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Cultural Competence: An Overview

Approval(s): APA, NBCC, NAADAC

Audience
This course is designed for all members of the interprofessional healthcare team.

Course Objective
The purpose of this course is to provide members of the interprofessional healthcare team with the knowledge, skills, and strategies necessary to provide culturally competent and responsive care to all patients.

Learning Objectives
Upon completion of this course, you should be able to:

1. Define cultural competence, implicit bias, and related terminology.
2. Outline social determinants of health and barriers to providing care.
3. Discuss best practices for providing culturally competent care to various patient populations.
4. Discuss key aspects of creating a welcoming and safe environment, including avoidance of discriminatory language and behaviors.

Faculty
Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families. (A complete biography appears at the end of this course.)

Faculty Disclosure
Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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INTRODUCTION

Culturally competent care has been defined as "care that takes into account issues related to diversity, marginalization, and vulnerability due to culture, race, gender, and sexual orientation" [1]. A culturally competent person is someone who is aware of how being different from the norm can be marginalizing and how this marginalization may affect seeking or receiving health care [1]. To be effective cross-culturally with any diverse group, healthcare professionals must have awareness, sensitivity, and knowledge about the culture involved, enhanced by the use of cross-cultural communication skills [2; 3].

Healthcare professionals are accustomed to working to promote the healthy physical and psychosocial development and well-being of individuals within the context of the greater community. For years, these same professionals have been identifying at-risk populations and developing programs or making referrals to resources to promote the health and safety of at-risk groups. But, because of general assumptions, persistent stereotypes, and implicit and explicit biases, culture-related healthcare disparities persist [2]. In the increasingly diverse landscape of the United States, assessing and addressing culture-related barriers to care are a necessary part of health care. This includes seeking to improve one's cultural competence and identifying blind spots and biases.

DEFINITIONS

CULTURAL COMPETENCE

In healthcare, cultural competence is broadly defined as practitioners' knowledge of and ability to apply cultural information and appreciation of a different group's cultural and belief systems to their work [4]. It is a dynamic process, meaning that there is no endpoint to the journey to becoming culturally aware, sensitive, and competent. Some have argued that cultural curiosity is a vital aspect of this approach.

CULTURAL HUMILITY

Cultural humility refers to an attitude of humbleness, acknowledging one's limitations in the cultural knowledge of groups. Practitioners who apply cultural humility readily concede that they are not experts in others' cultures and that there are aspects of culture and social experiences that they do not know. From this perspective, patients are considered teachers of the cultural norms, beliefs, and value systems of their group, while practitioners are the learners [5]. Cultural humility is a lifelong process involving reflexivity, self-evaluation, and self-critique [6].

DISCRIMINATION

Discrimination has traditionally been viewed as the outcome of prejudice [7]. It encompasses overt or hidden actions, behaviors, or practices of members in a dominant group against members of a subordinate group [8]. Discrimination has also been further categorized as lifetime, which consists of major discreet discriminatory events, or everyday, which is subtle, continual, and part of day-to-day life and can have a cumulate effect on individuals [9].

DIVERSITY

Diversity "encompasses differences in and among societal groups based on race, ethnicity, gender, age, physical/mental abilities, religion, sexual orientation, and other distinguishing characteristics" [10]. Diversity is often incorrectly conceptualized into singular dimensions as opposed to multiple and intersecting diversity factors [11].

INTERSECTIONALITY

Intersectionality is a term to describe the multiple facets of identity, including race, gender, sexual orientation, religion, sex, and age. These facets are not mutually exclusive, and the meanings that are ascribed to these identities are interrelated and interact to create a whole [12].

PREJUDICE

Prejudice is a generally negative feeling, attitude, or stereotype against members of a group [13]. It is important not to equate prejudice and racism, although the two concepts are related. All humans have prejudices, but not all individuals are racist. The popular definition is that "prejudice plus power equals racism" [13]. Prejudice stems from the process of ascribing every member of a group with the same attributes [14].

RACISM

Racism is the "systematic subordination of members of targeted racial groups who have relatively little social power…by members of the agent racial group who have relatively more social power" [15]. Racism is perpetuated and reinforced by social values, norms, and institutions.

There is some controversy regarding whether unconscious (implicit) racism exists. Experts assert that images embedded in our unconscious are the result of socialization and personal observations, and negative attributes may be unconsciously applied to racial minority groups [16]. These implicit attributes affect individuals' thoughts and behaviors without a conscious awareness.

Structural racism refers to the laws, policies, and institutional norms and ideologies that systematically reinforce inequities, resulting in differential access to services such as health care, education, employment, and housing for racial and ethnic minorities [17; 18].

BIAS: IMPLICIT AND EXPLICIT

In a sociocultural context, biases are generally defined as negative evaluations of a particular social group relative to another group. Explicit biases are conscious, whereby an individual is fully aware of his/her attitudes and there may be intentional behaviors related to these attitudes [19]. For example, an individual may openly endorse a belief that women are weak and men are strong. This bias is fully conscious and is made explicitly known. The individual's ideas may then be reflected in his/her work as a manager.

FitzGerald and Hurst assert that there are cases in which implicit cognitive processes are involved in biases and conscious availability, controllability, and mental resources are not [20]. The term "implicit bias" refers to the unconscious attitudes and evaluations held by individuals. These individuals do not necessarily endorse the bias, but the embedded beliefs/attitudes can negatively affect their behaviors [21; 22; 23; 24]. Some have asserted that the cognitive processes that dictate implicit and explicit biases are separate and independent [24].

Implicit biases can start as early as 3 years of age. As children age, they may begin to become more egalitarian in what they explicitly endorse, but their implicit biases may not necessarily change in accordance to these outward expressions [25]. Because implicit biases occur on the subconscious or unconscious level, particular social attributes (e.g., skin color) can quietly and insidiously affect perceptions and behaviors [26]. According to Georgetown University's National Center on Cultural Competency, social characteristics that can trigger implicit biases include [27]:

- Age
- Disability
- Education
- English language proficiency and fluency
- Ethnicity
- Health status
- Disease/diagnosis (e.g., human immunodeficiency virus [HIV])

- Insurance
- Obesity
- Race
- Socioeconomic status
- Sexual orientation, gender identity, or gender expression
- Skin tone
- Substance use

An alternative way of conceptualizing implicit bias is that an unconscious evaluation is only negative if it has further adverse consequences on a group that is already disadvantaged or produces inequities [20; 28]. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages [28].

When the concept of implicit bias was introduced in the 1990s, it was thought that implicit biases could be directly linked to behavior. Despite the decades of empirical research, many questions, controversies, and debates remain about the dynamics and pathways of implicit biases [21].

Specific conditions or environmental risk factors have been associated with an increased risk for certain implicit biases, including [130; 131]:

- Stressful emotional states (e.g., anger, frustration)
- Uncertainty
- Low-effort cognitive processing
- Time pressure
- Lack of feedback
- Feeling behind with work
- Lack of guidance
- Long hours
- Overcrowding
- High-crises environments
- Mentally taxing tasks
- Juggling competing tasks

ROLE OF INTERPROFESSIONAL COLLABORATION AND PRACTICE

The study of implicit bias is appropriately interdisciplinary, representing social psychology, medicine, health psychology, neuroscience, counseling, mental health, gerontology, gender/sexuality studies, religious studies, and disability studies [28]. Therefore, implicit bias empirical research and curricula training development lends itself well to interprofessional collaboration and practice (ICP).

The main characteristics of IPC allow for implicit and explicit biases to be addressed by the interprofessional team. One of the core features of IPC is sharing—professionals from different disciplines share their philosophies, values, perspectives, data, and strategies for planning of interventions [29]. IPC also involves the sharing of roles, responsibilities, decision making, and power [30]. Everyone on the team employs their expertise, knowledge, and skills, working collectively on a shared, patient-centered goal or outcome [30; 31].

Another feature of IPC is interdependency. Instead of working in an autonomous manner, each team member's contributions are valued and maximized, which ultimately leads to synergy [29]. At the heart of this are two other key features: mutual trust/respect and communication [31]. In order to share responsibilities, the differing roles and expertise are respected.

Experts have recommended that a structural or critical theoretical perspective be integrated into core competencies in healthcare education to teach students about implicit bias, racism, and health disparities [32]. This includes [32]:

- Values/ethics: The ethical duty for health professionals to partner and collaborate to advocate for the elimination of policies that promote the perpetuation of implicit bias, racism, and health disparities among marginalized populations.
- Roles/responsibilities: One of the primary roles and responsibilities of health professionals is to analyze how institutional and organizational factors promote racism and implicit bias and how these factors contribute to health disparities. This analysis should extend to include one's own position in this structure.
- Interprofessional communication: Ongoing discussions of implicit bias, perspective taking, and counter-stereotypical dialogues should be woven into day-to-day practice with colleagues from diverse disciplines.
- Teams/teamwork: Health professionals should develop meaningful contacts with marginalized communities in order to better understand whom they are serving.

Adopting approaches from the fields of education, gender studies, sociology, psychology, and race/ethnic studies can help build curricula that represent a variety of disciplines [33]. Students can learn about and discuss implicit bias and its impact, not simply from a health outcomes perspective but holistically. Skills in problem-solving, communication, leadership, and teamwork should be included [33].

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. Healthy People 2030 groups social determinants of health into five categories [34]:

- Economic stability
- Education access and quality
- Health care access and quality
- Social and community context
- Neighborhood and built environment

These factors have a major impact on people's health, well-being, and quality of life. Examples of social determinants of health include [34]:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

Social determinants of health also contribute to wide health disparities and inequities. For example, people who lack access to grocery stores with healthy foods are less likely to have good nutrition, which raises the risk of heart disease, diabetes, and obesity and lowers life expectancy compared with those who have easier access to healthy foods [34].

Promoting healthy choices will not eliminate these and other health disparities. Instead, public health organizations and their partners must take action to improve the conditions in people's environments. Healthcare providers play a role by identifying factors affecting the health of their patients, providing resources (when appropriate), and advocating for healthy environments.

BARRIERS TO PROVIDING CARE

Culturally diverse patients experience a variety of barriers when seeking health and mental health care, including:

- Immigration status
- Lower socioeconomic status
- Language barriers
- Cultural differences
- Lack of or poor health insurance coverage
- Fear of or experiences with provider discrimination
- Mistrust of healthcare systems

Such obstacles can interfere with or prevent access to treatment and services, compromise appropriate referrals, affect compliance with recommendations, and result in poor outcomes. Culturally competent providers build and maintain rich referral resources to meet patients' assorted needs.

Encountering discrimination when seeking health or mental health services is a barrier to optimal care and contributor to poorer outcomes in under-represented groups. Some providers will not treat patients because of moral objections, which can affect all groups, but particularly those who are gender and/or sexual minorities, religious minorities, and/or immigrants. In fact, in 2016, Mississippi and Tennessee passed laws allowing health providers to refuse to provide services if doing so would violate their religious beliefs [35]. However, it is important to remember that providers are obligated to act within their profession's code of ethics and to ensure patients receive the best possible care.

BEST PRACTICES FOR CULTURALLY RESPONSIVE CARE

The U.S. Department of Health and Human Services has outlined steps important to incorporate in evaluation and treatment planning processes to ensure culturally competent clinical and programmatic decisions and skills [36].

The first step is to engage patients. In nonemergent situations, it is important to establish rapport before asking a series of assessment questions or delving deeply into history taking. Providers should use simple gestures as culturally appropriate (e.g., handshakes, facial expressions, greetings) to help establish a first impression. The intent is that all patients feel understood and seen following each interaction. Culturally responsive interview behaviors and paperwork should be used at all times [36].

When engaging in any patient teaching, remember that individuals may be new to the specific language or jargon and expectations of the diagnosis and care process. Patients should be encouraged to collaborate in every step of their care. This consists of seeking the patient's input and interpretation and establishing ways they can seek clarification. Patient feedback can then be used to help identify cultural issues and specific needs. If appropriate, collaboration should extend to include family and community members.

Assessment should incorporate culturally relevant themes in order to more fully understand patients and identify their cultural strengths and challenges. Themes include [36]:

- Immigration history
- Cultural identity and acculturation
- Membership in a subculture
- Beliefs about health, healing, and help-seeking
- Trauma and loss

In some cases, it may be appropriate and beneficial to obtain culturally relevant collateral information, with the patient's permission, from sources other than the patient (e.g., family or community members) to better understand beliefs and practices that shape the patient's cultural identity and understanding of the world.

Practitioners should work to identify screening and assessment tools that have been translated into or adapted for other languages and have been validated for their particular population group(s). An instrument's cultural applicability to the population being served should be assessed, keeping in mind that research is limited on the cross-cultural applicability of specific test items or questions, diagnostic criteria, and concepts in evaluative and diagnostic processes [36].

Typically, culturally responsive care establishes holistic treatment goals that include objectives to improve physical health and spiritual strength; utilizes strengths-based strategies that fortify cultural heritage, identity, and resiliency; and recognizes that treatment planning is a dynamic process that evolves along with an understanding of patient history and treatment needs.

In addition to these general approaches, specific considerations may be appropriate for specific populations. While discussion of every possible patient subgroup is outside of the scope of this course, some of the most common factors are outlined in the following sections [36].

RACIAL BACKGROUNDS

Race and color impact the ways in which individuals interact with their environments and are perceived and treated by others. Race is defined as groups of humans divided on the basis of inherited physical and behavioral differences. As part of the cultural competence process and as a reflection of cultural humility, practitioners should strive to learn as much as possible about the specific racial/ethnic populations they serve [37]. However, considerable diversity exists within any specific culture, race, or ethnicity [37]. Cultural beliefs, traditions, and practices change over time, both through generations and within an individual's lifetime. It is also possible for the differences between two members of the same racial/ethnic group to be greater than the differences between two people from different racial/ethnic groups. Within-group variations in how persons interact with their environments and specific social contexts are also often present.

As with all patients, it is vital to actively listen and critically evaluate patient relationships. All practitioners should seek to educate themselves regarding the experiences of patients who are members of a community that differs from their own. Resources and opportunities to collaborate may be available from community organizations and leaders.

Finally, preferred language and immigration/migration status should be considered. Interpreters should be used when appropriate, with adherence to best practices for the use of interpretation services. Stressing confidentiality and privacy is particularly important for undocumented workers or recent immigrants, who may be fearful of deportation.

Black Patients

"Black" or "African American" is a classification that serves as a descriptor; it has sociopolitical and self-identification ramifications. The U.S. Census Bureau defines African Americans or Black Americans as persons "having origins in any of the Black racial groups of Africa" [38].

According to the U.S. Census, African Americans number 46.9 million as of 2020 [39]. By 2060, it is projected they will comprise 17.9% of the U.S. population [40]. This group tends to be young; 30% of the African American population in the United States is younger than 18 years of age. In 2019, the median age for this group was 35 years [41]. In terms of educational attainment, 89.4% of African Americans 25 years of age or older had a high school diploma or completed college in 2020 [39]. Texas has the largest African American population, at 3.9 million [41].

Historical adversity and institutional racism contribute to health disparities in this group. For the Black population, patient assessment and treatment planning should be framed in a context that recognizes the totality of life experiences faced by patients. In many cases, particularly in the provision of mental health care, equality is sought in the provider-patient relationship, with less distance and more disclosing. Practitioners should assess whether their practices connect with core values of Black culture, such as family, kinship, community, and spirituality. Generalized or Eurocentric treatment approaches may not easily align with these components of the Black community [42]. Providers should also consider the impact of racial discrimination on health and mental health among Black patients. Reports indicate that expressions of emotion by Black patients tend to be negatively misunderstood or dismissed; this reflects implicit or explicit biases.

Asian Patients

As of 2019, 22.9 million Americans identified as Asian [43]. Between 2000 and 2019, Asians experienced the greatest growth compared with any other racial group at 81% [44; 45]. The Chinese group represents the largest Asian subgroup in the United States, and it is projected that this population will grow to 35.7 million between 2015 and 2040 [46; 47]. In 2019, Chinese Americans (excluding Taiwanese Americans) numbered at 5.2 million [43]. They also have the highest educational attainment; 54.6% of Asians 25 years of age or older had a bachelor's degree or higher in 2019 [43].

"Asian" is a single term widely used to describe individuals who have kinship and identity ties to Asia, including the Far East, Southeast Asia, and the Indian subcontinent [48]. This encompasses countries such as China, Japan, Korea, Vietnam, Cambodia, Thailand, India, Pakistan, and the Philippines. Pacific Islander is often combined with Asian American in census data. The Pacific Islands include Hawaii, Guam, Samoa, Fiji, and many others [48]. There are more than 25 Asian/Pacific Islander groups, each with a different migration history and widely varying sociopolitical environments in their homelands [49].

Asian American groups have differing levels of acculturation, lengths of residency in the United States, languages, English-speaking proficiency, education attainment, socioeconomic statuses, and religions. For example, there are approximately 32 different languages spoken among Asian Americans, and within each Asian subgroup (e.g., Chinese), multiple dialects may be present [49; 50]. In 2019, California had the largest Asian American population, totaling 5.9 million [44].

Recommended best practices when caring for Asian American patients include:

- Create an advisory committee using representatives from the community.
- Incorporate cultural knowledge and maintain flexible attitudes.
- Provide services in the patients' primary language.
- Develop culturally specific questionnaires for intake to capture information that may be missed by standard questionnaires.
- Emphasize traditional values and incorporate traditional practices (e.g., acupuncture) into treatment plans, when appropriate and desired.
- Explore patient coping mechanisms that draw upon cultural strengths.

Latino/a/x or Hispanic Patients

In 2020, the Hispanic population in the United States numbered 60.6 million [51]. The majority of the Hispanic population in the United States (63.3%) identify themselves as being of Mexican descent [53]. Approximately 27% of the U.S. Hispanic population identify as Puerto Rican, Cuban, Salvadoran, Dominican, Guatemalan, Colombian, Honduran, Ecuadorian, or Peruvian [54].

In 2020, the Hispanic population comprised 18.7% of the U.S. population [51]. As such, they are the largest ethnic minority group in the United States. By 2060, Hispanics are expected to represent 31% of the U.S. population [55]. They are also a young group, with a median age of 29.8 years [51]. In 2019, the three states with the largest Hispanic population growth were Texas (2 million), California (1.5 million), and Florida (1.4 million); these three states have the largest Hispanic populations overall [52].

When involved in the care of Latinx/Hispanic individuals, practitioners should strive to employ *personalismo* (warm, genuine communication) and recognize the importance of *familismo* (the centrality of the family). More flexible scheduling strategies may be more successful with this group, if possible, and some patients may benefit from culturally specific treatment and ethnic and gender matching with providers. Aspects of Latino culture can be assets in treatment: strength, perseverance, flexibility, and an ability to survive.

Native American Patients

The Native American population is extremely diverse. According to the U.S. Census, the terms "Native American," "American Indian," or "Alaskan Native" refer to individuals who identify themselves with tribal attachment to indigenous groups of North and South America [56]. In the United States, there are 574 federally recognized tribal governments and 324 federally recognized reservations [57].

In 2020, it was reported that there were 7.1 million Native Americans in the United States, which is approximately 2% of the U.S. population [57]. By 2060, this number is projected to increase to 10.1 million, or 2.5% of the total population [57].

In general, this group is young, with a median age of 31 years, compared with the general median age of 37.9 years [58]. As of 2018, the states with the greatest number of residents identifying as Native American are Alaska, Oklahoma, New Mexico, South Dakota, and Montana [59]. In 2016, this group had the highest poverty rate (26.2%) of any racial/ethnic group [58].

Listening is an important aspect of rapport building with Native American patients, and practitioners should use active listening and reflective responses. Assessments and histories may include information regarding patients' stories, experiences, dreams, and rituals and their relevance. Interruptions and excessive questioning should be avoided if at all possible. Extended periods of silence may occur, and time should be allowed for patients to adjust and process information. Practitioners should avoid asking about family or personal matters unrelated to presenting issues without first asking permission to inquire about these areas. Native American patients often respond best when they are given suggestions and options rather than directions.

White American Patients

In 2021, 76.3% of the U.S. population identified as White alone [60]. The U.S. Census Bureau defines White race as person having origins in any of the original peoples of Europe, the Middle East, or North Africa [38]. While the proportion of population identifying as White only has decreased between 2010 and 2020, the numbers of persons identifying as White and another race/ethnicity increased significantly. The White population in the United States is diverse in its religious, cultural, and social composition. The greatest proportion of this group reports a German ancestry (17%), followed by Irish (13%), English (10%), and Italian (7%) [61].

Providers can assume that most well-accepted treatment approaches and interventions have been tested and evaluated with White American individuals, particularly men. However, approaches may need modification to suit class, ethnic, religious, and other factors.

Providers should establish not only the patient's ethnic background, but also how strongly the person identifies with that background. It is also important to be sensitive to persons multiracial/multiethnic heritage, if present, and how this might affect their family relationships and social experiences. Assumption of White race should be avoided, as White-passing persons of color have their own unique needs.

RELIGIOUS, CULTURAL, AND ETHNIC BACKGROUNDS

Religion, culture, beliefs, and ethnic customs can influence how patients understand health concepts, how they take care of their health, and how they make decisions related to their health. Without proper training, clinicians may deliver medical advice without understanding how health beliefs and cultural practices influence the way that advice is received. Asking about patients' religions, cultures, and ethnic customs can help clinicians engage patients so that, together, they can devise treatment plans that are consistent with the patients' values [37].

Respectfully ask patients about their health beliefs and customs and note their responses in their medical records. Address patients' cultural values specifically in the context of their health care. For example, one may ask [37]:

- "Is there anything I should know about your culture, beliefs, or religious practices that would help me take better care of you?"
- "Do you have any dietary restrictions that we should consider as we develop a food plan to help you lose weight?"
- "Your condition is very serious. Some people like to know everything that is going on with their illness, whereas others may want to know what is most important but not necessarily all the details. How much do you want to know? Is there anyone else you would like me to talk to about your condition?"
- "What do you call your illness and what do you think caused it?"
- "Do any traditional healers advise you about your health?"

Practitioners should avoid stereotyping based on religious or cultural background. Each person is an individual and may or may not adhere to certain cultural beliefs or practices common in his or her culture. Asking patients about their beliefs and way of life is the best way to be sure you know how their values may impact their care [37].

GENDER

Gender identity is a vital aspect of a person's experience of the world and of themselves. It also impacts the ways in which the world perceives and treats individuals, with a clear effect on the effective provision of health and mental health care. This section will focus on persons presenting as cisgender male or female; special considerations for those who are transgender, non-binary, or gender nonconforming will be explored in the next section.

An increasing amount of research is supporting a relationship between men's risk for disease and death and male gender identity, and the traditional male role has been shown to conflict with the fostering of healthy behaviors [62; 63]. Male gender identity is related to a tendency to take risks, and the predilection for risky behavior begins in boyhood [63; 64; 65]. In addition, boys are taught that they should be self-reliant and independent and should control their emotions, and societal norms for both boys and men dictate that they maintain a strong image by denying pain and weakness [62; 64; 65].

Issues related to male gender identity have several important implications for health. First, risky behavior is associated with increased morbidity and mortality. Second, the concept of masculinity leads to inadequate help- and information-seeking behavior and a reduced likelihood to engage in behavior to promote health [62; 64; 65]. These behaviors appear to be rooted in a decreased likelihood for men to perceive themselves as being ill or at risk for illness, injury, or death [62]. Third, male gender identity, coupled with lower rates of health literacy, creates special challenges for effectively communicating health messages to men [66; 67; 68]. Gender differences in health-related behaviors are consistent across racial/ethnic populations, although specific behaviors vary according to race/ethnicity [63].

Men's beliefs about masculinity and traditional male roles affect health communication, and healthcare practitioners should consider male-specific beliefs and perceptions when communicating with male patients. For example, because men tend to focus on present rather than future health, concepts of fear, wellness, and longevity often do not work well in health messages [69]. Instead, healthcare practitioners should focus more on "masculine" concepts, such as strength, safety, and performance, all of which tie into men's perceptions of their roles as providers and protectors.

Although men are more likely than women to lack a regular healthcare provider and to avoid seeking help or information, women are more likely to have a chronic condition requiring regular monitoring and are more likely to have forgone necessary health care due to the cost [70].

Providing gender-sensitive care to women involves overcoming the limitations imposed by the dominant medical model in women's health. This requires theoretical bases that do not reduce women's health and illness experience into a disease. This philosophy incorporates explanations of health and empowers women to effectively and adequately deal with their situations. The major components incorporated into the development of sensitive care include:

- Gender is a central feature.
- Women's own voices and experiences are reflected.
- Diversities and complexities are incorporated into women's experiences.
- Theorists reflect about underlying androcentric and ethnocentric assumptions.
- Sociopolitical contexts and constraints of women's experiences are considered.
- Guidelines for practice with specific groups of women are provided.

GENDER AND SEXUAL MINORITIES

The gender and sexual minority (GSM) population is a diverse group that can be defined as a subculture. It includes homosexual men, lesbian women, bisexual persons, transgender individuals, and those questioning their sexual identity, among others. The GSM population is diverse, representing all ages and all socioeconomic, ethnic, educational, and religious backgrounds. The population has been described as "hidden and invisible," "marginalized," and "stigmatized." As a result, the unique health and safety needs of the population have often been overlooked or ignored. Clear definitions of the concepts related to sexual identity will be helpful. The following is a glossary of terms used in discussions of this group [71; 72; 73; 74; 75; 76]:

Asexual/aromantic: An individual who does not experience sexual attraction. There is considerable diversity in individuals' desire (or lack thereof) for romantic or other relationships.

Bisexual: An adjective that refers to people who relate sexually and affectionately to both women and men.

Coming-out process: A process by which an individual, in the face of societal stigma, moves from denial to acknowledging his/her sexual orientation. Successful resolution leads to self-acceptance. Coming out is a lifelong process for lesbian, gay, bisexual, and transgender persons and their families and friends as they begin to tell others at work, in school, at church, and in their communities.

Gay: The umbrella term for GSM persons, although it most specifically refers to men who are attracted to and love men. It is equally acceptable and more accurate to refer to gay women as "lesbians."

Gender and sexual minorities (GSM): A term meant to encompass lesbian, gay, bisexual, trans, queer/questioning, intersex/intergender, asexual/ally (LGBTQIA) people as well as less well-recognized groups, including aromantic, two-spirited, and gender-fluid persons.

Heterosexism: An institutional and societal reinforcement of heterosexuality as the privileged and powerful norm.

Heterosexuality: Erotic feelings, attitudes, values, attraction, arousal, and/or physical contact with partners of the opposite gender.

Homophobia: A negative attitude or fear of non-straight sexuality or GSM individuals. This may be internalized in the form of negative feelings toward oneself and self-hatred. Called "internalized homophobia," it may be manifested by fear of discovery, denial, or discomfort with being LGBTQIA, low self-esteem, or aggression against other lesbians and gay men.

Homosexuality: The "persistent sexual and emotional attraction to members of one's own gender" as part of the continuum of sexual expression. Typically not used to describe people.

LGBTQIA: An acronym used to refer to the lesbian, gay, bisexual, transgender/transsexual, queer/questioning, intersex/intergender, asexual/ally community. In some cases, the acronym may be shortened for ease of use or lengthened for inclusivity. Members of this group may also be referred to as gender and sexual minorities (GSM).

Queer: An umbrella term to describe persons with a spectrum of identities and orientations that are outside of the heteronormative standard.

Sexual identity: The inner sense of oneself as a sexual being, including how one identifies in terms of gender and sexual orientation.

Sexual orientation: An enduring emotional, romantic, sexual, and/or affectionate attraction to another person. Individuals may experience this attraction to someone of the same gender, the opposite gender, both genders, or gender nonconforming.

Transgender: An umbrella term describing a number of distinct gender positions and identities including: crossdressing, transsexual, nonbinary, and intersex.

One's intrapersonal acceptance or rejection of societal stereotypes and prejudices, the acceptance of one's self-identity as a sexual minority, and how much one affiliates with other members of the GSM community varies greatly among individuals [77]. Some authors stress the diversity within the GSM community by discussing "GSM populations" [78]. For example, it is understandable that a GSM population living in rural areas of the United States would have little in common with a GSM population living in urban areas or "gay-friendly" neighborhoods. Additionally, mental health experts have suggested that "GSM community" symbolizes a single group of individuals who express their sexuality differently than the majority of heterosexual individuals. However, many distinct communities have been identified, including lesbian, gay, bisexual, and transgender [79]. Each community is different from the other as well as different from the heterosexual community. A culturally competent healthcare provider should keep this diversity in mind so that vital differences among these smaller groups are not lost when thinking of the GSM population in general.

Commonalities exist among the GSM communities as well. For example, many adolescents, whether gay, lesbian, bisexual, transgender, or questioning their sexual identity, lack sexual minority role models to assist with successful psychosocial development [79].

The subtle and pervasive ways that discomfort with GSM individuals may be manifested have been examined and, in some instances, categorized as "cultural heterosexism," which is characterized by the stigmatization in thinking and actions found in our nation's cultural institutions, such as the educational and legal systems [80]. "Cultural heterosexism fosters individual antigay attitudes by providing a ready-made system of values and stereotypical beliefs that justify such prejudice as natural" [81]. Perhaps the paucity of information about the GSM community in basic professional education has been a reflection of cultural heterosexism. Writers, funding sources, and publishers have been exposed to the same cultural institutions for many years.

Individuals generally begin to absorb these institutional attitudes as children and may consequently develop "psychologic heterosexism," which may also manifest as antigay prejudice. Many individuals, as children, have little contact with someone who is openly gay and, as a result, may not be able to associate homosexuality with an actual person. Instead, they may associate it with concepts such as "sin," "sickness," "predator," "outsider," or some other negative characteristic from which the individual wants to maintain distance [81]. Psychologic heterosexism involves (among other factors) considering sexual identity and determining that one does not want to think further about it. The direction of this thinking is undeniably negative, resulting in an environment that allows antigay hostility [81]. The impact of antigay prejudice on the physical and mental health of members of the LGBTQIA community and their families should not be underestimated [82; 83].

Sexual minority individuals also are not immune to societal attitudes and may internalize negative aspects of the antigay prejudice experience. Anxiety, depression, social withdrawal, and other reactions may result [2; 84]. While the study of psychologic heterosexism, both blatant and subtle, is in the early stages of research, it has had a measurable impact on the mental health of the GSM community [85; 86; 87; 88].

Examples of the range of manifestations of heterosexism and/or homophobia in our society are readily available. Without difficulty, each example presented here may be conceptualized as related to the emotional or physical health of a GSM individual or family member:

- A kindergarten student calls another child an LGBTQ+ slur but does not really know what he is saying.
- A teenage woman allows herself to become pregnant, "proving" her heterosexuality to herself, her family, and her friends.
- A parent worries that her 12-year-old daughter is still a "tomboy."
- An office employee decides to place a photo of an old boyfriend in her office rather than a photo of her gender-nonconforming partner of five years.
- A college student buries himself in his studies in an effort to ignore his same-sex feelings and replace feelings of isolation.
- Two teenage women, thought by peers to be transgender individuals, are assaulted and killed while sitting together in an automobile.
- A female patient is told by a healthcare provider that her haircut makes her look like a lesbian and is examined roughly.
- A gay man chooses not to reveal his sexual identity to his healthcare provider out of fear of a reduction or withdrawal of healthcare services.

The manifestations of heterosexism have inhibited our learning about the LGBTQIA population and its needs [78]. Gay patients have feared open discussion about their health needs because of potential negative reactions to their self-disclosure. Prejudice has impacted research efforts by limiting available funding [77]. All of these factors emphasize that the healthcare education system has failed to educate providers and researchers about the unique aspects of LGBTQIA health [83; 89].

Common Myths

Many myths surround homosexuality; a few are outlined below. The origin of these myths may be better understood after examining the history of homosexuality as well as the attitudes toward human sexuality in general. The history of the development of societal norms related to homosexuality includes misconceptions developed during times when research was not available on which to build a scientific knowledge base [82; 90; 91; 92].

Myth: Sexual orientation is a choice.

Fact: No consensus exists among scientists about the reasons that an individual develops his/her sexual orientation. Some research has shown that the bodies and brains of gay men and women differ subtly in structure and function from their heterosexual counterparts; however, no findings have conclusively shown that sexual orientation is determined by any particular factor or set of factors. Many people confuse sexual orientation with sexual identity. The reader may consider reviewing the definitions of these terms when further considering this myth.

Myth: Gay men and lesbians can be easily identified because they have distinctive characteristics.

Fact: Most gay and lesbian individuals conform to the majority of society in the way they dress and act. Further, a person's appearance is not necessarily an indication of sexual or romantic interests.

Myth: Gay individuals are child molesters.

Fact: This is a very damaging and heterosexist position. According to experts in the field of sexual abuse, the vast majority of those who molest children are heterosexual. The average offender is a White heterosexual man whom the child knows.

Myth: Gay people want to come into our schools and recruit our children to their "lifestyle."

Fact: Efforts to bring issues related to LGBTQIA history and rights into schools are not efforts to "convert," just as education on European history is not an effort to glamorize or "convert" to European identity. The intent has been to teach a more complete history of the world and to prevent children from mistreating LGBTQIA who are often the subjects of harassment and physical attacks. There is no evidence that people could be "recruited" to a gay sexual orientation, even if someone wanted to do this.

AGE

Elderly patients should be routinely screened for health and mental health conditions using tools specifically developed for this population, in spite of some practitioners' discomfort with asking questions about sensitive topics. These population-appropriate assessments may be included in other health screening tools [93].

Wellness and purpose have become important emphases when working with older adults [94]. In the past, aging was associated with disability, loss, decline, and a separation from occupational productivity. Although patient growth and positive change and development are values that practitioners embrace, the unconscious acceptance of societal myths and stereotypes of aging may prevent practitioners from promoting these values in elderly individuals [95].

Common Myths of Aging

Society holds several myths about the elderly. Many of these myths may be easily disputed based on data from the U.S. Census and other studies.

Myth: Most older adults live alone and are isolated.

Fact: In 2018, 70% of men and 46% of women 65 years and older were married. An estimated 28% lived alone [96]. According to a survey conducted in 2009, 9 out of 10 individuals 65 years of age and older stated they talked to family and friends on a daily basis [97]. In 2016, an estimated 20% of the U.S. population lived in a household comprised of two adult generations or a grandparent or at least one other generation, compared with 12% in 1980 [97; 98]. This multigenerational household trend particularly affects those 65 years and older, with 21% of these individuals living in multigenerational households in 2016. This group was second only to individuals 25 to 29 years of age (33%) [98]. Several factors have contributed to this trend, including growing racial and ethnic diversity and adults getting married later [97; 98].

Myth: Most older adults engage in very minimal productive activity.

Fact: In 2016, 18.6% of persons 65 years and older were employed or actively looking for work, and this population represents approximately 8% of the total labor force in the United States [99]. The elderly are more engaged in self-employed activities than younger persons. In 2016, 16.4% of those 65 years of age and older were self-employed, compared with an average of 5.5% of those 16 years to 64 years of age [100].

Myth: Life satisfaction is low among the elderly.

Fact: Data from the Berkeley Older Generation Study indicate that many elders are quite satisfied with their life [101]. More than one-third (36%) of persons older than 59 years of age and 15% of those older than 79 years of age stated they were currently experiencing the best time in their lives. A 2009 survey found that 60% of individuals 65 years of age and older stated they were very happy. A 2012 survey found that 65% of individuals 65 years of age and older indicated that the past year of their life has been normal or better than normal, and more than 80% of respondents agreed with the statement, "I have a strong sense of purpose and passion about my life and my future" [102]. Most of the factors that predict happiness for the young, such as good health and financial stability, also apply to the elderly. Older adults tend to report higher levels of well-being in part due to the quality of their social relationships [103].

PERSONS WITH MENTAL OR PHYSICAL DISABILITY

Americans with disabilities represent a large and heterogeneous segment of the population. The prevalence of disability varies by age group and definition. Based on the U.S. Census Bureau's 2013 American Community Survey (ACS), which describes disability in terms of functional limitations, 12.6% of the civilian U.S. noninstitutionalized population has a disability, defined as difficulty in hearing or vision, cognitive function, ambulation, self-care, or independent living [104]. The U.S. Department of Education, which uses categorical disability labels, estimates that 13% of children and youth 3 to 21 years of age have a disability (defined as specific learning disabilities, speech or language impairments, intellectual disability, emotional disturbance, hearing impairments, orthopedic impairments, other health impairments, visual impairments, multiple disabilities, deaf-blindness, autism, traumatic brain injury, or developmental delay) [104].

People with disabilities experience many health disparities. Some documented disparities include poorer self-rated health; higher rates of obesity, smoking, and inactivity; fewer cancer screenings (particularly mammography and Pap tests); fewer breast-conserving surgeries when breast cancer is diagnosed; and higher rates of death from breast or lung cancer [104].

Disability cultural competence requires appreciation of social model precepts, which recognize patients' rights to seek care that meets their expectations and values. The social model of disability has been characterized as centering disability as a social creation rather than an attribute of the patient [105]. As such, disability requires a social/political response in order to improve environmental factors affecting access and acceptance [105]. This involves adoption of person-first language, acknowledgement of social and environmental factors impacting persons abilities, and confronting disability-associated stigma.

VETERANS

The effects of military service and deployment to military combat on the individual and the family system are wide-reaching. According to the U.S. Department of Defense, there were 3.5 million current military personnel in 2020 and 18.3 million veterans in 2017 [132; 133]. The Army has the largest number of active duty members, followed by the Navy, the Air Force, and the Marine Corps [132]. Military service presents its own set of risk and protective factors for a variety of mental health issues, including post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), depression and suicide, substance abuse, and interpersonal violence. In particular, transitioning from combat back to home life can be particularly trying for veterans and their families.

As the number of military conflicts and deployments has increased since 2001, the need to identify and provide better treatment to veterans and their families has become a greater priority. The first step in providing optimal care is the identification of veterans and veteran families during initial assessments, with an acknowledgement that veterans may be any sex/gender and are present in all adult age groups [133].

Unfortunately, veterans and military families often do not voluntarily report their military service in healthcare appointments. In 2015, the American Medical Association updated its recommendations for social history taking to include military history and veteran status [134]. In addition, the American Academy of Nursing has designed the Have You Ever Served? Initiative to encourage health and mental health professionals to ask their patients about military service and related areas of concern [135]. This program provides pocket cards, posters, and resource links for professionals working with veterans and their families. Recommended questions for intake include [135]:

- Have you or has someone close to you ever served in the military?
- When did you serve?
- Which branch?
- What did you do while you were in the military?
- Were you assigned to a hostile or combative area?
- Did you experience enemy fire, see combat, or witness casualties?
- Were you wounded, injured, or hospitalized?
- Did you participate in any experimental projects or tests?
- Were you exposed to noise, chemicals, gases, demolition of munitions, pesticides, or other hazardous substances?

PROMOTING CULTURALLY SENSITIVE COMMUNICATION

Communication, the process of sending a message from one party to another, consists of both verbal and nonverbal components. Verbal and nonverbal communications are embedded within the culture of the parties disseminating the information and within the culture of the parties receiving the information. Communication is complex and multilayered because it involves unstated, implicit rules about a variety of factors, including physical distance between parties, tone of voice, acceptable topics of discussion, physical contact, and amount of eye contact [106]. Each of these variables is influenced by the perception of the level of formality/informality of the situation. Frequently, misunderstandings occur because the decoding and interpretation of these nonverbal cues are not accurate.

The verbal component of communication is just as complicated. Certainly, similarity in language shared by both parties enhances communication, but assuming that both parties in a conversation speak the same language, how the information is interpreted is still influenced by a host of factors. Linguists have posited that approximately 14,000 different meanings and interpretations can be extracted from the 500 most common English words [107]. Consequently, practitioners must be aware of the different communication styles held by diverse ethnic minority patients, as the clinical communication process is the primary vehicle by which problems and solutions are identified and conveyed [108].

Styles of communication can be classified from high- to low-context [109]. High-context cultures are those cultures that disseminate information relying on shared experience, implicit messages, nonverbal cues, and the relationship between the two parties [107; 110]. Members of these cultural groups tend to listen with their eyes and focus on how something was said or conveyed [106; 109]. On the other hand, low-context cultures rely on verbal communication or what is explicitly stated in the conversation [107]. Consequently, low-context communicators listen with their ears and focus on what is being said [106; 109; 110]. Western culture, including the United States, can be classified as a low-context culture. On the other hand, groups from collectivistic cultures, such as Asian/Pacific Islanders, Hispanics, Native Americans, and African Americans, are from high-context cultures [109].

Communicators from high-context cultures generally display the following characteristics [106; 107; 110; 111]:

- Use of indirect modes of communication
- Use of vague descriptions
- Less talk and less eye contact
- Interpersonal sensitivity
- Use of feelings to facilitate behavior
- Assumed recollection of shared experiences
- Reliance on nonverbal cues such as gestures, tone of voice, posture, voice level, rhythm of speaking, emotions, and pace and timing of speech
- Assimilation of the "whole" picture, including visual and auditory cues
- Emotional speech
- Use of silence
- Use of more formal language, emphasizing hierarchy between parties

On the other hand, low-context communicators can typically be described as [106; 107; 110]:

- Employing direct patterns of communication
- Using explicit descriptions and terms
- Assuming meanings are described explicitly
- Utilizing and relying minimally on nonverbal cues
- Speaking more and often raising their voices (more animated, dramatic)
- Often being impatient to get to the point of the discussion
- Using more informal language; less emphasis on hierarchy, more equality between parties (more friendly)
- Being more comfortable with fluidness and change
- Uncomfortable using long pauses and story-telling as a means of communicating

Understanding the distinctions between individuals who come from high- and low-context cultures can promote cultural sensitivity. However, it is vital that practitioners take heed of several words of caution. First, it is important not to assume that two individuals sharing the same culture (e.g., low-context culture) will automatically have a shared script for communicating. Second, it is important to not immediately classify an individual into a low- or high-context culture because of their ethnicity. A Chinese American man may not necessarily be a high-context communicator because he is Asian. A host of factors, such as level of acculturation, upbringing and socialization, education, and family immigration history, will all play a role in how one learns to communicate. Third, a major criticism of the discussion of low-/high-context cultures is that they reinforce dualism and ultimately oversimplify the complexities and nuances of communication [112].

Learning to communicate effectively also requires an understanding of how different conversational traits influence the communication process, or how information is conveyed and interpreted. Again, the goal of this section is not to simply dichotomize individuals' conversational styles into categories, but rather to understand the factors that play a role in how someone makes a decision on how to communicate [106].

As long as there are two parties involved in a conversation, nonverbal communication is inevitable, and it becomes salient particularly when it is processed from one culture to another. Nonverbal communication is any behavior (including gestures, posture, eye contact, facial expressions, and body positions) that transcends verbal or written forms of communication [113]. Nonverbal communication can enhance or reinforce what is said verbally, and conversely, it can completely contradict the message communicated verbally. It can also end up replacing what was verbally communicated if both parties do not share a native language [114].

In Western culture, communication is more direct and eye contact is highly valued. When eye contact is not maintained, many Westerners assume that the party is hiding pertinent information. However, in some cultures, reducing eye contact is a sign of respect [108]. Conversely, patients may interpret direct and indirect gazes differently. For example, in one study, Japanese individuals tended to rate faces with a direct gaze as angry and less pleasant compared with Finnish participants [115].

The amount of social space or distance between two communicating parties is culturally charged as well. Depending upon the social context, Westerners tend to maintain a distance of about three feet, or an arm's length, in conversations [107]. In a public setting, where both parties are engaged in a neutral, nonpersonal topic, Westerners will feel encroached upon and uncomfortable if an individual maintains a closer conversational distance. However, in other cultures, such as Latino and Middle Eastern, a closer distance would be the norm [107]. Chung recommends that in a clinical setting the practitioner allow patients to set the tone and social distance [116]. The practitioner can sit first and permit the patient to select where they want to sit.

Cross-cultural communication is by no means simple, and there is no set of rules to merely abide by. Instead, promoting culturally sensitive communication is an art that requires practitioners to self-reflect, be self-aware, and be willing to learn. Therefore, as practitioners become skilled in noticing nonverbal behaviors and how they relate to their own behaviors and emotions, they will be more able to understand their own level of discomfort and comprehend behavior from a cultural perspective [106].

CULTURALLY SENSITIVE ASSESSMENT GUIDELINES

Practitioners may be categorized as either disease-centric or patient-centric [117]. Disease-centered practitioners are concerned with sign/symptom observation and, ultimately, diagnosis. On the other hand, patient-centered practitioners focus more on the patient's experience of the illness, subjective descriptions, and personal beliefs [117]. Patient-centered practice involves culturally sensitive assessment. It allows practitioners to move assessment and practice away from a pathology-oriented model and instead acknowledge the complex transactions of the individual's movement within, among, and between various systems [118].

Practitioners who engage in culturally sensitive assessment nonjudgementally obtain information related to the patient's cultural beliefs, overall perspective, and specific health beliefs [119]. They also allow the patient to control the timing [120].

The goal is to avoid the tendency to misinterpret health concerns of ethnic minority patients. Panos and Panos have developed a qualitative culturally sensitive assessment process that focuses on several domains [119]. Each domain includes several questions a practitioner may address in order to ensure that he or she is providing culturally responsive care.

Alternatively, Kleinman suggests that the practitioner ask the patient what he or she thinks is the nature of the problem [121]. He highlights the following types of questions that may be posed to the patient [121]:

- Why has the illness/problem affected you?
- Why has the illness had its onset now?
- What course do you think the illness will follow?
- How does the illness affect you?
- What do you think is the best or appropriate treatment? What treatment do you want?
- What do you fear most about the illness and its treatment?

Similar to Kleinman's culturally sensitive assessment questions, Galanti has proposed the 4 Cs of Culture [122]:

- What do you call the problem?
- What do you think caused it?
- How do you cope with the problem?
- What questions or concerns do you have about the problem or treatment?

Pachter proposed a dynamic model that involves several tiers and transactions, similar to Panos and Panos' model [123]. The first component of Pachter's model calls for the practitioner to take responsibility for cultural awareness and knowledge. The professional must be willing to acknowledge that they do not possess enough or adequate knowledge in health beliefs and practices among the different ethnic and cultural groups they come in contact with. Reading and becoming familiar with medical anthropology is a good first step.

The second component emphasizes the need for specifically tailored assessment [123]. Pachter advocates the notion that there is tremendous diversity within groups. Often, there are many intersecting variables, such as level of acculturation, age at immigration, educational level, and socioeconomic status, that influence health ideologies. Finally, the third component involves a negotiation process between the patient and the professional [123]. The negotiation consists of a dialogue that involves a genuine respect of beliefs. The professional might recommend a combination of alternative and Western treatments.

Beckerman and Corbett further recommend that recently immigrated families be assessed for [124]:

- Coping and adaptation strengths
- Issues of loss and adaptation
- The structure of the family in terms of boundaries and hierarchies after immigration
- Specific emotional needs
- Acculturative stress and conflict for each family member

Practitioners should seek to understand the sociopolitical context of the origin country [125]. A migration narrative is also recommended, whereby an individual provides a story of their migration history. Asking about how long the family has been in the United States, who immigrated first, who was left behind, and what support networks are lacking gives the practitioner an overview of the individual's present situation [126]. The theme of loss is very important to explore. Types of losses may include family and friends left behind, social status, social identity, financial resources, and familiarity [126]. For refugees and newly immigrated individuals and families, assessment of basic needs (e.g., food, housing, transportation) is necessary [125].

Culturally sensitive assessment involves a dynamic framework whereby the practitioner engages in a continual process of questioning. Practitioners should work to recognize that there are a host of factors that contribute to patients' multiple identities (e.g., race, gender, socioeconomic status, religion) [127].

WELCOMING AND SAFE ENVIRONMENT

Improving access to care can be facilitated, in part, by providing a welcoming environment. The basis of establishing a safe and welcoming environment for all patients is security, which begins with inclusive practice and good clinician-patient rapport. Shared respect is critical to a patient's feeling

of psychological well-being. Security can also be fostered by a positive and safe physical setting. For patients who are acutely ill, both the illness experience and treatment process can produce trauma. This is particularly true if involuntary detainment or hospitalization is necessary, but exposure to other individuals' narratives of experienced trauma or observing atypical behaviors from individuals presenting as violent, disorganized, or harmful to themselves can also be traumatic. As such, care environments should be controlled in a way to minimize traumatic stress responses. Providers should keep this in mind when structuring the environment (e.g., lighting, arrangement of space), creating processes (e.g., layout of appointments or care systems, forms), and providing staff guidance (e.g., nonverbal communication, intonation, communication patterns). During each encounter, the patient's perception of safety is impacted by caretakers and ancillary staff.

Experts recommend the adoption and posting of a nondiscrimination policy that signals to both healthcare providers and patients that all persons will be treated with dignity and respect [128]. Also, checklists and records should include options for the patient defining their race/ethnicity, preferred language, gender expression, and pronouns; this can help to better capture information about patients and be a sign of acceptance to that person. If appropriate, providers should admit their lack of experience with patient subgroups and seek guidance from patients regarding their expectations of the visit.

Front office staff should avoid discriminatory language and behaviors. For example, staff should avoid using gender-based pronouns, both on the phone and in person. Instead of asking, "How may I help you, sir?" the staff person could simply ask, "How may I help you?" Offices that utilize electronic health records should have a system to track and record the gender, name, and pronoun of all patients. This can be accomplished by standardizing the notes field to document a preferred name and pronoun for all patients [129]. Some persons who identify as non-binary (i.e., neither or both genders) may prefer that plural pronouns (e.g., they) be used.

Questions should be framed in ways that do not make assumptions about a patient's culture, gender identity, sexual orientation, or behavior. Language should be inclusive, allowing the patient to decide when and what to disclose. Assurance of confidentiality should be stressed to the patient to allow for a more open discussion, and confidentiality should be ensured if a patient is being referred to a different healthcare provider. Asking open-ended questions can be helpful during a history and physical.

The FACT acronym may be helpful for healthcare providers. Providers should:

- **F**ocus on those health issues for which the individual seeks care
- **A**void intrusive behavior
- **C**onsider people as individuals
- **T**reat individuals according to their gender

Training office staff to increase their knowledge and sensitivity toward persons will also help facilitate a positive experience for patients.

CONCLUSION

Culture serves as a lens through which patients and practitioners filter their experiences and perceptions. Patients will bring their unique life stories and concerns to the practitioner, and their cultural values and belief systems will inevitably shape how the problem is defined and their beliefs about what is effective in solving the problem. However, the cultural backgrounds and values of patients are not necessarily scripts that define behavior, and when practitioners view culture as a strength and not a pathology, practitioners will be able to more effectively join with patients to mobilize change.

FACULTY BIOGRAPHY

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Customer Information/Answer Sheet/Evaluation insert located between pages 32–33.

TEST QUESTIONS
#97430 CULTURAL COMPETENCE: AN OVERVIEW

This is an open book test. Please record your responses on the Answer Sheet.
A passing grade of at least 80% must be achieved in order to receive credit for this course.

This 2 Hour/1.5 NBCC Clock Hour activity must be completed by February 28, 2025.

1. A nurse acknowledges that she still has a lot to learn about different racial and ethnic minority groups. She is willing to learn from her patients and assume the role of learner. This nurse is demonstrating
A) *diversity.*
B) *reflexivity.*
C) *explicit bias.*
D) *cultural humility.*

2. Intersectionality is a term to describe the multiple facets of identity, including race, gender, sexual orientation, religion, sex, and age.
A) *True*
B) *False*

3. An alternative way of conceptualizing implicit bias is that an unconscious evaluation is only negative if it has further adverse consequences on a group that is already disadvantaged or produces inequities.
A) *True*
B) *False*

4. Which of the following is NOT a risk factor in triggering implicit biases for health professionals?
A) *Uncertainty*
B) *Cognitive dissonance*
C) *Time pressure to make a rapid decision*
D) *Heavy workload and feeling behind schedule*

5. All of the following are categories of social determinants, EXCEPT:
A) *Race*
B) *Economic stability*
C) *Health care access and quality*
D) *Social and community context*

6. Which of the following has been identified as a core value of Black culture?
A) *Spirituality*
B) *Community*
C) *Family/kinship*
D) *All of the above*

7. Native American patients often respond best when they are given directions rather than suggestions and options.
A) *True*
B) *False*

8. Male gender identity is related to
A) *risk avoidance.*
B) *emotional demonstration.*
C) *denying pain and weakness.*
D) *teamwork and help-seeking.*

9. Cultural heterosexism is characterized by
A) *negative feelings toward oneself and self-hatred.*
B) *A negative attitude or fear of non-straight sexuality or GSM individuals.*
C) *considering sexual identity and determining that one does not want to think further about it.*
D) *the stigmatization in thinking and actions found in cultural institutions, such as educational and legal systems.*

10. Persons with disability experience higher rates of all of the following, EXCEPT:
A) *Obesity*
B) *Smoking*
C) *Cancer screening*
D) *Breast and lung cancer mortality*

11. Low-context cultures rely on verbal communication or what is explicitly stated in the conversation.
A) *True*
B) *False*

12. Which of the following is a typical characteristic of communication in high-context cultures?

A) *Use of more informal language*
B) *Speaking more and often raising one's voice*
C) *Assumption that meanings are described explicitly*
D) *Reliance on interpreting eye contact, gestures, and tone of voice*

13. Which of the following is an attribute of patient-centered practice?

A) *The practitioner focuses on observed signs and symptoms.*
B) *The practitioner is concerned with identifying the disease pathology.*
C) *The practitioner focuses on the subjective description of the illness.*
D) *The practitioner is not influenced by how the client/patient defines the illness.*

14. The basis of establishing a safe and welcoming environment for all patients is

A) *security.*
B) *autonomy.*
C) *beneficence.*
D) *maintaining distance.*

15. It is never appropriate for providers to admit their lack of experience with patient subgroups or to seek guidance from patients.

A) *True*
B) *False*

Be sure to transfer your answers to the Answer Sheet located between pages 32–33.
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PLEASE NOTE: Your postmark or facsimile date will be used as your test completion date.

Anxiety Disorders in Older Adults

Approval(s): APA, NBCC, NAADAC

Audience
This course is designed for the benefit of a broad range of allied health professionals, including but not limited to counselors, therapists, and social workers.

Course Objective
Older adults are the fastest growing demographic in the world, and anxiety disorders are the most common mental disorder in this age group. The purpose of this course is to provide clinicians with the knowledge and skills necessary in order to improve the assessment and treatment of anxiety disorders in older adults.

Learning Objectives
Upon completion of this course, you should be able to:

1. Describe the history and neuroanatomy of anxiety and anxiety disorder.
2. Discuss the assessment and classification of anxiety disorders in older adults.
3. Analyze the epidemiology of anxiety disorders in elderly patients.
4. Describe the clinical implications of late-life anxiety disorders and their treatment.

Faculty
Beyon Miloyan, PhD, received his PhD in Psychology from the University of Queensland in 2015 for his thesis on late-life anxiety disorders. He completed his postdoctoral training in the Epidemiology and Biostatistics of Aging program at the Johns Hopkins University before taking a tenure-track position in the School of Psychology and Health Sciences at Federation University, Australia. Dr. Miloyan has published 30 peer-reviewed journal articles and book chapters and has been teaching since 2012. He has supervised 10 student theses at doctoral, Master's, and undergraduate levels and served as an ad hoc peer reviewer for various journals in the fields of psychology, psychiatry, and public health.

Faculty Disclosure
Contributing faculty, Beyon Miloyan, PhD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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INTRODUCTION

The first known clinical case description of an anxiety disorder appeared in the medical corpus of the Ancient Greek physician Hippocrates. The description tells of Nicanor, a man who developed an extreme fear of a "flute girl" whom he encountered one night at a drinking party and who haunted him every night for many years. Five hundred years after this case description, the Ancient Roman Stoic philosophers Seneca the Younger and Cicero addressed the topic of anxiety at length, recognizing both its benefits and harms, depending on the severity and circumstances of the anxiety [1]. These texts reveal a sophisticated understanding of fear and anxiety among these ancient authors, even by modern medical standards. It was not until the 19th century that Charles Darwin noted essential similarities in the expression of fear and anxiety in mammals, reinforcing Seneca's notion that fear and anxiety are ultimately adaptive traits [2]. In its normal state, anxiety facilitates the management of potential future hazards [3; 4; 5]. In its extreme state, the individual regards it as excessive or distressing or it can cause impairment in the individual's daily life, thus constituting a disorder [6; 7].

The analogy of a smoke detector demonstrates the adaptive and maladaptive aspects of anxiety [8; 9]. Just as the function of a smoke detector is to signal potential fires so that one can take action to prevent harm, the function of anxiety is to signal any potential hazards so that preventive actions can be taken. In this analogy, an anxiety disorder is an extreme that renders the individual more sensitive to threat signals [10]. Although those with higher anxiety experience more false alarms (signals for a threat that does not occur), this is advantageous to the extent that it reduces the risk of a fatal miss. In other words, the costs associated with false alarms and misses are not equal: over-reacting to non-threats is generally less costly than failing to detect one danger. Nonetheless, living in a chronic state of high anxiety can take a long-term toll on an individual's health and quality of life, and in these cases, intervention is warranted.

Age-related changes in anxiety can occur over the course of one's life, and understanding these changes is key to facilitating clinical detection and treatment, particularly among older adults, who are the largest and fastest-growing age demographic in the United States. This course begins by addressing the neuroanatomy of anxiety, followed by its classification and a review of commonly used methods of assessment. The course goes on to cover the epidemiology of anxiety disorders in older adults, including its prevalence, incidence, course, risk factors, and consequences. Finally, treatment considerations are addressed.

NEUROANATOMY

In 1949, the Nobel Prize in Medicine was awarded to António Egas Moniz for his discovery of "a simple operation, always safe, [and] which may prove to be an effective surgical treatment in certain cases of mental disorder" [11]. Specifically, Moniz discovered the prefrontal leukotomy as a treatment for mental disorders, including anxiety disorders [12]. Since then, studies have found that damage to the ventromedial prefrontal cortex produces resistance against anxiety and depression [13; 14; 15; 16]. Despite the effective reduction of anxiety in these patients, it took many decades until research began to address the harms imposed by damage to the prefrontal cortex. For example, in addition to reducing anxiety, damage to the ventromedial prefrontal cortex also impairs self-regulation and decision-making and can induce sociopathic behaviors [17; 18; 19; 20; 21]. Similar patterns of anxiety reduction were also observed in one patient with focal bilateral lesions to the amygdalae who showed a similar pattern of impairment in her daily life as those with damage to the prefrontal cortex [22]. Although the prefrontal cortex and amygdala are critical structures in a neural network that is necessary for anxiety, these findings highlight the fact that damage to these structures comes with unintended consequences. These findings also highlight the more general point that, in treating anxiety disorders, it is also important to not abolish otherwise useful traits as it is to reduce the anxiety to a manageable level.

CLASSIFICATION

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) sub-classifies anxiety disorders into panic disorder, agoraphobia, specific phobia, social anxiety disorder, and generalized anxiety disorder (GAD) [6]. In the following sections, each of these subtypes are described, including the relevant criteria for diagnosis and a description of age-related differences in symptom patterns. The most frequently reported symptom(s) for each disorder in older adults are based on data from the National Epidemiological Survey on Alcohol and Related Conditions (NESARC).

PANIC DISORDER AND AGORAPHOBIA

Panic disorder is characterized by the occurrence of panic attacks. Panic attacks are defined as sudden, unexpected, and brief onsets of terror, accompanied by at least four of the following symptoms: sweating, trembling, chest pain, dizziness, nausea, chills or hot flashes, numbness or tingling, shortness of breath or choking, a feeling of loss of control, desensitization, or a fear of death. In order to be classified as panic disorder, the DSM requires such panic attacks to be accompanied by a period of at least one month in which the individual also fears the possibility of a future panic attack [6].

Two main subtypes of panic disorder have been observed, diverging between individuals with respiratory and non-respiratory symptoms [23; 24; 25]. Determining the subtype may be informative for treatment purposes. Older adults with panic disorder experience fewer symptoms of panic compared with younger adults, and their panic attacks are also reported to be less intense and shorter in duration [26; 27; 28; 29].

