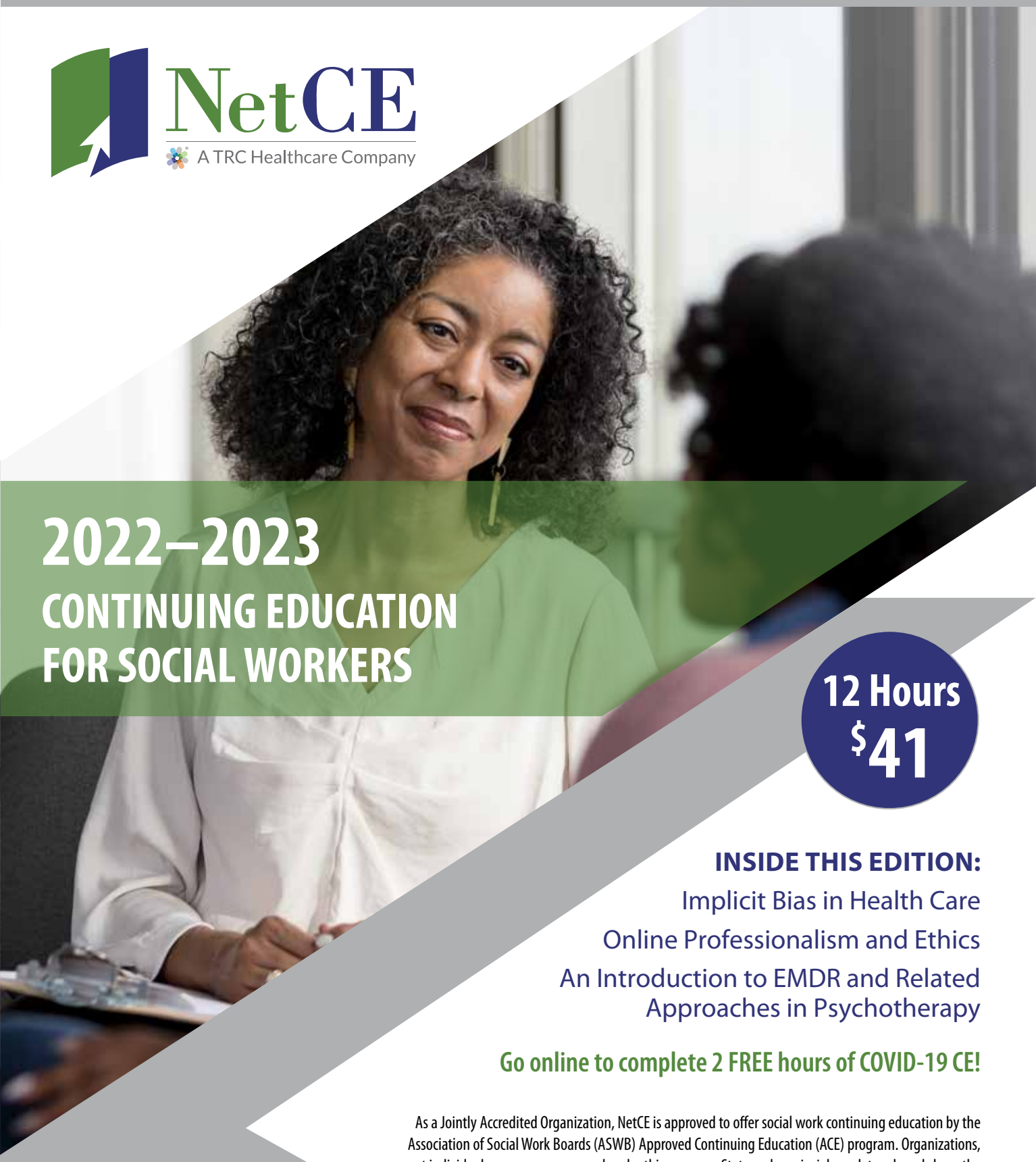
NetCE
A TRC Healthcare Company



2022–2023
CONTINUING EDUCATION FOR SOCIAL WORKERS

12 Hours
$41

INSIDE THIS EDITION:

Implicit Bias in Health Care

Online Professionalism and Ethics

An Introduction to EMDR and Related Approaches in Psychotherapy

Go online to complete 2 FREE hours of COVID-19 CE!

As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit.

NetCE.com/SW22B

NetCE
A TRC Healthcare Company

SPECIAL OFFER $41

12 Hours
Regular Price $60

Special Offer price of $41 valid through May 31, 2023
After May 31, 2023, price increases to $52

How to Complete this Special Offer

LEARN.

Read the enclosed course(s).

Complete the test questions at the end of each course.

CLICK.

Go to **NetCE.com/SW22B**. Enter your Quick Code and Customer ID (found on the back of your booklet), or complete the enclosed forms located between pages 28–29.

DONE.

Receive certificates of completion:
FAST By Mail
FASTER Fax/Email
FASTEST Online
Print from your NetCE transcript.

Receive Certificates of Completion: Go online to **www.NetCE.com/SW22B**, and sign in using your Quick Code and Customer ID found on the back of your booklet (or register if you're a new user).

We are a Nationally Approved Provider

As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. NetCE maintains responsibility for this course. **For more information regarding your continuing education requirements, please see page 56.**

NetCE | P.O. Box 997571 | Sacramento, CA 95899 | 800-232-4238 | Fax: 916-783-6067

CONTINUING EDUCATION FOR SOCIAL WORKERS 2022–2023

Published by NetCE,
a TRC Healthcare Company
P.O. Box 997571
Sacramento, CA 95899
Tel: 800-232-4238 (within the U.S.)
916-783-4238 (outside the U.S.)
Fax: 916-783-6067
Email: Info@NetCE.com
Website: www.NetCE.com

Implicit Bias in Health Care

3 Clinical Clock Hours

Audience
This course is designed for the interprofessional healthcare team and professions working in all practice settings.

Course Objective
The purpose of this course is to provide healthcare professionals with an overview of the impact of implicit biases on clinical interactions and decision making.

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

1. Define implicit and explicit biases and related terminology.
2. Evaluate the strengths and limitations of the Implicit Association Test.
3. Describe how different theories explain the nature of implicit biases, and outline the consequences of implicit biases.
4. Discuss strategies to raise awareness of and mitigate or eliminate one's implicit biases.

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.

Division Planner
Jane C. Norman, RN, MSN, CNE, PhD

Director of Development and Academic Affairs
Sarah Campbell

Division Planner/Director Disclosure
The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Accreditations & Approvals
As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final

authority to determine whether an individual course may be accepted for continuing education credit. NetCE maintains responsibility for this course.

NetCE is recognized by the New York State Education Department's State Board for Social Work as an approved provider of continuing education for licensed social workers #SW-0033.

This course is considered self-study, as defined by the New York State Board for Social Work. Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of licensed master social work and licensed clinical social work in New York. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice for an LMSW and LCSW. A licensee who practices beyond the authorized scope of practice could be charged with unprofessional conduct under the Education Law and Regents Rules.

Designations of Credit
Social Workers participating in this intermediate to advanced course will receive 3 Clinical continuing education clock hours.

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 #159001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168000190.

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.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement
It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

How to Receive Credit

- Read the following course.
- Complete the test questions at the end of the course.
- Return your Customer Information/Answer Sheet/Evaluation and payment to NetCE by mail or fax, or complete online at **www.NetCE.com/SW22B**.
- A full Works Cited list is available online at www.NetCE.com.

INTRODUCTION

In the 1990s, social psychologists Dr. Mahzarin Banaji and Dr. Tony Greenwald introduced the concept of implicit bias and developed the Implicit Association Test (IAT) as a measure. In 2003, the Institute of Medicine published the report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* highlighting the role of health professionals' implicit biases in the development of health disparities [1]. The phenomenon of implicit bias is premised on the assumption that while well-meaning individuals may deny prejudicial beliefs, these implicit biases negatively affect their clinical communications, interactions, and diagnostic and treatment decision-making [2; 3].

One explanation is that implicit biases are a heuristic, or a cognitive or mental shortcut. Heuristics offer individuals general rules to apply to situations in which there is limited, conflicting, or unclear information. Use of a heuristic results in a quick judgment based on fragments of memory and knowledge, and therefore, the decisions made may be erroneous. If the thinking patterns are flawed, negative attitudes can reinforce stereotypes [4]. In health contexts, this is problematic because clinical judgments can be biased and adversely affect health outcomes. The Joint Commission provides the following example [3]: A group of physicians congregate to examine a child's x-rays but has not been able to reach a diagnostic consensus. Another physician with no knowledge of the case is passing by, sees the x-rays, and says "Cystic fibrosis." The group of physicians was aware that the child is African American and had dismissed cystic fibrosis because it is less common among Black children than White children.

The purpose of this course is to provide health professionals an overview of implicit bias. This includes an exploration of definitions of implicit and explicit bias. The nature and dynamics of implicit biases and how they can affect health outcomes will be discussed. Finally, because implicit biases are unconscious, strategies will be reviewed to assist in raising professionals' awareness of and interventions to reduce them.

DEFINITIONS OF IMPLICIT BIAS AND OTHER TERMINOLOGIES

IMPLICIT VS. EXPLICIT BIAS

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 [5]. 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 [6]. 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 [2; 7; 8; 9]. Some have asserted that the cognitive processes that dictate implicit and explicit biases are separate and independent [9].

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 [10]. 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 [11]. According to Georgetown University's National Center on Cultural Competency, social characteristics that can trigger implicit biases include [12]:

- Age
- Disability
- Education
- English language proficiency and fluency
- Ethnicity
- Health status
- Disease/diagnosis (e.g., HIV/AIDS)
- 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 [6; 13]. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages [13].

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 [2].

OTHER COMMON TERMINOLOGIES

In addition to understanding implicit and explicit bias, there is additional terminology related to these concepts that requires specific definition.

Cultural Competence

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 [14]. 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 [15]. Cultural humility is a lifelong process involving reflexivity, self-evaluation, and self-critique [16].

Discrimination

Discrimination has traditionally been viewed as the outcome of prejudice [17]. It encompasses overt or hidden actions, behaviors, or practices of members in a dominant group against members of a subordinate group [18]. Discrimination has also been further categorized as lifetime discrimination, which consists of major discreet discriminatory events, or everyday discrimination, which is subtle, continual, and part of day-to-day life and can have a cumulate effect on individuals [19].

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" [20]. Diversity is often conceptualized into singular dimensions as opposed to multiple and intersecting diversity factors [21].

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 [22].

Prejudice

Prejudice is a generally negative feeling, attitude, or stereotype against members of a group [23]. 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" [23]. Prejudice stems from the process of ascribing every member of a group with the same attribute [24].

Race

Race is linked to biology. Race is partially defined by physical markers (e.g., skin or hair color) and is generally used as a mechanism for classification [25]. It does not refer to cultural institutions or patterns. In modern history, skin color has been used to classify people and to imply that there are distinct biologic differences within human populations [26]. Historically, the U.S. Census has defined race according to ancestry and blood quantum; today, it is based on self-classification [26].

There are scholars who assert that race is socially constructed without any biological component [27]. For example, racial characteristics are also assigned based on differential power and privilege, lending to different statuses among groups [28].

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" [29]. 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 [30]. 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 [31; 32].

MEASUREMENT OF IMPLICIT BIAS: A FOCUS ON THE IAT

Project Implicit is a research project sponsored by Harvard University and devoted to the study and monitoring of implicit biases. It houses the Implicit Association Test (IAT), which is one of the most widely utilized standardized instruments to measure implicit biases. The IAT is based on the premise that implicit bias is an objective and discreet phenomenon that can be measured in a quantitative manner. Developed and first introduced in 1998, it is an online test that assesses implicit bias by measuring how quickly people make associations between targeted categories with a list of adjectives [33]. For example, research participants might be assessed for their implicit biases by seeing how rapidly they make evaluations among the two groups/categories career/family and male/female. Participants tend to more easily affiliate terms for which they hold implicit or explicit biases. So, unconscious biases are measured by how quickly research participants respond to stereotypical pairings (e.g., career/male and family/female). The larger the difference between the individual's performance between the two groups, the stronger the degree of bias [34; 35]. Since 2006, more than 4.6 million individuals have taken the IAT, and results indicate that the general population holds implicit biases [3].

interactive activity

Visit https://implicit.harvard.edu/implicit and complete an assessment. Does it reflect your perception of your own biases? Did you learn anything about yourself?

Measuring implicit bias is complex, because it requires an instrument that is able to access underlying unconscious processes. While many of the studies on implicit biases have employed the IAT, there are other measures available. They fall into three general categories: the IAT and its variants, priming methods, and miscellaneous measures, such as self-report, role-playing, and computer mouse movements [36]. This course will focus on the IAT, as it is the most commonly employed instrument.

The IAT is not without controversy. One of the debates involves whether IAT scores focus on a cognitive state or if they reflect a personality trait. If it is the latter, the IAT's value as a diagnostic screening tool is diminished [37]. There is also concern with its validity in specific arenas, including jury selection and hiring [37]. Some also maintain that the IAT is sensitive to social context and may not accurately predict behavior [37]. Essentially, a high IAT score reflecting implicit biases does not necessarily link to discriminating behaviors, and correlation should not imply causation. A

meta-analysis involving 87,418 research participants found no evidence that changes in implicit biases affected explicit behaviors [38].

EXTENT OF IMPLICIT BIASES AND RISK FACTORS

Among the more than 4 million participants who have completed the IAT, individuals generally exhibited implicit preference for White faces over Black or Asian faces. They also held biases for light skin over dark skin, heterosexual over gender and sexual minorities (LGBTQ+), and young over old [39]. The Pew Research Center also conducted an exploratory study on implicit biases, focusing on the extent to which individuals adhered to implicit racial biases [40]. A total of 2,517 IATs were completed and used for the analysis. Almost 75% of the respondents exhibited some level of implicit racial biases. Only 20% to 30% did not exhibit or showed very little implicit bias against the minority racial groups tested. Approximately half of all single-race White individuals displayed an implicit preference for White faces over Black faces. For single-race Black individuals, 45% had implicit preference for their own group. For biracial White/Black adults, 23% were neutral. In addition, 22% of biracial White/Asian participants had no or minimal implicit racial biases. However, 42% of the White/Black biracial adults leaned toward a pro-White bias.

In another interesting field experiment, although not specifically examining implicit bias, resumes with names commonly associated with African American or White candidates were submitted to hiring officers [41]. Researchers found that resumes with White-sounding names were 50% more likely to receive callbacks than resumes with African American-sounding names [41]. The underlying causes of this gap were not explored.

Implicit bias related to sex and gender is also significant. A survey of emergency medicine and obstetrics/gynecology residency programs in the United States sought to examine the relationship between biases related to perceptions of leadership and gender [42]. In general, residents in both programs (regardless of gender) tended to favor men as leaders. Male residents had greater implicit biases compared with their female counterparts.

Other forms of implicit bias can affect the provision of health and mental health care. One online survey examining anti-fat biases was provided to 4,732 first-year medical students [43]. Respondents completed the IAT, two measures of explicit bias, and an anti-fat attitudes instrument. Nearly 75% of the respondents were found to hold implicit anti-fat biases. Interestingly, these biases were comparable to the scope of implicit racial biases. Male sex, non-Black race, and lower body mass index (BMI) predicted holding these implicit biases.

Certain conditions or environmental risk factors are associated with an increased risk for certain implicit biases, including [44; 45]:

- 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

THEORETIC EXPLANATIONS AND CONTROVERSIES

A variety of theoretical frameworks have been used to explore the causes, nature, and dynamics of implicit biases. Each of the theories is described in depth, with space given to explore controversies and debates about the etiology of implicit bias.

SOCIAL PSYCHOLOGICAL AND COGNITIVE THEORETICAL FRAMEWORKS

One of the main goals of social psychology is to understand how attitudes and belief structures influence behaviors. Based on frameworks from both social and cognitive psychology, many theoretical frameworks used to explain implicit bias revolve around the concept of social cognition. One branch of cognitive theory focuses on the role of implicit or nondeclarative memory. Experts believe that this type of memory allows certain behaviors to be performed with very little conscious awareness or active thought. Examples include tooth brushing, tying shoelaces, and even driving. To take this concept one step farther, implicit memories may also underlie social attitudes and stereotype attributions [46]. This is referred to as implicit social cognition. From this perspective, implicit biases are automatic expressions based on belonging to certain social groups [47]. The IAT is premised on the role of implicit memory and past experiences in predicting behavior without explicit memory triggering [48].

Another branch of cognitive theory used to describe implicit biases involves heuristics. When quick decisions are required under conditions of uncertainty or fatigue, and/or when there is a tremendous amount of information to assimilate without sufficient time to process, decision-makers resort to heuristics [49]. Heuristics are essentially mental short cuts that facilitate (usually unconscious) rules that promote automatic processing [50]. However, these rules can also be influenced by socialization factors, which could then affect any unconscious or latent cognitive associations about power, advantage, and privilege. Family, friends, media, school, religion, and other social institutions all play a role in devel-

oping and perpetuating implicit and explicit stereotypes, and cognitive evaluations can be primed or triggered by an environmental cue or experience [51]. When a heuristic is activated, an implicit memory or bias may be triggered simultaneously [47]. This is also known as the dual-process model of information processing [50].

BEHAVIORAL OR FUNCTIONAL PERSPECTIVES

Behavioral or functional theorists argue that implicit bias is not necessarily a latent or unconscious cognitive structure. Instead, this perspective recognizes implicit bias as a group-based behavior [52]. Behavior is biased if it is influenced by social cues indicating the social group to which someone belongs [52]. Social cues can occur rapidly and unintentionally, which ultimately leads to automatic or implicit effects on behavior. The appeal of a behavioral or functional approach to implicit bias is that it is amoral; that is, it is value- and judgment-free [52]. Rather than viewing implicit bias as an invisible force (i.e., unconscious cognitive structure), it is considered a normal behavior [53].

NEUROSCIENTIFIC PERSPECTIVES

Implicit bias has neuroscientific roots as well and has been linked to functions of the amygdala [2; 54]. The amygdala is located in the temporal lobe of the brain, and it communicates with the hypothalamus and plays a large role in memory. When situations are emotionally charged, the amygdala is activated and connects the event to memory, which is why individuals tend to have better recall of emotional events. This area of the brain is also implicated in processing fear. Neuroscientific studies on implicit biases typically use functional magnetic resonance imaging (fMRI) to visualize amygdala activation during specific behaviors or events. In experimental studies, when White research subjects were shown photos of Black faces, their amygdala appeared to be more activated compared to when they viewed White faces [55]. This trend toward greater activation when exposed to view the faces of persons whose race differs from the viewer starts in adolescence and appears to increase with age [54]. This speaks to the role of socialization in the developmental process [54].

It may be that the activation of the amygdala is an evolutionary threat response to an outgroup [56]. Another potential explanation is that the activation of the amygdala is due to the fear of appearing prejudiced to others who will disapprove of the bias [56]. The neuroscientific perspective of implicit bias is controversial. While initial empirical studies appear to link implicit bias to amygdala activation, many researchers argue this relationship is too simplistic [2].

STRUCTURAL OR CRITICAL THEORY

Many scholars and policymakers are concerned about the narrow theoretical views that researchers of implicit bias have taken. By focusing on unconscious cognitive structures, social cognition and neuroscientific theories miss the opportunity to also address the role of macro or systemic factors in contributing to health inequities [9; 57]. By focusing on the neurobiology of implicit bias, for example, racism and bias is attributed to central nervous system function, releasing the individual from any control or responsibility. However, the historical legacy of prejudice and bias has roots in economic and structural issues that produce inequities [58]. Larger organizational, institutional, societal, and cultural forces contribute, perpetuate, and reinforce implicit and explicit biases, racism, and discrimination. Psychological and neuroscientific approaches ultimately decontextualize racism [9; 57].

In response to this conflict, a systems-based practice has been proposed [59]. This type of practice emphasizes the role of sociocultural determinants of health outcome and the fact that health inequities stem from larger systemic forces. As a result, medical and health education and training should focus on how patients' health and well-being may reflect structural vulnerabilities driven in large part by social, cultural, economic, and institutional forces. Health and mental health professionals also require social change and advocacy skills to ensure that they can effect change at the organizational and institutional levels [59].

Implicit bias is not a new topic; it has been discussed and studied for decades in the empirical literature. Because implicit bias is a complex and multifaceted phenomenon, it is important to recognize that there may be no one single theory that can fully explain its etiology.

CONSEQUENCES OF IMPLICIT BIASES

HEALTH DISPARITIES

Implicit bias has been linked to a variety of health disparities [1]. Health disparities are differences in health status or disease that systematically and adversely affect less advantaged groups [60]. These inequities are often linked to historical and current unequal distribution of resources due to poverty, structural inequities, insufficient access to health care, and/or environmental barriers and threats [61]. Healthy People 2030 defines a health disparity as [62]:

> …a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

As noted, in 2003, the Institute of Medicine implicated implicit bias in the development and continued health disparities in the United States [1]. Despite progress made

to lessen the gaps among different groups, health disparities continue to exist. One example is racial disparities in life expectancy among Black and White individuals in the United States. Life expectancy for Black men is 4.4 years lower than White men; for Black women, it is 2.9 years lower compared with White women [63]. Hypertension, diabetes, and obesity are more prevalent in non-Hispanic Black populations compared with non-Hispanic White groups (25%, 49%, and 59% higher, respectively) [64]. In one study, African American and Latina women were more likely to experience cesarean deliveries than their White counterparts, even after controlling for medically necessary procedures [65]. This places African American and Latina women at greater risk of infection and maternal mortality.

Gender health disparities have also been demonstrated. Generally, self-rated physical health (considered one of the best proxies to health) is poorer among women than men. Depression is also more common among women than men [66]. Lesbian and bisexual women report higher rates of depression and are more likely than non-gay women to engage risk behaviors such as smoking and binge drinking, perhaps as a result of LGBTQ+-related stressors. They are also less likely to access healthcare services [67].

Socioeconomic status also affects health care engagement and quality. In a study of patients seeking treatment for thoracic trauma, those without insurance were 1.9 times more likely to die compared with those with private insurance [68].

CLINICAL DECISIONS AND PROVIDER-PATIENT INTERACTIONS

In an ideal situation, health professionals would be explicitly and implicitly objective and clinical decisions would be completely free of bias. However, healthcare providers have implicit (and explicit) biases at a rate comparable to that of the general population [6; 69]. It is possible that these implicit biases shape healthcare professionals' behaviors, communications, and interactions, which may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions [69]. They may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up [7].

In a landmark 2007 study, a total of 287 internal medicine physicians and medical residents were randomized to receive a case vignette of an either Black or White patient with coronary artery disease [70]. All participants were also administered the IAT. When asked about perceived level of cooperativeness of the White or Black patient from the vignette, there were no differences in their explicit statements regarding cooperativeness. Yet, the IAT scores did show differences, with scores showing that physicians and residents had implicit preferences for the White patients. Participants with greater implicit preference for White patients (as reflected by IAT score) were more likely to select thrombolysis to treat the White patient than the Black patient [70]. This led to the possible conclusion that implicit racial bias can influence clinical decisions regarding treatment and may contribute to racial health disparities. However, some argue that using vignettes depicting hypothetical situations does not accurately reflect real-life conditions that require rapid decision-making under stress and uncertainty.

PATIENTS' PERCEPTIONS OF CARE

It has been hypothesized that providers' levels of bias affect the ratings of patient-centered care [34]. Patient-centered care has been defined as patients' positive ratings in the areas of perception of provider concern, provider answering patients' questions, provider integrity, and provider knowledge of the patient. Using data from 134 health providers who completed the IAT, a total of 2,908 diverse racial and ethnic minority patients participated in a telephone survey. Researchers found that for providers who scored high on levels of implicit bias, African American patients' ratings for all dimensions of patient-centered care were low compared with their White patient counterparts. Latinx patient ratings were low regardless of level of implicit bias.

A 2013 study recorded clinical interactions between 112 low-income African American patients and their 14 non-African American physicians for approximately two years [71]. Providers' implicit biases were also assessed using the IAT. In general, the physicians talked more than the patients; however, physicians with higher implicit bias scores also had a higher ratio of physician-to-patient talk time. Patients with higher levels of perceived discrimination had a lower ratio of physician-to-patient talk time (i.e., spoke more than those with lower reported perceived discrimination). A lower ratio of physician-patient talk time correlated to decreased likelihood of adherence.

Another study assessed 40 primary care physicians and 269 patients [72]. The IAT was administered to both groups, and their interactions were recorded and observed for verbal dominance (defined as the time of physician participation relative to patient participation). When physicians scored higher on measures of implicit bias, there was 9% more verbal dominance on the part of the physicians in the visits with Black patients and 11% greater in interactions with White patients. Physicians with higher implicit bias scores and lower verbal dominance also received lower scores on patient ratings on interpersonal care, particularly from Black patients [72].

In focus groups with racially and ethnically diverse patients who sought medical care for themselves or their children in New York City, participants reported perceptions of discrimination in health care [73]. They reported that healthcare professionals often made them feel less than human, with varying amounts of respect and courtesy. Some observed differences in treatment compared with White patients. One Black woman reported [73]:

> When the doctor came in [after a surgery], she proceeded to show me how I had to get up because I'm being released that day "whether I like it or not"… She yanked the first snap on the left leg…So I'm thinking, 'I'm human!' And she was courteous to the White lady [in the next bed], and I've got just as much age as her. I qualify on the level and scale of human being as her, but I didn't feel that from the doctor.

