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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

Counseling Patients at the End of Life

Approval(s): APA, NBCC, NAADAC

Audience
This course is designed for all members of the interprofessional team responsible for supporting patients at the end of life.

Course Objective
The purpose of this course is to provide allied health professionals, physicians, nurses, and physician assistants with the knowledge and strategies necessary to best assist patients to seek and receive optimal end-of-life care.

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

1. Define palliative and end-of-life care.
2. Outline the role of health and mental health professionals in end-of-life counseling.
3. Identify psychological concerns present at the end of life.
4. Discuss key components of end-of-life conversations.
5. Analyze mental health interventions that can be incorporated into end-of-life care and bereavement.
6. Describe practical, ethical, and legal issues that can arise in the provision of end-of-life care.
7. Examine the impact of culture and culturally competent care on end-of-life decisions and support.

Faculty
Lisa Hutchison, LMHC, has more than 20 years of experience providing individual and group counseling with adults. She specifically focuses on teaching assertiveness, stress management, and boundary setting for empathic helpers. Ms. Hutchison graduated from the University of Massachusetts, Boston, with a Master's degree in education for mental health counseling.

Faculty Disclosure
Contributing faculty, Lisa Hutchison, LMHC, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planner
Alice Yick Flanagan, PhD, MSW
Margaret Donohue, PhD

Senior Director of Development and Academic Affairs
Sarah Campbell

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NetCE designates this continuing education activity for 2 NBCC clock hours.

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INTRODUCTION

End-of-life decisions can be complex and challenging. Health and mental health professionals can help with their expertise, whether it is for the person facing death, their family, surrogate decision makers, or caregiver. It is vital for health and mental health professionals to learn when and how to include end-of-life discussions into their sessions, assist with decision making and planning, and learn the differences between palliative and end-of-life care.

DEFINING END-OF-LIFE CARE

The terms palliative care and end-of-life care often are used interchangeably, but there are some differences. The goal of palliative care is to improve the quality of life of patients and their families when faced with life-threatening illness. This is achieved through the prevention and relief of suffering and treatment of pain and other physical, psychosocial, and spiritual problems [1]. Palliative care includes measures used to achieve comfort for the patient. Palliative care can be provided at any stage of a serious illness, including as early as the time of diagnosis. Unlike patients receiving end-of-life care, those receiving palliative care may still be pursuing curative treatment [2].

End-of-life care (which may include palliative care) is generally defined as care that is provided to seriously ill patients who have a prognosis of six months or less. It is care intended for the last few weeks or months of a patient's life. End-of-life care can be provided in a variety of settings, including the patient's home, nursing homes or assisted living facilities, or inpatient hospice facilities [2]. End-of-life care is a multidisciplinary team approach toward "whole person care." It is intended for people with advanced, progressive, incurable, or life-limiting illness to enable them to live as well as possible before they die [3]. This course will focus on end-of-life care.

THE ROLE OF HEALTH AND MENTAL HEALTH PROFESSIONALS IN END-OF-LIFE COUNSELING

The transition of care from eliminating or mitigating illness to preparing for death can be difficult for patients, families, and caregivers, and it can be equally difficult for healthcare professionals, who are expected to meet the physical and emotional needs of dying patients and their families [4]. By understanding the experiences of the dying patient, health and mental health professionals can best support the unique needs of each patient and the patient's loved ones as well as self and other members of the patient's healthcare team [4; 5; 6; 7]. Mental health professionals are uniquely positioned to address the cognitive, mental, and emotional needs that arise during this period of life-limiting illness [8; 9]. They work to normalize emotions during a difficult time; provide spiritual support; educate about normal physical, emotional, and social changes; and assist in managing practical problems. They also may develop relationships with survivors to provide a continuity of care following the patient's death. Health and mental health professionals work in a variety of settings that address end-of-life care, including health agencies, hospitals, hospice and home care settings, nursing homes, and courts [10].

Both end-of-life and palliative counseling are services provided by clinicians who work with the terminally ill. End-of-life counseling helps patients struggling with death or families struggling with the death of a loved one and may be provided by counselors, therapists, social workers, psychologists, critical care nurses, physicians, hospice workers, and others trained in working with emotions related to death, dying, grief, and bereavement [8].

Health and mental health providers provide services to diverse individuals in a variety of settings, including end-of-life settings, as part of an interprofessional team. In the end-of-life setting, clinicians help dying patients prepare for death with education and supportive therapeutic interventions that address the patient's physical, emotional, social, spiritual, and practical needs [10]. They also help patients and their families navigate the many challenges associated with dying, including end-of-life planning; managing stresses associated with life-limiting illness; assessing patients to develop interventions and treatment planning; advocating for patients' treatment plans; overcoming crisis situations; and connecting them with other support services [11; 12]. Life-limiting illness is mentally taxing and can exacerbate or incite symptoms of anxiety, depression, and trauma and make manifest complex presentations of cognitive decline. Providers can help differentiate between trauma symptoms, mental illness, or medical decline. Reducing mental health symptoms can help patients engage more meaningfully, including in the participation of end-of-life decisions [9]. A cohesive, standardized approach to end-of-life care addresses issues related to the patient, family, caregivers, and the team of healthcare professionals involved in providing care [12].

PSYCHOLOGICAL CONCERNS FOR PATIENTS AT THE END OF LIFE

Psychological suffering is a universal experience for patients at the end of life. It exists on a continuum and has many sources, including grief over anticipated loss or worry about unresolved issues. It is important to assess and differentiate the major types of distress in the dying patient and among their families to effectively treat these sources of suffering.

LIFE-CYCLE ISSUES/RELATIONSHIPS

Psychological responses to the news of a life-limiting illness will vary according to the patient's developmental stage. The young adult, about to become independent, might struggle with being thrust back into dependence upon parents or other adult figures. Parents of young children with life-limiting illness often are consumed with what and how much to tell their ill child, the impact of the child's illness on other siblings, and how to cope with the loss of the child's future. Worries about a spouse or partner are a common concern for older adults. They may feel cheated out of the expected rewards of a life of hard work. Worries about family members are a major issue for most patients at the end of life [13]. One study found that 92% to 97% of patients rated as extremely or very important "feeling appreciated by my family," "saying goodbye to people closest to me," "expressing my feelings to family," and "knowing that my family will be all right without me" [14]. Caregivers of patients with terminal illness also experience significant strains (e.g., adverse impact on work and finances) [15]. Awareness of these life-cycle and relationship issues can help the clinician listen for and inquire about concerns and emotions, normalize patient responses, and explore areas of distress [13].

MEANING AND IDENTITY

Illness comes with practical and emotional challenges that are unique to each patient. The clinician who understands what the illness means to the patient can identify specific concerns, address fears, provide reassurance, and help the patient make plans. Providing patients with the opportunity to share what their illness means can be therapeutic in and of itself [13]. Some patients state that finding meaning in illness is derived from the belief that their life has a purpose that extends beyond self. Others find that meaning enhances their ability to cope with their illness. Still others experience a loss of meaning when faced with life-limiting illness. The patient's ability to find and maintain a sense that life has purpose and meaning is associated with the ability to tolerate physical symptoms of the illness and protect against depression and a desire for hastened death [13]. Meaning and hope are closely allied in patients at the end of life, and hopes for the future reflect the patient's priorities.

Maintaining a sense of self is a high priority among patients with life-limiting illness, yet serious illness has a profound impact on patient self-identity. The physical and psychological losses (e.g., loss of feeling whole, loss of independence, loss of control) present major challenges to the patient's emotional health. Control and independence often are combined in the literature to mean the patient's dignity, or the "quality or state of being worthy, honored, or esteemed" [13]. Preservation of this dignity should be a primary concern of end-of-life care practitioners.

COPING AND STRESS

Confronting a life-limiting illness causes patients to make psychological adjustments to preserve equilibrium. Coping responses can include seeking information about the illness, staying busy to avoid thinking about the illness, resigning one's self to the illness, examining alternatives, and talking about feelings. Effective coping occurs when the patient is able to use active problem-solving strategies. Yet, as illnesses progress, patients' ability to perform cognitive tasks can decline. Some patients cope by defending against or denying the reality of their illness to fend off acute emotional distress. The dynamic tension between coping and defending/denying causes most patients to use a combination of these responses [13]. While denial is a powerful mechanism that helps preserve psychological equilibrium, it can have many negative effects, including refusal to accept death; lost trust in the healthcare team; focus on unrealistic treatment goals; and failure to make legal, financial, and healthcare arrangements [13]. Life-limiting illness represents a major adaptational challenge to patients' learned coping mechanisms. Psychosocial stressors enhance the likelihood that a patient will become depressed. Practical stressors (e.g., relationships, work, finances, legal matters) also can impact patients' ability to cope with their illness. Economic circumstances have been found to be a major stressor for patients and their families, often resulting in a decline in family economic well-being [13]. In one study, 20% of family members of seriously ill adult patients had to make a major life change (including quitting work) to care for their loved one; up to 31% of families lost all or most of their savings while caring for their ill loved one [14].

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) may first emerge, re-emerge, or worsen as individuals approach the end of life and may complicate the dying process. Unfortunately, lack of awareness of the occurrence and/or manifestation of PTSD at the end of life can result in it being unaddressed in these patients. Even if PTSD is properly diagnosed, traditional evidence-based, trauma-focused treatments may not be feasible or advisable for patients at the end of life, as they often lack the physical and mental stamina to participate in traditional psychotherapy [16]. Many therapies for PTSD require a longer window of treatment than a typical hospice period. Providers can tailor treatment for short-term interventions or use approaches such as the Stepwise Psychosocial Palliative Care (SPPC) model. The SPPC model is a multidimensional approach, integrating environmental, problem-solving, and other psychosocial interventions with patient advocacy in a patient-centered, time-sensitive manner. It incorporates techniques drawn from evidence-based approaches to PTSD, deploying them in a stage-wise manner appropriate for patients at the end of life [17]. Debriefing interventions have been widely used to treat PTSD and the psychological sequelae of traumatic events, and these approaches can be appropriate in the end of life.

Further, antidepressant, antianxiety, and antipsychotic agents may be used to manage intense symptoms. Support groups and psychoeducational approaches are also common approaches, but evidence of their effectiveness in this setting is lacking [13].

ANTICIPATORY GRIEF

Anticipatory grief is the experience of grieving the loss of a patient or loved one in advance of their death [18]. It is a response to impending loss of life, identity, function, hopes, and future plans and is associated with anxiety, depression, hopelessness, and strained communication [19]. Other intense emotions, such as fear and panic, can appear as a result of unexplained symptoms and uncertainties regarding treatment [20]. One study evaluated anticipatory grief in 57 family members of patients with terminal illness receiving palliative care services [18]. Elevated anticipatory grief was found in families characterized by relational dependency, lower education, and poor grief-specific support. These families also experienced discomfort with closeness and intimacy, neuroticism, spiritual crisis, and an inability to make sense of the loss [18]. Patients, families, caregivers, and clinicians all can experience anticipatory grief. Several factors (e.g., spiritual beliefs, quality of relationships, attitudes of close others or colleagues/peers) can influence the anticipatory grief toward either positive or negative outcomes [21].

As a core component of psychological flexibility, acceptance is beneficial in situations in which individuals have little or no control over circumstances, such as when faced with a life-limiting illness. Acceptance becomes an active process wherein the patient acknowledges and opens up to their situation in order to make the most of their remaining time. Although acceptance shares a strong relationship with anticipatory grief, depression, and anxiety, it is independent of anxious and depressive symptomatology and more likely to predict the level of anticipatory grief than anxiety or depression. A higher degree of acceptance is associated with lower anticipatory grief in patients in palliative care [19]. When anticipatory grief is an expression of past or current trauma, it may develop into complicated grief if left untreated. A thorough assessment is warranted to determine if the grief is current or connected to unresolved trauma. Consider treating the initial trauma before the anticipatory grief. At the end of life, if time does not allow for intensive treatment, look to reduce individual trauma symptoms or grief.

ANXIETY AND FEAR

Death is an ever-present reality despite increasingly technologically advanced health systems, longer survivals, and novel curative treatments for life-threatening conditions [22]. Fear of the unknown has been described as the propensity to experience fear caused by the perceived absence of information at any level of consciousness or point of processing [23]. Fear of death and dying is common. In one study, a majority (70%) of participants reported some, a little, or no fear of death and dying; 30% reported more severe fears [24]. A common fear in Western society is that the process of dying will be painful and prolonged and will reduce the quality of life. Other fears associated with death include [25]:

- Fear of separation from loved ones, home, and job
- Fear of becoming a burden to others
- Fear of losing control
- Fear for dependents
- Fear of pain or other worsening symptoms
- Fear of being unable to complete life tasks or responsibilities
- Fear for the fears of others (reflected fear)
- Fear of being dead

It is important that clinicians allow patients a full expression of these fears, without judgment. Patients with anxiety often cannot take in information and may ask the same questions over and over again. They may seek detailed information or not ask reasonable questions. They may be suspicious of the physician's recommendations or not ask questions because of regression or high levels of fear. They may over-react to symptoms or treatments or behave inexpressively and stoically. Their behavior may seem inconsistent and impulsive [13]. An ongoing assessment of anxiety symptoms and anxiety's various presentations is critical to maintaining the patient's mental health. Equally important is that the clinician recognize that anxiety in end-of-life care also may be the result of a pre-existing anxiety disorder or other undertreated symptoms, especially pain. A multidrug treatment regimen in the palliative care setting also can contribute to anxiety [13].

Thanatophobia

Thanatophobia is an extreme fear of death or of the dying process [26]. Fear of death as a disease entity behaves much like initial anxiety due to trauma that leads to PTSD [27]. Evidence suggests that thanatophobia is highest in patients who do not have high self-esteem, religious beliefs, good health, a sense of fulfillment in life, intimacy, or "a fighting spirit" [27]. While anxiety, depressive symptoms, and beliefs about what will happen after death can contribute to a patient's fear, death anxiety does not always follow after a diagnosis of life-limiting illness [27]. It appears to be a basic fear at the core of a range of mental disorders, including hypochondriasis, panic disorder, and anxiety and depressive disorders [28]. Antecedents of death anxiety include stressful environments and the experience of unpredictable circumstances, diagnosis of a life-threatening illness or the experience of a life-threatening event, and experiences with death and dying. Consequences of death anxiety include both adaptive and maladaptive presentations. When encountering death anxiety in a patient, assess for PTSD and the various anxiety disorders to determine whether it is anxiety-based or associated with an underlying trauma [22].

Death anxiety is a central feature of health anxiety and may play a significant role in other anxiety disorders [29]. Exposure to death-related themes has been found useful for the treatment of death anxiety [29]. A 2015 study that assessed death anxiety among patients with life-limiting cancer found that life stage, particularly having dependent children, and individual factors, such as lower self-esteem, increased patients' vulnerability to death anxiety [30]. Depressive symptoms also have been reported in health professionals who work with dying patients [31]. A 2011 study sought to assess the impact of death and dying on the personal lives of clinicians involved in end-of-life care [32]. Early life experiences and clinical exposure to death and dying helped the clinicians to live in the present, cultivate spirituality, and reflect on their own mortality and the continuity of life. Despite reporting accounts of death's ugliness, participants consistently described the end of life as a meaningful life stage [32]. Yet, not all clinicians find that working with patients at the end of life decreases their death-related anxiety, and many will require support and guidance. Burnout and death anxiety can be emotionally devastating, resulting in impaired performance that makes the goal of quality patient care almost impossible to accomplish [33]. All providers of end-of-life care should be reminded that they are not alone and that they can rely on other members of the healthcare team [34].

Education about death also may be helpful. In a 2015 study of 86 human services professionals, participation in a course on death, dying, and bereavement was shown to significantly reduce clinicians' fear of death and death anxiety [35]. In a study that included 42 nurses enrolled in death education programs, some affirmative impacts on the death distress of participants was observed [31]. Younger nurses consistently reported a stronger fear of death and more negative attitudes towards end-of-life patient care, indicating that workplace education might be beneficial [36]. One study investigated whether a brief induction of gratitude could reduce death anxiety [37]. Participants (mean age: 62.7 years) were randomly assigned into one of three conditions (gratitude, hassle, and neutral) and asked to write about a variety of life events before responding to measures of death anxiety. Participants in the gratitude condition reported lower death anxiety than those in the hassle and neutral conditions; no difference was observed between hassle and neutral conditions [37]. Even a temporary relief of death anxiety may help facilitate the making of important end-of-life decisions [37].

PAIN

Pain management is an integral part of palliative care. Pain management in end-of-life care presents unique opportunities in the patient-physician relationship [38]. In some instances, pain can be reduced when the patient has a sense of control and knows what to expect. Patients report feeling empowered by participating in treatment decisions with their physicians [39]. Pain management in children presents special challenges. A multidisciplinary team with an open attitude to differences, listening skills, availability, flexibility, creativity, resourcefulness, and empathy can help the child and his or her family live with the least pain possible [40]. For both adult and pediatric patients at the end life, planning for what could happen is often key. Honest, dynamic discussions about treatment goals and possible options and their respective side effects allows patients and their families to make choices that best fit their wishes [40]. Treating pain at the end of life means caring for all possible manifestations, including physical symptoms as well as psychological symptoms and reduced well-being. This can be achieved by integrating pharmacotherapy with psycho-socio-spiritual interventions [41].

DEPRESSION

Evidence of hopelessness, helplessness, worthlessness, guilt, and suicidal ideation are better indicators of depression in the context of life-limiting illness than neurovegetative symptoms [42]. Yet, diagnosing and treating depression in patients with life-limiting illness remains challenging for several reasons. Typical symptoms of depression (e.g., impaired concentration, anergia, sleep disturbances) also are common symptoms of advanced mental illness, and side effects from medications commonly used at the end of life can mimic depressive symptoms. Delirium occurs in up to 90% of patients at the end of life. A mistaken diagnosis of depression in a patient with hypoactive delirium can lead to a prescription for an antidepressant or psychostimulant, which can exacerbate the delirium. To further complicate assessment, patients frequently do not report or may disguise symptoms of depression at the end of life [43]. It can also be difficult to determine if pharmacotherapy or reflective listening would be the appropriate intervention for the specific patient.

An assessment of available screening tools and rating scales for depressive symptoms in palliative care found that the tool with the highest sensitivity, specificity, and positive predictive value was the question: "Are you feeling down, depressed, or hopeless most of the time over the last two weeks?" [43]. One structured approach was found to help clinicians differentiate major depressive disorder from common physical symptoms of the patient's illness. With this approach, physical criteria for a diagnosis of major depressive disorder are replaced by psychological symptoms (***Table 1***) [43].

