacher Potential Client	Child's Teacher Current Client	Former Child's Teacher Potential Client

Vignette 1A

Instructions: Please read the situation described below and imagine yourself as Dr. L. What do you think about this situation? How would you respond if this happened to you? Keep these questions in mind as you read the vignette below.

Dr. L has been a member of the local school board for three years along with S. They both enjoy their roles and are assets to the school district and community. Dr. L was approached by S at Dr. L's practice for counseling services regarding depressive symptoms. After discussing S's concerns, it seems likely, but not guaranteed, that S will require 20 bi-weekly sessions to address depression.

Dr. L is the only mental health provider in the community and the nearest referral source is approximately one-hour away. S reports that, due to work, family and transportation constraints, utilizing a service provider at that distance isn't feasible and would not be pursued. Dr. L's current schedule allows for these services and the needs appear to be within Dr. L's scope of practice.

As visible persons in a small community, Dr. L and S have contact with each other a couple of times per week, generally greeting each other and having minimal conversations about the weather or some community function. Once a month, Dr. L and S spend approximately two hours together as members of the local school board. A couple of times per year, additional meetings are called for special purposes. A variety of issues are discussed at the school board meetings. Dr. L and S agree on many issues; however, there are times when S and Dr. L do not agree.

Vignette 1B

Instructions: Please read the situation described below and imagine yourself as Dr. L. What do you think about this situation? How would you respond if this happened to you? Keep these questions in mind as you read the vignette below.

Dr. L has been a member of the local school board for three years, a role that is both enjoyed and seen as an asset to the school district and community. S (one of Dr. L's current therapy clients) informs Dr. L in a therapy session that S is running in the election to be a member of the same local school board on which Dr. L currently serves. S believes that this is a role that would be enjoyed. S has been seen by Dr. L for 10 bi-weekly sessions for depression and will likely need to be seen for 10 additional bi-weekly sessions.

Dr. L is the only mental health provider in the community and the nearest referral source is approximately one-hour away. S reports that, due to work, family and transportation constraints, utilizing a service provider at that distance isn't feasible and would not be pursued. S would like to continue therapy with Dr. L. Dr. L's current schedule allows for the continuation of these services and S's needs are within Dr. L's scope of practice.

As visible persons in a small community, Dr. L and S have contact with each other a couple of times per week, generally greeting each other and having minimal conversations about the weather or some community function. Once a month, Dr. L spends approximately two hours as a member of the school board. A couple of times per year, additional meetings are called for special purposes. A variety of issues are discussed at the school board meetings. Dr. L believes that Dr. L and S will probably agree on many issues; however, there may be times when S and Dr. L will not agree.

Vignette 1C

Instructions: Please read the situation described below and imagine yourself as Dr. L. What do you think about this situation? How would you respond if this happened to you? Keep these questions in mind as you read the vignette below.

Dr. L and S have served together as members on the local school board for three years, both of whom enjoyed their roles and were viewed as assets to the school district and community. Dr. L decided not to run for reelection. One month following Dr. L's school board service, S approached Dr. L for counseling services for depressive symptoms.

Dr. L is the only mental health provider in the community and the nearest referral source is approximately one-hour away. S reports that, due to work, family and transportation constraints, utilizing a service provider at that distance isn't feasible and would not be pursued. Dr. L's current schedule allows for these services and S's needs appear to be within Dr. L's scope of practice.

As visible persons in a small community, Dr. L and S have contact with each other a couple of times per week, generally greeting each other and having minimal conversations about the weather or some community function. During the three years serving together on the school board, Dr. L and S spent approximately two hours together each month. A couple of times per year, additional meetings were held for special purposes. A variety of issues were discussed at the school board meetings. Dr. L and S agreed on many issues; however, there were times when S and Dr. L did not agree.

Vignette 2A

Instructions: Please read the situation described below and imagine yourself as Dr. L. What do you think about this situation? How would you respond if this happened to you? Keep these questions in mind as you read the vignette below.

Dr. L and spouse decided to join the couple's golf league rotation at the local golf course. Every Friday evening for 10 weeks, Dr. L and spouse will be paired with a different couple to play a round of golf, which takes about 2 hours. Afterwards, a meal and social time will be provided at the club house.

After 5 weeks of playing in the couple's golf league, Dr. L was approached by S at Dr. L's practice for counseling services regarding depressive symptoms. After discussing S's concerns, it seems likely, but not guaranteed, that S will require 20 bi-weekly sessions to address depression.