Another participant was a Latino physician who presented to the emergency department. He described the following [73]:

> They put me sort of in the corner [in the emergency department] and I can't talk very well because I can't breathe so well. The nurse comes over to me and actually says, "Tu tiene tu Medicaid?" I whispered out, "I'm a doctor…and I have insurance." I said it in perfect English. Literally, the color on her face went completely white…Within two minutes there was an orthopedic team around me…I kept wondering about what if I hadn't been a doctor, you know? Pretty eye opening and very sad.

These reports are illustrative of many minority patients' experiences with implicit and explicit racial/ethnic biases. Not surprisingly, these biases adversely affect patients' views of their clinical interactions with providers and ultimately contribute to their mistrust of the healthcare system.

DEVELOPMENTAL MODEL TO RECOGNIZING AND REDUCING IMPLICIT BIAS

There are no easy answers to raising awareness and reducing health providers' implicit bias. Each provider may be in a different developmental stage in terms of awareness, understanding, acceptance, and application of implicit bias to their practice. A developmental model for intercultural sensitivity training has been established to help identify where individuals may be in this developmental journey [74; 75]. It is important to recognize that the process of becoming more self-aware is fluid; reaching one stage does not necessarily mean that it is "conquered" or that there will not be additional work to do in that stage. As a dynamic process, it is possible to move back and forth as stress and uncertainty triggers implicit biases [74]. This developmental model includes six stages:

- Denial: In this stage, the individual has no awareness of the existence of cultural differences between oneself and members of other cultural groups and subgroups. Individuals in this stage have no awareness of implicit bias and cannot distinguish between explicit and implicit biases.
- Defense: In this stage, the person may accept that implicit biases exist but does not acknowledge that implicit biases exist within themselves.
- Minimization: An individual in this stage acknowledges that implicit biases may exist in their colleagues and possibly themselves. However, he or she is uncertain of their consequences and adverse effects. Furthermore, the person believes he or she is able to treat patients in an objective manner.
- Acceptance: In the acceptance stage, the individual recognizes and acknowledges the role of implicit biases and how implicit biases influence interactions with patients.
- Adaptation: Those in the adaptation stage self-reflect and acknowledge that they have unrecognized implicit biases. Not only is there an acknowledgement of the existence of implicit bias, these people begin to actively work to reduce the potential impact of implicit biases on interactions with patients.
- Integration: At this stage, the health professional works to incorporate change in their day-to-day practice in order to mitigate the effects of their implicit biases on various levels—from the patient level to the organization level.

CREATING A SAFE ENVIRONMENT

Creating a safe environment is the essential first step to exploring issues related to implicit bias. Discussions of race, stereotypes, privilege, and implicit bias, all of which are very complex, can be volatile or produce heightened emotions. When individuals do not feel their voices are heard and/or valued, negative emotions or a "fight-or-flight" response can be triggered [76]. This may manifest as yelling, demonstrations of anger, or crying or leaving the room or withdrawing and remaining silent [76].

Creating and fostering a sense of psychological safety in the learning environment is crucial. Psychological safety results when individuals feel that their opinions, views, thoughts, and contributions are valued despite tension, conflict, and discomfort. This allows the individual to feel that their identity is intact [76]. When psychological safety is threatened, individuals' energies are primarily expended on coping rather than learning [76]. As such, interventions should not seek to confront individuals or make them feel guilty and/or responsible [77].

When implicit bias interventions or assessments are planned, facilitators should be open, approachable, non-threatening, and knowledgeable; this will help create a safe and inclusive learning environment [77]. The principles of respect, integrity, and confidentiality should be communicated [77]. Facilitators who demonstrate attunement, authenticity, and power-sharing foster positive and productive dialogues about subjects such as race and identity [76]. Attunement is the capacity of an individual to tacitly comprehend the lived experiences of others, using their perspectives to provide an alternative viewpoint for others. Attunement does not involve requiring others to talk about their experiences if

they are not emotionally ready [76]. Authenticity involves being honest and transparent with one's own position in a racialized social structure and sharing one's own experiences, feelings, and views. Being authentic also means being vulnerable [76]. Finally, power-sharing entails redistributing power in the learning environment. The education environment is typically hierarchical, with an expert holding more power than students or participants. Furthermore, other students may hold more power by virtue of being more comfortable speaking/interacting [76]. Ultimately, promoting a safe space lays a foundation for safely and effectively implementing implicit bias awareness and reduction interventions.

STRATEGIES TO PROMOTE AWARENESS OF IMPLICIT BIAS

As discussed, the IAT can be used as a metric to assess professionals' level of implicit bias on a variety of subjects, and this presupposes that implicit bias is a discrete phenomenon that can be measured quantitatively [79]. When providers are aware that implicit biases exist, discussion and education can be implemented to help reduce them and/or their impact.

Another way of facilitating awareness of providers' implicit bias is to ask self-reflective questions about each interaction with patients. Some have suggested using SOAP (subjective, objective, assessment, and plan) notes to assist practitioners in identifying implicit biases in day-to-day interactions with patients [80]. Integrating the following questions into charts and notes can stimulate reflection about implicit bias globally and for each specific patient interaction:

- Did I think about any socioeconomic and/or environmental factors that may contribute to the health and access of this patient?
- How was my communication and interaction with this patient? Did it change from my customary pattern?
- How could my implicit biases influence care for this patient?

When reviewing the SOAP notes, providers can look for recurring themes of stereotypical perceptions, biased communication patterns, and/or types of treatment/interventions proposed and assess whether these themes could be influenced by biases related to race, ethnicity, age, gender, sexuality, or other social characteristics.

A review of empirical studies conducted on the effectiveness of interventions promoting implicit bias awareness found mixed results. At times, after a peer discussion of IAT scores, participants appeared less interested in learning and employing implicit bias reduction interventions. However, other studies have found that receiving feedback along with IAT scores resulted in a reduction in implicit bias [81]. Any feedback, education, and discussions should be structured to minimize participant defensiveness [81].

INTERVENTIONS TO REDUCE IMPLICIT BIASES

Interventions or strategies designed to reduce implicit bias may be further categorized as change-based or control-based [58]. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors [58]. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

PERSPECTIVE TAKING

Perspective taking is a strategy of taking on a first-person perspective of a person in order to control one's automatic response toward individuals with certain social characteristics that might trigger implicit biases [82]. The goal is to increase psychological closeness, empathy, and connection with members of the group [4]. Engaging with media that presents a perspective (e.g., watching documentaries, reading an autobiography) can help promote better understanding of the specific group's lives, experiences, and viewpoints. In one study, participants who adopted the first-person perspectives of African Americans had more positive automatic evaluations of the targeted group [83].

interactive activity

Consuming media that presents a viewpoint and life experience different from your own can help minimize implicit biases. Visit the following sites and consider how they might challenge or expand your perception of each group. Internet searches can help identify many more options for various social groups.

Think Out Loud Podcast
Young Black people share their experiences growing up in Portland, Oregon.
https://podcasts.apple.com/us/podcast/young-black-people-share-their-experiences-growing/id274122573?i=1000496652363

George Takei: Growing Up Asian-American
This PBS clip is a brief introduction, and the subject can be further explored in Takei's book *They Called Us Enemy*.
https://www.pbs.org/wnet/pioneers-of-television/video/george-takei-growing-up-asian-american

Seattle Public Library LGBTQ Staff Picks
A reading list including books and films focusing on LGBTQ+ life, culture, history, and politics.
https://www.spl.org/programs-and-services/social-justice/lgbtq/lgbt-staff-picks

EMPATHY INTERVENTIONS

Promoting positive emotions such as empathy and compassion can help reduce implicit biases. This can involve strategies like perspective taking and role playing [77]. In a study examining analgesic prescription disparities, nurses were shown photos of White or African American patients exhibiting pain and were asked to recommend how much pain medication was needed; a control group was not shown photos. Those who were shown images of patients in pain displayed no differences in recommended dosage along racial lines; however, those who did not see the images averaged higher recommended dosages for White patients compared with Black patients [84]. This suggests that professionals' level of empathy (enhanced by seeing the patient in pain) affected prescription recommendations.

In a study of healthcare professionals randomly assigned to an empathy-inducing group or a control group, participants were given the IAT to measure implicit bias prior to and following the intervention. Level of implicit bias among participants in the empathy-inducing group decreased significantly compared with their control group counterparts [85].

INDIVIDUATION

Individuation is an implicit bias reduction intervention that involves obtaining specific information about the individual and relying on personal characteristics instead of stereotypes of the group to which he or she belongs [4; 82]. The key is to concentrate on the person's specific experiences, achievements, personality traits, qualifications, and other personal attributes rather than focusing on gender, race, ethnicity, age, ability, and other social attributes, all of which can activate implicit biases. When providers lack relevant information, they are more likely to fill in data with stereotypes, in some cases unconsciously. Time constraints and job stress increase the likelihood of this occurring [69].

MINDFULNESS

Mindfulness requires stopping oneself and deliberately emptying one's mind of distractions or allowing distractions to drift through one's mind unimpeded, focusing only on the moment; judgment and assumptions are set aside. This approach involves regulating one's emotions, responses, and attention to return to the present moment, which can reduce stress and anxiety [86]. There is evidence that mindfulness can help regulate biological and emotional responses and can have a positive effect on attention and habit formation [4]. A mindfulness activity assists individuals to be more aware of their thoughts and sensations. This focus on deliberation moves the practitioner away from a reliance on instincts, which is the foundation of implicit bias-affected practice [4; 87].

Mindfulness approaches include yoga, meditation, and guided imagery. Additional resources to encourage a mindfulness practice are provided later in this course.

Goldstein has developed the STOP technique as a practical approach to engage in mindfulness in any moment [88]. STOP is an acronym for:

- Stop
- Take a breath
- Observe
- Proceed

interactive activity

Visit the following website to view a short animated video on the STOP technique. After viewing the video, consider how you can incorporate the technique into your work.
https://elishagoldstein.com/short-animated-stop-practice-elisha-goldstein-phd

Mindfulness practice has been explored as a technique to reduce activation or triggering of implicit bias, enhance awareness of and ability to control implicit biases that arise, and increase capacity for compassion and empathy toward patients by reducing stress, exhaustion, and compassion fatigue [89]. One study examined the effectiveness of a loving-kindness meditation practice training in improving implicit bias toward African Americans and unhoused persons. One hundred one non-Black adults were randomized to one of three groups: a six-week loving-kindness mindfulness practice, a six-week loving-kindness discussion, or the waitlist control. The IAT was used to measure implicit biases, and the results showed that the loving-kindness meditation practice decreased levels of implicit biases toward both groups [90].

There is also some novel evidence that mindfulness may have neurologic implications. For example, one study showed decreased amygdala activation after a mindfulness meditation [91]. However, additional studies are required in this area before conclusions can be reached.

COUNTER-STEREOTYPICAL IMAGING

Counter-stereotypical imaging approaches involve presenting an image, idea, or construct that is counter to the oversimplified stereotypes typically held regarding members of a specific group. In one study, participants were asked to imagine either a strong woman (the experimental condition) or a gender-neutral event (the control condition) [92]. Researchers found that participants in the experimental condition exhibited lower levels of implicit gender bias. Similarly, exposure to female leaders was found to reduce implicit gender bias [93]. Whether via increased contact with stigmatized groups to contradict prevailing stereotypes or simply exposure to counter-stereotypical imaging, it is possible to unlearn associations underlying various implicit biases. If the social environment is important in priming positive evaluations, having more

positive visual images of members in stigmatized groups can help reduce implicit biases [94]. Some have suggested that even just hanging photos and having computer screensavers reflecting positive images of various social groups could help to reduce negative associations [94].

EFFECTIVENESS OF IMPLICIT BIAS INTERVENTIONS

The effectiveness of implicit bias trainings and interventions has been scrutinized. In a 2019 systematic review, different types of implicit bias reduction interventions were evaluated. A meta-analysis of empirical studies published between May 2005 and April 2015 identified eight different classifications of interventions [13]:

- Engaging with others' perspectives, consciousness-raising, or imagining contact with outgroup: Participants either imagine how the outgroup thinks and feels, imagine having contact with the outgroup, or are made aware of the way the outgroup is marginalized or given new information about the outgroup.
- Identifying the self with the outgroup: Participants perform tasks that lessen barriers between themselves and the outgroup.
- Exposure to counter-stereotypical exemplars: Participants are exposed to exemplars that contradict negative stereotypes of the outgroup.
- Appeal to egalitarian values: Participants are encouraged to activate egalitarian goals or think about multiculturalism, cooperation, or tolerance.
- Evaluative conditioning: Participants perform tasks to strengthen counter-stereotypical associations.
- Inducing emotion: Emotions or moods are induced in participants.
- Intentional strategies to overcome biases: Participants are instructed to implement strategies to over-ride or suppress their biases.
- Pharmacotherapy

Interventions found to be the most effective were, in order from most to least, [13]:

- Intentional strategies to overcome biases
- Exposure to counter-stereotypical exemplars
- Identifying self with the outgroup
- Evaluative conditioning
- Inducing emotions

In general, the sample sizes were small. It is also unclear how generalizable the findings are, given many of the research participants were college psychology students. The 30 studies included in the meta-analysis were cross-sectional (not longitudinal) and only measured short-term outcomes, and there is some concern about "one shot" interventions, given the fact that implicit biases are deeply embedded. Would simply acknowledging the existence of implicit biases be sufficient to eliminate them [95; 96]? Or would such a confession act as an illusion to having self-actualized and moved beyond the bias [95]?

Optimally, implicit bias interventions involve continual practice to address deeply habitual implicit biases or interventions that target structural factors [95; 96].

ROLE OF INTERPROFESSIONAL COLLABORATION AND PRACTICE AND IMPLICIT BIASES

The study of implicit bias is appropriately interdisciplinary, representing social psychology, medicine, health psychology, neuroscience, counseling, mental health, gerontology, LGBTQ+ studies, religious studies, and disability studies [13]. Therefore, implicit bias empirical research and curricula training development lends itself well to interprofessional collaboration and practice (ICP).

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 [97]. IPC also involves the sharing of roles, responsibilities, decision making, and power [98]. Everyone on the team employs their expertise, knowledge, and skills, working collectively on a shared, patient-centered goal or outcome [98; 99].

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 [97]. At the heart of this are two other key features: mutual trust/respect and communication [99]. 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 [100]. This includes [100]:

- 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 [78]. 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, so students can effect positive social change [78].

CONCLUSION

In the more than three decades since the introduction of the IAT, the implicit bias knowledge base has grown significantly. It is clear that most people in the general population hold implicit biases, and health professionals are no different. While there continue to be controversies regarding the nature, dynamics, and etiology of implicit biases, it should not be ignored as a contributor to health disparities, patient dissatisfaction, and suboptimal care. Given the complex and multifaceted nature of this phenomenon, the solutions to raise individuals' awareness and reduce implicit bias are diverse and evolving.

RESOURCES

American Bar Association
Diversity and Inclusion Center
Toolkits and Projects
https://www.americanbar.org/groups/diversity/resources/toolkits

National Implicit Bias Network
https://implicitbias.net/resources/resources-by-category

The Ohio State University
The Women's Place: Implicit Bias Resources
https://womensplace.osu.edu/resources/implicit-bias-resources

The Ohio State University
Kirwan Institute for the Study of Race and Ethnicity
http://kirwaninstitute.osu.edu

University of California, Los Angeles
Equity, Diversity, and Inclusion: Implicit Bias
https://equity.ucla.edu/know/implicit-bias

University of California, San Francisco,
Office of Diversity and Outreach
Unconscious Bias Resources
https://diversity.ucsf.edu/resources/unconscious-bias-resources

Unconscious Bias Project
https://unconsciousbiasproject.org

MINDFULNESS RESOURCES

University of California, San Diego
Center for Mindfulness
https://medschool.ucsd.edu/som/fmph/research/mindfulness

University of California, Los Angeles
Guided Meditations
https://www.uclahealth.org/marc/mindful-meditations

Mindful: Mindfulness for Healthcare Professionals
https://www.mindful.org/mindfulhome-mindfulness-for-healthcare-workers-during-covid

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 28–29.

TEST QUESTIONS
#97000 IMPLICIT BIAS IN HEALTH CARE

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 clock hour activity must be completed by August 31, 2024.

1. Which of the following is a social characteristic that can trigger implicit biases?
A) *Age*
B) *Disability*
C) *Skin tone*
D) *All of the above*

2. Dr. X, a physician, 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. Dr. X is demonstrating
A) *diversity.*
B) *reflexivity.*
C) *explicit bias.*
D) *cultural humility.*

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

4. What tool is used to quantitatively measure implicit bias?
A) *IAT*
B) *SOAP*
C) *STOP*
D) *fMRI*

5. More than 4.6 million individuals have taken the IAT, and results indicate that the general population does not hold implicit biases.
A) *True*
B) *False*

6. 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*

7. Rather than viewing implicit bias as an invisible force (i.e., unconscious cognitive structure), behavioral theorists consider it a normal behavior.
A) *True*
B) *False*

8. How might critical theory or a structural perspective be integrated into the values and ethics of interprofessional collaboration and practice?
A) *Advocate for more neurologic imaging studies to examine how implicit bias affects the brain.*
B) *Analyze how communications should reflect autonomous decision-making in its role in racism.*
C) *The ethical responsibility is to advocate for policies that perpetuate and reinforce implicit biases.*
D) *The role of health professionals is to focus less on the unconscious and instead emphasize explicit bias as the behaviors.*

9. Which of the following statements regarding health disparities is FALSE?
A) *Health disparities are linked to disadvantaged groups.*
B) *Health disparities refer to differences in health status and disease that are tied to structural inequities.*
C) *There are no differences in life expectancies among African Americans and White Americans.*
D) *The Institute of Medicine has implicated implicit bias in the development and continuance of health disparities.*

10. Healthcare providers have implicit (and explicit) biases at a rate comparable to that of the general population.
A) *True*
B) *False*

Test questions continue on next page ➔

11. Research indicates that healthcare professionals' implicit biases are not correlated with lower scores on patient/client satisfaction.
A) *True*
B) *False*

12. An implicit bias training is offered at a hospital, and a total of 50 health professionals attend. During the breakout session, training participants are assigned to discussion groups. One nurse agrees that implicit bias is prevalent, but she is quite sure she does not hold any implicit biases. Which developmental stage might this nurse be in?
A) *Defense*
B) *Minimization*
C) *Structural competence*
D) *Counter-stereotype acceptance*

13. If psychological safety is threatened, what might be a potential outcome in implicit bias training?
A) *Recriminations*
B) *Self-confessions of guilt*
C) *Health disparities increase*
D) *Learning may be compromised*

14. When implicit bias interventions or assessments are planned, facilitators should be open, approachable, non-threatening, and knowledgeable.
A) *True*
B) *False*

15. Some have suggested using SOAP (subjective, objective, assessment, and plan) notes to assist practitioners in identifying implicit biases in day-to-day interactions with patients.
A) *True*
B) *False*

16. Increasing awareness of biased thoughts and responses is an example of a change-based intervention.
A) *True*
B) *False*

17. As part of an implicit bias training, participants watch a film about an African American man's experiences navigating the health system and are asked to enter the protagonist's lived reality. What type of intervention is this?
A) *Priming*
B) *Attunement*
C) *Control strategies*
D) *Perspective taking*

18. Mr. A, a social worker, attempts to record personal information about his patients and not simply social characteristics. For example, he writes, "Patient is an elderly Hispanic woman, age 79 years. She lives with her daughter and is an avid pianist." What is this an example of?
A) *STOP*
B) *Priming*
C) *Power-sharing*
D) *Individuation*

19. Counter-stereotypical imaging approaches involve presenting an image, idea, or construct that is counter to the oversimplified stereotypes typically held regarding members of a specific group.
A) *True*
B) *False*

20. All of the following are concerns with research conducted to examine the effectiveness of implicit bias reduction interventions, EXCEPT:
A) *The studies conducted to examine implicit bias reduction interventions utilize cross-sectional and not longitudinal designs.*
B) *The studies conducted to examine implicit bias reduction interventions may not be generalizable to the general population.*
C) *The studies conducted to examine implicit bias reduction interventions have measured long-term but not immediate outcomes.*
D) *Study samples have tended to include psychology students and it is not clear whether findings can be applied to other populations.*

Be sure to transfer your answers to the Answer Sheet located between pages 28–29.
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.

Online Professionalism and Ethics

3 Social Work Ethics Clock Hours

Audience
This course is designed for social workers, psychologists, therapists, and mental health counselors who wish to increase their knowledge of how their online presence can affect their professional practice in terms of professionalism, ethics, and professional identity.

Course Objective
As Internet technologies increasingly become ingrained in our professional and personal lives, the issues of professionalism and ethics should be considered carefully. The purpose of this course is to increase practitioners' level of awareness and knowledge of how Internet tools impact professionalism and ethics in clinical practice.

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

1. Define Internet usage patterns and common Internet technologies.
2. Analyze how various Internet technologies are utilized in clinical practice.
3. Define professionalism.
4. Evaluate how the use of specific Internet technologies can affect professionalism and ethics.
5. Discuss how the use of Internet technologies can impact issues of boundaries, self-disclosure, privacy/confidentiality, and professional relationships.
6. Identify best practices for using Internet technologies as a clinical practitioner.

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.

Division Planner
Jane C. Norman, RN, MSN, CNE, PhD

Director of Development and Academic Affairs
Sarah Campbell

Division Planner/Director Disclosure
The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Accreditations & Approvals
As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. NetCE maintains responsibility for this course.

NetCE is recognized by the New York State Education Department's State Board for Social Work as an approved provider of continuing education for licensed social workers #SW-0033.

This course is considered self-study, as defined by the New York State Board for Social Work. Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of licensed master social work and licensed clinical social work in New York. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice for an LMSW and LCSW. A licensee who practices beyond the authorized scope of practice could be charged with unprofessional conduct under the Education Law and Regents Rules.

Designations of Credit
Social Workers participating in this intermediate to advanced course will receive 3 Social Work Ethics continuing education clock hours.

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 #159001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168000190.

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.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement
It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

How to Receive Credit

- Read the following course.
- Complete the test questions at the end of the course.
- Return your Customer Information/Answer Sheet/Evaluation and payment to NetCE by mail or fax, or complete online at **www.NetCE.com/SW22B**.
- A full Works Cited list is available online at www.NetCE.com.

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

Professionals are increasingly entering the digital world to network both socially and professionally. Internet technology can be a powerful tool when job searching and developing and expanding professional networks; however, it is important for individuals to use discretion and judgment in the types of information they post, as the casual and informal nature of social networking sites can make it easy to inadvertently cross professional boundaries. The term "digital footprint" has been used to refer to the digital content and evidence left behind as a result of posting on discussion boards, social networking sites, blogs, and other Internet platforms [1]. These digital footprints can affect how the public, colleagues, supervisors, and employers will perceive an individual in the future. In fact, it is becoming increasingly commonplace for individuals to search online for information about another individual, particularly for professional reasons. For example, 19% of online adults in one study had searched the Internet for information about an individual with whom they had a professional relationship [1]. Some universities and colleges will look up their applicants on social media as part of the admission process [7]. What might a photo of an applicant partying, drinking, or using substances convey to the admissions panel [79]?

One of the hallmarks of curricula in graduate professional degree programs is to socialize novice professionals about the profession's identity, ethical practice within the field, and sense of professionalism. However, with the advent of technology and the era of online venues, the notion of professional identity and boundaries can become blurred. In 2000, there was little written on e-professionalism; since then, recommendations have been formulated to help professionals ensure their professional and personal identities are appropriately presented online [100]. A review found that 63% of employers decided to reject potential employees after finding inappropriate or unprofessional content in their profiles on social networking sites [2; 79]. A nurse in Sweden was dismissed after she posted a photo of herself holding a piece of flesh during a brain operation [3]. Another nurse in New York was terminated for uploading a photo of an empty trauma room to her Facebook account [101]. Agencies and organizations have to weigh the risks and benefits of these online behaviors, including perceived professionalism and potential legal risks of compromising confidentiality [100].

In professions such as medicine, psychology, social work, mental health counseling, family therapy, and nursing, unprofessional online identities can have negative repercussions for both the client and practitioner. In addition, practitioners searching for information about clients on the Internet can result in damaged relationships and impact care. The Internet can be a powerful tool, but it is important to consider how

appropriate it is to access information about a client who has not disclosed the information within the therapeutic setting. For example, what is the practitioner's ethical obligation if a client posts depressive thoughts that might be indicative of suicidal risk on a social networking site [5]? In one scenario, a clinician conducted an Internet search of a young client because the grandfather refused to elaborate about the trauma experienced as a result of the client's parents' plane crash [4]. When the clinician utilized the information during the search in the therapeutic process, the grandfather terminated the sessions. The grandfather perceived this as a violation of privacy, and ultimately the working alliance was adversely affected. Even something as seemingly innocuous as sending out an e-mail correspondence from an Internet hotspot or public terminal to a client or a clinical supervisor with the client's name could potentially violate issues of privacy [6].

The goal of this course is to raise awareness and build the knowledge base of psychologists, social workers, mental health counselors, family therapists, physicians, and nurses regarding the impact of Internet technology on professionalism and ethics [14]. Technology has become an integral part of the American lifestyle, and it is crucial for practitioners to determine how it impacts their professional lives. Of course, having an online presence is not necessarily negative. Instead of fear and abstinence from Internet and social media, practitioners should be thoughtful and fully evaluate the risks and benefits of developing and maintaining an online presence.