Some patients fear that being diagnosed with depression will cause their medical providers to stigmatize them or treat their physical symptoms less aggressively. It may then be necessary to address these issues before the patient will be willing to accept treatment for depression [42]. Left untreated, depression in seriously ill patients can be associated with increased physical symptoms, suicidal thoughts, worsened quality of life, and emotional distress. It also can impair the patient's interaction with family and erode patient autonomy [43]. Although patients with terminal illness often have suicidal thoughts, they are usually fleeting. Sustained suicidal ideation should prompt a comprehensive evaluation [42].

PHYSICAL DEPRESSIVE SYMPTOMS VERSUS REPLACEMENT PSYCHOLOGICAL SYMPTOMS	
Physical Symptoms	**Replacement Psychological Symptoms**
Change in appetite	Tearfulness, depressed appearance
Sleep disturbance	Social withdrawal, decreased talkativeness
Fatigue	Brooding, self-pity, pessimism
Diminished ability to think or concentrate	Lack of reactivity, blunting
Source: [43]	*Table 1*

SUICIDALITY

Suicide is a response to two stimuli (i.e., pain and despair) that often overlap. The pain can be physical or psychological, but in either aspect, it consumes the person to the point of seeking release. Despair is the result of believing that there is no longer any hope of having a good life [44]. Uncertainty about how death will unfold and whether they will be able to cope can be intensely stressful for patients. For some, suicide may seem preferable to a protracted period of anxiety, uncertainty about the process of dying, and fear of substantial physical suffering [29]. Diagnosis of severe physical illness (e.g., chronic obstructive pulmonary disease, low-survival cancer, degenerative neurological conditions) is associated with higher suicide risk [162].

A Wish to Die

Despite research efforts to deepen understanding of why some patients with terminal illness express a wish to die, there is consensus that there is more to learn about the factors that influence such a wish [45]. A case study review of patients with terminal cancer diagnoses in palliative care sought to understand possible motivations and explanations of patients who express or experience a wish to die [45]. Intentions, motivations, and social interactions were key to understanding and analyzing a patient's wish-to-die statements. The study focused on motivations, which address the question (from the patient's perspective) of why a wish to die is present. Motivations appear to consist of three layers: reasons (the causal factors), meanings (explanatory factors), and functions (effects of the wish) [45]. Patients' motivations were not able to be explained by a single reason, and, for most, their wish to die had broader significance that reflected their personal values and moral understandings—that is, the "meaning" of their wish to die [45]. Patients reported nine types of meanings, with some appearing more frequently than others. The meanings were shaped by patients' personal experiences, cultural background, and relationships. Patients expressed that a wish to die can be a wish to [45]:

- Allow a life-ending process to take its course
- Let death put an end to severe suffering
- End a situation that is seen as an unreasonable demand
- Spare others from the burden of oneself
- Preserve self-determination in the last moments of life
- End a life that is now without value
- Move on to another reality
- Be an example to others
- Not have to wait until death arrives

Health and mental health professionals cannot properly address a patient's wish to die if the meanings of the wish remain unexplored. Meanings are loaded with moral beliefs that need to be understood and respected in communication, disease management, and care of patients and their families [45].

END-OF-LIFE CONVERSATIONS

Dr. Elisabeth Kübler-Ross is credited as one of the first clinicians to formalize recommendations for working with patients with life-limiting illness. Her book, *On Death and Dying*, identified a gap in our understanding of how both patients and clinicians cope with death [46]. She wrote that it could be helpful if people could talk about death and dying as an intrinsic part of life [47]. In writing specifically about psychotherapy with the terminally ill, Dr. Kübler-Ross stated: "It is evident that the terminally ill patient has very special needs which can be fulfilled if we take time to sit and listen and find out what they are" [47].

Patients who receive the news that they do not have long to live will experience strong emotions accompanied by questions, which can be viewed as opportunities for clinicians to provide answers and open a broader discussion about the end of life. Such questions (and answers) may include [48]:

- *How long have I got?*

  Giving patients a sense of how much time is left allows them to focus on what is important to them. Answers to this question should be clear and as accurate as possible, while acknowledging that exact timeframes are impossible to know.

- *Will palliative care help?*

  When palliative care is appropriate, it supports patients and their families/caregivers by helping them to manage their physical, mental/emotional, spiritual, and practical needs. For patients at the end of life, palliative care is almost always appropriate.

- *What is a "good death?"*

  The answer to this question varies depending on each patient's attitudes, cultural background, spiritual beliefs, and medical treatments. Patients' wishes regarding where they prefer to die (e.g., at home, in hospital) also should be discussed.

- *How will I know that the end is near?*

  The answer depends on the patient and the patient's illness, but events that commonly occur during the dying process include reduced appetite, gradual withdrawal from the outside world, and sleeping more.

Data derived from a national survey of physicians, nurses, social workers, chaplains, hospice volunteers, seriously ill patients, and recently bereaved family members indicate an overwhelming preference for an opportunity to discuss and prepare for the end of life [39]. And while a majority (92%) of Americans say it is important to discuss their wishes for end-of-life care, only 32% have had such a conversation [49]. A majority of patients also prefer that a healthcare provider initiate end-of-life discussions [50]. It is important to note that these discussions do not have to wait for the end of the patient's life. The American Psychological Association has identified four time periods when health and mental health professionals can contribute to end-of-life care [51]:

- Before illness strikes
- After illness is diagnosed and treatments begin
- During advanced illness and the dying process
- After the death of the patient, with bereaved survivors

The end-of-life conversation can be divided into four simple steps [50]:

- Initiate the discussion:
  - Establish a supportive relationship with the patient and the patient's family.
  - Help the patient to appoint a surrogate decision maker.
  - Elicit general thoughts about end-of-life preferences through the use of probing questions.
- Clarify the prognosis:
  - Be direct yet caring.
  - Be truthful but sustain spirit.
  - Use simple, everyday language.
- Identify end-of-life goals:
  - Facilitate open discussion about desired medical care and remaining life goals.
  - Recognize that, as death nears, most patients share similar goals (e.g., maximizing time with family and friends, avoiding hospitalization and unnecessary procedures, maintaining functionality, minimizing pain).
- Develop a treatment plan:
  - Provide guidance in understanding medical options.
  - Make recommendations regarding appropriate treatment.
  - Clarify resuscitation orders.
  - Initiate timely palliative care, when appropriate.

Optimal end-of-life care begins with an honest discussion between clinicians and patients about disease progression and prognosis [52]. Patients and families are sensitive to verbal and nonverbal cues during these discussions. It is therefore incumbent on the healthcare team to train themselves in active listening skills, correct body language, and appropriate empathic responses in order to convey information in a clear, concise, and empathic manner [3]. Physicians also must balance their desire to honor patient wishes and autonomy against the concern of inflicting psychological harm. A 2008 study sought to determine whether end-of-life discussions were associated with fewer aggressive interventions and earlier hospice referrals [53]. The study enrolled advanced cancer patients and their informal caregivers (332 dyads) and followed them up to the time of death, a median of 4.4 months later. Quality of life and psychiatric illness was assessed in bereaved caregivers a median of 6.5 months later. Thirty-seven percent of patients reported having end-of-life discussions at baseline. These discussions were associated with lower rates of ventilation, resuscitation, intensive care unit (ICU) admission, and earlier hospice enrollment. Overall, end-of-life discussions were associated with less aggressive medical care near death, better patient quality of life, and earlier hospice referrals [53].

PATIENT WISHES

What do patients consider important in the process of preparing for the end of their lives? How do their perspectives differ from the values of family members or healthcare providers [39]? A 2015 study was conducted to define what matters most about end-of-life care [54]. Providers and administrators from 14 specialized palliative care teams were interviewed and their responses were analyzed to derive themes depicting the universal essence of end-of-life care. The most predominate theme, mentioned by almost one-half of the respondents, was that the "patient's wishes are fulfilled" [54]. Honoring patient wishes involves identifying what a patient wants through open communication and end-of-life care planning, providing education about options, providing realistic expectations, and allowing patients to have control over decision making [54]. Clinicians can regularly promote communication and education about end-of-life care issues by taking the initiative and discussing each patient's goals for end-of-life care. These goals may change over time and with illness and should be regularly re-evaluated and restated [55]. The patient's cultural and/or religious background can influence end-of-life decisions regarding comfort care and patient management, who can be present at the time

GUIDELINES FOR BREAKING BAD NEWS
Formulate a plan. Mentally rehearse the steps of the conversation.
Schedule a time for the discussion to allow all important family members and medical staff to be present.
Meet in a quiet and private setting.
Make arrangements for a professional translator if English is not the first language of the patient/family. Meet with the professional translator before the discussion to discuss expectations.
Preface bad news with a phrase to prepare the patient or family, such as "I wish the results were different, but..."
Communicate clearly and minimize use of technical language.
Let the patient's and family's reactions guide the flow of the conversation. Allow silence.
Be empathetic and acknowledge the patient's/family's emotions.
Determine the family's level of understanding of the illness/situation to assess misconceptions, aspects of news that will be surprising, and their unique information needs.
Determine if the patient or any family members are "numbers people" so they can be provided the type of information with which they feel most comfortable.
Schedule a future meeting to discuss the bad news and options (e.g., in an hour, the next day, the next week).
Source: [159; 160; 161] *Table 2*

of death, who will make healthcare decisions, and where the patient wants to die [56]. Encourage patients to elaborate on their wishes with prompts such as [56]:

- "In my religion, we . . ." This will help patients describe religious traditions to be observed at death.
- "Where we come from . . ." This will help patients share important customs to be observed at death.
- "In our family, when someone is dying, we prefer . . ." This will help patients describe what they hope will happen at death.

BARRIERS TO END-OF-LIFE CONVERSATIONS

Barriers to end-of-life discussions can seriously interfere with the quality of remaining life for patients with terminal illness. Barriers have been identified as originating with patients/families, with healthcare professionals, and within the structure of the healthcare system [57].

Patient-Related Barriers

Patients often avoid discussing end-of-life care with their clinicians and may conceal the full extent of what and how they are feeling, given the scope of end-of-life decisions. Family members and significant others also can complicate end-of-life conversations when they either cannot or will not discuss and accept the advanced nature of the patient's disease or the patient's preferences concerning end-of-life care, or when they overestimate the chance of cure, placing unreasonable demands upon the clinician [57].

Clinician-Related Barriers

Clinicians might avoid end-of-life discussions with their patients because they are reluctant to cause pain or be the bearers of bad news. They may lack the necessary communication training and skills, particularly in the delivery of bad news. They may focus solely on clinical parameters or have medical-legal concerns. Clinicians may fear confrontation and/or disagreement with the patient's family, particularly if they feel ill-prepared for such discussions. They may have a lack of confidence in their own judgment of their patient's true condition [57; 58]. Structured and content-based interventions are needed to ensure that critical aspects of the patient's physical, psychological, and spiritual experience are not excluded from care. For healthcare professionals who are delivering bad news, guidelines for the conversation can help give structure and enhance the confidence of the clinician (***Table 2***).

Organizational Barriers

Barriers to end-of-life conversations also originate within the healthcare system. First, end-of-life discussions are not always considered part of routine care; clinicians are not always given the time and structure for discussing end-of-life issues. Next, coordination of these conversations, which becomes more necessary as the patient's illness progresses, may not be included as part of routine care. When patient care is provided by multiple clinicians across multiple sites, there is no clear directive about which clinician should be responsible for initiating and documenting end-of-life conversations. Last, decreased contact time and fewer long-term patient/clinician relationships inhibit end-of-life discussions [57].

No single clinician can successfully undertake all aspects of this challenge. End-of-life planning should be one component of a series of ongoing conversations that together can assist patients with advanced illness to approach death in accord with their own values and wishes. These necessary discussions can draw on the expertise of several disciplines, and the creation of a new professional role specializing in this area might be considered [57].

MENTAL HEALTH INTERVENTIONS FOR END-OF-LIFE CARE

Shortly after Kübler-Ross began to publish her work, group psychotherapists began developing systematic interventions for patients who were dying. This included Irvin Yalom in the 1980s, who was heavily influenced by existential philosophy. Yalom's work formed the basis for what became supportive expressive group psychotherapy (SEGT). SEGT was originally developed to help patients with metastatic breast cancer face and adjust to their existential concerns (e.g., death, meaninglessness), express and manage disease-related emotions, and enhance relationships with family and healthcare providers. SEGT challenged the thinking that group therapy for patients with terminal illness would be demoralizing [47; 59]. Over the next several decades, research in end-of-life care, patients' end-of-life needs, and the role of mental health professionals in these settings increased [47].

In the late 20th century, physician-assisted death (also referred to as medical aid in dying, physician aid in dying, physician-assisted suicide, or euthanasia) became a topic of interest as researchers sought to understand why some patients with life-limiting illness might want to hasten death [47]. Pain, depression, and physical symptoms were at first thought to be the primary motives behind the desire to hasten death, but literature in the 1990s and 2000s emphasized the psychological and existential correlates (i.e., depression, hopelessness, spiritual well-being) of physician-assisted death. This shift in emphasis led to the development of a number of psychotherapeutic interventions that focused on the psychological and spiritual needs of patients [47].

EVIDENCE-BASED PRACTICE RECOMMENDATION

According to the Institute for Clinical Systems Improvement, short-term psychotherapy modalities (e.g., dignity therapy) can provide reduction in depression and anxiety symptoms at the end of life.

(https://www.icsi.org/wp-content/uploads/2020/01/PalliativeCare_6th-Ed_2020_v2.pdf. Last accessed April 24, 2023.)

Level of Evidence: Expert Opinion/Consensus Statement

DIGNITY MODEL/DIGNITY THERAPY

Dignity therapy was one of the first interventions developed for use in end-of-life care [60]. This modality aims to relieve psycho-emotional and existential distress to improve the experiences of patients with life-limiting illness. It offers patients the opportunity to reflect on what is important to them and on what they might want to communicate to loved ones [61]. In dignity therapy, patients are invited to reflect on and later discuss what aspects of their life they most want recorded and remembered—often referred to as their "legacy" [62]. The sessions are audiotaped and guided by a framework of questions (provided in advance) that facilitate disclosure of the patient's thoughts, feelings, and memories. The interview is then transcribed and printed for the patient's review and editing, as desired. Once finalized, the document is given to the patient, who may (or may not) share with friends and family, as desired. In addition to providing a tangible legacy for the patient, dignity therapy helps enhance the patient's sense of meaning and purpose, thus contributing to a preservation of the patient's dignity [47].

A 2011 study revealed that the items most commonly included in legacy documents were autobiographical information, lessons learned in life, defining roles (e.g., vocations, hobbies), accomplishments, character traits, unfinished business, overcoming challenges, and guidance for others [63]. Dignity therapy has been shown to positively affect patients' sense of generativity, meaning, and acceptance near the end of life. Positive impacts on families and caregivers of dignity therapy participants provide additional support for the clinical utility of this intervention [64]. However, dignity therapy is not for every patient with terminal illness. Despite the demonstrated beneficial effects, its ability to mitigate outright distress (e.g., depression, desire for death or suicidality) has yet to be proven [65]. Acknowledged limitations of dignity therapy include having adequate time, space, and means to engage in this intervention. Dignity therapy also cannot be used with patients who are nonverbal or unconscious or with those who have severe cognitive limitations [66]. Further studies are needed to determine whether patients with specific types of terminal illnesses (e.g., oncologic, cardiac, renal, pulmonary, neurologic) or in specific age cohorts (e.g., pediatric, adult, geriatric) benefit more or less significantly in certain domains (e.g., measures of spiritual distress, autonomy, death anxiety) [66].

Life Review

Dignity therapy incorporates the concept of life review, which is the systematic and structured process of recalling past events and memories in an effort to find meaning and achieve resolution of one's life. It is conducted over four sessions in which patients chronologically review their childhood, adolescence, adulthood, and present situation. A health or mental health professional takes notes, but no other end product is produced [67]. Life review can be useful for patients of any age at the end of life [68]. Life review is typically structured around life themes (e.g., being a parent/grandparent, first job, life's work, important turning points) [69]. The process can be either reminiscent or evaluative. It also can teach or inform others and pass on knowledge and experience to a new generation. Life review conducted for therapeutic purposes can help patients cope with loss, guilt, conflict, or defeat and find meaning in their accomplishments [69]. In Western culture, life review may subsequently be shared with family or friends. For patients of

other cultures, life review may be more communal and may involve rituals that are an important part of the dying process [34]. Few studies have evaluated therapeutic life review interventions, but preliminary results are promising [67].

Narrative Approach

Narrative practice is built on the assumption that people live multistoried lives. This perspective allows patients to shift from one life story to another to give meaning to their lives and shape their identities. A narrative approach frees the care team from the role of "expert" to the role of "helper" who facilitates patients' creation of personal stories of agency at times of life-limiting illness [70]. Narrative therapy is a practical psychotherapeutic process in which the professional and patient collaborate to deconstruct cultural and personal narratives that negatively affect the patient's sense of resources, efficacy, and identity. Together, clinician and patient discover and enrich positive, empowering, and helpful stories that originate in the patient's previous experiences [71]. Narrative therapy is patient-centered and goal-directed. Goals are to help patients improve their sense of self, separate problematic experiences away from their identity, and see themselves outside problems they may be facing. Narrative interventions can help patients and their families create new meaning of the patient's illness and end-of-life experiences [72].

TERROR MANAGEMENT THEORY

The concept of terror management theory was developed in 1986 and was based upon the work of Ernest Becker, a cultural anthropologist who had written about death and anxiety [73; 74]. Terror management theory is the concept that people feel threatened by a deep and terrifying fear of living an insignificant life that is destined to be erased by death. People cope with the awareness of their mortality in different ways. Some will adopt a worldview that allows them to find meaning, purpose, and enduring significance; others simply avoid thinking about death altogether and instead devote themselves to leaving behind a legacy that will make them "immortal" [74; 75]. While the fear of death can promote insecurity and bias or prejudice (based upon one's worldview), terror management theory helps people use their awareness of death to consciously choose to take positive steps to find meaning in their lives [74]. The awareness of mortality can motivate people to prioritize growth-oriented goals, live according to positive standards and beliefs, and foster the development of peaceful, charitable communities [76].