Agoraphobia is characterized by a fear or avoidance of situations from which escape is difficult. The diagnosis requires a fear or avoidance of two or more of the following specific situations: public transportation, open spaces, closed spaces, crowds, or being alone in public. Although the presence of these fears is also associated with panic disorder and specific phobia, a distinguishing factor of agoraphobia is defined by the frequency of the aforementioned fears. Individuals with greater and more frequent occurrences of these fears tend to be classified as having agoraphobia [30].

Table 1 displays the most commonly reported panic symptoms among older adults (55 years of age and older) with a diagnosis of panic disorder (with or without agoraphobia). The total percentage of each symptom is displayed. The prevalence of panic disorder in this sample was 1.2% (95% confidence interval [CI]: 1.0–1.5).

SPECIFIC PHOBIA

The central feature of specific phobia is the fear or avoidance of specific objects or situations. These include, but are not limited to, animals (e.g., snakes or insects), the natural environment (e.g., storms, water, or heights), situations (e.g., typically closed or open spaces), and blood, injections, or injury. A diagnosis of specific phobia requires the individual to recognize that the fear or avoidance is unreasonable and to regard it as distressing or interfering with their everyday life. The most common fears reported by adults involve animals, heights, and flying [32; 33; 34]. However, older adults frequently report situational fears [35]. Individuals who report having at least one specific fear are likely to report having other fears [33; 36].

Table 2 displays the most commonly reported specific fears among older adults (55 years of age and older) with a diagnosis of specific phobia. The prevalence of specific phobia in this sample was 5.5% (95% CI: 5.0–6.0).

SOCIAL ANXIETY DISORDER

The core feature of social anxiety disorder is the fear or avoidance of social situations. The fear or avoidance concerns the possibility of negative judgment by others (e.g., resulting in embarrassment or humiliation). Social anxiety may pertain to particular types of social settings or situations, such as small or large group settings, or the anxiety may generalize to a variety of social situations. Older adults endorse fewer social anxiety symptoms relative to younger adults [37]. The most common social fears among older adults include public speaking or being confronted or criticized by others, while discomfort with and avoidance of social situations and experi-

PREVALENCE OF PANIC SYMPTOMS AMONG OLDER ADULTS WITH PANIC DISORDER			
Symptom	**Age Groups**		
	55 to 64 Years	**65 Years and Older**	**55 Years and Older**
Shortness of breath	82%	85%	83%
Heart racing/pounding	91%	82%	88%
Trembling/shaking	73%	69%	72%
Perspiring/sweating	75%	65%	72%
Felt as if choking	45%	57%	50%
Dizzy/lightheaded	74%	74%	74%
Things seemed unreal	61%	56%	59%
Tingling/numbness	57%	50%	54%
Flushes/hot flashes/chills	71%	53%	64%
Nauseous/upset stomach	50%	56%	53%
Pain/pressure in chest	63%	56%	60%
Going crazy/losing control	63%	61%	62%
Felt might die	58%	64%	60%
Source: [31]			*Table 1*

PREVALENCE OF SPECIFIC FEARS AMONG OLDER ADULTS WITH SPECIFIC PHOBIA				
Object of Fear/ Avoidance	**Age Groups**			
	55 to 64 Years	**65 to 74 Years**	**75 Years and Older**	**55 Years and Older**
Animals	57%	56%	62%	58%
Heights	53%	60%	49%	55%
Storms	26%	30%	45%	31%
Being in/on water	31%	41%	45%	37%
Flying	35%	36%	33%	35%
Crowds/lines	13%	12%	23%	15%
Closed spaces	40%	38%	41%	40%
Blood/injections	16%	11%	17%	15%
Public transportation	9%	6%	7%	7%
Going to the dentist	31%	32%	27%	30%
Hospitals	15%	12%	17%	15%
Source: [31]				*Table 2*

encing anxiety when thinking about social situations appears equally common to both younger and older adults [37; 38].

***Table* 3** displays the most commonly reported social fears among older adults (55 years of age and older) with a diagnosis of social anxiety disorder. The prevalence of social anxiety disorder in this sample was 2.0% (95% CI: 1.7–2.3).

GENERALIZED ANXIETY DISORDER

The central feature of GAD is intrusive worry, defined as repetitive thinking about potentially harmful future events. Worries generally pertain to everyday concerns and involve attempts to minimize the likelihood or consequences of disadvantageous outcomes. Although some degree of worry is recognized as helpful, when the individual reports experiences of excessive and uncontrollable worry for a period of six months or more, this constitutes a diagnosis of GAD if, and only if, the worry is also regarded by the individual as causing distress or impairment [39]. Age-related reductions in worry frequency have been observed in older adult samples from the United States, United Kingdom, Canada, and Australia [40; 41; 42; 43; 44; 45; 46]. There are also age-related differences in the subjects of individuals' worries. For example, for younger adults, common worries concern work, finances, and personal relationships. For older adults, these concerns

PREVALENCE OF SOCIAL ANXIETY SYMPTOMS AMONG OLDER ADULTS WITH SOCIAL ANXIETY DISORDER			
Symptom	**Age Groups**		
	55 to 64 Years	**65 Years and Older**	**55 Years and Older**
Social situations made you nervous	81%	85%	83%
Social situations made you upset/anxious	93%	93%	93%
Endured social situations that frightened you	88%	85%	87%
Avoided social situations out of strong fear	82%	72%	77%
More frightened in social situations than most people	80%	76%	78%
Thought fear of social situations stronger than it should be	92%	89%	90%
Had a panic attack in social situations	22%	8%	15%
Frightened of social situations out of fear of panic attack	16%	8%	12%
Remained in social situation despite fear of panic attack	20%	11%	15%
Source: [31]			*Table 3*

PREVALENCE OF GENERALIZED ANXIETY DISORDER SYMPTOMS AMONG OLDER ADULTS WITH GENERALIZED ANXIETY DISORDER			
Symptom	**Age Groups**		
	55 to 64 Years	**65 Years and Older**	**55 Years and Older**
Worry a lot about things you usually didn't worry about?	83%	72%	78%
Ever think your worrying was excessive?	56%	47%	52%
Often got tired easily	83%	81%	82%
Often had tense, sore, aching muscles	76%	67%	71%
Became so restless you paced, fidgeted, or could not sit still	62%	55%	58%
Often felt keyed up or on edge	82%	78%	80%
Often had trouble concentrating	83%	83%	83%
Often felt irritable	80%	62%	71%
Often had trouble falling/staying asleep	77%	72%	74%
Often forgot what you were talking about/mind went blank	75%	66%	70%
Often felt heart racing, skipping, or pounding in chest	59%	45%	52%
Often perspired/sweated	50%	35%	43%
Often had cold and clammy hands	44%	27%	36%
Often had dry mouth	58%	49%	54%
Often felt dizzy/lightheaded/like might faint	48%	53%	50%
Often felt nauseous	54%	34%	45%
Often urinated frequently	54%	47%	51%
Often had trouble swallowing/felt like lump in throat	37%	34%	35%
Often had pain/pressure in chest	40%	31%	36%
Often trembled/shook	34%	39%	36%
Often had trouble catching breath/felt like smothering	43%	33%	39%
Source: [31]			*Table 4*

give way to worries about personal health and the health and welfare of loved ones [41; 44; 46]. These "world issue" worries typically focus outwardly on problems that could be faced by future generations, which may be of particular relevance during this developmental life stage [43]. In fact, late-life developmental transitions have been associated with

other context-specific worries, such as concerns of becoming a burden after transitioning out of a primary caregiver role and into retirement [47; 48]. Caregiving, too, can be a significant source of worry, anxiety, and distress in later life [49; 50; 51]. Older adults who report financial worries tend to be concerned about receiving care and about their own capacity to make decisions [52]. However, despite the observation that older adults with GAD tend to endorse a greater variety of worries than matched non-GAD controls, there are fewer differences in the experience of worry between older adults with and without GAD than there are between younger adults with and without GAD [53; 54]. In essence, the expression of worry may vary significantly as a function of the developmental stage of the individual, with older adults endorsing worries commensurate with their changing life circumstances [55].

Table 4 displays the most commonly reported generalized anxiety disorder symptoms among older adults (55 years of age and older) with a diagnosis of GAD. The prevalence of GAD in this sample was 2.0% (95% CI: 1.7–2.3).

ASSESSMENT

STRUCTURED AND SEMI-STRUCTURED INTERVIEWS

The standard procedure for anxiety disorder assessment is the structured diagnostic interview, which is administered by a trained professional. The structured interview consists of pre-determined questions that assess for relevant symptoms based on diagnostic criteria. For example, an interview for GAD would start by asking the individual questions about the presence of worry symptoms over the past six months. If the interviewee answers this question affirmatively, the interviewer would then ask the individual about the presence of secondary symptoms associated with the worry (e.g., sleep, irritability). If the individual responds affirmatively to the minimum number of secondary symptoms required for a diagnosis of GAD, the individual would then be queried about the presence of distress or impairment due to the worry. The key advantage of the structured interview is its standardized administration, procedure, and scoring, which minimize bias and error in assessment. Two commonly used structured interviews for the assessment of mental disorders are the Diagnostic Interview Schedule (DIS) and the Composite International Diagnostic Interview (CIDI) [56; 57]. In addition, the Anxiety Disorders Interview Schedule (ADIS) is a structured diagnostic interview that was developed specifically for anxiety disorder assessment [58]. These interviews are regularly updated along with diagnostic criteria, as for example with new editions of the DSM. Structured interviews rely essentially on self-report; in addition to being administered by clinicians, they may also be conducted by trained lay persons and/or computer-assisted technology (as in epidemiologic surveys).

The examination modality of assessment contrasts with the interview technique in that the person conducting the assessment, typically a trained clinician, decides about the presence or absence of a symptom instead of relying on the report of the individual. The Structured Clinical Interview for the DSM (SCID) and the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) are examples of semi-structured interviews/examinations that allow the clinician to take a more flexible approach to the interview while retaining some degree of structure [59; 60]. Structured interviews and semi-structured examinations are not always practical to use because they are time-consuming to administer. Nonetheless, they are essential for validating briefer, easier to administer, and more widely used questionnaires and screening tools for use in particular contexts.

As a result of the evolving racial and immigration demographics in the United States, interaction with patients for whom English is not a native language is inevitable. Because diagnosing anxiety disorders is reliant on good communication, it is each practitioner's responsibility to ensure that interviews and assessments are conducted in such a way that allows for patient understanding. When there is an obvious disconnect in the communication process between the practitioner and patient due to the patient's lack of proficiency in the English language, an interpreter is required.

Mental health professionals should consider undertaking a language needs analysis for the service population and consider how to best meet identified needs. If possible, 10 to 15 minutes should be reserved in advance of sessions to brief the interpreter about the purpose of the meeting and to enable them to explain any cultural issues that may have bearing on the session.

RATING SCALES

Generalized Anxiety Disorder

The Generalized Anxiety Disorder 7-item (GAD-7) scale is a brief, self-administered screening instrument for use in medical settings. The scale assesses for symptoms occurring over the previous two weeks of the respondent's life [61; 62]. Each item is rated on a four-point scale (0 to 3) yielding a maximum score of 21. A score of 10 or greater indicates a probable diagnosis of GAD based on validation against the psychiatrist-administered SCID [62]. There is also a shorter, two-item version called the GAD-2. The GAD-7 (along with scoring instructions) can be accessed online at https://adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf. The GAD-2 consists of only the first two items of the GAD-7, with scores of 3 or greater indicating clinically significant anxiety symptoms [63].

Panic Disorder

The Panic Disorder Severity Scale (PDSS) is a brief, self-administered screening instrument [64]. There are seven items, each rated on a five-point scale (0 to 4) yielding a maximum score of 28. A score of eight or greater indicates a probable diagnosis of panic disorder based on validation

against the ADIS or the psychiatrist-administered SCID [65]. The PDSS and scoring instructions can be accessed online at http://www.goodmedicine.org.uk/files/panic,%20assessment%20pdss.pdf.

Social Anxiety Disorder

The Social Phobia Inventory (SPIN) is a self-administered screening instrument [66]. There are 17 items, each rated on a five-point scale (0 to 4), yielding a total score of 68. A score of 19 or greater indicates a probable diagnosis of social anxiety disorder. There also a shorter, three-item version called the Mini-SPIN [67; 68]. The SPIN and its scoring instructions can be accessed online at http://www.goodmedicine.org.uk/files/social%20anxiety,%20assessment%20spin.full_.tahoma_0.pdf.

Specific Phobia/Agoraphobia

There are currently no validated rating scales for the assessment of specific phobia or agoraphobia. However, screening for specific phobia is simpler than for other anxiety subtypes. The clinician starts by assessing whether the individual has a fear or avoidance of any specific stimulus or situation. If the individual answers affirmatively, then the clinician assesses whether the fear/avoidance is regarded as excessive or unreasonable and whether it interferes with the individual's life. Both criteria must be met for a patient to screen positive.

General (Transdiagnostic) Anxiety Screening

The Overall Anxiety Severity and Impairment Scale (OASIS) is a brief, transdiagnostic screening tool designed to assess for the severity of anxiety in the past week of the individual's life [69]. There are five items, each rated on a five-point scale (0 to 4), yielding a total possible score of 20. A raw score of 8 or greater indicates the presence of anxiety disorder based on validation against anxiety disorder diagnosis using the psychiatrist-administered SCID [70]. Raw scores of 10 and 12 indicate the presence of marked and severe anxiety, respectively, based on validation against the clinician-rated Clinical Global Impression-Severity (CGI-S) scale in a sample of individuals with any anxiety disorder ascertained using the Mini International Neuropsychiatric Interview (MINI) [71].

Scales for Older Adult/Geriatric Use

The Geriatric Anxiety Inventory (GAI) is a 20-item questionnaire designed specifically for older adults (65 years of age and older) [72; 73]. It is a self-report or clinician-administered measure, with each item rated on a binary response scale (agree/disagree), for a total score of 20. Scores of 10 or greater indicate a probable diagnosis of anxiety disorder. The GAI has been translated to more than 20 languages. The GAI has also been validated in clinical and non-clinical samples and in those with cognitive impairment and Parkinson disease [74; 75; 76]. There is also a five-item version called the Geriatric Anxiety Inventory-Short Form (GAI-SF) [77]. Both versions can be accessed online at http://gai.net.au.

The Geriatric Anxiety Scale (GAS) is a self-report questionnaire designed for use among adults 65 years of age and older [78]. The GAS contains 30 items, of which only 25 are used to derive a total score. The remaining five questions are used to help the clinician identify areas of concern for the respondent. Each item is rated on a four-point scale (from 0 to 3), yielding a total score of 100. The GAS consists of three sub-scales assessing somatic (9 items, total possible score: 36), cognitive (8 items, total possible score: 32), and affective (8 items, total possible score: 32) symptoms. There is also a shorter, 10-item version called the GAS-10 [79]. The standard GAS can be accessed at https://gerocentral.org/wp-content/uploads/2013/03/Geriatric-Anxiety-Scale-v2.0_FINAL.pdf, and the GAS-10 can be accessed at https://gerocentral.org/wp-content/uploads/2013/03/GAS-10-item-version-2015-1-15.pdf.

Assessment Implications

Compared with younger adults, older adults report fewer and less concrete anxiety symptoms across anxiety subtypes [40; 41; 42; 43; 45]. In addition to this, age-related neurocognitive impairment makes self-reporting a more difficult method of assessment [55]. For example, those with memory impairment can experience stressors that evoke negative effects without leaving memory traces [22; 80]. Although informant report can be a way of effectively gathering information about observable (e.g., physical) symptoms, it is ineffective for identifying unobservable (i.e., subjective) symptoms [81].

EPIDEMIOLOGY

This section addresses the epidemiology of anxiety disorders in older adults, which focuses on the occurrence, determinants, and course and consequences of anxiety disorders in the population. The focus is on the U.S. population, using data from nationally representative surveys. The section begins by addressing the occurrence of anxiety disorders by describing their prevalence and incidence. It then addresses the course and consequences of anxiety disorder, which includes their chronicity, persistence, and comorbidity. Finally, the determinants of anxiety disorders are explored by focusing on risk factors.

PREVALENCE

Prevalence is an estimate of the percent of individuals in the population who meet diagnostic criteria for anxiety disorder, either overall or by subtype. While lifetime prevalence estimates are concerned with the presence of anxiety disorders within the lifetime of individuals, these estimates are typically unreliable because they require respondents to recall prior episodes of anxiety and associated symptoms [82]. Estimating lifetime prevalence in older adults is particularly unreliable, due to general age-related memory deficits [83]. In contrast to lifetime prevalence, period prevalence estimates focus on the presence of anxiety disorder within a given timeframe,

ONE-YEAR PREVALENCE OF ANXIETY DISORDER AMONG ADULTS 55 YEARS OF AGE AND OLDER IN TWO NATIONAL SAMPLES

Population	Specific Phobia		Social Anxiety Disorder		Generalized Anxiety Disorder		Panic Disorder		Any Anxiety Disorder	
	NESARC	CPES[a]	NESARC	CPES	NESARC	CPES	NESARC	CPES	NESARC	CPES[b]
Total	5%	6%	2%	3%	1%	3%	1%	2%	9%	6%
Age (years)										
55–64	6%	8%	3%	5%	2%	4%	2%	2%	11%	9%
65–74	5%	5%	2%	3%	1%	2%	1%	1%	8%	4%
75+	3%	4%	1%	1%	1%	15%	1%	2%	6%	4%
Sex										
Male	4%	4%	2%	2%	1%	2%	1%	1%	6%	5%
Female	7%	7%	2%	4%	2%	3%	2%	2%	11%	7%
Education										
Less than high school	6%	10%	3%	4%	2%	3%	2%	2%	9%	7%
Completed high school	6%	5%	2%	3%	1%	2%	1%	1%	9%	5%
Some college	6%	6%	2%	3%	2%	4%	1%	2%	9%	9%
Bachelor's degree	4%	4%	1%	2%	1%	2%	1%	1%	7%	5%
Marital status										
Married or cohabiting	5%	5%	2%	2%	1%	2%	1%	1%	8%	4%
Widowed, divorced or separated	6%	8%	2%	5%	2%	4%	2%	2%	10%	9%
Never married	5%	7%	2%	6%	2%	2%	1%	2%	9%	7%

[a]Specific phobia was assessed in a sub-sample of 9,282 respondents from the NCS-R.
[b]Specific phobia was not included in the overall anxiety disorder estimate for the CPES.

Source: [31; 84] *Table 5*

typically 12 months. The data in this section are one-year prevalence estimates of anxiety disorder (i.e., whether anxiety disorders were present or absent in the past year of respondents' lives) in nationally representative samples of the U.S. population.

Anxiety disorders are the most prevalent mental disorders in older adults [54; 84]. The most prevalent subtypes are, in descending order, specific phobia, GAD, social anxiety disorder, and panic disorder. ***Table 5*** displays the one-year prevalence of anxiety disorders, both overall and by subtype, in the NESARC and the Collaborative Psychiatric Epidemiology Surveys (CPES) of the United States. The prevalence of anxiety disorders is higher among women relative to men, and the prevalence of all anxiety subtypes decreases among persons 75 years of age or older. Previous studies have also reported ethnic differences in prevalence, such that Native and White Americans have the highest prevalence, and Hispanic and Asian Americans have the lowest prevalence of anxiety disorders [85]. Black Americans have a higher or lower prevalence of anxiety disorders depending on subtype; specific phobias and GAD are more prevalent, comparable to Native and White Americans, whereas panic disorder and social anxiety disorder are less prevalent, closer to levels observed in Hispanic and Asian Americans. The prevalence of anxiety disorders does not vary substantially by educational attainment or marital status.

INCIDENCE

The incidence of a disease is defined as the rate at which new cases occur. In contrast to prevalence estimates, which are based on single diagnostic assessments, incidence estimates require at least two diagnostic assessments. The reason for this is that anyone meeting criteria for an anxiety disorder at any time is counted as a case for the purpose of prevalence estimation, whereas only those individuals who did not have anxiety disorder at time one and who went on to be diagnosed with anxiety disorder at time two are counted as cases for the purpose of incidence estimation, showing that the individuals represent new occurrences of the disorder. The individuals at time one who do not meet criteria for an anxiety disorder are the "risk set" and form the denominator of the incidence ratio, and the individuals at time two or later who meet criteria for an anxiety disorder form the numerator over the period in which the diagnostic assessments were made.

Just as the prevalence of anxiety disorder is higher in older adults than other mental disorders, so too is the incidence, or the rate of newly diagnosed cases [86]. The subtypes with the highest incidence, in descending order, are specific phobia, social anxiety disorder, panic disorder, agoraphobia, and GAD [87; 88]. Data from the Epidemiologic Catchment Area (ECA) study and National Comorbidity Survey (NCS) in the United States, and the Netherlands Mental Health Survey and Incidence Study (NEMESIS) indicate

that women have a higher incidence than men [88; 89]. Although anxiety disorder often peaks in young adulthood, there is a smaller but important second peak that occurs in older adulthood [88; 89].

COURSE

The chronicity of a disease refers to its persistence. Persistence is defined here as the percentage of respondents who meet diagnostic criteria for an anxiety disorder at baseline and who then meet criteria again at follow-up. Data from the NESARC indicate that approximately 30% of older adults (55 years of age and older) have persistent cases of anxiety disorder, or chronicity, assessed over a three-year follow-up period. The most persistent subtypes were specific phobia (25%) and GAD (20%), followed by social anxiety disorder (16%) and panic disorder (10%) [31].

There is high co-occurrence between anxiety and other mental disorders, particularly major depression [90; 92; 93]. Panic disorder and GAD have a particularly high comorbidity with mood and substance use disorders in adults [94]. Specific phobia has a strong association with social anxiety disorder and depression [95]. Finally, there are strong associations between social anxiety disorder, GAD, and bipolar disorder [91]. These patterns generally persist among older adults [54]. Anxiety subtypes also have high degrees of overlap [91; 94; 95].

EVIDENCE-BASED PRACTICE RECOMMENDATION

When assessing an adult with possible social anxiety disorder, the National Collaborating Centre for Mental Health recommends that clinicians be aware of comorbid disorders, including avoidant personality disorder, alcohol and substance misuse, mood disorders, other anxiety disorders, psychosis, and autism.

(https://www.nice.org.uk/guidance/cg159/resources/social-anxiety-disorder-recognition-assessment-and-treatment-pdf-35109639699397. Last accessed February 17, 2022.)

Level of Evidence: Expert Opinion/Consensus Statement

Data from the National Comorbidity Survey (NCS) suggest that anxiety disorders are also associated with various physical conditions [96]. While panic attacks are associated with vascular conditions, specific phobias are linked with respiratory conditions, and social anxiety disorder with metabolic conditions. Among older adults, there are high rates of anxiety disorders in individuals who have chronic obstructive pulmonary disease (COPD) and/or cardiovascular diseases [35; 97]. The Baltimore ECA study reports an association between blood-injection phobia and vascular complications among individuals with diabetes, which suggests the possibility that fear of blood and injections may interfere with medical treatment [98]. Blood-injection phobia is also associated with respiratory conditions, similar to the data on overall phobias in the NCS sample [99]. The prevalence of blood-injection phobia ranges from 4% to 8% in older adults [36; 100].

CONSEQUENCES

As discussed, anxiety is diagnosed as a disorder only when it is deemed by the individual to be a cause of distress and/or to interfere with daily life. In the NEMESIS study, those with anxiety disorder at baseline had more suicidal ideation and suicide attempts at three-year follow-up, after adjustment for demographic characteristics and past history of mental disorders [101]. Similar associations were observed in cross-sectional studies of the NESARC and NCS-R samples of adults residing in the United States [102].

Importantly, the findings of a 2016 systematic review and meta-analysis of prospective, longitudinal studies suggest that a diagnosis of any anxiety disorder at baseline is not associated with increased risk of all-cause mortality at follow-up [5]. In fact, in a population study of Norwegians, high anxiety symptoms were associated with lower mortality among individuals with depression [103]. In a population study of a 1946 UK birth cohort, individuals who demonstrated lower levels of trait anxiety in adolescence were associated with higher risk of accident mortality at follow-up [104]. Thus, low anxiety (but not high anxiety) is associated with increased mortality risk, and some degree of anxiety is beneficial for survival. Some anxiety likely encourages individuals to engage in preventive health behaviors. For example, women who worry about the possibility of breast cancer are more likely to seek routine screenings, people who are more worry-prone are more likely to vaccinate than those who worry less, and smokers with higher worries about their health have been found to be more likely to quit [105; 106; 107].

RISK FACTORS, RISK ASSESSMENT, AND PREVENTION

The two strongest risk factors for anxiety disorders among older adults are female sex and younger age [84; 108; 109]. However, other risk factors have also been identified. Cigarette smoking is shown to be a major risk factor of anxiety disorder onset, while smoking cessation is associated with reduced anxiety, suggesting that smoking interventions would have a significant effect on anxiety disorder onset [110; 111]. Another important risk factor of anxiety disorder onset in longitudinal studies is the occurrence of adverse life events, such as the ending of a relationship or the injury, illness, or death of a loved one [112; 113; 114].

The presence of adverse events at baseline is associated with an increased risk of overall anxiety disorder onset in older adults. In addition to female sex, history of any mood disorder, and cigarette smoking at baseline, lower levels of educational achievement are associated with higher risk of anxiety disorder onset at follow-up. Although previous studies have reported that excessive anxiety may be a result

of licit or illicit substance use or abuse, this has not been replicated in more recent analyses [115; 116; 117]. The association between anxiety disorder and increased substance abuse (including prescription medication) observed in prior studies has been interpreted as evidence of self-medication for emotional distress [118; 119; 120]. A 2019 study assessed the longitudinal association of baseline social anxiety disorder and incident alcohol use disorder at 3- and 10-year follow-up periods in two national samples and did not find evidence of an association between social anxiety and self-medication with alcohol [121].

The prevalence of anxiety disorder is substantially higher in medical versus community settings, and there is a particularly high prevalence of anxiety disorder in individuals with Parkinson disease and among caregivers of older adults [51; 61; 122; 123; 124; 125]. Studies have demonstrated that, in part, the psychological distress (e.g., anxiety and depression) experienced by caregivers is linked to their patients' overall cognitive well-being, patient functional ability, and the reported caregiver burden [126; 127; 128; 129].

TREATMENT

This section will review the available evidence base for the treatment of anxiety disorders. First, preference is given to systematic reviews and network meta-analyses in the general population. However, individual studies are also used in discussion of specific phobia due to a lack of more rigorous research.

PANIC DISORDER

A 2016 network meta-analysis of 54 intervention studies assessed the effectiveness of eight methods of psychological interventions for treating panic disorder with or without agoraphobia [130]. These interventions included [130]:

- Psychoeducation
- Supportive psychotherapy
- Physiological therapies
- Behavior therapy
- Cognitive therapy
- Cognitive behavioral therapy (CBT)
- Third-wave CBT
- Psychodynamic therapies

Researchers found that not one of these treatments was supported as being more efficacious than the others, although any psychological treatment was generally mildly efficacious in comparison with a wait-list control condition [130]. In a subsequent study, the same investigators assessed whether particular components of CBT were associated with better responses to treatment. They reported that face-to-face administration (as compared to self-help) and graded interoceptive exposure to the physiological aspects of the panic response are the most effective features of CBT for treating panic disorder, although it is important to note that the principle of totality applies: the whole of a treatment is more than the sum of its parts [131]. Individual studies addressing treatments for late-life panic disorder have found that both psychological and pharmacological interventions tend to be less efficacious for older adults compared with younger adults [132].

SOCIAL ANXIETY DISORDER

A systematic review and network meta-analysis compared the effectiveness of seven classes of psychological interventions, five classes of pharmacological interventions, and three control groups [133]. Interventions included:

- Promotion of exercise
- Exposure and social skills
- Group CBT
- Individual CBT
- Other psychological therapy (including interpersonal psychotherapy, mindfulness training, and supportive therapy)
- Psychodynamic psychotherapy
- Self-help with or without support

Individual CBT was found to be effective for acute treatment compared with waitlist control groups. Pharmacologic interventions included anticonvulsants, benzodiazepines, monoamine oxidase inhibitors (MAOIs), noradrenergic and serotonergic antidepressants, selective serotonin reuptake inhibitors (SSRIs), and selective norepinephrine reuptake inhibitors (SNRIs). SSRIs and SNRIs were found to be the most effective class of pharmacological treatment compared with placebo control groups [133].

In this study, the promotion-of-exercise intervention was not found to be effective; however, this was not actually an exercise intervention. A 2020 systematic review and network meta-analysis assessing the efficacy of aerobic, resistance, and mind-body training regimens for treating depression reported that actual exercise interventions elicit high levels of treatment compliance and can be effective in reducing depressive symptoms [134]. Thus, similar treatments may also prove to be efficacious for treating anxiety disorders or subtypes.

GENERALIZED ANXIETY DISORDER

The results of two systematic reviews and meta-analyses suggest that psychological therapy has short-term efficacy for treating GAD [135]. A systematic review and network meta-analysis of 27 randomized, double-blind, placebo-controlled studies compared the relative effectiveness of nine pharmacologic treatments of GAD [136]. Although none of the treatments stood out as being clearly more successful than the others, it was concluded that fluoxetine may be preferred for response and remission and sertraline for treatment tolerance. Sertraline is also the most cost-effective pharmacologic treatment of GAD [137]. A separate systematic review and meta-analysis of 27 clinical trials assessed the effectiveness

of psychological and pharmacologic treatments for late-life GAD [41]. In this study, benzodiazepines were found to be mildly efficacious relative to placebo, and psychotherapy was found to be mildly efficacious relative to waitlist control groups. A 2016 meta-analysis also reported that CBT is effective for treating GAD in older adults [138].

EVIDENCE-BASED PRACTICE RECOMMENDATION

According to the National Collaborating Centre for Mental Health, the recommended high-intensity psychological intervention for persons with generalized anxiety disorder is cognitive-behavioral therapy (CBT) or applied relaxation.

(https://www.nice.org.uk/guidance/cg113. Last accessed February 17, 2022.)

Level of Evidence: Expert Opinion/Consensus Statement

SPECIFIC PHOBIAS

Exposure therapy is the treatment of choice for specific phobias [139; 140]. This includes in vivo (real-life) and virtual reality exposure to phobic stimuli or situations. Virtual reality exposure therapy was introduced in the 1990s, and although it may have some treatment benefit, it has not been found to have strong efficacy [141]. A one-session exposure therapy treatment for specific phobias was pioneered more than 30 years ago with a suggested duration of two hours and was subsequently used to treat various specific phobia subtypes [142; 143; 144; 145]. More recent studies suggest that one session does not always turn out to be adequate and that multiple sessions are generally more efficacious [140; 146]. However, there may be some cases where the single-session approach is viable.

EVIDENCE-BASED PRACTICE RECOMMENDATION

The National Collaborating Centre for Mental Health recommends against routinely offering computerized CBT to treat specific phobias in adults.

(https://www.nice.org.uk/guidance/cg159/resources/social-anxiety-disorder-recognition-assessment-and-treatment-pdf-35109639699397. Last accessed February 17, 2022.)

Level of Evidence: Expert Opinion/Consensus Statement

Pharmacotherapy is not a common treatment for specific phobias. However, studies have sought to supplement exposure therapy using pharmacologic approaches. One such intervention administers cortisol to augment exposure therapy due to its role in interfering with memory for fearful scenarios [147; 148]. Although this treatment shows some efficacy, it does not seem to be particularly advantageous relative to exposure therapy alone. A second form of pharmacologic augmentation for exposure therapy, introduced more than 20 years ago, is the antibiotic D-cycloserine, which is thought to facilitate fear extinction due to its role as an *N*-methyl D-aspartate (NMDA) receptor agonist [149; 150]. D-cycloserine has also been used to augment exposure therapy for social anxiety disorder, with studies suggesting that this antibiotic can produce a marginal benefit for treating specific phobias and social anxiety disorder when combined with exposure therapy [151]. However, while these studies mention that the antibiotic is of a low dosage, they do not mention that this marginal benefit needs to be traded off against the risk of accelerating antibiotic resistance, which is a pressing global public health challenge. Computational studies suggest that increasing administration of low doses of antibiotics (as these studies suggest doing in conjunction with exposure therapy) accelerates resistance [152; 153].

Although the short-term efficacy of exposure therapy for specific phobias is moderately high, it is important to note that specific phobias are prone to high rates of relapse [139; 140; 154; 155; 156; 157]. Accordingly, studies have sought to eliminate conditioned responses to phobic stimuli over multiple contexts to make for a more successful extinction [158; 159; 160; 161; 162].

TREATMENT IMPLICATIONS

Given that anxiety itself is an adaptive trait, anxiety disorders are better seen as poorly regulated defenses than as defects. As decades of lesion studies indicate, a lack of anxiety may also create non-trivial problems for individuals' lives. Low levels of anxiety are associated with higher mortality risk, and those who report greater worries about particular health problems are likely to seek medical care and take preventative or corrective action [39; 103; 104; 105; 106; 107]. If some degree of anxiety is advantageous, then insufficient and excessive anxiety can both be considered maladaptive.

CONCLUSION

Anxiety facilitates the management of potential future hazards. Even though anxiety is effective at reducing danger, excessive anxiety is often a cause of significant distress and impairment, and anxiety disorders are the most prevalent mental disorders among older adults. Female sex and smoking are the strongest risk factors for late-life anxiety disorders, although adverse life events are also an important factor. About one-third of all cases have considerable chronicity, and therefore prevention is important. Interventions should focus on reducing anxiety to a sufficient, but not excessive, degree.

Customer Information/Answer Sheet/Evaluation insert located between pages 32–33.

TEST QUESTIONS
#76690 ANXIETY DISORDERS IN OLDER ADULTS

This is an open book test. Please record your responses on the Answer Sheet.
A passing grade of at least 80% must be achieved in order to receive credit for this course.

This 3 Hour/1 NBCC Clock Hour activity must be completed by February 28, 2025.

1. The first known case description of anxiety disorder appeared in
- A) *the Hippocratic Corpus.*
- B) *Charles Darwin's works.*
- C) *the International Classification of Diseases (ICD).*
- D) *the Diagnostic and Statistical Manual of Mental Disorders (DSM).*

2. Anxiety is a(n)
- A) *adaptive trait that facilitates the detection and management of threats.*
- B) *maladaptive trait that is a leading cause of mental distress and impairment.*
- C) *Both A and B*
- D) *None of the above*

3. António Egas Moniz was awarded the 1949 Nobel Prize for treating mental disorders with
- A) *leucotomy.*
- B) *psychotherapy.*
- C) *holistic medicine.*
- D) *pharmacotherapy.*

4. Two neural structures that are necessary for anxiety responses are the
- A) *temporal pole and amygdala.*
- B) *temporal pole and hippocampus.*
- C) *ventromedial prefrontal cortex and amygdala.*
- D) *ventromedial prefrontal cortex and hippocampus.*

5. Two main subtypes of panic disorder diverge between individuals with
- A) *suicidality and non-suicidality.*
- B) *mental and physical symptoms.*
- C) *comorbidity and multimorbidity.*
- D) *respiratory and non-respiratory symptoms.*

6. The standard for anxiety disorder assessment is the
- A) *ICD.*
- B) *DSM.*
- C) *structured interview.*
- D) *semi-structured interview.*

7. The Overall Anxiety Severity and Impairment Scale (OASIS) consists of
- A) *two items.*
- B) *five items.*
- C) *12 items.*
- D) *25 items.*

8. Informant report is effective for assessing what types of anxiety symptoms?
- A) *Physical but not mental symptoms*
- B) *Objective but not subjective symptoms*
- C) *Observable but not unobservable symptoms*
- D) *All of the above*

9. What is the most prevalent type of mental disorder in older adults?
- A) *Mood disorder*
- B) *Anxiety disorder*
- C) *Substance disorder*
- D) *Trauma and stress-related disorder*

10. The most prevalent anxiety disorder subtype in older adults is
- A) *panic disorder.*
- B) *specific phobia.*
- C) *social anxiety disorder.*
- D) *generalized anxiety disorder.*

Test questions continue on next page ➔

11. Which of the following groups of older adults (55 years of age or older) has the highest prevalence of any anxiety disorder according to data from the NESARC?
- A) *Women*
- B) *Persons with a Bachelor's degree*
- C) *Adults 75 years of age and older*
- D) *Those who are married or cohabitating*

12. The most persistent anxiety disorder subtype in older adults is
- A) *panic disorder.*
- B) *specific phobia.*
- C) *social anxiety disorder.*
- D) *generalized anxiety disorder.*

13. Compared with those without anxiety disorder, the mortality rate of older adults with anxiety disorders is
- A) *lower.*
- B) *higher.*
- C) *similar.*
- D) *fluctuating.*

14. The two biggest demographic risk factors for late-life anxiety disorders are
- A) *age and sex.*
- B) *age and education.*
- C) *age and marital status.*
- D) *education and marital status.*

15. The most significant modifiable risk factor for anxiety disorder is
- A) *age.*
- B) *education.*
- C) *adverse events.*
- D) *cigarette smoking.*

16. The prevalence of anxiety disorder is substantially lower in medical versus community settings.
- A) *True*
- B) *False*

17. Which class(es) of pharmacotherapy is the most effective in the treatment of social anxiety disorder?
- A) *MAOIs*
- B) *SSRIs and SNRIs*
- C) *Benzodiazepines*
- D) *Tricyclic antidepressants*

18. The treatment of choice for specific phobias is
- A) *cortisol.*
- B) *lithium.*
- C) *D-cycloserine.*
- D) *exposure therapy.*

19. Pharmacotherapy is a common treatment for specific phobias.
- A) *True*
- B) *False*

20. The clinician's principal objective in treating anxiety is to
- A) *remove distress completely.*
- B) *eradicate the anxiety completely.*
- C) *make the individual's life happier.*
- D) *reduce the anxiety to a manageable level.*

Be sure to transfer your answers to the Answer Sheet located between pages 32–33.
DO NOT send these test pages to NetCE. Retain them for your records.
PLEASE NOTE: Your postmark or facsimile date will be used as your test completion date.

Ethics for Counselors

Approval(s): NBCC, NAADAC

This course is designed to meet the requirement for ethics education in most states.*
Please see page 128 of this booklet for state-specific information.

Audience
This intermediate to advanced course is designed for counselors and related professionals.

Course Objective
The purpose of this course is to increase the professional counselor's knowledge base about ethical theories, principles, and the application of these principles to counseling practice. A historical context of ethics in counseling and in the larger context of the helping professions, such as medicine, social work, and other human service areas, will be explored. The course will also examine the specific components of ethical theories, ethical decision-making processes, the psychological context of moral development, multiculturalism, and the field's two major codes of ethics.

Learning Objectives
Upon completion of this course, you should be able to:

1. Discuss the historical context of ethics in counseling.
2. Define common terms such as ethics, values, morality, ethical dilemmas, and ethical principles.
3. Discuss the ethical principles in the American Counseling Association (ACA) Code of Ethics and the National Board for Certified Counselors (NBCC) Code of Ethics.
4. Differentiate between deontologic, teleologic, motivist, natural law, transcultural ethical, feminist, and multicultural theories.
5. Identify the different ethical decision-making models.
6. Discuss the psychologic context of ethical decision making by applying Lawrence Kohlberg's theory of moral development.
7. Outline ethical issues that emerge with counseling in managed care systems.
8. Review issues that arise in online counseling, including sociocultural context, ethical and legal issues, and standards for ethical practice.

Faculty
Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Michele Nichols, RN, BSN, MA, received her Associates Degree in Nursing in 1977, her Bachelor of Science Degree in Nursing in 1981 and obtained her Master of Arts Degree in Ethics and Policy Studies in 1990 through the University of Nevada, Las Vegas. She was Chief Nurse Executive at Valley Hospital Medical Center in Las Vegas, Nevada, and retired as the System Director for the Valley Health System University, a five hospital system in Las Vegas, Nevada. She is currently a volunteer nurse for Volunteers in Medicine of Southern Nevada.

Faculty Disclosure
Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Texas LPCs and LPCSs may apply 2 hours to their ethics requirement.
Texas MFTs and MFTSs may apply 5 hours to their ethics requirement.

A full Works Cited list is available online at www.NetCE.com. ***Mention of commercial products does not indicate endorsement.***

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Director of Development and Academic Affairs
Sarah Campbell

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This course has been approved by NetCE, as a NAADAC Approved Education Provider, for educational credits, NAADAC Provider #97847. NetCE is responsible for all aspects of their programming.

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This course is considered self-study by the New York State Board of Mental Health Counseling.

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Designations of Credit
NetCE designates this continuing education activity for 6 NBCC clock hours.

NetCE designates this continuing education activity for 6 continuing education hours for addiction professionals.

Individual State Behavioral Health Approvals
In addition to states that accept ASWB, NetCE is approved as a provider of continuing education by the following state boards: Alabama State Board of Social Work Examiners, Provider #0515; Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health, Provider #50-2405; Illinois Division of Professional Regulation for Social Workers, License #159.001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197.000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168.000190.

Special Approvals
This course fulfills the Florida requirement for 3 hours of Professional Ethics and Boundaries education.

About the Sponsor
The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

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INTRODUCTION

Ethical issues do not exist within a vacuum; rather, they emerge, evolve, and adapt within the sociocultural context of a particular society. In past decades, the field of professional ethics has received increased attention. Much of the discussion began in the 1960s in the medical field, where the blending of ethics, legalities, and medicine has become known as bioethics. Its emergence occurred because there was a need to talk about how research and healthcare decisions and regulations could be made, who could make them, and what their long-term implications would be. In the late 1960s, philosophers, theologians, physicians, lawyers, policy makers, and legislators began to write about these questions, hold conferences, establish institutes, and publish journals for

the study of bioethics. Around the same time, many existing professional organizations and agencies, such as those for counseling, social work, and law enforcement, began implementing their own ethical codes. When a new institution is young, the creation of a formal code of ethics is standard practice to inform prospective members, unify, advise, and protect existing members, help resolve ethics issues, protect those who the profession serves, and help establish and distinguish an organization, agency, and its members.

HISTORICAL CONTEXT OF COUNSELING ETHICS

HISTORY OF COUNSELING IN THE UNITED STATES

Modern psychology began with the work of Sigmund Freud in the 1880s in Vienna. By the early and mid-20th century, Sigmund Freud's psychoanalytical theories were being challenged, most notably by American psychologist Carl Rogers. While Freud examined the effects of the unconscious mind upon patients, Rogers' work focused on environmental factors, the patient's experience in the world, and the person-centered approach [50]. It was during this same time period that advanced education in medicine and certification was becoming required for psychoanalysts, because in the United States, analysis of the mind was viewed as a medical endeavor [50]. Frank Parsons, often called the father of vocational guidance, had established the new field of career counseling between the years 1906 and 1908 [52]. Rogers borrowed Parson's label, "counselor," and extended it to individuals who were educated in and practiced behavioral health both outside of the field of medicine and toward different goals than medical psychoanalysis [50]. This helped remove some of the prejudice against non-medically trained professionals and shifted the emphasis away from treating clients purely as medical patients to helping individuals and groups realize their developmental goals. The relatively new field of counseling that stemmed from Parsons' vocational guidance movement and Rogers' work was of particular value during World War II, when the need for vocational training became acute, and after the war, when a large number of people were integrating back into a society that had become profoundly different [51; 52]. Some returned with psychologic problems, and many were left with disabilities. Many more had come home to a country where they could not find jobs.

Around this time, the American Psychological Association (APA) and the Veterans Administration (VA) both formed counseling psychology branches. The post-war era was a defining period because the need for trained professionals was so great, and counselors were increasingly seen as critical human service providers in the fields of psychology and employment services. Guidance counseling, with a focus on educational and career advancement, was still seen as a somewhat separate profession. Today, each branch of counseling is considered a practical application of psychology because the focus on human development and wellness issues deals directly with strategies to enable personal and family growth, career development, and life enhancement [53]. In addition, counselors advocate for patients and clients and connect them to services.

HISTORY OF ETHICS

Ethics have been discussed in various arenas since ancient times. The ethics that most Western counselors are familiar with are derivatives of the virtue ethics system developed by Greek philosophers such as Socrates, Plato, and most notably, Aristotle, in the 5th century B.C.E. Virtue ethics were thought to be a way to make decisions in life that developed strong personal character, based on attaining permanent happiness through knowledge, reason, restraint, and striving for excellence in physical and intellectual pursuits [54]. The word ethics has evolved from the ancient Greek word *ethikos*, meaning moral character, and implies that a personal character is constructed. The ability to engage in the ethical decision-making process, or thinking analytically about how an action will be viewed in the context of the community by applying its upheld virtues, develops strong character. The action will be viewed by others who can determine that the decision-maker is a virtuous person if the outcome is in line with the values of society. The community will have positive feelings about the person, the person will have positive self-esteem, and the end result will be happiness.

The virtues (i.e., values) of a particular society are based on what has been deemed important to that society; for example, liberty and justice are among the most important American values. It could be said that one who upholds these values with the sole intention of being virtuous is acting in a righteous way according to Aristotelian virtue ethics [54]. In other words, virtues are values, and being virtuous is acting ethically. It must be acknowledged that not all societies have similar values and not all subgroups or individuals in a society have values similar to the mainstream. Therefore, codes of ethics must be developed to unify, guide, and protect individuals belonging to a group or institution and to protect the institution itself.

A familiar historical code of ethics, the Hippocratic Oath, also comes from Greece during the same time period as Aristotle's philosophies and embodies the values of ancient Greek ethics. A few of the oath's ethical principles, translated from the original text and listed here, relate to specific counseling ethical principles that will be discussed later in this course [55]:

I will use those dietary regimens which will benefit my patients according to my greatest ability and judgment, and I will do no harm or injustice to them. (*Ethical principles of beneficence and nonmaleficence*)

I will not use the knife, even upon those suffering from stones, but I will leave this to those who are trained in this craft. (*Ethical principle of competence*)

Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption, including the seduction of women or men, whether they are free men or slaves. (*Ethical principle of maintaining appropriate relationships*)

Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private. (*Ethical principles of confidentiality, trust, and privacy*)

Although Hippocrates' wrote this oath roughly 2,500 years ago, the ideas remain pertinent to health care today. This is likely due to the fact that the Hippocratic Oath is based on principles that are universally applicable.

Because Aristotelian virtue ethics can be adapted to fit any society or institution by reprioritizing the values to achieve positive end goals congruent with "normal" community values, many offshoots of virtue ethics exist. With the rise of Christianity in the Middle Ages came theologic ethical systems derived from the Aristotelian notion of virtue ethics. St. Augustine, in the 4th century C.E., put forth the idea that a relationship with and love of God, in addition to acting from virtue, leads to happiness [54]. In the 13th century C.E., St. Thomas Aquinas developed another Christian system of ethics by simply adding the values of faith, hope, and charity to the established virtues of Aristotelian ethics [54].

These two ethical systems, Aristotelian virtue ethics and Christian ethics, form the foundation of most ethical systems and codes used in modern Western society. It should be understood that other ethical systems have contributed to Western philosophies and have shaped modern ethics; for example, one of the traditional Asian ethical systems, Confucian ethics, is very similar to Aristotelian ethics with an added emphasis on obligations to others [54].

Recent History

Prior to the 1960s, healthcare decisions were part of the paternalistic role of physicians in our society. Patients readily acquiesced health decisions to their physicians because they were regarded almost as family. What drove this resolve of patients to acquiesce their medical care and treatment decisions to their physicians? David Rothman, as discussed in his book *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*, believes physicians were given such latitude by their patients because they were well known and trusted by their patients and the community in which they practiced [56]. There were no specialists. One physician took care of a patient and family for a lifetime. The frontier physician often knew the patient from birth to adulthood, made house calls, and was a family friend who knew best what the patient should do with a healthcare concern [56]. Since the 1960s, physicians have become strangers to their patients, largely due to three factors. First, World War II experimentation and other medical research brought attention to humans as test subjects and the rights that should be recognized on their behalf. Second, the modern structuring and organization in healthcare delivery moved patients from their familiar surroundings of home and neighborhood clinics to the often intimidating large hospital. Third, the medical technologic boom brought life-saving interventions. In today's healthcare model, the patient is evaluated and educated by the professional and encouraged to make their own determination about the course of treatment.

Several medical research events in the 20th century served as catalysts to strengthen the codifying principles and behaviors that protect the rights of all individuals. This spurred the creation of codes of ethics in human service arenas, including counseling. The codes of ethics that were developed were designed to protect all individuals from harm and strived to be inclusive of age, race, ethnicity, culture, immigration status, disability, educational level, religion, gender, sexual orientation, gender identity or expression, and socioeconomic status.

One event was the atrocities exposed during the Nuremberg trials in Germany in 1945 and 1946. Because an ethical code (e.g., the Hippocratic Oath) would condemn the acts committed by Nazi medical researchers, it can be deduced that either no ethical code existed or that ethics did not extend to certain populations.

Another significant event occurred in the United States when, in 1932, the Public Health Service initiated a syphilis study on 399 black men from Tuskegee, Alabama, who were unaware of their diagnosis. The goal of the study was to observe the men over a period of time to examine how the disease progressed in people of African descent, because most of the clinical data on syphilis came from evaluating people of European descent. When the study began, there were no effective remedies; however, fifteen years into the study, penicillin was found to be a cure for syphilis. The research participants were never informed, and treatment was withheld, in spite of the fact that by the end of the experiment, in 1972, 128 men had died either from the disease or related complications [1].

Finally, in 1967, children with mental retardation at the Willowbrook State School in New York were given hepatitis by injection in a study that hoped to find a way to reduce the damage done by disease. Although consent was obtained in this study, the consent sometimes had an element of coercion in that gaining admission to the school was difficult and parents were given a guarantee their child would be admitted if they consented to the participation of their child in the study.

It was events such as these that heightened the realization that organized standards of ethics were necessary to ensure that self-determination, voluntary consent, and informed

CODE OF ETHICAL BEHAVIORS UTILIZED IN HUMAN SERVICE DISCIPLINES	
Association	**Code**
National Board for Certified Counselors	NBCC Code of Ethics
National Association of Social Workers	NASW Code of Ethics
American Association for Marriage and Family Therapy	AAMFT Code of Ethics
American Mental Health Counselors Association	Code of Ethics for Mental Health Counselors
Association for Specialists in Group Work	ASGW Best Practices Guidelines
American Psychological Association	Ethical Principles of Psychologists and Code of Conduct
American Counseling Association	Code of Ethics and Standards of Practice
American School Counselors Association	Ethical Standards for School Counselors
International Association of Marriage and Family Counselors	IAMFC Code of Ethics
Association for Counselor Education and Supervision	Ethical Guidelines for Counseling Supervisors
Commission on Rehabilitation Counselor Certification	Code of Professional Ethics for Rehabilitation Counselors
National Association of Alcoholism and Drug Abuse Counselors	NAADAC Code of Ethics
National Rehabilitation Counseling Association	Rehabilitation Counseling Code of Ethics
National Organization for Human Services	Ethical Standards for Human Services Professionals
International Society for Mental Health Online	Suggested Principles for the Online Provision of Mental Health Services
Source: [2]	*Table 1*

consent, among other principles, were upheld and extended to all populations. In 1966, the Public Health Services established ethical regulations for medical research. In 1973, the first edition of the Hastings Center Studies pointed out the problems and the needs that would become paramount in developing healthcare research projects. Remarkable advances were projected in the areas of organ transplantation, human experimentation, prenatal diagnosis of genetic disease, prolongation of life, and control of human behavior. All of these had the potential to produce difficult problems, requiring scientific knowledge to be matched by ethical insight. This report laid the foundation for other disciplines to develop or revise their own ethics guidelines. In 1974, the National Commission for the Protection of Human Subjects was created by public law. Finally, in 1979, the Commission published *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. The Commission recommended that all institutions receiving federal research funding establish institutional review boards. Today, these boards, made up of researchers and lay people, review social science research proposals to ensure that they meet ethical standards for protecting the rights of the potential subjects. This was an initial entry into what would later be called bioethics.

Professional Ethics

In the 1970s, a new field of applied and professional ethics emerged, which had a dominant role in healthcare ethics. This new field emerged during a social and political climate that begged for answers to philosophical questions. For example, there were debates about welfare rights, prisoners' rights, and healthcare issues such as organ transplants, abortion, and end-of-life decisions.

It is within this backdrop that, in the 1980s, counselors began to further explore the profession's values. Drawing on ideas from philosophy and the newer field of applied ethics, counseling literature focused on ethical theories, ethical decision making, and ethical challenges confronted in direct practice, such as self-determination, informed consent, and the relationships among practitioners [6].

The federal government, private philanthropists and foundations, universities, professional schools, and committed professionals moved quickly to address these questions. A plethora of codes of ethical behaviors and guidelines have been set forth by many human service disciplines. ***Table 1*** provides a summary of codes of ethics commonly utilized by mental health professionals, counselors, marriage and family therapists, social workers, and other helping practitioners [2; 106; 107; 108; 109].

Development of Ethical Codes in Counseling

The APA was the first mental health organization to publish a code of ethics. The code was published in 1953, but an ethics committee had been formed before World War II. The original APA ethical code was based on more than 1,000 submissions by psychologists regarding ethical decisions they had made in their practice to determine which ethical dilemmas were common [53]. The American Counseling Association (ACA), originally called the American Personnel and Guidance Association, was created in 1952, formed an ethics committee in 1953, and published its first code of ethics in 1961. The National Board for Certified Counselors (NBCC) was established in 1982 by an ACA committee to implement and monitor a national certification system for counseling professionals. The NBCC is now an independent, non-profit organization that maintains the certification of more than 65,000 counselors in more than 40 countries, and its members and those seeking certification are required to follow the NBCC Code of Ethics to maintain their certification [57; 58].

Ford identifies several reasons that codes of ethics are developed [53]:

- To identify the purpose, goals, and values of an organization to members and those applying
- To give rights to and protect both clients and professionals
- To provide guidance for ethical decision making
- To influence public perception and ensure professionalism by showing that the organization will monitor itself for the public
- To send a message to law enforcement and government that the organization can enforce its own rules and regulate itself
- To help to establish an organization by differentiating it from similar institutions
- To establish a road toward being granted licensing of professionals in that field

Ethics and New Technologies

Internet technology has and will continue to have a tremendous impact on the economic, social, political, and cultural landscape. Not only has it affected commerce, but the fields of physical health, mental health, and counseling have also incorporated Internet technologies in the delivery of services and resources. As a result, the general public can access services from home within minutes at their convenience. Looking toward the future, as personal computers and computer software applications become less expensive and more accessible, an increasing number of agencies and organizations will be able to offer a diverse array of services via the Internet.

As a result, there has arisen a need for ethical standards for online counseling. Both the ACA and the NBCC have established practice guidelines for online counseling, which will be discussed in detail later in this course [100; 101].

PHILOSOPHICAL HISTORY OF MODERN ETHICS

It is important to understand historical philosophical underpinnings in order to understand the evolution of the definition of ethics and how today's ethical principles emerged [3]. Ethics can be viewed as developing within two major eras in society: modernism and postmodernism.

Modernism

The term modernism refers to an era during which scholars were encouraged to shift from a basis of metaphysics to rationalism in analyzing the world and reality [3]. In a modernist world, it is believed that reasoning can determine truth on all subjects [3]. Just as science evolved from being religion- or faith-based, modernists sought to understand social phenomena by explicating universal ethical laws [3].

Modernist philosophy argues that all individuals are similar and individual rights are supreme [4]. This philosophy has permeated much of biomedical ethics, and as such, each of the four ethical principles that form the backbone of ethical codes—autonomy, beneficence, nonmaleficence, and justice—should be universally adhered to and applied [5]. Utilitarian ethical principles, rationalism, and evidence-based scientific applications are at the heart of modernism [116].

Postmodernism

Postmodernism is a reaction to the belief that there is "rational scientific control over the natural and social worlds" [3]. Postmodernism is characterized by diversity, pluralism, and questioning the belief that there are objective laws or principles guiding behavior [3]. Postmodernists argue that ethical principles must take into account historical and social contexts to understand individuals' behaviors [4]. This philosophical climate emphasizes situational ethics in which there are no black-and-white rules about principles of good and bad. Ultimately, a set of universal ethical principles cannot be easily applied [3].

Since 2015, there has been increasing discussion regarding the apparent shift to postmodernism in the ethical landscape [116; 117]. In part spurred by the political environment in the United States during this period, the concept of a universal set of ethical principles appeared to be challenged; instead, ethical relativism appeared to move to the forefront. The growing use of social media and the Internet helped to present a highly individualized set of "truths" (or "alternative facts") [116].

Today, ethical codes and practices are also influenced by critical theory. Critical theorists focus on eliminating inequities and marginalization [112]. Ethics from this perspective

explores the role of power and power inequalities, exploring who or what defines truth and whose voices are represented [112]. Reality is a socially and culturally shared experience and is shaped and navigated by both the practitioner and client [118]. Therefore, ethics is not a top-down experience, whereby ethical rules are unilaterally imposed. Rather, handling and negotiation of ethical challenges should be a collaboration [118].

COMMON TERMS USED IN THE DISCUSSION OF ETHICS

VALUES

Frequently, the terms values and ethics are employed interchangeably; however, the terms are not synonymous. Values are beliefs, attitudes, or preferred conceptions about what is good or desirable, that provide direction for daily living. They stem from our personal, cultural, societal, and agency values. Rokeach has argued that values may be organized into two categories: terminal values and instrumental values [9]. Terminal values describe the desired end-goal for a person's life. Some that are identified by Rokeach are happiness, inner harmony, wisdom, salvation, equality, freedom, pleasure, true friendship, mature love, self-respect, social recognition, family security, national security, a sense of accomplishment, a world of beauty, a world at peace, a comfortable life, and an exciting life. Instrumental values are those that help a person to achieve their desired terminal values; they are the tools one uses to work toward an end goal. Instrumental values include love, cheerfulness, politeness, responsibility, honesty, self-control, independence, intellect, broad-mindedness, obedience, capability, courage, strength, imagination, logic, ambition, cleanliness, helpfulness, and forgiveness. Ultimately, all of these types of values influence how a person will behave. Not all individuals will identify with all of these values; most will have a few terminal values that are most important to them. When there is conflict or tension between instrumental values, such as politeness and honesty, individuals will begin to prioritize [9].

It is important for counselors to have a high level of self-awareness and to understand the nature and origins of value conflicts and the impact of values on their decisions. Values include our life experiences, worldview, cultural outlook, professional values, societal values (e.g., equality, freedom, justice, achievement, self-actualization), and religious beliefs. Values are also based on knowledge, aesthetics, and morals [10].

Whether values can or should be completely removed from counseling sessions is a topic of debate. Core values are key to successful interventions; however, there are two extremes in a counseling relationship that should be avoided [59]:

- Counselors should not act as a moral authority and try to influence clients to change their personal values in favor of the counselors'.
- Counselors should not struggle to create a value-free environment, because this can cripple the intervention.

The professional counselor's duty is to help a client assess thoughts, feelings, and actions and, perhaps, to help clients to reprioritize values. When a counselor shows his or her own values through the choice of words, identification of problems, and treatment strategies, the client will usually pick-up on the implied values and may decide to adopt some [59].

ETHICS

Ethics are the beliefs an individual or group maintains about what constitutes correct or proper behavior or actions [13]. To put it simply, ethics are the standards of conduct an individual uses to make decisions. The term morality is often confused with ethics; however, morality involves the judgment or evaluation of an ethical system, decision, or action based on social, cultural, or religious norms [13; 14]. The term morals or morality is derived from the Greek word *mores*, which translates as customs or values. The separation between ethics and values/morals is best illustrated in the following two examples.

Defense Lawyer W is representing a client who he knows has committed homicide because the client has admitted to the slaying in confidence. Murder goes against the values of American society and, more importantly for this example, against the values of the attorney, whose ethical duty is to defend the client to the best of his abilities, regardless of his feelings toward the client's action.