INTERNET AND DIGITAL TECHNOLOGY TRENDS

In order to understand the pervasive social, psychologic, and cultural impact of the Internet on the lives of individuals, it is important to obtain a brief glimpse of Internet and digital technology usage and consumption. In 2016 in the United States, it was estimated that 81% of households had Internet access [65]. In a 2018 study conducted by the Pew Research Center with adults 18 years of age and older, 89% reported Internet use, compared with 52% in 2000 and 76% in 2010 [8]. An estimated 73% of households in the U.S. had broadband Internet [8]. Individuals 18 to 29 years of age are the most likely to utilize the Internet (98%), while adults 65 years of age and older are the least likely (66%) [8]. There is no doubt that Internet technology has become a ubiquitous part of the American landscape. Although data published in the last several years is among the most current, the Internet landscape changes so rapidly that obtaining accurate data is nearly impossible.

SOCIAL NETWORKING

A huge number of individuals are using online social networking sites like Facebook and Instagram. As of 2010, the average American spends 6 hours and 35 minutes on blogs and social networking sites every month [9]. As of 2021, an estimated 69% of Americans 18 years of age and older used Facebook, 81% used YouTube, 40% had an Instagram profile, 31% used Pinterest, 28% reported using LinkedIn, 25% used Snapchat, and 23% used Twitter [76]. YouTube and Reddit were the only two platforms measured that saw statistically significant growth since 2019. Women and girls tend to use Facebook and Instagram at a slightly higher rate than men and boys, while men and boys are more like to report use of Reddit [76]. Instagram, Snapchat, and TikTok are more commonly used by younger individuals, while Facebook and WhatsApp appear to be more evenly used among all age groups [76].

The general belief is that social networking users are adolescents and young adults. While the percentage of adolescents and young adults using online social networking sites like Facebook and TikTok is higher compared to older adults, this is beginning to change. In 2021, 50% of adults 65 years of age and older used Facebook [76]. Older adults report using social networking technology to connect with people by sharing photos, personal news and updates, and links.

REVIEW OF INTERNET COMMUNICATION TOOLS

Before discussing how Internet technologies may impact professional ethics and conduct, it is important to have a clear understanding of the tools and terminology used. Each of the following applications presents unique benefits and challenges.

ELECTRONIC MAIL (E-MAIL)

E-mail is a form of electronic communication that involves sending messages over the Internet. It is one of the most commonly used Internet applications. It allows for the delivery of a message to another person or to a group of individuals rapidly, conveniently, and without incurring any per message charges (as with text messaging) [12].

CHATROOMS

A chatroom or chat group is a virtual community or venue in which a group of individuals can "dialogue" and share information about a common interest asynchronously (non-real time) or synchronously (real time). Chatrooms are often organized by specific topics or interests, such as a hobby, an illness, mental health disorders, or personal interests. For example, it is possible to find an online chatroom devoted to the discussion of depression.

BLOGS OR MICROBLOGS

Blogs are analogous to a website journal and generally consist of a log of entries displayed in chronologic order. Entries might include commentary, information about events, graphics, or videos posted by an individual or group. Blogs have become relatively popular and may be attractive to many partly because they require little technical expertise, are inexpensive, allow users to archive and refer back to previous entries, and facilitate connections with others, who may read and comment on entries [13]. Approximately 500 million blogs existed in 2019, and an average of 120,000 blog entries were generated each day [102].

There are many free services to develop and search for blogs, including Blogger, Google, Tumblr, WordPress, Wix, Weebly, Blogspot, SquareSpace, and LiveJournal [77]. Microblogging is similar to blogging, but with a limit on the number of characters that may be used. Twitter, for example, is limited to 140 characters [5]. According to Nielsen, women are more likely than men to blog, and one in three bloggers is a mother [10]. As of 2015, the top three blogging sites are Blogger, WordPress, and Tumblr [10].

INSTANT AND TEXT OR PHOTO MESSAGING

Instant messaging and text messaging are forms of synchronous communication whereby individuals communicate through text and/or photos using computers, cellular phones, or other devices. Text messaging has become one of the most popular forms of electronic communication, especially among adolescents and young adults. An estimated 81% of adults own a smartphone as of 2019 [78]. In a 2019 survey conducted by the Pew Research Center, 78% of cell phone owners in emerging countries use their phone for texting or messaging [58]. On average, persons 18 to 24 years of age send and receive 128 text messages every day [103]. Some estimate that they receive more than 2,000 texts monthly [104].

Applications that allow users to send photos or videos (usually modified with text and/or drawings) have also gained popularity since 2010. One popular example of this platform is Snapchat, which allows users to send images or videos and limit the amount of time they are available; after the set time, the file can no longer be accessed. Since 2019, the video-sharing platform TikTok has gained popularity. Teens are also likely to use apps such as Snapchat to send messages to friends (in lieu of or in addition to texting). Among cell phone owners 18 to 24 years of age, 65% were using this application as of 2021 [76].

SOCIAL NETWORKING WEBSITES

Social networking is a form of online communication that is comprised of "web-based services that allow individuals to construct a public or semi-public profile within a bounded system, articulate a list of other users with whom they share a connection, and view and traverse their list of connections and those made by others within the system" [15]. Examples of social networking sites include YouTube, Facebook, TikTok, LinkedIn, Pinterest, Twitter, Instagram, Snapchat, Tumblr, and Gab [76].

PHOTO OR VIDEO SHARING

Posting original photos and videos online is a common Internet activity, and there are a variety of ways that users may upload their images online. Most social media users include personal photos and videos on their online profiles; it is estimated that half of all persons using the Internet post original photos online [76]. A variety of photo- and video-based applications have been adopted by users, including Instagram, YouTube, TikTok, and Flickr.

WIKIs

Wikis, derived from the Hawaiian word for quick, are collaborative websites on which anyone with access can add, revise, or remove the content published [16]. The most popular wiki is Wikipedia, which is similar to a collaborative encyclopedia, but there are many specific wikis focusing on a single topic, such as suicide prevention or a video game. Often, access is not restricted, but in some cases, editing may be password restricted [16]. Wikis have grown tremendously popular, as they can be a vehicle to quickly access and share information [17]. Wikis have been developed in healthcare communities to promote continuing education and professional development [16].

USE OF INTERNET TOOLS IN CLINICAL PRACTICE

In addition to affecting personal life, recreation, and the dissemination of information, Internet technologies have also impacted the provision of health and mental health care. E-mail is one of the most commonly utilized web-based interventions in clinical practice [18]. E-mail-based counseling consists of asynchronous interactions between a counselor and client using text-based communications sent electronically. E-mail communications allow the client to provide brief narratives, and the counselor can structure the communication for exploration of the described symptoms with a problem-solving focus [19]. Some practitioners will use e-mail as a mechanism to provide support. The premise is that the opportunity to interact with another individual, even in writing, can help to mitigate maladaptive responses to stressors [20]. This may be the most useful for clients who cannot easily see a practitioner due to transportation issues or residing in remote areas. In addition, e-mail counseling or any type of counseling involving text-based communication may be cathartic for the client and allow him or her to control how much information to disclose and when to disclose it [80]. E-mail counseling has been likened to a journal, allowing clients to revisit conversations with counselors. E-mail counseling was also perceived as flexible and accessible [105].

Even with high risk and sensitive topics (e.g., suicide), e-mail counseling may be preferred to phone counseling if the client feels better able to express him/herself through writing [106].

In one study of abuse survivor care, nurse practitioners reported that e-mail technology allowed for immediate referrals, education, support, information, and guidance, improving their practice and level of care [20]. E-mails have also been used as a supplement for supervision, and they can serve as a journal of thoughts and questions between an intern and a supervisor to stimulate reflection [21]. Due to the convenience of e-mails and the ability to aggregate lists of e-mail addresses (e-mail distribution lists), forming groups in which participants interact through e-mail has proliferated [12]. A single individual can physically set-up distribution lists and send mass e-mails, or the distribution of the e-mails can be moderated through special software. E-mail software application systems are available to handle the task of subscribing or unsubscribing persons from the e-mail distribution list (LISTSERV) [12]. Such applications are often developed for the purpose of disseminating information or providing support for a specific issue [22]. They can be particularly helpful in keeping practitioners abreast of current information and connected with colleagues. These distribution lists may also be beneficial for training and continuing professional development [23]. In a study conducted by Cook and Doyle about the motivations of using e-mail-based counseling, many of the participants indicated that they preferred it to face-to-face counseling because it was less embarrassing and they had the ability to read and reread e-mails and reflect on the counseling sessions [59].

Online chatting, texting, and instant messaging refers to the exchange of brief written messages in quasi-real time (i.e., quasi-synchronously) between two phones or computers [80]. Common platforms for online counseling may include MSN, WhatsApp, SMS, or IMessage [81]. While online chatting is slower than talking, clients appear to disclose the problem more quickly, which may be attributable to characteristics of chatting that promote disinhibition [82]. In a qualitative study examining counselor/client e-mails and online chats, clients tended to get to the point of the problem more quickly in chats, while in e-mail counseling, clients wrote longer narratives with greater detail [82]. In e-mail counseling, there was more interactional space, while in online chat, there was more real-time interaction. Texting may also be used as an adjunct to traditional psychotherapy, particularly as a means of providing appointment reminders to increase treatment compliance [107]. Text messages can also increase rapport between the client and the counselor [107].

Chatrooms or discussion groups may be established to address specific topics or interests (e.g., surviving cancer, coping with depression). Ideally, these websites will have experienced practitioners acting as facilitators who may observe and guide the "conversations" [24; 25]. Benefits of discussion groups include lasting documentation of discussions (in the form of archived transcripts), the creation of a supportive environment, and a minimization of isolation. Online discussion boards offer an opportunity for members to be heard and to relate to others, reducing feelings of isolation [108]. In a study of a real-time chatroom offering peer counseling on a variety of emotional issues, the online peer counseling was found to be person-centered [60]. The youths who participated were satisfied with their counselor's ability to provide support. However, the counselors had difficulty providing solutions and assisting participants to think critically and generate solutions.

Blogs have traditionally been used in clinical practice in one of two ways [26]. First, they may be used as an online journal of life events, feelings or emotions, and personal views or belief systems. A community of readers and fellow bloggers may comment and share their life experiences with each other. These responses can be empathic and sincere, giving the blogger a sense of community, understanding, and support [109]. In this way, the blog can act as a record of symptoms and triggers and also as a support group of sorts. Second, blogs may be used by professionals to discuss a particular topic, with readers or other bloggers providing recommendations and feedback [26; 109]. In a 2005 study, researchers found that half of all evaluated blog posts were written with the purpose of self-help or self-therapy [27]. Third, blogs may be used as a form of social justice activism, encouraging people into social action and change [83].

A 2010 study analyzing 951 blogs related to health during a two-year period found that women wrote more than half of blogs, and almost half of the blogs were written by those in the health professions [28]. Typically, the blogs included links, archives, and comments sections, and most of the topics revolved around mental health. For example, more than one-quarter focused on autism, while another quarter concentrated on bipolar disorders. The blogs were informational but also contained personal experiences. They obtain support and help patients and caregivers cope. However, it could also be a cathartic mechanism for health professionals dealing with workplace stress to share challenges experienced in the healthcare sector.

Social networking sites are being used in the health and mental health fields to build and connect members within a community. These sites often collect information about their members by having them create profiles. Members then connect with each other based on information from their profiles [29]. In a survey study of 658 nurses, 85% indicated that social media was beneficial for work-related activities. Many received work-related messages online, and more than 50% subscribed to a medical-related social media site [110].

Because social support is an essential factor in helping people cope with medical conditions, social networking may be an important tool. The U.S. Department of Health and Human Services and the National Suicide Prevention Lifeline partnered with Facebook in an initiative to prevent suicide. As part of this program, if a Facebook user notices that a "friend"

posted a suicidal comment or a post that alluded to suicidal intent, the comment could be reported to the National Suicide Prevention Lifeline, with the "friend" then contacted via e-mail or an instant chat [61]. The Italian Service for Online Psychology (SIPO) also employs Facebook as a means to provide free online psychologic consultations [84]. Between November 2011 and June 2014, 284 individuals used Facebook for 30-minute consultations with an SIPO clinician. Depression was the most common reported presenting problem. In this example, Facebook chat offers a convenient and non-stigmatizing way to access mental health assistance, thereby eliminating barriers to access to traditional mental health care [84].

Video technology may be used to facilitate long-distance therapeutic interventions as well as to share repetitive therapeutic information. Real-time video conferencing, using secure networks or online technology like Zoom, Skype, Google Hangouts, Microsoft Teams, or FaceTime, can allow practitioners to provide care in underserved areas or to persons who are unable to travel even small distances to receive therapy [81].

Using technology, people can more easily provide both emotional and informational support to each other regardless of geographic or other barriers. One example of a social networking site for patients focusing on health and medical conditions is PatientsLikeMe (https://www.patientslikeme.com). There are also social networking sites specifically developed to allow healthcare professionals to connect with each other and share information. Examples include AllNurses (https://allnurses. com), Sermo (https://app.sermo.com), and Doximity (https://www.doximity.com).

OVERVIEW OF PROFESSIONALISM AND ETHICS

DEFINING PROFESSIONALISM

As noted, one of the hallmarks of curricula in graduate professional degree programs is to acquaint novice professionals about the profession's identity, ethical practice within the field, and sense of professionalism. Professional identity has been defined as a "frame of reference for carrying out work roles, making significant decisions, and developing as a professional" [30]. The developmental process of a practitioner's professional identity is a continual process involving attitudinal, behavioral, and structural changes that result in an understanding and acceptance of what is involved in being a professional. The development of a practitioner's professional identity begins in graduate school, and the process continues to affect future professional behaviors [30]. This dynamic process includes teaching knowledge, development of a professional identity, and socialization into the group or profession's norms and values [62].

To be even more exact, it is important to have a clear definition of what constitutes a profession. A profession is defined as involving, "the application of general principles to specific problems, and it is a feature of modern societies that such general principles are abundant and growing" [31]. Professions are characterized by two major dimensions: the substantive field of knowledge that the specialist professes to command, and the technique of production or application of knowledge over which the specialist claims mastery [31]. Therefore, professionals have or claim to have knowledge and apply this knowledge to specific problems.

Professionalism is defined as a set of norms endorsed by a collective community and is characterized by "a personal high standard of competence," including "the means by which a person promotes or maintains the image" of a profession [32]. Professionalism involves a set of qualities, including not only knowledge and clinical skills but commitment, integrity, altruism, individual responsibility, compassion, and accountability [33]. In health care, professionalism often involves employing and applying a unique set of clinical skills and scientific knowledge base [85]. In the helping professions, professionalism is designed to promote patient/client autonomy, protect the public, improve access to care, distribute constrained resources in a just and equitable manner, and ensure professional accountability to the public [34; 35].

In the past, and to some degree today, professional organizations defined specific behaviors and characteristics that conformed to the standards of a particular profession. Consequently, many graduate programs selected and screened students determined to be the "right kind" of person, one who met a set list of characteristics and behaviors that conformed to the standards of competence, ethics, and professionalism within the field [36]. In addition, there are codes of conduct to regulate behavior and supervisory processes to ensure appropriate use of autonomy [86]. Therefore, many argue that merely compiling a list of behaviors and characteristics does not allow for the fact that professionalism is field- and context-independent. The standards of professionalism, ethics, and competence are influenced by a range of external factors, such as the social, political, economic, and cultural goals of the professional institutions and organizations, social norms, and the experiences of clients/patients and their families [36]. There are also factors in the presentation of professionalism that can be more easily controlled. First impressions can be extremely influential in how a professional is perceived [37]. Professional appearance (e.g., clothing, hygiene, presentation) and behavior (e.g., language use, nonverbal cues, etiquette) are vital components of a positive first impression [37; 85]. Ultimately, professionalism forms the foundation of trust between the client/patient and practitioner [63].

E-professionalism is a set of online attitudinal and behavioral standards that conforms to the expectations and values of a profession (e.g., integrity, competence, confidentiality, beneficence) [111]. Unfortunately, it is not clear if one can simply apply traditional professional principles directly in the online environment [111]. Breaches of privacy and confidentiality on social media, blurring of personal and professional relationships, online civility, and violations of agency/organizational policies are common issues that should be addressed in e-professionalism guidelines [112].

ETHICS AND CODES OF ETHICS

It is not possible to talk about professionalism without a discussion of ethics. The code of ethics in a profession has been said to be the "hallmark of professionalism" [64]. Codes of ethics provide guidance to the public and professionals regarding the responsibilities of professionals. They also serve as vehicles for accountability in the profession and as a means for practitioners to self-monitor and enhance practice [87].

Ethics are beliefs about what constitutes correct or proper behavior, the principles of right conduct and how to live as a good person [38]. Ethical principles are statements that reflect one's obligations or duties [39]. General ethical principles common to the helping profession include [39]:

- Autonomy: An individual's right to make his or her own decisions
- Beneficence: The duty to do good
- Confidentiality: The duty to respect privacy and trust and to protect information
- 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

Based on these ethical principles, professions develop ethical codes that embody the values of the profession and guide behaviors of members. In an analysis of the codes of ethics of diverse professions, researchers were able to classify the codes into four domains [40]:

- The professional's qualities and characteristics
- Behaviors toward other professionals and colleagues
- Behaviors of professionals in a range of situations
- The responsibility of the profession and the professional to society and the common good

These same principles and values apply online. For example, if a practitioner posts unprofessional content on social media (e.g., a photo of him/herself surrounded by alcohol), how could this potentially affect his/her work with patients with alcohol use disorder? Could it harm the therapeutic goals? If so, this would violate the ethical principle of beneficence [79].

Although ethics and professionalism are different, there is considerable overlap. Acting professionally entails adhering to accepted codes of conduct and ethics within a given field, and acting in an ethical manner in online interactions is a good first step in ensuring online professionalism.

The International Society for Mental Health Online (ISMHO), established in 1997, formulated the Suggested Principles for the Online Provision of Mental Health Services in 2000 [88]. Many professional organizations have attempted to keep abreast advances in digital technology and its impact, and many have begun to revise their ethical standards to reflect the ubiquitous nature of technology in modern society. The American Counseling Association (ACA) added an addendum to their code of ethics in 1999 and, in 2005, finalized comprehensive guidelines for Internet counseling [88]. In the field of psychology, Guidelines for the Practice of Technology were developed by the American Psychological Association (APA), the Association of State and Provincial Psychology Boards, and the APA Insurance Trust [89]. In 2017, the National Association of Social Workers (NASW) Delegate Assembly approved updates to the NASW Code of Ethics, including new guidance regarding the role of technology in informed consent, privacy, confidentiality, competency, supervision, and client records [90]. In addition, in 2017 the NASW, in conjunction with the Association of Social Work Boards, the Council on Social Work Education, and the Clinical Social Work Association, published specific guidance in its publication Standards on Technology and Social Work Practice [91]. The American Nurses Association and the American Medical Association have developed opinion statements and toolkits for the appropriate use of technologies such as social media in their respective professions [92; 93].

INTERNET TECHNOLOGIES AND PROFESSIONALISM AND ETHICS

Internet technologies can be powerful tools when job-searching, developing and growing professional networks, promoting health and mental health, and providing support to clients. As a result, e-professionalism, or professionalism in the Internet world, should be instilled in practitioners [3; 94]. Some maintain that e-professionalism, the application of ethics online, and digital literacy should be essential components of the knowledge and skill of practitioners [83]. It is important, for example, to use discretion and judgment in the types of information made public online. The casual and informal nature of social networking sites, for example, can cause practitioners to inadvertently cross professional boundaries, which can negatively affect their professional identity and may breach ethical standards. If practitioners discuss work-related problems (e.g., difficult clients, conflicts with colleagues) on social media, it could disclose confidential information or qualify as abuse [95]. Not everyone considers how the image or persona portrayed online may be perceived in the future. Because the Internet can be a public forum, viewers do not necessarily avoid viewing personal, intimate, and/or embarrassing behaviors [41]. The issue may not be the ever-growing presence of Internet communications, but rather the seeming mindlessness or carelessness with which information is shared; this has been referred to as the diminishing of intentionality of online communication [42]. Practitioners may adhere to strict guidelines for self-disclosure in "real" life, but the Internet may defy practitioners' best intentions. Some have likened the Internet to a clinical practice in a rural area, where practitioners inevitably have unplanned encounters with their clients/patients due to the size of the community [42]. In some cases, individuals may inaccurately believe that the privacy settings will ensure confidentiality [95; 110]. With the Internet, practitioners have minimal control over when and how clients encounter information about them online [42]. The Internet has no expiration date, and anything posted online should be assumed to be permanent [66]. Unfortunately, many codes of ethics in fields such as medicine, psychology, social work, nursing, and counseling have struggled to keep up with these technologic changes [41]. In some cases, standards have been established for the provision of technology-assisted services (such as online counseling), but not for online professional conduct [43].

SOCIAL NETWORKING SITES

The use of social networking platforms can affect professional relationships and boundaries. In a 2013 survey of psychologists, social workers, and physicians, 59% of the practitioners indicated they maintained a Facebook account and 75% of users reported using a privacy setting [67]. Similarly, in a survey study with 695 psychology students and psychologists, 77% indicated they had an account on a social networking site, and of these users, 85% used privacy settings [42]. In a 2018 study with nursing students, 96.6% reported having a Facebook account [96]. However, practitioners were ambivalent about what to do when clients contacted them through a social networking site. It may appear to be an innocuous request, but it can bring up many ethical issues. If the practitioner accepts the client as a friend, the client may have access to personal information, blurring professional boundaries. If the practitioner does not accept the request, the client might misconstrue this as rejection, potentially harming the therapeutic relationship.

Similar issues may arise if information about a client is gleaned from a social networking site. In a study of 302 graduate psychology students, 27% had reported actively seeking out client information on the Internet; most stated they wanted to verify the clients' claims [41]. In a study with 346 undergraduates, participants were asked to evaluate their likelihood of posting different types of "problematic" information in their Facebook profiles and their perceptions of how others would view their image after seeing their profiles [44]. Gender differences were found; specifically, undergraduate men were more likely to report that their Facebook profile contained an image that was sexually appealing, wild, or offensive. Men were also more likely to post "problematic" content in their profiles compared to their female counterparts. In a qualitative study of 813 medical students and residents, 44% were found to have an account and only 33% of these profiles were made private [45]. Of the profiles that were not private, the researchers found that more than half included overt mentions of personal and/or ideologic views, such as political affiliation (50%), sexual orientation (52%), and relationship status (58%). In some cases, the medical students and residents had uploaded photos that could be interpreted negatively (e.g., photos with alcohol, excess drinking, drug use). In the study of graduate psychology students, 81% confirmed having some sort of online profile, with 37% reporting having a social networking page [46]. Of the students who used social networking, more than 65% used their real names and 13% stated they posted photos they would not want their faculty members to see. Nearly 30% stated they posted photos they would not want their clients to see, and 37% posted information they would not want to their clients to read. A study of first-year nursing students, participants reported ambivalence regarding patients seeing their posts in Facebook, perhaps because they lack clinical experiences [96]. In a content analysis of Facebook profiles of nurses in the United Kingdom and Italy, the researcher looked at photos posted and classified them according to the content [68]. Approximately 18.5% of the profiles included photos of the nurse engaged in unhealthy behavior, including smoking and drinking alcohol [68]. The representations of professionals' behaviors on social networking sites could inadvertently have a negative effect on the integrity of the profession [69].

Therapeutic boundaries are established to promote client beneficence and define the client/practitioner relationship. Informed consent, single-role relationship, and confidentiality support these boundaries [70]. The boundaries of the client-practitioner relationship will get blurred as online friendship interactions can lead to sharing of private information on the part of both parties, which may negatively impact the professional relationship [47; 79]. If practitioners find sensitive or embarrassing information about clients, they may be conflicted regarding the appropriate way to use this information. For example, a practitioner may be working with a client on abstaining alcohol, and in the session, the client denies having used alcohol in the past 24 hours. However, if the client and practitioner are linked on a social networking site, the practitioner may stumble onto a photo of the client at a party holding a beer bottle. There is no clear correct course of action. Should the practitioner utilize this information in the next clinical session? If the practitioner does bring it up, does it violate privacy issues? Will it affect the clinical rapport and relationship?

In some cases, social media profiles have been used by law enforcement or social service providers to guide their interactions with clients. For example, there have been reports of social workers "friending" a youth in foster care in order to keep track of them, using a client's social media post to demonstrate his/her lack of progress or faulty character, or using an online profile picture to search for someone [94].

A good first step is to consider the ethical ramifications of each action utilizing the ethical principles identified in many of the professional codes of ethics [41]:

- Beneficence (the duty to do good): How would the information obtained from a social networking site promote the well-being and welfare of the client?
- Fidelity (the duty to keep one's promises): How would the information gleaned about a client on a social networking site help promote trust?
- Nonmaleficence (the duty to do no harm): What harm might emerge from using social networking sites to find information about the client? How might this unintentionally harm the client?
- Autonomy (the individual's right to make his or her own decisions): How does the information found on a social networking site help to promote the client's ability to make his or her own choices about what to share or not in the clinical sessions? Will seeking information on the Internet without the client's consent violate autonomy and respect for the client?
- Justice (the duty to treat everyone fairly): How will the practitioner's being able to find information (or not) on a social networking site provide clues to the client's gender, race, sexual orientation, socioeconomic status, religion, ability, etc.? How might this information affect how the practitioner treats the client?

