FOCUS ON ETHICS
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Challenges and Benefits of Ethical Small-Community Practice

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Ethical dilemmas and boundary challenges are parts of daily life for psychologists who live and practice within small communities. Although rural psychologists are most readily identified as "small-community psychologists," there are a number of other settings that can be considered small communities—colleges, communities of color/ethnicity/culture, lesbian/gay/bisexual/transgender (LGBT), military, faith-based, feminist, criminal justice and corrections, suburban, disability, deaf/hearing impaired, chemical dependency, school districts, sport psychology, graduate training programs, and therapists who see other therapists as clients. Psychologists in these small communities strive to balance a traditional individualist perspective with a need to participate in and contribute to the overall wellness of the community in which they live and work. The 3 invited commentaries provide additional depth through their perspectives on rural, LGBT, and Latina/o community practice. Their insights model thoughtful and contemporary practice that challenges, enriches, and educates the larger field of ethical psychological practice.

Keywords: ethics, small communities, LGBT, multicultural, rural

Challenges and Benefits of Ethical Small-Community Practice

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When psychologists hear the terms *small*, *insulated*, or *contained* communities, rural and frontier settings may first to come to mind. The field of rural psychology has done much to expand our ideas of what constitutes ethical practice in small communities. Dilemmas regarding professional boundaries, limited resources and limits of competence, community expectations and values differences, issues with other professionals, working with peer and other community helpers, and burnout are among the ethical issues that have been identified by psychologists who live and practice in rural and frontier communities (Schank, 1998; Schank & Skovholt, 1997, 2006; Schank, Slater, Banerjee-Stevens, & Skovholt, 2003).

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The perspective began to expand by relating rural issues to issues faced in other small communities. Barnett and Yutrzenka (1995) connected rural ethical issues to those faced by psychologists in military communities, addressing the likelihood of out-of-therapy contact and the importance of compartmentalizing roles rather than relationships.

Gartrell (1992) and Lyn (1990) were among those who focused on small-community ethical issues in LGBT communities. Amada (1996) and Sharkin (1995) highlighted the ethical concerns of psychologists who practice in the small community of college counseling. Parham (1997) and Sue (1997) were among the first to bring attention to ethical issues in communities of color.

Psychologists in other small communities have entered the ever-widening discussion. Faith-based, feminist, criminal justice and corrections, military, suburban, disability, deaf/hearing impaired, chemical dependency, school districts, sport psychologists, graduate training programs, and psychotherapists who treat other psychotherapists represent other small communities with their own similar, yet unique, dilemmas. The dilemmas are further compounded by psychologists who are a part of two or more overlapping communities—for example, the gay Latino psychologist, who works at a small college near where he lives, may also counsel clients within the chemical dependency community; and those clients may show up at an AA group that the psychologist has attended for many years.

Primary Issues Across Most Small Communities

Psychologists in small communities are faced with myriad instances of possible overlap, particularly in treating clients who have relationships or connections with other clients and in overlapping social or professional relationships with others in their small community. The issue becomes how to handle dilemmas and overlap, rather than how to avoid them. Overlaps can occur by choice or by chance (Moleski & Kiselica, 2005). Those possibilities for overlap quickly multiply when broadened to include the psychologist's family members—young clients who are friends with the psychologist's child or business and social relationships between clients and the psychologist's partner or spouse. There will be numerous occasions when psychologists have out-of-therapy information about clients—information that they may at times need to "keep confidential from themselves" as they evaluate when and where they obtained the information and whether they can share that information with the client.

Psychologists in small communities are also constricted by high visibility and lack of privacy. Others in the community may be quick to react, either positively or negatively, to information about a particular client or case outcome. News travels fast in small communities, and inaccuracies abound. Personal behavior by the psychologist and members of his or her family is open to public perusal and discussion.

Acts of everyday living are self-disclosures, which challenge psychologists to remain within their appropriate role according to the situation—professional, personal, or social. The longer a psychologist works within a small community, the greater the potential for these kinds of overlaps.