Counselor T is a high school counselor in Oregon who is against the termination of pregnancy due to her personal and religious values; she has had several miscarriages and is currently experiencing difficulty becoming pregnant. Student A, 15 years of age, enters Counselor T's office in tears; the student has not told anyone that she is 9 weeks pregnant. She is seeking help regarding obtaining an abortion. Counselor T learns that her client was the victim of sexual abuse by her first adoptive parents. Other foster children and individuals in support groups, which Student A has come to know, were also victims of physical and sexual abuse by their adoptive parents. She expresses fear of alienation from her friends, concern about falling behind in school, and anguish at not being able to remain active in sports, which are "her way of coping with life." The student has stated that she does not want to give birth to a child because she is too young to raise it properly and would not put her child up for adoption for fear that it too would become a victim. In fact, she states that she does not know if she "ever wants to bring a child into this world."

It is apparent that the student's values differ from the counselor's values. Counselor T's employer has made it clear in their code of ethics that promoting well-being and self-determination is the primary responsibility of counselors. While abortion does not fit with Counselor T's personal values, society as a whole values independence, self-determination, and equal rights. Given the student's history and values, taken in the context of societal values and laws, it would be unethical for the counselor to impose her own personal values upon Student A.

It is important to remember that ethics must prevail over a counselor's personal values when value conflicts exist. As discussed, counselors are bound to the ethical duty to not act as moral authorities and force their values upon others. The professional relationship exists to benefit the client and fulfill the client's needs. A counselor's needs, such as the need to feel adequacy, control, and clients' change toward values similar to one's own values, will harm the relationship [59]. It is unethical to put personal needs before clients' needs [59].

Ethical Dilemmas

An ethical dilemma presents itself to a counselor when he or she must make a choice between two mutually exclusive courses of action. The action may involve the choice of two goods (benefits) or the choice of avoiding two harms (problems). If one side of the dilemma is more valuable or good than the other side then there is no dilemma because the choice will lean toward the side that is more desirable [15].

Ethical Decision Making

The process of resolving an ethical dilemma is the ethical decision-making process. Ethical decision making is influenced by values and the ethical principles to which individuals and groups adhere. Counselors are encouraged to gather all available resources and consider all possible outcomes before making decisions; this will be discussed in detail later in this course.

Ethical Principles

Ethical principles are expressions that reflect people's ethical obligations or duties [10]. These principles of correct conduct in a given situation originated from debates and discussions in ancient times and became the theoretical framework upon which we base our actions as individuals and societies. Most prominently, it was the Bible and Greek philosophers, such as Plato and Aristotle, who created most of the familiar ethical principles in use today. The following are general ethical principles that counseling professionals recognize [10]:

- Autonomy: The duty to maximize the individual's rights to make his/her own decisions
- Beneficence: The duty to do good
- Confidentiality: The duty to respect privacy and trust and to protect information
- Competency: The duty to only practice in areas of expertise
- Fidelity: The duty to keep one's promise or word
- Gratitude: The duty to make up for (or repay) a good
- Justice: The duty to treat all fairly, distributing risks and benefits equitably
- Nonmaleficence: The duty to cause no harm
- Ordering: The duty to rank the ethical principles that one follows in order of priority and to follow that ranking in resolving ethical issues
- Publicity: The duty to take actions based on ethical standards that must be known and recognized by all who are involved
- Reparation: The duty to make up for a wrong
- Respect for persons: The duty to honor others, their rights, and their responsibilities
- Universality: The duty to take actions that hold for everyone, regardless of time, place, or people involved
- Utility: The duty to provide the greatest good or least harm for the greatest number of people
- Veracity: The duty to tell the truth

While ethical principles are seemingly similar to values, they pertain specifically to ethics. For example, in medicine, there are many infections that can be prevented simply by hand washing. Hence, the value of cleanliness pertains to the ethical principle of nonmaleficence, or the duty to cause no harm. Based on general values and ethical principles, professions develop ethical codes that embody the values and ethics of the institution and guide the behavior of members. Unfortunately, codes of ethics do not always provide clear direction, and in some cases, the tenets of the codes are in direct conflict with each other.

VALUES AND ETHICAL PRINCIPLES IN ETHICAL CODES

ACA CODE OF ETHICS

The ACA Code of Ethics is divided into nine sections and a preamble. Each section is well organized into various subsections; for example, working backward, "Section A.9.a. Screening" contains selection criteria for group counseling in the "A.9. Group Work" category of "Section A: The Counseling Relationship" [8]. It is laid out in a concise, easily accessible format, which makes it a helpful tool for any professional counselor to use when trying to resolve ethical issues. The Code of Ethics must be studied and utilized by ACA members and is recommended for all counselors.

The preamble of the ACA Code of Ethics states that embracing professional values ultimately provides a basis for ethical behavior and decision-making in practice. The Code identifies ACA's core values and requires that ACA ethics prevail over personal values. The following are section headings as they appear in the Code followed by a synopsis

of the ethical guidelines and values expressed in each section [8]. Additionally, examples of related values and ethical principles are given. This synopsis of the ethical principles in the ACA Code of Ethics is meant to be an overview. Please refer to the full ACA Code of Ethics, available online at https://www.counseling.org/Resources/aca-code-of-ethics.pdf and in the ***Appendix***.

Section A: The Counseling Relationship

Counselors should always work to serve the client's best interest in a manner that is culturally sensitive. The primary goals of the counselor are to help people in need, to advocate, and to link clients to services that best fit their needs. However, a counselor's commitment to these goals is tested when presented with a client who may be unable to afford services. The code encourages pro bono work, when possible.

Informed consent is a prominent issue in health care. It is especially important to make all information about evaluation results, treatments, and what to expect from the counseling relationship, including the benefits and limitations of counseling, available to clients. The counselor must honestly and accurately represent their training, abilities, and experience to clients.

When conducting group work, each client's needs must be met in a way that also benefits the group; in turn, the client should benefit the group. Counselors must always do no harm and should avoid imposing their personal values upon others. Sexual or romantic relationships with clients (and clients' family members/former partners) are strongly discouraged and are prohibited for a period of five years after the professional relationship is terminated.

Some of the ethical principles expressed in this section include autonomy, beneficence, nonmaleficence, and competency. The values are honesty, responsibility, self-control, and helpfulness.

Section B: Confidentiality and Privacy

Trust is perhaps the most important aspect of a counseling relationship. A client's trust is earned by maintaining boundaries and respecting privacy. Information relating to client care should be shared with other professionals only with the consent of the client. When counseling minors or people with diminished capacity, all local and federal laws must be obeyed and a third party should be consulted before sharing any private information.

The limits of confidentiality should be discussed with clients, and counselors should remain aware of situations that confidentiality must be breached in order to protect the client or others from serious and likely harm (e.g., intended violence, life-threatening disease). When doubts exist about breaching confidentiality, counselors have a duty to consult with other professionals. If the court orders disclosure of confidential and private information, counselors must make an effort to obtain informed consent from the client and to block disclosure or severely limit its reach (i.e., only provide essential information).

All records and correspondence, including e-mail, should be protected within reason. Clients have a right to access their records, but access should be limited when there is compelling evidence that the information may potentially harm the client. The fundamental ethical principles that apply to this section are fidelity and veracity.

Section C: Professional Responsibility

The responsible counselor values honesty and is competent. Professional competence is an ethical standard, meaning counselors should only practice in areas in which they have the requisite knowledge and abilities. One can only help if he or she has the proper tools and the skills to utilize them effectively; techniques, procedures, and modalities used in practice should have a solid foundation of theory, empiricism, and/or science. Counselors must also improve their knowledge and abilities so they can further assist clients and contribute to the advancement of their profession. Advocating for positive social change and engaging in self-care activities are also highly recommended, and pro bono work is encouraged. Self-monitoring for impairment (i.e., physical, mental, or emotional illness that interferes with practice) and not practicing while impaired is important. The principles represented in this section are nonmaleficence, ordering, and universality. An important value is self-awareness.

Section D: Relationships with Other Professionals

When a network of colleagues is developed both inside and outside of the counselor's field of practice, different perspectives can be gained and shared. Having a support system of professionals in related disciplines can help to inform decision making, and ultimately, clients can benefit from these interrelationships. Counselors are also encouraged to alert the proper entities to ethical concerns, and a professional attitude should be maintained toward someone who exposes inappropriate behaviors, policies, or practices. Deficiencies or ethical concerns regarding employer policies require intervention (e.g., voluntary resignation from the workplace, referral to appropriate certification, accreditation, or state licensure organizations). Fidelity and veracity are ethical principles that apply in this section.

Section E: Evaluation, Assessment, and Interpretation

Appropriate assessment instruments should be used when evaluating a client, and care should be taken that these instruments and evaluations are culturally appropriate. This includes educational, psychologic, and career assessment tools that provide qualitative and quantitative information about abilities, personality, interests, intelligence level, achievement, and performance. It is important not to use the results of any test to the client's detriment and to make the results known to the client. In addition, one should note that in many instances, these tests were standardized on a population that may be different from the client's population

or identity. Informed consent and explanation of the goals of the assessment should be given in a language preferred by the client or his or her surrogate. Clients are to be given autonomy, and the counselor must apply the ethical principles of nonmaleficence and confidentiality.

Section F: Supervision, Training, and Teaching

Supervising counselors should have knowledge of supervisor models and be aware of supervisees' training, methods, and ethics while respecting their styles and values. Supervisors should foster an environment of openness and continued learning and should seek to minimize conflicts. Training sessions should be inclusive and positive. Romantic or sexual relationships with supervisees are prohibited; however, it may be beneficial in some circumstances to engage with supervisees in friendly or supportive ways (e.g., formal ceremonies, hospital visits, during stressful events). It is important to remember that the supervisor must also ensure client welfare; therefore, it is necessary to regularly assess supervisees' work and encourage their growth as counselors. Ethical principles that apply in this section are autonomy, respect, and universality.

Section G: Research and Publication

A main goal of research in counseling is to improve society, as many of the personal problems that counselors are enlisted to solve arise from clients' experiences in flawed social environments. Counselors should help with and participate in research. Research should not cause harm or interfere with participants' welfare. Informed consent must be maintained throughout the process, and all data must be kept private. Justice and confidentiality are paramount ethical concerns. When conducting research it is important to ensure that the benefits and risks are distributed equitably. Often, any benefits from research groups will only be short lived; it should be made clear that after the study has concluded, counseling interactions related to the study will cease. Also, participants must be confident that collected data will remain secure.

Section H: Distance Counseling, Technology, and Social Media

Counselors should have a good understanding of the evolving nature of the profession with regard to distance counseling, digital technology, and social media and how these resources can be used to better serve clients. Maintaining privacy and confidentiality in the digital world is more complex than with face-to-face counseling and maintaining hard-copy records. Every reasonable effort to protect digital client information should be made, and clients should be informed about the potential risks and limitations of distance counseling. The appropriateness of distance counseling should be considered for each client. The counselor's qualifications to provide the service are equally important. The laws and regulations of the counselor's location jurisdiction and of the client's location jurisdiction must be understood and followed. When counselors have a social media presence, the personal and professional presence should be separate and unmistakably distinct. Counselors are advised to avoid viewing clients' social media pages unless given expressed permission. Personal and confidential information should never be disclosed on public social media or forums. Confidentiality and nonmaleficence are especially important ethical principles in online and distance communications, and politeness, forethought, and clarity are especially critical when body and other nonverbal cues are unavailable because counseling is not face-to-face.

Section I: Resolving Ethical Issues

Counselors should be familiar with their agency's or institution's rules and regulations; these should be accepted and upheld or employment should be sought elsewhere. When ethical dilemmas arise, they should be resolved using communication with all those involved. When a conflict cannot be resolved among the parties involved, consultation with peers may be necessary. Ethical codes should be followed, but in some cases, this may conflict with laws (e.g., subpoena). It is advised that laws prevail over ethics when all other means of resolution are exhausted. Counselors who become aware of colleagues' ethics violations that are not able to be resolved informally are obligated to report them provided it does not violate client-counselor confidentiality. The ethical resolution of dilemmas or issues requires the application of the ethical principles of ordering, respect, reparation, and veracity. Values of honesty, courage, independence, and intellect, among many others, determine positive outcomes in adverse situations.

NBCC CODE OF ETHICS

The preamble of the NBCC's ethical code states that while counselors may work for agencies that also have their own ethical codes, all NBCC ethical guidelines must be followed to retain NBCC certification [58]. The Code is an assurance to other professionals, institutions, and clients that the certified counselor is expected to adhere to NBCC's ethical standards. While this code of ethics is intended for those who are certified by the NBCC, it is an excellent resource for all counselors. A synopsis of the directives contained in the Code of Ethics appears below; the word "counselor" will be used to replace "national certified counselor" [58].

Prevent Harm

Harms identified in this section include breach of confidentiality, privacy, and trust. Information learned in the counseling relationship (including test/assessment results and/or research data) may not be shared without client/legal guardian consent, barring the threat of imminent danger to self/others or court order. Out of the respect of privacy, only information that is pertinent to the counseling goals shall be solicited from clients. Steps must be taken to ensure that client records remain confidential, even following the incapacitation/death of the counselor; these include verbal communications, paper documents, test results, media recordings, and electronically stored documents. Social media must be used wisely and sensibly when communicating with clients or for sharing client information with other professionals; any

means of consultation with other professionals must ensure client confidentiality.

All relationships should be non-exploitive. Gifts from clients are generally not acceptable. When a gift is offered, careful judgment and documentation of the gift should be made. Physical, romantic, or sexual relationships are prohibited during and for a period of two years after termination of a professional relationship.

Provide Only Those Services for Which One Has Education and Qualified Experience

As with the ACA Code of Ethics, the ethical principle of competency is stressed. Counselors should recognize their limitations in all areas of practice, keep up with reviews and advancements in the field, and seek to improve their knowledge base. Only proven, established techniques may be used without client consent. Competency is an ethical priority for those who supervise others, both self-competency and an understanding of the competency of supervisees. Cultural competency is an important aspect of this directive, and counselors must ensure unbiased and nondiscriminatory practice.

There are many assessment tools and techniques available to counselors, and counselors should be competent in the use and interpretation of each they intend to use. Consideration must be given to the fact that many tests/assessments are culturally biased; open-mindedness about test/assessment performance is valued.

Promote the Welfare of Clients, Students, or Supervisees

Counselors should explain the ramifications of tests and results to clients and use assessments only for the client's benefit. Only current, reliable, and valid tests and assessments should be used. The results of a single test/assessment should never be used as the sole basis for a decision.

It is a counselor's duty to recognize if the services provided will benefit a client or if they would be better served by another counselor or institution. Consultation, supervisor assistance, or client referral is required if the services rendered are ineffective. A professional with whom consultation is sought must have the requisite experience to effectively respond to the issue. A written plan shall be agreed upon by the counselor and the consultant that identifies the specific issue, consultation goals, potential consequences of action, and evaluation terms. If no specific client information is shared between the consultant/consultee, it is not considered a consultation.

Communicate Truthfully

Credentials and qualifications should be accurately represented, and it is the responsibility of the counselor to correct known misrepresentations. Supervisors must identify their qualifications and credentials to supervisees and provide information regarding the supervision process.

Test results must be objectively and accurately interpreted, with consideration given to any irregularities in the administration of assessments or to any known unusual behavior or conditions (e.g., cultural factors, health, motivation) that may affect test results. Test results must be taken in the appropriate context. All communications with clients and colleagues, including those made electronically, are entered into the record. Clerical issues (e.g., change of address, appointment scheduling) are not an exception.

Act with Integrity to Preserve Trust

Client records are to be maintained for a minimum of five years and disposed of in a manner that assures confidentiality. Client confidentiality should be a priority of every subordinate employee with access to client records. Prior to the court-ordered release of client records, a reasonable attempt should be made to notify clients and former clients. Upon retirement from the profession, current and former clients should be notified.

Professional influence should not be misused, either for personal gain or at the expense of clients and their welfare. Testimonials from family/friends or current clients are not permitted. Counselors have the duty not to provide a reference for a counselor known to be unqualified.

Encourage Active Participation of Clients, Students, or Supervisees

Before or during the initial session, clients must be informed about the goals, limitations, purposes, procedures, and the potential risks and benefits of services and techniques. Information regarding rights and responsibilities must also be provided, including the potential limitations of confidentiality, particularly when working with families or groups.

Consent should be obtained before initiating services. The goals of the counseling relationship and written plans should be developed collaboratively with the client. Clients must agree to changes to the plan and these changes should be documented. The record should also contain information regarding other relationships that exist between the client and other mental health professionals. Upon request, client records must be released to the client. There can be a discussion of the repercussions of release if the counselor believes the information may harm the counseling relationship, but the client record belongs to the client. Upon realization of a lack of benefit for the client, termination of services should be discussed within a reasonable period. Termination of services must not take place without a justified cause, and an appropriate referral should be made.

Counselors have an obligation to ensure that services or research are conducted in an ethical manner. It is unethical to use any tests or techniques that have the foreseen potential to cause harm. Informed consent is paramount when conducting research, and every precaution must be taken to ensure the safety and confidentiality of research participants. Replicable and unbiased data is the product of honest research practices.

Adhere to Recognized Professional Standards and Practices

The underlying theme in this directive is that counselors have a responsibility to themselves, clients, and institutions to behave in an ethical manner consistent with the NBCC Code of Ethics. All applicable legal standards and professional regulations should be abided in all cases. Counselors speaking publicly should reflect their personal views and not those of an organization unless authorized to speak on its behalf. Tests and assessment administration and interpretation must comply with standard protocols. Identified security protocols for each must also be maintained.

Comply with Intellectual Property Laws

All counselors should consider plagiarism a breach of the Code of Ethics and give credit to the work of others when publishing work or research. If ethics violations occur, it is the counselor's duty to withdraw from the profession.

Counselors who are certified by the NBCC must follow the NBCC Code of Ethics. The Code may be reviewed online at https://www.nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf.

ETHICAL THEORIES

Ethical theories provide a framework that can be used to decide whether an action is ethical. These ethical systems are each made up of principles, precepts, and rules that form a specific theoretical framework, providing general strategies for defining the ethical actions to be taken in any given situation. In its most general and rudimentary categorization, ethics can be classified into two different headings: mandatory ethics and aspirational ethics [16]. When a counselor uses a mandatory ethics lens, he/she views the world in terms of polar opposites, in which one must make a choice between two behaviors. On the other hand, those who adopt aspirational ethics assume that there are a host of variables that play a role in benefiting the client's welfare [16]. For each ethical decision-making model, there is an underlying ethical theory that drives the model. Therefore, it is important to understand the various ethical theories.

VIRTUE ETHICS

As mentioned, virtue ethics developed from the Aristotelian philosophy that positive personal character is developed by acting based on the values of a particular society. According to Aristotle, there are two categories of virtues: intellectual and moral. Intellectual virtues include wisdom, understanding, and prudence; moral virtues encompass liberality and temperance [119]. A true virtue ethicist would act out of charity and good will rather than just following society's rules because they were expected to. Because virtues are "neither situation specific nor universal maxims," but instead are "character and community specific," virtue ethics allows an individual to have free will, both good and ill [54]. It is not a commandment that people must be benevolent and avoid doing evil; instead virtue ethics posits that if people uphold societal values then they will gain happiness. It is to this end that virtue ethical theory encourages people to act out of virtue. Virtue ethics forms the basis of religions throughout the world but is not inherently religious. This approach is different from deontologic ethics and teleologic ethics because rather than focusing on duty and consequences, respectively, virtue ethics' main focus is on the character of the person; it emphasizes the appraisal of the actor rather than the action [54].

DEONTOLOGIC ETHICAL THEORIES

Deontologic theories concentrate on considering absolutes, definitives, and imperatives [7]. Deontologic theories may also be referred to as fundamentalism or ethical rationalism [17]. The Greek word *deon* means duty or obligation, and the deontologic theorist would argue that values such as self-determination and confidentiality are absolute and definitive, and they must prevail whatever the circumstances (i.e., universally applicable) [17]. An action is deemed right or wrong according to whether it follows pre-established criteria known as imperatives. An imperative is viewed as a "must do," a rule, an absolute, or a black-and-white issue. This is an ethic based upon duty linked to absolute truths set down by specific philosophical schools of thought. Persons adhering to this perspective ask: What rules apply? What are the duties or obligations that provide the framework for ethical behavior [120; 121; 122]? As long as one follows the principles dictated by these imperatives and does his/her duty, one is said to be acting ethically.

The precepts in the deontologic system of ethical decision making stand on moral rules and unwavering principles. No matter the situation that presents itself, the purest deontologic decision maker would stand fast by a hierarchy of maxims. These maxims are as follows [18; 121]:

- People should always be treated as ends and never as means.
- Human life has value.
- Always to tell the truth.
- Above all in practice, do no harm.
- All people are of equal value.

The counseling professionals making ethical decisions under the deontologic ethical system see all situations within a similar context regardless of time, location, or people. It does not take into account the context of specific cultures and societies [17]. The terminology used in this system of beliefs is similar to that found in the legal justice system. Of course, enforcement of the rights and duties in the legal system does not exist in the ethical system.

One of the most significant features of deontologic ethics is found in John Rawls' *Theory of Justice*, which states that every person of equal ability has a right to equal use and application of liberty. However, certain liberties may be at competition with one another. Principles within the same ethical theoreti-

cal system can also conflict with one another. An example of this conflict might involve a decision over allocation of scarce resources. Under the principle of justice, all people should receive equal resources (benefits), but allocation can easily become an ethical dilemma when those resources are scarce. For instance, in national disasters, emergency response personnel would be among those ranked first to receive immediate stockpiles of food and drugs. Although this is in opposition with the principle of justice, it is supported by the principle of utility (greatest good).

A framework of legislated supportive precepts, such as the ACA Code of Ethics, serves counseling professionals by protecting them in their ethical practice. Most ethical codes are said to be deontologic because they set forth rules that must be followed. However, even these systems of thought will not clearly define the right answer in every situation. Most professionals will not practice the concept of means justifying the end if the means are harmful to the client. When duties and obligations conflict, few will follow a pure deontologic pathway because most people do consider the consequences of their actions in the decision-making process.

Theologic Ethical Theories

Well-known deontologic ethical theories are based upon religious beliefs and are strongly duty-bound. The principles of these theories promote a summum bonum, or highest good, derived from divine inspiration. A very familiar principle is the Golden Rule. Its Christian phrasing is "do unto others as you would have them do unto you;" however, the Golden Rule is present in various wordings in almost all cultures and religions throughout written history. One would be viewed as ethically sound to follow this principle within this system of beliefs. The most prevalent theologic ethical systems/religious ethics in the world are Christian (31.4%), Muslim (23.2%), Hindu (15%), Buddhist (7.1%), folk religions (5.9%), Jewish (0.2%), and other (0.8%), with 16.2% unaffiliated with any particular religion [60]. The most prevalent in the United States are Protestant (51.3%), Roman Catholic (23.9%), unaffiliated (16.1%), Mormon (1.7%), other Christian (1.6%), Jewish (1.7%), Buddhist (0.7%), Muslim (0.6%), and other (2.5%); 4% claim no religion [60].

According to this data, it would seem that about 80% of people in the United States are using deontologic/theologic ethics as their primary decision-making framework. However, when it comes to actual, real-world decision making, it is easy to see that purely deontologic/theologic pathways are followed less often, because, as discussed, people usually consider the implications of their actions or decisions upon the lives of others. Accordingly, in the United States, a separation of church and state is required so the common good is upheld, and the democratic system is determined to be the best source of governance rather than any one religious entity.

A 2004 Gallup poll found that 71% of Protestants and 66% of Catholics supported capital punishment [61]. Though it would seem that execution is against theologic ethics, many religious individuals have decided that the death penalty better safeguards the common good, in spite of an 88% criminologist and law enforcement expert-consensus that the death penalty does not deter homicide and other violent crime [104]. A 2000–2001 survey asked 10,000 women who had obtained induced abortions at 100 different providers throughout the United States about their religious affiliation. The results were that 70% identified as Catholic, Protestant, or Evangelical ("born-again") Christians and that an additional 8% identified as belonging to other religions; 22% had no religious affiliation [62]. These two examples are given to show that pure theologic ethical decision-making pathways are followed less often when people are faced with extremely difficult ethical dilemmas.

Categorical Imperative

Another fundamental deontologic ethical principle is Immanuel Kant's categorical imperative. An imperative is something that demands action. The first rule in Kant's theory is to only act in a way that you would wish all people to act, which is essentially a variation of the Golden Rule. Other rules are to treat people as both a means and an end and to never act in a way so as to cause disruption to universal good.

Kant believed that rather than divine inspiration, individuals possessed a special sense that would reveal ethical truth to them. The idea is that ethical truth is inborn and causes persons to act in the proper manner. Some of the ethical principles to come from Kant include individual rights, self-determination, keeping promises, privacy, and dignity.

TELEOLOGIC ETHICAL THEORIES

Telos is a Greek word meaning end, and the teleologic ethical theories or consequential ethics are outcome-based theories [123]. It is not the motive or intention that causes one to act ethically, but the consequences of the act [7]. If the action causes a positive effect, it is said to be ethical. So here, the end justifies the means. From this perspective, the question is: What are the possible good and bad outcomes? What would be the most or least harmful [120; 122; 123; 124]? Teleological theories focus more on societal effects of actions, while deontological theories emphasize effects on the individual [121]. Therefore, deontological theories may be more patient-centered.

Utilitarianism

Utilitarianism is the most well-known teleologic ethical theory. It is the principle that follows the outcome-based belief of actions that provide the greatest good for the greatest number of people [125]. So rather than individual goodness or rightness, this principle speaks for the group or society as a whole. Social laws in the United States are based upon this principle. The individual interests are secondary to the interest of the group at large. There are two types of utilitarianism: rule utilitarianism and act utilitarianism [125]. In rule utilitarianism, a person's past experiences are his influence toward achieving the greatest good. In act utilitarianism, the

situation determines whether an action or decision is right or wrong. There are no rules to the game; each situation presents a different set of circumstances. This is commonly referred to as situational ethics. In situational ethics, if the act or decision results in happiness or goodness for the client and their social context, it would be ethically right.

Individuals may choose the utilitarian system of ethics over another because it fulfills their own need for happiness, in which they have a personal interest. It avoids the many rules and regulations that may cause a person to feel lack of control. One of the limitations of utilitarianism is its application to decision making in counseling. In developing policies for a nation of people based upon the principle of doing the greatest good for the greatest number, several questions arise. Who decides what is good or best for the greatest number: society, government, or the individual? For the rest of the people, are they to receive some of the benefits, or is it an all or nothing concept? How does "good" become quantified in counseling?

Existentialism

One modern teleologic ethical theory is existentialism. In its pure form, no one is bound by external standards, codes of ethics, laws, or traditions. Individual free will, personal responsibility, and human experience are paramount. Existentialism lends itself to counseling because one of the tenets is that every person should be allowed to experience all the world has to offer. A critique of the existential ethical theory is that because it is so intensely personal, it can be difficult for others to follow the reasoning of a counselor, making proof of the ethical decision-making process a concern.

Pragmatism

Another modern teleologic ethical theory is pragmatism. To the pragmatist, whatever is practical and useful is considered best for both the people who are problem solving and those who are being assisted. This ethical model is mainly concerned with outcomes, and what is considered practical for one situation may not be for another. Pragmatists reject the idea that there can be a universal ethical theory; therefore, their decision-making process may seem inconsistent to those who follow traditional ethical models.

MOTIVIST ETHICAL THEORIES

The motivist would say that there are no theoretical principles that can stand alone as a basis for ethical living. Motivist belief systems are not driven by absolute values, but instead by intentions or motives. It is not the action, but the intent or motive of the individual that is of importance. An example of a motivist ethical theory is rationalism. Rationalism promotes reason or logic for ethical decision making. Outside directives or imperatives are not needed as each situation presents the logic within it that allows us to act ethically.

NATURAL LAW ETHICAL THEORY

Natural law ethics is a system in which actions are seen as morally or ethically correct if in accord with the end purpose of human nature and human goals. The fundamental maxim of natural law ethics is to do good and avoid evil. Although similar to the deontologic theoretical thought process, it differs in that natural law focuses on the end purpose concept. Further, natural law is an element in many religions, but at its core it can be either theistic or non-theistic.

In theistic natural law, one believes God is the Creator, and the follower of this belief has his understanding of God as reflected in nature and creation. The nontheistic believer, on the other hand, develops his understanding from within, through intuition and reason with no belief rooted in God. In either case natural law is said to hold precedence over positive (man-made) law.

The total development of the person, physically, intellectually, morally, and spiritually, is the natural law approach. Therefore, ethical decision making should not be problematic, as judgment and action should come naturally and habitually to the individual follower of natural law. A shortcoming with natural law ethics is that what might be a virtue for one person might be another person's vice [53]. Like existentialism, if virtue ethics is dependent on personal character it may not consistently lead to decisions that many others agree with [63].

TRANSCULTURAL ETHICAL THEORY

Another ethical theory used in counseling is a relatively modern system of thought that centers on the diversity of cultures and beliefs among which we now live. At its core, this ethic assumes that all discourse and interaction is transcultural because of the differences in values and beliefs of groups within our society. This concept has developed into what has become known as the transcultural ethical theory [27].

The concept of care from a transcultural perspective focuses on a comparative analysis of differing cultures' health/illness values, patterns, and caring behavior. Decisions are made on the basis of the value or worth of someone by the quality of interrelationships. This transcultural context encourages individual and global communities to question and to understand each other's beliefs and values. It is only within this context of understanding that one can make sound ethical decisions in a culturally diverse society.

The advantage to the transcultural ethical system is that while it recognizes the uniqueness of different cultures, it is based on various precepts of other ethical systems [27]. The disadvantage might be that Western society largely follows the deontologic and teleologic principles that also make up its legal system. In a society that values decision-making based on hard facts, one may have some difficulty in making decisions based upon other cultural beliefs and values. Many professionals may have difficulty with transcultural ethics'

reliance on close interrelationships and mutual sharing of differences that are required in this framework of ethical decision making.

Ethical Relativism/Multiculturalism

The ethical theory of relativism/multiculturalism falls under the postmodernist philosophical perspective and may be referred to as moral relativism [17]. Multiculturalism promotes the idea that all cultural groups be treated with respect and equality [19]. According to ethical relativists, ethical principles are culturally bound and one must examine ethical principles within each culture or society [17]. The question then becomes how ethical principles that are primarily deontologic and rooted in Western values are applicable in other societies. The challenge of ethical relativism is how to determine which values take precedent [17]. Greater detail will be focused on multiculturalism and diversity issues later in this course.

FEMINIST ETHICS

Feminist philosophy questions the origins, meanings, and implications of societal gender roles. Over the years, feminist ethics has focused on disputing three major patriarchal ideas [64]:

- Women's moral thinking is more contextual and less abstract than men's thinking.
- Values of empathy, caring, and nurturing are inherent in women, are more valued by women, and are shown more often by women.
- Values of free will and autonomy apply equally to men and women, not because of women's moral choice but because of the moral demands imposed on women as caretakers.

When the assumption is made that women are not able to engage in concrete thought, it is a short leap to assume that women are incapable of grasping complex, abstract ideas; this has been used as an argument against women participating in the professional world [65]. Feminist ethicists posit that, in general, women are forced to consider context because their moral priorities are focused differently than men, not because of an inherent difference in thinking style [65].

Of particular concern to feminist ethics in counseling and psychology are the perception of "female" moral priorities (e.g., benevolence, nonmaleficence, etc.) and the assignment of the values of caring, nurturing, and empathy to women. Because the duty of feeling goes against deontologic ethics (which fails to acknowledge sympathy, compassion, and concern as motives for decision making) reasoning based on these values can be seen as irrational [65]. It is a goal of feminist ethics to show that caring, nurturing, sympathy, empathy, benevolence, and concern, among other supposedly "female" values, are actually universal values that are simply discouraged in males. Ancient philosophers, such as Aristotle, have noted that relationships between men are impossible without such values [65]. It has been debated whether a counselor can be effective without a duty to feeling, whether or not it is acknowledged as such.

RELATIONAL ETHICS

A relational model of ethics focuses on the network of relationships and social connections rather than universal absolutes, as humans are embedded in a social web [113; 114; 126]. Cooperation and care are key in relational ethics. Gilligan's ethics of care is an example of relational ethics. At the heart of relational or care ethics is consideration of the care responsibilities of a practitioner [122].

ASSESSING ETHICAL THEORIES

It is important to remember a theory is not an absolute. Rothman encourages professionals to consider the following three questions when assessing ethical theories [15]:

- The authoritative question: Where does the theory turn to for validation of its basic assumptions or tenets—the Bible, law, philosophical constructs, or another source?
- The distributive question: Whose interest does the theory serve—the interests of every human being or only certain members of a community?
- The substantive question: What is the theory's ultimate goal—social justice, equality, happiness, or another desirable endpoint?

There are other indicators to assess ethical theories. First, a sound ethical theory must be clear and easily understood. It should be simple, with no more rules and principles than professionals are able to remember and apply to real-life professional situations. Second, it should be internally consistent. This means that the different parts of a theory should be in agreement and that different professionals applying the theory to similar circumstances should reach similar conclusions. Third, a good ethical theory should be as complete as possible, without major gaps or omissions. Finally, an ethical theory should be consistent with general daily experience and judgment. If an ethical theory is useful in helping to resolve moral dilemmas but is inconsistent with most or all our ordinary judgments, it will ultimately cause dissonance and will need to be modified.

PRACTICAL APPLICATIONS OF ETHICAL THEORIES

It is important to remember that ethical theories are just that—theories. They do not provide the absolute solutions for every ethical dilemma. They do provide a framework for ethical decision making when adjoined to the critical information we obtain from the clients and families. In other words, theories serve as lenses to how we approach the ethical dilemma or problem.

In reality, most counselors combine the theoretical principles that best fit the particular client situation. Whenever the professional relationship is established, a moral relationship exists. Moral reasoning is required to reach ethically sound decisions. This is a skill, not an inherent gift, and moral reasoning must be practiced so that it becomes a natural part of any counselor's life.

If a professional wears a deontologic lens, duty and justice are the underlying and unchanging moral principles to follow in making the decision. Wearing this theoretical lens, one argues that a person who becomes a helping professional accepts the obligations and duties of the role. Caring for clients who have contagious diseases, for example, is one of those obligations; therefore, refusal, except in particular circumstances, would be a violation of this duty. In the deontologic system, another unchanging moral principle, justice, would require healthcare professionals to provide adequate care for all patients. Refusing to care for a patient with HIV/AIDS would violate this principle.

Although all the ethical systems concern decisions about ethical problems and ethical dilemmas, the decision reached in regard to a specific conflict will vary depending on the system used. For example, a nurse working in a hospital setting assigned to a patient in the terminal stages of AIDS might have strong fears about contracting the disease and transmitting it to family. Is it ethical for him or her to refuse the assignment? If the nurse employs a utilitarian lens, they would weigh the good of the family members against the good of the patient. Based on the greatest good principle, it would be ethical to refuse working with the patient. In addition, because utilitarianism holds that the ends justify the means, preventing the spread of AIDS to the nurse's family would justify refusal of the assignment.

However, if the nurse adheres to the natural law system in shaping his or her ethical decisions, refusing to care for an AIDS patient would be unethical. One of the primary goals of the natural law system is to help the person develop to maximum potential. Refusing to have contact with the AIDS patient would diminish the patient's ability to develop fully. A good person, by natural law definition, would view the opportunity to care for an AIDS patient as a chance to participate in the overall plan of creation and fulfill a set of ultimate goals.

ETHICAL DECISION-MAKING FRAMEWORKS

The decision-making frameworks presented in this section are decision analyses. A decision analysis is a step-by-step procedure breaking down the decision into manageable components so one can trace the sequence of events that might be the consequence of selecting one course of action over another [23]. All ethical decision-making models include the steps of identifying the problem, identifying alternatives, consulting with others, and implementing and evaluating the decision [127]. Decision analysis frameworks provide an objective analysis in order to help professionals make the best possible decision in a given situation, build logic and rationality into a decision-making process that is primarily intuitive, and lay the potential outcomes for various decision paths [23]. They are also attempts to shift the process of moral decision making from the arena of the personal and subjective to the arena of an intellectual process, characterized by rigor and systematization [24]. They can be particularly helpful for novice practitioners to organize the information that surfaces when an ethical dilemma emerges [128]. The models assist in providing a linear series of steps to make an informed decision in order to reduce the likelihood of making a truncated decision [128].

Osmo and Landau note that there are two types of argumentation: explicit and implicit [25]. Implicit argumentation involves an internal dialogue, whereby the practitioner talks and listens to him/herself. This internal dialogue involves interpreting events, monitoring one's behavior, and making predictions and generalizations. It is more intuitive and automatic, and this type of dialoguing to oneself has tremendous value because it can increase the practitioner's level of self-awareness. However, Osmo and Landau also argue for the importance of counselors' use of explicit argumentation [25]. Research indicates that just because a professional code of ethics exists, it does not automatically guarantee ethical practice. Explicit argumentation involves a clear and explicit argumentation process that leads to the ethical decision. In other words, the counselor must provide specific and explicit justification of factors for a particular course of conduct regarding an ethical dilemma [25]. Explicit argumentation is like an internal and external documentation of one's course of action. One can explain very clearly to oneself and others why one made the choices.

Osmo and Landau employ Toulmin's theory of argumentation [25; 26]. Toulmin defines an argument as an assertion followed by a justification. According to Toulmin, an argument consists of six components: (1) the claim, (2) data, evidence, or grounds for the claim, (3) a warrant, which is the link between the claim and the data (may include empirical evidence, common knowledge, or practice theory), (4) qualification of the claim by expressing the degree of confidence or likelihood, (5) rebuttal of the claim by stating conditions that it does not hold, and (6) further justification using substantiation. In essence, decision-making frameworks are an attempt of explicit argumentation.

In general, decision analyses typically include the following: acknowledging the decision, listing the advantages or disadvantages (pros or cons), creating the pathways of the decision, estimating the probabilities and values, and calculating the expected value [23].

DECISION-MAKING MODELS FOR ETHICAL DILEMMAS

Kenyon's Ethical Decision-Making Model

Kenyon has adapted an ethical decision-making model from Corey, Corey, and Callanan and from Loewenberg and Dolgoff (***Table 2***) [10]. The first step in Kenyon's decision-making model is to describe the issue [10]. Counselors should be able to describe the ethical issue or dilemma, specifically, by identifying who is involved and what their involvement is, what the relevant situational features are, and what type of issue it is. Next, they should consider all available ethical guidelines; professional standards, laws, and regulations; relevant societal and community values; and personal values relevant to the issue.

Any conflicts should be examined. Counselors should describe all conflicts being experienced, both internal and external, and then decide if any can be minimized or resolved. If necessary, they may seek assistance with the decision by consulting with colleagues, faculty, or supervisors, by reviewing relevant professional literature, and by seeking consultation from professional organizations or available ethics committees.

After all conflicts are resolved, counselors can generate all possible courses of action. Each action alternative should be examined and evaluated. The client's and all other participants' preferences, based on a full understanding of their values and ethical beliefs, must be considered. Alternatives that are inconsistent with other relevant guidelines, inconsistent with the client's and participants' values, and for which there are no resources or support should be eliminated. The remaining action alternatives that do not pass tests based on ethical principles of universality, publicity, and justice should be discarded. Counselors may now predict the possible consequences of the remaining acceptable action alternatives and prioritize them by rank. The preferred action is selected and evaluated, an action plan is developed, and the action is implemented.

Finally, counselors may evaluate the outcome of the action and examine its implications. These implications may be applicable to future decision making.

In Kenyon's ethical decision-making framework, there are five fundamental components to this cognitive process. They encompass naming the dilemma, sorting the issues, solving the problem, and evaluating and reflecting [10].

Naming the dilemma involves identifying the values in conflict. If they are not ethical values or principles, it is not truly an ethical dilemma. It may be a communication problem or an administrative or legal uncertainty. The values, rights, duties, or ethical principles in conflict should be evident, and the dilemma should be named (e.g., this is a case of conflict between client autonomy and doing good for the client). This might happen when a client refuses an intervention or treatment that the counselor thinks would benefit the client. When principles conflict, such as those in the example statement above, a choice must be made about which principle should be honored.

KENYON'S ETHICAL DECISION-MAKING MODEL

1. Describe the issue.
2. Consider the ethical guidelines.
3. Examine the conflicts.
4. Resolve the conflicts.
5. Generate all possible courses of action.
6. Examine and evaluate the action alternatives.
7. Select and evaluate the preferred action.
8. Plan the action.
9. Evaluate the outcome.
10. Examine the implications.

Source: [10] *Table 2*

Sort the issues by differentiating the facts from values and policy issues. Although these three matters often become confused, they need to be identified, particularly when the decision is an ethical one. So, ask the following questions: what are the facts, values, and policy concerns, and what appropriate ethical principles are involved for society, for you, and for the involved parties in the ethical dilemma?

Solve the problem by creating several choices of action. This is vital to the decision-making process and to the client's sense of controlling his or her life. When faced with a difficult dilemma, individuals often see only two courses of action that can be explored. These may relate to choosing an intervention, dealing with family and friends, or exploring available resources. It is good to brainstorm about all the possible actions that could be taken (even if some have been informally excluded). This process gives everyone a chance to think through the possibilities and to make clear arguments for and against the various alternatives. It also helps to discourage any possible polarization of the parties involved. Ethical decision making is not easy, but many problems can be solved with creativity and thought. This involves the following:

- Gather as many creative solutions as possible by brainstorming before evaluating suggestions (your own or others).
- Evaluate the suggested solutions until you come up with the most usable ones. Identify the ethical and political consequences of these solutions. Remember that you cannot turn your ethical decision into action if you are not realistic regarding the constraints of institutions and political systems.

- Identify the best solution. Whenever possible, arrive at your decision by consensus so others will support the action. If there are no workable solutions, be prepared to say so and explain why. If ethics cannot be implemented because of politics, this should be discussed. If there are no answers because the ethical dilemma is unsolvable, the appropriate people also must be informed. Finally, the client and/or family should be involved in making the decision, and it is imperative to implement their choice.

Ethics without action is just talk. In order to act, make sure that you communicate what must be done. Share your individual or group decision with the appropriate parties and seek their cooperation. Implement the decision.

As perfect ethical decisions are seldom possible, it is important to evaluate and reflect. Counselors can learn from past decisions and try to make them better in the future, particularly when they lead to policy making. To do this [27]:

- Review the ramifications of the decision.
- Review the process of making the decision. For example, ask yourself if you would do it in the same way the next time and if the appropriate people were involved.
- Ask whether the decision should become policy or if more cases and data are needed before that step should occur.
- Learn from successes and errors.
- Be prepared to review the decision at a later time if the facts or issues change.
- It is important to remember that Kenyon's ethical decision-making framework is based on a rational model for ethical decision making. One of the criticisms of rational decision-making models is that they do not take into account diversity issues.

Ethical Principles Screen

Loewenberg and Dolgoff's Ethical Principles Screen is an ethical decision-making framework that differs slightly from the Kenyon model [28]. This method focuses on a hierarchy of ethical principles to evaluate the potential course of action for ethical dilemmas. The hierarchy rank prioritizes ethical principles; in other words, it depicts which principle should be adhered to first. The first ethical principle is more important than the second to the seventh [11]. Counselors should strive for the first ethical principle before any of the following ethical principles. In a situation where an ethical dilemma involves life or death, this ethical principle should be adhered to first before principle 6, which is adhering to confidentiality. When reading Loewenberg and Dolgoff's hierarchy, the counselor can see that only conditions to maintain the client's right to survival (ethical principle 1) or his/her right to fair treatment (ethical principle 2) take precedence to ethical principle 3, which is free choice and freedom or self-determination.

Collaborative Model for Ethical Decision Making

The Collaborative Model for Ethical Decision Making is relationally oriented and is based on values emphasizing inclusion and cooperation [27; 29]. Essentially, it entails four steps [27]:

- Identify the parties involved in the ethical dilemma.
- Define the viewpoints and worldviews of the parties involved.
- Use group work and formulate a solution in which all parties are satisfied.
- Identify and implement each individual's proposed recommendations for a solution.

LIMITATIONS OF ETHICAL DECISION-MAKING FRAMEWORKS

One of the criticisms of ethical decision-making frameworks is that they portray decision making in a linear progression, and in real life, such prescriptive models do not capture what professionals do [30]. In essence, these frameworks stem from a positivist approach. Positivism values objectivity and rationality. In subjectivity, one's values, feelings, and emotions are detached from scientific inquiry. Research has indicated that practitioners having these linear ethical decision frameworks in their knowledge base do not necessarily translate them into ethical practice. Consequently, Betan argues for a hermeneutic (i.e., interpretive) approach to ethical decision making. The person making the decision is not a detached observer; rather, the individual is inextricably part of the process. Betan maintains that this is vital because "ethics is rooted in regards to human life, and when confronting an ethical circumstance, one calls into service a personal sense of what it is to be human. Thus, one cannot intervene in human affairs without being an active participant in defining dimensions of human conduct and human worth" [30]. This does not necessarily mean that professionals should discard the linear approaches to ethical decision making. Rather, professionals should work toward understanding how the principles fit within the therapeutic context as well as the larger cultural context. Furthermore, some maintain that even if practitioners follow a decision-making model, they are often prone to rationalizing their decisions despite ethical violations [128]. Many ethical decision-making models also fail to take into account diversity and culture [129].

ETHICAL SELF-REFLECTION

Mattison challenges mental health professionals to not only use decision-making models to infuse logic and rationality to the decision-making process, but to also incorporate a more reflexive phase [24]. In many ways, Mattison's assertion is similar to Betan's call for integrating a hermeneutic perspective to ethical decision making. This is referred to as ethical self-reflection. The process is to learn more about oneself as

a decision maker or to better understand the lens one wears to make decisions [24]. It is impossible and unnecessary to remove one's character, conscience, personal philosophy, attitudes, and biases from the decision-making process [31]. Just as counseling emphasizes the person-in-situation perspective in working and advocating for clients, so too should the person-in-situation perspective be employed in increasing self-awareness as a decision maker in ethical situations [24]. The person-in-environment perspective argues that to understand human behavior, one must understand the context of the environment that colors, shapes, and influences behavior. Therefore, the counselor must engage in an active process by considering how their individual level (e.g., prior socialization, cultural values and orientations, personal philosophy, worldview), the client's domain (e.g., values, world views, beliefs), organizational context (i.e., organizational or agency culture, policies), professional context (i.e., values of the social work profession), and societal context (i.e., societal norms) all play a role in influencing moral decision making [24]. Supervision is also key in facilitating self-awareness and reflection when making ethical decisions [130].

PSYCHOLOGICAL CONTEXT OF MORAL DECISION MAKING

As discussed, ethical decision making does not operate within a vacuum. As Mattison acknowledges, there is an array of factors that influence the ethical decision-making process [24]. Consequently, it is impossible to talk about ethical decision making without looking at the psychology of moral development. Psychologists have looked at many of the same questions that philosophers have pondered but from their own professional perspective. Their theories of moral development permit us to learn something else about how moral disagreements develop and even how we may untangle them. Lawrence Kohlberg, a former professor at Harvard University, was a preeminent moral-development theorist. His thinking grew out of Jean Piaget's writings on children's intellectual development. Kohlberg's theories are based on descriptive norms (i.e., typical patterns of behavior) rather than on proven facts. Others in this field have taken issue with his categories, saying they are based too exclusively on rights-oriented ethical approaches, particularly those based on responsibility for others.

Kohlberg's stages of moral development theory presumes that there are six stages of moral development that people go through in much the same way that infants learn first to roll over, to sit up, to crawl, to stand, and finally to walk [32]. The following section is from Lawrence Kohlberg's theory on moral development. There are two important correlates of Kohlberg's system:

- Everyone goes through each stage in the same order, but not everyone goes through all the stages.
- A person at one stage can understand the reasoning of any stage below him or her but cannot understand more than one stage above.

These correlates, especially the latter one, are important when it comes to assessing the nature of disagreements about ethical judgments. Kohlberg has characterized these stages in a number of ways, but perhaps the easiest way to remember them is by the differing kinds of justification employed in each stage. Regarding any decision, the following replies demonstrate the rationale for any decision made within each stage level.

Stage 1: When a person making a stage 1 decision is asked why the decision made is the right one, he or she would reply, "Because if I do not make that decision, I will be punished."

Stage 2: When a person making a stage 2 decision is asked why the decision made is the right one, he or she would reply, "Because if I make that decision, I will be rewarded and other people will help me."

Stage 3: A stage 3 decision maker would reply, "Others whom I care about will be pleased if I do this because they have taught me that this is what a good person does."

Stage 4: At this stage, the decision maker offers explanations that demonstrate his or her role in society and how decisions further the social order (for example, obeying the law makes life more orderly).

Stage 5: Here, the decision maker justifies decisions by explaining that acts will contribute to social well-being and that each member of society has an obligation to every other member.

Stage 6: At this final stage, decisions are justified by appeals to personal conscience and universal ethical principles.

It is important to understand that Kohlberg's stages do not help to find the right answers, as do ethical theories. Instead, recognizing these stages helps counselors to know how people get to their answers. As a result, if you asked the same question of someone at each of the six levels, the answer might be the same in all cases, but the rationale for the decision may be different. For example, let us suppose that a counselor is becoming more involved in the life of his female client. He drives her home after Alcoholics Anonymous meetings and is talking with her on the weekends. Here are examples of the rationale for the counselor's decision and reply, in each stage, to the question of whether this relationship is appropriate.

Stage 1: "No, because I could lose my license if anyone found out that I overstepped the appropriate boundaries."

Stage 2: "No, because if I became known as a counselor who did that kind of thing, my colleagues might not refer clients to me."

Stage 3: "No, because that is against the law and professionals should obey the law," or, "No, because my colleagues would no longer respect me if they knew I had done that."

Stage 4: "No, because if everyone did that, counselors would no longer be trusted and respected."

Stage 5: "No, the client might benefit from our relationship, but it is wrong. I need to merely validate her as a human being."

Stage 6: "No, because I personally believe that this is not right and will compromise standards of good practice, so I cannot be a party to such an action."

These stages can give the counselor another viewpoint as to how ethical decisions can get bogged down. A person who is capable of stage four reasoning may be reasoning at any level below that, but he/she will be stymied by someone who is trying to use a stage six argument. Ideally then, if discussion is to be effective or result in consensus or agreement, the participants in that discussion should be talking on the same level of ethical discourse.

Whenever individuals gather to address a particular client's case, the members of the team must be sure that they are clear about what values they hold, both individually and as a group, and where the conflict lies. Is it between the values, principles, or rules that lie within a single ethical system? Is it between values, principles, or rules that belong to different ethical systems? When consensus has been reached, the members should be aware of the stage level of the decision.

Kohlberg's theory of moral development has been criticized for being androcentric. In other words, his moral dilemmas capture male moral development and not necessarily female moral development. Gilligan, backed by her research, argues that men and women have different ways of conceptualizing morality, and therefore, the decisions made will be different [33]. This does not necessarily mean that one conceptualization is better than the other. Brown and Gilligan maintain that men have a morality of justice while women have a morality of care [34]. Consequently, the goal is not to elevate one form of moral development as the scientific standard; rather, it is crucial to view feminine ethics of care as complementing the standard theories of moral development.

MANAGED CARE AND ETHICS

Managed care has changed the climate in the provision of health and mental health services, and a range of practitioners have been affected, including counselors. In part due to negative public perception, there has been a shift away from the term "managed care" and toward terms such as "behavioral health," "integrated behavioral health," and "behavioral mental health" to refer to managed mental health care [115]. This shift acknowledges that mental health issues are complex and involve physical, psychologic, and emotional components [20]. So, more coordinated and integrated services should ultimately benefit the consumer [20; 115]. This section is not meant to be an exhaustive discussion of how managed care has impacted ethical practice but is meant to provide an overview of the ethical issues raised in a managed care climate that is complex and multifaceted.

Managed care is a system designed by healthcare insurance companies to curb the increasing costs of health care. A third party (utilization reviewer) reviews treatment plans and progress and has the authority to approve further treatment or to terminate treatment [16]. In addition, certain types of interventions are reimbursable while other types of care are not [36].

The ethical concerns in managed care revolve around the issue of whether a counselor or other practitioner should continue to provide services outside the parameter of the managed care contract [16]. Is early termination of services deemed on a probability that payment will not be obtained? In a cost-benefit analysis, what is the role of the client? How does the ethical principle of beneficence come into play? Certain diagnoses will be deemed reimbursable by the managed care organization. Is it beneficial for the client if a different diagnosis is given in order for services to continue [131]?

At the core, it is the ethical conflict of distributive justice versus injustice [37]. Distributive justice stresses the role of fairness in the distribution of services and states that, at minimum, a basic level of care should be provided. However, the principle of distributive justice may be compromised when services are allocated based on fixed criteria and not on individuals' needs [37]. Situations will then emerge in which the utilization reviewer indicates that the client is not approved for more services, and the counselor may find him or herself unable to provide services that are still necessary. In this case, it is suggested that counselors utilize their roles as advocates to encourage and coach their clients to go through grievance procedures for more services from their managed care provider [37].

Another ethical issue emerging within counseling practice in a managed care environment is that of the counselor's fiduciary relationship with their agency versus a fiduciary relationship with the client [37]. Each relationship has competing sets of loyalties and responsibilities. First, the counselor has a fiduciary relationship to the managed care company. The responsibility to the agency is to keep expenditures within budget. Yet, there is also the counselor's obligation to the client's best interests and needs [37]. One way of managing this conflict is for counselors to be involved in the advocacy and development of policies that allow some leeway for clients who may require additional services.

Confidentiality, which is founded on respect and dignity, is of paramount importance to the therapeutic relationship. However, managed care systems also present challenges to the ethical issue of client confidentiality, as they often request that clients' records be submitted for review for approval of services [38; 131]. Consequently, counselors and other practitioners should explain up front and provide disclosure statements that establish the limits to confidentiality, what types of information must be shared, how this information is communicated, treatment options, billing arrangements, and other information [38; 39].

Regardless of what counselors might think of managed care, the counselor bears the responsibility of upholding his/her respective professional ethical principles. In order to assist counselors and other practitioners in developing their own ethical standards, the following self-reflective considerations for those working in a managed care environment should be considered [16]:

- Reflect on one's therapeutic and theoretical orientation and its compatibility with the philosophies of managed care. Depending on the assessment, counselors may have to reassess their practices or obtain additional training to acquire the necessary competencies to work in a managed care environment.
- Reflect on one's biases and values regarding managed care and how these attitudes influence one's practice.
- Develop a network of colleagues to act as peer reviewers, as they may evaluate one's ethical practice within the managed care climate.

DIVERSITY AND MULTICULTURALISM: ETHICAL ISSUES

As noted, it has been argued that ethical principles may not be easily applied to different cultural contexts. The majority of established ethical principles and codes have been formulated within a Western context; therefore, these ethical principles may have been formulated without consideration for linguistic, cultural, and socioeconomic differences. Harper argues that a cultural context must be taken into account because many of these groups constitute vulnerable populations and may be at risk of exploitation [17]. In this course, an inclusive definition of diversity is utilized, encompassing age, race, ethnicity, culture, immigration status, disability, educational level, religion, gender, sexual orientation, gender identity or expression, and socioeconomic status [40].

DEMOGRAPHIC SHIFTS

Coupled with the ever-changing socioeconomic backdrop, demographic trends indicate increasing diversification and multiculturalism in U.S. society, including rapidly growing ethnic minority populations relative to the white population; a continual influx of documented and undocumented immigrants; a growing number of individuals with various gender and sexual identities (4% to 17% of the total population); an unprecedented increase in the older American population; and a vast number of Americans with disabilities (57 million individuals) [41; 42; 43; 44; 45; 46]. This has profound implications for counselors, as culture (in a general sense) influences every aspect of our lives, including our social and psychologic reality [47]. Consequently, it is inevitable that counselors will work with more clients and settings than they are familiar or comfortable with. It is therefore advisable that counselors take into account cultural context and their clients' sociocultural identity when entering into a counseling relationship. Richmond writes that "counselors and clients are both emotionally invested in 'right living' issues. Since no therapy is value free, clients face the dilemma of finding a therapist with values similar to their own or having their values challenged. Therapists face the ethical issue of clarifying their own values and determining how to make them known" [66].

This is part of the ethical principle of competency. It is correct to admit to oneself that the knowledge/experience or willingness to effectively care for another individual is not currently possessed. When value conflicts are apparent from the start, it may be more ethical not to engage in a professional relationship with the client. Remember, multiculturalism is not a demand (i.e., one cannot be forced to apply the ethic); rather, it is the knowledge and understanding that cultures/social-groups operate on different value systems.

MULTICULTURALISM IN RESEARCH

It is important to note that culturally sensitive research is of particular value because many older studies, while perhaps not totally biased, may have been skewed due to a lack of cultural understanding. An example of this is a study of research conducted with elderly Japanese American populations in which participants signed agreements that they did not fully understand because they traditionally deferred judgment to their doctors regarding medical decisions; they also felt that not agreeing to participate would be disrespectful to their doctors and the researchers [67].

A positive example of a culturally appropriate study was one that was conducted within a Korean community in which research follow-ups took place at local ethnic grocery stores rather than in an institutional setting [68]. The businesses were identified as traditional gathering places whereas the institutions were identified as a source of fear or discomfort or were inconveniently located, which would have caused a reduction in willing participants. If the research had only been conducted in institutional settings, instead of getting a true cross section, the study would likely end up with participants who were of a certain type (e.g., more affluent, no mobility issues).

Both the ACA and the NBCC wish to further the goals of the field by encouraging counselors to give knowledge back to the profession through the release of culturally appropriate research [8; 58]. Publishing culturally oriented or culturally inclusive research upholds the ethical principles of gratitude, publicity, and justice.

DEBATES WITHIN MULTICULTURALISM/ DIVERSITY AND ETHICS

Much of the traditional ethical systems and philosophies that have influenced the United States stems from Christian-based and scientific empiricism [48]. Positivism assumes there is one universal that can be counted or measured. In addition, it postulates that reality is objective and value-free [48]. This positivistic approach to ethics was challenged by

Joseph Fletcher in 1966 when he published *Situation Ethics*. He challenged the assumption made by many scholars in the 20th century that one resolved ethical dilemmas by turning to universally accepted principles. His work caused a paradigm shift from a universal approach to ethics to deconstructing it and developing a constructivist, contextual approach [48]. Consequently, in situation ethics, one takes the context (including culture and diversity) into account.

In our multicultural society, how one views good or bad will inevitably vary from group to group. Consequently, one of the struggles when dealing with multiculturalism and diversity issues while developing ethical guidelines is the question of how to develop one ethical guideline that can fully apply to the many diverse groups in our society. The complexity of defining multiculturalism and diversity is influenced by the tremendous differences within a group in addition to the differences between groups. Certainly religion, nationality, socioeconomic status, education, acculturation, and different political affiliations all contribute to this within-group diversity. To make matters even more complex, multiculturalism and diversity within a society are dynamic rather than static [49]. Consequently, the questions that arise in this debate are, should ethical guidelines be based on the uniqueness of groups, taking into account distinct values, norms, and belief systems, or should ethical guidelines be developed based on the assumption that all human beings are alike [49]?

INFUSING DIVERSITY INTO THE ETHICAL DECISION-MAKING MODELS

Several ethical decision-making models have been reviewed in this course. The major criticism of these models is that they do not take into account issues of diversity. Garcia, Cartwright, Winston, and Borzuchowska developed the Transcultural Integrative Model for Decision Making, which includes a self-reflective activity [27]. This allows practitioners to recognize how cultural, societal, and institutional factors impact their values, skills, and biases. Furthermore, the model stresses the role of collaboration and tolerance, encouraging all parties to be involved in the evaluation of ethical issues and promoting acceptance of diverse worldviews [27].

The authors of this model maintain that its strength lies in the fact that it is based on several underlying frameworks: rational, collaborative, and social constructivist. It employs a rational model in providing a sequential series of procedures. The collaboration model is used because it acknowledges the importance of working with all stakeholders involved, employing a variety of techniques to achieve consensus. Finally, the Transcultural Integrative Model employs social constructivist principles by acknowledging that meanings of situations are socially constructed [27]. No single theoretical framework can provide solutions to complex and multifaceted ethical solutions; therefore, an array of strengths from various frameworks is harnessed. The Transcultural Integrative Model consists of four major steps, with sub-tasks within each step [27].