The same questions can be asked when practitioners use social networking sites to create profiles and post information. How might this information harm the client or jeopardize trust, credibility, and the working the relationship? If a practitioner is a supervisor, what issues of subtle coercion may arise [5]? Of course, each practitioner's behavior on social networking sites must be in accordance with the profession's ethical codes. Befriending a client or patient on a social networking site could potentially violate standards regarding multiple relationships or dual relationships [48].

Practitioners should use their self-reflective skills to ask themselves the following questions in order to guide the information they post on social networking sites [71; 95]:

- What information do you want to share?
  Is this information important, harmful, protected?
- Why do you want to share this information?
  What are the benefits and consequences of sharing the information?
- Who needs to see this information? Why?
- Where do I want to share this information?
- What professional boundary issues might "friending" someone pose?
- How might any "off-duty" conduct be perceived?
- How might a photo or post be taken out of context?
- How does my professional code of ethics or other organizational policies guide sharing this information?

E-MAIL DISTRIBUTION LISTS

The main ethical issues associated with e-mail distribution lists concern risks to confidentiality and privacy. Mass e-mail communications can be intercepted at four different points: prior to being e-mailed from the originating computer, during transmission, upon receipt, and when subpoenaed [24]. In one study, 10% of social workers reported having e-mailed something to the wrong person [97]. Some practitioners may utilize this technology to solicit professional consultation from their colleagues. If this is the case, they may describe a case in detail. Even if the client's name and specific identifying information are excluded, the details provided could increase the risk to violating confidentiality. This risk is further increased with the advent of data mining software, which can analyze and search e-mails for certain content or key words [23].

In addition, there is no insurance that the sender or receiver is the person whom they claim to be. A best practice to reduce these risks is to encrypt the e-mail, to alert the client that an e-mail will be sent, or to ask for a phone confirmation that the e-mail has been received [97].

One of the main applications of the ethical principle of respect for persons is informed consent. When seeking consultation from another colleague on the phone or face-to-face, practitioners obtain informed consent from their

clients; the same is true when using e-mail distribution lists for this purpose. Practitioners should inform clients they plan to use e-mail for the purpose of consultation and that certain details of the case will be provided. The potential for violations of privacy and confidentiality using this technology should be outlined [23].

CELL PHONES

Cell phones and smartphones are commonplace, and it is important to carefully consider the possible benefits and consequences before providing a personal cell phone number to a patient or client. First, conversations on cell phones cannot be guaranteed confidentiality, as it possible that the conversation will be intercepted by another device (e.g., baby monitor) [70]. Perhaps more importantly, cell phones can imply some level of personal familiarity that goes beyond the client/practitioner relationship [70]. Finally, giving a cell phone number may imply that the practitioner will be available at any time, including after professional hours. To create boundaries, practitioners may inform the client that messages will only be checked during work hours [97].

It is important to be upfront with clients regarding the use of a cell phone in order to clarify the policies and to obtain informed consent form [70]. Practitioners should explicitly discuss the circumstances under which a client may call the practitioner on his/her cell phone, when he/she would not be available, any additional fees involved, and the amount of time he/she will spend on the cell phone with the client.

BLOGS AND ONLINE DISCUSSION GROUPS

Concerns about privacy and confidentiality also apply to blogs and online discussions. Practitioners who write or comment on blogs must be sensitive to revealing personal identifiers of clients, which could violate practitioner/client confidentiality and privacy. Practitioners in the health fields should keep the Health Insurance Portability and Accountability Act (HIPAA) in the forefront of their minds when blogging or posting in online discussion groups. HIPAA privacy rules protect any identifiable health data, including any past, present, or future health information that can be used to identify an individual [49]. For example, a practitioner might blog about a difficult client who was treated at his or her workplace at a particular time and date [50]. Even if the client's name is not provided in the blog, if the blog author is not anonymous, it is possible that the workplace could be traced and the identity of the client linked back to the appointment book. Or a practitioner could post a message to his or her friends on a discussion board describing clinical experiences, but in doing so, express enough information about a client to be identifiable [49; 72]. It is also important to be careful of how clients or patients are depicted, including the tone and content of postings, so as not to threaten or damage the integrity of the professional field or discipline [51].

Conflict of interest is another ethical issue that may arise when using blogs or discussion boards. A practitioner should be cautious of openly endorsing any products or services. Some blogging software platforms, particularly free ones, automatically display advertisements along with the platform. It is vital to avoid dual relationships or have the appearance of having a conflict of interest with service providers. Some experts recommend limiting blog content to announcements about conferences, events, and professional organizations that represent the practitioner's field [26].

In a 2008 study involving 271 medical blogs, individual patients were described in 42% of the blogs, and 16.6% of these had sufficient identifiers, revealing the identity of physicians or patients [51]. The researchers found that 17.7% of the blogs depicted patients in a negative manner (by tone or content), and 11.4% contained product promotions, either by images or direct content. There is a definite need for practitioners to practice self-regulation and self-monitoring, carefully considering ethics and professionalism while blogging, so the ethical principles of respect for persons and beneficence are not compromised.

ONLINE SELF-DISCLOSURES

Much of science and medicine in Western culture is premised on the tenets of logical positivism, advocating for quantification and objectivity [52]. The psychology, counseling, mental health, and social work fields have followed suit, and as a result, paternalism has become the backbone of the patient/client and practitioner relationship. For example, the physician/patient relationship is typically characterized as hierarchical, with the physician viewed as the "expert." Many counseling and social work models, with the exception of feminist and humanistic orientations, similarly espouse this hierarchical relationship. Traditionally, practitioners are positioned as the "objective" experts, disclosing very little about themselves. In the Freudian tradition, therapists are supposed to present as a blank slate to reflect the client's image [79]. However, the extent to which practitioners self-disclose has changed with the growth of the Internet. With the prevalent use of Internet technologies, the client/patient is now an active consumer of health and mental health services, and they are more likely to use the Internet to research or share information about practitioners, services, and facilities [53]. Therefore, the question is not to what extent practitioners should disclose private information to their clients, but rather how to manage the Internet-driven self-disclosure that has become almost inevitable [54]. It is ultimately the practitioner's responsibility to develop the tone of the professional relationship [66]. Therefore, when disclosing information on social networking sites, the practitioner should take time to reflect on how it may affect the client and the therapeutic relationship.

There are three main types of self-disclosures, and the Internet can affect each of these types [53]:

- Deliberate self-disclosure: The practitioner intentionally discloses certain information, verbally or nonverbally. Internet examples include uploading a photo on LinkedIn, a professional social networking site, or posting information on a commercial website about one's professional background, training, and experiences.
- Accidental self-disclosure: Personal information about the practitioner is inadvertently revealed to the client. For example, a client sees his or her therapist at a boutique, which may reveal information that the practitioner had no plan of sharing. On the Internet, accidental self-disclosures can occur when clients inadvertently come across photographs of their practitioner in a non-professional setting or personal blog posts on a social networking site.
- Unavoidable self-disclosure: These types of revelations are not deliberate but are related to information conveyed by conducting the normal affairs of life. For example, wearing a wedding ring indicates one's marital status. Of course, one can argue whether this is deliberate or unavoidable. Again, photos uploaded on a website or a professional social networking account can reveal information that the practitioner has no control over.

There are two types of anonymity: visual anonymity and discursive anonymity [113]. Visual anonymity refers to a lack of physical or visual cues (e.g., a photo in an online profile) to provide the other party a sense of who is being represented online. Discursive anonymity refers to a lack of textual cues (e.g., use of an online pseudonym) to give a sense of who is being represented. It does not appear that type of anonymity affects the extent of online disclosure.

The most typical disclosures via Facebook profiles are of one's age, gender, education, and relationship status [98]. In the past, if a client asked about a practitioner's background, this could be used as an opportunity to understand the underlying dynamics of the client's interest. Ultimately, practitioners must be diligent in managing their images in both the face-to-face and Internet worlds. Issues of self-disclosure and transparency have moved outside the therapeutic encounter and onto the Internet, and online posts, blogs, threads in discussion forums, and mass e-mails will for the most part stay "alive" in the virtual world [54].

ONLINE SEARCHES FOR INFORMATION ON PATIENTS OR CLIENTS

Conducting online searches, commonly referred to as "Googling," is a common part of modern Internet use. Some practitioners engage in patient-targeted Googling, searching for a specific patient or client on the Internet [73]. In a 2014 study involving counseling graduate students, 75% reported using the Internet to search for information about a client, with 29.2% using Google and 19.5% using a social networking site. Of those who searched, more than 80% stated that they did not obtain informed consent from the client, did not document the search in the client's file, and did not consider this to be a confidentiality issue [73]. In a 2016 survey study, 39.4% of psychotherapists reported having looked online for additional information about their clients; 75% had not obtained client consent to do an online search [99].

There are cases in which patient-targeted Googling may have yielded fruitful clinical outcomes, such as locating family members of a patient with dementia after all other venues have been exhausted [73]. Searching online to obtain information about an individual's home has become a common Internet activity, but there may not be a place for such activity in the clinical encounter. It is vital for practitioners to draw a line between voyeurism and a clinical constructive goal [11; 73]. Although the Internet is considered public, for practitioners to make an active decision to search for additional information not given by the client may be a violation of his or her rights [74]. This continues to be an issue when considering what to do with information obtained online. If search results are documented in the client's record, it may impact their future care or insurance coverage [73]. In addition, it can undermine the therapeutic relationship and the client's trust in the practitioner and cause boundary issues [114]. Some experts assert that it may be inappropriate to search for online information about a client unless there is a clinical emergency [114].

The following questions may be useful when considering searching for client information on the Internet [94; 114]:

- Why do I want to conduct this search?
- How will the information obtained from the search affect engagement and treatment?
- Is an informed consent needed from the client before searching?

BEST PRACTICE GUIDELINES

In today's environment of technology and information proliferation, it is important to balance the amount of information available to clients and to carefully consider one's online persona as an extension of one's professional identity [55]. Practitioners must now actively manage their virtual identities and reputations. In order to do so, the following best practice guidelines have been established for practitioners when using Internet technologies for both personal and professional reasons.

The American College of Physicians and the Federation of State Medical Boards assert that standards for professional interactions should be consistent across all forms of communication, and care should be taken to preserve the relationship and maintain confidentiality, privacy and respect.

(https://www.acpjournals.org/doi/10.7326/0003-4819-158-8-201304160-00100. Last accessed April 25, 2021.)

Level of Evidence: Expert Opinion/Consensus Statement

USE PRIVACY FILTERS

When using social networking sites and/or blogs, practitioners should use a pseudonym, check their privacy filters, block certain personal information (e.g., birthdates, marital status, hometown), and research the restrictions in place for their online profiles in order to exercise control over who can access the information [79]. Most social networking sites and blog platforms have some kind of privacy filter available, but even when in use, clients may be able to view limited information (e.g., a profile picture). Practitioners should remember that privacy controls are subject to change at the discretion of the social media company [66]. Some experts recommend checking privacy settings every three to six months or with every software update [112].

POST CAUTIOUSLY

Practitioners should be cautious regarding posting client/patient information. The Internet has made the world smaller, and it is not difficult to trace the identity of the author of online postings. Furthermore, it is easy to inadvertently post information online that may violate a client's/patient's confidentiality and privacy [5]. Along these same lines, think twice about sharing personal information or photos online. The concept of digital footprints should be at the forefront of practitioners' minds. If any uploaded photos can be professionally compromising, they should not be posted. Consider the underlying message any information might convey [56; 112]. Certainly, photos that could endanger the privacy of clients or violate HIPAA rules should not be uploaded. Carefully weigh the costs and benefits of posting various information [46]. It is wise to assume that online forums are public, even if it says it is closed and private [100].

It is also important for practitioners not to use online platforms as mechanisms to vent about professional issues. Venting feelings of frustrations with clients, employers, supervisors, salaries, or an agency/organization are likely to be perceived negatively by colleagues and conveys a message of unprofessionalism [50; 115]. Reflect on how information posted on the Internet could undermine one's professional credibility as well as the legitimacy of the professional field [46].

THE "FRIEND" DILEMMA

As discussed, the issue of dual relationships is at the heart of deciding whether or not to accept patients/clients as "friends" on social networking sites [66]. The risks and the benefits should be weighed. If a patient or client invites a practitioner to be an online "friend," the practitioner can discuss dual relationships and the reasons why this is unprofessional and unethical; this request could become part of the clinical work [46; 47]. If the client becomes angry that the practitioner has "rejected" him or her or ignored the invitation, this could be discussed within the context of the client's previous experiences with loss, rejection, and self-esteem [97].

Consider crafting a professional statement about why accepting patients/clients as online friends is inappropriate. If this is an issue affecting your practice, spend time writing a standard statement to send to clients/patients regarding the professional policy not to accept clients as online friends [50]. This statement can be friendly but firm and should indicate the reasons it is not wise to establish this online relationship due to privacy and confidentiality issues. However, clients should be encouraged to discuss any issues with the practitioner during a scheduled session within the context of the therapeutic setting.

SEARCH WISELY

Practitioners should reflect on the underlying motivations for searching for client information on the Internet and how this information could be used positively. Therefore, searching for information about a client or patient is not necessarily unethical. Rather, consider how clients or the therapeutic relationship could ultimately be negatively affected by any information found and how the information can help the client [11; 46; 114]. In general, it is best to avoid searching for client information online.

However, practitioners should search for themselves on the Internet. Many professionals believe that everyone experiences some level of privacy through online obscurity, and in general, individuals take the path of least resistance in monitoring their online presence [57; 79]. This can be detrimental and may limit the practitioner's ability to control disclosures. Practitioners should conduct Internet searches regularly to monitor the information available about themselves and to have better control of the content [42]. Furthermore, if clients raise information they found on the Internet in a clinical session, this will prevent practitioners from being caught unaware.

SOCIAL MEDIA AND TECHNOLOGY IN INFORMED CONSENT

The content of informed consent forms should reflect the changing technologic times. The following points should be incorporated into informed consent forms [70; 72; 75; 79; 107]:

- How cell phones, e-mails, and social media will be used with the patient/client
- Whether the practitioner will search for information about the patient/client on the Internet
- How the practitioner will respond if contact is made by the patient/client on a social media site
- If the practitioner will take cell phone calls and, if so, parameters for use
- Whether there will be additional fees if the client makes contact with the practitioner via phone, e-mail, and/or social networking site
- Whether therapeutic issues will be discussed via e-mail
- If the practitioner does respond via e-mail, expected response turnaround time
- Risks and benefits of clients using social media within the therapeutic context

CONCLUSION

The landscape of professional practice has changed with the increasing use of Internet technology by both practitioners and clients/patients. The opportunities that the Internet affords are endless, and practitioners should reflect on how information posted online can have implications on their professional practice and their relationships with clients/patients. The codes of ethics and professional standards may not have necessarily kept up with the technologic changes, and therefore, there may not be clear guidelines on how to behave online. Ultimately, more education is needed for professionals entering the fields to prepare to make the complex ethical decisions they will face using new technologies. Clinical supervisors should initiate conversations with their supervisees regarding how online personas and identities can affect professional identities, credibility, and roles. Finally, psychologists, social workers, counselors, therapists, physicians, and nurses must take an active role in shaping the development of professional standards for the provision of services in the new online environment, conforming to the ethical and professional best practices in their respective fields.

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 28–29.

TEST QUESTIONS
#97663 ONLINE PROFESSIONALISM AND ETHICS

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 clock hour activity must be completed by April 30, 2024.

1. Which of the following statements regarding older adults' use of social networking sites is TRUE?
- A) *They have social networking accounts for professional reasons only.*
- B) *They tend not to use social networking sites at all due to their fear of technology.*
- C) *They are using Facebook more and more, with 50% using this platform in 2021.*
- D) *They comprise the largest proportion of users among the adult population in the United States.*

2. A chatroom or chat group is a virtual community or venue in which a group of individuals can "dialogue" and share information about a common interest.
- A) *True*
- B) *False*

3. Which web tool is analogous to an online journal, generally consisting of a log of chronologic entries?
- A) *Blog*
- B) *E-mail*
- C) *Chatroom*
- D) *Social networking site*

4. All of the following are social networking sites, EXCEPT:
- A) *TikTok*
- B) *YouTube*
- C) *Facebook*
- D) *Wikipedia*

5. Which of the following is a way Internet technologies can be used for clinical practice?
- A) *Provide patient support*
- B) *Self-help or self-therapy*
- C) *Dissemination of information*
- D) *All of the above*

6. Because social support is an essential factor in helping people cope with medical conditions, social networking may be an important tool.
- A) *True*
- B) *False*

7. PatientsLikeMe is an example of a
- A) *blog.*
- B) *mass e-mail list.*
- C) *social networking site.*
- D) *None of the above*

8. The development of a practitioner's professional identity begins and ends with his or her first job.
- A) *True*
- B) *False*

9. Professionalism is characterized by
- A) *a personal high standard of competence.*
- B) *a frame of reference for carrying out work roles.*
- C) *the application of general principles to specific problems.*
- D) *the developmental process of a practitioner's professional identity.*

10. E-professionalism is a set of online attitudinal and behavioral standards that conforms to the expectations and values of a profession.
- A) *True*
- B) *False*

11. An analysis of the codes of ethics of diverse professions classified professional codes of ethics into four domains, including
- A) *the professional's qualities and characteristics*
- B) *behaviors toward other professionals and colleagues*
- C) *behaviors of professionals in a range of situations*
- D) *All of the above*

12. The boundaries of the client-practitioner relationship will get blurred as online friendship interactions can lead to sharing of private information on the part of both parties.
A) *True*
B) *False*

13. Accepting a client's request to befriend him/her on a social networking site could potentially violate standards regarding
A) *online addiction.*
B) *dual relationships.*
C) *transference issues.*
D) *diminishing intentionality.*

14. What is the main ethical concern associated with using e-mail distribution lists for consultations?
A) *Risks to veracity*
B) *Risks to intentionality*
C) *Risks to the principle of justice*
D) *Risks to privacy and confidentiality*

15. Cell phones can imply some level of personal familiarity that goes beyond the client/practitioner relationship.
A) *True*
B) *False*

16. Which of the following is NOT a type of self-disclosure?
A) *Deliberate*
B) *Accidental*
C) *Accounted*
D) *Unavoidable*

17. If a healthcare professional has a website on which his or her educational background, licensures, and professional experience is described, what type of disclosure does this represent?
A) *Personal*
B) *Deliberate*
C) *Accidental*
D) *Unavoidable*

18. The most typical disclosures via Facebook profiles are of religious and political affiliations.
A) *True*
B) *False*

19. Which of the following is NOT considered a best practice guideline when managing one's virtual identity?
A) *Search for one's self on the Internet.*
B) *Use a privacy filter on online profiles.*
C) *Use online platforms as mechanisms to vent about professional issues.*
D) *Create a professional statement explaining why accepting patients/clients as online friends is inappropriate.*

20. Professionals should consider crafting a professional statement about why accepting patients/clients as online friends is inappropriate.
A) *True*
B) *False*

Be sure to transfer your answers to the Answer Sheet located between pages 28–29.
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.

An Introduction to EMDR and Related Approaches in Psychotherapy

6 Clinical Clock Hours

Audience
This course is designed for social workers, counselors, and therapists who are interested in incorporating EMDR-related approaches into their work with clients.

Course Objective
The purpose of this course is to provide an overview of the EMDR approach to treatment of trauma-related psychopathology in order for clinicians to evaluate its appropriateness for their clients.

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

1. Define trauma and explain the manifestation of unhealed trauma on the human experience, as conceptualized by the eye movement desensitization and reprocessing (EMDR) approach to psychotherapy and its adaptive information processing (AIP) model.
2. Explain how EMDR was discovered and developed by Francine Shapiro, making connections to the overall healing role of bilateral stimulation in the human experience.
3. Outline components of the AIP model.
4. Describe, in a general sense, how EMDR works to help a person stabilize, reprocess, and reintegrate after a traumatic experience(s).
5. Discuss the variations in how EMDR is used by clinicians in the modern era.
6. Distinguish what makes an intervention purely EMDR therapy versus an EMDR-related intervention.
7. Summarize the characteristics of candidates for EMDR therapy and related approaches.
8. Describe how to implement a basic "tapping in" strategy for client stabilization (an EMDR-informed intervention).
9. Discuss how to conduct a trauma history/assessment on a client using principles of the AIP model.
10. Decide whether or not further training in EMDR or an EMDR-related intervention is a good fit for one's own clinical repertoire.

Faculty
Jamie Marich, PhD, LPCC-S, LICDC-CS, REAT, RYT-500, RMT, (she/they) travels internationally speaking on topics related to EMDR therapy, trauma, addiction, expressive arts, and mindfulness while maintaining a private practice and online education operation, the Institute for Creative Mindfulness, in her home base of Warren, OH. She is the developer of the Dancing Mindfulness approach to expressive arts therapy and the developer of Yoga for Clinicians. Dr. Marich is the author of numerous books, including EMDR Made Simple, Trauma Made Simple, and EMDR Therapy and Mindfulness for Trauma Focused Care (written in collaboration with Dr. Stephen Dansiger). She is also the author of Process Not Perfection: Expressive Arts Solutions for Trauma Recovery. In 2020, a revised and expanded edition of Trauma and the 12 Steps was released. Two additional books are scheduled for publication in 2022: The Healing Power of Jiu-Jitsu: A Guide to Transforming Trauma and Facilitating Recovery and Dissociation Made Simple. Dr. Marich is a woman living with a dissociative disorder, and this forms the basis of her award-winning passion for advocacy in the mental health field.

Faculty Disclosure
Contributing faculty, Jamie Marich, PhD, LPCC-S, LICDC-CS, REAT, RYT-500, RMT, 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

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

Division Planner/Director Disclosure
The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Accreditations & Approvals
As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. NetCE maintains responsibility for this course.

NetCE is recognized by the New York State Education Department's State Board for Social Work as an approved provider of continuing education for licensed social workers #SW-0033.

This course is considered self-study, as defined by the New York State Board for Social Work. Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of licensed master social work and licensed clinical social work in New York. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice for an LMSW and LCSW. A licensee who practices beyond the authorized scope of practice could be charged with unprofessional conduct under the Education Law and Regents Rules.

Designations of Credit
Social Workers participating in this intermediate to advanced course will receive 6 Clinical continuing education clock hours.

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 #159001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168000190.

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.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement
It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

How to Receive Credit

- Read the following course.
- Complete the test questions at the end of the course.
- Return your Customer Information/Answer Sheet/Evaluation and payment to NetCE by mail or fax, or complete online at **www.NetCE.com/SW22B**.
- A full Works Cited list is available online at www.NetCE.com.

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

Eye movement desensitization and reprocessing (EMDR) is an approach to psychotherapy that continues to grow in popularity and utility with a variety of clinical populations. In this continuing education course, participants will receive an orientation to EMDR and how it is being used in a variety of clinical settings. Although not intended to be a full training course in EMDR, the course will provide a full explanation of how the therapy works and how the EMDR approach conceptualizes the impact of trauma on the human experience. As a result, some related techniques and clinical case conceptualization skills can be derived from the course, even if the reader is not fully trained in EMDR.

FOUNDATIONS: EMDR AND TRAUMA

In order to understand EMDR, it is first important to understand what trauma means and how unhealed trauma impacts human behavior. This section will briefly define and discuss what trauma means. From this general discussion, the section progresses to discuss the history of EMDR and explain how Dr. Francine Shapiro formally discovered and developed it. Although more detail about this process will inevitably be visited throughout the course, the basics are provided in this section. Then, the model that Dr. Shapiro developed based on her early work with EMDR, the adaptive information processing (AIP) model, will be examined. The AIP model provides a framework through which one can more precisely define trauma and the role unhealed trauma plays in shaping the human experience. It also provides a pathway for healing trauma using the mechanism of reprocessing. The AIP model may be valuable to clinical work whether or not EMDR therapy is used.

A BRIEF PRIMER ON TRAUMA

Trauma derives from the Greek word *traumatikos*, meaning wound. In a broad sense, trauma simply refers to human wounding, be it physical, emotional, verbal, sexual, spiritual, or in any other domain of human existence. When professionals discuss issues of trauma, it is rare to hear the same definition offered twice. The helping professions have done so much over the years to make the definition technical and clinical, yet many find it useful to keep the conceptualization of trauma as simple as possible: trauma refers to human wounding that has not yet been healed or otherwise addressed.

The American Psychological Association defines trauma as [1]:

> ...an emotional response to a terrible event, like an accident, rape, or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives.

This meaning, although useful as a technical operations definition, comes with limitations. First, for many survivors, trauma is not just a one-time event, it is a series of experiences, like growing up in poverty or as part of an oppressed group, with too many "events" to even name. Second, trauma manifests in different ways for different people contingent upon a variety of contextual factors. Thus, attempting to condense it into a single definition often seems forced and sterile. Bessel van der Kolk, MD, refrains from giving a standardized, set definition of trauma in his book *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. He does offer that [2]:

> Trauma, by definition, is unbearable and intolerable. Most rape victims, combat soldiers, and children who have been molested become so upset when they think about what they experienced that they try to push it out of their minds, trying to act as if nothing happened, and move on. It takes a tremendous amount of energy to keep functioning while carrying the memory of terror and the shame of utter weakness and vulnerability.