COGNITIVE-BEHAVIORAL THERAPY

The focus of traditional cognitive-behavioral therapy (CBT) is changing maladaptive thought patterns or perceptions that lead to mood disorders, such as anxiety and depression. But changing maladaptive thoughts to more realistic or positive ones does not always meet the needs of patients with life-limiting illness. These patients have very real fears about suffering and uncontrolled pain and other noxious symptoms, and their fears and thoughts are neither maladaptive nor unreasonable [77]. CBT adapted to end-of-life care can help patients identify "all-or-nothing" thinking and help them recognize that core parts of themselves remain unchanged [78].

Studies demonstrate that palliative care professionals have effectively applied CBT techniques to reduce mild-to-moderate anxiety or depression at the end of life and increase the patient's focus on the quality of remaining life [77; 79; 80]. For example, researchers incorporated elements of acceptance and commitment therapy (ACT) and dialectical behavior therapy (DBT). With ACT, patients learn to stop avoiding, denying, and struggling with their emotions. They instead learn to accept their emotions (and the source), accept their private circumstances, and not allow the circumstances to prevent them from moving forward in ways that serve their chosen values [81; 82]. DBT includes a strong educational component designed to provide patients with the skills to manage intense emotions [83].

MEANING-CENTERED PSYCHOTHERAPY

Meaning-centered group psychotherapy, based on the works of Viktor Frankl, was originally conceived as a group-based intervention for individuals with advanced cancer. Frankl's theory is existential in nature and postulates that the creation of meaning is a primary force of human motivation, even during times of great suffering [69]. The group therapy helps patients identify sources of meaning as a resource to sustain meaning, spiritual well-being, and purpose in the midst of suffering [47; 69]. Meaning-centered psychotherapy was later adapted for use with individual patients [84]. The goals of meaning-centered psychotherapy are to provide support for patients to explore personal issues and feelings related to their illness; to help patients identify sources of meaning; and to help patients discover and maintain a sense of meaning in life, even as their illness progresses [47]. Randomized controlled trials conducted to date, totaling nearly 800 patients, have demonstrated support for meaning-centered psychotherapy in improving spiritual well-being and reducing psychological stress in patients at the end of life [85; 86; 87]. The extent to which the observed results can be attributed to the patient's changes in sense of meaning require further study [47]. Like dignity therapy, meaning-centered psychotherapy has fueled multiple adaptations to target unique clinical populations and settings (e.g., bereaved family members, caregivers) [88; 89; 90].

COMPASSION-BASED THERAPY

Compassion-based therapy is rooted in an evolutionary analysis of basic social and emotional systems that motivate humans to live in groups, form hierarchies, help and share through alliances, care for kin, respond to threats, and seek states of contentment/safeness [91]. Compassion-based therapy can be supportive to those facing end-of-life decision making. It is inextricably linked to the inherent values, needs, and expectations of patients, families, and healthcare providers. Compassion coupled with a collaborative framework sustains patient- and family-centered care in end-of-life practice settings [92].

Compassion-based therapy offers a novel, transdiagnostic approach for reducing psychopathology and increasing well-being. It changes the focus of therapy from individual thoughts or unconscious conflicts toward the development of affiliative and prosocial functioning [93]. One overview of compassion-based therapies found at least eight different interventions (e.g., compassion-focused therapy, mindful self-compassion, cognitively based compassion training), six of which have been evaluated in randomized controlled trials. Compassion-based interventions demonstrated reduced suffering and improved life satisfaction for patients [93]. A systematic review conducted to assess the effectiveness of compassion-based therapy analyzed 14 studies, including three randomized controlled studies [94]. Compassion-focused therapy was effective with depressive disorders and for people who are highly self-critical. Compassion-based therapy is most effective when used in conjunction with other types of treatment and therapy [94].

Being Present

One of the most important therapeutic and compassionate aspects a health professional can offer is their presence. Listening to and allowing patients to express their end-of-life experience is healing and can be more comforting than guidance. One study investigated how palliative care chaplains work with patients at the point when it has been decided to cease active treatment, the point at which patients risk losing hope and falling into despair [95]. The author identified four types of presence in the chaplain-patient relationship that were a result of the chaplain's "being with the patient." Each type of presence (i.e., evocative, accompanying, comforting, hopeful) represented a discernable development in the chaplain/patient relationship—a theory of chaplain as hopeful presence [95].

The effects of educating patients and families about the importance of being present was the goal of a descriptive study that included 19 critical care nurses [96]. The nurses were interviewed to understand their experiences and perceptions about caring for patients and families transitioning from aggressive life-saving care to palliative and end-of-life care [96]. The nurses prioritized educating the family, advocating for the patient, encouraging and supporting the family's presence, protecting families, and helping them create positive memories. The family's presence at the end of life also helped them to process the reality of their loved one's death and make peace with it [96].

OTHER INTERVENTIONS

Researchers and clinicians have developed a variety of other interventions for end-of-life care. One proposed treatment is called short-term life review (STLR). Like dignity therapy, STLR interviews the patient for the purpose of creating a legacy album, but STLR differs from dignity therapy in the substance of the interview. A single published randomized controlled trial has examined the utility of STLR, and little research has been conducted to support the STLR approach. The research that has been published has suggested increases in spiritual well-being, sense of hope, and death preparedness among patients with terminal cancer [47; 97; 98].

Managing cancer and living meaningfully (CALM) is a brief, structured intervention developed for patients with advanced and/or terminal cancer [47; 99; 100]. The focus of CALM is similar to meaning-centered psychotherapy, but it provides less emphasis on spiritual well-being and existential issues due to its longer timeframe [47]. The first large-scale randomized controlled trial of CALM reports that individuals demonstrated significantly greater improvements in depressive symptoms and overall quality of life compared to those who received usual care [101].

Mindfulness

Mindfulness is the practice of paying deliberate attention to experiences of the present moment with openness, curiosity, and a willingness to allow things to be as they are [102]. End-of-life care is, by its nature, rooted in mindfulness through [103]:

- The healthcare team providing steady presence and compassion to the dying patient
- Bringing one's full attention to clinical assessments and supportive interactions and acknowledging what arises during these interactions for patients, families, and clinicians
- Being attuned to the dying and their needs, remaining present with their suffering
- Being genuinely interested in the patient's/family's experiences
- Allowing the full expression of personal experiences, with no attempt to change or fix them
- Cultivating compassion and acknowledging our shared humanity

Spiritual Care

Spiritual care is considered a basic tenet of palliative care and a responsibility of the entire end-of-life care team. Patients who receive good spiritual care report greater quality of life, better coping, and greater well-being, hope, optimism, and reduction of despair at the end of life. Despite these benefits, patients and caregivers often refuse spiritual care when offered. One study that sought to understand this reluctance focused on the effect of education. The authors reported that an educational intervention, which included explaining the services of hospice chaplains and the evidence-based benefits of spiritual support, led to greater patient/caregiver acceptance of spiritual care [104]. End-of-life counselors, therapists, and social workers are uniquely positioned to work with patients to explore the

variables that they and their families use as guiding principles when making difficult decisions [105]. This requires assessing the patient's spiritual, religious, and existential needs (i.e., spiritual needs) to provide appropriate interventions [106].

The specifics of how to conduct assessment are determined by individual healthcare organizations but usually consist first of obtaining a spiritual history of the patient and the patient's family. A variety of tools are available. The FICA acronym asks four questions about faith, importance/influence of beliefs, community involvement, and addressing issues of care [107]. The HOPE questions inquire about patients' sources of hope and meaning, whether they belong to an organized religion, their personal spirituality and practices, and what effect their spirituality may have on end-of-life care [108]. Reported barriers to spiritual assessment include clinician lack of time/experience, difficulty identifying patients who wish to discuss spiritual beliefs, and addressing concerns not regarded as the clinician's responsibility. Assessing and integrating patient spirituality into end-of-life care can build trust and rapport and strengthen the patient's relationship with the end-of-life care team [108]. Unaddressed spiritual issues may frustrate attempts to treat other symptoms and adversely impact the patient's quality of life [105].

Art and Music Therapy

Art and music therapists are becoming increasingly available to palliative care teams and are advancing the diverse and unique clinical services available to effectively meet the holistic needs of patients with serious illness [109]. Art can connect with deep psychological and physical pain, allowing the patient to find expression and relief. Studies have found that expressive arts (e.g., paint, clay, textiles, drawing) help patients more effectively deal with ambivalent emotions regarding life-death issues and communicate with their families about their feelings. It helps patients articulate their end-of-life journey beyond language [110; 111].

Art therapy also may be helpful in reducing burnout among end-of-life care providers by enhancing their emotional awareness, fostering meaning-making, and promoting reflection on death. One study found significant reductions in exhaustion and death anxiety in end-of-life care providers who participated in an art therapy program [38].

Music therapy incorporates music chosen by the patient in consultation with a qualified music therapist. The music is often chosen to arouse specific emotions that allow the patient to more easily access, recall, and interrogate memories, with the goal of understanding the role those memories play in the patient's current circumstances [38]. Music therapy also may be an effective adjuvant to pain management therapy [38].

BEREAVEMENT

As stated, Kübler-Ross wrote that it could be helpful if people could talk about death and dying as an intrinsic part of life and emphasized the importance of listening as a way for practitioners to support terminally ill patients and their families when confronting the realities of impending death [46; 47]. She subsequently applied her model to the experience of loss in many contexts, including grief and other significant life changes [112]. This model identified five stages of bereavement—denial, anger, bargaining, depression, and acceptance. Though the stages are frequently interpreted strictly and hierarchically, this was not Kübler-Ross's intention. She expressed that individual patients could manifest each stage differently, if at all, and might move between stages in a nonlinear manner [112]. Her model has received criticism in recent years and many alternative models (some based on Kübler-Ross's model) have been developed [112; 113; 114; 115].

PROLONGED GRIEF DISORDER

The death of a loved one is followed by an intensely emotional and disruptive period that gradually attenuates as the death is comprehended and accepted and its consequences understood (integration). It is a highly stressful period accompanied by the need to attend to a range of things not usually on one's agenda. Most people meet the coping demands and are able to find a pathway through the sorrow, numbness, and even guilt and anger that are part of the normal grieving process. A small minority, however, do not cope effectively. For them, the feelings of loss become debilitating. They do not improve with the passing of time and can become so long-lasting and severe that recovering from the loss and resuming a normal life is impossible without assistance [116]. These people are suffering from prolonged grief disorder, a syndrome in which healing is impeded and acute grief is intense and prolonged.

Prolonged grief disorder is the newest disorder to be added to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The disorder was added to the DSM-5-TR in 2022 after several decades of studies that suggested "many people were experiencing persistent difficulties associated with bereavement that exceeded expected social, cultural, or religious expectations" [117]. Prolonged grief disorder often co-occurs with other mental disorders (e.g., PTSD, anxiety, depression). Sleep problems, such as poor long-term sleep, occur in an estimated 80% of people with this disorder [118].

It is important to differentiate grief from depression. Grieving can be an appropriate response to loss, but if the symptoms persist, the Institute for Clinical Systems Improvement recommends that depression be considered.

(https://www.icsi.org/wp-content/uploads/2020/01/PalliativeCare_6th-Ed_2020_v2.pdf. Last accessed April 24, 2023.)

Level of Evidence: Expert Opinion/Consensus Statement

Prolonged grief disorder is defined as "intense yearning or longing for the deceased (often with intense sorrow and emotional pain) and preoccupation with thoughts or memories of the deceased. In children and adolescents, this preoccupation may focus on the circumstances of the death" [117]. In adults, this intense grief must still be present one year after a loss to be considered prolonged grief disorder; in children, the timeframe is six months. Additionally, the individual with prolonged grief disorder may experience significant distress or problems performing daily activities at home, work, or other important areas [117]. It is important for clinicians to differentiate prolonged grief disorder from usual acute grief, as well as depression and anxiety disorders [116]. Risk factors for prolonged grief disorder include past losses, separations that can impact current losses, and a history of depressive illness [115]. Symptoms include [117]:

- Identity disruption (e.g., feeling as though part of oneself has died)
- A marked sense of disbelief about the death
- Avoidance of reminders that the person is dead
- Intense emotional pain (e.g., anger, bitterness, sorrow)
- Difficulty reintegrating (e.g., unable to engage with friends, pursue interests, plan for the future)
- Emotional numbness
- Feeling that life is meaningless
- Intense loneliness and feeling of being detached from others

An estimated 7% to 10% of bereaved adults will experience the persistent symptoms of prolonged grief disorder, and 5% to 10% of bereaved children and adolescents will experience depression, PTSD, and/or prolonged grief disorder [118; 119]. Treatments using elements of CBT have been found to be effective in reducing symptoms [117]. Complicated grief treatment incorporates components of CBT and other approaches to help patients adapt to the loss. It focuses on accepting the reality of the loss and on working toward goals and a sense of satisfaction in a world without the loved one [118]. Research has shown that CBT is effective in addressing sleep problems associated with prolonged grief disorder. CBT also has been shown to be superior in long-term effects to supportive counseling in children and adolescents experiencing symptoms of prolonged grief disorder [119; 120].

Bereavement support groups can provide a useful source of social connection and support. They can help people feel less alone, thus helping to avoid the isolation that could increase the risk for prolonged grief disorder. Despite the existence of effective treatments, people experiencing prolonged grief disorder may not seek help. One study of 86 bereaved caregivers with symptoms of prolonged grief disorder found that only 43% accessed mental health services [121].

PRACTICAL, ETHICAL, AND LEGAL CONSIDERATIONS

Planning ahead provides patients with the most control over their end-of-life care, but not all patients have the opportunity to do so. End-of-life planning for the patient will include knowing the type of care they need and want, knowing where they want to receive this care, knowing what documents (e.g., advance directives) and associated costs to include in planning, and determining who will help carry out their wishes [122].

CAREGIVING AND SURROGACY

The vast majority (80%) of care given to hospice patients is provided by informal and unpaid caregivers who are often family members. They can be responsible for everything from the management of household and finances to medical and personal care. Providing this level of care can contribute to increased stress and health problems [123]. Caregivers often report significant levels of anxiety, depression, and perceived stress as well as poorer physical health and decreased quality of life compared with non-caregivers [124]. In one study, nearly one-third (31%) of caregivers reported moderate-to-high levels of anxiety [125]. Even family members who are not caregivers experience distress and require support. Supporting the growing number of family and other unpaid caregivers is an urgent public health issue. The need for adequate support is especially pressing when older patients and the loved ones who assist them are most vulnerable, as at the end of life [126]. Health and mental health professionals can help the caregiver and/or family by preparing them for their loved one's death, treating symptoms of burnout and stress, and offering grief counseling when desired [127].

Family members may be called upon to make decisions on their loved one's behalf if incapacitation becomes an issue. Ideally, the decision-making process will reflect the patient's physiologic realities, preferences, and recognition of what, clinically, may or may not be accomplished [128; 129]. Being a surrogate decision maker is stressful for many and can have negative emotional effects that last months or years [130]. Frequent tension can occur between the desire to respect the patient's values and the fear of responsibility for a loved one's death, a desire to pursue any chance of recovery, and a need to ensure family well-being [131]. Counseling for the surrogate both during and after the decision-making process can be beneficial.

Shared decision making also has been found to be beneficial. Healthcare providers can encourage decision makers to involve other family members. They can repeat relevant information in simple language, prompt them to think about what the patient would or would not want, and frequently remind them that everything that can be done is being done [132]. Support for the surrogate should foster respect for patient preferences and values and help reduce guilt about decisions made following the patient's death [132]. An ideal surrogate will participate in collaborative decision-making with care providers. If a surrogate avoids communication or requests interventions that are clearly not considered in the patient's best interest, counseling should be provided. If counseling is unsuccessful, replacement of the surrogate should be considered [133]. Family members who reside far away and who are not designated as decision maker also can create difficulties by trying to undo, contest, undermine, or alter decisions made by local family members who have long been involved in the patient's care. These disagreements can compromise the ability of the patient's healthcare team to provide quality care. These limits of formal advance care planning have led some practitioners to assert that informal conversations with patients' significant others are most critical to end-of-life planning [134].

Current practice frequently fails to promote patient goals. This is an area for future research and improvement. In the meantime, clinicians should encourage patients to document their own goals, including treatment preferences and preferences regarding how they want decisions to be made for them during periods of decisional incapacity. This is achieved through advance care planning [135; 136].

ADVANCE CARE PLANNING

Advance care planning is widely considered an essential step toward achieving end-of-life care that is consistent with the preferences of dying patients and their families. Advance care planning typically includes a living will and a durable power of attorney for health care, which enable patients to articulate and convey their treatment preferences while they are cognitively intact [136]. Advance care planning documents also can include do not resuscitate (DNR) orders, medical/physician order for life-sustaining treatment (MOLST/POLST), and informal documents of preference or other healthcare proxies. Ideally, these documents reflect discussions among the patient's family, surrogate, and healthcare provider about the patient's preferences for health care in the context of serious illness [129]. Advance care planning is considered an essential step for achieving a "good death" in which physical pain and emotional distress are minimized and the patient's and family members' treatment preferences are respected [134]. Advance care planning is associated with greater use of palliative care among dying patients, lower medical expenditures at the end of life, and less distress among patients and patients' families.

Race and socioeconomic disparities in rates of advance care planning have been documented. Policy advances (e.g., Medicare reimbursement for doctor-patient consultations) may increase rates of planning among populations who may not have access to professionals who encourage such preparations [136]. Health and mental health professionals can assist families in the process of preparing advanced care planning documents. Being a mediator in advance care planning conversations can provide clarity for patients and family members about the patient's wishes regarding death [137].

ETHICAL/LEGAL ISSUES

Ethical concerns and legal considerations can influence counseling at the end of life. Health and mental health providers are on the frontline supporting and guiding the patient and the patient's family through the dying process.

Autonomy

Autonomy, as viewed from the perspective of patients at the end of life, includes two core domains: "being normal" and "taking charge" [138]. These two domains account for the circumstances and clinical realities of people with life-limiting illness and allow clinicians to better understand their needs. Autonomy is, however, not just a concern when making choices of treatment for end-of-life care but also when supporting patients in their daily lives and active preparations for dying. This support can help relieve the patient of stress and the fear of being a burden to family [138]. When a patient expresses a fear over the loss of autonomy, it is important for clinicians to determine the source of the fear. Common sources of such fear include fear of becoming physically dependent on life-supporting technology; fear of losing independence; and fear of loss of engagement in meaningful activity. Often, the patient is simply expressing a desire to preserve self-determination regarding end-of-life care and planning [45]. The healthcare team respects patients' autonomy by giving them the information needed to understand the risks and benefits of a proposed intervention, as well as the reasonable alternatives (including no intervention), so that they may make independent decisions [139].