Step 1: Interpreting the Situation through Awareness

First, the counselor examines his/her own competence, values, attitudes, and knowledge regarding a cultural group. The counselor then identifies the dilemma not only from his/her own perspective, but also from the client's perspective. Relevant stakeholders, or meaningful parties relevant to the client's cultural context and value systems, are identified. Finally, cultural information is garnered (e.g., value systems, immigration history, experiences with discrimination, prejudice).

Step 2: Formulating an Ethical Decision

In the second step, the dilemma is further reviewed within its cultural context. It is important to examine the professional ethical code for specific references to diversity. A list of possible culturally sensitive and appropriate actions is formulated by collaborating with all parties involved. Each action is then evaluated from a cultural perspective, examining the respective positive and negative consequences. Again, feedback from all parties is solicited. Consultation with individuals with multicultural expertise is sought to obtain an outsider perspective. Finally, a course of action is agreed upon that is congruent with the cultural values and is acceptable to all parties involved.

Step 3: Weighing Competing, Nonmoral Values

Counselors should reflect and identify personal blind spots that may reflect values different from that of the cultural values of the client. Larger professional, institutional, societal, and cultural values should also be examined.

Step 4: Implementing Action Plan

In the final step, cultural resources are identified to help implement the plan. Cultural barriers that might impede execution of the plan, such as biases, stereotypes, or discrimination, are identified. After the action is implemented, it should be evaluated for accuracy and effectiveness. Such an evaluation plan should include gathering feedback from multicultural experts and culturally specific and relevant variables.

MULTICULTURALISM/DIVERSITY AND THE ACA CODE OF ETHICS

In the 2005 revision of the ACA Code of Ethics, the emphasis on the multicultural/diversity issues in counseling reminds professionals to consider sociocultural context when making ethical decisions. For example, section A.1.d. of the Code was changed to "Support Network Involvement" from "Family Involvement," realizing that in many instances a client may be alienated from a traditional family due to a variety of factors, including sexual or gender identity, interracial marriage, or religious differences; this revision persists in the 2014 ACA Code of Ethics [8; 69]. This is an example of the kind of sensitivity to diversity that must be applied in a professional relationship. It is not a new concept but is instead an increased awareness that informs applied ethics.

Other such examples are sections E.5.b. and E.5.c. of the Code, which remind counselors that in other cultures mental or emotional disorders may not be defined in the same ways they are in their culture [8; 69]. Also, in the past, certain sociocultural differences were viewed by the hegemony as anomalies that required treatment, and the Code advises counselors to be aware of these past prejudices and to not perpetuate them.

MULTICULTURALISM/DIVERSITY AND THE NBCC CODE OF ETHICS

Directive 26 of the NBCC Code of Ethics states that nationally certified counselors "shall demonstrate multicultural competence and shall not use techniques that discriminate against or show hostility towards individuals or groups based on gender, ethnicity, race, national origin, sexual orientation, disability, religion or any other legally prohibited basis" [58]. In addition to a working knowledge of a client's cultural norms, the counselor should have an understanding of the effect that discrimination and oversimplification have on various social groups.

Furthermore, Directive 48 states that counselors "shall accurately report test and assessment results and limit conclusions to those based on evidence, taking into consideration any influences that may affect results such as health, motivation and multicultural factors." It has been noted that many assessments, standardized tests, and techniques were normalized based on research with white, middle class populations. This includes psychologic test procedures and instruments in addition to educational or career assessment tools. Sociocultural norms and biases should be accounted for when interpreting results.

ONLINE COUNSELING

Despite the debate about the strengths and limitations of utilizing Internet technologies in the delivery of mental health services, there is a consensus that online counseling and mental health service will certainly become more popular, out of convenience and/or necessity [70]. Consequently, professionals must understand the clinical, legal, and ethical context of online counseling/therapy. Clinicians should be familiar with the empirical research in order to evaluate the strengths, challenges, and efficacy of online counseling and assist individuals who may be considering online counseling.

LIMITATIONS OF ONLINE COUNSELING

As a result of the relatively recent emergence of online counseling, some are concerned that established counseling theories apply specifically to face-to-face counseling and do not translate well to online counseling. It may not be easy to apply traditional theoretical frameworks and principles to online counseling [71]. However, as online practice becomes increasingly routine, more studies will be conducted to evaluate their effectiveness. Over time, a comprehensive knowledge base will be in place for clinicians, professionals, and researchers to utilize.

To date, one of the main challenges with the delivery of Internet counseling and mental health services involves the mechanisms for monitoring quality of services and accountability [72]. There is no established monitoring system to track the credibility and legitimacy of counselors' advertisements. There is also no accountability structure to review and monitor the quality and accuracy of information on websites [72]. These concerns may be amplified in cases of chat rooms or support groups, which may or may not involve a licensed and trained counselor. In some cases, these forums may open clients to a larger number of people who support a destructive behavior or lifestyle, as in the case of a number of pro-anorexia nervosa websites [73].

Another concern with online counseling is based on security and privacy issues. Computer hackers, for example, can access particular websites and compromise the confidentiality, privacy, and security of clients' disclosures as well as payment information, such as credit cards [72]. As online counseling websites become more sophisticated, there is a move toward using the same message security systems utilized by banking institutions [72].

Online counseling may not be conducive and appropriate for clients with severe emotional problems or who have serious psychiatric problems. In an emergency situation in which a client expresses suicidal or homicidal thoughts, counselors may not know where the client is located and be unable to implement emergency plans [72; 74]. In addition, they may not be able to warn vulnerable third parties [75]. However, similar challenges exist with telephone counseling or crisis hotlines [74]. Counselors may also have difficulty referring clients to appropriate local resources and services [75]. Even when clients share their locations, counselors may be unfamiliar with the range and quality of services in any given geographic area.

Another concern is the absence of nonverbal cues in online environments, such as chatrooms, e-mails, discussion forums, and even with videoconferencing. Counselors have traditionally relied on nonverbal cues to assist in diagnosing. Due to the lack of nonverbal cues, there is a greater likelihood for counselors to misread and misinterpret text-based messages; therefore, counselors must be careful in interpreting latent meanings [74]. Crying, irritability, and other signs of distress may not be detected, and side effects of medications such as tremors or akathisia may not be evident, even in a video call [76]. The online environment for counseling may not be conducive for certain clients who require visual and auditory cues, including clients who have paranoid tendencies or poor ego strength [74]. The lack of nonverbal cues is also a concern in the formation of a therapeutic alliance and establishment of rapport between the counselor and client.

Some argue that the anonymity offered by online counseling offsets this concern, as anonymity can promote greater rapport building and self-disclosure. Others believe it is impossible for an effective working alliance to be developed in an online environment [72; 77]. At this point, the results are mixed at best.

As noted, one of the potential advantages of the online environment is the time delay for both client and counselor responses [74]. It can provide both parties the opportunity to think before they converse. However, the downside of this time delay is that some clients may misinterpret the delay as abandonment or inattention, which can trigger anxiety [74]. Again, online counseling is not suited for everyone. Counselors must properly assess its applicability for each client.

Finally, there are many ethical and legal issues associated with online counseling. Because the Internet is available across state and national boundaries; state and legal jurisdictions by which the counselor practices may not apply [72].

Several states have passed legislation addressing the potential risks, consequences, and benefits to patients who decide to pursue counseling online. These laws generally require that patients must give both oral and written consent stating they are fully aware of the potential risks. In addition, counselors must document whether or not patients have the skills to truly benefit from counseling online [110].

The APA has developed guidelines for counselors who wish to provide telepsychology. These guidelines were created as a direct response to the growing use of technology, which ultimately helps to continue to reach more clients/patients. There are eight guidelines for counselors to consider [111]:

- Competence of the psychologist: Counselors should be competent with the use of the technologies needed and aware of the possible risks to online counseling.
- Standards of care in the delivery of telepsychology services: Counselors should make every effort to ensure that ethical and professional standards of care are followed throughout the duration of services.
- Informed consent: Counselors must obtain informed consent specific to the risks and benefits of telepsychology, including laws that may apply.
- Confidentiality of data and information: Counselors must protect client data and inform clients about the possible risks of using technology for telepsychology.
- Security and transmission of data and information: Counselors must use applicable security measures to protect client information.
- Disposal of data and information and technologies: Counselors should dispose of data and information in a way that reasonably protects it from unauthorized access.
- Testing and assessment: Counselors should be aware that screenings, tests, and other assessments used with clients may work in different ways when used online than when applied with clients face-to-face.
- Interjurisdictional practice: Counselors should be aware of laws that may exist when providing services outside one's jurisdiction or internationally.

ONLINE COMMUNICATIONS AND DISTANCE COUNSELING: A SOCIOCULTURAL CONTEXT

It is crucial to remember that technology is merely a tool to communicate and impart information. As with any form of communication, the sender and recipient of the message operate within a cultural context. Technologies are described as cultural tools that "transform, augment, and support cognitive engagement" [78]. The atmosphere of online groups, for example, is influenced by members' styles of participation, forms of interactions, roles assumed, and power sharing between members and the facilitator, all of which are influenced by the cultural, ethnic, and racial backgrounds of the members and the facilitator [78]. Race, culture, ethnicity, and gender influence communication patterns and attitudes toward technology usage.

Race, Culture, and Ethnicity

Johari, Bentley, Tinney, and Chia argue that reasoning pattern differentials and high- and low-context differentials must be taken into account in gaining an understanding of how ethnic minorities and individuals from other cultures assimilate information and communicate through computer technologies [79]. Thinking and reasoning patterns and approaches to problem solving, for example, vary from culture to culture. Individuals from Western countries like the United States tend to use linear reasoning, whereas individuals from Asia, the Mediterranean, and Latin America are characterized by more nonlinear or circular reasoning patterns [79].

Styles of communication can be classified from high-context to low-context [80]. High-context cultures are those cultures that disseminate information relying on shared experience, implicit messages, nonverbal cues, and the relationship between the two parties [81]. They tend to focus on "how" something was conveyed [55]. Low-context cultures rely on verbal communication and focus on what is explicitly stated in the conversation [81]. Western cultures, including the United States, can generally be classified as low-context. On the other hand, groups from collectivistic cultures such as Asian/Pacific Islanders, Hispanics, Native Americans, and African Americans are from high-context cultures [80].

Individuals from high-context cultures may require more social context in order to understand the meanings of the communication [79]. E-mail is a technology that can be viewed as more amenable to individuals from low-context cultures [79]. E-mails are perceived as a quick, easy way to communicate, in which the focus is on words to convey both content and meaning [79]. However, this form of com-

munication can place ethnic minorities or individuals from other cultures at a disadvantage. Some experts recommend that when using technology in education and, by extension, counseling, the facilitator should attempt to increase contextual cues [82]. Counselors may choose to provide biographical information about themselves and encourage brief introductions from everyone in an online support group [82]. This process of setting up rich contextual cues will assist in building rapport as well.

High- and low-context culture differentials can also impact the amount of information that can be assimilated. Individuals from high-context cultures (e.g., Korea, Japan) may experience information overload compared to those individuals from low-context cultures (e.g., Germany, the United States) [83]. Counselors should be sensitive to the amount of information a client can process and assimilate.

Other cultural values can influence technology usage. Individuals' attitudes about appropriate uses of time vary from culture to culture [84]. Monochronism refers to preference to perform tasks one at a time; polychronism refers to a preference to parallel task, performing more than one task simultaneously [84]. Certain cultures (e.g., Egypt and Peru) tend to be less concerned with slower technologies with some delay because they adhere to more polychronistic attitudes toward time [83].

Instructors who use Internet technology are cautioned to remember that writing styles, writing structure, web design, and multimedia all influence how students process and assimilate information and that the learning process does not exist in a cultural vacuum [85]. The same applies to Internet counseling. Vocabulary and grammar have varying meanings from culture to culture and signify different levels of respect and politeness [85]. For example, some cultures use more formal language to convey respect. Sentence structures, particularly if they are translated from one language into another, can inadvertently convey a completely different message, or they might sound too direct, appearing to be offensive [85]. Web design is also important, and the design should reflect the language of the cultural group. The English language, for example, is read from left to right, but some cultures read right to left. Therefore, icons and images should reflect these norms [85]. It is also important to remember that images are culturally sensitive and can perpetuate stereotypes [85].

Finally, individuals' perceptions of computer technologies may be influenced by cultural and gender role norms, and understanding cultural differences in attitudes toward computers may have implications in online counseling [86]. One would surmise that some ethnic minority groups may have less favorable attitudes toward computer technology in part due to practical barriers, such as cost and access. One ethnographic study revealed that economics is not the only factor; psychosocial barriers can also affect ethnic minority adults' perceptions about computers [87]. Some participants, for example, did not see themselves as the type of person who used computers. Some thought that computers were a luxury item, and their subcultural identity did not include the image of a computer user [87]. Similarly, in Menard-Warwick and Dabach's case studies of two Mexican families, affective factors included fear in using computers and anxiety revolving around a sense of entitlement [88].

Culturally embedded perceptions about gender roles also color attitudes toward computers. Some Hispanic men stated that computers and typing were considered female subjects in school. In other cases, some participants stated that computers were equated with educational success, but educational achievement was not part of their life tasks and roles [87].

Gender

It has been said that Internet and computer usage is male-dominated and that the Internet was developed by men for men [89]. Yet, some argue that the Internet democratizes and minimizes patriarchal communications between men and women in part because there are less social cues in online communication [90]. Consequently, differential status based on gender may potentially be reduced, ultimately equalizing communication patterns [90].

Those who argue that the Internet is male-dominated and reinforces male patriarchy attribute this to early socialization processes favoring males in computer, math, and science subjects [89; 91]. In the United States, men and women are roughly equal users of the Internet at home (79.4% and 78.5%, respectively) [103]. Yet, it is important to remember that examining the gender digital divide in terms of statistics of usage is misleading because the culture of gender and general societal expectations of men and women continue to influence attitudes toward Internet usage, computer technologies, and communication patterns and styles in online media.

In general, there are gender differences in how the Internet is used. Men have historically been more likely to use the Internet to find news, play games, seek information, and connect to audio broadcasts. Early on, men gained more sophisticated web skills, and were more comfortable and proficient in developing their own websites and changing preferences [89]. In one study, Weiser found gender differences in Internet patterns and applications [89]. Men had a tendency to use the Internet for entertainment and leisure such as pornography, games, and pursuing sexual relationships, while women were more likely to use the Internet for interpersonal communications and education [89].

Gender differences are also apparent in the content of Internet communications. When examining text of postings in online forums, women tend to gravitate toward topics that have practical ramifications and consequences and are less inclined to be drawn to topics that are abstract and theoretical [92]. They prefer to discuss personal issues, ask questions to solicit information, and give or garner information [92]. Men also may discuss personal issues, but prefer to focus on an issue, give or obtain information, ask questions, and discuss personal matters [92].

GENDER DIFFERENCES IN COMMUNICATION PATTERNS IN ONLINE MEDIA	
Women	**Men**
Attenuated assertions	Strong assertions
Apologies	Self-promotion
Explicit justifications	Presuppositions
Questions	Rhetorical questions
Personal orientation	Authoritative orientation
Support for others	Challenges to others
	Use of humor and sarcasm
Source: [102]	*Table 3*

In a qualitative study examining gender differences and technology use, particularly women's experiences with the use of the Internet, women were most likely to discuss how e-mail has helped them to keep in touch with family and friends. Instant messaging was also used as a way to keep in touch with children, particularly for single mothers with children at home alone [93]. Men also discussed the ability of the Internet to connect them to family and friends; however, male communication predominantly consisted of providing information, while women connected on a personal level [93].

Male communications are characterized as being more power-conscious; that is, they are more assertive in conveying information and less focused on exchanging information and developing relationships [90]. On the other hand, female communications are described as less power-dominated, as they tend to ask more questions and apologize more often [93]. Postings by female participants in online groups are characterized by more support and encouragement compared to the postings of male participants, who seek and receive information (***Table 3***) [93; 102]. Similarly, Rovai found that the majority of men in online forums tended to utilize an independent voice that was characterized as authoritative, impersonal, and assertive, while the majority of women used a connected voice described as supportive and helpful [94].

Some scholars argue that by emphasizing these dichotomies, stereotypes about women will be reinforced. Instead, it is important to focus on how the Internet serves to equalize interactions and relationships. Others argue that it is too simplistic to maintain that online communications equalize gender relationships due to the promotion of anonymity, as it might actually heighten stereotypical behavior, promote group norms, and trigger an "us" versus "them" behavior [95]. Interestingly, in one study, researchers found that one way to reduce stereotypical behaviors was to reduce the depersonalization and the anonymity of the online environment. Simply having individuals post their photos and share biographies with other participants in the online environment can promote greater personalization [96].

Regardless of the side of the debate, it is impossible to disregard the power of gender in shaping Internet communications. While some might hail the Internet as democratizing and equalizing gender relations, it is crucial to recognize that gender norms and the effects of socialization may be equally if not more powerful in online media. It should be noted that gender differences in the use of information and communication technology among the younger generations are minimal [105]. However, there is still debate regarding the effect of socialization and generational differences on Internet use behavior; for example, the youngest generations of proficient Internet and social media users have not yet become parents, workers, or spouses. It is too early to know if or how gender will affect online behavior as these individuals transition to adulthood [105]. Clinicians should be aware of the effects of gender on communication patterns and styles in individual and group online counseling.

ETHICAL AND LEGAL ISSUES

Various ethical concerns have been raised regarding online counseling. There is some concern that beneficence cannot be fully upheld with the use of electronic communications because the counselor may find it difficult to ensure the client's safety. In part, this safety concern is linked to the issue of privacy and confidentiality. It is nearly impossible to ensure that another party will not intercept the client/counselor interaction or that encryption methods will be foolproof [97]. For example, a client who is accessing the Internet at home could be interrupted by another individual who might see what was written, or an e-mail could be read by other family members, compromising the client's privacy. If a client is using a computer in the workplace, there is a possibility that others may read the online communication. In the United States, an employer has the legal right to read their employees' e-mail communications [71]. In some situations, the compromise of the client's privacy could prove particularly dangerous. Consider a victim of family violence who is caught by the abuser communicating with a counselor or an abuser hacking into the victim's computer system to access private information [97].

Beyond merely ensuring the client's physical safety, some argue it may not be possible for counselors to truly extend beneficence to clients in an online environment because the essence of therapeutic change rests upon the formation of the client-counselor rapport and relationship. However, this argument is based on the belief that a relationship cannot truly be developed in an online environment, an issue that remains controversial [97].

At the heart of the client-counselor relationship is confidentiality. A counselor adheres to the ethical principle that the information provided by the client will remain confidential. Moreover, the Internet does not exist within state or international borders, which then brings legal jurisdictions into question. What regulations about patient/doctor confidentiality will be adhered to, particularly if the counselor resides in one state and the client in another [72]?

As noted, one of the limitations of online counseling is the fact that neither party can be fully confident of the other's identity [72]. The clients may not give their identity, contact information, or physical location. Again, this has implications regarding ensuring client safety. In a traditional counseling relationship, if the client expresses a desire to hurt him/herself or others, the counselor is obligated to report this to the appropriate authorities. If a client never discloses his/her full name or contact information, then the counselor's ability to intervene or report is limited [97; 98]. Another concern revolves around minors who lie about their identity and age and who obtain treatment without parental consent [97]. Despite statements indicating that users must be older than 18 years of age or have parental consent, online counselors should still ask for age and birthdate during the intake process [98]. Although a minor could still lie, the online counselor has then done all that is possible to ensure that the client is not a minor [98].

There is also concern about the identity of counselors and their stated qualifications [97]. Online counselors' qualifications vary widely, from unlicensed therapists to licensed social workers, psychologists, and psychiatrists. Again, questions about licensing requirements across legal jurisdictions arise [99]. There is debate about which authorities and jurisdictions should be recognized for activities occurring on the Internet, as online counseling crosses geographical and governmental boundaries [71]. Normally, malpractice insurance is limited to the state(s) where the clinician is licensed to practice; online, the clinician may not be covered in "interstate" suits [76]. Some contend that if the client has accessed the clinician's website, then the client has actually "traveled" to the clinician's state [76]. These ethical and legal issues have not yet been firmly resolved.

ACA CODE OF ETHICS AND DISTANCE COUNSELING

Because online counseling has become increasingly popular, national counseling and other related professional organizations must develop ethical codes relating to online and other distance counseling. Clinicians should be familiar with the code of ethics for distance counseling in their professional organization as well as ethical codes in related professional disciplines.

Manhal-Baugus described two main ethical issues pertinent to distance counseling: information that is conveyed to the client about privacy/confidentiality and principles in establishing online relationships [100].

Information Privacy and Confidentiality

The ACA code of ethics highlights specific information that must be conveyed to the client and to the counselor. Counselors, for example, must clearly communicate to clients regarding their identity, qualifications, and areas of expertise. In turn, clients should also provide identification information at the beginning and throughout the relationship [8].

Information related to the inherent limitations of using computer technology and how privacy might be affected when transmitting information should be clearly communicated to clients [8]. Counselors must inform clients whether websites are secure and whether e-mail encryption is employed and should make every effort to ensure this is true. The client must acknowledge in a waiver that he/she understands that there are risks to confidentiality when information is disseminated over the Internet. Finally, all records and e-mail transcripts should be stored in a secure place [8].

Distance Counseling, Technology, and Social Media

Six principles related to establishing and maintaining distance counseling relationships are identified in the ACA's code of ethics [8]:

- **Knowledge and legal considerations**: Counselors should have clear understanding of the technical, legal, and ethical aspects of distance counseling, technology, and social media. The laws and regulations of the counselor's practice location and the client's location must be known. Counselors should only practice within their area(s) of expertise.
- **Informed consent and security**: Intervention plans should reflect the client's individual needs, and the client should decide whether to use alternatives to face-to-face counseling. The counselor must disclose her or his distance counseling credentials, physical location, and contact information; risks and benefits of distance counseling, technology, or social media; response times; and possible failure of technology and alternatives in this eventuality. Counselors discuss and the client acknowledges the security risks and confidentiality limitations involved with distance counseling.
- **Client verification**: Counselors must ensure that the client is who he or she purports to be. Steps must be taken to verify clients' identity throughout the relationship.
- **Distance counseling relationship**: Counselors should be sure that clients are completely able use the technology and that the client is suited to distance counseling. Clients should understand that misunderstandings are possible due to lack of nonverbal cues between both individuals in the relationship. If it is assessed and determined that distance counseling is not appropriate, counselors should first consider providing face-to-face services; referrals should be made to alternative services if this is not feasible.
- **Records and web maintenance**: Laws and statutes regarding electronic record storage dictate how counselors maintain and secure client files and personal information. Clients should be informed about the security measures and encryption used in their database. If transaction records are archived, counselors

should disclose how long these are kept. A distance counselor's licensure and professional certification board information should be linked on their website or personal page, and these links should be regularly updated.

- **Social media**: Counselors must maintain separate personal and professional social media profiles and/or web pages. Disclosure of confidential information on public social media or web pages must be avoided. Clients' Internet presence should remain private (even publicly shared information) unless a counselor receives consent.

NBCC STANDARDS FOR DISTANCE PROFESSIONAL SERVICES

The NBCC has issued a document, separate from their ethical code, containing guidelines for ethical behavior specific to e-mail, chat, and video based Internet counseling.

The following standards are from The NBCC Policy Regarding the Provision of Distance Professional Services, ©2016 National Board for Certified Counselors, Inc. and Affiliates. Reprinted with the permission of the National Board for Certified Counselors, Inc.™ and Affiliates; 3 Terrace Way, Greensboro, NC 27403-3660. In this section, "nationally certified counselor" is abbreviated as NCC.

1. NCCs shall adhere to all NBCC policies and procedures, including the Code of Ethics.
2. NCCs shall provide only those services for which they are qualified by education and experience. NCCs shall also consider their qualifications to offer such service via distance means.
3. NCCs shall carefully adhere to legal regulations before providing distance services. This review shall include legal regulations from the state in which the counselor is located as well as those from the recipient's location. Given that NCCs may be offering distance services to individuals in different states at any one time, the NCC shall document relevant state regulations in the respective record(s).
4. NCCs shall ensure that any electronic means used in distance service provision are in compliance with current regulatory standards.
5. NCCs shall use encryption security for all digital technology communications of a therapeutic type. Information regarding security should be communicated to individuals who receive distance services. Despite the use of precautions, distance service recipients shall be informed of the potential hazards of distance communications. Not the least of these considerations is the warning about entering private information when using a public access or computer that is on a shared network. NCCs shall caution recipients of distance services against using "auto-remember" user names and passwords. NCCs shall also inform recipients of distance services to consider employers' policies relating to the use of work computers for personal communications.
6. To prevent the loss of digital communications or records, NCCs who provide distance services shall maintain secure backup systems. If the backup system is also a digital mechanism, this too shall offer encryption-level security. This information shall be provided to the recipient of professional services.
7. NCCs shall screen potential distance service recipients for appropriateness to receive services via distance methods. These considerations shall be documented in the records.
8. During the screening or intake process, NCCs shall provide potential recipients with a detailed written description of the distance counseling process and service provision. This information shall be specific to the identified service delivery type and include considerations for that particular individual. These considerations shall include the appropriateness of distance counseling in relation to the specific goal, the format of service delivery, the associated needs (i.e., computer with certain capabilities, etc.), the limitations of confidentiality, the possibility of technological failure, anticipated response time to electronic communication, and any additional considerations necessary to assist the potential recipient in reaching a determination about the appropriateness of this service delivery format for their need(s). NCCs shall discuss this information at key times throughout the service delivery process to ensure that this method satisfies the anticipated goals, and if not, the NCC will document the discussion of alternative options and referrals in the client's record.
9. Because of the ease in which digital communications can inadvertently be sent to other individuals, NCCs shall adopt behaviors to prevent the distribution of confidential information to unauthorized individuals. NCCs shall discuss actions the recipient may take to reduce the possibility that they will send information to other individuals by mistake.
10. NCCs shall provide recipients of distance professional services with information concerning their professional credentials and links to the respective credentialing organization websites.
11. NCCs, either prior to or during the initial session, shall inform recipients of the purposes, goals, procedures, limitations, potential risks, and benefits of services and techniques. NCCs also shall provide information about rights and responsibilities as appropriate to the distance service. As a part of this type of service provision, NCCs shall discuss with recipients the associated challenges that may occur when communicating through distance means, including those associated with privacy and confidentiality.

12. In the event that the recipient of distance services is a minor or is unable to provide legal consent, the NCC shall obtain a legal guardian's consent prior to the provision of distance services. Furthermore, NCCs shall retain copies of documentation indicating the legal guardian's identity in the recipient's file.

13. NCCs shall avoid the use of public social media sources (e.g., tweets, blogs, etc.) to provide confidential information. To facilitate the secure provision of information, NCCs shall provide in writing the appropriate ways to contact them.

14. NCCs shall discuss with recipients the importance of identifying recipient-named contacts in the event of emergency situations. As a part of this discussion, NCCs will identify the circumstances in which these individuals will be contacted and what information will be shared with emergency contacts. NCCs will provide recipients of distance services with specific written procedures regarding emergency situations. This information shall include emergency responders near the recipient's location. Given the increased dangers intrinsic to providing certain distance professional services, NCCs shall take reasonable steps to secure reasonable referrals for recipients when needed.

15. NCCs shall develop written procedures for verifying the identity of the recipient, his or her current location, and readiness to proceed at the beginning of each contact. Examples of verification means include the use of code words, phrases, or inquiries. (For example, "Is this a good time to proceed?")

16. NCCs shall limit use of information obtained through social media sources (e.g., Facebook, LinkedIn, Twitter, etc.) in accordance with established practice procedures provided to the recipient at the initiation of services or adapted through ongoing informed consent process.

17. NCCs shall provide information concerning locations where members of the public may access the Internet free of charge or provide information regarding the location of complimentary Web communication services. In such cases, the informed consent process shall include the required discussion items, including how this affects confidentiality and privacy.

18. NCCs shall retain copies of all written communications with distance service recipients. Examples of written communications include e-mail/text messages, instant messages and histories of chat-based discussions even if they are related to housekeeping issues such as change of contact information or scheduling appointments.

19. At a minimum, NCCs shall retain distance service records for a minimum of five years unless state laws require additional time. NCCs shall limit the use of records to those permitted by law, professional standards, and as specified by the agreement with the respective recipient of distance services.

20. NCCs shall develop written procedures for the use of social media and other related digital technology with current and former recipients. These written procedures shall, at a minimum, provide appropriate protections against the disclosure of confidential information and the creation of multiple relationships. These procedures shall also identify that personal social media accounts are distinct from any used for professional purposes.

As previously indicated, all professional organizations have their own codes of ethics, and many of these ethical principles overlap. It is important to remember that counselors are bound to their employer's code of ethics, but often, professional organizations will explicitly highlight principles directly related to online counseling. Counselors are encouraged to review and become familiar with other organizations' codes of ethics.

INTERPROFESSIONAL COLLABORATION AND ETHICS

Interprofessional collaboration is defined as a partnership or network of providers who work in a concerted and coordinated effort on a common goal for clients and their families to improve health, mental health, and social and/or family outcomes [132]. It involves the interaction of two or more disciplines or professions who work collaboratively with the client on an identified issue [133]. Providers come together to discuss and address the same client problem from different lenses, which can ultimately produce more inventive and effective solutions [134]. The client/patient is not excluded from the process; rather, shared decision making by all team members advances the goal of improving client/patient outcome(s) [132].

Interprofessional collaborations have been touted for multiple reasons. Positive outcomes have been demonstrated on individual and organizational levels. For example, on the client level, reduced mortality, increased safety and satisfaction, and improved health outcomes and quality of life have been demonstrated [135; 136; 137]. Practitioners also experience benefits, including increased job satisfaction, staff retention, improved working relationships, and more innovative solutions to problems [135; 137; 138].

There is a difference between the traditional model of professional ethics and interprofessional ethics [139]. The traditional model revolves around a single profession's unique code of ethics, which addresses the specific profession's roles, expertise, core values, and ethical behaviors. Each professional's code of ethics demands the practitioner's loyalty and commitment to the values, specialty, and expertise [139]. On the other hand, interprofessional ethics emphasizes the relationship and interactions of practitioners from different professions and the unique ethical issues that emerge from working with a diverse team (e.g., interpersonal conflict, misuse of power, respect) [139]. Practitioners in an interpro-

fessional setting should engage in collective interprofessional ethics work, which is defined as "the effort cooperating professionals put into collectively developing themselves as good practitioners, collectively seeing ethical aspects of situations, collectively working out the right course of action, and collectively justifying who they are and what they do" [140].

CONCLUSION

The application of ethical theories and ethical decision making is challenging. Without a background of knowledge and understanding, counselors will struggle to make sound decisions about ethical problems and be unable to help clients and families in their decision making. Although every situation differs, decision making based upon ethical theories can provide a useful means for solving problems related to client situations. Hopefully, as a result of this course, you feel more prepared and confident in facing future ethical decision-making situations.

RESOURCES

Counselors play an important role in advocacy and education. To be more effective, counseling professionals may require additional resources.

American Association for Marriage and Family Therapy
https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx

American Counseling Association Code of Ethics
https://www.counseling.org/Resources/aca-code-of-ethics.pdf

APA Ethics Office
https://www.apa.org/ethics

Center for the Study of Ethics in the Professions
This center was established in 1976 for the purpose of promoting education and scholarship relating to the professions.
https://ethics.iit.edu

Ethics Resource Center
The Ethics Resource Center aims to strengthen ethical leadership worldwide by providing leading-edge expertise and services through research, education and partnerships. Although this may not be completely targeted to counselors, there are some resources that may be appropriate.
https://www.ethics.org

Ethics Updates
Ethics Updates is designed primarily to be used by ethics instructors and their students. It is intended to provide updates on current literature, both popular and professional, that relates to ethics.
http://ethicsupdates.net

NASW Code of Ethics
A code of ethics for social workers that may be used as a resource for counselors.
https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

National Board for Certified Counselors: Code of Ethics and Provision of Distance Professional Services
https://www.nbcc.org/Ethics

W. Maurice Young Centre for Applied Ethics
https://ethics.ubc.ca

APPENDIX: THE ACA CODE OF ETHICS

This appendix contains the entirety of the ACA Code of Ethics. It is reprinted with permission from the American Counseling Association.

SECTION A: THE COUNSELING RELATIONSHIP

Introduction

Counselors facilitate client growth and development in ways that foster the interest and welfare of clients and promote formation of healthy relationships. Trust is the cornerstone of the counseling relationship, and counselors have the responsibility to respect and safeguard the client's right to privacy and confidentiality. Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve. Counselors also explore their own cultural identities and how these affect their values and beliefs about the counseling process. Additionally, counselors are encouraged to contribute to society by devoting a portion of their professional activities for little or no financial return (*pro bono publico*).

A.1. Client Welfare

A.1.a. Primary Responsibility

The primary responsibility of counselors is to respect the dignity and promote the welfare of clients.

A.1.b. Records and Documentation

Counselors create, safeguard, and maintain documentation necessary for rendering professional services. Regardless of the medium, counselors include sufficient and timely documentation to facilitate the delivery and continuity of services. Counselors take reasonable steps to ensure that documentation accurately reflects client progress and services provided. If amendments are made to records and documentation, counselors take steps to properly note the amendments according to agency or institutional policies.

A.1.c. Counseling Plans

Counselors and their clients work jointly in devising counseling plans that offer reasonable promise of success and are consistent with the abilities, temperament, developmental level, and circumstances of clients. Counselors and clients

regularly review and revise counseling plans to assess their continued viability and effectiveness, respecting clients' freedom of choice.

A.1.d. Support Network Involvement

Counselors recognize that support networks hold various meanings in the lives of clients and consider enlisting the support, understanding, and involvement of others (e.g., religious/spiritual/community leaders, family members, friends) as positive resources, when appropriate, with client consent.

A.2. Informed Consent in the Counseling Relationship

A.2.a. Informed Consent

Clients have the freedom to choose whether to enter into or remain in a counseling relationship and need adequate information about the counseling process and the counselor. Counselors have an obligation to review in writing and verbally with clients the rights and responsibilities of both counselors and clients. Informed consent is an ongoing part of the counseling process, and counselors appropriately document discussions of informed consent throughout the counseling relationship.

A.2.b. Types of Information Needed

Counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor's qualifications, credentials, relevant experience, and approach to counseling; continuation of services upon the incapacitation or death of the counselor; the role of technology; and other pertinent information. Counselors take steps to ensure that clients understand the implications of diagnosis and the intended use of tests and reports. Additionally, counselors inform clients about fees and billing arrangements, including procedures for nonpayment of fees. Clients have the right to confidentiality and to be provided with an explanation of its limits (including how supervisors and/or treatment or interdisciplinary team professionals are involved), to obtain clear information about their records, to participate in the ongoing counseling plans, and to refuse any services or modality changes and to be advised of the consequences of such refusal.

A.2.c. Developmental and Cultural Sensitivity

Counselors communicate information in ways that are both developmentally and culturally appropriate. Counselors use clear and understandable language when discussing issues related to informed consent. When clients have difficulty understanding the language that counselors use, counselors provide necessary services (e.g., arranging for a qualified interpreter or translator) to ensure comprehension by clients. In collaboration with clients, counselors consider cultural implications of informed consent procedures and, where possible, counselors adjust their practices accordingly.

A.2.d. Inability to Give Consent

When counseling minors, incapacitated adults, or other persons unable to give voluntary consent, counselors seek the assent of clients to services and include them in decision making as appropriate. Counselors recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf.

A.2.e. Mandated Clients

Counselors discuss the required limitations to confidentiality when working with clients who have been mandated for counseling services. Counselors also explain what type of information and with whom that information is shared prior to the beginning of counseling. The client may choose to refuse services. In this case, counselors will, to the best of their ability, discuss with the client the potential consequences of refusing counseling services.

A.3. Clients Served by Others

When counselors learn that their clients are in a professional relationship with other mental health professionals, they request release from clients to inform the other professionals and strive to establish positive and collaborative professional relationships.

A.4. Avoiding Harm and Imposing Values

A.4.a. Avoiding Harm

Counselors act to avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm.

A.4.b. Personal Values

Counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature.

A.5. Prohibited Noncounseling Roles and Relationships

A.5.a. Sexual and/or Romantic Relationships Prohibited

Sexual and/or romantic counselor-client interactions or relationships with current clients, their romantic partners, or their family members are prohibited. This prohibition applies to both in-person and electronic interactions or relationships.

A.5.b. Previous Sexual and/or Romantic Relationships

Counselors are prohibited from engaging in counseling relationships with persons with whom they have had a previous sexual and/or romantic relationship.

A.5.c. Sexual and/or Romantic Relationships with Former Clients

Sexual and/or romantic counselor-client interactions or relationships with former clients, their romantic partners, or their family members are prohibited for a period of 5 years following the last professional contact. This prohibition applies to both in-person and electronic interactions or relationships. Counselors, before engaging in sexual and/or romantic interactions or relationships with former clients, their romantic partners, or their family members, demonstrate forethought and document (in written form) whether the interaction or relationship can be viewed as exploitive in any way and/or whether there is still potential to harm the former client; in cases of potential exploitation and/or harm, the counselor avoids entering into such an interaction or relationship.

A.5.d. Friends or Family Members

Counselors are prohibited from engaging in counseling relationships with friends or family members with whom they have an inability to remain objective.

A.5.e. Personal Virtual Relationships with Current Clients

Counselors are prohibited from engaging in a personal virtual relationship with individuals with whom they have a current counseling relationship (e.g., through social and other media).

A.6. Managing and Maintaining Boundaries and Professional Relationships

A.6.a. Previous Relationships

Counselors consider the risks and benefits of accepting as clients those with whom they have had a previous relationship. These potential clients may include individuals with whom the counselor has had a casual, distant, or past relationship. Examples include mutual or past membership in a professional association, organization, or community. When counselors accept these clients, they take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs.

A.6.b. Extending Counseling Boundaries

Counselors consider the risks and benefits of extending current counseling relationships beyond conventional parameters. Examples include attending a client's formal ceremony (e.g., a wedding/commitment ceremony or graduation), purchasing a service or product provided by a client (excepting unrestricted bartering), and visiting a client's ill family member in the hospital. In extending these boundaries, counselor stake appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no harm occurs.

A.6.c. Documenting Boundary Extensions

If counselors extend boundaries as described in A.6.a. and A.6.b., they must officially document, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. When unintentional harm occurs to the client or former client, or to an individual significantly involved with the client or former client, the counselor must show evidence of an attempt to remedy such harm.

A.6.d. Role Changes in the Professional Relationship

When counselors change a role from the original or most recent contracted relationship, they obtain informed consent from the client and explain the client's right to refuse services related to the change. Examples of role changes include, but are not limited to:

1. Changing from individual to relationship or family counseling, or vice versa;
2. Changing from an evaluative role to a therapeutic role, or vice versa; and
3. Changing from a counselor to a mediator role, or vice versa.

Clients must be fully informed of any anticipated consequences (e.g., financial, legal, personal, therapeutic) of counselor role changes.

A.6.e. Nonprofessional Interactions or Relationships (Other Than Sexual or Romantic Interactions or Relationships)

Counselors avoid entering into non-professional relationships with former clients, their romantic partners, or their family members when the interaction is potentially harmful to the client. This applies to both in-person and electronic interactions or relationships.

A.7. Roles and Relationships at Individual, Group, Institutional, and Societal Levels

A.7.a. Advocacy

When appropriate, counselors advocate at individual, group, institutional, and societal levels to address potential barriers and obstacles that inhibit access and/or the growth and development of clients.

A.7.b. Confidentiality and Advocacy

Counselors obtain client consent prior to engaging in advocacy efforts on behalf of an identifiable client to improve the provision of services and to work toward removal of systemic barriers or obstacles that inhibit client access, growth, and development.

A.8. Multiple Clients

When a counselor agrees to provide counseling services to two or more persons who have a relationship, the counselor clarifies at the outset which person or persons are clients and the nature of the relationships the counselor will have with each involved person. If it becomes apparent that the counselor may be called upon to perform potentially conflicting roles, the counselor will clarify, adjust, or withdraw from roles appropriately.

A.9. Group Work

A.9.a. Screening

Counselors screen prospective group counseling/therapy participants. To the extent possible, counselors select members whose needs and goals are compatible with the goals of the group, who will not impede the group process, and whose well-being will not be jeopardized by the group experience.

A.9.b. Protecting Clients

In a group setting, counselors take reasonable precautions to protect clients from physical, emotional, or psychological trauma.

A.10. Fees and Business Practices

A.10.a. Self-Referral

Counselors working in an organization (e.g., school, agency, institution) that provides counseling services do not refer clients to their private practice unless the policies of a particular organization make explicit provisions for self-referrals. In such instances, the clients must be informed of other options open to them should they seek private counseling services.

A.10.b. Unacceptable Business Practices

Counselors do not participate in fee splitting, nor do they give or receive commissions, rebates, or any other form of remuneration when referring clients for professional services.

A.10.c. Establishing Fees

In establishing fees for professional counseling services, counselors consider the financial status of clients and locality. If a counselor's usual fees create undue hardship for the client, the counselor may adjust fees, when legally permissible, or assist the client in locating comparable, affordable services.

A.10.d. Nonpayment of Fees

If counselors intend to use collection agencies or take legal measures to collect fees from clients who do not pay for services as agreed upon, they include such information in their informed consent documents and also inform clients in a timely fashion of intended actions and offer clients the opportunity to make payment.

A.10.e. Bartering

Counselors may barter only if the bartering does not result in exploitation or harm, if the client requests it, and if such arrangements are an accepted practice among professionals in the community. Counselors consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract.

A.10.f. Receiving Gifts

Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and gratitude. When determining whether to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift.

A.11. Termination and Referral

A.11.a. Competence within Termination and Referral

If counselors lack the competence to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives. If clients decline the suggested referrals, counselors discontinue the relationship.

A.11.b. Values within Termination and Referral

Counselors refrain from referring prospective and current clients based solely on the counselor's personally held values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature.

A.11.c. Appropriate Termination

Counselors terminate a counseling relationship when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit, or is being harmed by continued counseling. Counselors may terminate counseling when in jeopardy of harm by the client or by another person with whom the client has a relationship, or when clients do not pay fees as agreed upon. Counselors provide pre termination counseling and recommend other service providers when necessary.

A.11.d. Appropriate Transfer of Services

When counselors transfer or refer clients to other practitioners, they ensure that appropriate clinical and administrative processes are completed and open communication is maintained with both clients and practitioners.

A.12. Abandonment and Client Neglect

Counselors do not abandon or neglect clients in counseling. Counselors assist in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacations, illness, and following termination.

SECTION B: CONFIDENTIALITY AND PRIVACY

Introduction

Counselors recognize that trust is a cornerstone of the counseling relationship. Counselors aspire to earn the trust of clients by creating an ongoing partnership, establishing and upholding appropriate boundaries, and maintaining confidentiality. Counselors communicate the parameters of confidentiality in a culturally competent manner.

B.1. Respecting Client Rights

B.1.a. Multicultural/Diversity Considerations

Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared.

B.1.b. Respect for Privacy

Counselors respect the privacy of prospective and current clients. Counselors request private information from clients only when it is beneficial to the counseling process.

B.1.c. Respect for Confidentiality

Counselors protect the confidential information of prospective and current clients. Counselors disclose information only with appropriate consent or with sound legal or ethical justification.

B.1.d. Explanation of Limitations

At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify situations in which confidentiality must be breached.

B.2. Exceptions

B.2.a. Serious and Foreseeable Harm and Legal Requirements

The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end-of-life issues.

B.2.b. Confidentiality Regarding End-of-Life Decisions

Counselors who provide services to terminally ill individuals who are considering hastening their own deaths have the option to maintain confidentiality, depending on applicable laws and the specific circumstances of the situation and after seeking consultation or supervision from appropriate professional and legal parties.

B.2.c. Contagious, Life-Threatening Diseases

When clients disclose that they have a disease commonly known to be both communicable and life threatening, counselors may be justified in disclosing information to identifiable third parties, if the parties are known to be at serious and foreseeable risk of contracting the disease. Prior to making a disclosure, counselors assess the intent of clients to inform the third parties about their disease or to engage in any behaviors that may be harmful to an identifiable third party. Counselors adhere to relevant state laws concerning disclosure about disease status.

B.2.d. Court-Ordered Disclosure

When ordered by a court to release confidential or privileged information without a client's permission, counselors seek to obtain written, informed consent from the client or take steps to prohibit the disclosure or have it limited as narrowly as possible because of potential harm to the client or counseling relationship.

B.2.e. Minimal Disclosure

To the extent possible, clients are informed before confidential information is disclosed and are involved in the disclosure decision-making process. When circumstances require the disclosure of confidential information, only essential information is revealed.

B.3. Information Shared with Others

B.3.a. Subordinates

Counselors make every effort to ensure that privacy and confidentiality of clients are maintained by subordinates, including employees, supervisees, students, clerical assistants, and volunteers.

B.3.b. Interdisciplinary Teams

When services provided to the client involve participation by an interdisciplinary or treatment team, the client will be informed of the team's existence and composition, information being shared, and the purposes of sharing such information.

B.3.c. Confidential Settings

Counselors discuss confidential information only in settings in which they can reasonably ensure client privacy.

B.3.d. Third-Party Payers

Counselors disclose information to third-party payers only when clients have authorized such disclosure.

B.3.e. Transmitting Confidential Information

Counselors take precautions to ensure the confidentiality of all information transmitted through the use of any medium.

B.3.f. Deceased Clients

Counselors protect the confidentiality of deceased clients, consistent with legal requirements and the documented preferences of the client.

B.4. Groups and Families

B.4.a. Group Work

In group work, counselors clearly explain the importance and parameters of confidentiality for the specific group.

B.4.b. Couples and Family Counseling

In couples and family counseling, counselors clearly define who is considered "the client" and discuss expectations and limitations of confidentiality. Counselors seek agreement and document in writing such agreement among all involved parties regarding the confidentiality of information. In the absence of an agreement to the contrary, the couple or family is considered to be the client.

B.5. Clients Lacking Capacity to Give Informed Consent

B.5.a. Responsibility to Clients

When counseling minor clients or adult clients who lack the capacity to give voluntary, informed consent, counselors protect the confidentiality of information received—in any medium—in the counseling relationship as specified by federal and state laws, written policies, and applicable ethical standards.

B.5.b. Responsibility to Parents and Legal Guardians

Counselors inform parents and legal guardians about the role of counselors and the confidential nature of the counseling relationship, consistent with current legal and custodial arrangements. Counselors are sensitive to the cultural diversity of families and respect the inherent rights and responsibilities of parents/guardians regarding the welfare of their children/charges according to law. Counselors work to establish, as appropriate, collaborative relationships with parents/guardians to best serve clients.

B.5.c. Release of Confidential Information

When counseling minor clients or adult clients who lack the capacity to give voluntary consent to release confidential information, counselors seek permission from an appropriate third party to disclose information. In such instances, counselors inform clients consistent with their level of understanding and take appropriate measures to safeguard client confidentiality.

B.6. Records and Documentation

B.6.a. Creating and Maintaining Records and Documentation

Counselors create and maintain records and documentation necessary for rendering professional services.

B.6.b. Confidentiality of Records and Documentation

Counselors ensure that records and documentation kept in any medium are secure and that only authorized persons have access to them.

B.6.c. Permission to Record

Counselors obtain permission from clients prior to recording sessions through electronic or other means.

B.6.d. Permission to Observe

Counselors obtain permission from clients prior to allowing any person to observe counseling sessions, review session transcripts, or view recordings of sessions with supervisors, faculty, peers, or others within the training environment.

B.6.e. Client Access

Counselors provide reasonable access to records and copies of records when requested by competent clients. Counselors limit the access of clients to their records, or portions of their records, only when there is compelling evidence that such access would cause harm to the client. Counselors document the request of clients and the rationale for withholding some or all of the records in the files of clients. In situations involving multiple clients, counselors provide individual clients with only those parts of records that relate directly to them and do not include confidential information related to any other client.

B.6.f. Assistance with Records

When clients request access to their records, counselors provide assistance and consultation in interpreting counseling records.

B.6.g. Disclosure or Transfer

Unless exceptions to confidentiality exist, counselors obtain written permission from clients to disclose or transfer records to legitimate third parties. Steps are taken to ensure that receivers of counseling records are sensitive to their confidential nature.

B.6.h. Storage and Disposal After Termination

Counselors store records following termination of services to ensure reasonable future access, maintain records in accordance with federal and state laws and statutes such as licensure laws and policies governing records, and dispose of client records and other sensitive materials in a manner that protects client confidentiality. Counselors apply careful discretion and deliberation before destroying records that may be needed by a court of law, such as notes on child abuse, suicide, sexual harassment, or violence.

B.6.i. Reasonable Precautions

Counselors take reasonable precautions to protect client confidentiality in the event of the counselor's termination of practice, incapacity, or death and appoint a records custodian when identified as appropriate.

B.7. Case Consultation

B.7.a. Respect for Privacy

Information shared in a consulting relationship is discussed for professional purposes only. Written and oral reports present only data germane to the purposes of the consultation, and every effort is made to protect client identity and to avoid undue invasion of privacy.

B.7.b. Disclosure of Confidential Information

When consulting with colleagues, counselors do not disclose confidential information that reasonably could lead to the identification of a client or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided. They disclose information only to the extent necessary to achieve the purposes of the consultation.

SECTION C: PROFESSIONAL RESPONSIBILITY

Introduction

Counselors aspire to open, honest, and accurate communication in dealing with the public and other professionals. Counselors facilitate access to counseling services, and they practice in a nondiscriminatory manner within the boundaries of professional and personal competence; they also have a responsibility to abide by the *ACA Code of Ethics*. Counselors actively participate in local, state, and national associations that foster the development and improvement of counseling. Counselors are expected to advocate to promote changes at the individual, group, institutional, and societal levels that improve the quality of life for individuals and groups and remove potential barriers to the provision or access of appropriate services being offered. Counselors have a responsibility to the public to engage in counseling practices that are based on rigorous research methodologies. Counselors are encouraged to contribute to society by devoting a portion of their professional activity to services for which there is little or no financial return (*probono publico*). In addition, counselors engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities.

C.1. Knowledge of and Compliance with Standards

Counselors have a responsibility to read, understand, and follow the *ACA Code of Ethics* and adhere to applicable laws and regulations.

C.2. Professional Competence

C.2.a. Boundaries of Competence

Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population.

C.2.b. New Specialty Areas of Practice

Counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and protect others from possible harm.

C.2.c. Qualified for Employment

Counselors accept employment only for positions for which they are qualified given their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Counselors hire for professional counseling positions only individuals who are qualified and competent for those positions.

C.2.d. Monitor Effectiveness

Counselors continually monitor their effectiveness as professionals and take steps to improve when necessary. Counselors take reasonable steps to seek peer supervision to evaluate their efficacy as counselors.

C.2.e. Consultations on Ethical Obligations

Counselors take reasonable steps to consult with other counselors, the ACA Ethics and Professional Standards Department, or related professionals when they have questions regarding their ethical obligations or professional practice.

C.2.f. Continuing Education

Counselors recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity. Counselors maintain their competence in the skills they use, are open to new procedures, and remain informed regarding best practices for working with diverse populations.

C.2.g. Impairment

Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients.

C.2.h. Counselor Incapacitation, Death, Retirement, or Termination of Practice

Counselors prepare a plan for the transfer of clients and the dissemination of records to an identified colleague or records custodian in the case of the counselor's incapacitation, death, retirement, or termination of practice.

C.3. Advertising and Soliciting Clients

C.3.a. Accurate Advertising

When advertising or otherwise representing their services to the public, counselors identify their credentials in an accurate manner that is not false, misleading, deceptive, or fraudulent.

C.3.b. Testimonials

Counselors who use testimonials do not solicit them from current clients, former clients, or any other persons who may be vulnerable to undue influence. Counselors discuss with clients the implications of and obtain permission for the use of any testimonial.

C.3.c. Statements by Others

When feasible, counselors make reasonable efforts to ensure that statements made by others about them or about the counseling profession are accurate.

C.3.d. Recruiting Through Employment

Counselors do not use their places of employment or institutional affiliation to recruit clients, supervisors, or consultees for their private practices.

C.3.e. Products and Training Advertisements

Counselors who develop products related to their profession or conduct workshops or training events ensure that the advertisements concerning these products or events are accurate and disclose adequate information for consumers to make informed choices.

C.3.f. Promoting to Those Served

Counselors do not use counseling, teaching, training, or supervisory relationships to promote their products or training events in a manner that is deceptive or would exert undue influence on individuals who may be vulnerable. However, counselor educators may adopt textbooks they have authored for instructional purposes.

C.4. Professional Qualifications

C.4.a. Accurate Representation

Counselors claim or imply only professional qualifications actually completed and correct any known misrepresentations of their qualifications by others. Counselors truthfully represent the qualifications of their professional colleagues. Counselors clearly distinguish between paid and volunteer work experience and accurately describe their continuing education and specialized training.

C.4.b. Credentials

Counselors claim only licenses or certifications that are current and in good standing.

C.4.c. Educational Degrees

Counselors clearly differentiate between earned and honorary degrees.

C.4.d. Implying Doctoral-Level Competence

Counselors clearly state their highest earned degree in counseling or a closely related field. Counselors do not imply doctoral-level competence when possessing a master's degree in counseling or a related field by referring to themselves as "Dr." in a counseling context when their doctorate is not in counseling or a related field. Counselors do not use "ABD" (all but dissertation) or other such terms to imply competency.

C.4.e. Accreditation Status

Counselors accurately represent the accreditation status of their degree program and college/university.

C.4.f. Professional Membership

Counselors clearly differentiate between current, active memberships and former memberships in associations. Members of ACA must clearly differentiate between professional membership, which implies the possession of at least a master's degree in counseling, and regular membership, which is open to individuals whose interests and activities are consistent with those of ACA but are not qualified for professional membership.

C.5. Nondiscrimination

Counselors do not condone or engage in discrimination against prospective or current clients, students, employees, supervisees, or research participants based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital/partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law.

C.6. Public Responsibility

C.6.a. Sexual Harassment

Counselors do not engage in or condone sexual harassment. Sexual harassment can consist of a single intense or severe act, or multiple persistent or pervasive acts.

C.6.b. Reports to Third Parties

Counselors are accurate, honest, and objective in reporting their professional activities and judgments to appropriate third parties, including courts, health insurance companies, those who are the recipients of evaluation reports, and others.

C.6.c. Media Presentations

When counselors provide advice or comment by means of public lectures, demonstrations, radio or television programs, recordings, technology-based applications, printed articles, mailed material, or other media, they take reasonable precautions to ensure that:

1. The statements are based on appropriate professional counseling literature and practice,
2. The statements are otherwise consistent with the *ACA Code of Ethics*, and
3. The recipients of the information are not encouraged to infer that a professional counseling relationship has been established.

C.6.d. Exploitation of Others

Counselors do not exploit others in their professional relationships.

C.6.e. Contributing to the Public Good (*Pro Bono Publico*)

Counselors make a reasonable effort to provide services to the public for which there is little or no financial return (e.g., speaking to groups, sharing professional information, offering reduced fees).

C.7. Treatment Modalities

C.7.a. Scientific Basis for Treatment

When providing services, counselors use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation.

C.7.b. Development and Innovation

When counselors use developing or innovative techniques/procedures/modalities, they explain the potential risks, benefits, and ethical considerations of using such techniques/procedures/modalities. Counselors work to minimize any potential risks or harm when using these techniques/procedures/modalities.

C.7.c. Harmful Practices

Counselors do not use techniques/procedures/modalities when substantial evidence suggests harm, even if such services are requested.

C.8. Responsibility to Other Professionals

C.8.a. Personal Public Statements

When making personal statements in a public context, counselors clarify that they are speaking from their personal perspectives and that they are not speaking on behalf of all counselors or the profession.

SECTION D: RELATIONSHIPS WITH OTHER PROFESSIONALS

Introduction

Professional counselors recognize that the quality of their interactions with colleagues can influence the quality of services provided to clients. They work to become knowledgeable about colleagues within and outside the field of counseling. Counselors develop positive working relationships and systems of communication with colleagues to enhance services to clients.

D.1. Relationships with Colleagues, Employers, and Employees

D.1.a. Different Approaches

Counselors are respectful of approaches that are grounded in theory and/or have an empirical or scientific foundation but may differ from their own. Counselors acknowledge the expertise of other professional groups and are respectful of their practices.

D.1.b. Forming Relationships

Counselors work to develop and strengthen relationships with colleagues from other disciplines to best serve clients.

D.1.c. Interdisciplinary Teamwork

Counselors who are members of interdisciplinary teams delivering multifaceted services to clients remain focused on how to best serve clients. They participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the counseling profession and those of colleagues from other disciplines.

D.1.d. Establishing Professional and Ethical Obligations

Counselors who are members of interdisciplinary teams work together with team members to clarify professional and ethical obligations of the team as a whole and of its individual members. When a team decision raises ethical concerns, counselors first attempt to resolve the concern within the team. If they cannot reach resolution among team members, counselors pursue other avenues to address their concerns consistent with client well-being.

D.1.e. Confidentiality

When counselors are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, they clarify role expectations and the parameters of confidentiality with their colleagues.

D.1.f. Personnel Selection and Assignment

When counselors are in a position requiring personnel selection and/or assigning of responsibilities to others, they select competent staff and assign responsibilities compatible with their skills and experiences.

D.1.g. Employer Policies

The acceptance of employment in an agency or institution implies that counselors are in agreement with its general policies and principles. Counselors strive to reach agreement with employers regarding acceptable standards of client care and professional conduct that allow for changes in institutional policy conducive to the growth and development of clients.

D.1.h. Negative Conditions

Counselors alert their employers of inappropriate policies and practices. They attempt to effect changes in such policies or procedures through constructive action within the organization. When such policies are potentially disruptive or damaging to clients or may limit the effectiveness of services provided and change cannot be affected, counselors take appropriate further action. Such action may include referral to appropriate certification, accreditation, or state licensure organizations, or voluntary termination of employment.

D.1.i. Protection From Punitive Action

Counselors do not harass a colleague or employee or dismiss an employee who has acted in a responsible and ethical manner to expose inappropriate employer policies or practices.

D.2. Provision of Consultation Services

D.2.a. Consultant Competency

Counselors take reasonable steps to ensure that they have the appropriate resources and competencies when providing consultation services. Counselors provide appropriate referral resources when requested or needed.

D.2.b. Informed Consent in Formal Consultation

When providing formal consultation services, counselors have an obligation to review, in writing and verbally, the rights and responsibilities of both counselors and consultees. Counselors use clear and understandable language to inform all parties involved about the purpose of the services to be provided, relevant costs, potential risks and benefits, and the limits of confidentiality.

SECTION E: EVALUATION, ASSESSMENT, AND INTERPRETATION

Introduction

Counselors use assessment as one component of the counseling process, taking into account the clients' personal and cultural context. Counselors promote the well-being of individual clients or groups of clients by developing and using appropriate educational, mental health, psychological, and career assessments.

E.1. General

E.1.a. Assessment

The primary purpose of educational, mental health, psychological, and career assessment is to gather information regarding the client for a variety of purposes, including, but not limited to, client decision making, treatment planning, and forensic proceedings. Assessment may include both qualitative and quantitative methodologies.

E.1.b. Client Welfare

Counselors do not misuse assessment results and interpretations, and they take reasonable steps to prevent others from misusing the information provided. They respect the client's right to know the results, the interpretations made, and the bases for counselors' conclusions and recommendations.

E.2. Competence to Use and Interpret Assessment Instruments

E.2.a. Limits of Competence

Counselors use only those testing and assessment services for which they have been trained and are competent. Counselors using technology-assisted test interpretations are trained in the construct being measured and the specific instrument being used prior to using its technology-based application. Counselors take reasonable measures to ensure the proper use of assessment techniques by persons under their supervision.