Posttherapy relationships may be especially difficult to avoid in small communities. It may be awkward to avoid posttherapy casual relationships and friendships, but it may be even more problematic to enter into them. In their examination of nonromantic, nonsexual posttherapy relationships between psychologists and former clients, Anderson and Kitchener (1998) asked, "Is this posttherapy relationship avoidable, and if it is, why am I considering entering it? One year from now, will I be satisfied with my decision?" (p. 96). These two questions can provide an initial framework and careful consideration for psychologists who are wondering whether or not to enter into specific posttherapy relationships.

If managed ethically, overlapping relationships can be seen as an advantage when practicing in small communities. Psychologists are more likely to see the results of their work with clients and are more able to understand the context of the problems that clients bring to treatment. It is likely that small-community psychologists are already known and, hopefully, trusted within the community. Clients may seek them precisely because they are a part of the community and seen as someone who would understand clients' needs. Clients and community members often see overlap as a strength, and so could we.

Working with other professionals in the community presents interesting dilemmas in small communities. Different professionals may disagree with psychologists' need to maintain confidentiality and appropriate boundaries, and those disagreements must be handled with diplomacy by psychologists to avoid being seen as uncooperative or stand-off-ish. In addition, small-community psychologists face a difficult decision when required to report the unethical behavior of other professionals within the community or when having to make mandated child protection reports regarding others who are well-known throughout the community.

Good working relationships with other professionals are essential when working in a small community. These relationships can prove to be especially vital in securing additional resources and services for clients. Psychologists who "can't collaborate or who get caught up in turf wars simply don't last long" (Link, 2007, p. 58) in rural/frontier practice and when practicing in a range of other small communities.

Connections Across Small Communities

Picture a circle filled with different kinds of small-community ethical issues and then surround that circle with a list of all the different small communities. If we were to draw lines between each of the small communities and the ethical issues they face, we would see a web of connections. A few of the possible examples include the following:

1. Small-college and law-enforcement psychologists who are faced with similar yet differing pressures to reveal confidential information.

2. Rural and Native American psychologists who may have frequent out-of-therapy contact with clients and their families and who may collaborate with local helpers and healers.

3. Sport and faith-based psychologists who may attend events where clients are usually present.

4. Deaf/hard-of-hearing and chemical dependency psychologists who may socialize with clients and family members of clients within their small communities.

5. LGBT and African American psychologists who are sought for therapy precisely because they are visible within their own small community.

6. Asian American and rural psychologists who want to support businesses within their communities but must then deal with the strong possibility of business transactions with current or former clients and the families of those clients.

Small-community psychologists' lives are personally and professionally intertwined with those of their clients. Psychologists and their clients are known in family, social, and historical contexts. When multiplied across the various small communities, the numbers of psychologists who are facing these ethical issues constitute a significant part of psychology.

Steps to Minimize Risk

Barnett, Behnke, Rosenthal, and Koocher (2007) proposed six questions for psychologists to ask themselves when trying to make ethical decisions in the face of dilemmas: "Will doing this be helpful to my client?"; "Will this action likely harm anyone?"; "To whom do I owe an obligation or allegiance in this situation?"; "Will this action likely promote dependence on me by my client?"; "Are my actions consistent with how other psychologists treat their clients?"; and "Have I allowed my judgment to become impaired as a result of inadequate attention to my own care of needs?" (p. 8).

These are a few of the steps that small-community psychologists can take to minimize risk and, more important, to practice ethically and professionally.

1. Obtain Informed Consent

Given the risk of misinformation and rumors in small communities, psychologists should be especially clear with clients about confidentiality and its limits, how records are kept, and what services are and are not provided. This discussion should include the likelihood of incidental contact and the possibility or actuality of overlapping relationships, along with how these will be handled. Clients should also be informed about any consultation that psychologists enter into with other health professionals.

2. Document Thoroughly

Some psychologists believe that minimal documentation is most appropriate when dealing with overlapping relationships and other ethical issues. In fact, the opposite is true. It is important to thoroughly document any overlapping relationship and the psychologist's rationale for entering into the overlapping relationship. It is also necessary to document any consultation with other professionals around overlapping relationships and other ethical issues, as well as any discussion with clients themselves (Schank & Skovholt, 2006).