Distributive Justice

Distributive justice is the fair, equitable, and appropriate distribution of healthcare resources. It requires impartiality in the delivery of health service. Issues of distributive justice encountered in healthcare settings include the allotment of scarce resources, care of uninsured patients, conflicts of interest based on religious or legal grounds, and public health and safety issues. Despite these constraining influences, healthcare providers have an ethical obligation to advocate for fair and appropriate treatment of patients at the end of life [140; 141].

Beneficence

The principle of beneficence is the obligation of health and mental health professionals to act in the best interest of the patient [137]. Beneficence also includes preventing and avoiding harm and defending the most useful intervention for the patient [140; 141]. Beneficence is fundamental to dilemmas about the discontinuation, withholding, or withdrawal of medical treatment [137]. When wishes about end-of-life care are not known or cannot be communicated by the patient, end-of-life decisions should be made by the healthcare team as a result of consultations with the family or healthcare proxy [137].

Nonmaleficence

Nonmaleficence is the principle of refraining from causing unnecessary harm (i.e., first, do no harm) [137]. It also refers to the moral justification behind an intervention that might cause some pain or harm; harm is justified if the benefit of the intervention is greater than the harm to the patient and the intervention is not intended to harm [137]. The emphasis in nonmaleficence is on relieving the symptoms that harm the patient [142]. Health and mental health providers can exercise nonmaleficence by having an understanding of the moral principles and ethical codes governing end-of-life care. They can prevent undue harm by being as knowledgeable as possible about impending illnesses through relationships with the interprofessional team [137].

CULTURALLY COMPETENT CARE AT THE END OF LIFE

The clinician/patient discussion about end-of-life care is often a challenge and one that can be further complicated when the patient's cultural norms differ from that of the clinician. As discussed, values of medical care emphasize autonomy and individual rights to make life choices [143]. The Patient Self Determination Act of 1990 ensured that those rights are protected. This includes the rights to treatment choices, informed consent, truth-telling, open communication with healthcare providers, and control over the individual's own life and death [143; 144]. However, these core values may be in conflict with the values of many ethnic and culturally diverse groups in the United States and may lead to health disparities, fragmented care, inadequate or inappropriate symptom management, miscommunication with the patient and family, and a difficult and poor death for the patient [143].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The Institute for Clinical Systems Improvement asserts that clinicians caring for patients with serious illness should examine their own cultural values and assumptions about what constitutes "good" care for patients nearing the end of life, recognizing not all patients will share these same values, and ensure goals and decisions remain centered around the patient's values/beliefs.

(https://www.icsi.org/wp-content/uploads/2020/01/PalliativeCare_6th-Ed_2020_v2.pdf. Last accessed April 24, 2023.)

Level of Evidence: Expert Opinion/Consensus Statement

Enhanced cultural competency in end-of-life issues continues to be identified as a need for clinicians who provide care for patients at the end of life [143]. Healthcare providers should understand and recognize the specific influences that culture has on a patient's behavior, attitudes, preferences, and decisions about end-of-life care. It is important to note that a patient's identification as a member of a particular ethnic group or religion does not necessarily mean that the patient or patient's family adheres to beliefs associated with that ethnicity or religion [143]. Other factors (e.g., age, race, sex, ethnicity, health status, religion) also can influence how patients approach the end of life, and their cultural and religious backgrounds influence their definitions of and perceptions about what constitutes quality of life, suffering, and pain [145].

Other areas of end-of-life care that vary culturally include the method used for communicating "bad news," the locus of decision making, and attitudes toward advance directives and end-of-life care specifics [146]. In contrast to the emphasis on "truth telling" in the United States, it is not uncommon for healthcare professionals outside the United States to conceal serious diagnoses from patients, because disclosure of serious illness may be viewed as disrespectful, impolite, or even harmful to the patient. The emphasis on patient autonomy may conflict with the patient's preferences for family-based, physician-based, or shared family-physician-based decision making. Lower rates of completion of advance directives by patients of some ethnic backgrounds suggests a distrust of the healthcare system, healthcare disparities, and underutilization of health care [146; 147; 148].

An assessment should be made of how acculturated a patient and family are, their language skills, and whether an interpreter is needed [143]. The clinician should assess for [149]:

- Openness/willingness of the patient/family to discussing/accepting the diagnosis, prognosis, and death
- How decisions are made and what influences decision making (e.g., age, gender, hierarchy, quality of interfamily communication)
- What does physical pain mean and how should it be managed?
- Is there spiritual pain? Does the patient desire the help of a spiritual advisor? Does the patient/family want time and space for praying, meditation, and other rituals?
- The relevance of religious beliefs regarding the meaning of death
- How the body should be handled following death

The clinician also can take advantage of available resources, including community or religious leaders, family members, and language translators [149]. It is important to note that using professional interpreters for patients and with limited English proficiency will help ensure quality care. Convenience and cost lead many clinicians to use "ad hoc" interpreters (e.g., family members, friends, bilingual staff members) instead of professional interpreters. However, professional interpreters are preferred for several reasons. Several states have laws about who can interpret medical information for a patient, so healthcare professionals should check with their state's health officials about the use of ad hoc interpreters [150]. Even when allowed by law, the use of a patient's family member or friend as an interpreter should be avoided, as the patient may not be as forthcoming with information and the family member or friend may not remain objective [150]. Children should especially be avoided as interpreters, as their understanding of medical language is limited, and they may filter information to protect their parents or other adult family members [150]. Individuals with limited English language skills have actually indicated a preference for professional interpreters rather than family members [151].

Also important is the fact that clinical consequences are more likely with ad hoc interpreters than with professional interpreters [152]. A systematic review of the literature showed that the use of professional interpreters facilitates a broader understanding and leads to better clinical care than the use of ad hoc interpreters, and many studies have demonstrated that the lack of an interpreter for patients with limited English proficiency compromises the quality of care. The use of professional interpreters improves communication (errors and comprehension), utilization, clinical outcomes, and patient satisfaction with care [151; 153]. One review of case studies regarding professional interpretation noted that "patients with limited English proficiency in the United States have a legal right to access language services, and clinicians have legal and ethical responsibilities to communicate through qualified interpreters when caring for these patients" [154].

Culturally competent counseling for patients at the end of life begins with understanding their differing cultural, religious, and other important influential factors. It involves listening to and learning about patients' varying attitudes, preferences, and practices in order to integrate them into an appropriate plan of care [155]. Clinicians should treat all patients with dignity, respecting their rich cultural traditions and incorporating them into the plan of care. It means communicating with the patient and the patient's family in advance about how the plan of care is aligned with their beliefs, concerns, values, and preferences [145]. To deny the expression of different cultural worldviews in the context of end-of-life care would be to rob patients of the security and serenity that their cultural beliefs give them when faced with uncertainty and fear [156].

CONCLUSION

Health and mental health professionals provide services to diverse individuals in a variety of settings, including end-of-life settings, as part of an interprofessional team. In the end-of-life setting, these professionals help dying patients and their families prepare for death with education and supportive therapeutic interventions that address the patient's physical, emotional, social, spiritual, and practical needs using a patient-centered, culturally sensitive approach [10; 157]. Clinicians can regularly promote communication and education about end-of-life care issues by taking the initiative and discussing each patient's goals for end-of-life care [55]. The better informed the patient and family are, the more likely their decisions about end-of-life care will reflect their beliefs, values, and the best interests of the patient. This means having difficult conversations. All professionals should work to become comfortable with the most uncomfortable of topics. This work is not done alone. It is essential to lean on and consult colleagues and other members of the care team. End-of-life care often involves interactions between caregivers and various professionals (e.g., physicians, nurses, social workers, mental health professionals, clergy) who have distinct roles in preparing caregivers for the patient's death [158]. Aligning on key concepts and approaches to care can help to ensure that the best possible care and support are given at the end of life.

Customer Information/Answer Sheet/Evaluation insert located between pages 64–65.

TEST QUESTIONS
#77770 COUNSELING PATIENTS AT THE END OF LIFE

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 5 Hour/2 NBCC Clock Hour activity must be completed by April 30, 2026.

1. The goal of palliative care is to
- A) *avoid pursuing curative treatment.*
- B) *provide care only as close to diagnosis as possible.*
- C) *provide care for the last few weeks or months of a patient's life.*
- D) *improve the quality of life of patients and their families when faced with life-threatening illness.*

2. Which of the following professionals can provide end-of-life counseling?
- A) *Counselors*
- B) *Hospice workers*
- C) *Critical care nurses*
- D) *All of the above*

3. Reducing mental health symptoms
- A) *is not important in end-of-life care.*
- B) *can improve participation of end-of-life decisions.*
- C) *should be the only focus of clinicians at the end of life.*
- D) *can help patients disengage from painful conversations.*

4. Which of the following is a universal experience for patients at the end of life?
- A) *Intractable pain*
- B) *Spiritual epiphany*
- C) *Psychological suffering*
- D) *Reconnection with family*

5. Parents of young children with life-limiting illness often are consumed with all of the following, EXCEPT:
- A) *What and how much to tell their ill child*
- B) *How to cope with the loss of the child's future*
- C) *The impact of the child's illness on other siblings*
- D) *Dependence upon parents or other adult figures*

6. Which two concepts combined define dignity at the end of life?
- A) *Meaning and hope*
- B) *Serenity and respect*
- C) *Control and independence*
- D) *Interdependence and connection*

7. What is a possible negative effect of denial in patients at the end of life?
- A) *Wish to hasten death*
- B) *Focus on realistic treatment goals*
- C) *Excessive reliance on the healthcare team*
- D) *Failure to make legal, financial, and healthcare arrangements*

8. Economic circumstances have been found to be a major stressor for patients and their families, often resulting in a decline in family economic well-being.
- A) *True*
- B) *False*

9. Which of the following statements regarding post-traumatic stress disorder (PTSD) at the end of life is TRUE?
- A) *Most therapies for PTSD can be completed within a typical hospice period.*
- B) *Even if PTSD is diagnosed, it typically does not complicate the dying process.*
- C) *Practitioners have good awareness of the occurrence and/or manifestation of PTSD at the end of life.*
- D) *Traditional evidence-based, trauma-focused treatments may not be feasible or advisable for patients with PTSD at the end of life.*

10. Anticipatory grief is the experience of grieving the loss of a patient or loved one in advance of their death.
- A) *True*
- B) *False*

11. Elevated anticipatory grief was found in families characterized by all of the following, EXCEPT:
- A) *Higher education*
- B) *Relational dependency*
- C) *Poor grief-specific support*
- D) *Discomfort with closeness and intimacy*

12. When anticipatory grief is an expression of past or current trauma, it may develop into complicated grief if left untreated.
- A) *True*
- B) *False*

13. Thanatophobia is an extreme fear of
- A) *a loved one's death.*
- B) *life-saving medical care.*
- C) *death or the dying process.*
- D) *being present when someone dies.*

14. Treating pain at the end of life means caring for all possible manifestations, including physical symptoms as well as psychological symptoms and reduced well-being.
- A) *True*
- B) *False*

15. Some patients believe that being diagnosed with depression will cause their medical providers to treat their physical symptoms more aggressively.
- A) *True*
- B) *False*

16. Diagnosis with which of the following conditions is associated with increased risk of suicide?
- A) *Low-survival cancer*
- B) *Degenerative neurological conditions*
- C) *Chronic obstructive pulmonary disease*
- D) *All of the above*

17. Which of the following statements regarding end-of-life discussions is TRUE?
- A) *Patients prefer to initiate end-of-life discussions themselves.*
- B) *End-of-life discussions should take place only at end of a patient's life.*
- C) *Most Americans have had conversations about their end-of-life wishes.*
- D) *Most Americans say it is important to discuss their wishes for end-of-life care.*

18. Helping a patient appoint a surrogate decision maker is part of which step in an end-of-life conversation?
- A) *Initiation of the discussion*
- B) *Clarification of the prognosis*
- C) *Identification of end-of-life goals*
- D) *Development of the treatment plan*

19. Optimal end-of-life care begins with an honest discussion between clinicians and patients about disease progression and prognosis.
- A) *True*
- B) *False*

20. Honoring patients' end-of-life wishes involves all of the following, EXCEPT:
- A) *avoiding expectations.*
- B) *providing education about options.*
- C) *allowing patients to have control over decision making.*
- D) *identifying what a patient wants through open communication and end-of-life care planning.*

21. Which of the following statements regarding clinician-related barriers to end-of-life discussions is FALSE?
- A) *Clinicians may have a lack of confidence in their own judgment of their patient's true condition.*
- B) *Clinicians generally have extensive communication training and skills, particularly in the delivery of bad news.*
- C) *Clinicians might avoid end-of-life discussions with their patients because they are reluctant to cause pain or be the bearers of bad news.*
- D) *Clinicians may fear confrontation and/or disagreement with the patient's family, particularly if they feel ill-prepared for such discussions.*

22. In dignity therapy, patients
- A) *are taught mindfulness techniques.*
- B) *endure systematic confrontation of feared stimuli, with the aim of reducing fear of dying.*
- C) *are invited to reflect on and later discuss what aspects of their life they most want recorded and remembered.*
- D) *engage in a structured program of psychotherapy with a strong educational component designed to provide skills for managing end-of-life stresses.*

23. Compassion-based therapy changes the focus of therapy from individual thoughts or unconscious conflicts toward the development of affiliative and prosocial functioning.
- A) *True*
- B) *False*

24. Research that has been published on short-term life review (STLR) has suggested increases in spiritual well-being, sense of hope, and death preparedness among patients with terminal cancer.
- A) *True*
- B) *False*

Test questions continue on next page ➞

25. All of the following statements regarding spiritual care at the end of life is TRUE, EXCEPT:

A) *Spiritual care is considered a basic tenet of palliative care.*
B) *Patients and caregivers often refuse spiritual care when offered.*
C) *Spiritual care is a responsibility of mental health professionals only.*
D) *Patients who receive good spiritual care report greater quality of life, better coping, and greater well-being at the end of life.*

26. The FICA acronym to guide spiritual assessments consists of

A) *fidelity, insistence, culture, and alignment.*
B) *fostering religiosity, inspirational quality, connection, and adherence.*
C) *family involvement, integration of beliefs, consistency of practice, and aspects of spirituality.*
D) *faith, importance/influence of beliefs, community involvement, and addressing issues of care.*

27. Intense yearning or longing for the deceased (often with intense sorrow and emotional pain) and preoccupation with thoughts or memories of the deceased must continue how long to be considered prolonged grief disorder in adults?

A) *Three months*
B) *Six months*
C) *One year*
D) *Five years*

28. Health and mental health professionals can help caregivers and/or family by

A) *offering grief counseling when desired.*
B) *treating symptoms of burnout and stress.*
C) *preparing them for their loved one's death.*
D) *All of the above*

29. Beneficence is fundamental to dilemmas about the discontinuation, withholding, or withdrawal of medical treatment.

A) *True*
B) *False*

30. Which of the following statements about interpreters is TRUE?

A) *Interpreters should always engage in cultural brokering.*
B) *The use of professional interpreters improves communication, utilization, clinical outcomes, and patient satisfaction with care.*
C) *Any person fluent in a family's native language is as effective as a professional interpreter.*
D) *Families prefer to have information interpreted by another family member rather than by a professional interpreter.*

Be sure to transfer your answers to the Answer Sheet located between pages 64–65.
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.

Incorporating Musical Strategies into Clinical Practice

Approval(s): APA, NBCC, NAADAC

Audience

This course is designed for counselors, social workers, chemical dependency counselors, therapists, and pastoral counselors, especially because music holds special meaning for so many of the people that are served by these professions. This course will be especially relevant to professionals who seek creative methods for working with their clients.

Course Objective

The purpose of this course is to demonstrate how simple musical strategies can be incorporated into various treatment settings in order to enhance the overall healing process.

Learning Objectives

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

1. Discuss the historical and cultural roles of music and its impact on human healing.
2. Describe the basics of how music affects the human brain.
3. Explain the three-stage consensus treatment model.
4. Evaluate the use of musical techniques/approaches in the stabilization stage of treatment.
5. Analyze the use of musical techniques/approaches in the processing stage of treatment.
6. Outline the role of musical techniques/approaches in the reintegration stage of treatment.

Faculty

Jamie Marich, PhD, LPCC-S, 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 northeast Ohio. 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. In 2022 and 2023, Dr. Marich published two additional books: *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, REAT, RYT-500, RMT, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planners

Alice Yick Flanagan, PhD, MSW
Margaret Donohue, PhD

Senior Director of Development and Academic Affairs

Sarah Campbell

Division Planners/Director Disclosure

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INTRODUCTION

As humans, some of our most profound memories are associated with music—the song played at a wedding, the music popular when you were in high school, songs that you sang as a child, songs taught by a parent, a special relative, or a school teacher. On the other hand, not all musical associations are positive. If a marriage eventually fails, feelings of sadness or disgust may be elicited when one hears the song that played at their wedding. Hearing a song that was special to a deceased loved one can lead to tears upon the first several notes. Someone who was an unpleasant or traumatic person may have always listened to a certain band, song, or style of music, and hearing that music today may elicit a negative response.

Music plays a powerful role in accessing our memories and connecting to the deepest states of emotional expression. Few people who have some experience with the power of music, either as a musician or as a listener, would question the relevance of this statement. Because music plays such a powerful role in the human experience, it can be beneficial to take greater measures to integrate it into the helping processes. Incorporating music into clinical practice can enhance what you already do, and it is not necessary to obtain special training as music therapists. If one has an ability to tap into what music means to him/her personally and a passion for helping others, learning a few simple strategies within the trauma-sensitive model of treatment will allow the healing power of music to enhance clinical efficacy and ultimately benefit clients.

FOUNDATIONS

HISTORICAL AND CULTURAL CONTEXT

Reflection

Without overthinking, take a few minutes to write down how you would define music. Is it difficult for you?

German poet Heinrich Heine once wrote about music, "When words leave off, music begins" [1]. Indeed, most people find it difficult to describe what music is in words. The reality of experiencing music calls upon connections in the brain that have nothing to do with words. For those who believe in the spiritual or mystical capacities of music, the reasons that words cannot adequately be used to define it are even more salient.