Dr. L is the only mental health provider in the community and the nearest referral source is approximately one-hour away. S reports that, due to work, family, and transportation constraints, utilizing a service provider at that distance isn't feasible and would not be pursued. Dr. L's current schedule allows for these services and the needs appear to be within Dr. L's scope of practice.

In addition to the time at the golf course, Dr. L and S have contact with each other a couple of times per week in the community, generally greeting each other and having minimal conversations about the weather or some community function. Dr. L and spouse are enjoying the couple's golf league and social time immensely. Both Dr. L and S have attended the dinner/social time for about one hour each Friday evening.

Vignette 2B

Instructions: Please read the situation described below and imagine yourself as Dr. L. What do you think about this situation? How would you respond if this happened to you? Keep these questions in mind as you read the vignette below.

Dr. L and spouse have been playing in the couple's golf league rotation at the local golf course for the past three summers. The rotation involves being assigned to play a round of golf (about 2 hours) with a different couple every Friday evening for 10 weeks. In addition, a dinner/social time is provided following the golfing. S (one of Dr. L's current therapy clients) has been seen by Dr. L for 10 bi-weekly sessions for depression and will likely need to be seen for 10 additional bi-weekly sessions.

Client S informs Dr. L, in a therapy session, that S and spouse have just joined the couple's golf league scramble. It is very likely that Dr. L and spouse will be assigned to play golf with S and spouse at least once during the summer. Since the meal is included in the golf package, it is quite likely that Dr. L and spouse will spend about one hour at the weekly dinner/social time with S and spouse in a larger group setting.

Dr. L is the only mental health provider in the community and the nearest referral source is approximately one-hour away. S reports that, due to work, family, and transportation constraints, utilizing a service provider at that distance isn't feasible and would not be pursued. S would like to continue therapy with Dr. L. Dr. L's current schedule allows for the continuation of these services and S's needs are within Dr. L's scope of practice.

In addition to the potential time at the golf course, Dr. L and S have contact with each other a couple of times per week in the community, generally greeting each other and having minimal conversations about the weather or some community function. Dr. L and spouse enjoy the couple's golf league and social time immensely.

Vignette 2C

Instructions: Please read the situation described below and imagine yourself as Dr. L. What do you think about this situation? How would you respond if this happened to you? Keep these questions in mind as you read the vignette below.

Dr. L and spouse played in the couple's golf league rotation at the local golf course every Friday evening for 10 weeks. During the 10-week period, Dr. L and spouse were paired twice with S and spouse for golf. The rounds of golf took about 2 hours each. Afterwards, both couples routinely joined the rest of the couple's league at the club house for a meal and social time for about an hour each Friday.

One month after the golf league ended, Dr. L was approached by S at Dr. L's practice to request counseling services regarding depressive symptoms. After discussing S's concerns, it seemed likely, but not guaranteed, that S would require 20 bi-weekly sessions to address depression.

Dr. L is the only mental health provider in the community and the nearest referral source is approximately one-hour away. S reports that, due to work, family, and transportation constraints, utilizing a service provider at that distance isn't feasible and would not be pursued. Dr. L's current schedule allows for these services and the needs appear to be within Dr. L's scope of practice.

In addition to the time at the golf course, Dr. L and S have contact with each other a couple of times per week in the community, generally greeting each other and having minimal conversations about the weather or some community function. Dr. L and spouse enjoy the couple's golf league and social time immensely.

Vignette 3A

Instructions: Please read the situation described below and imagine yourself as Dr. L. What do you think about this situation? How would you respond if this happened to you? Keep these questions in mind as you read the vignette below.

Dr. L's child was diagnosed with Asperger's Syndrome in early elementary school which necessitated significant home-school contact over the past several years. Dr. L's child is currently in Jr. High School and is taught in the special education classroom for about 50% of the school day.

Although there is one other special education teacher for the Middle School, S is the one who teaches students needing a specialized curriculum and requiring services outside of the general education environment to the extent that Dr. L's child needs. S has been Dr. L's child's special education teacher for the past three years and will likely continue for one more year. Typically, Dr. L and spouse attend four educational planning meetings per school year with S and colleagues.