3. Set Clear Boundaries and Expectations, Both Within Yourself and With Clients

It is important that psychologists talk about clients' expectations of the therapist and the psychotherapy relationship and clarify their own obligations and limits, especially in situations where it is difficult to control out-of-office contact. Psychologists should consider the best possible outcome and the worst possible outcome, along with ways to address potential harm that may occur (Pope & Keith-Spiegel, 2008). Self-monitoring does not end once an initial decision is made. It is an ongoing process to ensure that actions are in the best interest of clients as situations and factors change during the ongoing course of treatment.

4. Pay Particular Attention to Issues of Confidentiality

It may be difficult for psychologists to remember where they learn specific information in situations where that information can come from both in-treatment and out-of-treatment sources. Word travels quickly and often inaccurately about work-related conversations and examples that may be used in presentations or meetings.

Although psychologists cannot control who is seen coming and going from their offices, they can control actions that may breach confidentiality. As an example, psychologists in rural areas often talk about needing to find ethical ways to handle financial transactions because depositing checks for copayments in a local bank could reveal the identity of clients to those who handle the deposits.

5. Get Involved in Ongoing Consultation and Education

As Smith and Fitzpatrick (1995) indicated, consultation is especially important in situations where it may be difficult to maintain appropriate boundaries and ethical standards. It is wise to build a network of trusted colleagues with whom psychologists can consult.

Education in the ethical issues of small communities is not commonly offered in most graduate programs, so it is imperative that small-community psychologists continue to seek relevant training. The reality is that "once a psychologist begins practicing in small communities, he or she quickly realizes the need for the development of ethical decision-making skills rather than quick answers to complicated situations" (Schank & Skovholt, 2006, p. 188).

Conclusions

The primary focus of this introductory article has been on the ethical issues common to those who practice within small communities. Small-community ethics are not a less-than-professional way to practice. Rather, they provide more depth and variety to the field. Instead of operating in silos, small communities can unite to explore issues and influence policy. Our understanding of small-community issues will be deepened by including and connecting the wide range of communities that are easily defined as similar, yet different, in what they bring to the discussion. The burgeoning Internet age has sped up the urgency of these issues as it becomes more and more difficult to maintain boundaries, especially for those in small and overlapping communities. These and other relevant issues are the focus of the invited commentaries that follow this article. Similarities and differences are addressed from the perspectives of psychologists who practice in a rural commu-

nity, the LGBT community, and the Latina/o community. Each author discusses the ethical issues related to boundary challenges, overlapping relationships, and confidentiality. Particular attention is paid to the high visibility of psychologists in these small communities, and each author also identifies cultural issues unique to the community in which he lives and works.

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Living and Working in a Rural Community

Craig M. Helbok

I would like to thank Janet Schank for her many contributions to the literature on the practice of psychology in rural and small communities, including this most recent lead article. Her work has been most valuable in my own research on this important topic. Many aspects of rural practice pose a challenge to the practitioner, such as dealing with multiple relationships, confidentiality, high visibility in the community, managing personal and professional boundaries, being a generalist but attending to boundaries of competence, and working in isolation, to name a few. In addition, many of these areas overlap. For example, being active in one's community can lead to more multiple relationships to consider and negotiate, which in turn can affect one's self-care and levels of stress; for example, in an urban setting, we might enjoy the anonymity of a local gym to relieve the stress from our workday, whereas in a rural community, we may be likely to run into our clients at the gym and feel we are still at work. One respondent in my research discussed being uncomfortable changing at the gym in front of patients, for example.

Although many of these facets of rural practice interact and deserve comment, I limit my comments to living and working in a rural community. Since my initial research on this topic, I have lived and worked in several small communities, from populations of 18,000 to fewer than 2,000 persons. In addition, I have stayed active in talking with other providers and researchers who work in rural communities and struggle with these issues. Despite the difficulties of living and working in a rural community, many providers find the unique characteristics of this work to be challenging and rewarding (Elkin & Boyer, 1987).