DEFINING MUSIC

Defining music may seem very basic. However, in the spirit of education and inquiry, consider a few linguistic attempts to define music.

Random House Dictionary defines music as, "an art of sound in time that expresses ideas and emotions in significant forms through the elements of rhythm, melody, harmony, and color" [18]. Wikipedia indicates that music is "an art form and cultural activities whose medium is sound organized in time. The common elements of music are pitch, rhythm, dynamics, and the sonic qualities of timbre and texture" [19]. Etymologically, the word "music" is derived from the Greek *mousike techne*, meaning art of the muses. Another Greek derivation is mousikos, meaning of or pertaining to the muses.

The purpose of this course is not to provide an overview of music terminology and theory. However, the first two examples show that, in a technical sense, defining music requires proficiency in other terminology, terms like pitch, tone, and timbre, that serves as the basis of what we appreciate in the end product as music. The etymologic derivation of the word music suggests a spiritual or mystical quality that many have been ascribed to music over the years, and for those who consider a focus on the technique of music distracting or simplistic, embracing the word origin as a means of definition may seem more suitable.

Honoring Individual Music Tastes

As with many constructs in the subjective human experience, defining or describing music will depend on the individual. Consider what music scholar Daniel J. Levitin posited regarding this idea [2]:

> What is music? To many, "music" can only mean the great masters—Beethoven, Debussy, and Mozart. To others, "music" is Busta Rhymes, Dr. Dre, and Moby. To one of my saxophone teachers at Berklee College of Music—and to legions of "traditional jazz" aficionados—anything made before 1940 or after 1960 isn't *really* music at all.

This is perhaps best illustrated by generational differences in popular music tastes. The clichéd notion that the music "kids these days" listen to is "just noise" has been perpetuated for decades.

Perhaps the ability that humans have to receive and appreciate music in so many different ways is part of what makes it so powerful, especially considering how it can be used in the healing process. One of the principles of counseling and healing is the art of being able to meet people where they are in their subjective experiences upon entering the clinical process, and honoring the musical tastes and proclivities of that individual may be one way to meet a person on the road of his or her journey.

Music in Global Cultures

Reflection

Think about your cultural background or how you were raised. What role does/did music play in your culture or in your way of life?

As Levitin states, "Mothers throughout the world, as far back in time as we can imagine, have used soft singing to soothe their babies to sleep, or to distract them from something that has made them cry" [2]. Music is a true cultural universal, an aspect of the human experience that is present in every culture in some form. Although music may carry different meanings and be performed or used differently among the various cultures of the world, every culture regards music or sound as significant [17]. Arguably, language, eating, and sex are the only other facets of the human experience that are true cultural universals, and these activities are required to continue the human species. It is interesting that music is as universal as these activities, which is a major reason why helping professionals can benefit from incorporating this powerful entity into the healing process.

Although providing a comprehensive treatise on the role that music plays in specific world cultures extends beyond the scope of this course, professionals are encouraged to investigate it more if it is of interest or if music will be incorporated into practice. If a client identifies strongly with a specific cultural heritage, seeking more information about the role of music in that culture may be helpful. Resources for additional research are included at the end of this course.

Music in the Healing Process

In her classic autobiographical tale Gather Together in My *Name*, writer Maya Angelou credits the power of music in her healing process [3]. She states, "Music was my refuge. I could crawl into the space between the notes and curl my back to loneliness." Indeed, many great musicians began as children who were awkward, traumatized, or otherwise unable to integrate their experiences with others around them and who sought music as a refuge for loneliness.

MUSIC AND THE BRAIN

Throughout the centuries, the idea that music can somehow pick up or take over where the spoken word leaves off or cannot reach has been prevalent. This conveys an essential truth about the human brain: it is not just a verbal instrument, and it is certainly not just a cognitive instrument. In fact, the brain is capable of processing information in such a variety of ways, it is important to consider how music can play a role in helping humans to process and express what words cannot.

To further the role of processing, it is vital to review some theories of basic psychology. MacLean's triune brain model suggests that the human brain actually operates as three separate minds, each with its own role and its own respective senses of time, space, and memory [4]. 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:

- 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 part of the 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. In music, the term harmony means, "the sounding of two or more musical notes at the same time in a way that is pleasant or desired" [5]. In contrast, multiple sounds being made at the same time out of harmony can sound like a cacophony or sheer racket. As with musical harmony, if the three brains of the triune brain are not working together, an unpleasant effect can occur. In individuals with unresolved trauma or other negative experiences, the limbic brain may be dominant, drowning out the other brain functions that may need to be heard in order for harmony to result.

Cognitive therapies are designed to activate and work with higher order thinking. However, for clients who have unprocessed trauma symptoms, the three brains are not fully communicating. During periods of intense emotional disturbance, the functions of the frontal lobe cannot be optimally accessed because the limbic brain, or "survival brain," is in control [6; 7].

Moreover, if a person is triggered into a fight, flight, or freeze response at the limbic level, one of the quickest ways to alleviate that pain after the distress is to feed the pleasure potential in the R-complex. Alcohol, drugs, food, sex, gambling, shopping, hoarding, or other reinforcing activities are particularly effective at managing the pain [8].

Traumatized individuals are often stuck in a survival mode. The limbic region of the brain is activated during the original trauma to help the traumatized person survive. Because the left and right frontal lobes are abandoned during the experience (resulting in awareness but lack of ability to process), the individual is never able to link the limbic activation to the frontal lobe. Thus, in developing treatment plans for traumatized individuals, using cognitive strategies that primarily target the frontal lobe may not be effective.

One reason trauma may remain unprocessed is due to a misunderstanding of what processing involves. In many Western cultures, clinicians tend to assume that talking is the best way to process trauma; however, in other cultures, approaches can vary from spiritual interventions to physical treatments. In many mental health and addiction treatment settings in the United States, talking is synonymous with processing. Although talking can help a person process, it is primarily a function of the frontal lobe. A person can talk about the trauma extensively, but until it is addressed at the limbic level, the trauma will likely remain a problem [9]. Experiential modalities, like music, are more likely to address limbic-level activity when compared to the classic "talking it out" strategies [9].

Music activates the physiologic systems of the body from the cognitive level of the brain down to the visceral level [10]. Music, by its design, unifies the triune brain, thus promoting a sense of harmonious integration. The primary reason for this unification is that the coming together of rhythm and melody bridges the primitive brain with the neocortex, the part of the brain responsible for higher level executive functioning [2].

Neuroanatomic studies reveal significant physical changes in major brain structures as a result of trauma. When untreated, these important structural alterations cause the symptoms of PTSD. Traumatic and chronic stress creates lasting changes in three important brain areas: the amygdala, hippocampus and prefrontal cortex [20; 21].

Properly applied, therapeutic interventions can stop the cycle of hyperarousal and fear by forming new pathways in the brain. Music can be a useful part of treatment for clients who have experienced trauma, as it produces neuroplasticity and neurogenesis. Music directly stimulates the amygdala, causing a normalizing effect for processing stimuli—such as interpreting the significance of faces, sounds, and voices. The amygdala network regulates social interactions by regulating the approach to new situations and the appropriate withdrawal from them. Musical compression waves also stimulate the hippocampus to regulate cortisol levels. In addition, music stimulates the reward pathway, which releases dopamine [22].

Levitin explains the significant role that music plays in the brain of the developing child, a phenomenon that he identifies as a cultural universal [2]. Music's function in the developing child is to help prepare the mind for a number of complex cognitive and social activities. For the developing brain, music is a form of play, an exercise that invokes higher level integrative processes that nurture exploratory competence, preparing children to eventually explore generative language development. A cultural universal that Levitin addresses is that of the mother singing to her child, noting that early, healthy mother-child relations often involve music (e.g., humming, lullabies). Moreover, these interactions are almost always accompanied by a rhythmic movement. According to Levitin, when vision, hearing, and movement work together "the infant lives in a state of complete psychedelic splendor" [2]. Music provides integration at the level of the brain that is concomitant with the healing process that we strive to promote as part of psychotherapy.

THE THREE-STAGE CONSENSUS MODEL OF TREATMENT

For those who treat problems related to traumatic stress, treatment is typically approached as a three-phase process [11; 12; 13; 14]. The stages of this three-stage consensus model of trauma treatment are:

- Stabilization or preparation: Working with clients to address their acute symptoms and developing a series of coping skills and other affect-regulation strategies for the purpose of distress tolerance
- Working through the trauma: Using a therapeutic approach or a series of therapeutic approaches and other supportive strategies to process the traumatic memory or memories and their impact, with the ultimate goal of resolution that leads to improved life functioning
- Reintegration/reconnection with society: Assisting the client to take the gains made during stabilization and working through the trauma and apply them to the improvement of life functioning, social interactions, and personal well-being

Trauma is defined in many ways, but it is important to remember that it is a noun; it refers to an actual experience or wounding. Often, clinicians describe trauma based on its effects, not the actual experience. The word "trauma" is derived from the Greek word that literally means wound. By considering what physical wounds are and how they affect humans, the meaning of emotional trauma may be further understood.

Emotional traumas also come in various shapes and sizes, resulting from many possible causes. For some, a simple trauma (wound) can clear on its own, but for others with more complex emotional variables, the healing process may take longer. If a traumatized individual does not obtain the proper conditions to heal, it will likely take longer for the trauma to resolve. In the meantime, other symptoms can manifest.

Operational definitions of trauma, as officially supported by the psychologic professions, are also useful. According to the American Psychological Association's Dictionary of Psychology, trauma is [15]:

> An event in which a person witnesses or experiences a threat to his or her own life or physical safety or that of others and experiences fear, terror, or helplessness. The event may also cause dissociation, confusion, and a loss of a sense of safety. Traumatic events challenge an individual's view of the world as a just, safe, and predictable place.

Helping professionals continue to debate whether certain types of trauma are "worse" than others. For instance, this definition goes on to propose that traumas caused by humans (e.g., rape, assault) often result in greater psychologic impact than those caused by nature (e.g., earthquakes, floods) [15]. Others, however, assert that trauma caused by people may be worse for certain people, depending on an individual's situation, constitution, and overall coping system in place to deal with the trauma. Because the human experience of trauma is fundamentally subjective, comparing traumas is difficult and generally not helpful.

It may seem odd to introduce a trauma treatment model into a course about incorporating music into the therapeutic process. However, this consensus model can be applicable to other disorders treated clinically in which some type of trauma plays a role in the development of the disorder. The model also offers a framework through which music can be incorporated into the therapeutic process in each of the three stages, depending on the individual needs of the client.

Another helpful construct to consider is that of complicated grief. First proposed by Helene Deutsch, a colleague of Sigmund Freud, complicated grief (or masked grief) refers to the experience of maladaptive or problematic psychologic symptoms that can be traced back to unresolved grief. Unexplained physical symptoms can also be attributed to a masked grief reaction [16]. As with unresolved trauma, music may help with coping, working through the complications, and helping the client to reintegrate when complicated or masked grief prevents him or her from optimally functioning in life. Throughout the course, many of the suggestions proposed for helping with unresolved trauma can be applied to unresolved grief, and vice versa.

STAGE 1: USING MUSIC FOR STABILIZATION

As noted, stabilization (also referred to as preparation) consists of working with clients to address their most acute symptoms and developing a series of coping skills and other affect-regulation strategies for the purpose of distress tolerance. In applied terms, a client is not expected to confront all of his or her problems on the first day of treatment, so it is important for the client and clinician to develop a series of strategies that can be used for coping, stress tolerance, and affect regulation. These skills do not have to be developed perfectly but practiced reasonably enough so the client will have healthy ways to self-soothe and cope when therapy becomes more intense. The following examples illustrate how musical strategies can be worked into the arsenal of coping skills and techniques for stabilization.

Case Studies

Case Study 1

Client A is a woman, 34 years of age, who is a survivor of extensive childhood sexual abuse. She presents for outpatient treatment, specifically to address unresolved issues that have affected her interpersonal functioning for years. Client A, a self-identified lesbian, recently got out of a manipulative relationship with a long-term partner, and she finds herself contemplating another equally dangerous relationship at the time that she presents for counseling. Client A has been recommended for eye movement desensitization and reprocessing (EMDR) therapy, a specialty treatment to address her post-traumatic stress disorder (PTSD). However, her therapist discovers that attempting EMDR immediately may be a bit of a problem because Client A has a difficult time visualizing, especially using visualization to develop safe coping resources. During the initial intake sessions, Client A reports that she is a lover of music, especially jazz music. She also indicates that although she struggled over the years with connecting with anything spiritual (primarily because her father was a member of a fundamentalist religious denomination and some of her sexual abuse occurred on the grounds of a school run by that denomination), listening to music is the closest she has come to meditating or "being spiritual."

In preparation for the more extensive therapy, her therapist asks if there are any specific songs that Client A feels are calming or empowering. After scanning her memory, she identifies one song that has both properties for her: "O-o-h Child" by the Five Stairsteps. With an empowering melody and a positive, future-oriented message of hope and healing, Client A and her therapist decide that this is an excellent song for her to use as part of her stabilization plan. The therapist obtains a copy of the song, and they listen to the song together in the office. Client A's therapist invites her to close her eyes if she feels comfortable, and she elects to do so. As the song progresses, a smile washes over her face, and when the song is over, Client A verbalizes, as best she can, how much calmer her body felt by really focusing on the song.

Client A reports that she has a copy of the song on her portable music device, so she is able to access it on her own if needed. Client A and her therapist agree that they will have this song ready to use to calm Client A at the end of a session if their exploration of her traumatic stress issues using the EMDR process becomes too disturbing for her.

Case Study 2

Client B is a man, 42 years of age, presenting to a new therapist after spending most of his adult life in the community mental health system. Having received a variety of diagnoses over the years, Client B's previous therapist concurred that he needed to be seen by a counselor who was trauma-sensitive, as he is having trouble processing the various abuses and losses he experienced as a younger man. When he presents for therapy, knowing that hypnotherapy, EMDR, and several other specialty interventions for trauma are available, he cautions the therapist, "I can't relax. Other therapists have tried, but I just cannot relax." When the therapist asks him what other methods he has used, he reports that it was mostly guided imagery and breathing. During the first session, shortly after issuing this warning, Client B's cell phone rings, sounding out a popular country music song. This spawns a productive discussion about his musical tastes, and the therapist asks the client if he is willing to experiment with sound and musical strategies to help him relax. Client B is excited to try this approach.

Client B begins by identifying a series of Christian music songs that he finds inspirational and peaceful. The therapist is able to access these songs online and starts to play one over her computer's speakers. She invites him to stay focused only on the song and to let himself relax. It takes some practice, but soon Client B is able to bring his focus back to the song when his thoughts begin wandering. After each song-based meditation, Client B and his therapist are able to discuss the feelings and body sensations that the song elicited.

Upon witnessing how responsive Client B is to sound, the therapist decides to implement a Tibetan singing bowl as a form of mindfulness meditation. Client B is invited, upon hearing each long, echoing cling of the bowl, to be mindfully aware of the sound. He reports that he finds this process extremely relaxing. Several sessions later, when Client B and his therapist agree that he is ready to explore some of his past issues with hypnotherapy, the Tibetan singing bowl and Client B's mindfulness practice are incorporated to help induce a state of hypnosis.

Case Study 3

Client C is a young woman who recently entered recovery from alcohol and opioid addictions. Although she presents for treatment and begins attending 12-step meetings with a solid sense of awareness that she has a problem, she is still struggling to manage her cravings in an effective manner. Her sponsor and her counselor have told her that any craving, or any negative feeling, will eventually pass, but it is up to her to identify an effective coping mechanism to deal with the moments when these feelings are strongest. Always a fan of music, Client C finds that playing a song she finds to be comforting and inspirational on a steady loop seems to help the negativity pass. In some cases, she plays one particular song 20 times. Often, she sings along, but at other times, she simply listens and allows the words and melody to absorb her. Even after five years of sobriety, Client C finds this "musical looping" strategy to be incredibly effective to help her manage triggers and thoughts of acting impulsively.

Reflection

Think of a song or series of songs that help you feel relaxed, empowered, or rejuvenated. What is it about the song that is special to you, and what are the words you can use to describe how that song makes you feel? If possible, spend the next several minutes mindfully connecting with the song. If your thoughts should drift elsewhere, bring them back to the song and stay mindfully aware of your listening experience.

Using Music in Guided Imagery

Not everyone is able to do guided imagery. This makes sense because not everyone is visually inclined. Yet in the culture of therapy, guided imageries are often the first or preferred relaxation strategy. If visually oriented guided imagery exercises are not working for a client, accessing imagery or relaxation through music can be an alternate strategy.

Almost any classic guided imagery exercise can be replaced with a piece of music. A classic example is the calm place (sometimes referred to as "safe place" or "happy place") exercise. In a calm place imagery, clients are typically asked to tell the therapist about a place they have been, a place they would like to go, or a place where they have only been in their imaginations that helps them feel calm. If a client cannot come up with anything, then the therapist typically suggests one of his or her own guided imageries, like a soothing beach or a tranquil forest. Then, the therapist will break down the image and invite the client to focus on various facets of it, like the blueness of the water in the ocean. Other senses may be incorporated, like listening to the waves on the beach or hearing the wind blow through the trees.

The point of these exercises is to get clients to use their own senses of imagination to experience a healthy, soothing escape from the stressors of life. By the end of an imagery exercise, if clients report feeling relaxed, then therapists typically interpret this to mean that the exercise went well. However, some clients simply will not be able to get relaxed. In these cases, the "image" in guided imagery can be replaced with a song or a series of sounds. This can involve cuing up a recording of a sound sample that the client has identified as positive (e.g., children laughing, waterfalls) or a whole song that the client has

identified as positive. When the sound clip or song is played, invite the client to just listen, simply noticing the sound/song. If, while listening to the sound or song, the client's attention appears to be drifting, invite the client to draw his or her focus back to the song, noticing any feelings or sensations that the sound or song is bringing up in the body.

After the sound or song has ended, take a moment to invite the client to just be with the silence and notice anything that might be coming up (e.g., body sensations, feelings, thoughts, memories) after listening to the song. What emerges from the experience of listening to the song can be used in the therapeutic process. Hopefully, the listening experience will have provided a positive, soothing experience for the client, but if for some reason it did not, information about what it did elicit can be used to better understand the client's experiences and how he/she may process music or sound. In cases in which listening to a piece of music brings up negative feelings (as any guided imagery may), spend a few moments verbally processing those feelings with the client, and then decide if the client wants to attempt another sound or song. In some cases, what the client thought would be a positive sound experience is not, but a different sound resource may be more positive.