Recently, Dr. L was approached by S at Dr. L's practice for counseling services regarding depressive symptoms. After discussing S's concerns, it seems likely, but not guaranteed, that S will require 20 bi-weekly sessions to address depression.

Dr. L is the only mental health provider in the community and the nearest referral source is approximately one-hour away. S reports that, due to work, family and transportation constraints, utilizing a service provider at that distance isn't feasible and would not be pursued. Dr. L's current schedule allows for these services and the needs appear to be within Dr. L's scope of practice.

Besides their contact through the school system, Dr. L and S also have contact with each other a couple of times per week in the community, generally greeting each other and having minimal conversations about the weather or some community function.

Vignette 3B

Instructions: Please read the situation described below and imagine yourself as Dr. L. What do you think about this situation? How would you respond if this happened to you? Keep these questions in mind as you read the vignette below.

Dr. L's child was diagnosed with Asperger's Syndrome in early elementary school which necessitated significant home-school contact over the past several years. Typically, Dr. L and spouse attend four educational planning meetings per school year.

Dr. L has been seeing S (a current therapy client) for 10 bi-weekly sessions for depression and will likely continue for 10 additional bi-weekly sessions to address depressive symptoms. During a recent session, S informed Dr. L that S had just been hired as the new Middle School special education teacher and will be the new teacher of Dr. L's child. Although there is one other special education teacher for the Middle School, S is the one who teaches students needing a specialized curriculum and requiring services outside of the general education environment to the extent that Dr. L's child needs. Currently, Dr. L's child is served in the special education classroom for about 50% of the school day. Therefore, everyday for the next three years, S will teach Dr. L's child for about half of the school day.

Dr. L is the only mental health provider in the community and the nearest referral source is approximately one-hour away. S reports that, due to work, family and transportation constraints, utilizing a service provider at that distance isn't feasible and would not be pursued. S would like to continue therapy with Dr. L. Dr. L's current schedule allows for the continuation of these services and S's needs are within Dr. L's scope of practice.

Besides the therapy sessions, Dr. L and S have contact with each other a couple of times per week in the community, generally greeting each other and having minimal conversations about the weather or some community function.

Vignette 3C

Instructions: Please read the situation described below and imagine yourself as Dr. L. What do you think about this situation? How would you respond if this happened to you? Keep these questions in mind as you read the vignette below.

Dr. L's child was diagnosed with Asperger's Syndrome in early elementary school which necessitated significant home-school contact over the past several years. Typically, Dr. L and spouse attend four educational planning meetings per school year.

S was Dr. L's child's special education teacher for the past three years. During this time, Dr. L's child was served in the special education classroom for about 50% of the school day. S taught Dr. L's child everyday for about half the day. Recently, S resigned the teaching position to open a daycare business. One month later, S visited Dr. L's practice requesting counseling services for depressive symptoms. After discussing S's concerns, it seems likely, but not guaranteed, that S will require 20 bi-weekly sessions to address depression.

Dr. L is the only mental health provider in the community and the nearest referral source is approximately one-hour away. S reports that, due to work, family and transportation constraints, utilizing a service provider at that distance isn't feasible and would not be pursued. Dr. L's current schedule allows for these services and the needs appear to be within Dr. L's scope of practice.

Besides their past contact, Dr. L and S continue to have contact with each other a couple of times per week in the community, generally greeting each other and having minimal conversations about the weather or some community function.

Appendix D: Pilot Study

Rural Mental Health Practitioners' Perceptions of Counseling Situations

Department of Psychology
Iowa State University
W112 Lagomarcino Hall
Ames, IA 50011-3180

Dear Rural Mental Health Professional:

My name is Deb McDermott, and I am a doctoral student in the Counseling Psychology program at Iowa State University. My interest in rural mental health has prompted me to conduct research in this area. Prior to conducting a national research project, I am collecting pilot data about counseling situations that I'm proposing to use in the study. I'm especially interested in your perceptions of these vignettes, as a rural mental health provider.

Enclosed are three vignettes, each with a brief survey, and a postage-paid return envelope. Please review the enclosed materials and decide if you would like to participate. Your participation is completely voluntary and will remain anonymous. Moreover, the University Institutional Research Board (IRB) at Iowa State University has approved this research. (Complete IRB-related information about this study is enclosed on a separate page.) Return of the surveys will constitute informed consent for participation. It should only take about 10-minutes to read the three vignettes and complete all three surveys.