E.2.b. Appropriate Use

Counselors are responsible for the appropriate application, scoring, interpretation, and use of assessment instruments relevant to the needs of the client, whether they score and interpret such assessments themselves or use technology or other services.

E.2.c. Decisions Based on Results

Counselors responsible for decisions involving individuals or policies that are based on assessment results have a thorough understanding of psychometrics.

E.3. Informed Consent in Assessment

E.3.a. Explanation to Clients

Prior to assessment, counselors explain the nature and purposes of assessment and the specific use of results by potential recipients. The explanation will be given in terms and language that the client (or other legally authorized person on behalf of the client) can understand.

E.3.b. Recipients of Results

Counselors consider the client's and/or examinee's welfare, explicit understandings, and prior agreements in determining who receives the assessment results. Counselors include accurate and appropriate interpretations with any release of individual or group assessment results.

E.4. Release of Data to Qualified Personnel

Counselors release assessment data in which the client is identified only with the consent of the client or the client's legal representative. Such data are released only to persons recognized by counselors as qualified to interpret the data.

E.5. Diagnosis of Mental Disorders

E.5.a. Proper Diagnosis

Counselors take special care to provide proper diagnosis of mental disorders. Assessment techniques (including personal interviews) used to determine client care (e.g., locus of treatment, type of treatment, recommended follow-up) are carefully selected and appropriately used.

E.5.b. Cultural Sensitivity

Counselors recognize that culture affects the manner in which clients' problems are defined and experienced. Clients' socioeconomic and cultural experiences are considered when diagnosing mental disorders.

E.5.c. Historical and Social Prejudices in the Diagnosis of Pathology

Counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and strive to become aware of and address such biases in themselves or others.

E.5.d. Refraining From Diagnosis

Counselors may refrain from making and/or reporting a diagnosis if they believe that it would cause harm to the client or others. Counselors carefully consider both the positive and negative implications of a diagnosis.

E.6. Instrument Selection

E.6.a. Appropriateness of Instruments

Counselors carefully consider the validity, reliability, psychometric limitations, and appropriateness of instruments when selecting assessments and, when possible, use multiple forms of assessment, data, and/or instruments in forming conclusions, diagnoses, or recommendations.

E.6.b. Referral Information

If a client is referred to a third party for assessment, the counselor provides specific referral questions and sufficient objective data about the client to ensure that appropriate assessment instruments are utilized.

E.7. Conditions of Assessment Administration

E.7.a. Administration Conditions

Counselors administer assessments under the same conditions that were established in their standardization. When assessments are not administered under standard conditions, as may be necessary to accommodate clients with disabilities, or when unusual behavior or irregularities occur during the administration, those conditions are noted in interpretation, and the results may be designated as invalid or of questionable validity.

E.7.b. Provision of Favorable Conditions

Counselors provide an appropriate environment for the administration of assessments (e.g., privacy, comfort, freedom from distraction).

E.7.c. Technological Administration

Counselors ensure that technologically administered assessments function properly and provide clients with accurate results.

E.7.d. Unsupervised Assessments

Unless the assessment instrument is designed, intended, and validated for self-administration and/or scoring, counselors do not permit unsupervised use.

E.8. Multicultural Issues/Diversity in Assessment

Counselors select and use with caution assessment techniques normed on populations other than that of the client. Counselors recognize the effects of age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on test administration and interpretation, and they place test results in proper perspective with other relevant factors.

E.9. Scoring and Interpretation of Assessments

E.9.a. Reporting

When counselors report assessment results, they consider the client's personal and cultural background, the level of the client's understanding of the results, and the impact of the results on the client. In reporting assessment results, counselors indicate reservations that exist regarding validity or reliability due to circumstances of the assessment or inappropriateness of the norms for the person tested.

E.9.b. Instruments with Insufficient Empirical Data

Counselors exercise caution when interpreting the results of instruments not having sufficient empirical data to support respondent results. The specific purposes for the use of such instruments are stated explicitly to the examinee. Counselors qualify any conclusions, diagnoses, or recommendations made that are based on assessments or instruments with questionable validity or reliability.

E.9.c. Assessment Services

Counselors who provide assessment, scoring, and interpretation services to support the assessment process confirm the validity of such interpretations. They accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use. At all times, counselors maintain their ethical responsibility to those being assessed.

E.10. Assessment Security

Counselors maintain the integrity and security of tests and assessments consistent with legal and contractual obliga-

tions. Counselors do not appropriate, reproduce, or modify published assessments or parts thereof without acknowledgment and permission from the publisher.

E.11. Obsolete Assessment and Outdated Results

Counselors do not use data or results from assessments that are obsolete or outdated for the current purpose (e.g., noncurrent versions of assessments/instruments). Counselors make every effort to prevent the misuse of obsolete measures and assessment data by others.

E.12. Assessment Construction

Counselors use established scientific procedures, relevant standards, and current professional knowledge for assessment design in the development, publication, and utilization of assessment techniques.

E.13. Forensic Evaluation: Evaluation for Legal Proceedings

E.13.a. Primary Obligations

When providing forensic evaluations, the primary obligation of counselors is to produce objective findings that can be substantiated based on information and techniques appropriate to the evaluation, which may include examination of the individual and/or review of records. Counselors form professional opinions based on their professional knowledge and expertise that can be supported by the data gathered in evaluations. Counselors define the limits of their reports or testimony, especially when an examination of the individual has not been conducted.

E.13.b. Consent for Evaluation

Individuals being evaluated are informed in writing that the relationship is for the purposes of an evaluation and is not therapeutic in nature, and entities or individuals who will receive the evaluation report are identified. Counselors who perform forensic evaluations obtain written consent from those being evaluated or from their legal representative unless a court orders evaluations to be conducted without the written consent of the individuals being evaluated. When children or adults who lack the capacity to give voluntary consent are being evaluated, informed written consent is obtained from a parent or guardian.

E.13.c. Client Evaluation Prohibited

Counselors do not evaluate current or former clients, clients' romantic partners, or clients' family members for forensic purposes. Counselors do not counsel individuals they are evaluating.

E.13.d. Avoid Potentially Harmful Relationships

Counselors who provide forensic evaluations avoid potentially harmful professional or personal relationships with family members, romantic partners, and close friends of individuals they are evaluating or have evaluated in the past.

SECTION F: SUPERVISION, TRAINING, AND TEACHING

Introduction

Counselor supervisors, trainers, and educators aspire to foster meaningful and respectful professional relationships and to maintain appropriate boundaries with supervisees and students in both face-to-face and electronic formats. They have theoretical and pedagogical foundations for their work; have knowledge of supervision models; and aim to be fair, accurate, and honest in their assessments of counselors, students, and supervisees.

F.1. Counselor Supervision and Client Welfare

F.1.a. Client Welfare

A primary obligation of counseling supervisors is to monitor the services provided by supervisees. Counseling supervisors monitor client welfare and supervisee performance and professional development. To fulfill these obligations, supervisors meet regularly with supervisees to review the supervisees' work and help them become prepared to serve a range of diverse clients. Supervisees have a responsibility to understand and follow the ACA *Code of Ethics*.

F.1.b. Counselor Credentials

Counseling supervisors work to ensure that supervisees communicate their qualifications to render services to their clients.

F.1.c. Informed Consent and Client Rights

Supervisors make supervisees aware of client rights, including the protection of client privacy and confidentiality in the counseling relationship. Supervisees provide clients with professional disclosure information and inform them of how the supervision process influences the limits of confidentiality. Supervisees make clients aware of who will have access to records of the counseling relationship and how these records will be stored, transmitted, or otherwise reviewed.

F.2. Counselor Supervision Competence

F.2.a. Supervisor Preparation

Prior to offering supervision services, counselors are trained in supervision methods and techniques. Counselors who offer supervision services regularly pursue continuing education activities, including both counseling and supervision topics and skills.

F.2.b. Multicultural Issues/Diversity in Supervision

Counseling supervisors are aware of and address the role of multiculturalism/diversity in the supervisory relationship.

F.2.c. Online Supervision

When using technology in supervision, counselor supervisors are competent in the use of those technologies. Supervisors take the necessary precautions to protect the confidentiality of all information transmitted through any electronic means.

F.3. Supervisory Relationship

F.3.a. Extending Conventional Supervisory Relationships

Counseling supervisors clearly define and maintain ethical professional, personal, and social relationships with their supervisees. Supervisors consider the risks and benefits of extending current supervisory relationships in any form beyond conventional parameters. In extending these boundaries, supervisors take appropriate professional precautions to ensure that judgment is not impaired and that no harm occurs.

F.3.b. Sexual Relationships

Sexual or romantic interactions or relationships with current supervisees are prohibited. This prohibition applies to both in-person and electronic interactions or relationships.

F.3.c. Sexual Harassment

Counseling supervisors do not condone or subject supervisees to sexual harassment.

F.3.d. Friends or Family Members

Supervisors are prohibited from engaging in supervisory relationships with individuals with whom they have an inability to remain objective.

F.4. Supervisor Responsibilities

F.4.a. Informed Consent for Supervision

Supervisors are responsible for incorporating into their supervision the principles of informed consent and participation. Supervisors inform supervisees of the policies and procedures to which supervisors are to adhere and the mechanisms for due process appeal of individual supervisor actions. The issues unique to the use of distance supervision are to be included in the documentation as necessary.

F.4.b. Emergencies and Absences

Supervisors establish and communicate to supervisees procedures for contacting supervisors or, in their absence, alternative on-call supervisors to assist in handling crises.

F.4.c. Standards for Supervisees

Supervisors make their supervisees aware of professional and ethical standards and legal responsibilities.

F.4.d. Termination of the Supervisory Relationship

Supervisors or supervisees have the right to terminate the supervisory relationship with adequate notice. Reasons for considering termination are discussed, and both parties work to resolve differences. When termination is warranted, supervisors make appropriate referrals to possible alternative supervisors.

F.5. Student and Supervisee Responsibilities

F.5.a. Ethical Responsibilities

Students and supervisees have a responsibility to understand and follow the *ACA Code of Ethics*. Students and supervisees have the same obligation to clients as those required of professional counselors.

F.5.b. Impairment

Students and supervisees monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They notify their faculty and/or supervisors and seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work.

F.5.c. Professional Disclosure

Before providing counseling services, students and supervisees disclose their status as supervisees and explain how this status affects the limits of confidentiality. Supervisors ensure that clients are aware of the services rendered and the qualifications of the students and supervisees rendering those services. Students and supervisees obtain client permission before they use any information concerning the counseling relationship in the training process.

F.6. Counseling Supervision Evaluation, Remediation, and Endorsement

F.6.a. Evaluation

Supervisors document and provide supervisees with ongoing feedback regarding their performance and schedule periodic formal evaluative sessions throughout the supervisory relationship.

F.6.b. Gatekeeping and Remediation

Through initial and ongoing evaluation, supervisors are aware of supervisee limitations that might impede performance. Supervisors assist supervisees in securing remedial assistance when needed. They recommend dismissal from training programs, applied counseling settings, and state or voluntary professional credentialing processes when those supervisees are unable to demonstrate that they can provide competent professional services to a range of diverse clients. Supervisors seek consultation and document their decisions to dismiss or refer supervisees for assistance. They ensure that supervisees are aware of options available to them to address such decisions.

F.6.c. Counseling for Supervisees

If supervisees request counseling, the supervisor assists the supervisee in identifying appropriate services. Supervisors do not provide counseling services to supervisees. Supervisors address interpersonal competencies in terms of the impact

of these issues on clients, the supervisory relationship, and professional functioning.

F.6.d. Endorsements

Supervisors endorse supervisees for certification, licensure, employment, or completion of an academic or training program only when they believe that supervisees are qualified for the endorsement. Regardless of qualifications, supervisors do not endorse supervisees whom they believe to be impaired in any way that would interfere with the performance of the duties associated with the endorsement.

F.7. Responsibilities of Counselor Educators

F.7.a. Counselor Educators

Counselor educators who are responsible for developing, implementing, and supervising educational programs are skilled as teachers and practitioners. They are knowledgeable regarding the ethical, legal, and regulatory aspects of the profession; are skilled in applying that knowledge; and make students and supervisees aware of their responsibilities. Whether in traditional, hybrid, and/or online formats, counselor educators conduct counselor education and training programs in an ethical manner and serve as role models for professional behavior.

F.7.b. Counselor Educator Competence

Counselors who function as counselor educators or supervisors provide instruction within their areas of knowledge and competence and provide instruction based on current information and knowledge available in the profession. When using technology to deliver instruction, counselor educators develop competence in the use of the technology.

F.7.c. Infusing Multicultural Issues/Diversity

Counselor educators infuse material related to multiculturalism/diversity into all courses and workshops for the development of professional counselors.

F.7.d. Integration of Study and Practice

In traditional, hybrid, and/or online formats, counselor educators establish education and training programs that integrate academic study and supervised practice.

F.7.e. Teaching Ethics

Throughout the program, counselor educators ensure that students are aware of the ethical responsibilities and standards of the profession and the ethical responsibilities of students to the profession. Counselor educators infuse ethical considerations throughout the curriculum.

F.7.f. Use of Case Examples

The use of client, student, or supervisee information for the purposes of case examples in a lecture or classroom setting is permissible only when (a) the client, student, or supervisee has reviewed the material and agreed to its presentation or (b) the information has been sufficiently modified to obscure identity.

F.7.g. Student-to-Student Supervision and Instruction

When students function in the role of counselor educators or supervisors, they understand that they have the same ethical obligations as counselor educators, trainers, and supervisors. Counselor educators make every effort to ensure that the rights of students are not compromised when their peers lead experiential counseling activities in traditional, hybrid, and/or online formats (e.g., counseling groups, skills classes, clinical supervision).

F.7.h. Innovative Theories and Techniques

Counselor educators promote the use of techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation. When counselor educators discuss developing or innovative techniques/procedures/modalities, they explain the potential risks, benefits, and ethical considerations of using such techniques/procedures/modalities.

F.7.i. Field Placements

Counselor educators develop clear policies and provide direct assistance within their training programs regarding appropriate field placement and other clinical experiences. Counselor educators provide clearly stated roles and responsibilities for the student or supervisee, the site supervisor, and the program supervisor. They confirm that site supervisors are qualified to provide supervision in the formats in which services are provided and inform site supervisors of their professional and ethical responsibilities in this role.

F.8. Student Welfare

F.8.a. Program Information and Orientation

Counselor educators recognize that program orientation is a developmental process that begins upon students' initial contact with the counselor education program and continues throughout the educational and clinical training of students. Counselor education faculty provide prospective and current students with information about the counselor education program's expectations, including:

1. The values and ethical principles of the profession;
2. The type and level of skill and knowledge acquisition required for successful completion of the training;
3. Technology requirements;
4. Program training goals, objectives, and mission, and subject matter to be covered;
5. Bases for evaluation;
6. Training components that encourage self-growth or self-disclosure as part of the training process;
7. The type of supervision settings and requirements of the sites for required clinical field experiences;
8. Student and supervisor evaluation and dismissal policies and procedures; and
9. Up-to-date employment prospects for graduates.

F.8.b. Student Career Advising

Counselor educators provide career advisement for their students and make them aware of opportunities in the field.

F.8.c. Self-Growth Experiences

Self-growth is an expected component of counselor education. Counselor educators are mindful of ethical principles when they require students to engage in self-growth experiences. Counselor educators and supervisors inform students that they have a right to decide what information will be shared or withheld in class.

F.8.d. Addressing Personal Concerns

Counselor educators may require students to address any personal concerns that have the potential to affect professional competency.

F.9. Evaluation and Remediation

F.9.a. Evaluation of Students

Counselor educators clearly state to students, prior to and throughout the training program, the levels of competency expected, appraisal methods, and timing of evaluations for both didactic and clinical competencies. Counselor educators provide students with ongoing feedback regarding their performance throughout the training program.

F.9.b. Limitations

Counselor educators, through ongoing evaluation, are aware of and address the inability of some students to achieve counseling competencies. Counselor educators do the following:

1. Assist students in securing remedial assistance when needed,
2. Seek professional consultation and document their decision to dismiss or refer students for assistance, and
3. Ensure that students have recourse in a timely manner to address decisions requiring them to seek assistance or to dismiss them and provide students with due process according to institutional policies and procedures.

F.9.c. Counseling for Students

If students request counseling, or if counseling services are suggested as part of a remediation process, counselor educators assist students in identifying appropriate services.

F.10. Roles and Relationships Between Counselor Educators and Students

F.10.a. Sexual or Romantic Relationships

Counselor educators are prohibited from sexual or romantic interactions or relationships with students currently enrolled in a counseling or related program and over whom they have power and authority. This prohibition applies to both in-person and electronic interactions or relationships.

F.10.b. Sexual Harassment

Counselor educators do not condone or subject students to sexual harassment.

F.10.c. Relationships with Former Students

Counselor educators are aware of the power differential in the relationship between faculty and students. Faculty members discuss with former students potential risks when they consider engaging in social, sexual, or other intimate relationships.

F.10.d. Nonacademic Relationships

Counselor educators avoid nonacademic relationships with students in which there is a risk of potential harm to the student or which may compromise the training experience or grades assigned. In addition, counselor educators do not accept any form of professional services, fees, commissions, reimbursement, or remuneration from a site for student or supervisor placement.

F.10.e. Counseling Services

Counselor educators do not serve as counselors to students currently enrolled in a counseling or related program and over whom they have power and authority.

F.10.f. Extending Educator-Student Boundaries

Counselor educators are aware of the power differential in the relationship between faculty and students. If they believe that a nonprofessional relationship with a student may be potentially beneficial to the student, they take precautions similar to those taken by counselors when working with clients. Examples of potentially beneficial interactions or relationships include, but are not limited to, attending a formal ceremony; conducting hospital visits; providing support during a stressful event; or maintaining mutual membership in a professional association, organization, or community. Counselor educators discuss with students the rationale for such interactions, the potential benefits and drawbacks, and the anticipated consequences for the student. Educators clarify the specific nature and limitations of the additional role(s) they will have with the student prior to engaging in a nonprofessional relationship. Nonprofessional relationships with students should be time limited and/or context specific and initiated with student consent.

F.11. Multicultural/Diversity Competence in Counselor Education and Training Programs

F.11.a. Faculty Diversity

Counselor educators are committed to recruiting and retaining a diverse faculty.

F.11.b. Student Diversity

Counselor educators actively attempt to recruit and retain a diverse student body. Counselor educators demonstrate commitment to multicultural/diversity competence by

recognizing and valuing the diverse cultures and types of abilities that students bring to the training experience. Counselor educators provide appropriate accommodations that enhance and support diverse student well-being and academic performance.

F.11.c. Multicultural/Diversity Competence

Counselor educators actively infuse multicultural/diversity competency in their training and supervision practices. They actively train students to gain awareness, knowledge, and skills in the competencies of multicultural practice.

SECTION G: RESEARCH AND PUBLICATION

Introduction

Counselors who conduct research are encouraged to contribute to the knowledge base of the profession and promote a clearer understanding of the conditions that lead to a healthy and more just society. Counselors support the efforts of researchers by participating fully and willingly whenever possible. Counselors minimize bias and respect diversity in designing and implementing research.

G.1. Research Responsibilities

G.1.a. Conducting Research

Counselors plan, design, conduct, and report research in a manner that is consistent with pertinent ethical principles, federal and state laws, host institutional regulations, and scientific standards governing research.

G.1.b. Confidentiality in Research

Counselors are responsible for understanding and adhering to state, federal, agency, or institutional policies or applicable guidelines regarding confidentiality in their research practices.

G.1.c. Independent Researchers

When counselors conduct independent research and do not have access to an institutional review board, they are bound to the same ethical principles and federal and state laws pertaining to the review of their plan, design, conduct, and reporting of research.

G.1.d. Deviation From Standard Practice

Counselors seek consultation and observe stringent safeguards to protect the rights of research participants when research indicates that a deviation from standard or acceptable practices may be necessary.

G.1.e. Precautions to Avoid Injury

Counselors who conduct research are responsible for their participants' welfare throughout the research process and should take reasonable precautions to avoid causing emotional, physical, or social harm to participants.

G.1.f. Principal Researcher Responsibility

The ultimate responsibility for ethical research practice lies with the principal researcher. All others involved in the research activities share ethical obligations and responsibility for their own actions.

G.2. Rights of Research Participants

G.2.a. Informed Consent in Research

Individuals have the right to decline requests to become research participants. In seeking consent, counselors use language that:

1. Accurately explains the purpose and procedures to be followed;
2. Identifies any procedures that are experimental or relatively untried;
3. Describes any attendant discomforts, risks, and potential power differentials between researchers and participants;
4. Describes any benefits or changes in individuals or organizations that might reasonably be expected;
5. Discloses appropriate alternative procedures that would be advantageous for participants;
6. Offers to answer any inquiries concerning the procedures;
7. Describes any limitations on confidentiality;
8. Describes the format and potential target audiences for the dissemination of research findings; and
9. Instructs participants that they are free to withdraw their consent and discontinue participation in the project at any time, without penalty.

G.2.b. Student/Supervisee Participation

Researchers who involve students or supervisees in research make clear to them that the decision regarding participation in research activities does not affect their academic standing or supervisory relationship. Students or supervisees who choose not to participate in research are provided with an appropriate alternative to fulfill their academic or clinical requirements.

G.2.c. Client Participation

Counselors conducting research involving clients make clear in the informed consent process that clients are free to choose whether to participate in research activities. Counselors take necessary precautions to protect clients from adverse consequences of declining or withdrawing from participation.

G.2.d. Confidentiality of Information

Information obtained about research participants during the course of research is confidential. Procedures are implemented to protect confidentiality.

G.2.e. Persons Not Capable of Giving Informed Consent

When a research participant is not capable of giving informed consent, counselors provide an appropriate explanation to, obtain agreement for participation from, and obtain the appropriate consent of a legally authorized person.

G.2.f. Commitments to Participants

Counselors take reasonable measures to honor all commitments to research participants.

G.2.g. Explanations After Data Collection

After data are collected, counselors provide participants with full clarification of the nature of the study to remove any misconceptions participants might have regarding the research. Where scientific or human values justify delaying or withholding information, counselors take reasonable measures to avoid causing harm.

G.2.h. Informing Sponsors

Counselors inform sponsors, institutions, and publication channels regarding research procedures and outcomes. Counselors ensure that appropriate bodies and authorities are given pertinent information and acknowledgment.

G.2.i. Research Records Custodian

As appropriate, researchers prepare and disseminate to an identified colleague or records custodian a plan for the transfer of research data in the case of their incapacitation, retirement, or death.

G.3. Managing and Maintaining Boundaries

G.3.a. Extending Researcher-Participant Boundaries

Researchers consider the risks and benefits of extending current research relationships beyond conventional parameters. When a nonresearch interaction between the researcher and the research participant may be potentially beneficial, the researcher must document, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the research participant. Such interactions should be initiated with appropriate consent of the research participant. Where unintentional harm occurs to the research participant, the researcher must show evidence of an attempt to remedy such harm.

G.3.b. Relationships with Research Participants

Sexual or romantic counselor-research participant interactions or relationships with current research participants are prohibited. This prohibition applies to both in-person and electronic interactions or relationships.

G.3.c. Sexual Harassment and Research Participants

Researchers do not condone or subject research participants to sexual harassment.

G.4. Reporting Results

G.4.a. Accurate Results

Counselors plan, conduct, and report research accurately. Counselors do not engage in misleading or fraudulent research, distort data, misrepresent data, or deliberately bias their results. They describe the extent to which results are applicable for diverse populations.

G.4.b. Obligation to Report Unfavorable Results

Counselors report the results of any research of professional value. Results that reflect unfavorably on institutions, programs, services, prevailing opinions, or vested interests are not withheld.

G.4.c. Reporting Errors

If counselors discover significant errors in their published research, they take reasonable steps to correct such errors in a correction erratum or through other appropriate publication means.

G.4.d. Identity of Participants

Counselors who supply data, aid in the research of another person, report research results, or make original data available take due care to disguise the identity of respective participants in the absence of specific authorization from the participants to do otherwise. In situations where participants self-identify their involvement in research studies, researchers take active steps to ensure that data are adapted/changed to protect the identity and welfare of all parties and that discussion of results does not cause harm to participants.

G.4.e. Replication Studies

Counselors are obligated to make available sufficient original research information to qualified professionals who may wish to replicate or extend the study.

G.5. Publications and Presentations

G.5.a. Use of Case Examples

The use of participants', clients', students', or supervisees' information for the purpose of case examples in a presentation or publication is permissible only when (a) participants, clients, students, or supervisees have reviewed the material and agreed to its presentation or publication or (b) the information has been sufficiently modified to obscure identity.

G.5.b. Plagiarism

Counselors do not plagiarize; that is, they do not present another person's work as their own.

G.5.c. Acknowledging Previous Work

In publications and presentations, counselors acknowledge and give recognition to previous work on the topic by others or self.

G.5.d. Contributors

Counselors give credit through joint authorship, acknowledgment, footnote statements, or other appropriate means to those who have contributed significantly to research or concept development in accordance with such contributions. The principal contributor is listed first, and minor technical or professional contributions are acknowledged in notes or introductory statements.

G.5.e. Agreement of Contributors

Counselors who conduct joint research with colleagues or students/supervisors establish agreements in advance regarding allocation of tasks, publication credit, and types of acknowledgment that will be received.

G.5.f. Student Research

Manuscripts or professional presentations in any medium that are substantially based on a student's course papers, projects, dissertations, or theses are used only with the student's permission and list the student as lead author.

G.5.g. Duplicate Submissions

Counselors submit manuscripts for consideration to only one journal at a time. Manuscripts that are published in whole or in substantial part in one journal or published work are not submitted for publication to another publisher without acknowledgment and permission from the original publisher.

G.5.h. Professional Review

Counselors who review material submitted for publication, research, or other scholarly purposes respect the confidentiality and proprietary rights of those who submitted it. Counselors make publication decisions based on valid and defensible standards. Counselors review article submissions in a timely manner and based on their scope and competency in research methodologies. Counselors who serve as reviewers at the request of editors or publishers make every effort to only review materials that are within their scope of competency and avoid personal biases.

SECTION H: DISTANCE COUNSELING, TECHNOLOGY, AND SOCIAL MEDIA

Introduction

Counselors understand that the profession of counseling may no longer be limited to in-person, face-to-face interactions. Counselors actively attempt to understand the evolving nature of the profession with regard to distance counseling, technology, and social media and how such resources may be used to better serve their clients. Counselors strive to become knowledgeable about these resources. Counselors understand the additional concerns related to the use of distance counseling, technology, and social media and make every attempt to protect confidentiality and meet any legal and ethical requirements for the use of such resources.

H.1. Knowledge and Legal Considerations

H.1.a. Knowledge and Competency

Counselors who engage in the use of distance counseling, technology, and/or social media develop knowledge and skills regarding related technical, ethical, and legal considerations (e.g., special certifications, additional course work).

H.1.b. Laws and Statutes

Counselors who engage in the use of distance counseling, technology, and social media within their counseling practice understand that they may be subject to laws and regulations of both the counselor's practicing location and the client's place of residence. Counselors ensure that their clients are aware of pertinent legal rights and limitations governing the practice of counseling across state lines or international boundaries.

H.2. Informed Consent and Security

H.2.a. Informed Consent and Disclosure

Clients have the freedom to choose whether to use distance counseling, social media, and/or technology within the counseling process. In addition to the usual and customary protocol of informed consent between counselor and client for face-to-face counseling, the following issues, unique to the use of distance counseling, technology, and/or social media, are addressed in the informed consent process:

- Distance counseling credentials, physical location of practice, and contact information;
- Risks and benefits of engaging in the use of distance counseling, technology, and/or social media;
- Possibility of technology failure and alternate methods of service delivery;
- Anticipated response time;
- Emergency procedures to follow when the counselor is not available;
- Time zone differences;
- Cultural and/or language differences that may affect delivery of services;
- Possible denial of insurance benefits; and
- Social media policy.

H.2.b. Confidentiality Maintained by the Counselor

Counselors acknowledge the limitations of maintaining the confidentiality of electronic records and transmissions. They inform clients that individuals might have authorized or unauthorized access to such records or transmissions (e.g., colleagues, supervisors, employees, information technologists).

H.2.c. Acknowledgment of Limitations

Counselors inform clients about the inherent limits of confidentiality when using technology. Counselors urge clients to be aware of authorized and/or unauthorized access to information disclosed using this medium in the counseling process.

H.2.d. Security

Counselors use current encryption standards within their websites and/or technology-based communications that meet applicable legal requirements. Counselors take reasonable precautions to ensure the confidentiality of information transmitted through any electronic means.

H.3. Client Verification

Counselors who engage in the use of distance counseling, technology, and/or social media to interact with clients take steps to verify the client's identity at the beginning and throughout the therapeutic process. Verification can include, but is not limited to, using code words, numbers, graphics, or other nondescript identifiers.

H.4. Distance Counseling Relationship

H.4.a. Benefits and Limitations

Counselors inform clients of the benefits and limitations of using technology applications in the provision of counseling services. Such technologies include, but are not limited to, computer hardware and/or software, telephones and applications, social media and Internet-based applications and other audio and/or video communication, or data storage devices or media.

H.4.b. Professional Boundaries in Distance Counseling

Counselors understand the necessity of maintaining a professional relationship with their clients. Counselors discuss and establish professional boundaries with clients regarding the appropriate use and/or application of technology and the limitations of its use within the counseling relationship (e.g., lack of confidentiality, times when not appropriate to use).

H.4.c. Technology-Assisted Services

When providing technology-assisted services, counselors make reasonable efforts to determine that clients are intellectually, emotionally, physically, linguistically, and functionally capable of using the application and that the application is appropriate for the needs of the client. Counselors verify that clients understand the purpose and operation of technology applications and follow up with clients to correct possible misconceptions, discover appropriate use, and assess subsequent steps.

H.4.d. Effectiveness of Services

When distance counseling services are deemed ineffective by the counselor or client, counselors consider delivering services face-to-face. If the counselor is not able to provide face-to-face services (e.g., lives in another state), the counselor assists the client in identifying appropriate services.

H.4.e. Access

Counselors provide information to clients regarding reasonable access to pertinent applications when providing technology-assisted services.

H.4.f. Communication Differences in Electronic Media

Counselors consider the differences between face-to-face and electronic communication (nonverbal and verbal cues) and how these may affect the counseling process. Counselors educate clients on how to prevent and address potential misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically.

H.5. Records and Web Maintenance

H.5.a. Records

Counselors maintain electronic records in accordance with relevant laws and statutes. Counselors inform clients on how records are maintained electronically. This includes, but is not limited to, the type of encryption and security assigned to the records, and if/for how long archival storage of transaction records is maintained.

H.5.b. Client Rights

Counselors who offer distance counseling services and/or maintain a professional website provide electronic links to relevant licensure and professional certification boards to protect consumer and client rights and address ethical concerns.

H.5.c. Electronic Links

Counselors regularly ensure that electronic links are working and are professionally appropriate.

H.5.d. Multicultural and Disability Considerations

Counselors who maintain websites provide accessibility to persons with disabilities. They provide translation capabilities for clients who have a different primary language, when feasible. Counselors acknowledge the imperfect nature of such translations and accessibilities.

H.6. Social Media

H.6.a. Virtual Professional Presence

In cases where counselors wish to maintain a professional and personal presence for social media use, separate professional and personal web pages and profiles are created to clearly distinguish between the two kinds of virtual presence.

H.6.b. Social Media as Part of Informed Consent

Counselors clearly explain to their clients, as part of the informed consent procedure, the benefits, limitations, and boundaries of the use of social media.

H.6.c. Client Virtual Presence

Counselors respect the privacy of their clients' presence on social media unless given consent to view such information.

H.6.d. Use of Public Social Media

Counselors take precautions to avoid disclosing confidential information through public social media.

SECTION I: RESOLVING ETHICAL ISSUES

Introduction

Professional counselors behave in an ethical and legal manner. They are aware that client welfare and trust in the profession depend on a high level of professional conduct. They hold other counselors to the same standards and are willing to take appropriate action to ensure that standards are upheld. Counselors strive to resolve ethical dilemmas with direct and open communication among all parties involved and seek consultation with colleagues and supervisors when necessary. Counselors incorporate ethical practice into their daily professional work and engage in ongoing professional development regarding current topics in ethical and legal issues in counseling. Counselors become familiar with the ACA Policy and Procedures for Processing Complaints of Ethical Violations and use it as a reference for assisting in the enforcement of the *ACA Code of Ethics*.

I.1. Standards and the Law

I.1.a. Knowledge

Counselors know and understand the *ACA Code of Ethics* and other applicable ethics codes from professional organizations or certification and licensure bodies of which they are members. Lack of knowledge or misunderstanding of an ethical responsibility is not a defense against a charge of unethical conduct.

I.1.b. Ethical Decision Making

When counselors are faced with an ethical dilemma, they use and document, as appropriate, an ethical decision-making model that may include, but is not limited to, consultation; consideration of relevant ethical standards, principles, and laws; generation of potential courses of action; deliberation of risks and benefits; and selection of an objective decision based on the circumstances and welfare of all involved.

I.1.c. Conflicts Between Ethics and Laws

If ethical responsibilities conflict with the law, regulations, and/or other governing legal authority, counselors make known their commitment to the *ACA Code of Ethics* and take steps to resolve the conflict. If the conflict cannot be resolved using this approach, counselors, acting in the best interest of the client, may adhere to the requirements of the law, regulations, and/or other governing legal authority.

I.2. Suspected Violations

I.2.a. Informal Resolution

When counselors have reason to believe that another counselor is violating or has violated an ethical standard and substantial harm has not occurred, they attempt to first resolve the issue informally with the other counselor if feasible, provided such action does not violate confidentiality rights that may be involved.

I.2.b. Reporting Ethical Violations

If an apparent violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution or is not resolved properly, counselors take further action depending on the situation. Such action may include referral to state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or appropriate institutional authorities. The confidentiality rights of clients should be considered in all actions. This standard does not apply when counselors have been retained to review the work of another counselor whose professional conduct is in question (e.g., consultation, expert testimony).

I.2.c. Consultation

When uncertain about whether a particular situation or course of action may be in violation of the *ACA Code of Ethics*, counselors consult with other counselors who are knowledgeable about ethics and the *ACA Code of Ethics*, with colleagues, or with appropriate authorities, such as the ACA Ethics and Professional Standards Department.

I.2.d. Organizational Conflicts

If the demands of an organization with which counselors are affiliated pose a conflict with the *ACA Code of Ethics*, counselors specify the nature of such conflicts and express to their supervisors or other responsible officials their commitment to the *ACA Code of Ethics* and, when possible, work through the appropriate channels to address the situation.

I.2.e. Unwarranted Complaints

Counselors do not initiate, participate in, or encourage the filing of ethics complaints that are retaliatory in nature or are made with reckless disregard or willful ignorance of facts that would disprove the allegation.

I.2.f. Unfair Discrimination Against Complainants and Respondents

Counselors do not deny individuals employment, advancement, admission to academic or other programs, tenure, or promotion based solely on their having made or their being the subject of an ethics complaint. This does not preclude taking action based on the outcome of such proceedings or considering other appropriate information.

I.3. Cooperation with Ethics Committees

Counselors assist in the process of enforcing the *ACA Code of Ethics*. Counselors cooperate with investigations, proceedings, and requirements of the ACA Ethics Committee or ethics committees of other duly constituted associations or boards having jurisdiction over those charged with a violation.

Customer Information/Answer Sheet/Evaluation insert located between pages 32–33.

TEST QUESTIONS
#77723 ETHICS FOR COUNSELORS

This is an open book test. Please record your responses on the Answer Sheet.
A passing grade of at least 80% must be achieved in order to receive credit for this course.

This 6 Hour/6 NBCC Clock Hour activity must be completed by April 30, 2025.

1. Virtue ethics is an ancient ethical system attributed to
- A) *Aristotle.*
- B) *Hippocrates.*
- C) *St. Augustine.*
- D) *St. Thomas Aquinas.*

2. Which of the following historical events reinforced the need for codified standards of ethics?
- A) *The Watergate trial*
- B) *The Belmont Report*
- C) *The guidance counseling movement*
- D) *Medical experiments conducted on Jews during the Nazi regime and on children at Willowbrook State School*

3. The Tuskegee experiment is one of the most publicized research projects referred to in ethical discussion today. It involved
- A) *mentally retarded children being given hepatitis by injection.*
- B) *elderly patients with chronic illness who were injected with live cancer cells.*
- C) *penicillin treatment withheld from African American test subjects with syphilis.*
- D) *affluent children given Nutrasweet in their Coca-Cola with a control group receiving regular Coca-Cola.*

4. All of the following are reasons ethical codes are developed, EXCEPT:
- A) *To protect clients and professionals*
- B) *To provide guidance for ethical decision making*
- C) *To grant professional immunity from legal action when ethics violations occur*
- D) *To help to establish an organization by differentiating itself from similar institutions*

5. Which philosophical viewpoint is characterized by diversity and pluralism?
- A) *Modernism*
- B) *Postmodernism*
- C) *Morality period*
- D) *Aesthetic value orientation*

6. Courage, cleanliness, and cheerfulness are examples of
- A) *morals.*
- B) *terminal values.*
- C) *ethical principles.*
- D) *instrumental values.*

7. Ethics may best be defined as
- A) *what is considered moral.*
- B) *Aristotle's philosophical concept.*
- C) *beliefs about what is correct or proper behavior.*
- D) *the only right action as determined by the institution one works for.*

8. Morality is best defined as
- A) *ethics.*
- B) *views on sexual behavior.*
- C) *the attitude of counselors.*
- D) *the judgment or evaluation of ethical principles based on social, cultural, and religious norms.*

9. What constitutes an ethical dilemma?
- A) *When the guiding principle of autonomy is violated*
- B) *Cognitive dissonance experienced by the professional*
- C) *When a professional witnesses another practicing paternalism*
- D) *When a choice must be made between two mutually exclusive courses of action*

10. Ethical principles are best defined as
- A) *expressions of morality.*
- B) *statements that reflect values of society.*
- C) *ideas that provide direction for daily living.*
- D) *expressions that reflect people's obligations or duties.*

11. The ethical principle of competency is the duty to
- A) *tell the truth.*
- B) *only practice in areas of expertise.*
- C) *enter into challenging relationships.*
- D) *try to solve problems faster than other counselors.*

12. Which of the following is NOT one of the nine sections included in the ACA Code of Ethics?
- A) *Resolving Ethical Issues*
- B) *Institutional Assumptions*
- C) *Professional Responsibility*
- D) *Confidentiality and Privacy*

13. Deontologic ethics is
- A) *the principle that all people are not of equal value.*
- B) *okay with lying if it is seen to be in the client's best interest.*
- C) *based upon the principle that people should always be treated as means to an end.*
- D) *a system of ethical decision making that stands on absolute truths and unwavering principles.*

14. Which of the following is considered a teleologic ethical theory?
- A) *Utilitarianism*
- B) *Theologic ethics*
- C) *Mandatory ethics*
- D) *All of the above*

15. Which of the following is NOT a component of decision analyses?
- A) *Calculating the expected value*
- B) *Creating the pathways of the decision*
- C) *Listing the pros or cons of the various decisions*
- D) *Identifying the perspectives of the ethical theories*

16. What is the main focus of the Ethical Principles Screen developed by Loewenberg and Dolgoff?
- A) *It is a screening method that allows for self-reflection and implicit argumentation.*
- B) *It is a method that focuses on a hierarchy of ethical principles to evaluate the potential course of action for ethical dilemmas.*
- C) *It assists counselors to identify his/her values and personal beliefs to set the context of ethical decision making.*
- D) *It lists out all the general ethical principles and asks the professional to identify the most meaningful to apply to the ethical dilemma.*

17. Lawrence Kohlberg identifies two important correlates of his six stages of moral development. One of these is that
- A) *everyone goes through each stage in a different order.*
- B) *every person can understand each stage of moral development.*
- C) *a person at one stage can understand any stage below him or her, but cannot understand more than one stage above.*
- D) *after a person progresses through a stage, he or she no longer understand the stage below, but can understand one stage above.*

18. Lawrence Kohlberg presumes there are six stages of moral development. A person making a stage 5 decision uses which of the following justifications?
- A) *"If I do not make that decision, I will be punished."*
- B) *"If I make that decision, I will be rewarded and other people will help me."*
- C) *"Others whom I care about will be pleased if I do this because they have taught me that this is what a good person does."*
- D) *"This decision will contribute to social well-being, and, as members of a society, we have an obligation to every other member."*

19. Which of the following ethical conflicts may be a concern in a managed care environment?
- A) *Distributive justice*
- B) *Client confidentiality*
- C) *Fiduciary relationships with clients vs. agencies*
- D) *All of the above*

20. According to Manhal-Baugus, the two main ethical issues in online counseling are privacy/confidentiality and
- A) *justice.*
- B) *beneficence.*
- C) *multiculturalism.*
- D) *principles of establishing online relationships.*

Be sure to transfer your answers to the Answer Sheet located between pages 32–33.
DO NOT send these test pages to NetCE. Retain them for your records.
PLEASE NOTE: Your postmark or facsimile date will be used as your test completion date.

Postpartum Depression

Approval(s)*: APA, NBCC

Audience
This course is designed for all health and mental health professionals who work directly with pregnant women, new mothers, and infants. The target audience is primarily those in the obstetric/gynecologic, neonatal, and psychiatric fields, but all professionals who provide services to women will benefit from this course.

Course Objective
The purpose of this course is to allow healthcare providers to detect postpartum depression using screening tools and a clinical assessment to intervene early and prevent the devastating consequences of the disorder.

Learning Objectives
Upon completion of this course, you should be able to:

1. Discuss the prevalence of postpartum depression (PPD), including historical and transcultural perspectives.
2. Identify risk factors for PPD evident prior to pregnancy, during pregnancy, and after birth.
3. Review the effects of biochemistry, such as serotonin, estrogen and progesterone, cortisol, and thyroid, on the development of PPD.
4. Describe the role of family history, stressful life events, and psychosocial factors in the etiology of depression.
5. List the emotional, physical, and cognitive symptoms of postpartum blues.
6. Discuss emotional, physical, cognitive, and behavioral symptoms of PPD.
7. Identify severe forms of postpartum disorders, focusing on postpartum psychosis and cases of infanticide.
8. Review the clinical assessment of PPD, including the Edinburgh Postnatal Depression Scale (EPDS) and the Postpartum Depression Screening Scale (PDSS).
9. List the effects of PPD on maternal bonding, mother-infant attachment, and a child's socioemotional and cognitive development.
10. Describe the potential long-term effects of PPD on children.
11. List maternal and familial complications of PPD, including marital conflict, suicide, and homicide.
12. Discuss self-care strategies for recovery, such as nourishment, sleep, rest and relaxation, exercise, and socializing.
13. Review the role of education in the diagnosis of and recovery from PPD.
14. Discuss the physiologic treatment of PPD with postpartum hormone treatments.
15. Specify pharmacologic treatment strategies, noting benefits, adverse reactions, and risks.
16. Discuss psychosocial interventions used in the treatment of PPD.
17. List strategies for preventing PPD, including screening, postpartum debriefing, companionship in the delivery room, psychotherapy, midwife continuity of care, and progesterone preventive treatment.

Faculty
Anele Runyion, RN, MS, received her diploma in nursing from Berea College School of Nursing in Berea, Kentucky. She subsequently received a Baccalaureate and Master's degree in psychiatric nursing from the University of California, San Francisco. She has extensive experience in psychiatric nursing, including adolescent and adult psychiatry. (A complete biography appears at the end of this course.)

Faculty Disclosure
Contributing faculty, Anele Runyion, RN, MS, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planner
Alice Yick Flanagan, PhD, MSW

Director of Development and Academic Affairs
Sarah Campbell

This course is not approved for New York LMHCs or LMFTs.
We anticipate this course will be NAADAC-approved by July 2022.

A full Works Cited list is available online at www.NetCE.com. ***Mention of commercial products does not indicate endorsement.***

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EVIDENCE-BASED PRACTICE RECOMMENDATION

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the study questions and course material for better application to your daily practice.

INTRODUCTION

The World Health Organization (WHO) has designated the first 28 days after birth as the neonatal period. Although it has never been officially designated, the postpartum period is considered to start about an hour after the delivery of the placenta and is complete six weeks after birth. After six weeks, the mother's physical status will largely return to the nonpregnant state in most instances [1].

The nature of the association between childbirth and mental disturbance is of great interest. It is during this critical postpartum period that the mother and her infant are the most vulnerable to both physical and emotional problems. During this time, there must be increased concern for women who are the most vulnerable to postpartum depression (PPD).

The etiology of PPD is complex and not readily understood by many healthcare professionals. Neurophysiologic changes, underlying postpartum changes, the stress of childbirth, and predisposing factors, such as genetics, the environment, and psychologic stressors, combine to produce PPD in some women. Furthermore, there are distinguishing characteristics in brain chemistry that involve a theory of cyclical hormonal patterns and mood disorders in women. Psychosocial factors such as past history of mood disorder; family history of depression; stressful relationships with spouse, family, and friends; and lack of sufficient social support also play a role in the development of PPD.

Please note that persons with PPD are referred to as women and mothers throughout this course. While most persons with PPD are cisgender women, it is important to acknowledge that persons of many gender identities and relationships to an infant may give birth and experience PPD. Further, there is some evidence that sexual minority women may be at greater risk for PPD and postpartum anxiety, indicating a possible role of sexual identity-based stigma and stress [241]. It is important to that patients be questioned regarding their preferred pronouns and titles and that this information be respected. This is an essential aspect of patient-centered care and will improve rapport and patient outcomes.

CATEGORIES OF POSTPARTUM MOOD DISORDERS

Postpartum mood disorders are generally divided into three categories: postpartum blues, or "baby blues," PPD, and postpartum psychosis. These conditions do not exist on a continuum; each category is a distinct postpartum state [2].

Postpartum blues, a mild and transient depression in the immediate postpartum period, occur in up to 85% of new mothers [3]. The condition is characterized by mild dysphoria, with symptoms such as tearfulness, fatigue, sleep disturbances, and physical exhaustion, that lasts a few days following delivery. The majority of women experiencing postpartum blues recover spontaneously within three to five days [2; 3; 4].

PPD occurs in approximately 10% to 15% of new mothers [2; 3; 5]. According to multiple studies, PPD occurs at the same rate in new mothers around the world [6]. There is little evidence to suggest that any country or class of persons is not at risk for PPD. Symptoms usually occur shortly after childbirth but may occur as late as one year after delivery. PPD is a serious, long-lasting type of depression in women that can have harmful consequences for the mother and child if undetected and untreated [3].

The symptoms of PPD are similar to the symptoms of any major depressive disorder. However, due to the unique issues regarding the mother-infant relationship, the adaptation to parenthood following the delivery of a baby, and the impact of the mother's depression on the infant, PPD should be considered in its own right as a unique mood disorder suffered by postpartum women [7].

The third type of postpartum mental disturbance, postpartum psychosis, occurs in 1 to 2 of every 1,000 new mothers [8; 9]. If undetected and untreated, postpartum psychosis presents a danger to both the life of the mother and her infant. Infanticide is rare but does occur in 1 of 250,000 women with postpartum psychosis [10]. An estimated 5% of patients with postpartum psychosis will attempt infanticide or suicide [9].

Screening for postpartum mood disorders as early as possible following childbirth is essential for early detection and treatment. Treatment strategies include a combined approach to address both the physiologic and psychologic factors that precipitate PPD. If the condition is detected and treated early, there is a greater likelihood of complete symptom relief in a shorter time span than if detection and treatment are delayed. Screening early for PPD in all new mothers, with referral of affected women to appropriate healthcare professionals, should become the standard of care for all childbearing women.

HISTORICAL PERSPECTIVE

Documentation of PPD can be traced to the writings of Hippocrates in the fourth century B.C.E. Hippocrates described melancholia as a state of "aversion to food, despondency, sleeplessness, irritability, and restlessness" [6]. Galen (131–201 C.E.) described melancholia as "fear and depression, discontent with life, and hatred of all people" [6]. Greco-Roman medicine recognized melancholia in the form of fear, suspicion, aggression, and suicidal thoughts. In 1436, the life story of a young mother was published and described how she felt "insane" and despaired of her life and survival after the birth of her first child [11].

In the 19th century, two French physicians became interested in PPD. In 1838, Dr. J.E.D. Esquirol documented 90 women with emotional problems and divided their illnesses into three types: illnesses that occurred during pregnancy, those that occurred immediately after childbirth, and those that occurred six weeks or more after birth. Many of these women had suffered in silence for fear of being stigmatized, misunderstood, or removed from their families [2].

In 1858, Dr. Louis Victor Marcé similarly observed 300 French women using the three categories established by Dr. Esquirol. He concluded that the types of emotional illnesses occurring in the postpartum time frame had unique characteristics of their own. He was convinced that there was an element in the body's physical mechanism causing postpartum illness, although he could not identify it. Marcé's conclusions have become important cornerstones of modern thinking on PPD and the endocrine system [2].

The symptoms of puerperal septicemia in women following birth confused the issue of PPD until the more widespread use of hand washing, antiseptic techniques, penicillin, and other antibiotics in the early 1900s. The removal of the toxicity of septicemia from the hazards of childbirth seemingly uncovered the problems of PPD [10]. In 1926 in the United States, two researchers declared that depression after childbirth was no different than any other depression in women. The term "postpartum" was not used in any textbooks describing depression in women at that time [11]. The "blues" that had long been recognized by midwives were brought to the

attention of psychiatrists by Dr. Bruce Pitt in England. In 1964, Pitt interviewed 100 women at the Royal London Hospital between day 7 and 10 after birth. He discovered that 50% of these women had felt tearful or depressed since giving birth. For six of these women, the depression lasted a month or longer [10].

In 1971, Dr. Katherine Dalton, a British obstetrician, published the results of a survey conducted among 500 women from birth to six months postpartum. She concluded that 7% of the women developed PPD severe enough to require medical treatment, although none required hospitalization. With the publication of these findings in the *British Journal of Psychiatry*, psychiatrists and psychologists began to appreciate that depression experienced by new mothers extended beyond the postpartum blues [10].

The Marcé Society, an international medical society founded in 1980, has held conferences throughout the world to further the study of PPD. In 1987, the *British Journal of Psychiatry* published an article that established the standard of care for screening for PPD [12]. The Edinburgh Postnatal Depression Scale (EPDS) was introduced and has subsequently become the standard screening tool for PPD [10; 12].

In the United States in the 1980s, women began to be recognized as having distress and inability to care for their infants after birth. Counseling was provided to assist these women to resolve their stresses and conflicts. In 1986, Dr. James Hamilton presented the idea that postpartum disorders were biologically driven. Mainstream medicine and psychiatry did not address these problems at the time, resulting in inadequate recognition and treatment [13].

In the last decade, greater emphasis has been placed on the role of a woman's brain chemistry in the development of depression in the postpartum period. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), published by the American Psychiatric Association, does not recognize PPD as a distinct entity. Instead, patients must meet the criteria for a major depressive episode and the criteria for the peripartum-onset specifier (onset during pregnancy or in the four weeks following delivery) [14; 15]. Limiting the onset of symptoms of depression to within four weeks postpartum has been considered too restrictive by some researchers and clinicians [2]. Postpartum Support International has argued that the timeframe should be extended to six months postpartum. Debate continues regarding how PPD fits into the larger classification of depressive disorders [16; 17].

There are many mother and baby admission units in psychiatric hospitals in England, Wales, Canada, Australia, and New Zealand [18; 19]. In the United States, Sichel and Driscoll established a mother-baby admissions unit in a Boston Psychiatric Hospital during the 1990s. A mother-baby day hospital has also been established at Brown University Medical School in Rhode Island [20]. In 2011, the first inpatient perinatal psychiatric unit for new mothers with severe PPD in the United States opened at the University of North Carolina at Chapel Hill hospital [21]. Several states have passed legislation either mandating screening for PPD or mandating education of PPD for all pregnant women [22; 23; 24; 25]. In 2015, federal legislators introduced a bill titled "Bringing Postpartum Depression Out of the Shadows Act of 2015 [H.R. 3235]." The legislation would authorize the Department of Health and Human Services to make grants to states for screening and treatment for maternal depression [26]. This bill was not passed by the Senate. However, the 2019 budget included provision for a task force to address maternal mental health and to present findings to Congress in 2020 [229].

CULTURAL PERSPECTIVE

Although PPD occurs worldwide, cultural differences can influence the perception of depression in women. Culture influences the expression and interpretation of symptoms, the definition of stressors, the nature of the social support system, and the relationship between healthcare provider and patient. Culture also dictates whether certain expressions of symptoms are socially acceptable. An individual's view of illness and health is also culturally bound. Displays of emotion may be encouraged in some cultures and discouraged in others [27].

Anthropologic studies show that cultural perceptions shape attitudes toward illness. Many cultures may not recognize depression as a disorder due to cultural differences or religious interpretations of emotional expressions. In some cultures, such as Nepalese, it would be considered inappropriate for a woman to seek treatment for sadness. In India, depression is viewed as a spiritual experience, described as the "suffering of the spirit" [28]. Muslims in some Arab countries also perceive depressive symptoms as a religious experience, connoting a deep understanding of the tragic nature of the human condition. Cultures that place a high value on social harmony, including many cultures in Africa and Asia, may encourage and support the suppression of internal conflict in women. Women living in these cultures would likely be reluctant to discuss emotional issues with their healthcare providers.

The explicit or implicit gender roles present in various cultures also affect expressions of PPD. Many women live in subordinate roles to their husbands and/or family in a patriarchal culture that disallows independent expression of self. Feelings may be suppressed in these cultures to safeguard women from cultural exclusion or punishment [28].

In Western societies, the hospital stay has generally been shortened to very few days following birth, after which the new mother is left virtually on her own. However, some cultures have rituals and myths surrounding childbirth that acknowledge the special attention required for postpartum women during their recuperation period. For example, a seven- to eight-day period is observed in some parts of the Philippines, during which time the new mother is given a

special diet, heat treatment, and herbal medications, and she is expected to rest at home. The Ibido people of Nigeria create a "fattening room" for new mothers, where they are cared for by older women and are expected to only eat, sleep, and care for their infants. Other cultures have similar special rituals that accord distinct recognition to the new mother [2]. Whether the incidence of PPD is lower in these cultures is yet to be determined.

Dr. Laurence Kruckman, an anthropologist who has studied various cultural rituals, asserts that North American women may experience postpartum emotional disorders because [2]:

- The postpartum period is not structured as a distinct event that has particular needs.
- There is little social recognition of a woman's transition to the role of mother.
- Mothers receive minimal assistance after childbirth, including information about caring for themselves and their children.

Given these differences in cultural perception of sadness and depression and of childbirth, it is interesting to note that studies conducted in Canada, Puerto Rico, France, West Germany, Italy, Lebanon, Korea, New Zealand, and Taiwan show incidences of PPD comparable to those reported in the United States and the United Kingdom [13]. PPD has also been reported in women in Uganda, Sumatra, and Guatemala [10]. In addition, a study of 2,423 White, African American, Hispanic, and Asian/Pacific Islander women who had recently given birth in Massachusetts found that being foreign-born was associated with postpartum anhedonia in each group except Hispanics [29]. However, this may be linked more to the unique stressors of living as an immigrant or away from family.

In order to provide optimum care, healthcare professionals should understand how depression is viewed in the culture of the women who seek treatment. The cultural views of motherhood and the rituals and myths of childbirth should be taken into consideration when treating any woman during and after her pregnancy.

RISK FACTORS

RISK FACTORS EVIDENT PRIOR TO PREGNANCY

PPD affects women of all ages, economic statuses and racial/ethnic backgrounds. Any woman who is pregnant or has given birth can develop PPD. Whether the birth is a first child or one of multiple births has not been shown to affect the incidence of PPD. However, women with a history of depressive episodes have a greater risk for developing PPD than women with no prior history of depression. The risk of PPD is highest in women younger than 25 years of age with a prior history of mood instability. Among these women, it is estimated that 30% to 40% will have a postpartum episode of depression [30]. There are additional risk factors evident prior to pregnancy that may increase the chances of developing PPD, including [5; 30; 32; 70; 225]:

- Past history of depression or other mental health problems
- Family history of mood instability
- Difficulties in relationships with the father of the baby or family, especially the woman's own mother
- Insufficient social support or peer support group
- Onset of depression immediately prior to conception
- Social or financial stressors, such as money or housing problems
- Mood disturbances, such as premenstrual syndrome (PMS)
- Infertility treatment
- History of abuse
- High school or lower levels of education

RISK FACTORS EVIDENT DURING PREGNANCY

Depression may occur during pregnancy and, if not treated, continue and worsen after childbirth. The number of women who develop depression during pregnancy is difficult to determine. In many cases, depression during pregnancy is not recognized or treated because normal pregnancy can cause similar symptoms, including fatigue, sleep disturbances, stronger emotional reactions, and changes in body weight. However, it is important that depression during pregnancy be diagnosed and managed, as it may be harmful to both the mother and the infant if not treated [19].

Treating depression during pregnancy is a challenge because the vast majority of antidepressants cross the placenta and can have negative effects on fetal development. Psychiatrists, family practice physicians, and obstetricians may find themselves in a dilemma when diagnosing and treating depression in pregnant women. As previously noted, the onset of depression may not become evident until symptoms become severe due to the similarity of depressive symptoms and neurovegetative signs during pregnancy [33]. Although diagnosis and treatment pose a serious challenge, early recognition, diagnosis, and treatment are warranted [33]. Indication of certain risk factors that may contribute to depression during pregnancy can be helpful in a prenatal assessment. Risk factors for an onset of depression during pregnancy include [5; 33; 225]:

- History of depression or substance abuse
- Family history of mental illness
- Lack of support from family and friends
- Anxiety about the fetus
- Problems with a previous pregnancy or birth
- Marital or financial problems

- Young maternal age
- Single mother
- Stressful life event, such as moving to a new area or death of family member
- Excessive fatigue
- Feelings of worthlessness
- Divorce

EVIDENCE-BASED PRACTICE RECOMMENDATION

According to the U.S. Preventive Services Task Force, risk factors for depression during pregnancy and postpartum include poor self-esteem, child-care stress, prenatal anxiety, life stress, decreased social support, single/unpartnered relationship status, history of depression, difficult infant temperament, previous postpartum depression, lower socioeconomic status, and unintended pregnancy.

(https://jamanetwork.com/journals/jama/fullarticle/2484345. Last accessed March 27, 2020.)

Level of Evidence: Expert Opinion/Consensus Statement

RISK FACTORS EVIDENT AFTER BIRTH

Risk factors for PPD following the birth of a baby are similar to those present prior to conception and during pregnancy. Any combination of the following factors should be considered concerning, as it indicates a potential to develop PPD [5; 32; 34; 225]:

- Persisting postpartum anhedonia without sufficient social support
- Feeling detached from the infant, not wanting to hold the baby, having negative thoughts about the baby
- Persistent sleep disturbances
- A fussy infant who has problems feeding or has colic
- Signs of developing depression, such as anxiety or feeling overwhelmed
- Birth complications or a difficult labor
- A birth that did not live up to expectations
- Having an infant with special needs
- Excessive fatigue
- Feeling overwhelmed with responsibilities of new parenthood and experiencing persistent self-doubt about mothering ability
- Stress from changes in home and work routines, coupled with unrealistic expectations of motherhood
- Feelings of loss: loss of identity or self-image, loss of control, loss of body image, or feeling less attractive
- Previous episode of PPD
- An episode of anxiety or depression during pregnancy
- Prior experience of postpartum blues after delivery
- History of mood changes related to normal menstrual cycle
- Any major changes resulting in undue stress during pregnancy, such as a death in the family, unresolved conflict with her spouse, divorce, or moving from one location to another

ETIOLOGY

The integration of biochemistry, hormonal functions, genetic history, stressful life events, and psychosocial factors allows the potential for an occurrence of PPD. Any episode of depression in women is affected by the considerable impact of female biology on the emotional lives of women. The full consequences of female reproductive events and their effect on brain chemistry should be considered in any assessment of depression in women [13].