Schank makes an important point that many small communities, sometimes located within a larger urban community, often share characteristics similar to a rural community. Several respondents mentioned this in my research, including respondents who work with specific disability groups, such as the deaf community; work specifically with gay and lesbian patients; provide employee assistance programs in the workplace; are military psychologists; or work with specific ethnic or religious groups. Although these communities may share similar characteristics to rural communities, such as being highly visible or difficulties managing confidentiality and multiple relationships, there are still differences, as the rural practitioner will quickly notice. For example, addictions counselors in an urban setting, who are in recovery themselves, may be well known in the recovery community and struggle with multiple relationships; however, they still may be able to find 12-Step meetings where they are anonymous. However, at the rural chemical dependency treatment program for which I provided consultation, which served several counties, the addictions counselors were not able to find any 12-Step meetings within an hour or longer drive without running into many of their patients. In an urban setting, too, patients may have more access to resources like public transportation, drop-in centers, and social services that are not available in rural communities.

Certainly one of the most identified ethical concerns when working in a rural community is coping with multiple relationships (Faulkner & Faulkner, 1997; Jennings, 1992; Schank, 1998;

Schank & Skovholt, 1997). When working in a rural community, providers are immediately confronted with the reality that they will be interacting with patients outside of the therapeutic frame in a number of different contexts. These extratherapeutic contacts involve a change in roles, one that can be disconcerting for therapists initially. In my research, therapists talked about being uncomfortable with patients learning so much about them from these contacts. Some providers discussed their discomfort when, for example, their children are misbehaving in public and how it might reflect on them as a therapist. Of course, several writers also point out that it can be therapeutic for patients to know the therapist outside the therapeutic relationship, to see that therapists are people with problems that they overcome too (Sterling, 1992). It is clear from the anecdotal writing of therapists working in rural communities, and from research, that multiple relationships are more common in rural communities, and that managing the change in roles from the therapeutic relationship can be disconcerting for therapists who live and work in a rural community.

As Schank articulates, it is not only the multiple relationships that therapists have with their patients that present an ethical concern, but therapists also have to manage relationships between themselves and patients who know each other, or a patient who turns out to work closely with a friend of the therapist, or having their children befriend a patient or children of a patient. A community can seem to quickly close in on therapists as they learn how small this interconnected network of relationships, personal and professional, can be. Another example of the overlap of ethical principles in small communities is that multiple relationships can lead to concerns about confidentiality, as therapists need to pay attention to where they learned information that may come up in routine conversations with community members, whether it was from a conversation at the grocery store, the media, the little league team meeting, or a therapy session. Therapists will also learn much about their patients outside the therapy session from members of the community and from other patients. They need to decide how, when, and whether to bring this information into the therapeutic frame.

These ethical dilemmas are inevitable, and Schank lists some important proactive steps to minimize risk. One of the most important is to discuss these issues with patients at the first session and make this part of the informed consent. For example, I always talk with patients about how they want to handle incidental contacts in the community because saying hello to a patient in the community can break confidentiality. It is also important to discuss what information is shared with whom and who has access to the medical record (e.g., how are medical staff not involved in a patient's treatment discouraged from reading community members' medical records?). I talk to patients about what kinds of information I put in my notes, which are generally quite pithy because of these concerns. Because of personal and professional overlap with some patients, it is important to talk specifically about boundaries, role demands, and the therapeutic frame so that the session does not become overly social.

An area that I have found to be very important in working in rural communities is the high level of visibility the psychologist, or provider, has in the community. Several writers have pointed out that to build a practice in a rural community, to develop trust and respect in the community, it is necessary to become involved in the community (Barbopoulos & Clark, 2003; Helbok, 2003; Koocher & Keith-Spiegel, 1998; Martinez-Brawley, 1986; Stockman, 1990; Wilcoxon, 1989). Visibility in the community overlaps with multiple relationships, but also, importantly, affects the way therapists take care of themselves and how they mange the complexities of professional and personal life in a small community. Some providers avoid doing things in the community altogether. To quote a respondent in my survey of rural ethics (Helbok, Marinelli, & Walls, 2006), "I have avoided somewhat getting involved in community organizations due to not wanting dual relationships or uncomfortable encounters. I have avoided joining the health clubs for the same reason" (p. 42). To model the use of self-disclosure, I share that one of the ways I take care of myself is the use of mind–body practices, such as meditation and yoga. As a health psychologist in a medical center, I also recommend such mind–body practices as a tool for patients to cope with anxiety or chronic medical conditions. Therefore, when I worked in one rural community, I tended to avoid the local yoga or meditation classes because I recommended patients try those classes; instead, I traveled some distance to take a yoga class. I also traveled each year to do a week-long meditation/yoga retreat to be with like-minded people and to rejuvenate my self-care practices. Fortunately for myself, my hospital made our rehabilitation fitness center available to staff after hours.