FRANCINE SHAPIRO AND THE DISCOVERY OF EMDR

There is a clear link between unhealed trauma and symptoms manifesting in the body. Dr. Shapiro began her work with mind-body medicine connections as far back as the late 1970s, as a result of her own experiences with cancer recovery. As Dr. Shapiro explains in her story of how her serendipitous discovery in a park one day led her to develop what would become EMDR, she was always experimenting on herself. In a 2011 documentary, Shapiro explained that as she was walking, she noticed that some distressing thoughts, the types of thoughts that you would normally have to bring up and consciously engage, began to disappear. Shapiro, in the spirit of mindfulness, kept paying attention, and when a type of disturbing thought came up she noticed that her eyes started moving back and forth. After her series of spontaneous eye movements, she recalled the thought and noticed that it did not have the same charge as before. This ushered in a process of experimenting on herself, her colleagues, and willing volunteers; what emerged were the initial procedures of eye movement desensitization, or EMD [3; 4].

Shapiro's initial working hypothesis was that she stumbled into a simple desensitization technique, something that essentially tapped into rapid eye movement (REM) sleep in an awakened state. The *Journal of Traumatic Stress Studies* published her first formal research, a randomized controlled study, in 1989 [5]. Shortly after that publication, she added the concept of reprocessing to create EMDR. As she continued to develop her work, she noticed that the procedures elicited free associations that allowed people to process memories or other remnants of painful experiences that were not processed at the time of the memory. Hence the use of the term reprocessing instead of just processing. In 1990, a visually impaired individual presented for treatment and thus could not easily track eye movements. At that point, many in the field had already begun referring to EMDR as the "finger-waving technique" (usually in a pejorative sense) to reference the procedure used to guide clients to move their eyes back and forth. Although the eye movements happened spontaneously in her initial walk of discovery, she induced them purposefully in others by moving her hand across a person's plane of vision. This blind individual could not easily track eye movements, so Shapiro and those close to her began experimenting with alternative forms of creating bilateral stimulation. A device was created to generate audio tones that alternated back and forth, and they also discovered that tapping alternately on the individual's legs could produce similar effects. Although eye movements remain the most researched mode for creating the bilateral stimulation, actual eye movements are not required to do EMDR. Indeed, many individuals who present for treatment prefer the audio tones or the various forms of tactile stimulation to fully engage in the process. This will be discussed in detail later in this course.

EMD, and later EMDR, was initially met with a great deal of skepticism by the psychotherapeutic professions in general. Shapiro hypothesizes that many academics criticized what she was doing because clinicians were so enthusiastic about it. As clinicians, and later those with academic credibility, began to discover how the approach seemed to offer an answer to healing traumas where traditional talk methods had been failing, EMDR began to attract more believers. Although skepticism about EMDR remains to this day, it is becoming increasingly more mainstream within the helping professions due to the growing body of research supporting its efficacy. In discussing preferred treatments for post-traumatic stress disorder (PTSD) in the modern era, EMDR is typically listed alongside the more traditional approaches, such as cognitive-behavioral therapy (CBT) and prolonged exposure. In 2013, the World Health Organization (WHO) guidelines for trauma care identified trauma-focused CBT and EMDR therapy as the only psychotherapies recommended for children, adolescents, and adults with PTSD [6]. Before 2016, EMDR appeared on the National Registry of Evidence-Based Programs and Practices (NREPP), a list published by the Substance Abuse and Mental Health Services Administration (SAMHSA) following rigorous research and review. The NREPP was discontinued in 2018 and was replaced by the Evidence-Based Practices Resource Center [7; 8; 9]. A plethora of clinical bodies worldwide, including the American Psychiatric Association, the American Psychological Association, and the International Society for Traumatic Stress Studies, have listed EMDR on their best practices or highly efficacious lists in the treatment of PTSD since the early 2000s [10].

interactive activity

Show Me the Research

Interested in reviewing the specific research that led to EMDR being widely accepted? The Francine Shapiro Library, available at https://www.emdr.com/francine-shapiro-library, catalogues everything that has ever been published on EMDR—positive, negative, or neutral. Scholarly, clinical, and popular articles/other resources are represented in this database.

In several publications and interviews, Dr. Shapiro has conveyed that EMDR is a bit of a clunky name, indicative of the therapy in its original form. In an interview with Dr. Shapiro, she revealed that today she would name it something like "reprocessing therapy" [3]. As will continue to be highlighted throughout this course, eye movements are not essential to EMDR therapy, but Shapiro explains that she chose to keep the name EMDR for historical reasons.

As of 2014, Dr. Shapiro is advocating those who practice, research, and write about EMDR to begin using the term EMDR therapy instead of just EMDR. For her, it is important to distinguish that the simple technique has evolved into a distinct approach to psychotherapy that deserves to be discussed in the same way as CBT and other approaches referred to as therapy. The WHO definition of EMDR in their practice guidelines clearly uses the language to describe EMDR as a distinct approach to psychotherapy [6]:

> [EMDR] therapy is based on the idea that negative thoughts, feelings, and behaviors are the result of unprocessed memories. The treatment involves standardized procedures that include focusing simultaneously on (a) spontaneous associations of traumatic images, thoughts, emotions, and bodily sensations and (b) bilateral stimulation that is most commonly in the form of repeated eye movements. Like CBT with a trauma focus, EMDR aims to reduce subjective distress and strengthen adaptive beliefs related to the traumatic event. Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework.

ADAPTIVE INFORMATION PROCESSING: TRAUMA AND THE EMDR APPROACH

The existence of a model that distinguishes EMDR from other forms of psychotherapy is one of the reasons that EMDR merits distinction as a type of therapy. The model Shapiro developed was originally called the accelerated information processing model, now referred to as the adaptive information processing (AIP) model. In a 2014 communication to the members of the EMDR International Association (EMDRIA), Shapiro made the correlation that CBT, psychodynamic therapy, and EMDR therapy have unique foundations of pathology and approaches to treatment (***Table 1***) [11].

The AIP is a model, not a theory, although upon reviewing earlier information processing models published in the 1950s and 1960s, one can see clear roots in behaviorist theory. Originally published in the second edition of Shapiro's textbook *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures*, the AIP model has gone through various permutations in semantics and points of emphases. The basic hypotheses of the AIP model, as published by the EMDRIA, are [12]:

- The neurobiologic information processing system is intrinsic, physical, and adaptive.
- This system is geared to integrate internal and external experiences.
- Memories are stored in associative memory networks and are the basis of perception, attitude, and behavior.
- Experiences are translated into physically stored memories.
- Stored memory experiences are contributors to pathology and to health.
- Trauma causes a disruption of normal adaptive information processing, which results in unprocessed information being dysfunctionally held in memory networks.
- Trauma can include Criterion A events, as defined in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), and/or the experience of neglect or abuse that undermines an individual's sense of self-worth, safety, ability to assume appropriate responsibility for self or other(s), or limits one's sense of control or choices.
- New experiences link into previously stored memories, which are the basis of interpretations, feelings, and behaviors.
- If experiences are accompanied by high levels of disturbance, they may be stored in the implicit/nondeclarative memory system. These memory networks contain the perspectives, affects, and sensations of the disturbing event and are stored in a way that does not allow them to connect with adaptive information networks.
- When similar experiences occur (internally or externally), they link into the unprocessed memory networks and the negative perspective, affect, and/or sensations arise.
- This expanding network reinforces the previous experiences.
- Adaptive (positive) information, resources, and memories are also stored in memory networks.
- Direct processing of the unprocessed information facilitates linkage to the adaptive memory networks and a transformation of all aspects of the memory.
- Nonadaptive perceptions, affects, and sensations are discarded.
- As processing occurs, there is a posited shift from implicit/nondeclarative memory to explicit/declarative memory and from episodic to semantic memory systems.
- Processing of the memory causes an adaptive shift in all components of the memory, including sense of time and age, symptoms, reactive behaviors, and sense of self.

The roots of Shapiro's training as a behavioral psychologist are evident in this model, which is now well-known to EMDR therapists. The Gagné model is the earliest in behavioral theory resembling the AIP model [13]. In her work, Shapiro specifically cites models by Peter Lang, Stanley Rachman, Gordon Bower, Edna Foa, and Michael Kozak as forerunners to the AIP.

The AIP model recognizes that humans learn things, either about themselves or their surrounding world, as a result of traumatic experience. When trauma remains unprocessed, so do these trauma-charged pieces of information, and there is an evitable effect on output (e.g., how we feel, how we think, how we act). For example, if the traumatic experience(s) leaves a cognitive imprint of "I'm not good enough," this is likely to manifest in other areas of human experience. Consider how the belief "I'm not good enough" might play out emotionally, somatically, or even spiritually. A solid course of reprocessing (such as with EMDR therapy) allows the maladaptively stored belief ("I'm not good enough") to shift to a more positive, natural opposite ("I am good enough"). It is not enough for the belief to be confronted. Many patients who have had therapy before know what their negative beliefs are and may even know what they should believe, but the shift has not internalized [14].

For people who continue to manifest distress at an emotional, somatic, and/or spiritual level, the processing work should incorporate these other channels. As explained in the AIP model, unprocessed components or manifestations of memory can be stored in a variety of states—visual, cognitive, sonic, emotional, somatic, existential, or a combination [15]. These states can transform during processing to an adaptive resolu-

FOUNDATIONS OF PSYCHODYNAMIC THERAPY, CBT, AND EMDR THERAPY		
Therapy	**Foundation of Pathology**	**Treatment**
Psychodynamic therapy	Intrapsychic conflicts	Transference/verbal "working through"
CBT	Dysfunctional beliefs and behaviors	Direct procedural manipulations of beliefs and behaviors
EMDR therapy	Unprocessed psychologically stored memories	Accessing and processing of memories, triggers, and future templates
Source: [11]		*Table 1*

tion. Information processing transmutes information through all accessed channels of memory. For Shapiro, the modality of choice is EMDR therapy, but there are many other ways to process "stuck" information. The key is determining where a person is still "stuck" and accessing that channel. For many clients, the cognitive work has been done, but the emotional, somatic, or existential work still needs to be completed [14].

There is a great deal in the AIP model that can be useful to a general understanding of trauma and how, when it remains unhealed, it inevitably impacts human behavior. There are many ways to engage in processing to an adaptive resolution. Examples include drumming, dancing, praying, meditating, writing, creating, sharing with others, and receiving bodywork. In Shapiro's view, because EMDR therapy calls upon so many components of the human experience (e.g., thinking, feeling, sensing, remembering, believing, seeing, hearing) in its standard protocol, it is the ideal way to process maladaptively stored traumatic memories to an adaptive resolution. The specifics of the protocol and how it calls upon these elements to set up EMDR work will be discussed in detail later in the course.

Perhaps the most significant concept that clinicians beyond EMDR have drawn from in Shapiro's AIP work is the taxonomy of large-T and small-t trauma. Shapiro developed EMDR and the AIP model in the era of the DSM-III and DSM-IV, in which the qualifying traumas for a diagnosis of PTSD generally needed to be threats to life or limb (or perceived to be), referred to as Criterion A traumas. Hence, large-T traumas, or events that most people would find upsetting (e.g., war, natural disaster), are essentially Criterion A traumas. Although many clinicians still consider the large-T/small-t taxonomy useful, Shapiro has moved away from this original distinction, now opting for the term "adverse life experiences" [11]. These adverse life experiences may or may not qualify for a DSM-5 diagnosis of PTSD. It is important to note that it was never intended for people to use the large-T/small-t system as a value judgment; small-t trauma can be just as valid and just as clinically significant as large-T trauma [15]. The hope is that using the term "adverse life experiences" will keep inadvertent value judgments from taking place.

The DSM-5 significantly expanded the definition of Criterion A trauma. In the DSM-IV-TR, Criterion A trauma required there to be some threat to physical integrity or life. In the DSM-5, witnessing a traumatic experience (real or threatened) happen to someone else also qualifies, as does violent or accidental death (real or threatened) to a family memory or close friend. Sexual assault and certain cases of vicarious traumatization connected to work experiences also now qualify as Criterion A [16]. Although the presence of a Criterion A trauma is a necessary qualification for a diagnosis of PTSD, not all persons who experience Criterion A trauma will develop PTSD.

Newer versions of the AIP model reflect this shift away from the "small-t trauma" language. This nomenclature is preferable, especially in cultures (e.g., military, public safety) in which a "traumatized" label may come with stigma. Additionally, even though Shapiro's initial conceptualization of large-T and small-t trauma was a significant advancement in how trauma is viewed, many perceived these distinctions as value judgments, with the implication that large-T traumas are automatically worse than small-t traumas. However, it is clear that small-t traumas can be just as damaging and just as clinically significant as the large-T traumas that would qualify for PTSD.

Shapiro's introduction of the small-t concept (now adverse life experiences not meeting the criteria for PTSD) was a revolutionary step forward in how trauma is conceptualized. It is now accepted that trauma does not have to qualify for PTSD or fit DSM Criterion A for it to be life-changing or even clinically significant. Shapiro defined these adverse life experiences as upsetting life events that may prove difficult to heal and integrate into one's larger experience [15]. This can include a variety of experiences, including racial or ethnic discrimination, verbal abuse, bullying, divorce, a medical crisis, spiritual abuse, mind control, emotional blackmail, or loss of a pet. While these traumas may not have the life-threatening connotation of Criterion A, they can be life-altering. If a person is not able to process or make sense of an experience due to a variety of reasons, these traumas can be just as damaging [14].

Many clients struggle with these types of adverse life experiences, believing that if they did not experience a major disaster, then their trauma is somehow less legitimate or significant. Professionals and family members may reinforce this devastating belief by comparing traumas and oppressions. There will always be critics who reject the "small-t trauma" concept, dismissing such events as not traumatic and as an essential part of the human experience. It is important to remember that experiencing a trauma is not pathologic, but when traumas are unresolved and unhealed, problems can ensue. People whose lives are affected by unprocessed adverse life experiences have every right to access treatment, regardless of whether the experiences are considered Criterion A, especially psychotherapy and other psychosocial interventions that can help them to heal [14].

Several mental health conditions may be explained or exacerbated by unresolved adverse life experiences that do not meet the criteria for PTSD diagnosis. The links between major depressive disorders, persistent depressive disorder, and various anxiety disorders and earlier, unprocessed life experiences are apparent. Even personality disorders, long regarded as difficult to treat, may be better conceptualized in light of the pervasive impact of unresolved trauma on childhood development. In the book *The Angry Heart: Overcoming Borderline and Addictive Disorders*, Joseph Santoro suggests that borderline personality disorder is a manifestation of complex PTSD [17]. Many of the Cluster B personality disorders develop in individuals who experienced profound trauma in childhood, usually a combination of Criterion A traumas and adverse life experiences not meeting this standard [14].

DEFINING EMDR

DEMYSTIFYING BILATERAL STIMULATION AS A HEALING MECHANISM

Before exploring how EMDR is believed to work, it is important to examine how bilateral stimulation, in general, can provide healing to the brain. There are countless examples of how bilateral stimulation is accessed in nature for healing or other positive mechanisms of action. Cultures around the globe have used bilateral processes, specifically drumming and dancing, for millennia. Bilateral stimulation refers to any alternating, back-and-forth movement. As discussed, Shapiro initially developed EMDR with bilateral eye movements following her serendipitous discovery, although she soon discovered that alternating taps on the legs, hands, or with the feet, or bilateral audio tones could produce a similar effect. Many believe that EMDR accesses a natural healing mechanism (i.e., bilateral stimulation) that exists within the brain.

There is evidence in world literature, history, and anthropology indicating that others before Shapiro noticed the effects of bilateral stimulation, especially in cultures where dancing and drumming have been used for centuries as a way to release distress [18]. The books and poems of Native American author Sherman Alexie document how tribes have utilized dance, an activity of tactile bilateral stimulation, to cope with distress and heighten performance for centuries [19; 20]. Kyra Gaunt documented how generations of African American girls have used clapping games, double-dutch jump rope, and other bilateral rhythmic activities to transition into adulthood [21]. Massage therapists also use bilateral stimulation quite a bit. For instance, a massage therapist will often alternate pressure from shoulder to shoulder or from hip to hip.

Bilateral stimulation is everywhere. Walking is bilateral stimulation, as is running, swimming, and dancing. As Linda Curran observed in *Trauma Competency* [22]:

> Bilateral stimulation is not dangerous, nor is EMDR as a modality. If it were, wouldn't it follow that we should all abreact when walking, snapping our fingers, or playing Miss Mary Mac? However, when administered by clinicians without prerequisite knowledge to effectively address and treat trauma's sequelae, the EMDR protocol proves challenging, fear-inducing, and oftentimes, traumatizing for clinicians and re-traumatizing for clients.

Although clients may never have heard of EMDR, they may have adopted bilateral "techniques" to help alleviate stress, such as tossing an item from hand to hand or watching a swaying object. EMDR builds on these seemingly innate tendencies for therapeutic benefit.

EMDR AND THE BRAIN

A precise, scientifically infallible explanation of how exactly EMDR works to help people process trauma within the human brain is still lacking. However, such a delay in precise knowledge does not negate the validity of the evidence for EMDR's efficacy. For example, it took 40 years after the discovery of penicillin's antibacterial action before the medical community was able to exactly explain how it works at a biologic level [2]. It is possible to offer a general profile of what is believed to happen in the brain during EMDR therapy. First, it is important to offer a rudimentary explanation of how unhealed traumatic experiences are stored in the human brain. Then, the course will provide a discussion of what the extant literature and research reveal about how EMDR therapy and related information assists with processing these experiences.

For survivors of trauma, the twists and tangles in the neuronetworks of the brain exist within the lower levels: the limbic brain and the brain stem. In working with trauma, the most basic concept to grasp, based on MacLean's triune brain model, is that the human brain is composed of three separate brains, each with its own separate functions and senses of time (e.g., the R-complex brain or brainstem, the limbic brain, and the cerebral brain or neocortex) [23]. While this model's use in terms of neuroanatomic evolution is considered by some to be outdated or oversimplified, it is useful as a purely explanatory tool. It describes the brain structure in a manner that is easy to understand and use as a conceptualization for treatment planning [23]:

- The R-complex brain (reptilian brain): Includes the brainstem and cerebellum. It controls reflex behaviors, muscle control, balance, breathing, and heartbeat, and is very reactive to direct stimulation.
- The limbic brain: Contains the amygdala, hypothalamus, and hippocampus. It is the source of emotions and instincts within the brain, including attachment and survival. When this part of the brain is activated, emotion is activated. According to MacLean, everything in the limbic system is either agreeable (pleasure) or disagreeable (pain/distress), and survival is based on the avoidance of pain and the recurrence of pleasure.
- The neocortex (or cerebral cortex): Contains the frontal lobe and is unique to primates. The more evolved brain, it regulates executive functioning, which can include higher-order thinking skills, reason, speech, meaning, and sapience (e.g., wisdom, calling on experience).

Humans rely on all three brains to function. Thus, optimal processing of information would require all three brains to harmoniously operate to facilitate this essential processing. When the regulatory capacities of the limbic brain are impaired, it works longer and harder than it was ever intended to, causing the symptoms associated with traumatic stress.

interactive activity

In a CBS affiliate news story, psychiatrist Daniel Amen, MD, speaks with a survivor of complex trauma shortly after he completes a brain scan. Amen explains to this patient, an adult child of a parent with alcohol use disorder, a veteran of the first Gulf War, and a recent survivor of an accident, "Your brain is working too hard." This phrase simply and elegantly explains how the brain, especially the limbic brain, is affected by unresolved trauma. This clip, which also serves as a three-minute orientation to EMDR, may be viewed here: https://www.youtube.com/watch?v=zBtqWrs2-K0.

The goal of successful trauma processing is to move or to connect the charged material from the limbic brain into a part of the brain that is more efficient in its long-term storage capacities. Most persons working in the psychologic professions have cared for a person in crisis at one point or another, often encouraging the person to "leave the past in the past" and "focus on the now." These interventions are often a default because so much of the training in the helping professions is cognitively focused, making it natural for those with traditional training to confront a person's negative thinking or attempt to persuade a person to see the positive spin in any negative situation. This approach is often unsuccessful, perhaps because it only engages the neocortex, not the entire brain. It is the limbic region of the brain, activated during the original trauma to help the person survive (through flight, fight, or freeze to submission), where the unprocessed material remains. Because the left frontal lobe is "turned off" (i.e., no blood flow) and the right frontal lobe is "abandoned" (i.e., awareness but lack of ability to process) during trauma, the individual is unable to link the limbic activation with frontal lobe functions during the experience. For a person in crisis or intense emotional distress, this process is playing out in real time and/or triggers from earlier, unprocessed experiences fuel the distress.

As noted, for optimal healing to occur, all three brains must work together; unprocessed trauma creates disconnection in the brain. Any movement-based or body-based intervention automatically works with the limbic and reptilian brains, and this activation can be valuable in accessing and processing traumatic life experiences.

The bilateral processes involved with EMDR, whether they are eye movements, audio tones, or tactile motions, stimulate all three brains. In 2014, Pagani, Hogberg, Fernandez, and Siracusano published a comprehensive summary on all of the imaging and other biologic monitoring studies conducted on EMDR therapy to date [24]. EMDR-related neurobiologic changes were monitored by electroencephalogram (EEG) during therapy sessions and showed a shift of the maximal activation from emotional limbic to cortical cognitive brain regions—the first documented finding of its kind. Neuroimaging investigations of the effects of psychotherapies treating PTSD, including EMDR therapy, have reported findings consistent with modifications in cerebral blood flow on single photon emission computed tomography, in neuronal volume and density (on magnetic resonance imaging), and in brain electric signal on EEG. This validates the belief that the mechanisms of EMDR therapy promote positive shifts in where traumatic memories are stored in the brain. Some hypothesize that long-term positron emission tomography scan studies will reveal how EMDR works to heal the traumatized brain [24].

HOW EMDR IS CONDUCTED

As discussed, Shapiro clearly views the present state of her discovery as a separate and distinct form of psychotherapy with a theoretical model as a guide and distinct phases. The EMDRIA maintains a standing definition of what constitutes EMDR that is very closely aligned with Shapiro's ideas. There are several different types of protocols required for therapy to be considered EMDR [15]. In the broadest sense, the protocol refers to Shapiro's eight-phase model of EMDR treatment: client history, preparation, assessment, desensitization, installation, body scan, closure, and re-evaluation.

Client History

In EMDR therapy, client history is similar to the intake/assessment procedure that is used in all forms of psychotherapy. In this phase, the clinician takes a basic client history, a relationship begins to be established, and the clinician ultimately determines if EMDR treatment is appropriate for the client. An AIP-informed approach should be used in the gathering of this history.

Preparation

The second phase, preparation, continues the development of the therapeutic alliance and integration of exercises designed for client stabilization. These can include, but are not limited to, guided visualizations like the "safe place" exercise. Generally, the more complex the client, the more preparation will be needed. The essential goal of this phase is to ready the client for deeper work on the traumatic memories/issues in phases three through six.

Assessment

The assessment phase involves determining the target(s) of EMDR processing. In EMDR training, clinicians learn a series of questions that compose a targeting sequence. (This is covered more fully later in this course.)

Desensitization

Desensitization consists of the application of bilateral stimulation sets after establishing the targeting sequence, designed to shift the traumatically stored material into more adaptive states. The time that one spends in desensitization (i.e., the number and length of bilateral stimulation sets) varies from client to client. Some clients can work through desensitization of a targeting sequence in one session, and others need several sessions. If desensitization is not completed within an allotted session, phase seven should be done before ending the appointment; the next session may be reopened with phase three.

Installation

Installation follows successful processing of the targeted memory or issue, working with the positive belief states or other positive shifts a person's desensitization has allowed. The same bilateral stimulation process is used to install, or promote integration of, these more positive states.

Body Scan

In the sixth phase, the client should check in with any shifts that have occurred in his or her body as a result of the desensitization and installation. If the body scan is relatively clear, one moves on to the next phase. If some distress or disturbance remains at a body level, more desensitization is necessary; the memory or issue likely did not process deeply enough. This should continue until the body scan is relatively clear. The body scan is a technique used in many mind-body practices (e.g., mindfulness meditation) and was adapted by Shapiro for use in the EMDR protocol.

Closure

Closure consists of the procedures that a client and clinician implement to bring a session to a place where the client feels calm enough, especially at the affective/somatic level, to leave a session. These procedures may include exercises and strategies developed in the preparation phase.

Re-Evaluation

The final phase, referred to as re-evaluation, involves continuing to monitor client progress after a successful processing through of a targeting sequence. Together, the client and clinician determine the other targets that may need to be addressed in order for the client to achieve his or her goals (in which case the EMDR therapy cycles back through phases three through seven). The re-evaluation process can also include the target of future templates or scenarios connected to the work done in previous phases. Re-evaluation, in theory, can continue indefinitely.

Putting the Protocol into Action

The parallels to the three-stage consensus model of trauma treatment (e.g., stabilization, processing, reintegration) are obvious. Pierre Janet originally published the three-stage model in 1889, and it has stood the test of time as a best practice framework in the treatment of trauma, regardless of the specific modality or approach [25]. Phases one and two of the EMDR model are analogous to stabilization, phases three through six equate with processing, and phases seven and eight correspond with reintegration.

Shapiro also describes EMDR as having a three-pronged protocol, meaning that EMDR therapy is designed to clear out past disturbances in order to improve present and future functioning [15]. This three-pronged protocol also makes good sense. The purpose of EMDR is to help a person live a more adaptive life, so clear connections to present and future functioning should be made when visiting the past [15].