This exercise can be taken a step further by adding a "cuing" component. With any resource-building activity used in stabilization, it is typically not enough to use a positive exercise like a guided imagery or musical guided imagery without putting it to the test. With cuing, the client is asked to bring up a negative stressor or stimulus (typically avoiding major traumas during this stabilization process). If the negative stimulus has a sound that goes along with it (e.g., the screeching of a voice, the thump of files being dropped onto a desk at work), invite the client to notice that stressor. After the client spends a few moments with the stressor, ask where he or she most feels or experiences the stressor and see if he or she can describe it (e.g., a tight knot in the stomach, pinching needles in the shoulders). Then, play the positive sound clip or song and invite the client to engage in the same reflective process. Invite the client to focus only on the sound or song, steering attention as best as possible away from the stressor or negative body reaction. After the sound exercise is complete, ask the client what happened to the body sensation. If the musical exercise worked, the negative body experience will have been replaced with something more positive or significantly diminished in intensity.

The next step is to begin with the body cuing of the stressor (or another stressor for this next phase of the exercise) and then, instead of playing the song, invite the client to simply bring up the sound or song in his or her head without directly playing it. If clients can learn to recall the song in order to address the negative effects of the stressor, this will give them a coping strategy to use even if they are in a position in which they cannot easily get to a device that plays music.

Another variation is to use the sound clips or piece of music together with a guided imagery. Some clients who respond to guided imagery find that sounds or pieces of music in the background give the imagery additional impact. Whenever possible, the sounds should match the imagery (e.g., waves for a beach image, chanting or religious music for a religious scene). One may also use theta wave music. Any calming music that is typically marketed for meditation or yoga may work to help enhance guided imageries, and most of these recordings make use of rhythms or vibrations that are able to stimulate theta wave activity in the brain, the frequency at which a brain is most likely to enter into a drowsy or hypnotic state. Adding these calming, meditative sound patterns or pieces of music while you are working on a guided imagery exercise can be beneficial to the client.

Music Relaxation to Improve Sleep Quality

Relaxing and calming music listening can, furthermore, be helpful to improve sleep and also to reduce depression. Insomnia and recurrent nightmares are common symptoms of PTSD, anxiety, and depression. One study investigated two nonpharmacologic approaches to treatment for clients with PTSD—progressive muscular relaxation and music relaxation [23]. Music relaxation was found to significantly reduce depression and increase sleep efficiency, with improvements in sleep latency, sleep activity, and wake episodes. In addition, sleep efficiency was highly correlated to reduction in depression scores. The music composed for the study featured a slow, repeated melody on piano with background violins and bells.

Making a Playlist

The term playlist is a relatively new addition to the English lexicon, popularized by the advent of mp3 players and other electronic musical storage devices. Listeners are less likely to listen to an entire album and instead tend to make a customized list of songs that they can access at any time for listening. A playlist can be a good adjunct to the therapeutic process, because a client can work to make, with or without assistance, a list of songs to meet a specific therapeutic need at any given moment. Even if a client does not have a portable music device, playlists can be burned to a CD. Helping navigate the technology aspect of music aggregation may be necessary for some clients.

Playlists can typically be made using a series of songs that flow along the following themes:

- Soothing/calming
- Empowering
- Motivating

If a client is about to encounter a potentially stressful experience in life, it would be advisable to bring up the soothing/calming playlist. If a client is going to take a very important test for work or school and struggles with low self-confidence, listening to the empowering playlist on the way to take the test may be helpful. For a client who is struggling to stay sober, listening to a motivating playlist on a daily basis could be a powerful adjunct to his or her recovery program.

Reflection

Choose one of the themes listed above (soothing/calming, empowering, or motivating) and list 5 to 10 songs or sounds that you would include on this playlist for yourself. If you want to take this exercise a step further, create and add this playlist to your portable music device or make a CD.

There are a few cautions to consider when working on playlists with clients. A major caution, especially when working with young people, relates to how you help the client screen the music on his or her playlist, as this is a very delicate process. On one hand, the client may choose songs that seem radically inappropriate for a healing exercise. For example, including a violent rap song on a motivating playlist may raise some red flags in your clinical head. However, it is important not to minimize the client's choice of song if the song carries great meaning, especially in a survival context, for the client. If a song does raise a red flag, ask the client to explain what the song means, giving him or her a chance to justify the inclusion of that song on the playlist. If concerns persist, express them in a gentle manner; this can often lead to a very good dialogue about adaptive versus maladaptive (e.g., healthy vs. unhealthy) coping strategies.

Using Music to Build a Vocabulary of Feelings

The screening conversation described in the previous section can also serve a powerful function in the area of helping a client to better explain and express feelings. When a person is asked to describe what a certain song means to him or her, it can open up a whole new conversation about coping over the years and how certain songs make him or her feel, especially in relation to life experiences.

Music can be used in a variety of ways to help clients express feelings when they may otherwise lack the vocabulary to do so. There are two major ways that this can be accomplished. First is to add the step of asking the client, assuring him that there are no right or wrong answers, to describe feelings the song induces after the musical variation on the guided imagery exercise. Again, this process may require some guidance. If a client cannot put a specific word to a feeling (e.g., sad or happy), it may help to ask, "When you listen to that song, what happens in your body?" or "You seemed very happy when you were listening to that song. Am I observing that correctly? What about the song seems to make you happy (or insert any other feeling that you might observe)?"

Secondly, one could invite the client to share feelings or experiences through music that may be difficult to express in precise words. Looking at song lyrics may provide insight into a client's feelings, and one can build off of those song lyrics to get the client not just to talk about his or her feelings, but also to take some pauses and experience them within the context of the session.

Clients who are struggling may be invited to bring to the next session a song or series of songs that best explains his or her life or current struggles. This exercise may not work for everyone, but for those clients who like music for listening pleasure, it may give them something from which to springboard when it comes to the often-daunting process of feeling exploration.

Using Music in Group Setting

Both the playlist activity and using music to build a vocabulary of feelings can be easily worked into group settings. Adolescents, who may be prone to finding treatment groups boring and repetitive, tend to react positively to sharing a song or two from their playlist with the rest of the treatment group. Engaging in group listening, an activity common in most cultures, can lead to fascinating discussions about how individuals in the group interpret the song. Productive therapeutic discussions can stem from groups listening to a song that one group member brought to the session.

The group facilitator also has the ability to do a group "vocabulary of feelings" exercise by playing a song for the group. After inviting clients to listen to the song as a group and notice the reactions that come up in their bodies upon listening to the song, a discussion can be facilitated. Group members often end up relating to each other during this process, and a group member who struggles with identifying and verbalizing feelings may be assisted by hearing other group members share. The only major caution in group work, at any stage, is to ensure the facilitator is available after the group to discuss any disturbing reactions that a client may have experienced while the song played, as clients may not feel comfortable sharing them with the whole group.

One study involving veterans with PTSD explored spontaneous drumming in a group [24]. Reductions in PTSD symptoms were observed following drumming sessions, with veterans accessing their traumatic memories in a safe way, expressing intense emotions, and regaining a sense of control. Playing music in a group offers a way to normalize focus and attention and can lead to a feeling of harmony with the group.

Clients Who Play an Instrument, Sing, or Write Songs

Of course, not all clients are musically inclined, but for those who are, there are additional options for incorporating music into the healing process. For many people with musical talents, the disorder that brought them into treatment in the first place (e.g., addiction, a mental illness, complicated adjustment) may have caused them to abandon their musical pursuits. Thus, suggesting returning to music as a coping strategy to help with stabilization can be a powerful technique. It is important to reiterate to clients that if they choose to take their instruments out again, or if they choose to sing again, it is not important that they perfect the craft, especially if they were once competent at it. Rather, tapping into the joy that can be experienced simply by playing and creating should be emphasized, encouraging the client to be gentle with him or herself during the process of rediscovery.

Songwriting can help feelings take new flight. For clients who mention that they have written songs or that they play an instrument and maybe write some poetry, ask if they have ever considered writing music as part of their therapy. Again, emphasize that it does not need to be perfect. If it is emotionally pure and can help with coping, it can be used as part of stabilization.

One study explored the role of songwriting in veterans with PTSD [25]. In this study, clients wrote songs about their combat experiences, then listened to the song daily for four weeks. At the end of the study, there was a 33% decline in PTSD symptoms and a 22% decline in depression symptoms.

STAGE 2: USING MUSIC FOR PROCESSING/ WORKING THROUGH PAST MATERIAL

There are several terms in the literature on trauma and psychotherapy that have been used to describe the second stage of treatment. One common term is processing, or making sense of an experience and learning. Processing can include achieving the resolution needed to move on from a traumatic experience or series of experiences. Some therapists prefer the term reprocessing, using the logic that because the traumatic experiences were never processed adaptively in the first place, then they need to be reprocessed. Reprocessing can be defined as consciously accessing an affected memory or experience and striving to bring about a more adaptive experience or resolution. This stage can be described as a working through of the trauma, or using a therapeutic approach or series of approaches and other supportive strategies to process the traumatic memory and its impact, with the ultimate goal of resolution that leads to improved life functioning.

In the mental health professions, there is an erroneous assumption made by many well-meaning professionals that working through of the trauma must include talking about it. While clients may need to work through the trauma in a properly supportive context, talking about the trauma is not necessarily what needs to happen in order for processing to take place. When one considers the triune brain model introduced earlier in this course, it is clear that the part of the brain responsible for talking and language is totally different from the part of the brain where traumatic memories are maladaptively, or problematically, stored. While talking about the trauma is not totally negative, it typically needs to be coupled with a physical or multisensory activity in order to be effective. This can include exercise, yoga, imagery, meditation or prayer, art or drawing, journaling or creative writing, or engaging in psychotherapies that are designed to incorporate the whole body (e.g., EMDR, hypnotherapy, emotional freedom technique, somatic processing, progressive relaxation, systematic desensitization, exposure therapy, psychomotor therapy, neuro-emotional technique). Musical strategies can be ideal for helping a person work through traumas or negative experiences, either by listening or creating. This section will continue to explore some powerful ways that music can be incorporated into the healing process.

Case Studies

Case Study 1

Client D is a man, 29 years of age, who enters outpatient counseling treatment. In his initial assessment, Client D reveals a series of traumas resulting from being bullied in school due to his visual learning disorders and maneuvering the household dynamics in his family of origin. Both of his parents were severe alcoholics and addicts. The client experienced a major loss at 12 years of age when his alcoholic father, who taught the client a love of music (specifically, the Beatles), died in the client's arms. These experiences have yielded problematic negative beliefs, including a need to hide emotions and a feeling of being intellectually inferior. These cognitions appear to be at the root of his depressive symptoms. Client D first manifested depressive symptoms (e.g., low motivation, hopelessness, poor energy, fleeting suicidal ideations) at 13 years of age, and they have intensified over the years as various life stressors were introduced.

Before presenting for treatment, Client D had been involved with five other counselors who were primarily cognitive-behavioral in their orientation. Client D found these treatments only minimally helpful; thus, he is willing to try alternative methods. Client D is determined to be a good candidate for EMDR, although he is unable to develop a traditional, visually based "safe place," a strategy that is often used as stabilization in EMDR treatment, which makes sense considering his history with visual learning problems. Client D responds very well to using a piece of music instead of an image.

When working through the trauma is commenced with EMDR, Client D begins blocking immediately, and his therapist is considering abandoning EMDR as an intervention. During his twelfth EMDR session, with the distress levels of his major traumas still very high, the therapist makes a decision to have a few musical tracks available (primarily music of the Beatles) that she has determined (based on her musical experience) could potentially unblock the client if he is stuck in an "unfeeling loop." During a major block in this session, the counselor chooses to play a Beatles song ("Let It Be") that was specifically meaningful to Client D's father. As he listens to the song, the client is able to cry and release feelings about his parents that he has been holding on to. At the next session, the distress levels connected to his major trauma memories (measured on Wolpe's 0–10 subjective units of distress scale) decreased by half.

Client D participates in three more traditional EMDR sessions with use of the musical interweave with no major shifts in distress levels but numerous reported improvements in depressive symptoms. Client D, who had been on extended leave from work due to his depression, is able to return to work, and he graduates from college, which he had previously thought would be impossible. Due to financial concerns, Client D elects to terminate treatment, but he feels that the treatment has helped him get to a "better, more manageable" place overall. Client D reports a general alleviation in his depressive symptoms through better expressing his feelings, with a definite improvement in self-awareness.

Case Study 2

Client E is a graduate student in psychology who presents for counseling services to fully resolve her issues of childhood sexual abuse. Although Client E has seen several counselors in the past and has engaged in a great deal of work on her own (e.g., self-help reading, journaling), she knows that there is still some material left to be resolved if she is going to help other people work on their traumatic issues. Client E admits that she is very intellectual but has difficulty expressing herself emotionally. An eclectic approach is taken to work with this client, with elements of hypnotherapy, EMDR, and trauma-focused cognitive-behavioral therapy incorporated, with the goal of helping Client E tap into the emotional states that she has long been repressing.

Client E has had no problem stabilizing and shows a good ability to intellectually process what happened to her at the time of her sexual abuse, but she acknowledges that she is blocked off from the feeling. Journaling, talking, and using EMDR with traditional visual elements does not seem to help. Then, one session, as Client E and her counselor walk through the experience of the sexual assaults again, Client E remembers that the 1980s song "Tainted Love," performed by Soft Cell, was always playing in the background on the stereo whenever her abuser molested her. Client E is willing to listen to the song during a counseling session, hoping that adding the element of sound will add another level of exposure that might help her tap into the emotions she needs to access in order for resolution to be achieved. As soon as the song is introduced, the client displays a higher level of affective connection with the memories of the abuse, which ultimately helps her to release many of the terror-based feelings that she had been repressing.

Case Study 3

Client F presents for counseling treatment to help her manage mental health symptoms. A woman in her 50s, Client F has been medically treated for mood management concerns over the years, but in talking to a clergy member, she realized that she needed to enter counseling to address the past traumas that she never seems to get over. Client F is certain that if she could resolve these issues, she would be better able to manage her mood.

Client F is treated using trauma-focused cognitive-behavioral therapy. This approach incorporates many of the standard principles of cognitive-behavioral therapy but emphasizes the importance of examining the past or trauma-related etiologies of negative schema. Although she reports immediate relief from the distress and torture she typically experiences when thinking of her past, she seems to have difficulty integrating it into her present ability to deal with her emotions. Her therapist observes that there still seems to be a great incongruence between what she is feeling and what she is articulating. At one point about midway through the treatment sessions, the therapist asks Client F, "What do you think would help you to really connect with these feelings that you are still holding on to?" Client F pauses for a moment and then reports, "Probably the sound of children laughing. That sound has always brought me great comfort but has caused me great emotion at the same time...probably because when I was a kid, I always wished I could laugh, but I couldn't."

At this point, the therapist obtains a sound sample of children laughing online. She encourages Client F to sit comfortably in the office recliner and notice. Client F does this, and upon hearing the laughter, there is an immediate release of emotion. The therapist allows Client F to experience the release, then they continue with their sessions, noticing a greater shift in Client F's ability to express her emotions after this simple, sonically assisted catharsis.

Strategies for Helping a Client Encounter Past Material

Using Music to Access "Stuck" Material

Traumatic memories cause disturbance because they have never been processed, or digested, to an adaptive state of resolution. In essence, they become stuck in the volatile, limbic regions of the brain and will likely remain so unless a therapeutic mechanism is used to process the traumatic material. As noted, different methods can be used to assist in this process, and

no one method seems to be a panacea for everyone. Because music is stored in the brain in state-specific forms, it makes sense that music can be used alone or in concert with other therapeutic techniques to elicit emotion and ultimately help a person through his or her unprocessed trauma [2].

Before proceeding with these suggestions, it is important to reiterate that these methods should not be tried unless proper stabilization is in place. Movement from stabilization to the working through of the traumatic material is largely a clinical judgment call; there is no one stage at which this movement should occur. Although perfect stabilization is not realistic for someone with unresolved traumatic material, there should be some reasonable assurance that the client is able to access the coping and stabilization skills covered as part of stage 1 during periods of high distress.

With stabilization in place, one can begin to think critically about how music can be used to help a client process trauma. The most obvious way that this can be accomplished is to directly ask the client if he or she remembers any music or sounds associated with the traumatic memory or memories. Some clients may have similar remembrances to that of Client E—a musical memory associated with a specific traumatic experience. Even if a specific piece of music is not associated, the client may have a clear connection to a specific sound, like the harsh tone of an abuser's laugh, the sound of an explosion, or the steps of an abusive mother.

Reflection

Spend a moment reflecting on the concept of empowerment. What songs or what styles of music most empower you? What songs would you would put on a playlist to access during various times of need?

Even if a client does not associate a piece of music or sound with a traumatic experience, if a solid working alliance is in place, one may consider probing the client about it. For instance, invite a client to be silent for a moment, and as he or she brings up the image or memory of the traumatic experience, ask him or her to notice if there are any sounds in the memory.

Regardless of the primary therapeutic modality used in one's practice to help a client work through traumatic memories, elements of music and sound can be incorporated. The most ideal set-up would be to have access to easily played music through a computer with speakers. This will allow a song or sound to be played during the session as a means of enhancing the therapeutic modality. This choice can be a valuable tool to accessing part of the memory connecting to it emotionally. Playing the right piece of music (or sound sample) connected to the traumatic experience at the right time can be the application of the plunger needed to unclog one's emotional drain.

Although the ideal is to have access to sound samples in the office, this access is not totally necessary for the technique to work. Inviting clients to tune into the sound element of a memory can also work. In other words, bring up the same traumatic memory but invite the client to remember the sounds of the event.

Musical Journaling

Journaling is a method clients often incorporate to help with catharsis. In some cases, people begin journaling on their own; others begin at the direct suggestion of a therapist. Journaling can be useful during stage 2 work, especially because emotional material may arise between office sessions and the journal is an excellent place to record and to work through some of these new discoveries. Clients should be assured that journal writing does not have to be perfect; it is simply a place where one can express some of the thoughts and the feelings that are causing distress.