It is acknowledged that brain chemistry has a major role in producing depression. In some ways, a woman's brain functions differently than a man's brain, which in turn affects the experiences and manifestations of depression [13]. Sex differences in depressive episodes begin to appear as early as adolescence, a time of major changes in the neuroendocrine reproductive cycle with the onset of menses. This indicates the significant impact that brain chemistry has in the development of mood disorders in women [35].

The areas of the brain affected by female reproductive hormones (i.e., estrogen and progesterone) are the same as those known to regulate mood stability and behavior. Therefore, it may be concluded that different hormonal circumstances can alter mood and anxiety in a woman [13]. There are several events associated with a woman's reproductive cycle that provoke mood instability in predisposed individuals, including the use of oral contraceptives, phases of the menstrual cycle, pregnancy and the postpartum period, and menopause. The vulnerability of women for mood instability bears some relationship to the fluctuation of ovarian steroids during specific phases of the reproductive cycle [36; 37].

The areas of the brain associated with anxiety and mood disorders are the limbic brain and the cortex. The paralimbic cortex is the first layer of the cortex that surrounds the limbic brain. The cingulate gyrus is a part of the limbic brain that is believed to be involved in the fight/flight response, mood regulation, and the maternal bonding process. It works collaboratively with other structures of the limbic brain. The instinct for mothering, nurturing, and the emotional responses of the mother toward her infant emanate from the cingulate gyrus area of the brain. This area has evolved to allow for the development of bonding behavior between mother and infant, thus assuring the attachment process [13].

In addition to the cingulate gyrus, the limbic brain is composed of the amygdala, hippocampus, hypothalamus, and thalamus. In concert with the cortex, these areas of the brain recall, correlate, store, and impart emotion to all experiences. The amygdala is an almond-shaped structure that responds to perceived threats to determine whether to fight, flee, or freeze. It is believed that this segment of the brain modulates the production of the neurotransmitters serotonin and norepinephrine. Researchers have discovered that the amygdala is overactive in depressed persons. This finding correlates with the clinical assessment of the simultaneous occurrence of stress with depression [13].

The hippocampus is involved in the creation of memories and in the modulation of stress responses and emotions. The hypothalamus, which is connected to the pituitary gland, orchestrates the menstrual cycle, thyroid function, physiologic stress responses, body temperatures, the sleep-wake cycle, appetite, growth, and lactation. Secretions from the hypothalamus stimulate the release of hormones from the pituitary gland. The feeling of fear, which is an emotion that colors perception, emanates from this area of the brain. Unresolved fear can lead to an incapacitating anxiety, which may also be present in depressed persons [13].

Every significant event in life is accompanied by emotions. These events are thus emotional experiences that are "recorded" in the brain. The "emotional brain" is thought to consist of the prefrontal cortex, which is the area located directly above the eyes, and the frontal cortex. The prefrontal cortex is significantly involved with developing judgment [13]. Sichel and Driscoll refer to the connections between the limbic brain, the paralimbic brain, and the prefrontal cortex as the "prefrontal limbic complex" [13]. This complex has a large role in processing emotions, regulating mood, and storing memories. The memories of powerful life experiences, both stressful and pleasurable, are stored in this area of the brain.

Intellect and good judgment are functions of the prefrontal cortex that override the instinctual urges of the limbic brain; the cortex acts as a buffer to inhibit impulses originating from the limbic brain. If it is too overwhelmed by hormonal fluctuations, the prefrontal cortex may no longer be able to inhibit angry and/or aggressive impulses. Aggressive behavior breaks through when chemical dysregulation within the mood pathways overcomes the buffering effects of the prefrontal cortex. The chemistry of the mood pathway must be stabilized and the disruption in the limbic brain soothed to allow the prefrontal cortex to function properly. If the chemical equilibrium between the paralimbic areas and the cortex is disrupted, then mood regulation can be destabilized [13].

Neurotransmitters are the chemical messengers that allow the nerve cells within the brain to communicate with each other. They help determine the mood pathways in the brain and serve as a chemical messenger system that travels through and innervates the prefrontal limbic complex [13].

Although there are numerous neurotransmitters, those that primarily affect anxiety and mood are dopamine, serotonin, norepinephrine, gamma-amino butyric acid (GABA), and glutamate. Together, these neurotransmitters regulate thinking, emotions, and behavior. Dopamine is involved in learning, memory, and emotional arousal. Norepinephrine is a hormone similar to adrenaline that is released during stress. A lack of norepinephrine may be associated with depression [38]. An excess of norepinephrine can produce agitation or irritability, which also frequently accompanies depression. GABA regulates how fast messages are sent along the nerve cells and helps to maintain a steady rhythm. Excessive stimulation of nerve cells produces a sense of anxiety [34].

These neurotransmitters are operative in both sexes. However, reproductive hormones that act in the same areas of the brain play a part in producing the unique characteristics of depression in women [19]. It is thought that the dramatic rise in reproductive hormones during pregnancy and the equally dramatic fall in these hormones following childbirth neurochemically affect those areas of the brain associated with mood stability. During pregnancy, the elevated levels of estrogen and progesterone have the effect of elevating mood. After delivery, the precipitous drop in the levels of these hormones creates a lowering of mood in some women [13].

The fact that these hormones are measured as nearly absent immediately following delivery of the baby and the placenta is a significant factor in producing depression in women whose brain chemistry may have already been destabilized by earlier events. These hormones are not produced again until approximately six weeks after delivery, when the next menstruation begins [10].

BIOCHEMICALS INVOLVED IN POSTPARTUM DEPRESSION

Serotonin

Serotonin is a neurotransmitter known to be involved in mood and anxiety disorders. It is one of the major classes of chemical messengers known as monoamines and is associated with the induction of emotional calmness and the perception and regulation of pain, restful sleep, sexual behavior, and appetite control. A person's general level of well-being depends largely on his or her levels of serotonin [19].

Serotonin imbalance is thought to be one of the causes of depression, and it may be a source of PPD. Inadequate amounts of serotonin may lead to sleep disturbance, agitation, worry, lethargy, and hopelessness, all of which are symptoms of depression [39; 40]. Multiple studies have linked low-expressing serotonin transporter (5-HTT) genotypes and PPD, and this is an interesting area of research for future treatment options [41].

Serotonin levels in the brain are regulated by reabsorption into the nerve cell, breakdown within the synapse, availability of storage, timing of release, number of receptors, and the amount of tryptophan in the daily diet. Changes occurring

in any of these areas can alter the serotonin pathway and/or availability and lead to anxiety or depression. Serotonin is formed from tryptophan, a basic protein building block stored in nerve cells. Adequate levels of tryptophan are essential to ensure the availability of serotonin. Alternatively, a depressive state can be induced by a depletion of tryptophan [13].

As noted, there are numerous estrogen and progesterone receptors in the same area of the brain where serotonin acts. Research has indicated that reproductive hormone levels seem to influence the availability of tryptophan [42]. The serotonin pathway is heavily influenced by hormonal fluctuations occurring normally during the menstrual cycle and during other major reproductive events, including the postpartum period. The integrity of this serotonin pathway may be jeopardized after childbirth due to the precipitous drop in estrogen and progesterone [13].

Estrogen and Progesterone

Women have a greater lifetime risk than men for depression, with two times the incidence of depressive episodes or recurrent depression [43; 44]. Because higher risk is correlated with gender, it is highly likely that reproductive hormones in women play a role in mood instability [43; 44].

Stabilization of brain chemistry is necessary in order for all systems to function normally. Any disturbances in any one area of the prefrontal-limbic complex affects all other areas. A woman's reproductive cycle and the resultant shifts in hormone levels within the brain can produce a disruption. If a woman's brain chemistry has been altered by previous stressful life events, hormonal shifts can be the catalyst that destabilizes the system and disrupts the capacity to stabilize mood. The impact of normal hormonal fluctuations caused either by the menstrual cycle or reproduction on an already destabilized brain chemistry may induce depression [13].

Estrogen

Estrogen and progesterone can induce changes in all of the neurochemical pathways involved in mood disturbances. This may be a vital aspect of mental health for women, but it remains largely unstudied [13; 44; 45]. Estrogen and progesterone influence serotonin levels as well as the function of the other neurotransmitters [42].

Estrogen receptors are present in many areas of the brain; however, they are found significantly clustered in the limbic area. Estrogen appears to help maintain the orderly firing rates of serotonin, dopamine, acetylcholine, and norepinephrine from nerve cells, which are involved with promoting positive moods, memory, thinking, perception, motivation, appetite, sex drive, anxiety, and stress responses. Estrogen can affect the action of these chemicals by altering the number of receptors on the nerve cells, slowing the breakdown of neurotransmitters, and enhancing sensitivity. Estrogen also enhances glutamate activity; glutamate is another neurotransmitter that encourages mood stability [13].

Sichel and Driscoll believe that estrogen may act within the brain as a natural antidepressant and mood stabilizer [13]. When estrogen levels drop, as they do after childbirth, this effect would presumably be reversed. Fluctuations of estrogen levels at any point during a woman's reproductive cycle can disrupt the delicate balance of neurotransmitters and affect a woman's mood stability. Thus, under normal circumstances, estrogen could be regarded as protecting women against depression [46; 47].

Mood changes, however, do not occur in all women during their menstrual cycle or during the postpartum period [48]. Therefore, it seems that some women have a natural resilience to withstand the impact of hormonal changes. In a study to explore possible early biomarkers of PPD, researchers found that serum estradiol and estriol levels were similar among patients with and without PPD, indicating that a difference in sensitivity of the pathway, at the receptor level or the targets themselves, may be responsible for onset of PPD [49]. In fact, the women in the study who developed PPD were found to be more likely to have an estrogen-sensitive gene expression pattern, indicating that genetic testing of at-risk women may be useful in guiding treatment decisions in the future. Other researchers have proposed that a subgroup of women who constitute a "hormone-sensitive" PPD phenotype may be particularly sensitive to the effects of perinatal changes in hormone levels. Study of this subgroup independent of other PPD phenotypes may identify the underlying pathophysiology and help in the development of novel treatment targets [50].

Progesterone

Progesterone is produced during the second phase of the menstrual cycle and functions to dismantle the nerve connections established by estrogen, decreasing the number of available estrogen receptors [13]. Like estrogen, progesterone is also available in large quantities during pregnancy and drops significantly after childbirth.

Estrogen, progesterone, and endorphins work in concert to influence the brain's chemical pathways. The hypothalamus is responsible for controlling reproductive hormones (i.e., follicle-stimulating hormone [FSH], luteinizing hormone [LH], estrogen, and progesterone), mood, weight, and the circadian day/night rhythm. When an event changes the production or availability of any one of these, there can be an upset of the delicate balance of all the components. During the abrupt decline in estrogen and progesterone, for example, following labor and delivery, there may be a subsequent instability of mood, sleep, and weight (gain or loss) [10].

Conversely, as soon as conception occurs, levels of estrogen and progesterone begin to rise. When the placenta takes over the production of estrogen and progesterone from the ovaries, the level of progesterone rises to 50 times higher than the normal peak of progesterone during the menstrual cycle, and the level of estrogen rises to 130 times higher than the normal peak [10; 19]. The amount of hormones produced by

the adrenals also increases during pregnancy; therefore, twice as many corticosteroids are produced. During pregnancy all of these hormones are controlled by the hypothalamus, the placenta, and the fetal adrenals [10].

As noted, after childbirth and delivery of the placenta, there is a precipitous drop in the levels of estrogen and progesterone. A small amount of estrogen is present, but progesterone is almost completely absent. As a result of these falling levels, available serotonin also decreases. There is an approximate six-week period postpartum during which estrogen and progesterone production is absent; this persists until a new menstrual cycle begins. It is during this critical period, between birth and six weeks postpartum, that a new mother is considered to be the most susceptible to emotional disturbance [10].

Studies conducted by Dalton and colleagues in the United Kingdom indicated a correlation between symptoms in women who were feeling postpartum blues and a drop in blood levels of progesterone [10]. Levels of progesterone were measured over a five-day period. As progesterone levels decreased, women in the study reported increased feelings of sadness [10].

Another study administered high doses of estradiol and progesterone to women, then withdrew it abruptly. Researchers found that 62% of women in the study with a history of PPD had an onset of mood disorder. Interestingly, none of the women without a history of PPD demonstrated symptoms of a mood disorder [30].

Cortisol

Traumatic events provoke a stress response and the release of cortisol, along with other stress hormones. While necessary for survival, this protective stress hormone can exhaust or overwhelm an individual if its level remains too high. When the stress response continues unabated, the nerve cells can continue to maintain the response after the precipitating event has ended, causing emotional distress [13].

In pregnant women, placental hormones stimulate the production of cortisol, the level of which remains high until the placenta is delivered. There is conflicting evidence regarding the role of cortisol levels in PPD [51; 52; 53; 54]. Discrepancies in the studies of cortisol and PPD may result from the lack of control for variables that influence cortisol levels, such as stressful life events. However, it is possible that the sustained high levels, and subsequent drop, of cortisol may have an effect on mood stability in the postpartum period. Some have suggested that women for whom cortisol levels remain higher after delivery of the placenta may have a greater risk of developing PPD [52].

Thyroid Hormones

The role of the thyroid gland is to produce thyroid hormones, including levothyroxine (T4) and L-triiodothyronine (T3). These hormones influence the body's metabolism as well as the function of many organs. T3 is the more biologically active hormone, and it is thought to be the hormone that functions at the cellular level. When the thyroid is underactive, nonfunctioning, or has been surgically removed, hypothyroidism, or insufficient production of thyroid hormone, will develop. Thyroid hormones affect the body's metabolism in multiple areas, including the regulation of vitamins, proteins, carbohydrates, electrolytes, water, and the immune system. They can also alter the actions of other hormones and drugs.

Approximately 5% to 7% of postpartum women have abnormal thyroid levels [55; 56]. Thyroid dysfunction is associated with depressed mood, and in one study, having a thyroid-stimulating hormone (TSH) level greater than 4.0 mU/L at delivery was associated with increased risk for depressive symptoms at six months postpartum [42; 57; 58; 59]. Thyroid dysfunction has not been consistently identified in PPD; however, there may be a subgroup for whom it does play a role.

If thyroid levels remain abnormal, it can alter the effectiveness of the treatment for depression [13]. Therefore, laboratory tests of thyroid function, particularly in women with signs or symptoms of thyroid dysfunction, should be included in the evaluation for PPD. Screening for thyroid dysfunction in the postpartum period may help identify women at risk for PPD; however, consensus guidelines do not advocate screening of all women [42; 60; 61].

According to the American Thyroid Association, there is insufficient evidence to conclude whether an association exists between postpartum depression and postpartum thyroiditis. However, as it is a potentially reversible cause of depression, women with postpartum depression should be screened for thyroid dysfunction and appropriately treated.

(https://academic.oup.com/jcem/article/97/8/2543/2823170. Last accessed March 27, 2020.)

Level of Evidence: B (At least fair evidence that the service improves important health outcomes and benefits outweigh harms)

FAMILY HISTORY

Some families appear to be more prone to depressive illness than others [13]. Therefore, a woman's genetic makeup may be a risk factor for PPD. A detailed family history specifically documenting incidences of depression or mental illness is useful in any PPD assessment.

With this in mind, certain traits are possible indicators of disturbances in brain chemistry and mood instability in some individuals [30]. Some important traits that may become evident when taking a patient's history include:

- Family history of suicide or a preoccupation with suicidal thoughts
- Family history of depression
- Family history of addiction to alcohol or drugs
- Poor judgment as indicated by inappropriate or impulsive financial, sexual, or violent behavior
- Aggression
- Grandiose expressions and behaviors
- Family history of bipolar disorder
- Unstable or chaotic lifestyles
- Lack of empathy for others
- Enmeshed or estranged family system
- Family history of bouts of rage or physical abuse
- Extremely rigid parents (disciplinarians)
- Compulsive behavior

The presence of any of these traits in a woman's family may be indicative of a family history of alterations in brain chemistry and mood instability, which may have been inherited by the patient [2; 13; 30].

As noted, some women seem to display a resilience to chemical dysregulation, and these women do not have mood destabilization at critical junctures in the hormonal reproductive cycle. Much research is being conducted in this area of inquiry to determine the role genetics play in protecting from and/or inducing PPD [13]. As discussed, genetic differences in estrogen signaling, cortisol levels, and serotonin expression have all been linked to higher risks of PPD [41; 49; 52].

STRESSFUL LIFE EVENTS

Childhood traumatic events and powerful emotional responses to those events are unconsciously encoded in the paralimbic cortex area of the brain. A woman who has endured traumatic events early in life can become psychologically and biochemically overloaded. These biochemical changes then predispose her for a depressive episode in response to various reproductive events later in life, including pregnancy and childbirth. Over time, it becomes increasingly difficult to maintain physiologic and psychologic balance. When a woman's history is examined closely, certain stressful life events preceding PPD may be present. These stressful events, many of which may have occurred early in life, sensitize the brain and may affect its biochemistry and subsequent behavior. Evidence of prior mood disturbance is often present in a depressed woman's history [13].

The brain's mood pathways can presumably be restored to normal following one depressive event without any further episodes, assuming that the depression is treated aggressively and appropriately. However, research has shown that 70% of those who become depressed will have another depressive episode [13; 62].

PSYCHOSOCIAL FACTORS

Part of a woman's preparation for motherhood involves her expectation and anticipation of the event and her ideals regarding labor, delivery, the child, and how she will feel. These ideals are often based on the image of the "perfect" mother or "perfect" child. A significant discrepancy may exist between what is expected and the actual delivery and birth of the baby. Confusion, unhappiness, and guilt may be the result. Even the happiest of new mothers feel some disappointments, and high concern over mistakes and perfectionism are risk factors for PPD [63; 64].

It is observed that women with PPD do not experience the initial stages of motherhood as they had fantasized; consequently, their disappointments are more intense and severe. Women with postpartum blues or depression may seem unable to deal with disappointments with equanimity. When a woman is already biochemically predisposed to depression, unfulfilled expectations, unanticipated losses, and/or lack of social support create the potential for PPD to develop. For a woman with PPD, disappointments will be felt more intensely and with a greater degree of emotional sensitivity and self-criticism [63].

There are many expectations attached to having a baby. For a woman without a positive relationship with her mother, there may be a desire to demonstrate that she can be a better parent to her child, or she may have the fantasy that having a baby will bring her emotionally closer to her mother. If a woman feels that her own mother was a poor role model, she may have conflicting emotions about becoming a mother herself. This can lead to self-criticism and intensify feelings of being a "bad mother," which often accompany depressive symptoms of PPD [13].

Fears of being a "bad mother" or admitting to thoughts of harming one's baby may be particularly heightened among racial/ethnic minority women who are greater risk for having children removed or being deemed "unfit" by child welfare workers [233; 234]. This appears to be especially prevalent in African American and Black families and may be a barrier to seeking care [235].

In some cases, the child may have been conceived with the idea that it would improve a relationship with the partner or bring greater harmony to a marriage [63]. Pregnancy conceived to resolve a troubled marriage may actually worsen an already difficult relationship as a result of the additional adjustments a pregnancy demands. Due to the hormonal changes caused by pregnancy, women may be particularly sensitive. Disharmony in a marriage can trigger depression in a pregnant woman, making her more vulnerable to PPD [19].

Desertion of a partner or husband during or after pregnancy produces enormous stress on a new mother. The lack of support that a partner affords to the new baby may create a crisis and negatively impact the woman's ability to care for her child. Mixed emotions of anger, guilt, and insecurity

can be critical stressors if a woman's partner is absent or unsupportive. Marital conflict is a common finding among depressed pregnant women and women with PPD [65; 66].

In some families, especially in some cultures, enormous value is placed on male heirs; therefore, there may be a considerable amount of pressure to have a male child. In these cases, having a female child can be a huge disappointment, and the woman may feel that she is a failure [63].

The psychologic impact of infertility may also play a role in the development of depression in some women. Impaired fertility affects approximately 12.3% of women of childbearing age in the United States [67]. Studies of women receiving fertility treatments have shown that these women generally had less satisfaction with life, higher levels of anxiety, and tested higher on the depression scores than women who were fertile [19]. Infertility had an impact on sexuality and self-esteem, and women being treated for infertility were likely to blame themselves and to avoid contact with friends [68]. Women receiving, or who have received, fertility treatments require compassion, understanding, and support. Treatments can take considerable time and require a woman to deal with the emotional and mental consequences of hope and loss. Fertility medications themselves, which generally act on the pituitary gland, may disrupt mood stability [19].

The expectations of motherhood carry an immense emotional weight. Fantasies about the kind of mother a woman will be establish presumptions of having to behave, respond, and feel a certain way. When a woman's reactions do not correspond to these idealized fantasies, there may be resulting feelings of failure and self-defeating disappointment [63; 69]. Most women have coping mechanisms that allow them to deal with the conflicting emotions of disappointment and joy, or love and resentment, and are able to enjoy being mothers. Women with PPD have great difficulty dealing with these ambivalent, conflicting feelings and, as a result, are unable to maintain emotional balance [63].

TYPES AND SEVERITY OF POSTPARTUM DISORDERS

POSTPARTUM BLUES

Postpartum blues, also referred to as "baby blues," is the most common type of postpartum mood disturbance, occurring in approximately 70% to 85% of all new mothers [3; 70]. Its onset is usually shortly after birth, and it generally resolves within 10 days [2; 3]. A study by Iles et al. indicated a characteristic pattern of mood changes that peaked on day 5 after delivery and declined by day 10, perhaps best described as a period of emotional upheaval following birth [71]. Incessant crying and tearfulness are the most common emotional expressions of postpartum blues [2; 3].

Miller and Rukstalis prefer the term "postpartum reactivity" to describe the mood fluctuations that occur with postpartum blues, as they believe the term "blues" is often confused with depression [72]. However, the term "baby blues" has been popularized in modern culture and is often used to describe the phenomenon that occurs shortly after birth. It is important to distinguish the postpartum blues from PPD both to avoid confusion and to aid in treatment.

Postpartum blues are characterized by heightened responsiveness to stimuli, wide mood swings, tearfulness, and irritability. The exhaustion and fatigue experienced by women following birth significantly alters sleep patterns, further inducing mood alterations and irritability secondary to sleep deprivation [73]. The cause of the postpartum blues is considered to be primarily physiologic in nature [72].

The incidence of postpartum blues varies in different cultures; however, it has been demonstrated in every culture in which it has been studied [72; 74; 75; 76; 77]. Psychosocial variables that affect postpartum blues tend to influence how women express their emotions, but not whether the blues occur [72]. Therefore, research into the most accurate assessment tool for postpartum blues and depression across cultures is ongoing [3; 39].

As discussed, incessant crying and tearfulness are the most common emotional expressions of the postpartum blues. The tearfulness is not necessarily linked to sadness, but occurs in response to numerous environmental triggers, such as insufficient milk production, too much or too little attention from nurses, or a sarcastic remark [10]. Essentially, an emotional oversensitivity exists. All of the emotions associated with childbirth are normal and healthy so long as they are not excessive and resolve within one to two weeks [10]. The signs and symptoms of postpartum blues include [10; 13; 72]:

Emotional Symptoms

- Crying easily
- Mood swings
- Feelings of sadness for no reason
- Irritability towards the baby and/or the other parent
- Anxiety
- Excessive worrying
- Emotional sensitivity

Physical Symptoms

- Fatigue
- Apathy
- Exhaustion
- Inability to sleep

Cognitive Symptoms

- Poor concentration
- Confusion

- Slowness to learn new skills (e.g., bathing and feeding the new baby)
- Mental fatigue

Healthcare professionals in contact with a mother who is experiencing postpartum blues should listen to her without judgment and explain that what she is experiencing is not uncommon, she is not to blame, and the symptoms should soon resolve, allowing her to return to her normal state. Women are treated by one set of healthcare professionals during prenatal visits and an entirely new set after childbirth. This can produce its own set of problems. The attitude of nurses and other healthcare professionals towards mothers who are experiencing postpartum blues can help or hinder the mothers' recovery [10].

The postpartum period is a challenging time for any mother, but may be particularly difficult for first-time mothers who may feel insecure and apprehensive about their new maternal responsibilities. Attending to the demands of a new infant who requires total care while also recovering from fatigue and sleeplessness can be overwhelming. In some countries, home visits are key in providing emotional support and practical advice to new mothers as a matter of routine. For example, in the United Kingdom, it is common for nurses to make home visits to provide support and advice to new mothers. In the United States, however, this is less common, with minimal support often available for mothers during this unique and stressful time. In most instances, a mother is discharged from the hospital to her home situation and is left to navigate the postpartum period and care for herself and her new baby on her own [2].

An estimated 10% to 25% of women experiencing the transient state of postpartum blues will subsequently become seriously depressed [2; 3; 78]. The development of a more serious depression involves psychologic and psychosocial factors that are not prevalent in the development of the postpartum blues. An early warning sign for more serious depression is feeling overwhelmed combined with suicidal ideation; this should not be ignored. Feeling overwhelmed is normal after childbirth, but feeling suicidal is not. Being overwhelmed and/or distressed for longer than two weeks should be a warning signal that the patient requires an evaluation for depression.

POSTPARTUM DEPRESSION

With an annual live birth rate of nearly 4 million in the United States each year, an estimated 600,000 women experience PPD in the United States [79; 80]. Women who miscarry or whose children are stillborn are also susceptible to PPD. When this group is included in the figures, an estimated 900,000 women suffer from PPD each year [80]. Several studies have shown that PPD occurs with greater frequency in the first 3 months following childbirth than in the 6 or 12 months following [81]. Although exact percentages vary, it has been reported that between 40% to 90% of PPD cases occur within three months after childbirth. Nonetheless, women should be carefully assessed throughout the first year after childbirth, as PPD can occur up to one year postpartum [66; 70].

In some cases, the first symptoms of PPD occur within hours or days after birth and increase in severity over the following weeks. When this is the case, mothers often do not understand what is happening; they do not understand why they are not happy about the new baby in the way that they are expected to be [10].

It has been posited that PPD diagnoses should be exclusive to the postpartum period [10]. If a woman has been depressed prior to giving birth, depression in the postpartum period may be diagnosed as recurrent depression. PPD has been formally defined as, "the first occurrence of psychiatric symptoms severe enough to require medical help, occurring after childbirth and before the return of menstruation" [10].

Women for whom PPD is their first incidence of depression tend to experience a shorter duration of symptoms, be significantly less likely to experience recurrent depression outside the postpartum period, and be more likely to experience subsequent PPD [66]. Whether PPD is determined to be the first episode of depression may depend upon the clinician's history-gathering skills. Many women who are diagnosed with PPD as a first episode of depression may realize, upon careful examination, that they have experienced depressive symptoms in the past, although the symptoms may never have been diagnosed as depression [13; 82].

Whether it is the first or a recurrent depressive episode, PPD is a serious, debilitating depression that affects the mother in profound ways. PPD is classified as a major depressive disorder [13]. It is characterized as a downward spiral in total functioning, involving mood changes and changes in bodily functions, including appetite, concentration, sleep-wake cycles, and energy levels [13; 82].

Similar to postpartum blues, the symptoms of PPD can be classified as emotional, physical, cognitive, or behavioral. Ultimately, the mind and body are both affected by biochemical dysregulation of the brain.

Emotional Symptoms

The emotional symptoms of PPD may include [2; 3; 5; 10; 13; 82]:

- Pervasive sense of sadness and melancholy
- Loss of interest and enjoyment in life
- Loss of interest in all or most of usual activities
- Irritability and emotional outbursts
- Unpredictable tearfulness and crying spells
- Hopelessness and helplessness
- Suicidal thoughts
- Feeling overwhelmed
- A sense of emotional numbness or of feeling trapped
- A strong sense of failure, inadequacy, and guilt

- Fear of being alone
- Feelings of shame

Physical Symptoms

The physical manifestations of PPD are diverse and include [2; 3; 5; 13; 82]:

- Sleep disturbances (i.e., sleeping either too little or too much)
- Increased or decreased appetite
- Weight gain or significant weight loss
- Decreased energy, lethargy, and fatigue
- Restlessness and agitation
- Loss of libido and disinterest in sexual activity
- Headaches
- Chest pains and palpitations
- Hyperventilation

Cognitive Symptoms

When PPD affects cognitive abilities, it may present as [2; 3; 10; 82]:

- Thoughts of worthlessness
- Recurrent thoughts of death or suicide
- Difficulty concentrating
- Memory problems
- Difficulty thinking clearly and making decisions
- Pervasive anxiety with excessive fear and worry
- Excessive concern about the welfare of the child
- Negative self-talk
- Thoughts of harming the baby

Behavioral Symptoms

Finally, the behavioral symptoms of PPD are [2; 3; 10; 82]:

- Withdrawal from her infant, spouse, family, and friends
- Physical neglect of herself and/or her infant
- Physical and mental exhaustion
- Inability to cope with daily routine
- Lack of concern for herself or her infant
- Neglect of personal environment

Symptoms may vary among women and over time in any one woman. Not every woman will have all of these symptoms. There are some general ways these symptoms might be expressed, giving the clinician clues to look for in women who might be predisposed to PPD.

Due to the shame experienced by some women with PPD and the subsequent secrecy with which they may hide their symptoms, it may not be obvious to a clinician how this illness impacts mothers and their children, spouses, and families. Women with PPD who ask for help often find that their problems are minimized or trivialized. It is crucial to understand how much women suffer from this disorder and acknowledge that their symptoms are not trivial. A description of the most common symptoms of PPD may therefore be helpful in diagnosing and managing the disorder.

Pervasive Sense of Sadness and Melancholy

Some women may feel sad most of the time; others have days in which their moods seem more normal and they feel good. However, the good moods do not last more than one or two days, after which the sadness falls upon them again.

Loss of Interest and Enjoyment in Life and Usual Activities

Women who are depressed suffer from lethargy, fatigue, and apathy. Family and friends may find it difficult to accept that activities that once brought the individual pleasure no longer interest her. It may be too difficult for women with PPD to generate sufficient energy to even engage in certain activities.

Irritability and Emotional Outbursts

Irritability is one of the main mood changes most women experience with PPD. This type of irritability is characterized by emotional swings from anger to distress. Frequently, attacks of irritability end with uncontrollable sobbing. Mothers find that this irritability is out of their control, which adds to the distress [3; 10]. If the irritability continues, it can make dealing with the tasks of caring for an infant very difficult and can damage other relationships. Irritability may be expressed either verbally or through physical violence. Mothers may describe themselves as intolerant, impatient, jittery, short-tempered, spiteful, or quarrelsome. Irritability varies in its intensity among women with PPD and may develop in the weeks to months after childbirth.

Unpredictable Tearfulness and Crying Spells

Another of the most common symptoms of PPD is tearfulness and uncontrollable sobbing, with or without discernible external stimuli. These symptoms are also common among women who experience the postpartum blues; however, if these symptoms continue beyond two weeks after birth, they should be considered as part of the onset of PPD.

Sleep Disturbances

All new mothers experience a change in sleep patterns. Due to the baby's presence and the need for feedings during the night, most new mothers suffer from some degree of sleep deprivation. There is a different quality to sleep problems in women with PPD. These women have difficulty getting to sleep, have disturbed sleep, and/or wake early and are unable to go back to sleep. Insomnia is a common complaint. Even when they do sleep, it is never enough; the sleep is not refreshing. Five hours of solid sleep is often recommended; however, women with PPD are rarely able to sleep for that length of time. It is usual for new mothers to have their sleep interrupted by a crying baby, but women with PPD report

that they cannot go to sleep even when the baby is settled and goes to sleep. They may lie awake worrying. Although rare, some women with PPD report sleeping too much [2; 82].

Feeling Overwhelmed and Unable to Cope

Most mothers realize that they have new responsibilities and demands with the arrival of a child. Some new mothers feel overwhelmed by the constant demands of caring for infants, fulfilling the role of mother and wife/partner, and maintaining other relationships. They may also feel pressure to run the household smoothly, especially if caring for additional children. Bothered by fatigue and lack of sleep, it is difficult not to feel overwhelmed at times. However, mothers experiencing PPD can feel overwhelmed by the smallest tasks, such as changing diapers. A strong feeling of helplessness and a lack of confidence in her ability to cope undermines any self-confidence she may have enjoyed prior to her depression.

Hopelessness and Helplessness

For some women with PPD, there is a loss of hope in life. Women may wish they were dead and have thoughts of suicide. Although thoughts of harming oneself are prevalent among women suffering from PPD, these drastic thoughts often are not that they actually want to die, but that they want the situation to change and feel hopeless about being able to change it. In some instances, thoughts of suicide may become too strong to resist, and some women with PPD do complete suicide. Any thoughts of suicide should be taken seriously and warrant immediate intervention [2; 69].

A Sense of Failure and Inadequacy

An inability to cope with everyday functions may lead to a negative self-concept and negative self-talk. The negative perception of self can be so convincing that an individual believes she is incompetent as a woman, wife, and mother. Such feelings are difficult to eliminate for women who are depressed [69].

Thoughts of Worthlessness or Guilt

One of the most prominent features that a woman with PPD experiences is that somehow she is not worthy of having a child; she may feel that because of the depressive symptoms, she is a bad mother. These thoughts may cause an individual to detach herself, in an effort to hide perceived inadequacies from others. Women who believe that they are "bad mothers" also have significant feelings of guilt. There is an accompanying loss of self-confidence in other areas of life that is difficult to shake. These women may have excessive guilt about any minor wrongs committed in the past [2; 69].

Difficulty Concentrating, Thinking Clearly, and Making Decisions

The loss of concentration associated with PPD may cause women to forget things that ordinarily come easily, such as turning off the stove or putting things away. Everyday tasks may become so difficult that they seem monumental. In order to cover up the confusion, women may avoid certain activities. Women who were previously leaders or extroverts or who enjoyed a high level of confidence prior to childbirth may be distressed by a loss of confidence. Loss of confidence is often accompanied by a desire to withdraw from one's surroundings, become detached, and avoid socializing or making contact with other people [10; 69].

Pervasive Anxiety with Excessive Fear and Worry

Anxiety is a common symptom that accompanies depression. Symptoms of anxiety may be felt emotionally, cognitively, and/or physically. Anxiety permeates everything a woman with PPD experiences, bringing with it a feeling of dread that does not resolve with any amount of reassurance. Anxiety can be incapacitating, affecting the ability to think, concentrate, or make sound decisions [34; 69].

Thoughts of Harming the Baby

Any thoughts of harming the baby should be taken seriously, and immediate help should be given. Unfortunately, suicide and homicide can be consequences of PPD. Although a mother may not wish to harm her baby, these thoughts may have an alarming obsessive quality that could eventually override her ability to make rational judgments to control her behavior [2; 69].

POSTPARTUM PSYCHOSIS

Postpartum psychosis is an extreme condition that can occur during the postpartum period. The term "psychosis" is defined as a mental state characterized by being out of touch with reality [2]. Postpartum psychosis affects approximately 1 or 2 in 1,000 first-time mothers [3; 15]. For women who experience psychosis after the birth of their first child, the risk increases by 50% for subsequent deliveries [15]. The major risk factors for postpartum psychosis are a personal history of PPD or psychosis, a family history of depression, or the presence of bipolar disorder [3; 15; 43; 69]. One study found that nearly 10% of women hospitalized for psychiatric conditions before delivery went on to develop postpartum psychosis after their first child was born [83]. When it does occur, psychosis in a new mother constitutes a psychiatric emergency, requiring immediate treatment and, in many cases, psychiatric hospitalization.

Women are seven times more likely to be hospitalized for a psychotic episode during the first month after delivery than at any other time before or after childbirth [69]. For women with a history of postpartum psychosis, the risk of psychiatric hospitalization after childbirth is increased [8]. One-half of all psychotic mothers are admitted to a psychiatric hospital within 14 days of delivery [13]. In one study, 90% of women with postpartum psychosis had an onset of symptoms within four weeks of delivery [83]. In most women, symptoms develop within the first two weeks postpartum [3].

Several studies have indicated that the incidence of postpartum psychosis worldwide has been essentially unchanged over the last century and a half [8; 84; 85]. The fact that the rate has remained constant suggests that modern scientific medi-

cal care and the mother's physical health are not factors in the development of the condition. Although the prevalence has remained unchanged, maternal morbidity and mortality have been greatly reduced [8].

Psychosis may take different forms depending upon a woman's history of prior psychiatric illness. Psychotic disorders in the postpartum period are typically characterized by an abrupt onset, severe symptoms, and dramatic, difficult, and disruptive features [3]. As noted, symptoms of psychosis usually occur in the first few days to weeks after childbirth. However, in some cases psychosis occurs immediately following delivery [3; 8].

Postpartum psychosis may not be obvious unless the mother is questioned about her emotions and mental status. She may be successful at hiding her psychotic thinking until it manifests in her behavior. Psychosis may also be delayed until after the mother stops breastfeeding, which produces a secondary hormonal shift and may trigger depressive or psychotic symptoms in predisposed women. Fortunately, postpartum psychosis is rare [3]. Nonetheless, it is the most dangerous and tragic postpartum disorder and should not be overlooked [2].

Postpartum psychosis is characterized by hallucinations, delusions, confusion, extreme agitation, inability to carry on a coherent conversation, and inability to sleep or eat [3; 69]. Moods may swing from euphoria to homicidal or suicidal ideation in a short period of time without warning. The risk of suicide or infanticide requires immediate attention. Safeguards should be established to protect the mother from harming herself or her baby until psychiatric intervention becomes available [13]. Irrationality is the hallmark of postpartum psychosis, and a mother's behavior may be peculiar or described as bizarre. She may engage in frenzied activities, as though in response to stimuli not apparent to anyone other than herself [10].

Psychotic women may become paranoid or suspicious of other people's intentions or behavior. Women may imagine that people are ridiculing or talking about them. In extreme cases, individuals may refuse food or prevent their infants from feeding appropriately [2; 69]. Psychotic mothers feel alienated from what is going on around them, and to the observer, they may appear obviously disturbed.

Mood alterations may suggest a postpartum manic-depressive psychosis or bipolar disorder. Women with this illness have extreme polarity of moods, from bliss to deep depression [69]. The manic state is marked by physical hyperactivity, a rapid rate of speech, disconnected thought patterns, and grandiose ideas. There may also be periods of anger or aggression, with verbal or physical manifestations. Delusions may center on perceived special powers, fame, or capability to carry out enormous exploits. The infant may also be incorporated into the delusions, creating a risk of harm. The depressive phase is profound in its depth of despair. Bipolar psychosis is dramatic and usually (although not always) occurs in postpartum women who have a history of bipolar disorder prior to pregnancy [2; 69].

Psychosis may also result in auditory or visual hallucinations [69]. Visual hallucinations present distorted or unreal images of the people around her, the environment, or her baby, and they can be very disturbing and frightening. Auditory hallucinations include hearing voices that appear to come from sources that are not present. These hallucinations become dangerous when they issue commands to commit certain acts that would ordinarily be against her will; these are called command hallucinations. If these commands coerce a woman to hurt her baby and are too compelling for her to resist, they may lead to infanticide [2; 69].

Women with postpartum psychosis may also feel pressured to get rid of the baby or to give the baby away because they are convinced something is terribly wrong with it or with themselves. Women may completely reject their babies and refuse to have anything to do with them as a result of delusions that the baby is defective. Some express the belief that death would be an improvement for the child. Reassurances ordinarily do not work in cases of postpartum psychosis; no amount of evidence to the contrary will change the attitude towards the baby. In these circumstances, a mother should never be left alone with the child. Furthermore, the baby should not be forced upon her, as she could harm the child in her delusional state [10]. As the mother's psychosis is treated and her delusions abate, assisting her in bonding with her infant, under direct supervision, becomes possible.

Another symptom of psychosis is confusion or disorientation [69]. Confusion is defined by a lack of awareness of identity, surroundings, or time. Disorientation, on the other hand, is characterized by forgetfulness from one moment to the next. If confusion and disorientation are present, organic brain conditions should be ruled out. An acute organic brain condition is a medical emergency and should be diagnosed and treated immediately. Generally, when the condition is corrected, the symptoms will resolve [2]. As with the onset of any psychotic or delirious symptoms, toxic, metabolic, and neurologic causes should be ruled out. Toxic delirium and psychosis may present with similar symptomatology [8; 86].

If, for some reason, a psychotic mother must be cared for at home, it is essential that both the mother and her baby remain under constant observation by family or friends who have been educated about postpartum psychosis and know when and whom to call in case of an emergency. A psychotic mother's actions are totally irrational, and irreversible damage can be done if she is left alone [2]. Possible other sources of supervision include home health providers or social workers.

Relatives and friends should be warned of the possibility of psychosis returning even if a mother is treated in a psychiatric hospital and released. There is a danger of psychosis returning at the resumption of menstruation, even if the mother is undergoing continuous psychiatric outpatient treatment. Twenty-four hour surveillance is necessary at this vulnerable time [3; 10].

INFANTICIDE

It is estimated that 1 in every 250,000 women with postpartum psychosis commits infanticide [10]. Any time a new mother is psychotic, the risk of infanticide should be considered. There is always a possibility that the mother will incorporate the baby into her delusional thinking, and this will increase the risk of infanticide [2; 3]. When healthcare professionals are unaware of the symptoms of psychosis and how dangerous the condition is for the mother and her baby, tragedy can occur. Psychotic mothers retain little ability to appreciate what they are doing; some may kill their infants unwittingly in a state of confusion, when out of touch with reality [13].

In general, healthcare professionals should be alert for early signs of psychosis, such as agitation, hyperactivity, or restlessness following delivery [69]. Suspicious, paranoid ideations might manifest as a certainty that there is something seriously wrong with the baby or that nurses are hurting or trying to poison the baby. These symptoms are usually indicators that the mother is in the early phases of a psychosis; they should be reported immediately to facilitate a psychiatric consultation [10].

It is also important to note that cases of child abuse and infanticide are not limited to mothers who are psychotic. A study of mothers of children younger than 3 years of age found that 41% of depressed mothers had thoughts of harming their child [87]. However, postpartum psychosis is a significant risk factor for both ideation of child harm and completed infanticide.

Legal Issues

In the United Kingdom, it was lawyers, not medical professionals, who first appreciated that a mother who killed her baby was temporarily mentally disturbed. The crime of infanticide was introduced into law in England and Wales in 1922, and later amended in the Infanticide Act of 1938 [87; 88]. This law states that a mother who kills her own child can be charged with a lesser offence of infanticide, not murder. Murder, if proved, must be punished by a prison sentence. This only covers the killing of an infant younger than 12 months of age and does not extend to other individuals [10]. At least 20 other countries with infanticide laws have followed the British precedent, including Australia, Canada, Germany, India, Japan, and the Philippines [236].

Given the rigidity with which the legal system in the United States views mental illness, infanticide becomes legally challenging. By the time a case of infanticide reaches trial, the mother's mental status has usually improved and is no longer psychotic. An aggressive prosecutor can make it appear as though the psychosis was fabricated to cover up the crime. In many cases, there are inadequate records to support the mother's claim that she did not know what she was doing and that she killed her child, "in a fit of insanity, which has since passed" [8]. However, change may be coming to the United States. In 2018, a law was passed in Illinois (PA100-0574) to recognize postpartum illness as a factor in criminal cases [237]. This law makes PPD and postpartum psychosis mitigating factors in sentencing.

The public understandably finds infanticide repugnant and incomprehensible. Without proper instruction from the judge at trial and without a specific law to guide jurisprudence in cases of infanticide, it is difficult for a jury to acquit a mother when an infant has been killed. However, given the media focus on cases of infanticide, some guilty verdicts have been overturned in the Court of Appeals. There may be a tendency toward leniency developing in the United States; however, mothers in the United States who commit infanticide may face the death penalty [89]. In a case study of 24 infanticide cases in the United States in which postpartum psychosis was the defense, 33% of defendants were found not guilty by reason of insanity, 17% were given probation, and 42% were incarcerated, with 8% sentenced to life in prison [87]. The laws in the United States that govern insanity pleas and infanticide remain inconsistent, differing from state to state [88; 89; 90]. The DSM-5 includes the diagnosis of major depressive disorder "with peripartum onset" specifier. This specifier applies if the onset of mood symptoms occurs during pregnancy or in the four weeks following delivery [14]. Some had lobbied for the specifier to include the six months following delivery [91]. Judges, without precedents to follow, generally attempt to give broad latitude to infanticide defendants [8].

Broad latitude shown to infanticide defendants by the justice system is a step in the right direction, but it does not fully address the realities of postpartum psychosis. Sichel and Driscoll have stipulated that, "there is a difference between a person who kills with malice and one who kills under the influence of postpartum psychosis" [13]. There are women who do harm their children with malice; however, the criminal justice system, when properly supplied with accurate information regarding postpartum psychosis, should conceivably be able to enact laws that protect women who kill their infants while under the influence of postpartum psychosis [13; 89].

Spectrum of Infanticidal Thoughts and Actions

Infanticidal fears, or women who think about or are frightened about harming their baby and manage to resist, have not been studied carefully. There are few statistics on the frequency of these fears in women with PPD or postpartum psychosis. Mothers may not readily confess to such fears if they are aware that they may be incarcerated or that their children may be removed from their care [10].

Dalton studied PPD and, in her research, saw an unusual number of women charged with infanticide or who, under the influence of postpartum psychosis, have very nearly killed their children. She noted three varieties of infanticide: those occurring shortly after birth while the mother is acutely psychotic; those occurring with the return of menstruation; and those occurring during "domestic feuds." According to

Dalton, many of these incidents "do not appear in the press or in law reports and remain hidden from the public" [10].

ASSESSMENT FOR POSTPARTUM DEPRESSION

CLINICAL ASSESSMENT

Data from the Centers for Disease Control and Prevention (CDC) Pregnancy Risk Assessment Monitoring System (PRAMS) and the U.S. Preventive Services Task Force (USPSTF) indicate that 10% to 15% of new mothers suffer from PPD, and up to 85% experience postpartum blues [92; 93; 94; 95]. A 2017 study found a decline in PPD from 14.8% in 2004 to 9.8% in 2012 [230]. The rate of depressive disorders diagnosed at the time of delivery increased from 4.1 per 1,000 hospitalizations in 2000 to 28.7 per 1,000 hospitalizations in 2015 [231]. The CDC has therefore recommended that healthcare providers address the issue of PPD during prenatal visits, preferably during the third trimester [92]. Other sources, including the USPSTF, recommend assessing for depression throughout the prenatal period [94; 96]. The USPSTF has stated that screening pregnant and postpartum women for depression may reduce depressive symptoms in women and that screening instruments can identify pregnant and postpartum women who need further evaluation and who may need treatment [94]. The screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up [94; 97].

Consultation with patients about their risk for psychiatric illness during the postpartum period also should be discussed [92; 96]. Clinicians should understand that knowing about a pregnant woman's mental and emotional state is as important as knowing about her neurophysiologic status. This initial assessment should include a psychosocial history that is sufficiently comprehensive to determine a woman's vulnerability to developing PPD [96]. Early detection and treatment of depression during pregnancy can prevent a more serious downward spiral into PPD following delivery [94]. Early treatment has also been shown to decrease the duration of PPD [73].

Both the USPSTF and the American College of Obstetricians and Gynecologists recommend that assessment for depression using a standardized, validated tool occur at least once during the perinatal period [94; 97]. Women with current depression or anxiety, a history of perinatal mood disorders, or risk factors for perinatal mood disorders should receive close monitoring, evaluation, and assessment [97]. Women most likely to suffer from PPD often describe pregnancy as "one of the worst times of my life" or a "very hard time" [98]. In order to avoid a delay in learning about a woman's problems caring for the baby or herself, a plan for early detection of women at risk for PPD should be in place [94; 97].

Specific areas should be addressed in the initial clinical assessment [13; 96]. This includes asking a woman about any prior history of depression or hormonal mood changes, such as premenstrual irritability. Patients should also be asked if they have ever been treated for depression or if any family members have been depressed, suicidal, or hospitalized for a psychiatric illness [94; 96].

Many women are reluctant to reveal a personal history of mental disorder; therefore, education regarding the occurrence of postpartum blues and PPD should accompany the discussion about personal history. Educational materials should be available and distributed in clinics or women's health centers. Questions asked by clinicians will make more sense to a woman if she understands that PPD is a complication of childbirth and that she is undergoing an evaluation for her sensitivity to this condition. Reassuring patients that most women go through pregnancy and childbirth with minimal problems can help to put them at ease.

Although women may initially be reluctant to reveal personal information regarding their mental/emotional state or psychosocial history, many women who have had PPD relate how they wish that someone had told them about the illness before it happened to them. This is important because knowing what is causing their altered moods and behavior helps to give women a sense of control [11; 99; 100].

The lack of openness, public awareness, and education about PPD contributes to its secrecy. Ignorance of this disorder causes women to not seek treatment, which in turn can allow the depression to worsen and potentially endanger both the mother and her baby. Educational materials made available to pregnant women are an excellent way to begin an assessment of a woman's risk for developing PPD.

When an assessment indicates that a prenatal woman is at risk for developing PPD, she should be referred to a mental health clinician for further evaluation. A collaborative relationship between the woman's healthcare provider and the mental health clinician should be maintained throughout the woman's pregnancy and postpartum period [94]. Establishing specific boundaries at the outset makes for better, more effective treatment for the mother [73]. Kennedy et al. recommend an interdisciplinary model of care that includes practitioners from the mental health, women's health, medicine, pediatrics, nursing, nutrition, and social work fields [73]. A team approach will most likely serve the mother's and her family's needs. It is essential that an accurate diagnosis of depression is made by a qualified professional. If clinicians cannot detect high risk on their own, they should refer the patient to a specialist. As stated, the USPSTF recommends that the assessment be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up [94; 97].

Various states have enacted PPD legislation that mandates that information regarding PPD be made available to women and their families. For example, New Jersey specifically

POSTPARTUM DEPRESSION SCREENING SCALE (PDSS)	
Dimensions	**Sample Statement**
Sleeping/eating disturbances	Tossed and turned for a long time trying to fall asleep
Anxiety/insecurity	Felt really overwhelmed
Emotional lability	Cried a lot for no real reason
Cognitive impairment	Thought I was going crazy
Loss of self	Felt like I was not normal
Guilt/shame	Felt like a failure as a mother
Contemplating harming oneself	Just wanted to leave this world
Source: [103]	*Table 1*

requires that physicians, nurse midwives, and other licensed health care professionals providing postnatal care to women screen new mothers for PPD symptoms prior to discharge from the birthing facility and at the first few postnatal check-up visits [23]. Hospitals and other healthcare facilities must provide departing fathers/partners and/or other family members with written information about PPD as needed, including its symptoms, methods of coping with the illness, and treatment resources to overcome the spillover effects of the illness and improve their ability to be supportive of the new mother. Illinois requires professionals to screen new mothers before discharge, to invite PPD screening at prenatal visits and at each well-baby checkup until the infant's first birthday, and to provide information to partners and families [24]. Other states (e.g., Minnesota) require that materials regarding PPD be made available to new mothers, partners, and their families, but do not specifically mandate screening [101]. Healthcare professionals should be familiar with state law in their jurisdiction.

Healthcare professionals who have 24-hour contact with women after delivery should be equipped to recognize women who are struggling with depressive symptoms beyond postpartum blues. These women should be referred for psychiatric consultation and follow-up before being discharged from the hospital. These women should also be given an emergency number to call if suicidal or infanticidal ideation emerges. To assist the healthcare professional in detecting which women are at highest risk, several screening tools have been developed; two examples of validated instruments are the Edinburgh Postnatal Depression Scale (EPDS) and the Postpartum Depression Screening Scale (PDSS).

EDINBURGH POSTNATAL DEPRESSION SCALE

The EPDS has been developed to assist primary care professionals to detect mothers suffering from PPD. The EPDS was created at health centers in Livingston and Edinburgh and consists of ten short statements. The mother chooses one of the four possible responses to indicate how she has been feeling during the past week. The responses are then given a score between 0 and 3. Most mothers complete the scale without difficulty in less than five minutes [12].

A validation study showed that mothers who scored above 13 were likely to be suffering from a depressive illness of varying severity. Nevertheless, the EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week, and in doubtful cases, it may be usefully repeated after two weeks. The scale will not detect mothers with anxiety neuroses, phobias, or personality disorders. Users should be instructed to [12]:

- Underline the response that comes closest to how they have been feeling in the previous seven days.
- Complete all ten items. Avoid discussing answers with others.
- Complete the scale by herself. However, if a patient has limited English proficiency or difficulty reading, she may require assistance.

The EPDS may be used to screen women at six to eight weeks postpartum. The pediatric health clinic or postpartum checkup may provide suitable opportunities for its completion.

The EPDS is limited to certain depressive symptoms and does not evaluate a woman's exhaustion, irrational irritability, or thoughts of harming her baby. These symptoms should be examined during a clinical assessment by asking specific questions relevant to these areas. Nonetheless, the EPDS is the most widely used screening tool available to detect PPD [10]. Given prenatally, the EPDS has been shown to effectively identify women at risk for PPD [102]. The EPDS may be accessed online at http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf.

POSTPARTUM DEPRESSION SCREENING SCALE

Beck and Gable developed the PDSS, a 35-item self-report instrument, in an effort to improve early detection of PPD [103]. The screening scale is composed of seven dimensions, each of which consists of specific questions relevant to the dimension being measured (***Table 1***).

Women are asked to indicate their degree of disagreement or agreement with each item on a scale of 1 (strongly disagree) to 5 (strongly agree). The validity of this scale to detect PPD has been tested and validated to be effective for screening women after delivery [103; 104; 105]. Additionally, a woman's response to items in the self-harm dimension can be used to gauge her level of suicidal thinking.

The test yields an overall severity score falling into three ranges:

- Normal adjustment
- Significant symptoms of PPD
- Positive screen for major PPD

The PDSS is available in short and long versions, with a manual for use in clinical settings.

COMPLICATIONS OF POSTPARTUM DEPRESSION

PROBLEMS IN THE MOTHER-INFANT RELATIONSHIP

The occurrence of PPD raises concerns about the quality of the mother-infant relationship and the potential impact of a mother's depression on the infant. One important aspect of the mother-infant relationship is a mother's adjustment to her baby and her understanding of her infant's needs and communications. When a mother's depression interferes with her sensitivity to her baby, their interactions can have a negative effect on the child [106; 107].

Where there is evidence of impairment in the mother-infant relationship as a result of maternal depression, the Scottish Intercollegiate Guidelines Network recommends additional interventions specifically directed at that relationship be offered.

(https://www.sign.ac.uk/assets/sign127_update.pdf. Last accessed March 27, 2020.)

Level of Evidence: C (Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal, directly applicable to the target population and demonstrating overall consistency of results)

Bonding

The benefits of bonding are well known. Most hospitals have incorporated a ritual of mother-infant bonding that occurs shortly after delivery, whereby the infant is placed in the mother's arms. It is often referred to as the moment of "falling in love," when the mother looks into the eyes of the infant and the infant looks back. Whether born of myth or scientific reasoning, bonding is considered an important element in initiating the mother-infant attachment. The ritual is important, but not essential. If, for some reason, this initial bonding is missed, as in the case of a caesarean section, it is obtainable the moment the mother sees her baby for the first time [108].

Bonding, in actuality, is a process of closeness, comfort, and familiarity that develops over time [19]. When the process of bonding with an infant is disrupted, it can have long-term consequences for the future relationship between mother and child. The delay in developing attachment may be unusually prolonged and delayed with a clinically depressed mother. This attachment difficulty may take different forms. The mother may not be nurturing to the infant, or she may have limited interaction with the infant. In some cases, the depressed mother may reject her baby emotionally and refuse to have anything to do with the infant. The mother may have an adverse sentiment towards the baby and handle the baby with irritability. Depressed mothers may also be outwardly angry or resentful toward the infant. Some mothers are so consumed with fears of harming their child that they avoid even touching him or her. All of these emotions and attitudes toward the child affect the process of attachment [2; 109].

Klier and Muzik describe the role of perinatal psychiatry in maternal-infant bonding issues [110]. They classify the disorders of mother-infant bonding into three groups [110]:

- Delay, ambivalence, or loss in maternal response: Ambivalence or delay in bonding may be due to a mother's disappointment about her feelings toward the infant. She may have no feelings, feel estranged from the infant, or feel the infant is not hers.
- Rejection (threatened or established): Rejection of the infant is expressed through strong negative feelings. The mother may dislike or hate the infant and express regret over the infant's birth. There is a notable absence of affectionate behavior, such as kissing, hugging, cooing, and cuddling. Essentially, she wants to keep the infant away from her. A mother may feel trapped by motherhood, and the infant is the source of the entrapment. She may wish the infant would be stolen, given away, or killed.
- Pathologic anger: Pathologic anger toward the infant may be a mild form, which causes the mother distress but is controllable. Alternatively, it may be more severe, leading the mother to scream or yell at the infant or have an impulse to harm or kill the baby.

A study of approximately 100 subjects found that mother-infant bonding disorders were present in 29% of those diagnosed with PPD [111].

Bonding difficulties should be assessed immediately to determine if intervention is necessary. Women may be reluctant to admit these problems, but they also may be grateful to receive help from someone who understands their distress [110].

Mother-Infant Attachment

Researchers of infant behavior have come to acknowledge that the establishment of social relationships is a primary process of development. When a child successfully accomplishes communication with others, normal development occurs. A child who does not engage the world successfully will not develop normally, regardless of the source of the failure. Success or failure depends upon three critical processes [112]:

- The integrity and capacity of the infant's physiologic systems and central nervous system to organize and control physiologic states and behavior
- The integrity of the infant's communicative system to express the infant's intention for action to the caretaker and the extent to which the infant succeeds
- The caretaker's capacity to read the infant's communications appropriately and willingness to take appropriate action

These processes make up what is called "mutual regulation," which is the capacity of both the mother (or other caregiver) and infant to express their intentions, appreciate the intentions of the other, and allow each other to achieve their goals [112].

The literature on maternal-child interactions supports the concept of caretaker behavior as an external regulator of the infant's states. Maternal body warmth modulates infants' physiologic systems [108; 112]. The quality of a caretaker's efforts affects the function, structure, and neurochemical architecture of the infant brain. Both mother and infant appreciate and adjust their behavior in relation to their partner's behavior and the state of the interaction. This system of meaning is established long before the child can engage in words, and the effects have lifetime consequences [112].

Both mother and infant develop the skill to sense when the interaction fulfills the infant's needs or when the mother's intervention met her intention. Adjustments are made as they develop sensitivity to each other's responses. This is how the mother-child relationship develops and sets the course for the development of future relationships for the infant. The development of an effective sense of self and a reliable relationship with caregivers is crucial for the establishment of stable and secure relationships in the future [112; 113].

Studies have shown that when the mother is depressed, a break in the mutual regulatory system occurs [114]. Depressed mothers disrupt the interaction in two distinct ways: intrusiveness and withdrawal. It has been reported that intrusive mothers with PPD engaged in rough handling, spoke in an angry tone of voice, and interfered with their infants' activities. Withdrawn mothers, by contrast, were disengaged, unresponsive, and affectively flat and did little to support their infants' activities.

Both disruptions have a deleterious effect on the infant's development [112]. The infants of intrusive mothers eventually adopt an angry and protective style of coping, which is used defensively in anticipation of the mother's behavior. Infants of withdrawn mothers attempt to regulate their own emotional states. They may fail at social connectedness due to the mother's lack of response. Eventually, the infant will attempt to regulate their affective states, resulting in passivity and withdrawal [115]. Infants of either intrusive or withdrawn mothers develop a negative affective core characterized by anger and sadness, a representation of the mother as unresponsive and untrustworthy, and a representation of themselves as ineffective and helpless. This does not lead to successful normal development unless some intervention changes the mother's interaction style [112; 115; 116].

IMPACT ON SOCIOEMOTIONAL AND COGNITIVE DEVELOPMENT

Research on infants' early social development demonstrates a remarkable sensitivity to the quality of their interpersonal environment from the first days of life [95; 106; 117]. Findings from a study conducted at the Winnicott Research Unit in London suggest that exposure to maternal depression in the early postpartum months may have an enduring influence on child psychologic adjustment. Researchers report that, "depression has been found to be associated with insensitive and negative maternal interactions with the infant in the early postpartum months, particularly if the depression persists" [118].