On the other hand, as Barbopoulos and Clark (2003) point out, it is important not to isolate oneself completely from the community too. There are many ways to be involved in the community, such as giving presentations, working with schools, and the like. I feel that it is important to achieve some balance in this, to be involved and a part of the community, but also to find ways to create our own space, to rejuvenate or center ourselves, even if it means needing to travel some distance. This can make us better providers and members of the community in which we live and work. As Schank points out, because these ethical dilemmas are an inevitable aspect of our work in small or rural communities, we need to be that much more diligent. Although the ethical codes apply to our work as professionals, in a rural community where professional and personal boundaries so often overlap, we have to extend our thinking about ethical practices to both domains as well.

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Life With the Village People: A Psychologist in the LGBT Community

Douglas C. Haldeman

Attend a Gay Pride parade in any American city or town, and it will quickly become apparent how much diversity exists within what is known as the LGBT community. Although we are united by virtue of our sexual orientation or gender identity, we are also distinct entities as gay, lesbian, bisexual, and transgender. We also include those who identify as "I" (Intersex), "Q" ("Queer" or "Questioning"), and "A" ("Allies," who may themselves identify as heterosexual or other). Our unity provides significant overlap in terms of shared interests as well as social and political separation from the dominant heterocentric culture. Our identities, however, are distinct; moreover, we vary in terms of race/ethnicity, age, socioeconomic status, and ability. Therefore, when we talk about the LGBT community, we must first determine what LGBT people we are talking about.

Furthermore, the importance of the community has been incorporated into all theoretical models of identity development for LGBT people (Fassinger & Arseneau, 2006). The experience of coming to terms with a lesbian, gay, bisexual, or transgender identity can mark the end of a long period of isolation. Connection, at least to some degree, with a community that offers opportunities for social activity, activism, or contribution has been found to be an important aspect of solidifying one's LGBT identity. Some recent scholarship contends that for some youth, we are entering a "postgay" society in which the traditional delineation of an LGBT community is no longer necessary, and that total assimilation with the mainstream culture is possible (Savin-Williams, 2010). This may be true for some generational cohorts in some geographic areas; nevertheless, prevailing social attitudes in much of the country require the safety and cohesion of an LGBT community. In particular, as Schank (this issue) correctly points out, many LGBT clients seek practitioners who are members of their own community.

This fact raises the prospect that LGBT practitioners in urban areas of any size are likely, at some point, to encounter clients or their family members in the course of living their personal lives. Social networking on the Internet exponentially increases this possibility. Broadly construed, ethics provide us a context for how to think about certain potentially conflictual situations with clients. Schank raises issues of ethical consideration that are applicable to LGBT communities and the psychologists who serve them. In many midsize and even large urban areas, the LGBT community itself can be small or geographically contained. What does it mean to encounter a client in the gay shopping district? At a gay bar? At a party? When a psychologist participates in a political activity or a Gay Pride march, how does it feel for clients to also be involved? How about at a gay athletic competition, a religious ceremony, or any number of other potential points of contact in the community? What does it mean to belong to the board of a local gay or professional organization along with a current or former client? As a general rule of guidance, I base all of my decisions in this area primarily on what is of optimal service to the therapeutic relationship.

As a practitioner who has lived and worked in my community for over 30 years, I have had the opportunity to face a variety of the above-mentioned situations. In addition, the Internet has made it impossible for a psychologist to be an unknown entity; aspects of our personal lives are accessible to anyone with a computer. Recent literature (Gallardo & McNeill, 2009) suggests that multicultural competence is enhanced with clinical examples. For example, my husband and I breed and show dogs. Anyone interested (and occasionally clients are) can find out how our dogs did at the weekend shows. This in and of itself can become an interesting therapeutic issue. My perspective is not that such issues are to be avoided, but rather that they be dealt with in the context of the therapeutic relationship.