Your feedback and suggestions are extremely valuable to this study and will be used to improve the counseling situations for use in a subsequent national study. Your responses will be aggregated and anonymous. This study and the subsequent national project have the potential of advancing the knowledge of rural mental health practices.

Please feel free to ask questions at any time. For further information about this pilot study or the research project contact Deb McDermott at 641-755-3611, debmcd@iastate.edu or Dr. Norman Scott at 515-294-1509, nascott@iastate.edu.

Please complete and return the surveys by August 15, 2005. Your responses are essential for this project. Thank you in advance for your consideration and support!

Sincerely,

Deb McDermott, Ed.S.
Doctoral Student in Counseling Psychology
Iowa State University
debmcd@iastate.edu
(641) 755-3611

Norman A. Scott, Ph.D.
Associate Professor of Psychology
Department of Psychology
Iowa State University
nascott@iastate.edu
(515) 294-1509

INFORMED CONSENT DOCUMENT

Title of Study: Rural Mental Health Practitioners' Perceptions of Counseling Situations
Investigators: Deborah McDermott, Ed.S., Principal Investigator
Norman A. Scott, Ph.D., Faculty Supervisor

This is a research study. Please take your time in deciding if you would like to participate.

DESCRIPTION OF STUDY
The purpose of this study is to collect rural mental health practitioners' perceptions of the enclosed counseling situations. You are being invited to participate in this study because you are a licensed mental health practitioner practicing in Greene, Dallas, or Guthrie counties in Iowa.

DESCRIPTION OF PROCEDURES
Your participation is voluntary. You are being asked to complete 3 very brief, anonymous questionnaires that will involve you reading 3 counseling situations and estimating how similar these situations are to those you encounter in your practice. This task will take about ten (10) minutes. You may skip any questions or items that you do not wish to answer or that make you feel uncomfortable.

RISKS
There are no known risks associated with this study. Nonetheless, you should feel free to not answer any questions about which you feel uncomfortable.

BENEFITS
While there is no direct benefit to you by participating in this study, the feedback that only you can provide will be greatly appreciated and will aid us in better understanding counseling situations rural mental health practitioners face.

COSTS AND COMPENSATION
You will not incur any costs from participating in this study and will not be compensated for participating in this study. For your convenience, a postage paid return envelop is provided for return of the questionnaires.

PARTICIPANT RIGHTS
Your participation in this study is completely anonymous and voluntary, and you may choose to not answer any question that makes you feel uncomfortable.

CONFIDENTIALITY
Your responses to these surveys will be treated as confidential information and will remain **anonymous**. Access to the data from this study will be restricted to the principal investigator and supervisor. Results of this study will be used to improve the counseling vignettes for use in a succeeding national survey. By completing and returning the surveys in the enclosed postage paid envelope, you will have given your consent for participation.

QUESTIONS OR PROBLEMS
Questions about the survey can be addressed to Debby McDermott, Department of Psychology, debmcd@iastate.edu (641-755-3611), or to Dr. Norman A. Scott, Department of Psychology, nascott@iastate.edu (515-294-1509). If you have any questions about the rights of research subjects at Iowa State University, please contact, Ginny Austin-Eason, at the Human Subjects Research Office, 1138 Pearson Hall (515-294-4566) or Diane Ament, the Research Compliance Officer, at the Office of Research Compliance, 1138 Pearson Hall (515-294-3115).

Vignette '1A…3C'

Instructions: After reading each situation presented (vignette) please respond to the following items by circling your response.

How similar is the description of this situation (vignette) to those you encounter in your practice? (Circle One)

Very Dissimilar	Moderately Dissimilar	Slightly Dissimilar	Slightly Similar	Moderately Similar	Very Similar

How realistic or believable is this situation? (Circle One)

Very Unrealistic	Moderately Unrealistic	Slightly Unrealistic	Slightly Realistic	Moderately Realistic	Very Realistic

How clear is the description of this situation? (Circle One)

Very Unclear	Moderately Unclear	Slightly Unclear	Slightly Clear	Moderately Clear	Very Clear

How frequently do you encounter situations similar to this vignette in your practice? (Circle One)

Very Infrequently	Moderately Infrequently	Slightly Infrequently	Slightly Frequently	Moderately Frequently	Very Frequently

To what degree do you perceive this situation to be ethically challenging? (Circle One)

Very Unchallenging	Moderately Unchallenging	Slightly Unchallenging	Slightly Challenging	Moderately Challenging	Very Challenging

If you were Dr. L, how comfortable would you be taking the client on as part of your caseload? (Circle One)

Very Uncomfortable	Moderately Uncomfortable	Slightly Uncomfortable	Slightly Comfortable	Moderately Comfortable	Very Comfortable

How could this story (vignette) be improved? Please list all feedback and or comments. *Use the back of this page to respond.*

If comfortable, please describe the most ethically challenging situation that you've encountered in your practice in the last year. *Use the back of this page to respond.*

Thank you for your assistance with this project!