As with other traditional therapeutic strategies, music and sound can also be incorporated into the journaling process. Songwriting is a logical extension of journaling, but a client does not have to be a songwriter or musically inclined to benefit from musical journaling. Clients may compile a series of songs that reflect what they are experiencing as part of healing from traumatic memories. This exercise can be taken a step further by encouraging the client to put a playlist together and listen to it, then journal in a very free-verse, stream-of-consciousness manner about the feelings that a song or a whole playlist are generating. If a client is more inclined to prayer and meditation, he or she can listen and meditate instead of listening and writing; many options can be explored.

Music-Assisted Focusing and Somatic Psychology

Focusing and somatic methods are two related approaches that are often employed to resolve traumatic memories. Focusing involves paying attention to inward body cues, resulting in increased awareness of how the body reacts in certain situations. The purpose of focusing is not to get in touch with how one feels or thinks in specific situations or when pondering a particular memory; rather, it allows one to access what is going on physically in the body during a specific situation or when faced with a memory. In somatic psychology, a client learns to track, on a body level, his or her sense of experience [13].

A simple way to incorporate principles of focusing and somatic experiencing is to replace the often-used therapy questions of "How does that make you feel?" or "What do you think about that?" with the question, "What is going on in your body right now?" Clients can be invited to notice and share any body sensations. The following is an example of incorporating such a strategy without music.

Client: I don't even have words for it anymore. My mother just makes me so mad! I don't know if I can even talk to her after this last incident.

Therapist: So, even as we're talking about your mother right now, what is happening in your body?

Client: She just makes me want to jump out of my skin. My stomach is in knots, too.

Therapist: Just sit back for a moment and be with those body sensations. Don't judge them. Notice that your mother makes you experience those sensations in your body. (Quiet for several moments.) So, what's happening now?

Whatever the client may report in this flow, continue to ask questions that are connected to the body experience and allow the client to notice it nonjudgmentally. This body-based tactic is one of the simplest ways to bring the body, and thus the whole brain, into the therapeutic process.

Focusing and somatic techniques as forms of processing may not come easily to everyone, especially to those who are blocked off emotionally or, as is the case with many trauma survivors, who are out of touch with their body experiences. To introduce the idea of focusing and listening to the body, music can be added. The process here is similar to the discussion in stage 1 in terms of using music to develop a vocabulary of feelings. In this approach, the client will identify a song that is part of his or her life experience, perhaps one of the songs that the client came up with during a musical journaling exercise.

If a client has difficulty selecting a song that matches his or her experience, the clinician can suggest one. Then, cue the song or sound clip and invite the client to simply pay attention to the body as the song plays. Let the client know that he or she may talk about body sensations during this process or simply stay silent and observe the music. After the song or sound sample has ended, ask the question, "What is going on in your body right now?" If a person is otherwise blocked from expressing body-based experiences, the likelihood is greater that he or she will be able to articulate feelings if music is used to assist.

Using Strategies in Group Settings

For counselors with solid experience facilitating a working group (i.e., one in which most members are actively working on the change process) with safeguards in place to properly close groups in which intense material has been shared, music strategies can be adapted for group implementation in stage 2 work. If the majority of group members seem to be stuck on a particular issue (e.g., maintaining resentments, using dangerous activities to escape pain, repressing emotional experiences), identify a song that, if played for the group, may elicit a cathartic experience in some members. Even if only one group member is obviously affected when the song is played, other group members may relate to and be impacted by the experience. Any sharing brought about by the music is material for clinical discussion within the group.

If a member of the group is using musical journaling as a strategy in between sessions, consider inviting that group member to share some of his or her creations and/or discoveries with the group. Once again, a great deal of meaningful discussion can result from this sharing.

A focusing exercise with music can also be applied in a group setting. As the piece of music is played, encourage listening with nonjudgmental recognition of the body sensations, feelings, experiences, or memories that the music elicits. The operative difference is to facilitate a discussion about the experience with the rest of the group following the initial exercise. The hope is that, in sharing experience and prompting further discussion, members of the group can derive therapeutic benefit.

Assessing Ability/Skill to Use Music in Stage 2

It is likely that many professionals will feel confident about using some music-based strategies in stage 1 work, although incorporating music into the stage 2 process may not be for everyone. While incorporating these strategies into stage 2 may seem easier with a vast knowledge of music, musical competence or talent is not a prerequisite to use music in this stage. However, having a basic appreciation of music and its healing potential is an important component of using music in this stage of the therapy process.

Even more important than music appreciation is being willing and able to handle the intense level of emotion that may be elicited from incorporating music into working through trauma. If a therapist has the self-awareness to help people work through their traumas without getting dysregulated, incorporation of some of these strategies into therapy practice is possible and potentially very beneficial. Some professionals may be more comfortable if they try some of these techniques on their own first. For instance, do a focusing and body-awareness exercise after playing a piece of music that relates to the story of your own life and experience how powerful these strategies can be.

STAGE 3: USING MUSIC IN THE REINTEGRATION (RETURN TO OPTIMAL FUNCTIONING) STAGE

As discussed, reintegration/reconnection with society is the third stage of the consensus model. In this stage, the therapist assists the client to take the gains made during the stabilization and working through of trauma stages and apply them to the improvement of life functioning, social interactions, and personal well-being. Clearly, if a client is seeking outpatient services, then reintegration-type activities and returning to optimal functioning are being done throughout therapy. However, the importance of reintegration as a separate stage following the working through of trauma cannot be overestimated. The goal of work in the reintegration stage is to help a client learn how to maneuver through life without burden and return to the optimal functioning that he or she deserves, and music can help with this process.

Case Studies

Case Study 1

Client G is a high school student of above-average intelligence who has always struggled with standardized testing. Though she likes music, she has never fully appreciated how it could help her cope with test anxiety. Having taken all of the courses she needs to prepare and working with her guidance counselor to address the mental blocks that she needs to overcome, she feels ready to retake the Scholastic Assessment Test (SAT) at the beginning of her senior year. A few days before the test, her friend hands her a CD that he created for her. He explains that he included the song "Eye of the Tiger" and that she should listen to it on a loop before going in to take the test. Not only does Client G find listening to this music energizing, but she also finds the meaning behind the song and the CD touching. The fact that her friend thought of her enough to send his motivation with her gives her an extra boost of confidence that helps her to perform as best as she can on the exam.

Case Study 2

Client H is a firefighter and emergency medical technician in a small town who has struggled with symptoms of PTSD for more than seven years. A perceived lack of understanding and compassion in his department is exacerbating his PTSD symptoms, and he finds going to work and dealing with others to be the most miserable part of his job, in some ways a more difficult task than fighting fires and rescuing people. Although Client H is not a musician, he enjoys music and is happy his therapist is willing to entertain his discussions about songs, no matter how dark they are. Client H completes a full course of stabilization (stage 1) and working through of the trauma (stage 2) using EMDR and some trauma-focused cognitive-behavioral therapy strategies. However, Client H's main concern continues to be returning to work now that he is feeling better. Together, Client H and his therapist develop a coping plan in order to deal with the drama in his work setting. Part of this plan includes listening to "angry" music in the car on the way to work. For Client H, getting his angst out by singing along with hardcore heavy metal music in the car on the way to work helps him to release his anticipatory anxiety about interacting with his fellow employees. Although Client H uses gentler techniques (e.g., breathing, grounding) while at the fire station, he finds that having the musical outlet in his car makes a difference for him in being able to return to work.

Case Study 3

Client I is a man, 58 years of age, who presents for PTSD treatment following a major robbery at his place of work. During the robbery, Client I was shot and barely escaped with his life. Client I initially struggled during his treatment, but he eventually experienced a great reduction in PTSD symptoms using a combination of pharmacotherapy (prescribed by a staff psychiatrist), trauma-focused cognitive-behavioral therapy, art therapy, and some somatic experiencing. Although Client I does not seem to connect with traditional EMDR therapy when his therapist attempts it, there is one element that he does like—the sound tones. (In EMDR, eye movements do not have to be used to generate the bilateral stimulation that defines the EMDR approach to psychotherapy. Alternating tapping/tactile sensations or beeps [typically generated by a specialized machine that can provide the alternation] are acceptable alternatives.) Client I indicates that simply putting the headphones on and focusing only on the beeps proves to be extremely relaxing. The therapist observes that drawing seems to help him with processing the trauma and listening to the tones serves as a form of soothing self-hypnosis.

As an experiment, Client I is sent home one day with a CD of just the beeping sounds on a loop to determine if it will have an effect even without the alternating capacity generated by the EMDR machine. At his next appointment, Client I reports that when he needed to relax, he simply put on his "beeping" CD and he was able to relax. He also noted a decrease in heart rate during listening sessions.

Upon termination of treatment, Client I indicates that using his "beeping" CD has become a regular part of his life whenever he feels panic or anxiety. Although Client I has done work in therapy to address the traumatic material, he continues to live in a dangerous neighborhood near the place of his shooting, so triggers are unavoidable. Client I indicates that the "beeps" are something he will call upon whenever he needs to relax and self-soothe.

Strategies for Reintegration

If one is able to incorporate some of the strategies from stages 1 and 2 into practice with clients, the same logic can be carried into stage 3 work. If stage 3 is the period during which the client is returning to optimal functioning, certain needs must be met for this to happen. Perhaps the client will identify a need to feel a greater sense of empowerment overall or a continual need to calm him or herself in certain situations. Whatever the need, a musical strategy may be applied.

Applying Skills from Earlier Stages with Redirected Purpose

The playlist strategies identified for stage 1 work can be applied to stage 3 as well, depending on client need. The client may want to move songs around on the playlists, deleting some and adding others, depending on how their experiences have changed as the result of therapy. The meditation-like strategy of using music to replace guided imagery can also be applied in stage 3. If a client must face a difficult situation, using a piece of music that has been identified as a positive resource can be a big help.

Even some of the skills from stage 2 can be applied as stage 3 reintegration strategies, especially those that involve songwriting or listening to a piece of music to help a client connect with his or her feelings and body experiences. Clients who are having trouble listening to their body or to their intuition can listen to a piece of music and spend time noticing body-level reactions; this is a strategy that can be used throughout life.

Using Music to Define/Embrace Empowerment

Empowerment is a term often used in the therapeutic literature, and therapists are charged to empower clients, with the ultimate goal of clients being able to tap into their own senses of power. As one official definition reads, empowerment "provides a client with a sense of achievement and realization of his or her own abilities and ambitions" [15].

The right song can certainly help clients tap into personal empowerment. Songs that allow clients to feel better about themselves and their place in the world can be an important part of reintegration. If a client is open and willing to define songs that can help with the empowerment process, this is a benefit to the therapeutic process.

INCORPORATING MUSIC INTO TELEHEALTH SERVICES

During the COVID-19 pandemic and continuing after, there has been an increased interest in and utilization of telehealth mental health services. Some populations, including active-duty military service members and those living in remote or underserved areas, rely almost exclusively on access to mental health care via distance counseling and therapy. Music can be easily and effectively adapted to be incorporated into these types of services. Research indicates that including music in tele-therapy yields positive participant responses, including decreases in pain, anxiety, and depression [26]. Clients who rely on telehealth services should not be excluded from these types of interventions; distance delivery of music through digital platforms can be a part of all phases of trauma processing and ensuring continuity of care [26].

CONCLUSION

For those who have chosen to access and harness it, the healing potential of music cannot be paralleled. As discussed in this course, music is a vital part of the human experience in every global culture, and because there are so many different varieties of music, it has great power to reflect and honor the subjectivity of the human experience. Thus, one can argue that if music is not used as part of the therapeutic process, we are missing an opportunity to truly understand a client and work with a medium that honors one's individuality.

This course has reviewed some foundational material about music, specifically looking at definitions and interpretations within historical and cultural contexts. Fundamental knowledge about how music works at the brain level and the role that music can play in promoting harmony among the various functions of the human brain were explored. The three-stage consensus model of trauma treatment was presented as a paradigm of treatment, through which approaches to music-based interventions were presented.

One does not need to be a musician or even conversant in music to be able to incorporate musical interventions into clinical practice. All it takes is common sense and an awareness of how music has impacted your life, your memory, and even your own healing.

RESOURCES

BOOKS

Oxford University Press' Global Music Series: Wade BC. *Thinking Musically: Experiencing Music, Expressing Culture*. New York, NY: Oxford University Press; 2012.

Dorrell P. *What is Music? Solving a Scientific Mystery*. Auckland: Philip Dorrell; 2005.

Levitin D. *This is Your Brain on Music: The Science of a Human Obsession*. New York, NY: Plume/Penguin; 2007.

WEBSITES

American Music Therapy Association
https://www.musictherapy.org

Association for Creativity in Counseling
https://www.creativecounselor.org

European Society for the Cognitive Sciences of Music
https://www.escomsociety.org

International Association of Expressive Arts Therapy
https://www.ieata.org

Customer Information/Answer Sheet/Evaluation insert located between pages 64–65.

TEST QUESTIONS
#76823 INCORPORATING MUSICAL STRATEGIES INTO CLINICAL PRACTICE

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 5 Hour/2 NBCC Clock Hour activity must be completed by March 31, 2026.

1. Etymologically, the word "music" is derived from the Greek *mousike techne*, meaning
- A) *open wound.*
- B) *art of the muses.*
- C) *food of the gods.*
- D) *science of sound.*

2. Which of the following is considered a cultural universal?
- A) *Sex*
- B) *Music*
- C) *Eating*
- D) *All of the above*

3. According to the triune brain model, the amygdala, hypothalamus, and hippocampus are part of the
- A) *neocortex.*
- B) *limbic brain.*
- C) *cerebral cortex.*
- D) *R-complex (reptilian) brain.*

4. One reason trauma may remain unprocessed is due to a misunderstanding of what processing involves.
- A) *True*
- B) *False*

5. Music activates the physiologic systems of the body from the cognitive level of the brain down to the visceral level.
- A) *True*
- B) *False*

6. In the developing brains of children, music
- A) *is a form of punishment.*
- B) *inhibits exploratory competence.*
- C) *invokes lower level integrative processes.*
- D) *prepares the brain for the eventual exploration of generative language development.*

7. Which of the following is NOT one of the stages of the three-stage consensus model?
- A) *Stabilization*
- B) *Precontemplation*
- C) *Working through the trauma*
- D) *Reintegration/reconnection with society*

8. Complicated grief is
- A) *a gradual movement toward an acceptance of loss.*
- B) *a severe grief reaction that continues for several months.*
- C) *a grief reaction that occurs in anticipation of an impending loss.*
- D) *the experience of maladaptive or problematic psychologic symptoms resulting from unresolved grief.*

9. During stage 1 (stabilization) treatment, the major goal is
- A) *addressing acute symptoms.*
- B) *resolving traumatic memories.*
- C) *developing a series of coping skills for distress tolerance.*
- D) *Both A and C*

10. Stabilization skills must be developed perfectly in order for the client to have healthy ways to self-soothe and cope when therapy becomes more intense.
- A) *True*
- B) *False*

11. Which of the following statements regarding the use of music in guided imagery is TRUE?
- A) *Music should only be used if a client requests it.*
- B) *Only lyrical music is useful for guided imagery exercises.*
- C) *Almost any classic guided imagery exercise can be replaced with a piece of music.*
- D) *If visually oriented guided imagery exercises are not working, using music will not be successful.*

12. If, while listening to the sound or song, the client's attention appears to be drifting, invite the client to draw his or her focus back to the song.
- A) *True*
- B) *False*

13. Calming music developed for meditation or yoga often makes use of rhythms or vibrations that stimulate
- A) *heart and respiratory rates.*
- B) *theta wave activity in the brain.*
- C) *gamma wave activity in the brain.*
- D) *recall and memory enhancement.*

14. Music relaxation has been found to significantly reduce depression and increase sleep efficiency, with improvements in sleep latency, sleep activity, and wake episodes.
- A) *True*
- B) *False*

15. When making a playlist is incorporated into therapy, some clients may require
- A) *help navigating the technology.*
- B) *a list of acceptable music and songs.*
- C) *prompting to only listen to full albums.*
- D) *All of the above*

16. All of the following are acceptable playlist themes, EXCEPT:
- A) *Triggering*
- B) *Motivating*
- C) *Empowering*
- D) *Soothing/calming*

17. Music can be used in a variety of ways to help clients express feelings when they may otherwise lack the vocabulary to do so.
- A) *True*
- B) *False*

18. When incorporating music into stage 1 (stabilization) work in a group setting, facilitators should ensure
- A) *that no one finds the work boring.*
- B) *group members do not discuss their own musical tastes.*
- C) *they are available after the session to discuss any disturbing reactions.*
- D) *discussions are limited to the music and not identifying feelings elicited by the exercise.*

19. In the context of trauma counseling, reprocessing is defined as
- A) *forgetting traumatizing past experiences.*
- B) *developing coping strategies to improve life functioning.*
- C) *reintegrating into society after completing inpatient therapy.*
- D) *consciously accessing a traumatic memory and striving to bring about a more adaptive experience or solution.*

20. According to the triune brain model, talk therapy alone may not be effective for stage 2 (processing/working through trauma) because
- A) *talking about trauma is always re-traumatizing.*
- B) *traumatic memories and language originate in the same part of the brain, making processing difficult.*
- C) *the part of the brain responsible for storing traumatic memories is not accessible with conscious thought.*
- D) *the part of the brain responsible for language is different from the part of the brain where traumatic memories are maladaptively stored.*

21. Before beginning any approaches to working through past trauma, it is important that
- A) *proper stabilization is in place.*
- B) *the client is not reliant on stabilization skills.*
- C) *the role of music in therapy is discussed with the client.*
- D) *the client no longer feels any anxiety or stress as a result of traumatic material.*

22. The most obvious way that music can be used to help a client process trauma is to directly ask the client if he or she remembers any music or sounds associated with the traumatic memory or memories.
- A) *True*
- B) *False*

23. Which of the following is an example of a musical journaling exercise?
- A) *Listening to one's favorite album*
- B) *Tracking, on a body level, how music affects one's body*
- C) *Recording an original song inspired by trauma processing work*
- D) *Writing about the feelings that a song or whole playlist generates*

Test questions continue on next page ➜

24. Focusing involves
- A) *paying attention to inward body cues.*
- B) *spending time meditating on a single mantra.*
- C) *evaluating how one thinks in a specific situation.*
- D) *getting in touch with how one feels in a specific situation.*

25. If a client has difficulty selecting a song that matches his or her experience, the clinician should not suggest one.
- A) *True*
- B) *False*

26. Even if only one group member is obviously affected when the song is played, other group members may relate to and be impacted by the experience.
- A) *True*
- B) *False*

27. Having a basic appreciation of music and its healing potential is not an essential component of using music in this stage of the therapy process.
- A) *True*
- B) *False*

28. The goal of stage 3 (reintegration) work is to
- A) *ensure that full catharsis takes place.*
- B) *stabilize the client following stage 2 work.*
- C) *help the client identify approaches to cope with stressors in everyday life.*
- D) *take the gains made in the first two stages and apply them to improve life functioning.*

29. Musical strategies identified for stage 1 (stabilization) and stage 2 (working through past trauma)
- A) *are applicable to all clients at all points in therapy.*
- B) *are not appropriate for stage 3 (reintegration) work.*
- C) *should be abandoned as the client progresses with therapy.*
- D) *may be applied to stage 3 (reintegration) with some modification.*

30. Empowerment is defined as providing a client with
- A) *a strong desire to do or to achieve something.*
- B) *listening to his or her own bodies and intuition.*
- C) *a sense of achievement and realization of his or her own abilities.*
- D) *finding his or her own way without outside support or resources.*

Be sure to transfer your answers to the Answer Sheet located between pages 64–65.
DO NOT send these test pages to NetCE. Retain them for your records.
PLEASE NOTE: Your postmark or facsimile date will be used as your test completion date.