As small-community practitioners serving LGBT individuals, the social contexts in which we may encounter clients in our community vary greatly. Our role as psychologist does not change. This is the way in which I contextualize all interactions, be they accidental (as at a social function) or as the result of mutual interest (such as at a sporting event or a political fundraiser). It is my expectation that clients understand that I have a personal life, and that there is a likelihood of extraoffice encounters. This is where the risk assessment questions posed by Barnett, Behnke, Rosenthal, and Koocher (2007) and Schank's guidelines are critical. Delineating the boundaries of the therapeutic relationship and understanding the nature of confidentiality are of primary importance in working with LGBT clients.

In the chance encounter outside the office, I make it clear in my practice policy statement that the client, as holder of the privilege, will have control over any social interaction. In public, the client chooses to initiate contact—or not—regardless of whether it is a gay or mainstream venue. With respect to public social situations, my rule of thumb is the following: If I would be uncomfortable being observed by a client, I don't do it. I can go to parties, gay bars, club meetings, or the gym (which can be a bit awkward) knowing that I would never exhibit other than professional behavior in public. If I encounter a client, I wait for him to acknowledge me, and if he does, I engage in a bit of superficial banter. This generally works fine for my high-functioning clients.

Not all clients, however, are high functioning. One client who was going through a difficult healing process around childhood sexual trauma saw me shopping in a grocery store. I did not see him, but he noticed me. At the next session, his emotional fragility was evident as he processed the fear and discomfort he had experienced at just the sight of me. By my very presence in public, he felt exposed and vulnerable. Of course, I reassured him that I would never have greeted him first even had I seen him, but the

episode unveiled a level of his own pain that turned out to be of therapeutic utility.

Even with high-functioning clients, it is not always easy to navigate social concerns without generating issues that then come back into the therapy office. A case in point: I am a long-distance runner, as well as politically active in my community. A client saw me at the annual 5-mile race that precedes the Gay Pride march and rally in my city. He was very enthusiastic about seeing me, and asked whether we might run together. At first, I felt uncomfortable. I am prepared for superficial social interactions, but the prospect of running even a short race with a client caught me off guard. I asked myself, "What is the likely effect of this on our therapeutic relationship? What would we talk about on the run? What if I am too slow/fast for him? If I agree, does this jeopardize some aspect of the therapeutic boundary? If I decline, am I being overly rigid?"

My snap decision was to run with the client. I had, after all, encouraged him to get involved in some kind of physical fitness program to help address his chronic anxiety, and here was an opportunity to "walk the talk," as it were. I acknowledged that I had never done anything of this sort before, so I took him aside to ask his consent to several conditions: that we would not attempt a "session" while running, but keep the conversation light; that we would agree to separate if either of us found the other's pace too slow or fast; that if we encountered others with whom we were acquainted, it would be up to him to make introductions (or not). And finally, if either of us felt uncomfortable for any reason, we would consent to separate.

The run went well, and I think we both enjoyed ourselves. The pace, fortunately, turned out to be fine for both of us and we kept the conversation primarily to the topic of running itself: gear, weather, events, etc. After the race, we parted with a handshake; still, I felt worried that I had gone too far in pushing this boundary, so I brought the incident up at my next consultation group. The consensus was that no ethical standards had been violated in a one-time unplanned activity, but that the real "test" would come at the next session to gauge the effect of the experience on the client. When next I saw the client, I brought up our race together, and asked whether he had any residual feelings or thoughts that he wanted to discuss. He paused for a moment (as though the issue was the farthest thing from his mind) and simply said, "No. I thought it was pretty cool that we could do something healthy together besides talk." I'm still not making a habit of running with clients. The episode, however, taught me that ethical questions surrounding extrasession boundaries are determined by a combination of factors relating to the client and the situation.