Feedback or improvements on Vignette ‘1A…3C’:

The most ethically challenging situation that you’ve encountered in the last year:

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Institutional Review Board
Office of Research Compliance
Vice Provost for Research
1138 Pearson Hall
Ames, Iowa 50011-2207
515 294-4566
FAX 515 294-4267

DATE: July 13, 2005

TO: Deborah McDermott
FROM: Human Subject Research Compliance Office

RE: **IRB ID #** 05-332
STUDY REVIEW DATE: July 12, 2005

The Institutional Review Board has reviewed the project, "Rural Mental Health Providers' Perceptions of Counseling Situations (Pilot Study)" requirements of the human subject protections regulations as described in 45 CFR 46.101(b)2. The applicable exemption category is provided below for your information. Please note that you must submit all research involving human participants for review by the IRB. Only the IRB may make the determination of exemption, even if you conduct a study in the future that is exactly like this study.

The IRB determination of exemption means that this project does not need to meet the requirements from the Department of Health and Human Service (DHHS) regulations for the protection of human subjects, unless required by the IRB. We do, however, urge you to protect the rights of your participants in the same ways that you would if your project was required to follow the regulations. This includes providing relevant information about the research to the participants.

Because your project is exempt, you do not need to submit an application for continuing review. However, you must carry out the research as proposed in the IRB application, including obtaining and documenting (signed) informed consent if you have stated in your application that you will do so or required by the IRB.

Any modification of this research must be submitted to the IRB on a Continuation and/or Modification form, prior to making any changes, to determine if the project still meets the Federal criteria for exemption. If it is determined that exemption is no longer warranted, then an IRB proposal will need to be submitted and approved before proceeding with data collection.

cc: Norm Scott
Psychology

Summary of Pilot Study Results

	Similar	Realistic	Clear	Frequency Encounter	Ethical Challenge	Comfort Level
1A	M = 4.4 s.d. = .89	M = 5.0 s.d. = .71	M = 5.6 s.d. = .55	M = 4.2 s.d. = .84	M = 5.0 s.d. = .71	M = 2.8 s.d. = 1.30
1B	M = 3.25 s.d. = 2.06	M = 5.25 s.d. = .96	M = 6.0 s.d. = 0	M = 3.25 s.d. = 2.06	M = 5.75 s.d. = .50	M = 1.5 s.d. = 1.00
1C	M = 4.75 s.d. = .96	M = 5.0 s.d. = .82	M = 5.25 s.d. = .5	M = 4.75 s.d. = .5	M = 4.75 s.d. = .5	M = 3.5 s.d. = 1.29
2A	M = 4.75 s.d. = .5	M = 5.5 s.d. = .58	M = 5.25 s.d. = .5	M = 4.5 s.d. = .58	M = 5.0 s.d. = .82	M = 2.25 s.d. = 1.26
2B	M = 4.0 s.d. = 1.0	M = 4.2 s.d. = .84	M = 4.6 s.d. = .55	M = 4.2 s.d. = .84	M = 4.8 s.d. = .84	M = 2.4 s.d. = 1.14
2C	M = 3.0 s.d. = .82	M = 5.5 s.d. = .58	M = 6.0 s.d. = 0	M = 2.5 s.d. = 1.73	M = 5.25 s.d. = .96	M = 1.5 s.d. = .58
3A	M = 3.75 s.d. = .5	M = 5.5 s.d. = .58	M = 5.5 s.d. = .58	M = 2.25 s.d. = 1.26	M = 5.75 s.d. = .5	M = 1.25 s.d. = .5
3B	M = 4.0 s.d. = 2.16	M = 5.0 s.d. = .82	M = 5.0 s.d. = 0	M = 3.0 s.d. = 1.82	M = 5.75 s.d. = .5	M = 1.5 s.d. = .58
3C	M = 3.2 s.d. = .84	M = 4.4 s.d. = .55	M = 5.2 s.d. = .45	M = 2.4 s.d. = .89	M = 4.0 s.d. = 1.22	M = 3.0 s.d. = 1.22

Verbatim comments made on Pilot Study:

The most ethically challenging situation that you've encountered in the last year:

Typically if you are residing in a small town and possibly have lived their for your whole life the probability of providing service to people you know personally happens pretty frequently.