Parents are crucial figures to an infant, acting as the primary partners in teaching their children, through their interactions, how to modulate their emotional states. These lessons help children learn to cope with failure, anger, and frustration, as well as how to channel these emotions into productive activities. A faulty foundation can result in a failure to cope as the child enters a larger social arena.

A mother's unresponsiveness or inappropriate parenting during infancy may prevent the child from achieving the developmental goals of social interaction and object exploration. If an infant learns that a parent is unavailable and unreliable, it interferes with the infant's development of a sense of mastery and control over events; the infant develops a sense of helplessness and hopelessness [112]. Infants eventually become aware of their mothers' anger, sadness, or hostility and begin to react to their parents' state of mind. Infants also must cope with their own sadness, anger, and apprehensiveness. Tronick and Weinberg speculate that infants become hypervigilant of their mothers' emotional state in order to protect themselves [112]. They must also protect themselves from their mother's responses by disallowing a high level of emotional arousal. Therefore, they become emotionally constricted. One study has indicated that, at the end of the first year, infants of depressed mothers express less intense emotional reactions to stressful situations and are less emotionally responsive than infants of nondepressed mothers. These early patterns can lead to the development of pathologic methods of coping [112; 115].

Typically, mothers learn to read their infants' intentions and to understand how they can respond to fulfill their infants' needs. A mother eventually knows that when the infant cries it is because he or she is hungry, cold, or needs a diaper change. This is learned through interaction with the infant. These interactions take place over time and are part of a child's process of establishing social relatability.

A depressed mother may misread an infant's intentions and react angrily rather than supportively. This confuses the infant and may ultimately cause the infant to stop attempting to interact socially for fear of rejection. The pattern that is established does not promote a healthy or successful strategy for reaching out to others. In order to facilitate healthy interactions, it is essential for a mother to comprehend her infant's state of consciousness and for the infant to comprehend the mother's state of consciousness [112].

Studies have attempted to research cognitive functioning in infants of mothers with PPD at 18 months and 5 years of age. Results of these studies suggest that the quality of the mother's communication was influenced both by her mental state and the level of adversity that she experienced [119]. Further research supported this study, indicating that PPD may have lasting adverse effects on a child's cognitive development [120]. A review of studies showed that PPD reduced children's cognitive performance by impairing maternal mental and behavioral care [117]. A study of 1,053 mothers of infants 6 to 18 months of age found that 46.7% (491 mothers) suffered mild to extremely severe depression. The results indicated a correlation between mothers' depression levels and developmental delay in infants and a significant correlation between mothers' depression and development delays in gross-motor and problem-solving skills [121].

The way in which a mother engages with her infant in the postpartum months comes to influence the general nature of infant cognitive performance. One study considered a concept, originally proposed by Winnicott in 1956, that a depressed mother's interactions with her infant could be "good enough" to sustain a relationship without serious negative outcomes [119]. In instances in which there are no additional adverse circumstances at home for the mother, she may be able to provide "good enough" mothering in spite of her depression. Campbell and Cohn confirm that a consistent variable affecting a positive outcome in the early postpartum mother-infant relationship is a depressed mother's ability to provide a "good enough" environment for her infant [7].

In a separate study, latent depressive cognitions were investigated in 94 children of depressed and nondepressed mothers in a situation of mild stress [122]. Results indicated that children who had been exposed to maternal depression either in the previous 12 months or at any other time during their lifetime were more likely than children whose mothers were not depressed to express thoughts of hopelessness, pessimism, and low self-worth.

Kurstjens and Wolke found that long-term effects may be present when a mother's depression is chronic [123]. In the postpartum period, chronic depression in mothers may make infants more vulnerable to negative outcomes; short-lived depressions may have fewer consequences for the quality of the mother-infant relationship and for infant development. It is thought that short-lived PPD with an onset in the first few weeks postpartum and resolution by four to five months should have less of an impact on the quality of the attachment than depressions lasting six months or longer [123]. A longitudinal study of 296 mother-child dyads found that maternal depression at 30 to 90 days postpartum and at 12 months was significantly associated with the language development of infants at 12 months of age, with the impact correlated with the duration of the mother's depression [95].

However, some studies have shown that women experiencing depression in the early postpartum period may continue to have difficulties in their relationship with their infants, despite remission of their symptoms [7]. Factors influencing a more positive outcome for the mother-infant relationship include satisfaction with spousal support and help with childcare and involvement in early treatment for PPD [7; 73; 124; 125].

It is important to identify factors that might buffer the mother-infant relationship in order to secure a more positive outcome. Studies suggest that chronically depressed mothers who remain at home full-time without support may have more difficulty relating to their babies than mothers who work outside the home at least part-time [7]. Mothers who benefit from considerable support and help from others may be considered low risk. The other parent of the child and other family members may provide childcare and sufficient support to help circumvent potential problems, or alternate caregivers may help buffer the infant from stressful interactions with a depressed mother. The partner's presence, level of functioning, and willingness to participate in childcare alters the consequences of PPD for children [7; 124].

POTENTIAL LONG-TERM EFFECTS ON CHILDREN

A study has been completed assessing the long-term effects on the children of mothers who were depressed three months postpartum [126]. In a community sample from two general practices in London, 149 women were given psychiatric interviews at three months after childbirth, and 89% of their children were assessed at 11 years of age. The children of women who were depressed at three months postpartum suffered attention deficit problems, difficulty with mathematics, and were more likely than other children to have special educational needs. The cognitive deficits present at 11 years of age may be a result of the quality of the infant's social environment in the first three months of life. Problems were noted in the children whether or not the mothers' depression continued beyond three months. Boys were more severely affected than girls. These effects on cognitive development

were not altered by the parent's intelligence quotient (IQ) or socioeconomic status, or by the mother's later mental health problems. In this study, PPD was a risk factor for children's subsequent cognitive and behavioral problems. These findings demonstrate a long-term legacy of PPD that continues to affect children's intellectual development into adolescence [126]. Subsequent studies have reported similar findings [127; 128; 129].

Protective factors make a difference in long-term outcomes. Successful breastfeeding can offer an emotional interaction between mother and infant that fosters regulation of attention and learning. Mothers' levels of distress and self-preoccupation are seemingly reduced during the act of breastfeeding, while focusing on the infants' satisfaction [126]. Furthermore, not all depressed mothers are insensitive toward their infants.

CONFLICTS IN THE MARITAL RELATIONSHIP

PPD puts a strain on marital relationships. According to Dalton and Horton, PPD is a significant medical cause of marital and relationship breakdown [10]. This is especially true when a woman's depression is untreated and/or chronic. Marital conflict and dissatisfaction are generally common in the first year after childbirth; PPD intensifies stress on the relationship during this period. Support from the baby's other parent or a partner is critical to a woman's recovery from PPD and may act as a buffer to the mother-infant interaction. Most partners do offer support to women coping with PPD. However, as the effects of depression multiply, they may become impatient or frustrated by the extra burden. In some cases, husbands or partners may be unsupportive or become verbally abusive, intentionally or unintentionally. Even when a husband or partner is supportive, the woman may feel, due to her depression and feelings of being overwhelmed, that it is not enough [63]. Lack of communication and misunderstandings of feelings, behavior, and attitudes are common occurrences. Each partner perceives the other as being uninterested in his or her activities. Given that women with PPD are often preoccupied and withdrawn, these problems may not be resolved and miscommunication can grow. Women may feel ashamed to ask for help, which can create a strain in the relationship [63].

Three areas have been identified as the most affected: the need for practical support, emotional needs, and sexuality. These are complex issues that should be dealt with, and most couples struggle to resolve conflicts in these areas. Assistance from health or mental health professionals may be needed and has shown to be helpful to women with PPD and their husbands or partners [63].

SUICIDE

Statistics show that psychiatric disorders, and specifically suicide, account for 20% to 30% of all maternal deaths [130]. A review of deaths from 2006 to 2008 identified psychiatric illness as the leading cause of maternal deaths in the United Kingdom [131]. In the United States, suicide is considered the greatest cause of maternal mortality in the year following childbirth [132].

Approximately 5% of women with postpartum psychosis complete suicide. Therefore, suicide prevention in a woman with PPD or psychosis should be a high priority [133; 134; 135]. Although there are no specific statistics for suicide rates among women with PPD, a 2013 study of service women in the United States found that suicidality (i.e., completed suicides, suicide attempts, and suicide ideation including thoughts of self-harm) was 42 times more prevalent in first-time mothers with PPD than in those without [136]. The risk of suicide in people with a major depressive disorder is about 25 times that of the general population. Most suicides in depressed persons are among those who do not receive treatment [137].

For women with PPD, suicide is an ever-present possibility [10; 136]. Many women with PPD have reported continual fears of suicide or suicidal thoughts. These women may act on suicidal thoughts out of hopelessness and a sense of desperation. Family members and those close to mothers with PPD should be instructed to keep the danger of suicide in the forefront of their minds at all times. A failed suicide attempt may be followed by a successful suicide if it is not taken seriously and appropriate treatment undertaken.

Eight out of ten suicidal persons give some sign of their intentions [138]. Persons who talk about suicide, threaten to attempt suicide, or call suicide crisis centers are 30 times more likely to attempt suicide than those that do not [138]. Although not all suicidal individuals indicate their plans, nearly three-fourths of all persons who commit suicide have visited a physician in the four months before their deaths [138]. It is therefore advisable that mental status and signs of suicidal ideation be assessed at every contact with postpartum women [139].

Recognizing warning signs of suicidality is essential to suicide prevention. Warning signals may include [138; 140]:

- Feelings of despair and hopelessness. The more these feelings are described as unbearable, the more likely it is that the idea of suicide will enter the person's mind.
- Organization of surroundings or affairs. When a woman is making preparations for her absence or giving away prized possessions, it is possible she is seriously considering suicide.
- Establishment of a specific suicide plan. If a person has a specific method in mind, she is more likely to follow through on suicidal thoughts.
- Alcohol or drug abuse. Substance abuse in a depressed person has the effect of enhancing impulsive behavior and clouding judgment.
- Improved feeling of well-being. Paradoxically, a person with depression is more likely to attempt suicide just when she is on the way to recovery.

HOMICIDE

As noted, approximately 5% of women with postpartum psychosis commit infanticide [133]. Therefore, postpartum psychosis poses an immediate danger to the infant, who may require protection from the mother. Mother-infant interactions require supervision until the mother is successfully treated for her psychosis. There are no statistics available to indicate how many mothers with PPD (but not psychosis) commit infanticide. Although a psychotic mother may be a threat to her infant if she goes untreated, there is no evidence to date to suggest that these mothers are a danger to other people [133].

If a mother with PPD or postpartum psychosis tells any family member or healthcare professional that she is having thoughts of harming her baby, she should be taken seriously and immediate help should be forthcoming. If she is not already being treated for depression or psychosis, she should be referred immediately for psychiatric consultation and treatment. A mother who expresses concern that thoughts of harming her baby are becoming strong and she is afraid she might act on them should be supervised when she is with her baby. Alternatively, she may require hospitalization. A mother with PPD or postpartum psychosis who indicates that she has thought about harming or wants to harm her baby should never be dismissed.

STRATEGIES FOR RECOVERY

SPONTANEOUS RECOVERY

Postpartum blues produce symptoms of increased emotionality and sensitivity in new mothers. These symptoms are transitory and usually resolve within 5 to 10 days without the necessity of formal treatment. However, there is no clear evidence that women recover spontaneously from PPD [141]. Mothers who are breastfeeding may appear to have recovered from depression when, in fact, they have not. Some women may breastfeed their children for months to years, during which time they may be protected from depression by the production of prolactin. Depression may appear in these women after they stop breastfeeding [19]. Other studies of PPD and breastfeeding practices suggest that a mother's breastfeeding self-efficacy can both put her at risk for PPD and can predict a change in symptoms of currently experienced PPD [142; 143]. This should all be taken into account when assessing women for recovery and symptom resolution, and it should also reinforce the need for early screening for PPD [143]. It has been suggested that there may be a possibility for spontaneous recovery in depressed women with milder symptoms and a shorter duration [144]. Unfortunately, withholding treatment while waiting for a spontaneous recovery may put women at risk for a more chronic or severe depressive episode [145; 146].

SELF-CARE

For women with PPD, the reduction of stress is essential to protecting against further anxiety and to help the brain restore its own potential for self-regulation. In addition to the professional treatment a woman receives for her depression, she may choose to engage in certain activities to reduce stress and to promote a calmer, more relaxed state of mind [13; 147].

Caring for a new baby is demanding, and mothers who are depressed can easily feel overwhelmed. To take care of the baby adequately, she must also take care of herself. Eating healthily, getting enough rest and relaxation, doing gentle exercises, and socializing are all part of maintaining and promoting health.

Diet

New mothers should consume two to three portions daily of protein-rich foods, such as fish, cheese, eggs, nuts, or meat. Four to five portions of fruit and vegetables should also be part of the diet [10]. Dalton and Horton recommend that starchy foods every three hours be added to the regular diet for a woman with PPD [10]. This may allow women with PPD to maintain sufficiently high blood sugar levels required to effectively utilize available progesterone. A carbohydrate-rich food should be eaten within one hour of waking and one hour before bedtime. Foods high in carbohydrates include flour, rice, potatoes, oats, and corn. Starchy foods added to a healthy diet of fruits, vegetables, and protein are not necessarily fattening; this may be stressed to new mothers.

Tryptophan is a vital amino acid that must be consumed, as the body does not produce it. Tryptophan can be obtained through plant or animal proteins, such as peanuts, brown rice, soybeans, fish, turkey, and beef. In the brain, tryptophan is converted into serotonin, which facilitates a calming effect [19]. Ensuring that sufficient quantities of iron, folic acid, and vitamin A are being obtained is also an important aspect of the postpartum diet [1].

Research has indicated that omega fatty acids may have a protective effect against PPD. In a Norwegian study of omega-3 fatty acid levels (generally from seafood consumption) in women throughout and after pregnancy, a low omega-3 index in late pregnancy was associated with higher depression score three months postpartum [148]. A 2012 meta-analysis supported this finding, noting that poor omega-3 intake is common among women of childbearing age [41].

Rest and Relaxation

Sleep is necessary to restore a woman's mood and brain chemistry following pregnancy, labor, and delivery. The brain requires a minimum of five hours of uninterrupted sleep per day to restore itself to normal functioning [13].

If possible, a spouse or other caregiving partner can alternate nights getting up to take care of the baby, allowing the mother to sleep at least five hours at a time. Knowing in advance that arrangements for nighttime feedings and attention to the

baby can be made, mothers may ask for help without feelings of guilt or inadequacy [5]. Because women with PPD often complain of insomnia, a safe sedative may be prescribed to allow patients to obtain enough sleep.

As women with PPD may be overstressed and overly focused on perceived inadequacies, only those things that are of high priority, such as taking care of herself and the baby, should be attempted. Ideally, she should obtain assistance with household chores, such as cooking, cleaning, and shopping, at least for the first few weeks to allow more time for her to rest. Extended family can be useful if they are available and willing to help [5]. Family members or friends should also be allowed to help with childcare and other activities of daily living. This will free the mother's time for therapy sessions, support groups, and unpressured time with the baby [5].

Exercise

Exercise is important to a sense of well-being, as it enhances production of endorphins in the brain. Exercise can also help to promote a sense of calm, relaxation, and better sleep. For women with PPD, exercises should be gentle, not strenuous, and may include walking, swimming, physical therapy, and massage [149; 150].

Socializing

Although it may be difficult to do, a woman should be encouraged to discuss her feelings with her partner/husband, close family members, and intimate friends. Hiding feelings due to shame and embarrassment contributes to isolation and loneliness. Therefore, although it may be difficult, it will ultimately help a depressed woman to have companionship. Isolation can lead to a sense of detachment from others, which may make depressive symptoms worsen. The depressed woman should avoid spending all of her time alone. Whenever possible, she should be encouraged to get dressed and leave the house.

It is also important for a woman with PPD to spend time alone with her partner/husband when the baby is quiet or asleep. These times together can be productive for both parents and allow them to be together without the usual stress of caring for a new baby [5].

EDUCATION

Knowledge about PPD can be very helpful to new mothers who suffer symptoms of depression. Women have reported that not understanding their symptoms greatly added to their distress [11; 100]. Given the effects of PPD on new mothers, it is vital to send a new mother home with proper education about one of the most common complications of delivery and its effects on her and her baby. In addition to having patient education materials on PPD readily available, it is equally important for healthcare professionals to educate women about parenting skills. Taking the time to discuss the care of a new baby can make a big difference in helping new mothers feel competent and confident.

EVIDENCE-BASED PRACTICE RECOMMENDATION

According to the American Psychiatric Association, education about the symptoms and treatment of major depressive disorder should be provided to postpartum mothers in language that is readily understandable to the patient.

(https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf. Last accessed March 27, 2020.)

Strength of Recommendation: I (Recommended with substantial clinical confidence)

Partners also need education regarding PPD and potentially coping with a depressed mother. In cases when PPD has been diagnosed, a partners' education might consist of suggestions regarding their supporting role in assisting their partner through recovery. The following suggestions may be helpful [10; 63; 149]:

- Listen without giving logical advice or trying to fix the problem.
- Offer hope that she will recover.
- Take care of the baby as much as possible.
- Ensure that the mother gets at least five continuous hours of sleep during the night whenever possible.
- Make regular, unsolicited offers of assistance.
- Hire household help, if possible.

Partners should not feel helpless or useless if they have been advised about how to offer emotional and practical support to mothers with PPD [63]. Partners often find that they have unexpected physical and emotional adjustments after having a baby. They may experience their own form of exhaustion as a result of changes in household schedule, interrupted sleep, increased financial responsibilities, and concern for the mother's emotional and physical needs. Partners should be encouraged to participate as much as possible in educational activities and to also seek professional help should they begin to feel overwhelmed with the additional burdens of new parenthood and PPD [149].

There is some evidence that men may experience a form of PPD following the birth of their child [151; 152]. The strongest predictor of paternal PPD in one study was the presence of maternal depression, with symptoms tending to arise after those of the mother [152]. Therefore, fathers should also be assessed for signs and symptoms of depression in the postpartum period, particularly when their partner is depressed. Educating both parents can assist them to work together for mutual benefit and for the benefit of the baby, and may alleviate possible marital discord. In one analysis, fathers reported fewer depressive symptoms if they received support from midwives, child health nurses, and their partners (mothers) [240].

TREATMENT STRATEGIES

PHYSIOLOGIC

Hormone Therapy

A reduction in hormones after delivery is thought to be a major factor in the etiology of PPD in predisposed women. Therefore, the use of hormonal treatment as prophylaxis or a treatment component seems plausible. Since 1970, several studies were carried out investigating the efficacy of either estrogen or progesterone in the management of PPD. There are several problem areas in these studies, both in regards to methodologic issues and in the use of different hormones in the studies [153]. More structured research is necessary in order to ascertain efficacy.

Estrogen

The value of estrogen in the treatment of PPD is supported by studies conducted between 1970 and 2002. However, methodologic shortcomings make the studies unreliable. The use of estrogen in the postpartum period, particularly the use of synthetic estrogen, may have significant side effects [153]. In addition, more recent evidence indicates the impact of reproductive hormones may be mediated by differences in sensitivity to estrogen among postpartum women [49].

Measurements of hormonal levels proved to be one methodologic flaw. Levels of hormones measured from plasma sampling determine the total amounts of progesterone and estrogen rather than the free fraction, which is unbound to plasma proteins and freely permeates into the central nervous system. It is this biologically active fraction that modulates the synthesis of proteins, neurotransmitters, and receptors in the central nervous system. Thus, serum levels of hormones may render inaccurate results [153]. Dalton and Horton stipulate that the only accurate method of measuring free estrogen and progesterone levels is via saliva testing [10].

In 1996, Gregoire et al. conducted a double-blind, placebo-controlled study of estrogen skin patches in the treatment of PPD [154]. The women who participated in the study had either severe or chronic depressive symptoms that began 3 months postpartum and persisted up to 18 months. The women were assessed monthly using the EPDS. Although the study concluded that estrogen was better than placebo in relieving both dysphoric mood and biologic symptoms of depression, many of the women who received estrogen took antidepressants simultaneously [154]. The use of estrogen combined with antidepressants requires further consideration.

Other studies have been conducted evaluating estrogen as a treatment for PPD; however, many of these studies were also complicated by the co-administration of antidepressants, which leads to inconclusive evidence of the benefits of estrogen alone to treat PPD. Whether estrogen is of value in the treatment of PPD is yet to be determined [153; 155; 156].

There are concerns regarding the risks associated with the use of synthetic estrogens in the postpartum period, including the increased risk for the development of deep vein thrombosis, cardiovascular complications, endometrial hyperplasia, problems with breastfeeding, and increased depression. The safest dosage and route of administration should be clarified before it can be recommended [153]. There are no reported studies on the use of natural estrogen in the treatment of PPD [155].

Estrogen may be taken orally, vaginally, transdermally, or through a device inserted into the uterus. Natural estrogens are available through the use of skin patches, transdermal creams, or vaginal creams [13]. Natural transdermal estrogen creams, such as bio-identical 17-beta estradiol and vaginal creams, are available only from compounding pharmacies.

According to the Scottish Intercollegiate Guidelines Network, the use of estrogen therapy in the routine management of patients with postpartum depression is not recommended.

(https://www.sign.ac.uk/assets/sign127_update.pdf. Last accessed March 27, 2020.)

Level of Evidence: B (High-quality systematic reviews of case control or cohort studies, directly applicable to the target population, and demonstrating overall consistency of results)

Progesterone

It has been suggested that only naturally occurring progesterone has mood-elevating properties [10]. Thus, studies using synthetic progestogens as prophylaxis or treatment for PPD are not comparable to studies using natural progesterone.

Critics of Dalton's use of progesterone both as prophylaxis and treatment for PPD cite methodologic problems and the fact that the dosages are not standardized. Other criticisms include the fact that patients who participated in the studies were volunteers and there was not an adequately constructed control group against which to test the treatments [153]. Although criticisms of Dalton's progesterone treatments persist, no further studies have been conducted on the use of natural progesterone for the treatment of PPD [155].

One problem with the use of progesterone is that it cannot be given successfully by mouth or as a skin patch, but must be administered by injection or vaginal or rectal suppository. According to Dalton and Horton, 400-mg suppositories administered twice daily are the minimum effective dose [10]. However, empirical data has not found progesterone to be effective in the treatment of PPD and it may intensify depressive symptoms in some patients [157].

As with estrogen, the largest concentration of progesterone receptors is in the limbic area of the brain, which is considered to be the center of emotion. The amount of progesterone

present in the blood is not as important in regards to PPD treatment as the amount of progesterone that reaches the nuclei and is then metabolized [10].

Progesterone receptors will not transport molecules of progesterone in the presence of adrenalin, because during times of stress the receptors transport corticosteroids rather than progesterone into the nuclei. If there is low blood sugar, the progesterone receptors transport glucocorticoids back into the cells in preference to progesterone. This helps to explain why oral progesterone is not effective. Oral progesterone must pass through the liver, which contains many progesterone receptors that metabolize the progesterone before it reaches the brain. Also, progesterone does not pass easily through the skin into the blood stream and is therefore not suitable for administration by cream or patch. There are no routine laboratory tests to determine the number or function of progesterone receptors [10].

Progesterone therapy may be given with any other medications, including antidepressants. It is considered safe for women who are breastfeeding. Progesterone should be halted for a 14-day period every month beginning with menstruation. As noted, the minimum effective dose for management of depressive symptoms is 400 mg suppositories twice daily or, alternatively, one 50 mg injection daily. These doses can be titrated upward to a maximum of six 400 mg suppositories daily or one 100 mg injection daily. Blood sugar should be monitored and kept stable [10].

Given the controversy over treatment of PPD with estrogen or progesterone, consensus has not been reached on the use of hormonal treatments for PPD. This area of inquiry deserves further study.

PHARMACOTHERAPY

Healthcare professionals should engage in a dialogue with patients with PPD to determine the treatment or medication that works best and to attempt to establish an informed decision. There is no way to know in advance which medication will be the most effective in treating PPD for an individual. If a woman has taken an ineffective medication for depression in the past, then it is wise to avoid it. If a medication has been effective in the past, it should be considered the drug of choice [2]. The main classifications of antidepressants used to treat depression are selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs), and atypical antidepressants.

Selective Serotonin Reuptake Inhibitors

SSRIs affect the action of the neurotransmitter serotonin. When serotonin is released in the synapse between neurons, it is reabsorbed by the brain cells, through the process of reuptake. Depression is assumed to be connected with decreased availability of serotonin and other neurotransmitters; therefore, interference with the reuptake of serotonin allows more to be available to boost communication in the brain. SSRIs inhibit only the reuptake of serotonin. Because SSRIs affect only one neurotransmitter, they presumably have fewer uncomfortable side effects than the more traditional antidepressants [158; 159]. The more acceptable side effect profile of SSRIs makes them the drugs of choice for many depressive disorders [159; 160].

Some of the most commonly used SSRIs are fluoxetine, paroxetine, sertraline, fluvoxamine, escitalopram, and citalopram [159; 161]. Of these drugs, fluoxetine, paroxetine, and sertraline are prescribed most often [159; 162]. Fluvoxamine, which is approved to treat obsessive-compulsive disorder, is sometimes used off-label to treat depression [161].

Benefits

The major benefit of SSRIs is their effectiveness in reducing symptoms of depression more quickly than the tricyclic antidepressants. These medications are also less likely than other antidepressants to have adverse interactions with other medications. However, some do exist [161].

SSRIs are especially useful if given in the early stages of depression, when symptoms are mild-to-moderate and are particularly effective in patients with obsessive-compulsive symptoms (particularly fluvoxamine) [161]. However, they are also effective for severe depressive disorders. Administration of an SSRI should result in elevated mood, lessened depressive symptoms, and an increase in self-confidence. Women should also experience less fatigue and a renewed ability to care for themselves and their babies. As depression improves, medication may be gradually decreased and eventually discontinued altogether [158; 160].

Treatment with antidepressants as early as possible in the course of the illness may shorten and lessen the symptoms of PPD, affecting change within several weeks rather than months. Antidepressant treatment also reduces parenting stress. Improvement in the mother-infant interaction then has the benefit of reducing the negative impact of PPD on child development [127; 133]. It should be noted that the effects of the SSRIs may not be seen for many days or weeks after instituting treatment.

Possible Adverse Reactions

The side effects of SSRIs are generally considered to be milder than traditional antidepressants, although there are still several side effects. They may initially increase anxiety or panic symptoms, and so should be avoided in patients whose depression includes these features. Those sensitive to SSRIs may have more severe reactions. Side effects may include [163; 164]:

- Loss of appetite, weight loss
- Increased appetite, weight gain
- Nausea
- Allergic reactions, rash
- Dry mouth
- Headache

- Nervousness
- Restlessness
- Manic or hypomanic behavior
- Agitation
- Irritability/Anxiety
- Tremors
- Dizziness
- Increased sweating
- Insomnia
- Convulsions (rarely)
- Sexual dysfunction
- Drowsiness

Side effects that do occur usually subside after two weeks, when the body adjusts to the medications [161; 165]. Adverse drug interactions have been noted with [163; 164]:

- All other antidepressants
- Antihistamines
- Diabetes medications
- Antihypertensives
- Psychotropic drugs
- Caffeine
- Alcohol
- Cough suppressants
- Theophylline
- Tobacco
- Warfarin

These substances should be avoided while taking an SSRI for depression [164].

There are also certain medical conditions that warrant caution when considering the use of SSRIs, including [163; 164]:

- Epilepsy
- Individuals receiving electroconvulsive therapy
- A personal or family history of bipolar disorder
- Heart disease
- Liver or kidney disease (Severe kidney or liver disease can result in higher than normal levels of the SSRIs.)
- Bleeding disorders
- Manic-depressive disorder
- Pregnancy or breastfeeding

Patients should be cautioned not to abruptly stop taking SSRIs, as withdrawal symptoms may occur [165; 166].

Risks

The U.S. Food and Drug Administration (FDA) has alerted healthcare professionals and the public regarding a potentially life-threatening condition called serotonin syndrome. Serotonin syndrome, or serotonin toxicity, results from an excess of serotonergic activity in the central nervous system. It is seen only rarely in postpartum women, usually when multiple antidepressants, such as TCAs, MAOIs, St. John's wort, or opioids are combined. Serotonin syndrome is a medical emergency that requires immediate treatment. Symptoms and signs of this syndrome include [167; 168]:

- Restlessness
- Tachycardia
- Diarrhea
- Nausea
- Vomiting
- Overactive reflexes
- Loss of coordination
- Hallucinations
- Hyperthermia
- Hypertension
- Coma

A risk of violent behavior has been associated with the use of SSRIs in a small number of people. In adverse drug event monitoring in the United Kingdom, violent events were reported in 56 of 13,741 (0.41%) patients taking paroxetine and 60 of 12,692 (0.47%) patients taking fluoxetine [169]. At the time of the study, researchers concluded that instances of serious violence among individuals using antidepressants were likely to be very rare [169]. However, Swedish researchers examined data from more than 850,000 individuals and found that SSRI use was linked to a 43% increased risk for violent crime among people 15 to 24 years of age. There was no significant association among older individuals [170].

An increased risk of suicidal thinking and behavior has been observed in young adults 18 to 24 years of age who are taking antidepressants, generally during the first one to two months of treatment. In 2004, the FDA issued a black-box warning about the increased risk of suicidality for all antidepressants. The warning has been updated and states that, "antidepressants increased the risk [compared to placebo] of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with major depressive disorder and other psychiatric disorders. Anyone considering the use of [any antidepressant] in a child or adolescent must balance this risk with the clinical need" [171; 172]. The warning statements also emphasize that depression and certain other psychiatric disorders are themselves the most important causes of suicide [172].

Patients of all ages, including adolescent mothers with PPD, should be monitored carefully for clinical worsening, unusual changes in behavior, or suicidal risk both if treated with antidepressants or if no pharmacologic treatment is offered. Families and caregivers should be advised of the need for close observation and communication with the prescriber [172]. Fluoxetine is approved for use in children and adolescents

for the treatment of major depressive disorder. Fluoxetine, sertraline, and fluvoxamine are approved for use in children and adolescents for the treatment of obsessive-compulsive disorder [163]. The remaining antidepressants are not FDA-approved for use in children [163; 172; 173]. The issue of treatment of depression in the pediatric population is hotly debated and requires additional research [174; 175].

The FDA has recommended that healthcare providers consider the following points when treating patients with antidepressants [172]:

- All patients being treated with antidepressant medications, particularly those being treated for depression, should be watched closely for worsening of depression and for increased suicidal ideation or behavior.
- Close observation may be especially important when antidepressant medications are started for the first time or when doses have been changed.
- Patients whose symptoms worsen while being treated with antidepressants, including an increase in suicidal ideation or behavior, should be evaluated immediately.
- Consideration should be given to changing the therapeutic regimen, including discontinuing the medication, in patients whose depression is consistently worse or who are experiencing symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the person's presenting symptoms.

Patients taking antidepressants should be encouraged to be alert to the emergence of anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (i.e., psychomotor restlessness), hypomania, mania, other unusual changes in behavior, worsening of depression, and suicidal ideation, especially early during antidepressant treatment and when the dose is adjusted. Families and caregivers of patients should be advised to observe for the emergence of such symptoms on a day-to-day basis, as changes may be abrupt. Such symptoms should be reported to the patient's prescriber or health professional, especially if they are severe, abrupt in onset, or were not part of the patient's presenting symptoms. Symptoms such as these may be associated with an increased risk for suicidal thinking and behavior and indicate a need for very close monitoring and possibly changes in the medication [171; 172].

Women who are planning to breastfeed should be made aware that antidepressant medications are secreted in breast milk, and breastfeeding while taking antidepressants exposes infants to potential effects of these drugs. However, the concentration of antidepressants in breast milk represents relatively low doses. In general, if lower-risk interventions are not effective, pharmacotherapy should be considered. As with any medication use, the benefits should be carefully weighed against the risks to the patient and infant. The same risk assessment should apply to continuing breastfeeding in those with severe depressive symptoms. For those taking antidepressants, toxic symptoms appearing in an infant should be reported immediately [133].

The AAP recommends exclusive breastfeeding for six months, with continuation for one additional year as mutually desired by the mother and child. If breastfeeding is helping a mother bond with her infant (rather than contributing to symptoms), it should be incorporated into PPD treatment. Alternatively, if breastfeeding is contributing to a woman's distress, she should not feel guilty for choosing to seek alternative forms of feeding.

Studies have shown that SSRIs peak in the breast milk seven to nine hours after maternal dosing. The highest concentrations are found in the hindmilk [163; 176; 232]. The best time to nurse is one hour before taking the SSRIs. If a mother must breastfeed during the peak concentration, she may nurse for a brief period and discard the hindmilk, which will help to reduce the amount of medication the baby receives [177].

A few studies of breastfeeding children have found low infant serum levels of sertraline [178; 179]. Another study indicated the relative safety of nortriptyline, paroxetine, and sertraline [180]. Although sertraline may appear to be the safest SSRI for breastfeeding mothers, the long-term neurobehavioral development of exposed infants has not been investigated [163; 176]. A review of evidence about the safety of each SSRI during pregnancy found evidence suggesting a teratogenic potential of the whole SSRI class. The teratogenic effects are mainly in the heart region, often described as septal defects [181].

Fluoxetine produces the highest proportion of infant levels (22%), elevated more than 10% above the average maternal level, and fluoxetine has a longer half-life than either sertraline or paroxetine [166]. Two case reports of nursing infants whose mothers were taking fluoxetine related instances of increased irritability, colic, increased crying, decreased sleep, increased vomiting, and watery stools [176]. The long-term neurobehavioral development of infants exposed to fluoxetine has not been investigated. It is a drug "of concern" and should be used with caution in nursing mothers [163].

The Scottish Intercollegiate Guidelines Network recommends avoiding doxepin for treatment of depression in women who are breastfeeding. If initiating selective serotonin reuptake inhibitor treatment in breastfeeding women, then fluoxetine, citalopram, and escitalopram should be avoided, if possible.

(https://www.sign.ac.uk/assets/sign127_update.pdf. Last accessed March 27, 2020.)

Level of Evidence: D (Non-analytic studies or expert opinion)

In the past, the AAP has maintained a list of drugs for which the effect on nursing infants is unknown but may be of concern [182]. However, in 2010 the AAP retired this guideline [183]. The AAP now states that only a small proportion of medications are contraindicated in breastfeeding mothers or are associated with adverse effects on their infants [184]. Prescribers are advised to follow labelled warnings and consult online tools, such as LactMed (https://www.ncbi.nlm.nih.gov/books/NBK501922), for up-to-date information on medication use during breastfeeding [184; 185].

Serotonin-Norepinephrine Reuptake Inhibitors

SNRIs act by inhibiting the reuptake of the neurotransmitters serotonin and norepinephrine. This results in an increase in the extracellular concentrations of serotonin and norepinephrine and therefore an increase in neurotransmission [186; 187]. Most SNRIs, including venlafaxine, desvenlafaxine, levomilnacipran, and duloxetine, are several-fold more selective for serotonin over norepinephrine.

Benefits

SNRIs are a newer class of antidepressants, with use in the United States beginning in the 2000s. As such, there is not a large body of evidence comparing SNRIs to other available antidepressants. Venlafaxine is especially beneficial in treating anxiety in depressed patients. At lower doses (75 mg/day), venlafaxine acts much like an SSRI; SSRI-like side effects such as gastrointestinal upset often improve at higher doses (150–300 mg/day) [187]. However, discontinuation syndrome has been reported to be markedly worse for venlafaxine when compared to other SNRIs. The SNRIs also have an important role as second-line agents in patients who have not responded to SSRIs

Adverse Reactions

Safety, tolerability, and side effect profiles of SNRIs are similar to SSRIs, with the exception that the SNRIs have been associated (rarely) with sustained elevated blood pressure. SNRIs can be used as first-line agents, particularly in patients with significant fatigue or pain syndromes associated with the episode of depression [186; 187]. Typical side effects include [163]:

- Headache
- Fatigue
- Dizziness
- Insomnia
- Anxiety
- Nausea
- Xerostomia
- Sexual dysfunction
- Weakness
- Diaphoresis

The manufacturer of venlafaxine specifically does not recommend breastfeeding during therapy [163].

Tricyclic Antidepressants (TCAs)

TCAs act by increasing levels of both serotonin and norepinephrine in the brain. In this way, TCAs differ from SSRIs in that they affect two neurotransmitters rather than just serotonin, and they have a different side effect profile. As with SSRIs, there is no way of knowing which antidepressant will be most beneficial to each individual woman [159].

The most common TCAs are clomipramine, amitriptyline, nortriptyline, desipramine, trimipramine, and imipramine. Treatment with TCAs should be at the lowest possible therapeutic dose to minimize possible side effects. To be most effective, antidepressant treatment should be combined with counseling or psychotherapy in most instances [188].

Benefits

The main benefit of TCAs is their long history of effectiveness in treating depression. TCAs were first utilized in the late 1950s and have amassed a record of treatment success [188]. Therefore, TCAs remain a viable option. Women for whom PPD is a recurrent depression may have a prior history of success with one of the TCAs, which makes the choice easier [160].

Some benefits of TCA use are the same as those described for SSRIs, including the reduction of symptoms and the potential positive effects of the mother's rapid recovery. Relief from symptoms can help a mother function despite continuing depressive symptoms and difficulty coping with problems. The degree of response, from a slight relief of symptoms to complete relief, depends on a variety of factors related to the individual woman and the severity of the depression being treated [159]. A potential benefit of nortriptyline for breastfeeding women is that it usually produces undetectable infant levels [180]. There are no food restrictions with any of the TCAs, with the exception of caffeine and alcohol.

Adverse Reactions

TCAs tend to have more adverse side effects than SSRIs. Although side effects associated with TCAs vary with the individual and the specific antidepressant taken, in some cases, the side effects may make the drug unusable for some women. Some typical side effects are [163; 189]:

- Drowsiness
- Anxiety
- Restlessness
- Dry mouth
- Constipation
- Blurred vision
- Urinary retention
- Cognitive and memory difficulties

- Weight gain
- Increased sweating
- Dizziness
- Decrease in sexual ability and desire
- Muscle twitches
- Fatigue and weakness
- Nausea
- Increased heart rate
- Arrhythmias (very rare)

These side effects usually resolve within two weeks and can be reduced by lowering the dosage or switching to another TCA. If the adverse effects are unbearable or if they do not resolve, use of the medication is discontinued. When discontinuing an antidepressant, doses should be gradually tapered to avoid withdrawal symptoms [159].

Risks

There are a variety of factors that contraindicate the use of TCAs. TCAs should not be prescribed to anyone with a history of heart disease, as they may cause cardiovascular problems. There have also been cases of TCAs triggering manic episodes in patients with a personal or family history of bipolar disorder [190; 191]. It is also important not to prescribe TCAs with any of the following medications or other items, as there are risks of dangerous interactions [189]:

- Bicarbonate of soda
- Oral contraceptives
- Some sleeping medications
- Some anticoagulants
- Aspirin
- Other antidepressants
- Diabetes medications
- Antiarrhythmic medications
- Mood stabilizers and anticonvulsants
- Pain medications and anesthetics
- Blood pressure medications
- Stimulants
- Weight loss drugs
- Diuretics
- Thyroid supplements
- Tobacco
- Antihistamines
- Alcohol
- Antibiotics
- Sedatives and tranquilizers
- Estrogen
- Disulfiram
- Antipsychotic drugs
- Antifungal agents
- Ephedrine

Heart arrhythmias have been reported in adolescents taking desipramine; therefore, extreme caution is advised about the use of desipramine with adolescent mothers [159; 189]. The drug is not FDA approved for use in pediatric patients [163]. Due to the possibility of serious cardiac complications, TCAs can be lethal if misused at high doses [163]. Because suicidality is a risk in PPD, the danger of overdosing should be considered in prescribing TCAs [188].

As approximately 50% of all new mothers choose to breastfeed, treatment with antidepressants should be of concern [133]. As mentioned, while essentially all antidepressant medications transfer to breast milk, different medications are excreted at different levels. The treatment goal should be to minimize the amount of antidepressant the baby receives while maximizing the mother's emotional health. For healthy, full-term babies, the known benefits of breast milk could outweigh the potential hazards of most antidepressant medications [177]. The TCA doxepin should be avoided due to a case report of infant respiratory distress. Data on citalopram, fluvoxamine, bupropion, and venlafaxine are more limited, and their use cannot be recommended during breastfeeding. One study evaluating the potential consequences of TCA exposure through breast milk followed exposed children through preschool age and found that exposed children were developmentally similar to non-exposed children [186].

Monoamine Oxidase Inhibitors (MAOIs)

There are a small number of people for whom MAOIs are the best treatment [159]. Monoamine oxidase, an enzyme found in the brain, destroys neurotransmitters such as serotonin and norepinephrine. MAOIs act by inhibiting the activity of monoamine oxidase, blocking the breakdown of the neurotransmitters and making more serotonin and norepinephrine available to the neurons [192; 193]. The traditional MAOIs are phenelzine, tranylcypromine, selegiline, and isocarboxazid [192; 193].

Benefits

MAOIs work more quickly than TCAs and provide relief from symptoms shortly after beginning treatment. MAOIs are generally prescribed for people who do not initially respond to TCAs or SSRIs and for cases of atypical depression. Due to their stimulating effect, MAOIs may be preferable in the treatment of chronic low-level depression [159; 163].

Adverse Reactions

The side effects of the common MAOIs are generally minimal. When adverse effects do occur, they include dizziness, rapid heartbeat, loss of sexual interest, and food interactions [163; 192]. MAOIs can react with certain foods, alcohol, and some medications to produce a severe reaction. Reactions,

which may not appear until several hours following ingestion of the medication, may include a severe rise in blood pressure, headache, nausea, vomiting, rapid heartbeat, confusion, seizures, stroke, psychotic symptoms, or coma [192].

Foods that contain a high level of tyramine can interact with MAOIs [163]. These foods mostly consist of aged cheeses; smoked, dried, or fermented meat; fish; air-dried sausages; soy products; red wine; beer and ale; fava beans; ripe figs; Brewer's yeast or yeast extracts; pickled or salted herring; beef or chicken liver; overripe bananas or avocados; sauerkraut; soups made from beef bouillon or Asian soup stocks, such as miso soup; white wine; gin; vodka; sour cream; yogurt; saccharine; and chocolate. Any of these foods can cause problems if ingested in large amounts [194].

Drug interactions are similar to those described for TCAs and may occur with [163; 195]:

- Other antidepressants
- Asthma medications
- Cold, cough, allergy, sinus, and decongestant medications
- Diabetes medications
- Antihypertensives
- Mood stabilizers
- Painkillers and anesthetics
- Sedatives and tranquilizers
- Stimulants and street drugs
- Weight loss and appetite-suppression medications

MAOIs should also never be combined with SSRIs due to the risk of serotonin syndrome [159; 163]. Serotonin syndrome, or serotonin toxicity, results from an excess of serotogenic activity in the central nervous system. The symptoms include tachycardia, diaphoresis, hypertension, hyperthermia, clonus, and disseminated intravascular coagulation. It is seen only rarely in postpartum women, usually when multiple antidepressants, such as SSRIs, SNRIs, TCAs, MAOIs, and St. John's wort, are combined [159; 163].

Brexanolone

In 2019, the FDA approved the first drug specifically for the treatment of PPD [226]. Chemically, brexanolone is identical to endogenous allopregnanolone, a hormone that decreases after childbirth. It modulates GABA-A receptors, which become dysregulated in the postpartum period [163]. It is administered as a continuous IV infusion over a total of 60 hours (2.5 days) [226].

At the time of its approval, it is available only through a restricted program called the Zulresso Risk Evaluation and Mitigation Strategies Program that requires the drug be administered by a healthcare provider in a certified healthcare facility. Patients must be enrolled in the program prior to administration of the drug [226].

Benefits

Studies indicate that infusion of brexanolone results in a significant and clinically meaningful reduction in HAM-D total score in women with severe PPD, compared with placebo [227]. The drug appears to have a rapid onset of action and durable treatment response, adding a novel option for women with severe or refractory disease [227; 228].

Adverse Reactions

Side effects to brexanolone can occur after the infusion has concluded and the patient has been discharged home. Moderate effects include sedation, dizziness, faintness, xerostomia (dry mouth), and skin flushing. More serious and/or potentially life-threatening effects include loss of consciousness, severe sedation, anaphylaxis, and suicidal thoughts (particularly in those younger than 25 years of age) [238].

Risks

Brexanolone includes a black-box warning regarding the risk of serious harm due to the sudden loss of consciousness and for potential risk to children. During treatment, patients are monitored every two hours for loss of consciousness. If loss of consciousness occurs, treatment is immediately discontinued until the patient regains consciousness and symptoms resolve. Patients are also monitored for hypoxia via continuous pulse oximetry with alarm throughout treatment. If hypoxia develops, treatment is immediately terminated [239]. While receiving the infusion, patients must be accompanied during interactions with their child(ren). Patients should be counseled on the risks and instructed that they must be monitored for these effects at a healthcare facility for the entire 60 hours of infusion. Patients should not drive, operate machinery, or do other dangerous activities until feelings of sleepiness from the treatment have completely dissipated [226].

PSYCHOSOCIAL INTERVENTIONS

Individual Therapy

Often, individual therapy and antidepressant medications are combined in a treatment regimen. However, some women with PPD will respond well to psychotherapy alone [63]. The decision of whether to use a medication is based on a complex combination of factors that include the severity of symptoms, the individual's preferences, the response to other treatments or changes in support, and the risk of side effects. In many cases, support and education alone are not effective treatments for PPD, and medication must be added. The presence of certain symptoms, such as loss of concentration, severe insomnia, confusion, extreme indecisiveness, and severe feelings of guilt, indicate that psychotherapy alone will not be a sufficient treatment option. It is important to remember that in severe cases of PPD, medications may contribute to a quicker, fuller, and longer-lasting recovery [63; 196].

Success has been reported with the use of interpersonal psychotherapy [66; 196]. However, it is unclear whether individual psychotherapy is effective prophylaxis to prevent

recurrence of PPD in the five years after the initial onset of depression. Individual psychodynamic psychotherapy and cognitive behavioral therapy have also been effective in the treatment of PPD [196; 197; 198]. All women with PPD should be offered psychosocial treatment, and this is of particular urgency for women with severe symptoms or psychosis. Some women, however, may refuse treatment.

Group Therapy

As is well known, group therapy is an established form of professional treatment involving several individuals with similar issues meeting together at a specified time. The group is usually led by a singular therapist, but may include more than one group leader. Group therapy sessions may be limited to a specific number of meetings or may be ongoing. Meetings may be structured, with a set agenda or format for each group, or nondirective, with no specific topic except those issues that the participants decide to discuss. To obtain the best results, group therapy should be combined with individual psychotherapy rather than undertaken as a singular therapeutic regimen, especially for those depressed mothers who require individualized care.

The advantages of group therapy are that it is cost effective, reduces isolation, and offers support and empathy from others with similar problems. The disadvantages are that there is no one-on-one interaction between the therapist and each individual, and the group is not specifically tailored to meet each individual's particular needs [34]. Additionally, some mothers' childcare responsibilities may interfere with their ability to attend and participate in group therapy sessions [199]. A feasibility study on the effects of telecare therapy (i.e., a combination of cognitive-behavioral therapy, relaxation techniques, and problem-solving strategies) indicated that this may be an effective treatment option for women with PPD who are unable to attend group therapy sessions or support groups [200].

Support Groups

Social groups and self-help groups specifically established for women with PPD may be very helpful. These groups are not intended to provide therapeutic outcomes, but are created to provide support, empathetic listening, understanding, and information, all of which are important for depressed mothers. Women who wrote about their experiences with PPD specified that these groups gave them valuable practical guidance on day-to-day issues [11; 99].

Self-help groups for PPD are usually led by a woman who has personal experience with PPD. This woman shares her knowledge and experience as guidance for other women, helping them deal with PPD. Resources for treatment of PPD and practical advice are usually part of such groups. They are also beneficial experiences for those women who feel alone and isolated [63].

According to one study, social support groups did not positively affect depressive symptoms per se, but did have a positive effect on the mother-infant interaction [66]. Another small study found that depression scores following participation in a weekly peer support group were similar to a community sample [31]. Support groups and self-help groups are no substitute for formal treatment. Like group therapy, they are best used as an adjunct to traditional therapy and medical intervention.

Overall, both psychosocial (e.g., peer support, nondirective counseling) and psychologic (e.g., cognitive behavioral therapy, interpersonal psychotherapy) interventions have been found to be effective in reducing symptoms of PPD and, more recently, to be effective in preventing PPD [201]. These interventions significantly reduce the number of women who develop PPD. However, the long-term benefits are unknown and larger trials are needed to determine the specific benefits of each type of intervention [201; 202].

Psychiatric Hospitalization

Mothers suffering from severe mental illness in the postpartum period will inevitably require psychiatric hospitalization as part of their treatment. Unless the mother and infant are admitted together to a specialty unit, there may be little or no contact between them for several days or weeks. Separation of the mother and infant may have negative consequences [203]. However, the consequences (e.g., delayed bonding, cessation of breastfeeding) are secondary to the patient's and child's safety.

The physical separation of mother and infant protects the infant from the potential risks of interaction with a severely ill mother. However, separating mother and infant may have adverse effects on their subsequent relationship and the infant's socioemotional development. Although there are concerns about admitting infants with their mothers to psychiatric hospitals, there is no evidence of major disadvantages, and the advantages afforded to the mother and infant seem to be great [203].

Other concerns about the effects of separation include stunting of parenting skills and lack of infant attachment. These concerns have led mental health units in some countries to develop ways to provide psychiatric care for mentally ill mothers without separating them from their children [204].

Studies have shown that mothers separated from their infants during hospitalization have a longer duration of illness and experience greater difficulty bonding with their infants than mothers jointly admitted to a mother-baby unit. Most of the mothers admitted to a mother-baby unit showed a positive clinical outcome and were discharged home to care for their infant without further supervision. Mothers in a supportive social relationship had the best chance for a positive outcome [205].

Mother-baby units have been difficult to maintain in the United States. Although they offer significant advantages to mothers and families, data to support cost effectiveness are not available, which is a barrier to implementation [206]. As an example, the Women and Infant's Hospital, associated with Brown Medical School in Rhode Island, has operated since 1999. Services are provided in a mother-baby day hospital. The hospital admits both pregnant women with psychiatric problems and postpartum psychiatric patients for therapy [20].

PREVENTIVE STRATEGIES

Prevention of PPD is of utmost interest to researchers and clinicians, and it is clear that preventing severe depression would have clear benefits for mothers and children. Two barriers to effective and efficient postpartum care in the United States have been identified: the lack of parity between insurance coverage for mental and physical illnesses decreases access to care, and the current model of postpartum care fails to incorporate screening and follow-up. In developing a prevention model in the United States, these concerns should be taken into account. The types of prevention strategies employed should be determined by the risk factors with which a woman presents. Early detection and treatment are keys to a full recovery [207]. Healthcare professionals involved in childbirth education are in an excellent position to offer pregnant women anticipatory information about postpartum complications, including PPD [124].

SCREENING

An effort to place greater emphasis on identifying any previous psychiatric illness in pregnant women and their families, combined with the continuous observation of the psychologic well-being of women during pregnancy, will enable potential sufferers of PPD to receive treatment at the earliest possible stage. In addition to screening for PPD during pregnancy, screening at six weeks, three months, and six months postpartum should become routine. It remains the primary responsibility of physicians treating women of childbearing age to ensure that all healthcare professionals involved in prenatal care have a full knowledge of the devastating effects of PPD and actively work to detect women at risk as early as possible [10]. As noted, the EPDS is the most accepted and widely used screening tool available today and takes only a few minutes to administer. Having a standardized mechanism of screening available for all pregnant women should become the standard of care. Without a formal assessment, most depressive symptoms will remain undetected by primary care health professionals [201].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The Scottish Intercollegiate Guidelines Network recommends inquiry about depressive symptoms should be made, at minimum, on booking in and postpartum at four to six weeks and three to four months.

(https://www.sign.ac.uk/assets/sign127_update.pdf. Last accessed March 27, 2020.)

Level of Evidence: D (Non-analytic studies or expert opinion)

POSTPARTUM DEBRIEFING

For all women who have given birth, prevention planning should consist of an unstructured debriefing in the postpartum ward by a nurse, midwife, or someone functioning in a similar capacity. Studies show that providing women the opportunity to talk about their feelings following delivery allows them to integrate and make sense of their birth experiences. One study of postpartum debriefing, which is regularly utilized in many British and Australian hospitals, showed that unstructured debriefing resulted in a significant decrease in the likelihood of depressive symptoms [207]. These results indicate that even a short meeting with a nurse or similar professional involving listening, support, counseling, and explanations may be sufficient to prevent PPD in some first-time mothers. Evidence in support of formal, structured debriefings is inconclusive [208; 209; 210].

COMPANIONSHIP IN THE DELIVERY ROOM

It is believed that negative perceptions of labor and delivery, particularly a lengthy or difficult labor, may be a precursor to developing PPD. It is also posited that not having a supportive companion during labor and delivery might place women at risk for PPD. This would suggest that preventive work can be carried out in the delivery room [207; 211; 212; 213].

One study examining companionship during labor and delivery designed an intervention involving a community volunteer to provide support during labor and delivery. The companion was instructed to use touch and verbal communication to comfort, reassure, and praise the woman. The study found that depression scores were significantly lower for women with a companion during labor and delivery compared to those women who did not have a companion [207]. A 2013 meta-analysis did not find evidence that companionship during delivery improved maternal mental health in the postpartum period, but the authors concluded that there was no harm with the use of support during childbirth and it could be considered due to the positive effects on the labor experience and newborn responsiveness [214]. They also state that "continuous support from a person who is present solely to provide support, is not a member of the woman's social network, is experienced in providing labor

support, and has at least a modest amount of training, appears to be most beneficial" [214].

BRIEF PSYCHOTHERAPY

Interpersonal psychotherapy and cognitive behavioral therapy have been useful in preventing depression among at-risk persons. Consequently, there is interest in determining whether brief psychotherapy could be used to prevent PPD among predisposed women. In one study conducted among women who were considered at high risk for developing PPD, the effectiveness of group psychotherapy was tested [215]. Risk factors were identified as previous episodes of depression, mild-to-moderate levels of depressive symptoms, poor social support, and a life stressor within the past six months. The therapy consisted of four weekly, one-hour group sessions based on an interpersonal psychotherapy model. Each group was comprised of four to six women. The study found that improvement in depression scores was significantly greater among women in the intervention group compared to women receiving no therapy. Women receiving brief psychotherapy were significantly less likely to develop PPD. Authors of another study followed 34 women with perinatal depression through a nine-week cognitive behavioral therapy group program. On completion of the program, 80% of the women showed a clinically significant improvement in depressive symptoms as well as meaningful gains in social support, mother-infant bonding, and quality of partner relationship [216]. These findings suggest that brief group psychotherapy may be an effective prevention strategy for women who are at risk for PPD. However, more research is necessary to determine the usefulness of this treatment [216; 217].

A single, brief cognitive behavioral therapy session taking place prior to being discharged from the hospital has also been shown to be effective in preventing PPD in at-risk women. In this study, women were considered to be at-risk if they were experiencing elevated depressive symptoms shortly after birth. The therapy given was a one-hour, individual session consisting of education, support, empathetic listening, and a cognitive-behavioral approach to dealing with ideas of perfectionistic standards. The researchers concluded that a single, brief intervention provided to high-risk women focusing on education, support, and modification of maladaptive thoughts can help to reduce the incidence of PPD [207]. While long-term effectiveness remains unclear, psychosocial and psychologic interventions (i.e., professionally based postpartum home visits, telephone-based peer support, interpersonal psychotherapy) have been found to significantly reduce the number of women who develop PPD [201].

The Mother-Infant Dyad

Most interventions to prevent PPD focus on just the mother rather than on the mother-infant dyad. One study examined the effectiveness of practical resources for effective postpartum parenting, a new PPD prevention protocol that aims to treat women at risk for PPD by promoting maternally mediated behavioral changes in their infants, while also including mother-focused skills [218]. Fifty-four women were included in this randomized control trial. Results indicate that this novel, brief intervention was well tolerated and effective in reducing maternal symptoms of anxiety and depression, particularly at six weeks postpartum [218].

Another study tested perinatal dyadic psychotherapy (PDP), a dual-focused mother-infant intervention designed to prevent or decrease maternal PPD and improve aspects of the mother-infant relationship that are related to the child's development [219]. Forty-two first-time mothers with depressive symptoms (recruited from hospital postpartum units) and their 6-week-old infants were enrolled and randomized to receive either the PDP intervention or usual care plus depression monitoring by telephone. The PDP intervention consisted of eight home-based, nurse-delivered mother-infant sessions consisting of supportive, relationship-based, mother-infant psychotherapy and a developmentally based infant-oriented component focused on promoting positive mother-infant interactions. Measures of maternal depression, anxiety, self-esteem, parenting stress, and mother-infant interaction were collected at baseline, post-intervention, and three-month follow-up. Depression and anxiety symptoms and diagnoses decreased significantly and maternal self-esteem increased significantly across the study time frame, with no differences between the two groups. There also were no significant differences between the groups on parenting stress or mother-infant interaction. No participants developed onset of PPD during the study. The authors concluded that although this novel intervention holds potential for treating depression in the context of the mother-infant relationship, usual care plus depression monitoring showed equal benefit [219]. Further research is needed.

A novel maternal-infant dyadic group therapy intervention was the focus of an open-label pilot study that targeted mothers with mood or anxiety disorders and their infants 6 to 12 months of age [220]. Three 12-week groups were conducted using evidence-based maternal and mother-infant dyadic strategies to enhance mood, insight, parenting, and mentalizing capacity. Outcome measures included recruitment and retention rates, reasons for nonparticipation, and missed sessions. Enhanced insight, parenting capacity, affect regulation, and positive interaction with the infant were supported with self-report surveys and interviews [220].

CONTINUITY OF CARE

Prevention studies involving care by midwives or other healthcare professionals suggest that the incidence of PPD in the general population may be reduced by providing personalized care to women in the hospital and at home after childbirth [201]. Continuity of care is ensured if the same professional provides personalized care during home visits. Ideally, the same nurse or midwife would provide care throughout the antepartum and postpartum periods, tailoring the care to the individual woman's needs rather than to a standardized care plan. A program focused on continuity of care, individualization, and emotional support has the

potential to prevent or minimize the effects of PPD and could be implemented for many pregnant women [201; 207; 221; 222]. Home visits should become the standard of care of at-risk women [201].

Because women are more likely to be engaged with health care during pregnancy, those involved in their care have a unique opportunity. By emphasizing prevention, addressing disparities, and focusing on integrating behavioral healthcare into primary care settings, those involved in the care of women can dramatically and positively impact women's health [223].

PREVENTIVE HORMONE TREATMENT

The use of hormones in the prevention of recurrence of PPD was first reported in 1964 [10]. There is some conflicting evidence regarding the efficacy of progesterone and estrogen, and the use of synthetic progestins is associated with increased risk of developing PPD [155; 224].

If utilized, it is advised that, upon completion of labor, the patient is given 100 mg of progesterone by injection daily for seven days, followed by a 400 mg suppository twice daily until the return of menstruation. The dosage of suppositories may be increased if the mother experiences a return of mild early symptoms. Each woman should also be equipped with information about the symptoms of PPD [10]. At the end of two months, if menstruation has not begun and no symptoms appear, the number of suppositories may be reduced and then discontinued. If menstruation has begun and symptoms appear, progesterone should be given from day 14 of the cycle until the next menstruation. Natural progesterone should only be given in the prescribed method of administration. Studies have been conducted on progesterone preventive treatment in 1985, 1989, 1994, and 1995 [10]. In these studies, the prevention of symptom recurrence was 90% to 92% successful.