In my professional role as a psychologist, I have encountered clients in classes for which I have been a guest lecturer, as well as on the boards of gay and professional organizations. Always I make it clear that the therapeutic relationship comes first, and that I will monitor and maintain a clear boundary in the relationship. So far, this policy has worked well in extraoffice encounters. After all, I share a passion with most of my clients for advancing equality in all aspects for our community. It has proved to be a positive factor in the therapeutic connection. One year in the local Gay Pride march, the LGBT Committee of the state psychological association marched as a group. I will never forget the enthusiasm of one client who later told me how proud he was when he and his friends saw our group. "It was amazing," he said, "for us to see all of our therapists marching by. It means that you're healing our whole community."

Ethics are the fundamental elements that inform our thinking about therapeutic relationships. In a world where LGBT individuals have suffered at the hands of a heterocentric or homophobic culture, the maintenance of appropriate boundaries is essential. This does not preclude, however, the consideration that all individuals belonging to marginalized communities often benefit from a thoughtful consideration of what boundaries are too rigid and what boundaries are too permeable. The best advice for working in the LGBT community is to consider, from some of the questions posed here, what flexibility provides the optimal benefit for the therapeutic relationship.

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Advancing Clinical and Contextual Practice: Working With the Latina/o Community

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In working with the Latina/o community, particularly with the poor, working-class Latina/o communities, the issues addressed by Janet Schank (this issue) are highly consistent with good sound cultural practices with this community. In fact, Prilleltensky, Dokecki, Frieden, and Ota Wang (2007) would argue that "wellness cannot flourish in the absence of justice, and justice is devoid of meaning in the absence of wellness" (p. 19). I appreciate Schank's lead article because it is critical that we expand our "small" community mentality, particularly when working with ethnocultural communities, to reflect the larger ecological systems in which those we intend to serve reside. From an ethnocultural perspective, the lead article reinforces the notion that good culturally responsive practice should be our primary focus when working clinically (Gallardo, Johnson, Parham, & Carter, 2009). It is within this context that I share some comments regarding the importance of working, both clinically and contextually, with the Latina/o community.

Schank states, "If managed ethically, overlapping relationships can be seen as an advantage when practicing in small communities" (p. 503). Culturally responsive practice with the Latina/o community calls for an expansion of our roles as psychologists (Comas-Diaz, 2006; Falicov, 2007; Robbins, Schwartz, & Szapoc-

znik, 2004; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). Manoleas, Organista, Negron-Velasquez, and McCormick (2000) reported that one of the primary characteristics of Latina/o clinicians working with Latina/o clients was implementing "a flexible 'sense of boundaries' and view clients and their families holistically" (p. 388). In addition, they also found that Latina/o clinicians were more likely to self-disclose to their Latina/o clients versus with non-Latina/o clients and to follow up after a missed appointment by calling their Latina/o clients or by talking with neighbors, family, and compadres about the client's status. These characteristics are consistent with the multiple roles that many Latina/o clinicians occupy when working with Latina/o clients and their families. Moreover, when working with the poor, working-class Latina/o community, it is impossible to assume an individualistic perspective when so much of the community's survival is reliant on a collectivistic mentality that can include one's family, faith-based communities, and the overall community at large. As noted by Schank, if we continue to expand our perspectives to accept overlapping relationships as potential strengths and not limitations, we are more likely to see the results of our work with clients and better understand the context of the problems facing our clients. This is critical as we attempt to situate the practice of psychology within a Latina/o framework and from an ecological perspective (Andres-Hyman, Ortiz, Anez, Paris, & Davidson, 2006; Robbins et al., 2004).

Latina/o psychologists working within the Latina/o community, where the psychologist may also live and engage in community activities, presents many opportunities to build trust, work collaboratively, and facilitate change. Aldarondo (2007) encourages human service providers to consider the expansion of one's role to be more in sync with the lived experiences of the communities we serve. He also states, "our goodwill and individual-oriented clinical skills are a poor match for the persistent effects of harsh social realities in the lives of those seeking our assistance" (p. xix). In essence, when working with the poor, working-class Latina/o community, it is our collaboration and willingness to accompany (Martin-Baro as cited in Aron & Corne, 1994) the community that will ultimately help us include "justice" in our work toward wellness.