Former classmates seeking counseling; family member seeking counseling.

I worked outside of the community where I reside, but do find that clients are often related to other clients we have without our knowledge until later sometimes. Also, sometimes we have a limited number of therapists who travel to our small community clinic outreach towns and may live together as a favor to one another.

I worked for Catholic Charities in an urban area but lived in a rural town, where I went to church. Several times (3-5) I received referrals of people who also attended my church. I was also the youth minister and actively participated in my church. It was very important to the clients that they have a therapist of the same denomination. I actually transferred one client (May, 2005) because she would be in my youth group the following school year. I spoke very openly to the family about the situation & our dual relationship. Our profession makes it extremely difficult to not encounter dual relationships. Those who have been in the profession longer sometimes have less of an ethical issue that those who have graduated in the last 10 years—from what I have experienced.

Running into former and present clients in town and managing boundary issues.

Feedback or improvements:
Vignette 3B:
Is "S" agreeable to being seen under these conditions? Then my response is, we're supposed to keep the clients' best interests in mind…this is a good vignette to get people thinking.

Vignette 2C:
This situation is slightly challenging only because I know ethically, Dr. L can't golf in that particular league any longer—according to our code of ethics.

Inter-item Correlations

	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Years in Practice		-.10	.01	-.03	-.16*	-.08	-.09	-.004	.02	-.11	-.08	-.03	-.05
2. Hrs. Worked/Week			-.02	.11	.17*	-.06	-.10	.04	.07	.12	.24	.17	.20
3. Enjoys Practice				.14	.06	.11	.07	-.03	03	-.11	-.14	-.08	.16
4. Opportunities for Consultation					.30**	.48**	.17*	.003	-.09	.28**	-.16*	-.01	.17*
5. Frequency of Consultation						.18*	.36**	-.001	.04	-.03	.13	.07	.13
6. Opportunities for Supervision							.54**	.06	-.02	.08	-.05	-.004	-.02
7. Frequency of Supervision								.03	-.02	-.10	-.002	.05	-.01
8. Own Practice-Challenge of MRR									.44**	.03	.16*	.01	.11
9. Own Practice-Frequency of MRR										-.17*	.20*	.12	.12
10. Own Practice-Accessibility of Referrals											.14	.10	-.02
11. MBI-EE												.59**	-.003
12. MBI-DP													-.08
13. MBI-PA													

* $p < .05$, ** $p < .01$

Appendix F: IRB Approval Form

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Institutional Review Board
Office of Research Assurances
Vice Provost for Research
1138 Pearson Hall
Ames, Iowa 50011-2207
515 294-4566
FAX 515 294-4267

DATE: April 21, 2006

TO: Deborah McDermott

FROM: Institutional Review Board,
Office of Research Assurances

RE: IRB ID: 06-122

Approval Date of Modification: April 12, 2006
Date for Continuing Review: March 14, 2007

The Chair of the Institutional Review Board Chair has reviewed and approved the modification of your protocol entitled: "Rural Psychologists' Responses to Multiple-Role Ethical Delimmas and Job Burnout."

As a reminder, the **continuing review date** for this study is no later than March 14, 2007.

Please remember, any further **changes in the protocol or consent form** may not be implemented without prior IRB review and approval, using the "Continuing Review and/or Modification" form. Research investigators are expected to comply with the principles of the Belmont Report, and state and federal regulations regarding the involvement of humans in research. These documents are located on the Office of Research Assurances website or available by calling (515) 294-4566, www.compliance.iastate.edu.

You must promptly report any of the following to the IRB: (1) **all serious and/or unexpected adverse experiences** involving risks to subjects or others; and (2) **any other unanticipated problems involving risks** to subjects or others.

Upon completion of the project, please submit a Project Closure Form to the Human Subjects Research Office to officially close the project.

CC: Professor Norman Scott