A comprehensive meta-analysis published in 2000 and updated in 2008 concluded that synthetic progestogens should be used with caution in the postpartum period and that the role of natural progesterone in the prevention and treatment of PPD requires further evaluation. Estrogen therapy was found to be of modest value for treatment of severe PPD, while its role in the prevention of recurrent PPD requires further research [46; 47; 155].

CONCLUSION

PPD is a major complication of childbirth. Given the potential negative consequences for the mother, baby, and entire family, early detection and treatment are essential. Studies have shown that PPD not only responds well to treatment, but is preventable [207]. Further, there is evidence that rates of PPD and severity of symptoms increased during the COVID-19 pandemic, attributed partially to pandemic-related stress and lack of available support [242; 243]. However, there remains a knowledge gap about PPD and its effects on women and children. This knowledge gap exists in most facets of society, including the healthcare sector. PPD remains a misunderstood illness that is often improperly diagnosed and treated.

All healthcare professionals who treat pregnant women should assess their patients for the early warning signs and risks of PPD and undertake the appropriate courses of action [124]. Devastating cases of suicide and infanticide can be prevented, and the potential harm to families through isolation and neglect can be minimized.

In addition to educating themselves, healthcare providers should educate all pregnant women about the symptoms of PPD and the resources available to treat it. Screening for PPD and education about PPD should become the standard for postpartum care.

GLOSSARY

Adrenal glands: A pair of small glands above each kidney responsible for producing numerous hormones, including adrenaline; also referred to as adrenals

Acetylcholine: A neurotransmitter released and hydrolyzed in certain synaptic transmissions of the nervous system and in the initiation of muscle contraction

Adrenaline: A neurotransmitter produced by the adrenal gland released in response to fear, heightened emotion, or other physiologic stresses

Amygdala: A group of neuronal nuclei in the dorsomedial temporal lobe that subserve informational learning in conjunction with the hippocampus

Brain stem: The portion of the brain, composed of the medulla oblongata, the pons, and the midbrain, that governs a variety of vegetative functions and contains sensory and motor fibers of passage

Cerebral cortex: The outermost region of the cerebrum, consisting of several dense layers of neural cell bodies and including numerous conscious centers; also referred to as gray matter

Circadian rhythm: A biologic rhythm about one day in length

Cortex: The outer layer of an organ, such as the brain

Corticosteroids: Hormones produced by the cortex of the adrenal glands

Cortisol: A steroid hormone produced and released by the adrenal gland that helps to regulate blood sugar, blood pressure, and bone growth as well as other functions

Dysphoria: A lowering of mood, characterized by malaise, unrest, or anxiety

Endocrine gland: An organ that releases hormones into the blood to act on distant cells

Endometrium: The inner lining of the uterus

Estrogen receptor: A protein on some cells to which an estrogen molecule can attach

Etiology: The causative agent of a disorder or disease

Follicle: A cyst or sac in which each egg in the ovary develops

Follicle-stimulating hormone (FSH): A hormone produced by the pituitary, acting on the ovary to ripen the follicles and produce estrogen

Gonadotrophin releasing hormone (GnRH): A hormone from the hypothalamus that stimulates the ovaries in women

Hippocampus: The area of the brain involved in learning and memory

Hormone receptors: Compounds that transport hormone molecules into the nucleus of cells

Human chorionic gonadotropin (hCG): The placental hormone of pregnancy

Hypothyroidism: An underactive thyroid function caused by abnormally low levels of circulating thyroid hormone; symptoms include physical and mental sluggishness, weight gain, hair loss, and infertility

Hypothalamus: A portion in the brain that produces hormones that initiate the reproductive cycle as well as other functions

Limbic system: A group of structures in the brain operating below the level of consciousness important in regulating such behavior as eating, drinking, aggression, sexual activity, and expressions of emotion; the emotional brain

Luteinizing hormone (LH): The hormone secreted by the pituitary that triggers ovulation and the production of progesterone

Menarche: The first menstruation at puberty

Menstrual clock: A specialized portion of the hypothalamus responsible for the cyclical timing of menstruation

Neurotransmitters: Chemical signals that communicate among neurons, resulting in electrical impulse activity, altered gene expression, growth, and survival

Oxytocin: A hormone produced by the pituitary gland that causes uterine contractions

Pituitary gland: A pea-sized gland located between and behind the eyes in the base of the brain that secretes hormones to control many other glands in the body, including ovaries, thyroid, and adrenal glands; it is controlled by the hypothalamus

Postpartum: The period following childbirth, generally considered to be six weeks

Progesterone: A hormone produced by the ovaries for the preparation of the lining of the uterus and the production of numerous corticosteroids

Steroids: A family of lipid molecules including cholesterol and the naturally-occurring hormones estrogen, progesterone, and testosterone

Synapse: The junction between nerve cells

Thyroid gland: A gland located in the neck in front and on each side of the trachea that secretes thyroxin and other hormones responsible for numerous metabolic and essential processes

RESOURCES

American College of Nurse-Midwives
http://www.midwife.org

National Institute of Mental Health
https://www.nimh.nih.gov

Postpartum Education for Parents
http://www.sbpep.org

Postpartum Support International
http://www.postpartum.net

U.S. Department of Health and Human Services Office on Women's Health
https://www.womenshealth.gov

APPENDIX

MISCONCEPTIONS AND MYTHS REGARDING PPD: PATIENT EDUCATION

Myth: *Women who have PPD are weak and lacking in character. They probably bring it on themselves.*

Fact: There are numerous factors that cause PPD. Women who have PPD are no weaker than any other women nor do they bring it on themselves.

Myth: *Depression is just an excuse to get out of difficult circumstances.*

Fact: Depression is not an excuse nor is it sought deliberately by any person. It happens to them. The sufferer should not be blamed for her depression.

Myth: *PPD is just a temporary sadness or something a woman can just "snap out of" and "pull herself together."*

Fact: PPD is not simply sadness or something a woman can just "snap out of." PPD can impair a woman's social and physical functioning to the point of disability and even suicide.

Myth: *There is nothing a medical professional can do about depression. It is untreatable.*

Fact: Depression is caused by an interaction of biologic and environmental influences. It is a treatable condition.

Myth: *Once depressed, it is a lifetime problem. The person never recovers.*

Fact: Depression can recur and seem to be a lifetime problem for some people. However, depression is a treatable illness, and the depressed person can recover and live a normal, healthy life.

Myth: *Women with PPD are demonstrating that they are self-centered and manipulative.*

Fact: Women with PPD are suffering an emotional disorder. Their symptoms are real, not manipulative.

Myth: *Depression does not require medical treatment. One can cure depression by will power, buying a new dress, throwing a party, drinking champagne, or taking a vacation.*

Fact: Depression requires medical treatment. Will power alone cannot cure depression, as it involves experiencing a lack of pleasure in things of everyday life such as shopping, partying, and vacations. Drinking alcoholic beverages can worsen depression.

Myth: *Medications used for treating depression are habit forming.*

Fact: Medications used for treating depression are not habit forming. As depression goes into remission, drugs can be tapered off and stopped.

Myth: *When a depressed mother expresses suicidal ideation, she has no intention of acting on them. She is probably just trying to get special attention.*

Fact: Suicide is always a risk with a mother who is depressed. Any expressed suicidal ideas should be taken seriously.

Myth: *People who do complete suicide just do it; they do not talk about it.*

Fact: People who complete suicide have generally given clues to their friends and family of their intentions. These clues are often not understood or not taken seriously.

Myth: *If a person is suspected of having suicidal thoughts, one should not talk about it as it will make it worse.*

Fact: An empathetic, tactful discussion about suicidal thoughts with a person who is depressed often alleviates the risk of suicide and assists the person to obtain appropriate medical care.

Myth: *Only women from lower socioeconomic levels suffer from PPD.*

Fact: Low socioeconomic status can be a factor for PPD; however, it affects women across all socioeconomic levels.

FACULTY BIOGRAPHY

Anele Runyion, RN, MS, received her diploma in nursing from Berea College School of Nursing in Berea, Kentucky. She subsequently received a Baccalaureate and Master's degree in psychiatric nursing from the University of California, San Francisco. She has extensive experience in psychiatric nursing, including adolescent and adult psychiatry.

For twenty years she was psychiatric nurse consultant and coordinator of psychiatric nursing consultation at San Francisco General Hospital. She was Assistant Clinical Professor in Mental Health, Community and Administrative Nursing at the University of California, San Francisco. She created and co-chaired a National Psychiatric Consultation/Liaison Conference in 1987, which provided continuing education in nursing. This conference meets annually and has subsequently become an international conference.

She created a brief curriculum and practicum in consultation/liaison nursing for graduate nursing students at UCSF that is currently being practiced. As a psychiatric nurse consultant, she assisted non-psychiatric nurses in the hospital to assimilate and integrate psychological principles into their practice. During this time, she developed a protocol for management of acute post-traumatic stress response. This protocol was adopted by the hospital as a standard care plan for nursing management of patients with acute post-traumatic stress response in the non-psychiatric areas of the hospital.

Ms. Runyion has published and spoken nationally. She was listed in Who's Who in American Nursing in 1991-1992 and 1996-97. Currently, she is a self-employed consultant and writer.

Customer Information/Answer Sheet/Evaluation insert located between pages 32–33.

TEST QUESTIONS
#96363 POSTPARTUM DEPRESSION

This is an open book test. Please record your responses on the Answer Sheet.
A passing grade of at least 80% must be achieved in order to receive credit for this course.

This 15 Hour/5 NBCC Clock Hour activity must be completed by March 31, 2023.

1. Postpartum blues, a mild and transient depression in the immediate postpartum period, occur in up to 85% of new mothers.
A) *True*
B) *False*

2. Postpartum depression (PPD) occurs in approximately what proportion of new mothers?
A) *1% to 5%*
B) *10% to 15%*
C) *50% to 65%*
D) *80% to 90%*

3. An estimated 50% of patients with postpartum psychosis will attempt infanticide or suicide.
A) *True*
B) *False*

4. The first documentation of PPD can be traced to
A) *Galen.*
B) *Marcé.*
C) *Esquirol.*
D) *Hippocrates.*

5. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) recognizes PPD as a distinct entity.
A) *True*
B) *False*

6. Cultural perspectives influence all of the following aspects of PPD, EXCEPT:
A) *Incidence*
B) *Expression of symptoms*
C) *Interpretation of symptoms*
D) *The relationship between the healthcare provider and patient*

7. All of the following are considered risk factors for PPD when they are present prior to pregnancy, EXCEPT:
A) *Infertility treatment*
B) *Socioeconomic stressors*
C) *Excessive involvement of family members*
D) *Past history of depression or other mental health problems*

8. Which of the following is a risk factor for PPD if present during pregnancy?
A) *Older maternal age*
B) *First-time motherhood*
C) *Anxiety about the fetus*
D) *History of multiple pregnancies*

9. Which of the following is NOT considered a risk factor for PPD if present after childbirth?
A) *Persistent sleep disturbances*
B) *Having a manipulative character*
C) *Having an infant with special needs*
D) *Birth complications or a difficult labor*

10. The areas of the brain affected by female reproductive hormones are the same as those known to regulate mood stability and behavior.
A) *True*
B) *False*

11. What part of the limbic brain is believed to be involved in the fight/flight response?
A) *Thalamus*
B) *Hippocampus*
C) *Hypothalamus*
D) *Cingulate gyrus*

12. The prefrontal limbic complex plays a large role in
A) *intellect.*
B) *good judgment.*
C) *processing emotions.*
D) *orchestration of the menstrual cycle.*

Test questions continue on next page ➔

13. An excess of norepinephrine can produce agitation or irritability.
A) *True*
B) *False*

14. Serotonin is
A) *released in response to stress.*
B) *formed from excess dopamine.*
C) *does not significantly affect depression in women.*
D) *associated with perception and regulation of pain.*

15. Men have a greater lifetime risk than women for depression, with two times the incidence of depressive episodes or recurrent depression.
A) *True*
B) *False*

16. Under normal circumstances, estrogen could be regarded as protecting women against depression.
A) *True*
B) *False*

17. Progesterone is produced primarily during
A) *childbirth.*
B) *the postpartum period.*
C) *the first phase of the menstrual cycle.*
D) *the second phase of the menstrual cycle.*

18. Some have suggested that women for whom cortisol levels remain lower after delivery of the placenta may have a greater risk of developing PPD.
A) *True*
B) *False*

19. Screening for thyroid dysfunction in postpartum women is important because
A) *it may cause depression in some women.*
B) *it is able to definitively identify patients at risk for PPD.*
C) *approximately 70% of women have abnormal thyroid levels in the postpartum period.*
D) *All of the above*

20. A detailed family history specifically documenting incidences of depression or mental illness is useful in any PPD assessment.
A) *True*
B) *False*

21. Which of the following is an aspect of family history that may predispose a woman for the development of PPD?
A) *Aggression*
B) *Ordered lifestyles*
C) *Heightened empathy for others*
D) *Absent or extremely lenient parents*

22. Approximately what percentage of those who become depressed will have another depressive episode?
A) *15%*
B) *30%*
C) *50%*
D) *70%*

23. In general, women with PPD do not experience the initial stages of motherhood as they had fantasized; consequently, their disappointments are more intense and severe.
A) *True*
B) *False*

24. Studies of women receiving fertility treatment have shown that these women generally had more satisfaction with life, lower levels of anxiety, and had lower scores on depression scales than women without infertility.
A) *True*
B) *False*

25. Postpartum blues generally resolve within
A) *1 day.*
B) *3 days.*
C) *10 days.*
D) *30 days.*

26. The most common emotional expressions of postpartum blues are
A) *exhaustion and irritability.*
B) *incessant crying and tearfulness.*
C) *anxiety and hyperresponsiveness.*
D) *mood swings and sleep disturbances.*

27. Incessant crying and tearfulness are the most common emotional expressions of the postpartum blues.
A) *True*
B) *False*

28. An early warning sign for more serious depression is feeling overwhelmed combined with suicidal ideation.
A) True
B) False

29. It has been reported that 40% to 90% of PPD cases occur
A) within three months after childbirth.
B) six months after childbirth.
C) nine months after childbirth.
D) more than nine months after childbirth.

30. Women for whom PPD is their first incidence of depression tend to experience a longer duration of symptoms.
A) True
B) False

31. Which of the following is considered a physical symptom of PPD?
A) Sleep disturbances
B) Fear of being alone
C) Neglect of one's environment
D) Inability to cope with normal routine

32. Which of the following is NOT a cognitive symptom of PPD?
A) Hallucinations
B) Pervasive anxiety
C) Memory problems
D) Difficulty concentrating

33. Irritability is one of the main mood changes most women experience with PPD.
A) True
B) False

34. Sleep disturbances associated with PPD are
A) characterized by unrestful sleep.
B) generally caused by the baby's presence.
C) often characterized by excessive sleeping.
D) attributed to the need for nighttime feedings.

35. For some, a prominent feature of PPD is the belief that one is not worthy of having a child.
A) True
B) False

36. Postpartum psychosis has an incidence in first-time mothers of
A) 1 in 3.
B) 1 or 2 in 100.
C) 1 or 2 in 1,000.
D) 1 or 2 in 100,000.

37. Psychosis in a new mother rarely requires psychiatric hospitalization.
A) True
B) False

38. Symptoms of postpartum psychosis typically develop more than three weeks postpartum.
A) True
B) False

39. Which of the following is considered a characteristic of postpartum psychosis?
A) Delusions
B) Extreme agitation
C) Inability to carry on a coherent conversation
D) All of the above

40. Psychosis-associated confusion is defined by a lack of awareness of identity, surroundings, or time.
A) True
B) False

41. There is a danger of controlled postpartum psychosis returning at the resumption of menstruation, even if the mother is undergoing continuous psychiatric outpatient treatment.
A) True
B) False

42. Suspicious, paranoid ideations are usually indicators that the mother is in the early phases of a psychosis.
A) True
B) False

43. Preferably, healthcare professionals should address the issue of PPD
A) prior to discharge.
B) as soon after delivery as possible.
C) at the six-week follow-up visit.
D) during the third trimester.

Test questions continue on next page ➔

44. Both the USPSTF and the American College of Obstetricians and Gynecologists recommend that assessment for depression using a standardized, validated tool occur at least once during the perinatal period.
- A) *True*
- B) *False*

45. What is the most widely used screening tool available to detect PPD?
- A) *Depressed Mothers Screening Tool (DMST)*
- B) *Postpartum Depression Rating Scale (PDRS)*
- C) *Edinburgh Postnatal Depression Scale (EPDS)*
- D) *Postpartum Depression Screening Scale (PDSS)*

46. Which of the following statements measures the guilt/shame dimension as defined by the Postpartum Depression Screening Scale (PDSS)?
- A) *Felt really overwhelmed*
- B) *Felt like I was not normal*
- C) *Felt like a failure as a mother*
- D) *Just wanted to leave this world*

47. The PDSS yields an overall severity score falling into three ranges. Which of the following is NOT a PDSS severity score?
- A) *Normal adjustment*
- B) *Significant symptoms of PPD*
- C) *Positive screen for major PPD*
- D) *Positive screen for postpartum psychosis*

48. When a mother's depression interferes with her sensitivity to her baby, their interactions can have a negative effect on the child.
- A) *True*
- B) *False*

49. Mother-infant bonding dysfunction
- A) *is present in less than 5% of cases of PPD.*
- B) *is not a source of negative effects on the child.*
- C) *may have long-term consequences for the mother-child relationship.*
- D) *may be classified into five different groups: delay, ambivalence, rejection, normal, and established.*

50. Establishment of a child's social relationships is closely linked to mother-infant attachment, which can be delayed or absent in women with PPD. Success or failure of this primary developmental process depends upon all of the following, EXCEPT:
- A) *The ability and success of the infant's communicative system to express the infant's needs*
- B) *The integrity and capacity of the infant's physiologic systems and central nervous system*
- C) *The caretaker's ability to read the infant's communications correctly and to take the appropriate action*
- D) *The caregiver's ability to express her needs and to feel that they are being responded to in an appropriate manner*

51. "Mutual regulation" is defined as the relationship between a mother and her child.
- A) *True*
- B) *False*

52. Depressed mothers manifest the break in the mutual regulatory system as being either intrusive or withdrawn. Intrusive mothers often
- A) *are affectively flat.*
- B) *handle the infant roughly.*
- C) *speak quietly or not at all.*
- D) *engage in little support for the infant's activities.*

53. The infants of withdrawn mothers eventually adopt an angry and protective style of coping.
- A) *True*
- B) *False*

54. A mother's unresponsiveness or inappropriate parenting during infancy may prevent the child from achieving the developmental goals of social interaction and object exploration.
- A) *True*
- B) *False*

55. It is thought that short-lived PPD with an onset in the first few weeks postpartum and resolution by four to five months should have less of an impact on the quality of the attachment than depressions lasting six months or longer.
- A) *True*
- B) *False*

56. According to one study, children of women who were depressed three months after childbirth were at greater risk for all of the following long-term effects, EXCEPT:
A) *Aggression*
B) *Attention deficit problems*
C) *Difficulty with mathematics*
D) *Increased incidence of special education needs*

57. Marital conflict and dissatisfaction are generally uncommon in the first year after childbirth.
A) *True*
B) *False*

58. Which of the following is NOT one of the three areas in a relationship most affected by PPD?
A) *Sexuality*
B) *Practical support*
C) *Emotional needs*
D) *Contraception/family planning*

59. In the United States, the greatest cause of maternal mortality in the year following childbirth is
A) *AIDS.*
B) *cancer.*
C) *suicide.*
D) *homicide.*

60. Persons who talk about suicide, threaten to commit suicide, or call suicide crisis centers are 30 times more likely to attempt suicide than those that do not.
A) *True*
B) *False*

61. Parents who expresses concern that thoughts of harming their baby are becoming strong and fear they could be acted on should be supervised when they are with their baby.
A) *True*
B) *False*

62. PPD usually resolves when individuals stop breastfeeding.
A) *True*
B) *False*

63. If possible, mothers should sleep a minimum of
A) *two hours at a time.*
B) *three hours at a time.*
C) *four hours at a time.*
D) *five hours at a time.*

64. Individuals with depression should be encouraged to spend most of their time alone.
A) *True*
B) *False*

65. In one study, the strongest predictor of paternal PPD was
A) *social or financial stressors.*
B) *presence of maternal depression.*
C) *a personal history of mental illness.*
D) *insufficient social or family support.*

66. An increase in hormones after delivery is thought to be a major factor in the etiology of PPD in predisposed women.
A) *True*
B) *False*

67. According to Dalton and Horton, the minimum effective dose of progesterone in the treatment of PPD is
A) *100-mg suppository administered four times a day.*
B) *400-mg suppository administered twice a day.*
C) *400 mg administered subcutaneously daily.*
D) *600 mg administered subcutaneously twice a day.*

68. Symptoms and signs of serotonin syndrome include all of the following, EXCEPT:
A) *Nausea*
B) *Tachycardia*
C) *Hyperthermia*
D) *Underactive reflexes*

69. For women taking a selective serotonin reuptake inhibitor (SSRI), the best time to breastfeed is
A) *one hour before taking the medication.*
B) *immediately after taking the medication.*
C) *one hour after taking the medication.*
D) *seven to nine hours after taking the medication.*

Test questions continue on next page ➔

70. Possible side effects of feeding and sleep disorders have been reported in breastfeeding infants of mothers taking
A) *sertraline.*
B) *fluoxetine.*
C) *paroxetine.*
D) *clomipramine.*

71. Tricyclic antidepressants are contraindicated in patients
A) *also taking disulfiram.*
B) *who use oral contraceptives.*
C) *with a history of heart disease.*
D) *All of the above*

72. The presence of certain symptoms, such as loss of concentration, severe insomnia, confusion, extreme indecisiveness, and severe feelings of guilt, indicates that psychotherapy alone will not be a sufficient treatment option.
A) *True*
B) *False*

73. All women with PPD should be offered psychosocial treatment.
A) *True*
B) *False*

74. As part of the treatment of PPD, group therapy is
A) *not cost effective.*
B) *ineffective in reducing feelings of isolation.*
C) *tailored to meet an individual's specific needs.*
D) *an opportunity to interact with others with similar problems.*

75. Which of the following is a barrier to effective and efficient postpartum care in the United States?
A) *PPD is not recognized as a "true" disease.*
B) *Lack of insurance coverage decreases access to care.*
C) *Current model incorporates screening and follow-up.*
D) *All of the above*

76. In addition to screening for PPD during pregnancy, it is recommended that clinicians screen postpartum women at
A) *every contact with the patient.*
B) *2 weeks, 6 weeks, and 9 weeks.*
C) *6 weeks, 3 months, and 6 months.*
D) *3 months, 12 months, and 24 months.*

77. For all women who have given birth, PPD prevention planning should include an unstructured debriefing in the postpartum ward.
A) *True*
B) *False*

78. A single, brief cognitive behavioral therapy session taking place prior to being discharged from the hospital has been shown to be effective in preventing PPD in at-risk women.
A) *True*
B) *False*

79. Home visits should become the standard of care of at-risk women.
A) *True*
B) *False*

80. Several studies regarding the efficacy of natural progesterone for the prevention of PPD found that prevention of symptom recurrence was
A) *15% to 23% successful.*
B) *29% to 56% successful.*
C) *75% to 82% successful.*
D) *90% to 92% successful.*

Be sure to transfer your answers to the Answer Sheet located between pages 32–33.
DO NOT send these test pages to NetCE. Retain them for your records.
PLEASE NOTE: Your postmark or facsimile date will be used as your test completion date.

Course Availability List

These courses may be ordered by mail on the Customer Information form located between pages 32–33.
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www.NetCE.com

PROMOTING THE HEALTH OF GENDER AND SEXUAL MINORITIES

#71793 • 5 APA Hours, 2.5 NBCC Hours

Book By Mail – $33 • **ONLINE – $25**

Purpose: The purpose of this course is to provide mental and behavioral health professionals with strategies that promote cultural competency when treating and caring for these patients, supporting the concept of patient-centered care.

Faculty: Leslie Bakker, RN, MSN

Audience: This course is designed for members of the interdisciplinary team, including social workers, counselors, and therapists, working in all practice settings.

Special Approval: This course is designed to meet requirements for LGBTQ and cultural competency education.

HIV/AIDS: EPIDEMIC UPDATE FOR BEHAVIORAL HEALTH PROFESSIONALS

#74713 • 7 ASWB Hours, 2 NBCC Hours

Book By Mail – $43 • **ONLINE – $35**

Purpose: In view of the already existing crisis in health care in the United States, the problems associated with providing the necessary care for persons with HIV infection or AIDS are significant. The purpose of this course is to address those problems in the discussion of epidemiology, pathophysiology, transmission, complications, treatment advancements, prevention, ethical and legal aspects of care, and workplace concerns.

Faculty: Alice Yick Flanagan, PhD, MSW; Jane C. Norman, RN, MSN, CNE, PhD; John M. Leonard, MD

Audience: This course is designed for all behavioral health professionals, including social workers, counselors, and marriage and family therapists, who may be involved with the care of persons with HIV or AIDS.

Special Approval: This course meets the qualifications for 6 hours of continuing education credit for Chemical Dependency Counselor in the area of HIV, Hepatitis C, and/or STDs as required by the Texas Licensed Chemical Dependency Counselor Program.

FRONTOTEMPORAL DEMENTIA

#76102 • 2 APA Hours, 1 NBCC Hour

Book By Mail – $23 • **ONLINE – $15**

Purpose: Understanding the epidemiology, pathology, clinical features, diagnostic process, genetics, symptom treatment/management, role of brain autopsy, and current research provides a foundation for the care of patients with FTD and support for their families. The purpose of this course is to provide mental health professionals with current information on frontotemporal dementia (FTD).

Faculty: Ellen Steinbart, RN, MA; Lauren E. Evans, MSW

Audience: This course is designed for mental and behavioral health professionals who may intervene to support patients with frontotemporal dementia and their families.

Special Approval: This course meets the Illinois requirement for Alzheimer/dementia education.

BEHAVIORAL ADDICTIONS

#76411 • 15 APA/NAADAC Hours, 6 NBCC Hours

Book By Mail – $83 • **ONLINE – $75**

Purpose: The purpose of this course is to provide social workers, counselors, therapists, and other mental health professionals with the knowledge and skills to appropriately identify, diagnose, and treat behavioral addictions.

Faculty: Mark Rose, BS, MA, LP

Audience: This course is designed for mental health practitioners who may intervene in diagnosing and treating behavioral addictions in their patients.

MASS SHOOTERS AND EXTREMIST VIOLENCE: MOTIVES, PATHS, AND PREVENTION

#76431 • 15 APA/NAADAC Hours, 5 NBCC Hours

Book By Mail – $83 • **ONLINE – $75**

Purpose: The purpose of this course is to provide health and mental health professionals with the knowledge and skills necessary to identify persons on paths to extreme violence and to intervene to prevent mass shooting events.

Faculty: Mark Rose, BS, MA, LP

Audience: This course is designed for all healthcare professionals who may intervene to identify persons at risk for committing acts of mass violence.

SUICIDE ASSESSMENT AND PREVENTION

#76441 • 6 APA/NAADAC Hours, 2 NBCC Hours

Book By Mail – $38 • **ONLINE – $30**

Purpose: The purpose of this course is to provide behavioral and mental health professionals with an appreciation of the impact of depression and suicide on patient health as well as the skills necessary to identify and intervene for patients at risk for suicide.

Faculty: Mark Rose, BS, MA

Audience: This course is designed for social workers, therapists, counselors, and other professionals who may identify persons at risk for suicide and intervene to prevent or manage suicidality.

Special Approval: This course is designed to meet requirements for suicide assessment and prevention education. This course is approved by the State of Washington Department of Health to fulfill the requirement for Suicide Prevention training for healthcare professionals. Approval number TRNG.TG.60715375-SUIC.

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Course Availability List *(Cont'd)*

CLINICAL SUPERVISION: A PERSON-CENTERED APPROACH

Supervision

#76863 • 10 ASWB Hours, 3 NBCC Hours

Book By Mail – $58 • **ONLINE – $50**

Purpose: The purpose of this course is to help supervisors or potential supervisors in the human services or helping professions to more effectively work with those they are entrusted to supervise.

Faculty: Jamie Marich, PhD, LPCC-S, LICDC-CS, REAT, RYT-200, RMT

Audience: This course is designed for professional clinicians, including counselors, social workers, therapists, psychologists, and pastoral counselors, who supervise others, clinically and/or administratively.

Special Approval: This course is designed to meet the requirements for supervision education.

DOMESTIC AND SEXUAL VIOLENCE

#77791 • 5 APA Hours, 2 NBCC Hours

Book By Mail – $33 • **ONLINE – $25**

Purpose: The purpose of this course is to provide professionals with the skills and confidence necessary to identify victims of sexual or domestic violence and to intervene appropriately and effectively.

Faculty: Alice Yick Flanagan, PhD, MSW; John M. Leonard, MD

Audience: This course is designed for a wide range of behavioral and mental health professionals, including social workers, mental health counselors, and marriage and family therapists.

FAMILIES OF PATIENTS WITH CHRONIC ILLNESS

#91693 • 10 APA Hours, 3.5 NBCC Hours

Book By Mail – $58 • **ONLINE – $50**

Purpose: The purpose of this course is to increase the knowledge base of social workers, physicians, nurses, marriage and family therapists, and other allied healthcare professionals who work with chronically ill patients and their families, in order to effectively address the impact of chronic illness on the entire family system.

Faculty: Alice Yick Flanagan, PhD, MSW

Audience: This course is designed for physicians, nurses, social workers, marriage and family therapists, and any healthcare professionals involved in the care of chronically ill patients.

THE CORONAVIRUS DISEASE (COVID-19) PANDEMIC

FREE ONLINE

#94150 • 2 ASWB Hours

Book By Mail – $8 • **FREE ONLINE**

Purpose: The purpose of this course is to provide physicians, nurses, and other healthcare professionals an overview of the 2019–2020 global outbreak of novel human coronavirus (SARS-CoV-2) infection, including background epidemiology, clinical features, mode of transmission, epidemic potential, and the clinical and public health measures recommended to limit the spread of infection and control the outbreak.

Faculty: John M. Leonard, MD

Audience: This course is designed for physicians, nurses, and other healthcare professionals who may identify or educate patients regarding coronavirus infection.

Special Approval: This course is not approved for New York LMHCs or LMFTs.

MEDICAL MARIJUANA AND OTHER CANNABINOIDS

#95172 • 5 APA/NAADAC Hours, 3.5 NBCC Hours

Book By Mail – $33 • **ONLINE – $25**

Purpose: The purpose of this course is to provide healthcare professionals with unbiased and evidence-based information regarding the use of marijuana and other cannabinoids for the treatment of medical conditions.

Faculty: Mark Rose, BS, MA, LP

Audience: This course is designed for physicians, nurses, physician assistants, pharmacists, social workers, therapists, and counselors in the primary care setting involved in the care of patients who use or who are candidates for the therapeutic use of marijuana or other cannabinoids.

ATTENTION DEFICIT HYPERACTIVITY DISORDER

#96213 • 5 APA Hours, 2 NBCC Hours

Book By Mail – $33 • **ONLINE – $25**

Purpose: Attention deficit hyperactivity disorder (ADHD) has a significant effect on day-to-day functioning and quality of life; however, it often goes unrecognized. The purpose of this course is to educate healthcare professionals about the epidemiology, diagnosis, and management of ADHD.

Faculty: John J. Whyte, MD, MPH; Paul Ballas, DO

Audience: This course is designed for all physicians, nurses, and social work/counseling groups involved in the care of patients with attention deficit hyperactivity disorder.

MENTAL HEALTH ISSUES COMMON TO VETERANS AND THEIR FAMILIES

CT, WV Mandate

#96341 • 2 APA/NAADAC Hours, 0.5 NBCC Hours

Book By Mail – $23 • **ONLINE – $15**

Purpose: The purpose of this course is to provide health and mental health professionals with an appreciation of the impact of military service on patient health as well as the skills necessary to effectively identify and intervene for these patients.

Faculty: Alice Yick Flanagan, PhD, MSW; Mark Rose, BS, MA, LP

Audience: This course is designed for physicians, nurses, psychologists, social workers, therapists, counselors, and other healthcare professionals who may treat veterans or their family members.

Special Approvals: This course is designed to meet the Connecticut requirement for 2 hours of education on mental health conditions common to veterans and family members of veterans.

This course is designed to meet the West Virginia requirement for 2 hours of education on mental health conditions common to veterans and family members of veterans.

Prices are subject to change. Visit www.NetCE.com for a list of current prices.

Course Availability List *(Cont'd)*

ONLINE COUNSELING AND THERAPY: CRITICAL ISSUES

Telehealth

#96733 • 5 APA Hours, 3 NBCC Hours

Book By Mail – $33 • **ONLINE – $25**

Purpose: As Internet technologies continue to expand and become more accessible to the general public, their use in clinical helping professions will surely continue to grow. Due to the increasing prevalence of the Internet and its use in clinical practice, the purpose of this course is to provide an overview of the practice issues, strengths and limitations, and legal and ethical issues pertaining to ONLINE counseling.

Faculty: Alice Yick Flanagan, PhD, MSW

Audience: This course is designed for social workers, therapists, mental health counselors, nurses, and other allied health professionals who work in a clinical practice setting.

Special Approval: This course is designed to meet requirements for telehealth education.

OPIOID USE DISORDER

Substance Abuse

#96963 • 10 APA/NAADAC Hours, 4 NBCC Hours

Book By Mail – $58 • **ONLINE – $50**

Purpose: Practice guidance for opioid use disorder in primary care has not kept pace with rapid, profound changes in this area, leaving healthcare professionals with outdated and incomplete information to guide the clinical management of opioid use disorder and related morbidity. The purpose of this course is to close this gap to allow healthcare professionals to provide the best, evidence-based care to patients with opioid use disorder.

Faculty: Mark Rose, BS, MA

Audience: This course is designed for medical and mental healthcare providers, including physicians, nurses, pharmacy professionals, social workers, and counselors/therapists who may be involved in identifying or treating opioid use disorder.

Special Approval: This course is designed to meet requirements for substance abuse education.

IMPLICIT BIAS IN HEALTH CARE

IL Mandate

#97000 • 3 APA Hours, 1.5 NBCC Hours

Book By Mail – $23 • **ONLINE – $15**

Purpose: The purpose of this course is to provide healthcare professionals an overview of the impact of implicit biases on clinical interactions and decision making.

Faculty: Alice Yick Flanagan, PhD, MSW

Audience: This course is designed for the interprofessional healthcare team and professions working in all practice settings.

Special Approval: This course meets the Illinois requirement for implicit bias education.

Prices are subject to change. Visit www.NetCE.com for a list of current prices.

SEXUAL HARASSMENT PREVENTION: THE ILLINOIS REQUIREMENT

IL Mandate

#97081 • 1 APA Hour, 0.5 NBCC Hours

Book By Mail – $23 • **ONLINE – $15**

Purpose: The purpose of this course is to provide health and mental health professionals with clear knowledge of the consequences of sexual harassment and the skills to help combat harassment in the workplace.

Faculty: Lauren E. Evans, MSW

Audience: This course is designed for physicians, physician assistants, nurses, pharmacists, social workers, therapists, and all members of the interprofessional healthcare team who may act to prevent sexual harassment.

Special Approvals: This course is designed to fulfill the Illinois requirement for 1 hour of continuing education in the area of sexual harassment prevention.

HUMAN TRAFFICKING AND EXPLOITATION: THE TEXAS REQUIREMENT

TX Mandate

#97470 • 5 APA Hours, 2 NBCC Hours

Book By Mail – $33 • **ONLINE – $25**

Purpose: The purpose of this course is to increase the level of awareness and knowledge about human trafficking and exploitation so health and mental health professionals can identify and intervene in cases of exploitation.

Faculty: Alice Yick Flanagan, PhD, MSW

Audience: This course is designed for Texas physicians, nurses, social workers, pharmacy professionals, therapists, mental health counselors, and other members of the interdisciplinary team who may intervene in suspected cases of human trafficking and/or exploitation.

Special Approval: This course has been approved by the Texas Health and Human Services Commission (HHSC) to meet the requirements for human trafficking training.

SLEEP DISORDERS

#98883 • 10 APA Hours, 4 NBCC Hours

Book By Mail – $58 • **ONLINE – $50**

Purpose: Many of the complications associated with sleep disorders are preventable, making early diagnosis and appropriate treatment vital. The purpose of this course is to provide healthcare professionals with the information necessary to identify and effectively treat sleep disorders, thereby improving patients' quality of life and preventing possible complications.

Faculty: Teisha Phillips, RN, BSN

Audience: This course is designed for all healthcare professionals, including physicians, nurses, pharmacists, and mental health practitioners, who are involved in the care of patients experiencing a sleep-related disorder.

Special Approval: This course is not approved for New York LMHCs or LMFTs.

AGING AND LONG-TERM CARE

#99353 • 3 APA Hours, 2.5 NBCC Hours

Book By Mail – $23 • **ONLINE – $15**

Purpose: The purpose of this course is to provide the tools necessary for social workers, counselors, mental health professionals, and allied health professionals to successfully assess and care for older adults, an increasingly large portion of the U.S. population.

Faculty: Alice Yick Flanagan, PhD, MSW

Audience: This course is designed for nurses, social workers, counselors, mental health professionals, and allied health professionals involved in the care of older adults.

Counselor and Therapist Continuing Education Requirements by State

State	COUNSELOR	THERAPIST
	Approval Accepted/Hours by Home Study	Approval Accepted/Hours by Home Study
Alabama	APA, NBCC/10✶	NBCC/20✶, ♦
Alaska	APA, NBCC, ASWB, NAADAC/20✶	Accepted by Board/22✶, ❖, ♦
Arizona	APA, NBCC, ASWB, NAADAC/30✶, ❖, ♦	APA, NBCC, ASWB, NAADAC/30✶, ❖, ♦
Arkansas	APA, NBCC/24✶	APA, NBCC/24✶
California	APA, NBCC, ASWB/36✶, ♦	APA, NBCC, ASWB/36✶, ♦
Colorado	Accepted by Board/20 Coursework, 20 Independent learning♦	Accepted by Board/20 Coursework, 20 Independent learning♦
Connecticut	APA, NBCC, ASWB/15❖, ♦	APA, NBCC, ASWB/15❖, ♦
Delaware	APA, NBCC, ASWB, NAADAC/20	APA, NBCC, ASWB, NAADAC/20
District of Columbia	APA, NBCC, ASWB, NAADAC/40✶, ♦	APA, NBCC/15✶, ♦
Florida	#50-2405/30✶, ♦	#50-2405/30✶, ♦
Georgia	APA, NBCC, ASWB/10✿	APA, NBCC, ASWB/10✿
Hawaii	No CE Required	APA, NBCC/45✶
Idaho	APA, NBCC, ASWB/20✿	APA, NBCC, ASWB/20✿
Illinois	#197.000185/30♦	#168.000190/30♦
Indiana	APA, NBCC, ASWB, NAADAC/40✶	APA, NBCC, ASWB, NAADAC/40✶
Iowa	NBCC/40✶	NBCC/40✶
Kansas	Accepted by Board/30✶, ♦	Accepted by Board/40✶, ♦
Kentucky	NBCC/10✶, ♦	Not Approved/15
Louisiana	NBCC/10 in print & 20 online✶, ♦	Not Approved/20
Maine	APA, NBCC/55✶, ♦	APA, NBCC/55✶, ♦
Maryland	NBCC, NAADAC/10	NBCC, NAADAC/10
Massachusetts	NBCC/LMHC 15♦; LRC May Seek Board Pre-approval	May Seek Board Pre-approval/15
Michigan	No CE Required♦	No CE Required♦
Minnesota	APA, NBCC, ASWB/LPC 10; NBCC/LADC 40✶, ❖	Not Approved/7.5
Mississippi	NBCC/24✶	May Seek Board Pre-approval/6✶
Missouri	APA, NBCC, ASWB/40♦	APA, NBCC, ASWB/40♦
Montana	Accepted by Board. Must be scope of practice/20	Accepted by Board. Must be scope of practice/20
Nebraska	Accepted by Board/20✶	Accepted by Board/20✶
Nevada	Accepted by Board/20✶, ♦	Accepted by Board/20✶, ♦
New Hampshire	APA, ASWB, NBCC/20✶, ♦	APA, ASWB, NBCC/20✶, ♦
New Jersey	APA, NBCC, NAADAC, ANA/LPC, LRC 40✶, ❖; LCADC 20❖, ♦; CADC 30❖, ♦	APA, NBCC, NAADAC, ANA/20✶, ❖
New Mexico	APA, NBCC, ASWB, NAADAC/12 in print & 12 online✶, ♦	APA, NBCC, ASWB, NAADAC/12 in print & 12 online✶, ♦
New York	#MHC-0021/36 May complete all hours through 7/1/22 due to COVID-19	#MFT-0015/36 May complete all hours through 7/1/22 due to COVID-19
North Carolina	NBCC/40; APA, NAADAC/15✶	Accepted by Board/20✶
North Dakota	APA, NBCC/LAPC, LPC, LPCC 15✶	Not Approved/7.5✶
Ohio	NBCC/LPC, LPCC 30✶, ♦	May Seek Board Post-approval/30♦
Oklahoma	May Seek Board Pre-approval/10♦, ✿	May Seek Board Pre-approval/10♦
Oregon	APA, NBCC/40✶, ❖, ♦	APA, NBCC/40✶, ❖, ♦
Pennsylvania	APA, NBCC, ASWB/30✶, ♦	APA, NBCC, ASWB/30✶, ♦
Rhode Island	APA, NBCC, ASWB, NAADAC/MHC 40; NAADAC/SAC, CADC, CAADC, CCDP, CPS 40✶; NAADAC/CPRS 20✶	APA, NBCC/MFT 40
South Carolina	NBCC, NAADAC/15✶	NBCC, NAADAC/15✶
South Dakota	APA, NBCC/40✶	APA, NBCC/40✶
Tennessee	APA, NBCC/5 per year✶	APA, NBCC/5 per year✶
Texas	Accepted by Board LPC 24✶,♦; Accepted by Board, NAADAC/LCDC 40✶, ♦	Accepted by Board/30✶; MFTA/15
Utah	Accepted by Board/10✶, ♦	Accepted by Board/15✶, ♦
Vermont	APA, NBCC/28✶	APA, NBCC/10✶
Virginia	APA, NBCC, ASWB, NAADAC/20✶	APA, NBCC, ASWB, NAADAC/20✶
Washington	APA, NBCC, ASWB, NAADAC/MHC 26✶, ♦; CC, CA 12✶, ♦; CDP 40✶, ♦	APA, NBCC, ASWB, NAADAC/26✶, ♦
West Virginia	NBCC/20✶, ♦	Not Approved/15✶, ♦
Wisconsin	APA, NBCC, ASWB, NAADAC/30✶	APA, NBCC, ASWB, NAADAC/30✶
Wyoming	Accepted by Board/45✶, ♦	Accepted by Board/45✶, ♦

✶ Special mandate: Ethics
❖ Special mandate: Cultural Competence
♦ Additional requirements: Please go to www.NetCE.com/credit.php for more information.
✿ Ethics must be live participatory; home study not accepted, or must be preapproved.

Continuing Education (CE) credits for psychologists are provided through the co-sponsorship of the American Psychological Association (APA) Office of Continuing Education in Psychology (CEP). The APA CEP Office maintains responsibility for the content of the programs.

NetCE has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6361. Programs that do not qualify for NBCC credit are clearly identified. NetCE is solely responsible for all aspects of the programs.

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Why does NBCC award fewer hours than APA and NAADAC? NBCC requires 6,000 words per hour, while APA and NAADAC accept other methods to determine hours, such as pilot testing and reading level.

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You may complete ALL four courses for a maximum payment of $62, or pay the individual course price, whichever is less.

✓	Course #	Course Title / Hours (NBCC Clock Hours)	Price
	97430	Cultural Competence: An Overview / 2 Hours (1.5 NBCC Clock Hours)	$15
	76690	Anxiety Disorders in Older Adults / 3 Hours (1 NBCC Clock Hour)	$15
	77723	Ethics for Counselors / 6 Hours (6 NBCC Clock Hours)	$30
	96363	Postpartum Depression / 15 Hours (5 NBCC Clock Hours)	$75

Additional Courses Available by Mail (ACCESS ONLINE FOR A DISCOUNT!)
Payment must accompany this form. To order by phone, please have your credit card ready.

✓	Course #	Course Title / Hours*	Price
☐	71793	Promoting the Health of Gender & Sexual Minorities / 5	$33
☐	74713	HIV/AIDS: Epidemic Update for Behavioral Health Prof. / 7	$43
☐	76102	Frontotemporal Dementia / 2	$23
☐	76411	Behavioral Addictions / 15	$83
☐	76431	Mass Shooters and Extremist Violence / 15	$83
☐	76441	Suicide Assessment and Prevention / 6	$38
☐	76863	Clinical Supervision: A Person-Centered Approach / 10	$58
☐	77791	Domestic and Sexual Violence / 5	$33
☐	91693	Families of Patients with Chronic Illness / 10	$58
☐	94150	The Coronavirus Disease (COVID-19) Pandemic / 2 (FREE ONLINE!)	$8
☐	95172	Medical Marijuana and Other Cannabinoids / 5	$33
☐	96213	Attention Deficit Hyperactivity Disorder / 5	$33
☐	96341	Mental Health Issues Common to Veterans / 2	$23
☐	96733	Online Counseling and Therapy: Critical Issues / 5	$33
☐	96963	Opioid Use Disorder / 10	$58
☐	97000	Implicit Bias in Health Care / 3	$23
☐	97081	Sexual Harassment Prevention: The Illinois Req. / 1	$23
☐	97470	Human Trafficking & Exploitation: The Texas Req. / 5	$33
☐	98883	Sleep Disorders / 10	$58
☐	99353	Aging and Long-Term Care / 3	$23

***See Course Availability List, pages 125–127 for NBCC Clock Hours.**

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Answer Sheet

(Completion of this form is mandatory)

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Please note the following:

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- Darken only one circle per question.
- Use pen or pencil; please refrain from using markers.
- **Information on the Customer Information form must be completed.**

#97430 CULTURAL COMPETENCE: AN OVERVIEW—2 HOURS

Please refer to pages 16–17.

Expiration Date: 02/28/25 — *May be taken individually for $15*

	A	B	C	D		A	B	C	D		A	B	C	D
1.	❍	❍	❍	❍	6.	❍	❍	❍	❍	11.	❍	❍	❍	❍
2.	❍	❍	❍	❍	7.	❍	❍	❍	❍	12.	❍	❍	❍	❍
3.	❍	❍	❍	❍	8.	❍	❍	❍	❍	13.	❍	❍	❍	❍
4.	❍	❍	❍	❍	9.	❍	❍	❍	❍	14.	❍	❍	❍	❍
5.	❍	❍	❍	❍	10.	❍	❍	❍	❍	15.	❍	❍	❍	❍

#76690 ANXIETY DISORDERS IN OLDER ADULTS—3 HOURS

Please refer to pages 29–30.

Expiration Date: 02/28/25 — *May be taken individually for $15*

	A	B	C	D		A	B	C	D
1.	❍	❍	❍	❍	11.	❍	❍	❍	❍
2.	❍	❍	❍	❍	12.	❍	❍	❍	❍
3.	❍	❍	❍	❍	13.	❍	❍	❍	❍
4.	❍	❍	❍	❍	14.	❍	❍	❍	❍
5.	❍	❍	❍	❍	15.	❍	❍	❍	❍
6.	❍	❍	❍	❍	16.	❍	❍	❍	❍
7.	❍	❍	❍	❍	17.	❍	❍	❍	❍
8.	❍	❍	❍	❍	18.	❍	❍	❍	❍
9.	❍	❍	❍	❍	19.	❍	❍	❍	❍
10.	❍	❍	❍	❍	20.	❍	❍	❍	❍

#77723 ETHICS FOR COUNSELORS—6 HOURS

Please refer to pages 80–81.

Expiration Date: 04/30/25 — *May be taken individually for $30*

	A	B	C	D		A	B	C	D
1.	❍	❍	❍	❍	11.	❍	❍	❍	❍
2.	❍	❍	❍	❍	12.	❍	❍	❍	❍
3.	❍	❍	❍	❍	13.	❍	❍	❍	❍
4.	❍	❍	❍	❍	14.	❍	❍	❍	❍
5.	❍	❍	❍	❍	15.	❍	❍	❍	❍
6.	❍	❍	❍	❍	16.	❍	❍	❍	❍
7.	❍	❍	❍	❍	17.	❍	❍	❍	❍
8.	❍	❍	❍	❍	18.	❍	❍	❍	❍
9.	❍	❍	❍	❍	19.	❍	❍	❍	❍
10.	❍	❍	❍	❍	20.	❍	❍	❍	❍

#96363 POSTPARTUM DEPRESSION—15 HOURS

Please refer to pages 119–124.

Expiration Date: 03/31/23 — *May be taken individually for $75*

	A	B	C	D		A	B	C	D		A	B	C	D		A	B	C	D
1.	❍	❍	❍	❍	21.	❍	❍	❍	❍	41.	❍	❍	❍	❍	61.	❍	❍	❍	❍
2.	❍	❍	❍	❍	22.	❍	❍	❍	❍	42.	❍	❍	❍	❍	62.	❍	❍	❍	❍
3.	❍	❍	❍	❍	23.	❍	❍	❍	❍	43.	❍	❍	❍	❍	63.	❍	❍	❍	❍
4.	❍	❍	❍	❍	24.	❍	❍	❍	❍	44.	❍	❍	❍	❍	64.	❍	❍	❍	❍
5.	❍	❍	❍	❍	25.	❍	❍	❍	❍	45.	❍	❍	❍	❍	65.	❍	❍	❍	❍
6.	❍	❍	❍	❍	26.	❍	❍	❍	❍	46.	❍	❍	❍	❍	66.	❍	❍	❍	❍
7.	❍	❍	❍	❍	27.	❍	❍	❍	❍	47.	❍	❍	❍	❍	67.	❍	❍	❍	❍
8.	❍	❍	❍	❍	28.	❍	❍	❍	❍	48.	❍	❍	❍	❍	68.	❍	❍	❍	❍
9.	❍	❍	❍	❍	29.	❍	❍	❍	❍	49.	❍	❍	❍	❍	69.	❍	❍	❍	❍
10.	❍	❍	❍	❍	30.	❍	❍	❍	❍	50.	❍	❍	❍	❍	70.	❍	❍	❍	❍
11.	❍	❍	❍	❍	31.	❍	❍	❍	❍	51.	❍	❍	❍	❍	71.	❍	❍	❍	❍
12.	❍	❍	❍	❍	32.	❍	❍	❍	❍	52.	❍	❍	❍	❍	72.	❍	❍	❍	❍
13.	❍	❍	❍	❍	33.	❍	❍	❍	❍	53.	❍	❍	❍	❍	73.	❍	❍	❍	❍
14.	❍	❍	❍	❍	34.	❍	❍	❍	❍	54.	❍	❍	❍	❍	74.	❍	❍	❍	❍
15.	❍	❍	❍	❍	35.	❍	❍	❍	❍	55.	❍	❍	❍	❍	75.	❍	❍	❍	❍
16.	❍	❍	❍	❍	36.	❍	❍	❍	❍	56.	❍	❍	❍	❍	76.	❍	❍	❍	❍
17.	❍	❍	❍	❍	37.	❍	❍	❍	❍	57.	❍	❍	❍	❍	77.	❍	❍	❍	❍
18.	❍	❍	❍	❍	38.	❍	❍	❍	❍	58.	❍	❍	❍	❍	78.	❍	❍	❍	❍
19.	❍	❍	❍	❍	39.	❍	❍	❍	❍	59.	❍	❍	❍	❍	79.	❍	❍	❍	❍
20.	❍	❍	❍	❍	40.	❍	❍	❍	❍	60.	❍	❍	❍	❍	80.	❍	❍	❍	❍

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Evaluation

(Completion of this form is mandatory)

CTH22

Last Name _____ First Name _____ MI _____

State _____ License # _____ Expiration Date _____

To receive continuing education credit, completion of this Evaluation is mandatory.

Compliance with APA, NBCC, and ASWB requires that providers collect a course evaluation from the participant that includes assessment of the content, delivery method, and achievement of the individual learning objectives.

Please read the following questions and choose the most appropriate answer for each course completed.

1. Was the course content new or review?
2. How much time did you spend on this activity, including the questions?
3. Would you recommend this course to your peers?
4. Did the course content support the stated course objective?
5. Did the course content demonstrate the author's knowledge of the subject and the current state of scientific knowledge?
6. Was the course content free of bias?
7. Before completing this course, did you identify the necessity for education on the topic to improve your professional practice?
8. Have you achieved all of the stated learning objectives of this course?
9. Has what you think or feel about this topic changed?
10. Was this course appropriate for your education, experience, and licensure level?
11. Was the administration of the program to your satisfaction?
12. Were the materials appropriate to the subject matter?
13. Are you more confident in your ability to provide client care after completing this course?
14. Do you plan to make changes in your practice as a result of this course content?
15. If you requested assistance for a disability or a problem, was your request addressed respectfully and in a timely manner?

#97430
Cultural Competence
2 Hours

1. ☐ New ☐ Review
2. _____ Hours
3. ☐ Yes ☐ No
4. ☐ Yes ☐ No
5. ☐ Yes ☐ No
6. ☐ Yes ☐ No
7. ☐ Yes ☐ No
8. ☐ Yes ☐ No
9. ☐ Yes ☐ No
10. ☐ Yes ☐ No
11. ☐ Yes ☐ No
12. ☐ Yes ☐ No
13. ☐ Yes ☐ No
14. ☐ Yes ☐ No
15. ☐ Yes ☐ No ☐ N/A

#76690
Anxiety Disorders
3 Hours

1. ☐ New ☐ Review
2. _____ Hours
3. ☐ Yes ☐ No
4. ☐ Yes ☐ No
5. ☐ Yes ☐ No
6. ☐ Yes ☐ No
7. ☐ Yes ☐ No
8. ☐ Yes ☐ No
9. ☐ Yes ☐ No
10. ☐ Yes ☐ No
11. ☐ Yes ☐ No
12. ☐ Yes ☐ No
13. ☐ Yes ☐ No
14. ☐ Yes ☐ No
15. ☐ Yes ☐ No ☐ N/A

#77723
Ethics for Counselors
6 Hours

1. ☐ New ☐ Review
2. _____ Hours
3. ☐ Yes ☐ No
4. ☐ Yes ☐ No
5. ☐ Yes ☐ No
6. ☐ Yes ☐ No
7. ☐ Yes ☐ No
8. ☐ Yes ☐ No
9. ☐ Yes ☐ No
10. ☐ Yes ☐ No
11. ☐ Yes ☐ No
12. ☐ Yes ☐ No
13. ☐ Yes ☐ No
14. ☐ Yes ☐ No
15. ☐ Yes ☐ No ☐ N/A

#96363
Postpartum Depression
15 Hours

1. ☐ New ☐ Review
2. _____ Hours
3. ☐ Yes ☐ No
4. ☐ Yes ☐ No
5. ☐ Yes ☐ No
6. ☐ Yes ☐ No
7. ☐ Yes ☐ No
8. ☐ Yes ☐ No
9. ☐ Yes ☐ No
10. ☐ Yes ☐ No
11. ☐ Yes ☐ No
12. ☐ Yes ☐ No
13. ☐ Yes ☐ No
14. ☐ Yes ☐ No
15. ☐ Yes ☐ No ☐ N/A

#97430 Cultural Competence: An Update — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

#76690 Anxiety Disorders in Older Adults — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

#77723 Ethics for Counselors — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

#96363 Postpartum Depression — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

Signature _____

Signature required to receive continuing education credit.

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Evaluation *(Continued)*

CTH22

Last Name _____ First Name _____ MI _____

Check the letter grade which best represents each of the following statements.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

Learning Objectives (After completing this course, I am able to):

#97430 CULTURAL COMPETENCE: AN OVERVIEW—2 HOURS (Course expires 02/28/25)

• Define cultural competence, implicit bias, and related terminology.	☐ A	☐ B	☐ C	☐ D	☐ F
• Outline social determinants of health and barriers to providing care.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss best practices for providing culturally competent care to various patient populations.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss key aspects of creating a welcoming and safe environment, including avoidance of discriminatory language and behaviors.	☐ A	☐ B	☐ C	☐ D	☐ F

#76690 ANXIETY DISORDERS IN OLDER ADULTS—3 HOURS (Course expires 02/28/25)

• Describe the history and neuroanatomy of anxiety and anxiety disorder.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss the assessment and classification of anxiety disorders in older adults.	☐ A	☐ B	☐ C	☐ D	☐ F
• Analyze the epidemiology of anxiety disorders in elderly patients.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe the clinical implications of late-life anxiety disorders and their treatment.	☐ A	☐ B	☐ C	☐ D	☐ F

#77723 ETHICS FOR COUNSELORS—6 HOURS (Course expires 04/30/25)

• Discuss the historical context of ethics in counseling.	☐ A	☐ B	☐ C	☐ D	☐ F
• Define common terms such as ethics, values, morality, ethical dilemmas, and ethical principles.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss the ethical principles in the American Counseling Association (ACA) Code of Ethics and the National Board for Certified Counselors (NBCC) Code of Ethics.	☐ A	☐ B	☐ C	☐ D	☐ F
• Differentiate between deontologic, teleologic, motivist, natural law, transcultural ethical, feminist, and multicultural theories.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify the different ethical decision-making models.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss the psychologic context of ethical decision making by applying Lawrence Kohlberg's theory of moral development.	☐ A	☐ B	☐ C	☐ D	☐ F
• Outline ethical issues that emerge with counseling in managed care systems.	☐ A	☐ B	☐ C	☐ D	☐ F
• Review issues that arise in online counseling, including sociocultural context, ethical and legal issues, and standards for ethical practice.	☐ A	☐ B	☐ C	☐ D	☐ F

#96363 POSTPARTUM DEPRESSION—15 HOURS (Course expires 03/31/23)

• Discuss the prevalence of postpartum depression (PPD), including historical and transcultural perspectives.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify risk factors for PPD evident prior to pregnancy, during pregnancy, and after birth.	☐ A	☐ B	☐ C	☐ D	☐ F
• Review the effects of biochemistry, such as serotonin, estrogen and progesterone, cortisol, and thyroid, on the development of PPD.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe the role of family history, stressful life events, and psychosocial factors in the etiology of depression.	☐ A	☐ B	☐ C	☐ D	☐ F
• List the emotional, physical, and cognitive symptoms of postpartum blues.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss emotional, physical, cognitive, and behavioral symptoms of PPD.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify severe forms of postpartum disorders, focusing on postpartum psychosis and cases of infanticide.	☐ A	☐ B	☐ C	☐ D	☐ F
• Review the clinical assessment of PPD, including the Edinburgh Postnatal Depression Scale (EPDS) and the Postpartum Depression Screening Scale (PDSS).	☐ A	☐ B	☐ C	☐ D	☐ F
• List the effects of PPD on maternal bonding, mother-infant attachment, and a child's socioemotional and cognitive development.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe the potential long-term effects of PPD on children.	☐ A	☐ B	☐ C	☐ D	☐ F
• List maternal and familial complications of PPD, including marital conflict, suicide, and homicide.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss self-care strategies for recovery, such as nourishment, sleep, rest and relaxation, exercise, and socializing.	☐ A	☐ B	☐ C	☐ D	☐ F
• Review the role of education in the diagnosis of and recovery from PPD.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss the physiologic treatment of PPD with postpartum hormone treatments.	☐ A	☐ B	☐ C	☐ D	☐ F
• Specify pharmacologic treatment strategies, noting benefits, adverse reactions, and risks.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss psychosocial interventions used in the treatment of PPD.	☐ A	☐ B	☐ C	☐ D	☐ F
• List strategies for preventing PPD, including screening, postpartum debriefing, companionship in the delivery room, psychotherapy, midwife continuity of care, and progesterone preventive treatment.	☐ A	☐ B	☐ C	☐ D	☐ F

Signature _____

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