It is at this juncture that I want to extend even further Schank's statements about seeing opportunities for growth and change in our expansion and inclusion of "small" communities. Our understanding of "small" becomes rather "large" if we are engaged in working toward the amelioration of contextual issues that affect our client's lives. From a Latina/o cultural perspective, it is impossible to engage in one without the other. Schank highlights some important "ethical" considerations and recommendations, but it is our willingness to begin from a cultural mindset at the outset (Gallardo et al., 2009) that will ultimately determine whether we are engaging in facilitating change for our clients, particularly from a Latina/o perspective. In our collaboration and willingness to accompany the community, we immediately run into a clash of values between that which is "traditional" and that which is "cultural."

In my work with unserved and underserved Latina/o communities, it is has been essential for the community to know who I am first and foremost. As noted by Schank when referring to psychologist overlapping roles, "Clients may seek them precisely because they are a part of the community and seen as someone who would understand clients' needs. Clients and community members often see overlap as a strength, and so could we" (p. 503). This is where our willingness to situate ourselves culturally at the outset, without abandoning our "traditional" clinical skill set, becomes critical.

My work with the Latina/o community has been one of consolidation, consolidation of my traditional graduate education with the cultural realities faced by my community. It has been my willingness to be transparent in my work with both the community and other professionals, combined with my personal and professional experiences in working with poor, working-class Latina/o communities, that have equipped me with the most important skill of all—the ability to think in a way that is culturally harmonious. Questions that I reflect on when working clinically and in building relationships with the local Latina/o community include how my questioning, relationship with, and personal reactions reflect the larger sociopolitical, sociocultural climate with my community. If I cannot answer these questions, then I am not thinking critically about the issues facing the "individual" or community I am working with. In essence, my "small" community just expanded to include many others. Most important, my willingness to think critically and understand that there are larger contextual issues at hand calls into question my "individual" intervention sans community and context.

The "ethical dilemma" from this perspective is whether or not we, as psychologists, continue to implement individual interventions with the knowledge that these interventions might be limited in their capacity to facilitate change. From a Latina/o ethical perspective, approaching this situation by engaging the family, community, and context becomes essential. The expansion of our role into systemic engineers for our clients also encourages "overlapping" relationships that, when understood in context, might be the most ethical decision we can make. In my work with the Latina/o community, it is not uncommon for me to have meals, spend time with families, work with multiple members of the same family and community, and self-disclose. It might be critical to connect with the client or community out of the "therapeutic context" to facilitate any meaningful change for the client and community. Having a trusting relationship is essential to working in meaningful and culturally consistent ways with the Latina/o community. However, as Schank notes, it is important to understand the "steps to minimizing risks" when engaging in "small" community-based work. My concern with this statement is that until we change the paradigm and reframe our work with ethnocultural communities, the suggestions noted by Schank to "minimize" risks will be used to justify the continuation of separating "our commitments and obligations as professionals from our commitments and obligations as citizens and to subordinate the latter to the former" (Aldarondo, 2007, p. 13).

More important, the language of "minimizing risks" is consistent with how our current ethics code is interpreted and implemented, despite its intent and the intent of Schank's article. Both, at least from my perspective, demonstrate that these "overlapping" relationships are, at times, unavoidable and can be seen as potential opportunities for therapeutic growth and not necessarily areas of ethical concern if handled accordingly. It is here that we are challenged with an "ethical dilemma" when we know that our work must expand but continue to remain securely neutral and on the sidelines. If we embrace this expansion, as Schank notes, and embrace our work in "small communities," then we are likely to

see more opportunities than limitations. It is critical that we continue to integrate the "traditional" with the "cultural" and expand our capacity for growth as a profession and as individual psychologists.

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Call for Nominations

The Publications and Communications (P&C) Board of the American Psychological Association has opened nominations for the editorships of **Journal of Experimental Psychology: Learning, Memory, and Cognition; Professional Psychology: Research and Practice; Psychology and Aging; Psychology, Public Policy, and Law;** and **School Psychology Quarterly** for the years 2013–2018. Randi C. Martin, PhD, Michael C. Roberts, PhD, Ronald Roesch, PhD, and Randy W. Kamphaus, PhD, respectively, are the incumbent editors.

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