The third usage of protocol work relates to how a clinician sets up and executes an EMDR session. In essence, the script that trainees are given to complete phases three through six, which includes elements like measuring subjective units of distress (SUDs) and the validity of cognition (VoC) scale, would be a part of the protocol. The prescribed, sequenced steps for phases three through six, as originally produced

SAMPLE 11-STEP PROTOCOL FOR EMDR	
Scripted Step	**Sample Response/Action from Client**
Identify the presenting issue or memory	Never feeling safe when I get in a car because of a bad accident that happened five years ago.
What picture represents the worst part of that incident?	Seeing the truck that hit me moving into my lane. (NOTE: If no picture is available, the "worst part" may be a sensation, sound, or other sensory imprint.)
What words go best with that picture to describe how you feel about yourself now?	I am in danger.
When you bring up that picture, what would you like to believe about yourself now?	I am safe in general.
When you think of that picture (the truck changing lanes), how true does "I am safe" feel to you now on a scale from 1 (completely false) to 7 (completely true)?	2
When you bring up that picture and the words "I am in danger," what emotions do you feel now?	Fear, terror
On a scale of 0 (no disturbance) to 10 (the most disturbance imaginable), how disturbing does the incident feel to you now?	8
Where do you feel it in your body?	The chest (racing heartbeat)
Desensitization	The client holds the picture of the truck changing lanes together with the racing heartbeat in his chest, and puts it together with the negative belief "I am in danger."
Apply stimulation for approximately 12 to 24 sets of bilateral stimulation, then ask, "What are you getting now?"	I am noticing how my heart is racing even faster.
After the client reports a new experience, have the client "go with that." That experience can be anything: a new memory, a new sensation, a new thought, a new twist on the memory, or nothing. The general principle is to "keep going" with whatever comes up until the SUDs=0, the VoC=7, and the body scan is clear.	
Source: Compiled by Author	*Table 2*

by Shapiro, are also referred to as the 11-step procedure (***Table 2***) [15]. Prescribed usage of the SUDs and VoC scales is a major part of this protocol. The SUDs scale, originally developed by behaviorist Joseph Volpe, is the classic 0–10 scale of intensity. In EMDR, 0 means no distress, while 10 signals maximum possible distress. The VoC scale was developed as a way to measure the validity of certain cognitions, like "I am good enough." This is a 1–7 scale, in which 1 equals completely false, and 7 equals completely true. Although this was originally developed to avoid confusion, many clinicians and clients have found the 1–7 VoC scale to be one of the most confusing parts of the EMDR protocol. Alternatively, clients may opt to give percentages, for instance, "'I'm good enough' is 80% true in this moment."

All of these steps are the "ideal" of how a targeting sequence should work—the textbook set-up of an EMDR session following preparation that is designed to take a client deeper on his or her journey of resolving the traumatic memory. After mastering this basic targeting sequence, it can be applied to any situation, memory, issue, or cognition. Of course, there are considerations that should be taken into account based on individual clients. For example, when working with children, the language should be modified to be developmentally appropriate. Some clients may not feel it is possible to come down to a zero level with their SUDs rating simply because something happened. In her text, Shapiro validates this phenomenon as possible or ecologic. Many people can leave the SUDs at a 1 or 2 and have a clear body scan, a completely true positive cognition, and corresponding behavior changes.

Several books have been published on how to use these standard EMDR protocols in special situations [26; 27; 28]. There are many spin-off protocols available, some of which were developed by Shapiro (e.g., the Recent Events Protocol) and many that other clinicians have developed. Most of these specialty protocols are simple variations on this basic targeting sequence. An exception to that would be Shapiro's own phobia protocol, where she advises that the following six states connected to the phobia should all be processed

in separate target sequences: the first, the worst, the most recent, any ancillary events related to the phobia, any present stimuli, and any other physical sensations/signs of fear.

In evaluating the question of how EMDR works, it is a blend of model, methodology, and mechanism. There is a clear model associated with EMDR therapy (i.e., the AIP model), the methodology is the eight-phase protocol, and the mechanism is the impact of EMDR in the brain. There are clinicians who have taken deviations from the founder's word-for-word presentation, and for many, using these variations has been vital to using EMDR with clients.

THE FOUR FACES OF EMDR: VARIATIONS

It is Shapiro's stance that EMDR therapy should be executed exactly as she presents it in order for it to be done with optimal efficacy. Although this position has served EMDR well in terms of research validation, for many clinicians, the strict protocols do not allow for enough variation based on individual clients. The EMDRIA definition of EMDR allows for some flexibility and adaptability based on client development. For example, in working with children or clients of another culture, it may be imperative to change the language in the protocol. But the EMDRIA definition of EMDR uses Shapiro's eight phases and maintains that phases three through six should not be altered. (Phases one, two, seven, and eight can be more easily adapted.) Shapiro maintains that EMDR is an interaction between client, clinician, and method, although many critics believe that too much emphasis on method is at the expense of an organic client-clinician interaction [15].

When returning to a clinical setting, modification of certain aspects of the textbook protocol may be necessary in order to honor clients' organic leading of the experience and to honor one's inner prompting to bring other parts of the therapeutic training experience. If variations in the strict protocol are supported by outcomes, there is no reason to adhere to pure EMDR methods.

One way to conceptualize variations in EMDR approaches is the Four Faces of EMDR model [29]. According to this model, EMDR takes four major shapes in modern-day clinical practices, and clinicians tend to resonate with the presentation that most speaks to their personality; no approach is "better" than another.

Face 1

Face 1 is protocol-oriented EMDR, or what Shapiro now refers to as EMDR therapy (with the new emphasis on therapy). To this point, this course has focused primarily on Face 1. Therapists who identify as Face 1 EMDR therapists generally learn best through having a scripted series of protocols to follow and feel most secure when clinically practicing within such paradigms.

Face 2

Face 2 EMDR is more flexible than a Face 1 approach. Face 2 EMDR uses Shapiro's original protocols and procedures, with modifications made by the clinician to better suit the clinician's personal style or to better accommodate the client's learning/processing style and other unique needs. Flexible EMDR therapy is still largely regarded as an approach to psychotherapy. However, many who practice flexible EMDR choose to incorporate other models of treatment conceptualization aside from Shapiro's AIP model [15]. People who practice flexible EMDR are more likely than Face 1 practitioners to use the general EMDR approach to psychotherapy alongside of another approach to psychotherapy (e.g., 12-step facilitation, ego-state therapy, Gestalt, CBT, mindfulness-informed interventions, expressive arts therapies, attachment theory).

Face 2 EMDR therapists, in addition to naturally making combinations with other theories and approaches to psychotherapy, are more likely to make modifications in the strict 11-step set up for phases three through six. These modifications can be made while still adhering to Shapiro's eight essential phases. For example, in her modified protocol, Parnell streamlined the set-up to be less clunky and significantly less numeric [18]. ***Table 3*** is a hypothetical example of how EMDR phase three assessment may be set up using Parnell's classic modification.

Clinically, Parnell, and many Face 2 and Face 3 EMDR therapists, have found a modified approach to work as well as the longer set-up because the essential ingredient of EMDR is being met: the traumatic neural network is being accessed and then stimulated. Clients' ratings, which often work well in research, do not often translate to clinical practice. In Parnell's work, SUDs ratings or the positive cognitions may be used when they organically arise during desensitization. For example, if the bulk of a session is spent processing and a therapist wants to check in about distress level, obtaining SUDs ratings at various intervals can be a good chance to determine how the client is moving with the memory/issue. However, when setting up the targeting sequence and the client is getting distressed, stopping to ask for ratings can disrupt the process.

Many EMDR experts, like Laurel Parnell, David Grand, Robin Shapiro, and Ricky Greenwald, have written about widening the scope of EMDR. Grand's work, *Natural Flow EMDR*, eventually channeled into him developing his own intervention, brainspotting, and Greenwald has long advocated for the use of EMDR within the classic three-stage consensus model of trauma-informed treatment [30].

Face 2 (and 3) EMDR therapists are more likely than Face 1 EMDR therapists to use other approaches to bilateral stimulation aside from eye movements. Although many Face 1 EMDR therapists will use the alternative forms

SAMPLE EMDR PROTOCOL WITH MODIFICATION	
Step	**Sample Response from Client**
Identify the target memory	Never feeling safe when I get in a car because of a bad accident that happened five years ago.
Identify an associated image (or worst part of the incident)	Seeing the truck that hit me moving into my lane. (NOTE: If no picture is available, the "worst part" may be a sensation, sound, or other sensory imprint.)
Identify emotions	Fear, terror
Describe body sensation or discomfort	Racing heartbeat
Identify negative cognition	I'm in danger.
When the client is visibly distressed, begin desensitization with bilateral stimulation.	
Source: Compiled by Author	*Table 3*

of stimulation, many adhere to an "eye movements first" policy, because those are the most researched. Face 2 EMDR therapists often give clients the choice of what stimulation modality they prefer.

Face 3

Those who practice in Face 3 are considered even more off-book, especially with Shapiro's assertions that EMDR is a distinct approach to therapy, not a technique. For Face 3 therapists, EMDR is simply used as an adjunctive technique or procedure to another psychotherapeutic orientation. With this face, EMDR does not dominate or guide the treatment. Some Face 3 practitioners stay true to Shapiro's eight-phase main protocol, whereas others modify it to suit their main orientation. They use the desensitization procedure as a technique to work through blocks with various degrees of fidelity to the 11-step setup.

An example of a Face 3 EMDR clinician is Linda Curran. Curran has shared the following thoughts that encapsulate Face 3 EMDR [29]:

> I believe that EMDR is a modality that has proved efficacious in both internal resourcing and reprocessing traumatic material. There should be no need for me, or any other clinician, to renounce his/her chosen discipline to utilize EMDR as a modality…I completely identify with old-school trauma therapy, a.k.a. Gestalt therapy. Gestalt therapy is a humanistic, present-centered, relational psychotherapy with an emphasis on contact, body/somatic awareness, and the working through of unfinished business. As PTSD (both simple and complex) is the quintessential disorder of unfinished physiologic, emotional, and cognitive business, Gestalt therapy lends itself perfectly. In terms of EMDR, I do EMDR, but I am not an EMDR therapist.

Face 4

EMDR-informed interventions, Face 4, exist as separate and distinct modalities or approaches developed by clinicians who were originally trained in EMDR and have used EMDR-informed interventions or evolutions of original EMDR elements to create a new technique or approach to therapy. Perhaps the most popular new modality that has grown from experimentation within EMDR is brainspotting. In 2013, David Grand published his first book on the phenomenon, a technique derived from EMDR but with greater simplicity in implementation [30]. Other evolutions include the developmental needs meeting strategy (DNMS), developed by Shirley Jean Schmidt; induced after-death communication, by Alan Botkin; and progressive counting, developed by Ricky Greenwald [31; 32]. Of these modalities, progressive counting has some empirical evidence suggesting it is at least as effective as EMDR. As Greenwald promotes, it is easier to learn and to teach than standard EMDR [32]. Although delving into a full exploration of each therapy is beyond the scope of this course, research on these therapies may help therapists determine if they may be useful in their practice, especially if traditional EMDR does not totally resonate.

In 2008, Laurel Parnell published a book, *Tapping In,* that teaches the general public how to use bilateral tapping [33]. The Parnell book was somewhat controversial at the time it was published, but Shapiro has since published a book on self-help techniques derived from EMDR [34].

CANDIDATES FOR EMDR

A variety of clients can benefit from EMDR therapy or EMDR-related techniques, presuming that the clients are open to exploring the possibilities. EMDR has, to date, been officially validated for clients with PTSD. However, there are a plethora of case studies, field reports, and other research articles demonstrating the efficacy of EMDR for a variety of diagnoses. If one can appreciate the role of adverse life

experiences in causing or exacerbating other diagnoses, using EMDR with other diagnoses is not a stretch. However, official empirical research is lagging, so clinical practice recommendations do not generally recommend it as an approach yet. Another issue is that PTSD and other trauma-related diagnoses exist comorbid with other major diagnoses, like substance use disorders and eating disorders. Although EMDR has not been officially validated as a treatment for addiction, many clinicians have incorporated EMDR into their work with addicts because of the high comorbidity between substance use disorders and trauma- and stressor-related disorders. As long as the client is sufficiently stabilized, using EMDR phase two approaches or stabilization approaches from other traditions, the trauma reprocessing phases of EMDR can be used with most willing clients.

In many cases, clients who have tried standard "talk therapy" approaches and have not met their goals are generally willing to attempt EMDR because it offers a different avenue. Each client can go through phases one and two, as long as the treating clinician is sensitive to the dynamics of trauma-sensitivity. For instance, in doing phase one work, the issue of taking a detailed trauma history should not be forced if clinical judgment suggests that relaying the entire history verbally would worsen the client's condition. Some general recommendations for determining whether a client is a candidate for EMDR include [29]:

- Can the client maintain dual awareness of past and present? In other words, if a safe place or other guided visualization exercise is done with the client or a target is set on a past memory, will the client know that he or she is still in the office and not really going there? Dual awareness is essential for the most effective, safest EMDR.
- If the client is taking psychotropic medications, especially for conditions like organic mood disorder (e.g., bipolar) or organic psychotic disorders (e.g., schizoaffective disorder), is he or she stable? The period when a client and his/her psychiatrist are experimenting to try to find the right combination and dosage is not the best time to do any kind of trauma-processing work. In the early days of EMDR, many did not venture into using it with clients who had severe mental illnesses other than PTSD. However, EMDR practitioners are continuing to find that if safety conditions are met and appropriate modifications are made to meet the client where he or she is at, EMDR is not necessarily off limits.
- Are the client's basic needs being met? If the client's basic needs (e.g., food, shelter, safety) are not being met, it is generally not a good time to do trauma-processing work. Consider working with a case manager or other community resources to ensure the client's basic needs are being met before starting processing; this is part of the preparation and stabilization process.
- For clients with eating disorders, simply eradicating the core trauma with EMDR or any other modality will not resolve the eating disorder. Rather, a sensible behavioral plan combined with stabilization work is needed as a base. Consider collaborating with other behavioral health and wellness professionals, if needed. Then, trauma processing can be titrated into the treatment to enhance the treatment gains and help with relapse prevention.
- For clients with addictions and other acting-out behaviors, simply eradicating the core trauma with EMDR or any other modality will generally not resolve the behavioral manifestation. Collaborative strategies, at which Face 2 and Face 3 EMDR practitioners excel, are key. For instance, behavior modification plans and EMDR do not have to be mutually exclusive; they can work well in concert. As with eating disorders, titrate the trauma processing into the treatment to enhance the treatment gains and help with relapse prevention.

The American Psychological Association conditionally recommends EMDR for the treatment of patients with post-traumatic stress disorder (PTSD). During EMDR therapy, clinical observations suggest that an accelerated learning process is stimulated by EMDR's standardized procedures.

(https://www.apa.org/ptsd-guideline/ptsd.pdf. Last accessed May 11, 2022.)

Level of Evidence: Expert Opinion/Consensus Statement

Shapiro has also recommended that clinicians should not do EMDR with a client they would not normally feel comfortable treating [4; 15]. For instance, if a clinician is very comfortable working with addiction, using EMDR therapy with addicted clients would likely be appropriate. However, if one does not usually work with young children or couples, EMDR should not be done with those types of clients because he or she may not competent in the modifications that may need to be made. In general, if a client who is often defined as a part of a "special population" (e.g., children, military, gender and sexual minorities) seeks out EMDR, the likelihood of their success is greater if they are working with a clinician who understands that population.

CASE STUDIES

Case 1: Client D

Client D approaches a counselor for services after reading about her work with trauma and addiction. He is 57 years of age and has nine years of sobriety from alcohol at the time he seeks help. A successful businessman during his drinking

days, he changed professions in recovery and pursued an advanced degree to work as a treatment clinician. At the time he presents for counseling, he is working in a prominent leadership position in a treatment setting. Although Client D has been an active member of a 12-step fellowship for many years, he finds himself struggling with the rigidity on certain issues as interpreted by many groups. He is actively exploring ways to expand his recovery wellness. In the history taking, Client D reveals that his biological mother relinquished him at the time of his birth. After spending seven days in a home for unwed mothers, a couple unable to conceive adopted him. Five years later, they were able to naturally conceive Client D's younger sister, and then years later they adopted another son from an unwed mother. Client D describes that, overall, he was well cared for by his adopted parents and he describes his childhood as relatively carefree. However, there are still some issues from that period that continue to play out in his life.

When Client D presents for services, he is unsure if he can even name the relinquishment and experiences connected to being adopted as trauma. However, he has keen awareness that even though he is sober and successful in his work, he is struggling in many other life domains, namely connecting with others. He has also identified problems with compulsive overeating throughout the years, even following his sobriety from alcohol. In the initial history-taking session, the counselor explains to Client D that trauma does not have to meet PTSD criteria to name it as trauma, explaining the concept of adverse life experiences as they are described in the AIP model. She also uses the wound metaphor as a teaching device.

Client D is traveling a great distance to see the counselor for services. During the initial history-taking session, the counselor assesses him to be sufficiently stable and capable of handling an extended history. She asks him to write out as much of a narrative as he is comfortable writing about his history. Upon reading his presentation, the following statements are identified as trauma-fueled statements influencing his presenting maladaptive symptoms and become candidates for EMDR targeting sequences:

- "I have vague memories of feeling like I was under the microscope whenever I was with people."
- When his friends found out he was adopted (at around 6 years of age), they acted in total disbelief and shifted their attitude toward him: "I am guessing I may have felt at the time that something was wrong with [being adopted]."
- "I felt hugely ashamed and humiliated. I guess more important is that it added to my feelings that something was wrong with me. I no longer felt safe around other people or myself."
- "I seemed to become distant or withdrawn. I remember beginning to feel at all times like I didn't belong wherever I went."
- "Some of my fondest childhood memories come from spending time at the lake."
- "I got sober in August 2005, still wondering, as I had my whole life, who I was, where I had come from, and if I had blood family still living."
- At the prospect of meeting his biological half-sister, with whom he was just able to establish contact: "I fear that I'll disappoint her somehow."
- On his general reason for seeking services: "I still feel like a chronic malcontent who is often dissatisfied and rebellious."

In this initial session, the counselor begins gathering information about Client D's existing coping skills, most of which were gained from 12-step exposure. He mentions that he has begun exercising again, and she encourages him to continue. The two begin discussing a plan for how Client D could build more body-based coping skills (e.g., breathing) into his daily regimen. The counselor provides him with online resources that teach breathing and related skills, and he is willing to try these before the second session.

When Client D presents for his second session, he and the counselor review which breathing strategies worked best for him and discuss other visualizations that might work for distress tolerance. The counselor picks up on his statement in the history that some of his fondest childhood memories came from spending time at the lake, and they transition this into a safe place exercise with bilateral stimulation. Client D chooses to alter the place for the purpose of the exercise and use the serenity of a Caribbean beach and also chooses tactile bilateral stimulation (using a machine to create the tapping). They also "tap in" a positive experience the client had at a 12-step meeting the night before the session. Anything positive and adaptive can be frontloaded, pre-installed, or "tapped in" as an act of preparation.

Client D responds well to these preparation exercises, and by the third session he expresses readiness to commence processing. The counselor reads the negative self beliefs that were identified in his narrative and asks him to notice which one(s) seemed to most resonate in his body as distressing. For him, it is clearly the statement, "Something is wrong with me." The counselor sets up the targeting sequence using a combination of the traditional 11-step setup and the Parnell modified protocol. (Note: This counselor generally does not rely on numbers unless she feels it is useful for the process to ask.) Client D is able to give the following information at the start of the first reprocessing session:

- Negative cognition: Something is wrong with me.
- Positive/preferred cognition (client's goal): I can work through it.
- Floatback to earliest recollection of the negative cognition: The day when client's two friends made a big deal about him being adopted. The client was called a liar and accused of deceit.

- Worst part (not necessarily an image): Client D feels he was the last to know that adoption is something people do not want to talk about.
- Emotions: Anger (mostly at himself)
- Body: Hands go tense

Client D is instructed to hold all of these things together and to "just notice" his experience as the counselor turns on the machine to begin the bilateral stimulation. As a technical note, when bilateral stimulation is used to install positive material in phase two preparation, the speed is on the slower side. However, when a client is processing, the speed of the bilateral stimulation is generally faster, analogous to pressing down on the gas pedal to move the client through distress. The technical choices associated with speed are generally covered in standard EMDR trainings.

Within the first two to three sets of bilateral stimulation, Client D is able to very deeply connect with what is going on his body. For the client, a self-confessed intellectual who has the tendency to overanalyze, being able to just sit with body level experience and notice is huge. The bilateral stimulation is applied at one-minute intervals, and at the end of each set, the counselor checks in to see what Client D is noticing. Whatever he reports, the counselor advises him to "go with that" or "just notice that." The free association components of EMDR are a major part of the reprocessing experience, because clinicians do not ask the clients "What are you thinking?" or "What are you feeling?" The goal is not to analyze and interpret in a verbal sense. Rather, when something comes up, the client is encouraged to just notice, be curious, and explore, as the stimulation is applied. For Client D, many of his check-ins reveal experiences like, "There is a heaviness in my chest when I think about [the sound of his peers' laughter]." He just notices this feeling as the stimulation is applied, and after several sets, he begins spontaneously manifesting his own insights. Toward the end of the first reprocessing hour, he is able to make a connection with the positive cognition, "I'm okay. I'm content." At the end of the session, when the counselor checks in with him about the initial issue/belief, he reports a clear body scan. His initial goal statement/positive cognition of "I can work through it" is completely true, and he is able to name two other positive cognitions to claim as completely true: "I am a human being" and "I can trust myself." The session ends with installing both of these completely true positive cognitions together with the clear body scan.

In the second reprocessing session, Client D and the counselor check back in with the initial memory that was taken through the targeting sequence in the session prior to determine if anything else may have come up. Client D reports, "I now have the power to observe it—I was just a kid. I should forgive myself for putting myself through all of that." He says that in the session prior, he felt as though he was reliving it. This shift in perspective about the memory is a common experience after memories are processed with EMDR. In the spirit of the three-pronged protocol, the counselor and Client D commence the second reprocessing session by having him just notice how he presently views the memory. By going with the free association together with the application of bilateral stimulation, Client D spontaneously begins articulating new positive beliefs about himself that he is able to work with and come to as completely true statements: "I have the power," "I've got this," "I am safe," and "I don't have to protect myself anymore." Additionally, the two positive beliefs that he reported in the previous session held as completely true statements. In the final check-in during that second reprocessing session, the client reports a clear body scan and articulates two new positive beliefs: "I am whole" and "I don't feel judged anymore." He states, "I'm anchored, attached to the present."

In the next session, after checking in with the positive beliefs to make sure that they hold as true statements, the counselor transitions into future template work. There is an option to take the other negative statements identified in the client's history and set those up as separate targeting sequences. However, when the counselor checks in with Client D about these statements, they no longer seem valid. In EMDR, it is common to have a generalization phenomenon, defined as the automatic resolution of other memories and issues of concern that occurs after reprocessing the memory that seems the most charged to the client. Thus, the two move into working on the future element of the three-pronged protocol after having successfully worked through the past and present.

For his future template, Client D states that he wants to work on issues of connectedness and problems connecting with others. Following some organic dialogue about the issue, he identifies the belief that he is somewhat confident that he can connect with others. The counselor asks him what is keeping him from complete confidence that he could connect, and he immediately identifies a message that he received in 12-step recovery: "Ego is bad." The counselor asks him to consider that notion and any body experiences as he holds it. After applying a few sets of bilateral stimulation, Client D recognizes that he is kinder and gentler—and that he could extend that to himself and others. He then makes a connection to a famous story in 12-step recovery about the "bright-light experience," and he relates feeling that he finally has something to give to others. Previously, his feeling like a fraud, both personally and professionally, stood in the way. In the next few sets of bilateral stimulation, he makes connections to his family and work life. He ends the session expressing: "I am more than a victim, a survivor, or a 'rescue.' I am whole." The client and counselor install this realization as a completely true positive belief.

The final two in-person sessions with Client D can be described as EMDR re-evaluation. The positive beliefs achieved in previous sessions hold as completely true statements with clear body scans. Natural conversation progresses into discussing what potential pitfalls that he might see in moving forward. Client D identifies, "I can find fault like there's a reward for it, at least that's been my pattern." He states that this tendency began around the time of the target memory, at 6 years of age. The counselor asks him to hold the present experience of that memory together with his insight about finding fault. After a couple sets of bilateral stimulation, he expresses: "That's my head talking, not my heart or my soul." In the next set: "That's a useless energy drain." The counselor decides, in testing the potency of the generalization effect, to inquire about one of the client's other negative beliefs identified at the time of history taking: "I am disconnected." She asks him how valid that belief seems in the moment, and he responds, "It was a delusion—I'm finding the connection within." The counselor instructs him to "go with that" for a few sets for bilateral stimulation, and he ultimately expresses, "I am home." When asked what, to him, the opposite of "I am disconnected" would be (i.e., his positive cognition), he states, "I have the capacity to be connected." He reports this is a completely true statement, and it is installed with bilateral stimulation and a clear body scan. Client D then holds this positive belief as he pictures future life scenarios, and no distress or concern registers.

Client D and the counselor follow up via phone call three weeks after the last session (as part of the re-evaluation process), and the client notes overall positive progress and maintenance of goals in the weeks since the final in-person session. He states he is no longer "obsessing" over how he feels and is "over" his fraud complex. He reports 20 pounds of weight loss in the weeks since his EMDR work and an increase in faith that everything in his life is going to be fine. A final phone call one month later confirms the maintenance of these gains.

Discussion

Client D's story is an example of EMDR therapy being used as a recovery enhancement measure. Although clinically not meeting the criteria for PTSD upon presentation, it is clear that trauma, especially attachment-related or developmental trauma, continued to cause symptoms of depression and overall disconnection with life, even after his substance use disorder was put into remission. Client D's journey may read like a textbook case of how EMDR can work very quickly, and in many ways, his case allows for that because he presented for treatment already reasonably stabilized; he had a job, nine years of sobriety, strong family support, and a willingness to work on himself. In essence, he was the model client for an EMDR clinician. The reality can be somewhat different, often treating clients who have not worked on themselves to the level Client D had. Additionally, clients generally described as survivors of complex trauma can also pose a challenge in conducting strict EMDR. Deborah Korn observed, "While EMDR and other trauma treatments have been proven efficacious in the treatment of simpler cases of PTSD, the effectiveness of treatments for more complex cases has been less widely studied" [35].

The more complicated the client, the more contingencies should be planned for in the delivery of EMDR. Many Face 2 EMDR practitioners believe that enhanced flexibility allows counselors to be better able to work with these subjectively more complicated clients. In addition, more complicated clients generally require a longer period in phase two preparation, especially if they are coming to treatment with little to no skills for regulating distress.

Case 2: Client J

Client J, a lower-income white woman who is 39 years of age, has been in and out of community mental health facilities for the better part of her adult life. She suffers from both bipolar disorder and PTSD, resulting from a series of abuses at the hands of her parents with alcohol use disorders and sexual assaults in late adolescence. Although Client J has never been diagnosed with a substance use disorder, she reports periods of substance abuse throughout her adult life to cope with stress, usually when she is not compliant with her medications for the bipolar disorder. She struggles significantly with medication compliance. Although her bipolar symptoms are regulated when she is medicated, she often complains about the side effects and the cost of the medications.

Her counselor does not initially consider EMDR, because Client J seems so unstable. The client is adamant that if she is just prescribed the right medication, all of her problems will go away. During the first two months of treatment, the counselor carefully meets her where she is and does not use overt confrontation, even about behaviors that are clearly detrimental to her mental health progress (e.g., choosing certain friends, attempting to reason with her equally troubled ex-husband). As a result, a solid alliance forms. Through some trial and error, Client J's psychiatrist is able to find a medication that works well in keeping the bipolar symptoms reasonably stabilized, and the level of the client's day-to-day lability significantly decreases.

During the first few months, the counselor works with Client J on coping skills, including guided imagery and deep breathing. She responds well to these two exercises, so the counselor suggests that they try adding some tactile bilateral stimulation, explaining that the tapping may help further enhance her relaxation. The two work on a light-stream guided imagery technique, together with some tactile stimulation, and Client J reports that she feels more relaxed than ever before. During the next session, the counselor teaches Client J a guided imagery safe place exercise using bilateral stimulation, and she reports that she likes this exercise as well. For the next one to two months, they focus on these trauma-informed coping exercises. Because Client J does not

have much good going on in her life, aside from receiving subsidized housing and having a solid relationship with her case manager, building resources becomes incredibly important.

After observing how well Client J responds to the preparation exercises, the counselor explains that stimulation could be used in a different way to help process some of her traumatic memories, and the client is willing to try this approach. The first several sessions of trauma processing with EMDR are all over the place, and the counselor uses a significant amount of interweave, or open-ended questions/statements typically used to assist complex clients work through blocks within the EMDR processing. However, after these first several sessions, Client J is able to quickly process a series of traumatic memories that are both recent (e.g., an accident) and deep-seated (e.g., past abuse). EMDR is used off and on over a nine-month period. (Breaks in formal EMDR bilateral reprocessing occur because, during some sessions, Client J states a need to just talk, which could be viewed as part of re-evaluation.) Significant improvements in Client J's overall self-image and decision-making begin. In the counselor's last contact with Client J by phone, she reports that she is remaining on her bipolar medications and realizes that she will probably need to do so for the rest of her life. However, her mood swings are no longer as violent and her lifestyle choices have improved because much of the underlying traumatic material has been processed.

Discussion

If the counselor had rushed into reprocessing past traumas with EMDR, more harm would have resulted. It was important to introduce coping skills/preparation slowly and carefully, then add the bilateral stimulation, and then proceed with trauma processing. If one prepares for the journey, the journey will be smoother—a major lesson in helping people processing their traumatic memories with EMDR.

STABILIZATION, ASSESSMENT, AND SELF-HELP USING EMDR

STABILIZATION, PREPARATION, AND THE "TAPPING IN" APPROACH

Phase two EMDR preparation corresponds with the general stage of stabilization in the three-stage framework for trauma processing originally published by Janet [25]. The three-stage consensus framework is often considered a best practice for trauma-informed care, and regardless of which therapeutic modality one practices or primarily uses in clinical practice, it is vital to stabilize or prepare clients at the affective level before taking them deeper into their processing work. Even therapists who do not practice EMDR can learn the basic bilateral "tapping" approach for affect regulation or for installing any other positive resource or coping method with which a client resonates. These skills should be practiced on oneself before attempting to teach them to a client.

Monkey Tap/Butterfly Hug

In nature, primates cross their arms over their chest and tap their shoulders in an alternating pattern to self-soothe. This natural phenomenon of bilateral stimulation may be duplicated to practice self-soothing. EMDR therapists refer to this exercise as Butterfly Hug or Monkey Tap. It is taught with the following steps:

- Cross your arms over your chest.
- Begin tapping your hands against your body in a slow, deliberate, alternating fashion. Use the same slow pace as the walking meditation; tapping quickly can induce anxiety.
- Tap for about one minute and then return your hands to your lap or the table and just breathe for a few moments. Repeat as many sets as needed for relaxation.
- Be mindful that the appropriate speed of tapping varies from person to person. If the tapping ever seems to induce anxiety, it generally means that you are tapping too fast. What is slow to one person might be fast to someone else. So, honor individual variation.
- You do not have to cross the arms over your chest to benefit from tapping; some people find this intrusive. Alternately, you can tap your feet from side-to-side or tap your hands against the arms of a chair or on the tops of your knees.

When a person finds a speed and style of tapping that works the best for him or her, this general tapping principle can be used to "tap in" or "install" positive associations. This can be a positive memory, a positive belief statement, elements of a guided visualization exercise, or the presence of a sacred person or guide. Another sensory stimulus that is positive to the client, such as a pleasurable scent, a song with a positive connotation, or a tactile sensation (e.g., a hot bath, a warm blanket), may be introduced.

CONDUCTING A TRAUMA HISTORY/ ASSESSMENT INFORMED BY THE AIP MODEL

Many people learn EMDR but do not use the therapy to its fullest capacity, either because of their own lack of confidence or need to practice more or because the clientele they serve is not ready for much work past phase two preparation. However, even if counselors/therapists do not use full-scale EMDR for trauma reprocessing, having EMDR training inevitably influences the way that they ask questions. Refer back to the tenets of the AIP model presented in an earlier section of this course and consider how this model could improve one's approach to history taking and assessment.

Asking a person to identify the beliefs about self that have been acquired throughout life is a powerful gateway through which to assess for trauma, or in AIP terms, to ascertain negative cognitions and their origins. Having a patient rehash the whole trauma narrative is generally counterproductive and can potentially cause more harm than good. Instead, ask the client to identify two or three significantly negative, driving beliefs about the self that seem to be causing problems. Tracing the origins of these beliefs will likely provide most, if not all, of the information needed to begin working with the client in a trauma-sensitive manner in whatever modality is selected.

Some individuals come into professional services with a clear sense of their blocking negative beliefs; "I'm not good enough," "I'm to blame," or "The world is out to get me" are very common. People may have a sense of some but may not recognize others.

As an assessment strategy, begin by having a client identify core driving beliefs. A general list of negative schema or self-defeating beliefs may be used as a guide. After identifying the core negative beliefs, consider asking any one of the following questions (based on clinical judgment) to trace the origin of that belief:

- When was the first time you ever remember getting that message about yourself?
- When was the worst time you ever remember getting that message about yourself?
- When was the most recent time that you received that message about yourself?
- What role did your loss play in giving you this message?
- Does this message predate the loss in any way?

Using a negative cognitions list and asking these questions will often provide the necessary information about any traumas, whether or not they are PTSD level, and the contexts surrounding them. Clients' answers may be used to initiate a dialogue, if appropriate. Deciding when to use this strategy is up to clinical discretion. If a client is sufficiently stable and a strong rapport has been built in an initial session, the exercise may be done at that time. Other times, it may be best to wait until the second to fourth session to ensure the client has obtained at least some basic affect regulation skills and will be able to handle the intensity that doing such an exercise might elicit.

Using such an assessment strategy will help identify the key themes and, in discovering the themes, more fully appreciate the context. This type of strategy may simply be a guide for communication with the client. The information obtained here can be used to devise the best possible treatment plan, help select strategies and approaches, and when the time comes for deeper work, help identify the key issues for processing.

Part of a trauma-informed assessment is learning about the client's sense of future orientation. A potentially damaging assumption professionals make is that every client wants a better future. In some cases, the client may not be coming into treatment for himself or herself; a friend, a family member, the legal system, or an employer may want the client to seek help. External motivation does not necessarily mean that treatment will not work, but it is a variable that should be taken into consideration in treatment planning. Perhaps most significantly, trauma can leave a person with a disintegrated sense of a future. If a person is operating with negative beliefs of hopelessness (e.g., "I will never amount to anything"), these cognitions will likely need to be addressed before that client can consider future goals. Minimal or no future orientation does not mean that treatment will be ineffective, but it must be addressed as part of the treatment before a person can conceptualize future planning.

FURTHER TRAINING AND COLLABORATION

IS EMDR TRAINING RIGHT FOR MY CLINICAL PRACTICE?

Shapiro's initial intention was for people to read an article about the EMD/EMDR protocol and implement it into their existing therapy, and anyone can pick up a book and learn the process, like many early leaders did. Indeed, many people continue to learn EMDR this way. However, supervised practice and/or engaging in EMDR therapy (as a client) is generally necessary to crystallize the learning. Advanced training is also a great safeguard if one's competency is ever called into question (e.g., in a liability issue or board complaint).

There are official basic training programs endorsed by EMDRIA and those that are not. For a list of complete EMDRIA-approved training providers, visit https://www.emdria.org. The official guidelines for an EMDRIA-approved basic training are a minimum 20 hours of instructional training (usually split into two parts or over the course of a semester), 20 hours of supervised practicum, plus 10 hours of consultation following the training. The price can range from $1,200 to $5,000. Some organizations, like the EMDR Humanitarian Assistance Programs, offer lower cost, full-scale trainings, although employment with a publicly funded agency is generally necessary in order to access the trainings. More information about these trainings and eligibility is available at https://www.emdrhap.org.

Completing a basic training does not confer the title of Certified EMDR Therapist in the eyes of EMDRIA; only the descriptor of "trained in EMDR" may be used. Clinicians can practice with partial training (i.e., completed the first part of a full training program), although the full basic training is recommended. In order to obtain EMDR's official credential, one must also complete an additional 12 hours of continuing

education training every two years, 20 hours of additional consultation with an EMDRIA-approved consultant, and documentation of practicing EMDR in a minimum of 50 sessions with at least 25 clients are required. To be clear, EMDRIA certification is not mandatory to be able to practice EMDR. Some insurance companies may require official certification to list a provider on their panels as specializing in EMDR, but this is the only possible financial benefit (other than the marketing of using the credential).

In response to the intensity of EMDRIA-approved channels and the financial impediments that keep many people from seeking trainings, many individuals and organizations began offering modified trainings. Some even ventured into offering certifications alternate to the EMDRIA certification. Most of these programs teach the basic fundamentals of the EMDR protocol but cannot lead to EMDRIA-approved certification. These non-EMDRIA-sanctioned trainings have been the source of much controversy, but ultimately, EMDR is not a trademarked therapy and alternate training options are allowed, though without a road to official certification.

It is imperative, particularly if investing in the full training, to have clients with which to practice the therapy, or the skills gained in training may be lost. It is also important to be sure that one's employer allows EMDR therapy and that the clients in one's practice are candidates for the full process. Working in a community agency with complicated clients does not rule out being able to master and use EMDR, yet this is generally best done if ongoing consultation and support are available.

COLLABORATING WITH EMDR PROVIDERS

When clients are referred to an EMDR provider, the first step will be classic phase one history-taking: an evaluation about the presenting problem, assessment of how unresolved trauma/adverse life experiences may be complicating that problem, and determination of the client's appropriateness for EMDR. A significant proportion of referred clients will not be candidates for EMDR, typically because of overmedication with central nervous system depressants (particularly benzodiazepines, generally a strong inhibitor of trauma processing work) and/or poor motivations for wanting to do the EMDR work.

Preliminary evidence suggests that an EMDR clinician can successfully do EMDR with another therapist's client or as part of a treatment team that includes several clinicians [36; 37]. A strong rapport with a primary therapist may translate to greater trust in the EMDR clinician. It is good practice, when working together, to obtain a release of information so collaborative contact can occur. In cases of long-term therapy, some time may be spent in the EMDR history-taking session exploring the primary therapeutic relationship. Positive statements about collaboration can create an effective bridge of trust and rapport from the original therapist to the EMDR practitioner.

CONCLUSION

EMDR is a modern psychotherapy that draws on many time-honored approaches to healing. The way that founder Francine Shapiro integrated many of these methods into a singular approach to psychotherapy has been a significant innovation in the helping professions. There is a great deal of interest in EMDR, yet much misunderstanding about the therapy still abounds. This course has been designed to allow professionals to have a general knowledge of EMDR and to make decisions about what role the therapy can play in their clients' lives. Some people who take this course may go on to get trained, and others may be open to using collaborative referrals with EMDR providers in their clinical work.

GLOSSARY

Adaptive information processing (AIP) model: A model constructed by EMDR founder Francine Shapiro to provide a framework for explaining how unhealed trauma affects human behavior and how reprocessing can assist in moving unprocessed material to more adaptive states. Strong roots in behaviorist theory and older models of this nature.

Assessment: Phase three in Shapiro's eight-phase EMDR protocol. Involves determining where to target the EMDR processing and setting up that target. In EMDR training, clinicians learn a series of questions that compose a targeting sequence.

Bilateral stimulation: Any back-and-forth movement across the center plane of the body. In EMDR, common uses of bilateral stimulation include alternating horizontal or diagonal eye movements, audio tones, or tapping.

Body scan: Phase six in Shapiro's original eight-phase protocol. Consists of checking in with any shifts that have occurred in the client's body as a result of the desensitization and installation. If the body scan is relatively clear, one moves on to phase seven. If some distress or disturbance remains at a body level, more desensitization is applied, suggesting that the memory or issue did not process deeply enough. Continue until body scan is relatively clear.

Brainspotting: An approach to processing traumatic memories developed through experimenting with standard EMDR, credited to David Grand.

Client history: Phase one in Shapiro's eight-phase EMDR protocol. Similar to the intake/assessment procedure that is used in all forms of psychotherapy. In this phase, the clinician takes a basic client history, a relationship begins to be established, and the clinician ultimately determines if EMDR treatment is appropriate for the client.

Closure: Phase seven in Shapiro's eight-phase EMDR protocol. These are the procedures that a client and clinician implement to bring a session to a place where the client feels calm enough, especially at the affective/somatic level, to leave a session.

Desensitization: Phase four in Shapiro's eight-phase EMDR protocol. The application of bilateral stimulation sets after setting up the targeting sequence, designed to shift the traumatically stored material into more adaptive states. The time that one spends in desensitization (i.e., the number and length of bilateral stimulation sets) varies from client to client.

Developmental needs meeting strategy (DNMS): An approach to reprocessing traumatic memories and psychotherapy developed by Shirley Jean Schmidt, who originally began her work within EMDR.

Eye movement desensitization (EMD): The forerunner to what is now referred to as EMDR.

Eye movement desensitization and reprocessing (EMDR): Defined by creator Francine Shapiro as a distinct approach to psychotherapy. The therapy offers unprocessed, physiologically stored memories as the etiology of problems in functioning, and the treatment involves accessing and processing of memories, triggers, and future templates. The treatment involves standardized procedures that include focusing simultaneously on spontaneous associations of traumatic images, thoughts, emotions, and bodily sensations and bilateral stimulation, most commonly in the form of repeated eye movements. Like CBT with a trauma focus, EMDR aims to reduce subjective distress and strengthen adaptive beliefs related to the traumatic event. Unlike CBT with a trauma focus, EMDR does not involve detailed descriptions of the event, direct challenging of beliefs, extended exposure, or homework.

EMDR International Association (EMDRIA): An organization that exists separately from Shapiro's EMDR Institute. Formed in 1995, EMDRIA works closely with Shapiro and is the official overseer of standards and training in EMDR therapy.

Generalization: A phenomenon that occurs when reprocessing the memory that seems the most charged to the client results in the other memories and issues of concern automatically resolving themselves due to their intricate connection to that charged memory.

Induced after-death communication: An approach to psychotherapy developed by Alan Botkin, originally an EMDR therapist. A system in which clients report being able to conduct unfinished conversations/business with their deceased love ones. Many see this as a "mystical" offshoot of traditional EMDR.

Installation: Phase five in Shapiro's eight-phase EMDR protocol. Following successful processing of the targeted memory or issue, working with the positive belief states or other positive shifts that to which a person's desensitization has allowed. The same bilateral stimulation process is used to install, or promote integration of, these more positive states.

Preparation: Phase two in Shapiro's eight-phase EMDR protocol. Continued development of the therapeutic alliance and integration of exercises designed for client stabilization. These can include, but are not limited to, guided visualizations. Generally, the more complex the client, the more preparation will be needed. The essential goal of this phase is to ready the client for deeper work on the traumatic memories/issues.

Progressive counting: An approach to psychotherapy/reprocessing traumatic memories within a phase-model of trauma treatment.

Re-evaluation: Phase eight in Shapiro's eight-phase EMDR protocol. Continuing to monitor client progress after a successful processing through of a targeting sequence. This can also include target future templates or scenarios connected to the work done in previous phases. Re-evaluation, in theory, can continue indefinitely.

Three-pronged protocol: A concept positing that EMDR therapy is designed to clear out past disturbance so as to improve present and future functioning.

Customer Information/Answer Sheet/Evaluation insert located between pages 28–29.

TEST QUESTIONS

#76032 AN INTRODUCTION TO EMDR AND RELATED APPROACHES IN PSYCHOTHERAPY

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 clock hour activity must be completed by May 31, 2025.

1. **Trauma is derived from the Greek word *traumatikos*, meaning**
   A) *spirit.*
   B) *death.*
   C) *wound.*
   D) *challenge.*

2. **For many survivors, trauma is not just a one-time event, it is a series of experiences.**
   A) *True*
   B) *False*

3. **Which of the following people is credited as the founder of eye movement desensitization and reprocessing (EMDR)?**
   A) *Pierre Janet*
   B) *Francine Shapiro*
   C) *Ricky Greenwald*
   D) *Bessel van der Kolk*

4. **The first study on EMD, the forerunner to EMDR, was published in**
   A) *1887.*
   B) *1965.*
   C) *1989.*
   D) *2004.*

5. **Which form of bilateral stimulation is used as a mechanism of reprocessing in EMDR?**
   A) *Audio tones*
   B) *Eye movements*
   C) *Tactile sensations/tapping*
   D) *All of the above*

6. **The World Health Organization (WHO) guidelines for trauma care identify trauma-focused CBT and EMDR therapy as the only psychotherapies recommended for children, adolescents, and adults with PTSD.**
   A) *True*
   B) *False*

7. **The model that explains how EMDR works is called**
   A) *the reprocessing and adoptive model.*
   B) *the adaptive information processing model.*
   C) *the accelerated information processing model.*
   D) *Gagné's (behaviorist) information processing model.*

8. **The foundation of pathology in EMDR therapy is**
   A) *chemical imbalance.*
   B) *intrapsychic conflicts.*
   C) *dysfunctional beliefs and behaviors.*
   D) *unprocessed psychologically stored memories.*

9. **Which of the following is a basic hypothesis of the adaptive information processing (AIP) model?**
   A) *Trauma causes a disruption of normal adaptive information processing.*
   B) *Stored memory experiences are contributors to pathology and to health.*
   C) *The neurobiologic information processing system is intrinsic, physical, and adaptive.*
   D) *All of the above*

10. **If experiences are accompanied by high levels of disturbance, they may be stored in the explicit/declarative memory system.**
    A) *True*
    B) *False*

11. **The AIP model recognizes that traumatic experiences prevent humans from learning things, either about themselves or their surrounding world.**
    A) *True*
    B) *False*

12. **According to the AIP model, traumatic memories can be stored in which state?**
    A) *Somatic*
    B) *Cognitive*
    C) *Emotional*
    D) *All of the above*

13. Trauma does not have to qualify for PTSD or fit DSM Criterion A for it to be life-changing or even clinically significant.
A) *True*
B) *False*

14. Many of the Cluster B personality disorders develop in individuals who experienced profound trauma in childhood.
A) *True*
B) *False*

15. Bilateral stimulation is a relatively new and uncommon phenomenon.
A) *True*
B) *False*

16. What are the three "brains" in MacLean's triune brain model?
A) *Animal, human, and abnormal*
B) *Neocortex, limbic, and R-complex*
C) *Pre-frontal lobe, midbrain, and R-complex*
D) *Amygdala, hippocampus, and hypothalamus*

17. The goal of successful trauma processing is to move or to connect the charged material from the limbic brain into a part of the brain that is more efficient in its long-term storage capacities.
A) *True*
B) *False*

18. According to a 2014 neurobiologic review of existing information, EMDR is believed to induce
A) *a brief seizure.*
B) *stimulated cerebral blood flow.*
C) *enhanced activation in the pre-frontal cortices of the brain.*
D) *a shift of the maximal activation from emotional limbic to cortical cognitive brain regions.*

19. How many phases are in Shapiro's standard EMDR protocol?
A) *3*
B) *4*
C) *8*
D) *11*

20. The second phase of EMDR treatment is
A) *body scan.*
B) *assessment.*
C) *preparation.*
D) *client history.*

21. In the context of EMDR treatment, desensitization consists of the application of bilateral stimulation sets after establishing the targeting sequence.
A) *True*
B) *False*

22. Continuing to monitor client progress after a successful processing through of a targeting sequence is referred to as what phase in EMDR therapy?
A) *Closure*
B) *Assessment*
C) *Re-evaluation*
D) *Re-integration*

23. In evaluating the question of how EMDR works, it is a blend of model, methodology, and mechanism.
A) *True*
B) *False*

24. In the Four Faces of EMDR model, which Face best describes work like Parnell's modified EMDR protocol?
A) *Face 1*
B) *Face 2*
C) *Face 3*
D) *Face 4*

25. Face 2 (and 3) EMDR therapists are less likely than Face 1 EMDR therapists to use other approaches to bilateral stimulation aside from eye movements.
A) *True*
B) *False*

26. Which of the following emerging therapeutic approaches was developed as an EMDR-informed intervention?
A) *Hakomi*
B) *Brainspotting*
C) *Somatic experiencing*
D) *Rational emotive behavioral therapy*

27. EMDR has been officially validated as a treatment for addiction.
A) *True*
B) *False*

Test questions continue on next page ➔

28. Which of the following clients would be considered the least appropriate for EMDR therapy that directly targets the reprocessing of traumatic memories?
- A) *A client with three children at home*
- B) *A client with six months of quality sobriety from alcohol and heroin*
- C) *A client with psychotic symptoms who struggles with maintaining dual awareness*
- D) *A child who is living in a chaotic home environment with good basic coping skills and has a supportive case manager*

29. For clients with eating disorders, simply eradicating the core trauma with EMDR or any other modality will not resolve the eating disorder.
- A) *True*
- B) *False*

30. Which of the following statements encapsulates a best practice in the use of EMDR with special populations?
- A) *EMDR should only be used in clients without a history of addiction.*
- B) *EMDR is too risky for use outside of adults with PTSD as a primary diagnosis.*
- C) *EMDR is EMDR—the technique will work regardless of your experience with a population.*
- D) *If the clinician is not comfortable working with that group, it is generally not wise to proceed doing EMDR with that population.*

31. In EMDR, interweave refers to
- A) *the cognitive-behavioral elements of EMDR.*
- B) *the interaction of various stored traumatic memories.*
- C) *the free association process that happens during reprocessing.*
- D) *open-ended questions/statements typically used to assist complex clients to work through blocks within the EMDR processing.*

32. The practice of crossing one's arms over the chest and tapping one's shoulders in an alternating pattern is referred to as
- A) *tapping in.*
- B) *Monkey Tap.*
- C) *Butterfly Squeeze.*
- D) *progressive counting.*

33. Which of the following approaches is consistent with conducting a trauma history/assessment informed by the AIP model?
- A) *Identifying negative beliefs about others*
- B) *Providing a general list of negative beliefs*
- C) *Avoiding the origins of any negative beliefs*
- D) *Having the client recount the whole trauma narrative*

34. What is required to become a Certified EMDR Therapist through the EMDR International Association?
- A) *A weekend/three-day training course*
- B) *A full basic training plus 10 hours of consultation*
- C) *A letter of recommendation from a current EMDR therapist*
- D) *A full basic training, plus 20 hours of consultation, extra continuing education, and documentation of hours with clients*

35. When clients are referred to an EMDR provider, the first step will be
- A) *a body scan.*
- B) *phase one history-taking.*
- C) *a desire to reprocess and resolve.*
- D) *installation of positive associations.*

Be sure to transfer your answers to the Answer Sheet located between pages 28–29.
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 28–29.
We encourage you to **GO GREEN**. Access your courses **online** or download as an **eBook** to save paper and **receive a discount** or sign up for **One Year of Unlimited Online CE for only $79!** Additional titles are also available.
www.NetCE.com

BEYOND THERAPY: THE BASICS OF CLINICAL DOCUMENTATION

#71072 • 4 Clock Hours

Book By Mail – $28 • **ONLINE – $20**

Purpose: The purpose of this course is to provide clinicians with a broader understanding of documentation and its relationship to the standards of practice governed by regulatory bodies in order to fully support client care.
Faculty: Lisa Kathryn Jackson, MA, LPCC, NCC
Audience: This course is designed for all licensed behavioral healthcare professionals, including social workers, counselors, and therapists.

EVIDENCE-BASED PRACTICE IN SOCIAL WORK

#71482 • 3 Clock Hours

Book By Mail – $23 • **ONLINE – $15**

Purpose: The purpose of this course is to increase the knowledge base of social workers and other allied mental health professionals who can work to incorporate the tenets of evidence-based practice into their own work with clients.
Faculty: Alice Yick Flanagan, PhD, MSW
Audience: This course is designed for social workers in all settings with an interest in evidence-based practice.

PROMOTING THE HEALTH OF GENDER AND SEXUAL MINORITIES

#71793 • 5 Clock Hours

Book By Mail – $33 • **ONLINE – $25**

Purpose: More individuals who identify as gender and sexual minorities and their families want culturally appropriate information as well as support and referral. 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.

MASS SHOOTERS AND EXTREMIST VIOLENCE: MOTIVES, PATHS, AND PREVENTION

#76431 • 15 Clock 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 Clock 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.

CLINICAL SUPERVISION: A PERSON-CENTERED APPROACH

#76863 • 10 Clock 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 requirements for supervision education.

RACIAL TRAUMA: THE AFRICAN AMERICAN EXPERIENCE

#76920 • 5 Clock Hours

Book By Mail – $33 • **ONLINE – $25**

Purpose: The purpose of this course is to provide mental and behavioral health professionals with the knowledge and skills necessary to provide trauma-informed care to African American clients.
Faculty: Tanika Johnson, EdD, MA, LPC-MHSP, LMHC, NCC, BC-TMH, CCTP
Audience: This course is designed for mental and behavioral health professionals who provide services to African American clients who have experienced racial trauma.

Are you licensed in other states?
Our Unlimited Online Special Offer includes all state mandates!
www.NetCE.com/Unlimited

Prices are subject to change. Visit www.NetCE.com for a list of current prices.

Course Availability List *(Cont'd)*

DOMESTIC AND SEXUAL VIOLENCE
#77791 • 5 Clock 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 Clock 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.

MEANINGS OF MENOPAUSE: CULTURAL CONSIDERATIONS
#93503 • 5 Clock Hours
Book By Mail – $33 • **ONLINE – $25**
Purpose: The purpose of this course is to provide social workers, counselors, and healthcare providers with an understanding of the multifaceted attitudes toward aging, sexuality, and gender roles so they may provide culturally competent and sensitive interventions targeted to the unique psychosocial issues confronted by menopausal women.
Faculty: Alice Yick Flanagan, PhD, MSW
Audience: This course is designed for social workers, psychologists, therapists, mental health counselors, nurses, physicians, and other members of the interdisciplinary team who work with women.

MEDICAL MARIJUANA AND OTHER CANNABINOIDS
#95172 • 5 Clock 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.

HUMAN TRAFFICKING AND EXPLOITATION
#96312 • 5 Clock Hours
Book By Mail – $33 • **ONLINE – $25**
Purpose: As human trafficking becomes an increasingly more common problem in the United States, healthcare and mental health professionals will require knowledge of human trafficking patterns, the health and mental health needs of human trafficking victims, and successful interventions for victims. 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 physicians, nurses, social workers, psychologists, therapists, mental health counselors, and other members of the interdisciplinary team who may intervene in suspected cases of human trafficking and/or exploitation.

OBSESSIVE-COMPULSIVE DISORDER
#96473 • 4 Clock Hours
Book By Mail – $28 • **ONLINE – $20**
Purpose: The purpose of this course is to provide healthcare professionals with a basic understanding of obsessive-compulsive disorder (OCD), its clinical manifestations, and basic treatment approaches in order to facilitate optimum patient care and outcomes.
Faculty: John J. Whyte, MD, MPH
Audience: This course is designed for healthcare professionals working with adults or adolescent patients who exhibit symptoms of obsessive-compulsive disorder.

METHAMPHETAMINE USE DISORDER
#96953 • 5 Clock Hours
Book By Mail – $33 • **ONLINE – $25**
Purpose: Methamphetamine use has risen alarmingly, reaching epidemic proportions in some regions. The purpose of this course is to provide a current, evidence-based overview of methamphetamine abuse and dependence and its treatment in order to allow healthcare professionals to more effectively identify, treat, or refer patients who use methamphetamine.
Faculty: Mark Rose, BS, MA, LP
Audience: This course is designed for health and mental health professionals who are involved in the evaluation or treatment of persons who use methamphetamine.

Prices are subject to change. Visit www.NetCE.com for a list of current prices.

Course Availability List *(Cont'd)*

OPIOID USE DISORDER

#96963 • 10 Clock 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.

SEXUAL HARASSMENT PREVENTION: THE ILLINOIS REQUIREMENT

#97081 • 1 Clock Hour

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.

Additional Approval: AACN Synergy CERP Category C

Special Approvals: This course is designed to fulfill the Illinois requirement for 1 hour of continuing education in the area of sexual harassment prevention.

CULTURAL COMPETENCE: AN OVERVIEW

#97430 • 2 Clock Hours

Book By Mail – $23 • **ONLINE – $15**

Purpose: 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.

Faculty: Alice Yick Flanagan, PhD, MSW

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

CHILD ABUSE IN ETHNIC MINORITY AND IMMIGRANT COMMUNITIES

#97583 • 10 Clock Hours

Book By Mail – $58 • **ONLINE – $50**

Purpose: The purpose of this course is to facilitate appropriate and culturally sensitive responses on the part of allied healthcare professionals to cases of child abuse and neglect.

Faculty: Alice Yick Flanagan, PhD, MSW

Audience: This course is designed for physicians, nurses, social workers, therapists, mental health counselors, and other allied health professionals who may intervene in suspected cases of child abuse.

ELDER ABUSE: CULTURAL CONTEXTS AND IMPLICATIONS

#97823 • 5 Clock Hours

Book By Mail – $33 • **ONLINE – $25**

Purpose: The purpose of this course is to increase the knowledge base of social workers, nurses, physicians and other allied health professionals about elder abuse, assessment, and intervention. This curriculum will focus on abuse against elders in domestic settings perpetrated by family members.

Faculty: Alice Yick Flanagan, PhD, MSW

Audience: This course is targeted to physicians, nurses, social workers, and other allied health professionals who may identify and intervene in cases of elder abuse.

AGING AND LONG-TERM CARE

#99353 • 3 Clock 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.

Prices are subject to change. Visit www.NetCE.com for a list of current prices.

Social Worker Continuing Education Requirements by State

State	Approval Accepted by Board	Hours Allowed by Home Study
Alabama	#0515 & ASWB	LICSW, LMSW, LBSW, LICSW-PIP 20✶, ♦
Alaska	ASWB	45✶, ❖, ♦
Arizona	ASWB	30✶, ❖, ♦
Arkansas	Approved	15✶
California	ASWB	36✶, ♦
Colorado	Approved	40 (Coursework)
Connecticut	ASWB	6❖, ♦
Delaware	ASWB	LCSW 40✶, ♦; LMSW 30✶, ♦; LBSW 20✶, ♦
District of Columbia	ASWB	12✿, ♦
Florida	#50-2405	30✶, ♦
Georgia	ASWB	10✿
Hawaii	ASWB	45✶
Idaho	ASWB	20✶
Illinois	#159.001094	15✶, ❖, ♦
Indiana	ASWB	40✶
Iowa	ASWB	27✶, ♦
Kansas	Accepted by Board	40✶, ♦
Kentucky	ASWB	LCSW, CSW 27✤, ♦; LSW 12✤, ♦
Louisiana	Accepted by Board	20✶, ♦ May complete all hours by distance learning through 8/31/2023
Maine	Accepted by Board	10✶, ♦
Maryland	ASWB	LCSW, LGSW, LCSW-C 20✶; LBSW 15✶
Massachusetts	ASWB	LICSW 30♦; LCSW 20♦; LSW 15♦; LSWA 10♦
Michigan	ASWB	22.5✶, ♦; Cultural❖
Minnesota	ASWB	20✶, ♦
Mississippi	ASWB	20✶, ❖
Missouri	ASWB	40✶, ♦ May complete all hours by home study through 2021/2022 renewal due to COVID-19
Montana	Accepted by Board of Scope of Practice	20
Nebraska	ASWB	20✶
Nevada	ASWB	LASW, LSW 30✶, ♦; LISW, LCSW 36✶, ♦
New Hampshire	ASWB	20✶, ♦
New Jersey	NASW-NJ†	LCSW 40✶, ❖, ♦; LSW 30✶, ❖, ♦; CSW 20✶, ❖, ♦
New Mexico	ASWB	30♦, ✤, ❖
New York	SW-0033†	36♦ May complete all hours by home study through 1/1/23 due to COVID-19
North Carolina	ASWB	20✶
North Dakota	ASWB	10✶
Ohio	ASWB	LISW 30♦, ✶; LSW, SWA 30✶
Oklahoma	ASWB	8✶
Oregon	ASWB	RBSW 20✶; LMSW 30✶; LCSW 40✶; Semi-retired LCSW 20✶
Pennsylvania	ASWB	30✶, ♦
Rhode Island	ASWB	8✶, ❖
South Carolina	ASWB	40♦
South Dakota	ASWB	10
Tennessee	Accepted by Board	LCSW, LAPSW 15✶; LMSW 12✶; LBSW 9✶, ♦
Texas	Accepted by Board	30✶
Utah	ASWB	15✶, ♦
Vermont	ASWB	LICSW 5✶; LMSW None
Virginia	ASWB	LCSW 30✶; LBSW, LMSW, LSW 15✶
Washington	ASWB	SWIs, SWAs 26✶, ♦; SWIA, SWAAs 18✶
West Virginia	ASWB	20 (in-print), 10 (online) ✶, ♦
Wisconsin	ASWB	26✿
Wyoming	ASWB	45✶, ♦

✶ Special mandate: Ethics
❖ Special mandate: Cultural Competence
♦ Additional requirements: Please go to www.NetCE.com/ce-requirements for more information.
✤ Ethics must be completed through an approved provider.
✿ Ethics must be live participatory.
† Selected courses approved. See individual course details at www.NetCE.com.

As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. **State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit.**

NetCE
A TRC Healthcare Company

Customer Information

(Incomplete information may delay processing.)

For office use only:
SW22B

Please print your Customer ID # located on the back of this catalog. *(Optional)*

Order/complete by mail
P.O. Box 997571
Sacramento, CA 95899-7571

Order/complete by fax
(916) 783-6067

Contact us
(800) 232-4238

Email us
help@NetCE.com

Order/complete online
www.NetCE.com/SW22B

Last Name First Name MI

State License # Exp.

State Additional License # Exp.

License Type (circle one): LSW / LBSW / LCSW / LISW / LICSW / LMSW / LSWA / CSW / MSW / LAMSW / SWA / SW / Other:

Address

City State Zip

Phone ( )

Fax ( )

Email

☐ Sign me up for NetCE Alerts, Promotions, License Reminders, and More!

Receive certificate(s) by:
☐ Online Access - FREE! Email required
☐ Email - FREE!
☐ Fax - FREE!
☐ Mail - Add $6 for shipping and handling

Complete before May 31, 2023, pay $41

Complete after May 31, 2023, pay $52

ENCLOSED SPECIAL OFFER: 12 CLOCK HOURS

You may complete ALL three courses for a maximum payment of $41, or pay the individual course price, whichever is less.

✓	Course #	Course Title / Clock Hours	Price
☐	97000	Implicit Bias in Health Care / 3 Clock Hours	$15
☐	97663	Online Professionalism and Ethics / 3 Clock Hours	$15
☐	76032	An Introduction to EMDR & Related Approaches in Psychotherapy / 6 Clock Hours	$30

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 / Clock Hours	Price
☐	71072	Beyond Therapy: The Basics of Clinical Documentation / 4	$28
☐	71482	Evidence-Based Practice in Social Work / 3	$23
☐	71793	Promoting the Health of Gender & Sexual Minorities / 5	$33
☐	76431	Mass Shooters and Extremist Violence / 15	$83
☐	76441	Suicide Assessment and Prevention / 6	$38
☐	76863	Clinical Supervision: A Person-Centered Approach / 10	$58
☐	76920	Racial Trauma: The African American Experience / 5	$33
☐	77791	Domestic and Sexual Violence / 5	$33
☐	91693	Families of Patients with Chronic Illness / 10	$58
☐	93503	Meanings of Menopause: Cultural Considerations / 5	$33
☐	95172	Medical Marijuana and Other Cannabinoids / 5	$33
☐	96312	Human Trafficking and Exploitation / 5	$33
☐	96473	Obsessive-Compulsive Disorder / 4	$28
☐	96953	Methamphetamine Use Disorder / 5	$33
☐	96963	Opioid Use Disorder / 10	$58
☐	97081	Sexual Harassment Prevention: The Illinois Req. / 1	$23
☐	97430	Cultural Competence: An Overview / 2	$23
☐	97583	Child Abuse in Minority and Immigrant Comm. / 10	$58
☐	97823	Elder Abuse: Cultural Contexts and Implications / 5	$33
☐	99353	Aging and Long-Term Care / 3	$23

☐ Check or Money Order (*payable to NetCE*)
☐ VISA / MasterCard / AmEx / Discover

Please print name (as shown on credit card)

Credit card #

/
Expiration date

Security code

Security code is last three numbers from back of credit card, in the signature area. Four numbers on front of card, above the account number on AmEx cards.

Signature

Special Offer (before May 31, 2023) $41

$52 (after May 31, 2023)

I would like my certificates mailed for an additional $6

Additional Courses

Subtotal

Expedited Delivery

Do not include Sales Tax $ 0
(Applicable sales tax is included for sales made to California addressees.)

Grand Total

Expedited mail delivery (within 2 to 3 days) is available in most areas at an additional charge of $35. Call for information on international delivery.

Prices are subject to change. Visit www.NetCE.com for a list of current prices.

SW22B

Answer Sheet

(Completion of this form is mandatory)

NETCE
P.O. BOX 997571
SACRAMENTO, CA
95899-7571

Please note the following:

- A passing grade of at least 80% must be achieved on each course test in order to receive credit.
- Darken only one circle per question.
- Use pen or pencil; please refrain from using markers.
- **Information on the Customer Information form must be completed.**

#97000 IMPLICIT BIAS IN HEALTH CARE—3 CLOCK HOURS

Please refer to pages 13–14.

Expiration Date: 08/31/24

May be taken individually for $15

	A	B	C	D		A	B	C	D		A	B	C	D		A	B	C	D
1.	❍	❍	❍	❍	6.	❍	❍	❍	❍	11.	❍	❍	❍	❍	16.	❍	❍	❍	❍
2.	❍	❍	❍	❍	7.	❍	❍	❍	❍	12.	❍	❍	❍	❍	17.	❍	❍	❍	❍
3.	❍	❍	❍	❍	8.	❍	❍	❍	❍	13.	❍	❍	❍	❍	18.	❍	❍	❍	❍
4.	❍	❍	❍	❍	9.	❍	❍	❍	❍	14.	❍	❍	❍	❍	19.	❍	❍	❍	❍
5.	❍	❍	❍	❍	10.	❍	❍	❍	❍	15.	❍	❍	❍	❍	20.	❍	❍	❍	❍

#97663 ONLINE PROFESSIONALISM AND ETHICS—3 CLOCK HOURS

Please refer to pages 28–29.

Expiration Date: 04/30/24

May be taken individually for $15

	A	B	C	D		A	B	C	D		A	B	C	D		A	B	C	D
1.	❍	❍	❍	❍	6.	❍	❍	❍	❍	11.	❍	❍	❍	❍	16.	❍	❍	❍	❍
2.	❍	❍	❍	❍	7.	❍	❍	❍	❍	12.	❍	❍	❍	❍	17.	❍	❍	❍	❍
3.	❍	❍	❍	❍	8.	❍	❍	❍	❍	13.	❍	❍	❍	❍	18.	❍	❍	❍	❍
4.	❍	❍	❍	❍	9.	❍	❍	❍	❍	14.	❍	❍	❍	❍	19.	❍	❍	❍	❍
5.	❍	❍	❍	❍	10.	❍	❍	❍	❍	15.	❍	❍	❍	❍	20.	❍	❍	❍	❍

#76032 AN INTRODUCTION TO EMDR & RELATED APPROACHES IN PSYCHOTHERAPY—6 CLOCK HOURS

Please refer to pages 50–52.

Expiration Date: 05/31/25

May be taken individually for $30

	A	B	C	D		A	B	C	D		A	B	C	D		A	B	C	D
1.	❍	❍	❍	❍	11.	❍	❍	❍	❍	21.	❍	❍	❍	❍	31.	❍	❍	❍	❍
2.	❍	❍	❍	❍	12.	❍	❍	❍	❍	22.	❍	❍	❍	❍	32.	❍	❍	❍	❍
3.	❍	❍	❍	❍	13.	❍	❍	❍	❍	23.	❍	❍	❍	❍	33.	❍	❍	❍	❍
4.	❍	❍	❍	❍	14.	❍	❍	❍	❍	24.	❍	❍	❍	❍	34.	❍	❍	❍	❍
5.	❍	❍	❍	❍	15.	❍	❍	❍	❍	25.	❍	❍	❍	❍	35.	❍	❍	❍	❍
6.	❍	❍	❍	❍	16.	❍	❍	❍	❍	26.	❍	❍	❍	❍					
7.	❍	❍	❍	❍	17.	❍	❍	❍	❍	27.	❍	❍	❍	❍					
8.	❍	❍	❍	❍	18.	❍	❍	❍	❍	28.	❍	❍	❍	❍					
9.	❍	❍	❍	❍	19.	❍	❍	❍	❍	29.	❍	❍	❍	❍					
10.	❍	❍	❍	❍	20.	❍	❍	❍	❍	30.	❍	❍	❍	❍					

NetCE
A TRC Healthcare Company

Evaluation

(Completion of this form is mandatory)

SW22B

Last Name _____ First Name _____ MI _____

State _____ License # _____ Expiration Date _____

To receive continuing education credit, completion of this Evaluation is mandatory.

Compliance with Association of Social Work Boards (ASWB) standards 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?

#97000
Implicit Bias in Health Care
3 Clock 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

#97663
Online Professionalism & Ethics
3 Clock 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

#76032
EMDR & Related Approaches
6 Clock 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

#97000 Implicit Bias in Health Care — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

_____

#97663 Online Professionalism and Ethics — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

_____

#76032 An Introduction to EMDR and Related Approaches in Psychotherapy — 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.

NetCE
A TRC Healthcare Company

Evaluation *(Continued)*

SW22B

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):

#97000 IMPLICIT BIAS IN HEALTH CARE—3 CLOCK HOURS (Course expires 08/31/24)

• Define implicit and explicit biases and related terminology.	☐ A	☐ B	☐ C	☐ D	☐ F
• Evaluate the strengths and limitations of the Implicit Association Test.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe how different theories explain the nature of implicit biases, and outline the consequences of implicit biases.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss strategies to raise awareness of and mitigate or eliminate one's implicit biases.	☐ A	☐ B	☐ C	☐ D	☐ F

#97663 ONLINE PROFESSIONALISM AND ETHICS—3 CLOCK HOURS (Course expires 04/30/24)

• Define Internet usage patterns and common Internet technologies.	☐ A	☐ B	☐ C	☐ D	☐ F
• Analyze how various Internet technologies are utilized in clinical practice.	☐ A	☐ B	☐ C	☐ D	☐ F
• Define professionalism.	☐ A	☐ B	☐ C	☐ D	☐ F
• Evaluate how the use of specific Internet technologies can affect professionalism and ethics.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss how the use of Internet technologies can impact issues of boundaries, self-disclosure, privacy/confidentiality, and professional relationships.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify best practices for using Internet technologies as a clinical practitioner.	☐ A	☐ B	☐ C	☐ D	☐ F

#76032 AN INTRODUCTION TO EMDR AND RELATED APPROACHES IN PSYCHOTHERAPY—6 CLOCK HOURS (Course expires 05/31/25)

• Define trauma and explain the manifestation of unhealed trauma on the human experience, as conceptualized by the eye movement desensitization and reprocessing (EMDR) approach to psychotherapy and its adaptive information processing (AIP) model.	☐ A	☐ B	☐ C	☐ D	☐ F
• Explain how EMDR was discovered and developed by Francine Shapiro, making connections to the overall healing role of bilateral stimulation in the human experience.	☐ A	☐ B	☐ C	☐ D	☐ F
• Outline components of the AIP model.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe, in general sense, how EMDR works to help a person stabilize, reprocess, and reintegrate after a traumatic experience(s).	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss the variations in how EMDR is used by clinicians in the modern era.	☐ A	☐ B	☐ C	☐ D	☐ F
• Distinguish what makes an intervention purely EMDR therapy versus an EMDR-related intervention.	☐ A	☐ B	☐ C	☐ D	☐ F
• Summarize the characteristics of candidates for EMDR therapy and related approaches.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe how to implement a basic "tapping in" strategy for client stabilization (an EMDR-informed intervention).	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss how to conduct a trauma history/assessment on a client using principles of the AIP model.	☐ A	☐ B	☐ C	☐ D	☐ F
• Decide whether or not further training in EMDR or an EMDR-related intervention is a good fit for one's own clinical repertoire.	☐ A	☐ B	☐ C	☐ D	☐ F

Signature _____

Signature required to receive continuing education credit.

Want More CE Choices?

NetCE
A TRC Healthcare Company

Get One Year of Unlimited Online CE for ONLY $79!
Includes access to our entire course library of more than 750 hours, including special offers and state-required courses!

COVID-19 SPECIAL OFFER FOR MHPs
The Coronavirus Disease (COVID-19) Pandemic • Online Professionalism and Ethics • Families of Patients with Chronic Illness
15 Hours $41 *(Not Available to New York Social Workers)*

PSYCHIATRIC SPECIAL OFFER
Obsessive-Compulsive Disorder • Opioid Use Disorder • Postpartum Depression
29 Hours $62 *(Not Available to New York Social Workers)*

ADDICTION SPECIAL OFFER
Methamphetamine Use Disorder • Cannabis and Cannabis Use Disorders • Cocaine Use Disorder
15 Hours $41

GLOBAL HEALTH SPECIAL OFFER
The Coronavirus Disease (COVID-19) Pandemic • Bioterrorism • Domestic and Sexual Violence
12 Hours $41 *(Not Available to New York Social Workers)*

The above Online Specials are included with your Unlimited Subscription or may be purchased individually.

To order, please visit www.NetCE.com.

BUSINESS HOURS: Monday through Friday, 8am-5pm Pacific Time. We are closed on weekends and holidays.

CUSTOMER SERVICE: 800-232-4238 or help@netce.com. Call or email us for customer assistance, course catalogs, additional certificates, or transcripts. If you require special assistance, please contact the Director of Development and Academic Affairs to inform her of your needs by calling 800-232-4238.

RETURN POLICY: Satisfaction guaranteed or your money back within 30 days of purchase, unless certificates have been issued. Please return the materials and include a brief note of explanation. For more information, please contact help@NetCE.com.

TURNAROUND TIME: Your order is processed the day it is received. Course material and/or certificates of successful completion are returned to you via first class mail, fax, or email.

MAILING PREFERENCES: To modify your mailing preferences or to view our privacy policy, please go to www.NetCE.com.

PRICING: Prices are subject to change. Visit www.NetCE.com for a list of current prices.

RETURNED CHECKS: If, for any reason, your check is returned, you will be contacted requesting a cashier's check or money order for the full amount of the order plus a $35 reinstatement fee. In addition, we are unable to accept temporary checks.

If you have questions about your license or certification renewal or state requirements, please contact your board. A list of approvals and accreditations is available on our website at www.NetCE.com.

NetCE
A TRC Healthcare Company

NetCE | P.O. Box 997571 | Sacramento, CA 95899 | 800-232-4238 | Fax: 916-783-6067

NetCE
A TRC Healthcare Company

P.O. Box 997571
Sacramento, CA 95899

Vol. 147
No. 26
SW22B

Complete online at NetCE.com/SW22B

Quick Code#

Customer ID#

Like us at NetCE!

We Recycle

Scan this QR code to get started. If you do not have a smartphone or QR code reader, please visit **NetCE.com/SW22B.**