Ethics for Counselors

Approval(s): NBCC, NAADAC

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

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

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

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

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

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

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

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

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

Contributing faculty, Michele Nichols, RN, BSN, MA, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Senior Director of Development and Academic Affairs
Sarah Campbell

Director Disclosure
The director has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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

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

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This course is considered self-study by the New York State Board of Marriage and Family Therapy.

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

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

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- A full Works Cited list is available online at www.NetCE.com.

INTRODUCTION

Ethical issues do not exist within a vacuum; rather, they emerge, evolve, and adapt within the sociocultural context of a particular society. In past decades, the field of professional ethics has received increased attention. Much of the discussion began in the 1960s in the medical field, where the blending of ethics, legalities, and medicine has become known as bioethics. Its emergence occurred because there was a need to talk about how research and healthcare decisions and regulations could be made, who could make them, and what their long-term implications would be. In the late 1960s, philosophers, theologians, physicians, lawyers, policy makers, and legislators began to write about these questions, hold conferences, establish institutes, and publish journals for the study of bioethics. Around the same time, many existing professional organizations and agencies, such as those for counseling, social work, and law enforcement, began implementing their own ethical codes. When a new institution is young, the creation of a formal code of ethics is standard practice to inform prospective members, unify, advise, and protect existing members, help resolve ethics issues, protect those who the profession serves, and help establish and distinguish an organization, agency, and its members.

HISTORICAL CONTEXT OF COUNSELING ETHICS

HISTORY OF COUNSELING IN THE UNITED STATES

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

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

HISTORY OF ETHICS

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

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

and not all subgroups or individuals in a society have values similar to the mainstream. Therefore, codes of ethics must be developed to unify, guide, and protect individuals belonging to a group or institution and to protect the institution itself.

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

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

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

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

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

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

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

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

Recent History

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

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

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

Another significant event occurred in the United States when, in 1932, the Public Health Service initiated a syphilis study on 399 black men from Tuskegee, Alabama, who were unaware of their diagnosis. The goal of the study was to observe the men over a period of time to examine how the disease progressed in people of African descent, because most of the clinical data on syphilis came from evaluating people of European descent. When the study began, there were no effective remedies; however, fifteen years into the study, penicillin was found to

be a cure for syphilis. The research participants were never informed, and treatment was withheld, in spite of the fact that by the end of the experiment, in 1972, 128 men had died either from the disease or related complications [1].

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

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

Professional Ethics

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

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

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

Development of Ethical Codes in Counseling

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

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

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

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

Source: [2] *Table 1*

Ethics and New Technologies

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

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

PHILOSOPHICAL HISTORY OF MODERN ETHICS

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

Modernism

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

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

Postmodernism

Postmodernism is a reaction to the belief that there is "rational scientific control over the natural and social worlds" [3]. Postmodernism is characterized by diversity, pluralism, and questioning the belief that there are objective laws or principles guiding behavior [3]. Postmodernists argue that ethical principles must take into account historical and social contexts to understand individuals' behaviors [4]. This philosophical climate emphasizes situational ethics in which there are no

black-and-white rules about principles of good and bad. Ultimately, a set of universal ethical principles cannot be easily applied [3].

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

Today, ethical codes and practices are also influenced by critical theory. Critical theorists focus on eliminating inequities and marginalization [112]. Ethics from this perspective explores the role of power and power inequalities, exploring who or what defines truth and whose voices are represented [112]. Reality is a socially and culturally shared experience and is shaped and navigated by both the practitioner and client [118]. Therefore, ethics is not a top-down experience, whereby ethical rules are unilaterally imposed. Rather, handling and negotiation of ethical challenges should be a collaboration [118].

COMMON TERMS USED IN THE DISCUSSION OF ETHICS

VALUES

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

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

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

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

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

ETHICS

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

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

Counselor T is a high school counselor in Oregon who is against the termination of pregnancy due to her personal and religious values; she has had several miscarriages and is currently experiencing difficulty becoming pregnant. Student A, 15 years of age, enters Counselor T's office in tears; the student has not told anyone that she is 9 weeks pregnant. She is seeking help regarding obtaining an abortion. Counselor T learns that her client was the victim of sexual abuse by her first adoptive parents. Other foster children and individuals in support groups, which Student A has come to know, were also victims of physical and sexual abuse by their adoptive parents.

She expresses fear of alienation from her friends, concern about falling behind in school, and anguish at not being able to remain active in sports, which are "her way of coping with life." The student has stated that she does not want to give birth to a child because she is too young to raise it properly and would not put her child up for adoption for fear that it too would become a victim. In fact, she states that she does not know if she "ever wants to bring a child into this world."

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

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

Ethical Dilemmas

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

Ethical Decision Making

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

Ethical Principles

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

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

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

VALUES AND ETHICAL PRINCIPLES IN ETHICAL CODES

ACA CODE OF ETHICS

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

The preamble of the ACA Code of Ethics states that embracing professional values ultimately provides a basis for ethical behavior and decision-making in practice. The Code identifies ACA's core values and requires that ACA ethics prevail over personal values. The following are section headings as they appear in the Code followed by a synopsis of the ethical guidelines and values expressed in each section [8]. Additionally, examples of related values and ethical principles are given. This synopsis of the ethical principles in the ACA Code of Ethics is meant to be an overview. Please refer to the full ACA Code of Ethics, available online at https://www.counseling.org/Resources/aca-code-of-ethics.pdf and in the ***Appendix***.

Section A: The Counseling Relationship

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

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

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

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

Section B: Confidentiality and Privacy

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

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

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

Section C: Professional Responsibility

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

Section D: Relationships with Other Professionals

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

Section E: Evaluation, Assessment, and Interpretation

Appropriate assessment instruments should be used when evaluating a client, and care should be taken that these instruments and evaluations are culturally appropriate. This includes educational, psychologic, and career assessment tools that provide qualitative and quantitative information about abilities, personality, interests, intelligence level, achievement, and performance. It is important not to use the results of any test to the client's detriment and to make the results known to the client. In addition, one should note that in many instances, these tests were standardized on a population that may be different from the client's population or identity. Informed consent and explanation of the goals of the assessment should be given in a language preferred by the client or his or her surrogate. Clients are to be given autonomy, and the counselor must apply the ethical principles of nonmaleficence and confidentiality.

Section F: Supervision, Training, and Teaching

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

Section G: Research and Publication

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

Section H: Distance Counseling, Technology, and Social Media

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

Section I: Resolving Ethical Issues

Counselors should be familiar with their agency's or institution's rules and regulations; these should be accepted and upheld or employment should be sought elsewhere. When ethical dilemmas arise, they should be resolved using communication with all those involved. When a conflict cannot be resolved among the parties involved, consultation with peers may be necessary. Ethical codes should be followed, but in some cases, this may conflict with laws (e.g., subpoena). It is advised that laws prevail over ethics when all other means

of resolution are exhausted. Counselors who become aware of colleagues' ethics violations that are not able to be resolved informally are obligated to report them provided it does not violate client-counselor confidentiality. The ethical resolution of dilemmas or issues requires the application of the ethical principles of ordering, respect, reparation, and veracity. Values of honesty, courage, independence, and intellect, among many others, determine positive outcomes in adverse situations.

NBCC CODE OF ETHICS

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

Professional Responsibilities

Counselors have a responsibility to themselves, clients, and institutions to behave in an ethical manner consistent with the NBCC Code of Ethics. All applicable legal standards and professional regulations should be abided in all cases. Counselors speaking publicly should reflect their personal views and not those of an organization unless authorized to speak on its behalf.

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

Credentials and qualifications should be accurately represented, and it is the responsibility of the counselor to correct known misrepresentations. Counselors who are no longer able to competently practice shall seek professional assistance or withdraw from the practice of counseling. In addition, counselors who have reasonable cause to believe that another mental health professional has engaged in unethical behavior, must report the matter to NBCC except when State regulations require immediate reporting.

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

Counseling Relationships

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

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

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

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

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

Supervision and Consultation

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

Counselors who act as educators or supervisors should avoid multiple relationships and specifically must refrain from sexual or romantic intimacy (in-person or electronic) with students or supervisees during and for at least five years following last academic/supervisory contact.

Supervisors must identify their qualifications and credentials to supervisees and provide information regarding the supervision process. Counselor supervisors should strive to establish a helpful and safe supervisory environment, always promoting the welfare and continued professional development of supervisees. This includes providing regular, substantive feedback and establishing procedures for responding to crisis situations.

Testing, Appraisal, and Research

Counselors should explain the ramifications of tests and results to clients and use assessments only for the client's benefit. Only current, reliable, and valid tests and assessments should be used. The results of a single test/assessment should never be used as the sole basis for a decision. It is a counselor's duty to recognize if the services provided will benefit a client or if they would be better served by another counselor or institution.

There are many assessment tools and techniques available to counselors, and counselors should be competent in the use and interpretation of each they intend to use. Consideration must be given to the fact that many tests/assessments are culturally biased; open-mindedness about test/assessment performance is valued. Tests and assessment administration and interpretation must comply with standard protocols. Identified security protocols for each must also be maintained.

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

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

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

Act with Integrity to Preserve Trust

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

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

Social Media and Technology

Social media must be used wisely and sensibly when communicating with clients or for sharing client information with other professionals; any means of consultation with other professionals must ensure client confidentiality. Policies must be in place to delineate the appropriate use of social media and other related digital technology as it relates to current and former clients. This policy should identify differences between private and professional accounts and measures to prevent confidentiality breaches. Professional accounts should only be used to post information related to professional services that does not create multiple relationships or violate client confidentiality.

Clients should be provided with instructions for how to securely and appropriately contact with their counselor, including the risks of inappropriate technology use. Counselors should become familiar with the privacy and security settings of social media and other electronic platforms used to provide services and how these settings can impact confidentiality.

Counselors should not access clients' social media accounts without documented discussion, client permission, and a specific clinical purpose. The privacy of clients' online activities and personas should be respected, and counselors must refrain from establishing non-professional online relationships with clients.Counselors who are certified by the NBCC must follow the NBCC Code of Ethics. The Code may be reviewed online at https://www.nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf.

ETHICAL THEORIES

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

VIRTUE ETHICS

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

DEONTOLOGIC ETHICAL THEORIES

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

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

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

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

One of the most significant features of deontologic ethics is found in John Rawls' *Theory of Justice*, which states that every person of equal ability has a right to equal use and application of liberty. However, certain liberties may be at competition with one another. Principles within the same ethical theoretical system can also conflict with one another. An example of this conflict might involve a decision over allocation of scarce resources. Under the principle of justice, all people should receive equal resources (benefits), but allocation can easily become an ethical dilemma when those resources are scarce. For instance, in national disasters, emergency response personnel would be among those ranked first to receive immediate stockpiles of food and drugs. Although this is in opposition with the principle of justice, it is supported by the principle of utility (greatest good).

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

Theologic Ethical Theories

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

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

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

Categorical Imperative

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

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

TELEOLOGIC ETHICAL THEORIES

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

Utilitarianism

Utilitarianism is the most well-known teleologic ethical theory. It is the principle that follows the outcome-based belief of actions that provide the greatest good for the greatest number of people [125]. So rather than individual goodness or rightness, this principle speaks for the group or society as a whole. Social laws in the United States are based upon this principle. The individual interests are secondary to the interest of the group at large. There are two types of utilitarianism: rule utilitarianism and act utilitarianism [125]. In rule utilitarianism, a person's past experiences are his influence toward achieving the greatest good. In act utilitarianism, the situation determines whether an action or decision is right or wrong. There are no rules to the game; each situation presents a different set of circumstances. This is commonly referred to as situational ethics. In situational ethics, if the act or decision results in happiness or goodness for the client and their social context, it would be ethically right.

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

Existentialism

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

Pragmatism

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

MOTIVIST ETHICAL THEORIES

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

NATURAL LAW ETHICAL THEORY

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

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

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

TRANSCULTURAL ETHICAL THEORY

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

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

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

Ethical Relativism/Multiculturalism

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

FEMINIST ETHICS

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

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

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

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

RELATIONAL ETHICS

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

ASSESSING ETHICAL THEORIES

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

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

There are other indicators to assess ethical theories. First, a sound ethical theory must be clear and easily understood. It should be simple, with no more rules and principles than professionals are able to remember and apply to real-life professional situations. Second, it should be internally consistent. This means that the different parts of a theory should be in agreement and that different professionals applying the theory to similar circumstances should reach similar conclusions. Third, a good ethical theory should be as complete as possible, without major gaps or omissions. Finally, an ethical

theory should be consistent with general daily experience and judgment. If an ethical theory is useful in helping to resolve moral dilemmas but is inconsistent with most or all our ordinary judgments, it will ultimately cause dissonance and will need to be modified.

PRACTICAL APPLICATIONS OF ETHICAL THEORIES

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

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

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

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

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

ETHICAL DECISION-MAKING FRAMEWORKS

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

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

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

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

DECISION-MAKING MODELS FOR ETHICAL DILEMMAS

Kenyon's Ethical Decision-Making Model

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

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

After all conflicts are resolved, counselors can generate all possible courses of action. Each action alternative should be examined and evaluated. The client's and all other participants' preferences, based on a full understanding of their values and ethical beliefs, must be considered. Alternatives that are inconsistent with other relevant guidelines, inconsistent with the client's and participants' values, and for which there are no resources or support should be eliminated. The remaining action alternatives that do not pass tests based on ethical principles of universality, publicity, and justice should be discarded.

KENYON'S ETHICAL DECISION-MAKING MODEL

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

Source: [10] *Table 2*

Counselors may now predict the possible consequences of the remaining acceptable action alternatives and prioritize them by rank. The preferred action is selected and evaluated, an action plan is developed, and the action is implemented.

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

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

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

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

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

- Gather as many creative solutions as possible by brainstorming before evaluating suggestions (your own or others).
- Evaluate the suggested solutions until you come up with the most usable ones. Identify the ethical and political consequences of these solutions. Remember that you cannot turn your ethical decision into action if you are not realistic regarding the constraints of institutions and political systems.
- Identify the best solution. Whenever possible, arrive at your decision by consensus so others will support the action. If there are no workable solutions, be prepared to say so and explain why. If ethics cannot be implemented because of politics, this should be discussed. If there are no answers because the ethical dilemma is unsolvable, the appropriate people also must be informed. Finally, the client and/or family should be involved in making the decision, and it is imperative to implement their choice.

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

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

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

Ethical Principles Screen

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

Collaborative Model for Ethical Decision Making

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

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

LIMITATIONS OF ETHICAL DECISION-MAKING FRAMEWORKS

One of the criticisms of ethical decision-making frameworks is that they portray decision making in a linear progression, and in real life, such prescriptive models do not capture what professionals do [30]. In essence, these frameworks stem from a positivist approach. Positivism values objectivity and rationality. In subjectivity, one's values, feelings, and emotions are detached from scientific inquiry. Research has indicated that practitioners having these linear ethical decision frameworks in their knowledge base do not necessarily translate them into ethical practice. Consequently, Betan argues for a hermeneutic (i.e., interpretive) approach to ethical decision making. The person making the decision is not a detached observer; rather, the

individual is inextricably part of the process. Betan maintains that this is vital because "ethics is rooted in regards to human life, and when confronting an ethical circumstance, one calls into service a personal sense of what it is to be human. Thus, one cannot intervene in human affairs without being an active participant in defining dimensions of human conduct and human worth" [30]. This does not necessarily mean that professionals should discard the linear approaches to ethical decision making. Rather, professionals should work toward understanding how the principles fit within the therapeutic context as well as the larger cultural context. Furthermore, some maintain that even if practitioners follow a decision-making model, they are often prone to rationalizing their decisions despite ethical violations [128]. Many ethical decision-making models also fail to take into account diversity and culture [129].

ETHICAL SELF-REFLECTION

Mattison challenges mental health professionals to not only use decision-making models to infuse logic and rationality to the decision-making process, but to also incorporate a more reflexive phase [24]. In many ways, Mattison's assertion is similar to Betan's call for integrating a hermeneutic perspective to ethical decision making. This is referred to as ethical self-reflection. The process is to learn more about oneself as a decision maker or to better understand the lens one wears to make decisions [24]. It is impossible and unnecessary to remove one's character, conscience, personal philosophy, attitudes, and biases from the decision-making process [31]. Just as counseling emphasizes the person-in-situation perspective in working and advocating for clients, so too should the person-in-situation perspective be employed in increasing self-awareness as a decision maker in ethical situations [24]. The person-in-environment perspective argues that to understand human behavior, one must understand the context of the environment that colors, shapes, and influences behavior. Therefore, the counselor must engage in an active process by considering how their individual level (e.g., prior socialization, cultural values and orientations, personal philosophy, worldview), the client's domain (e.g., values, world views, beliefs), organizational context (i.e., organizational or agency culture, policies), professional context (i.e., values of the social work profession), and societal context (i.e., societal norms) all play a role in influencing moral decision making [24]. Supervision is also key in facilitating self-awareness and reflection when making ethical decisions [130].

PSYCHOLOGICAL CONTEXT OF MORAL DECISION MAKING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MANAGED CARE AND ETHICS

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

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

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

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

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

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

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

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

DIVERSITY AND MULTICULTURALISM: ETHICAL ISSUES

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

DEMOGRAPHIC SHIFTS

Coupled with the ever-changing socioeconomic backdrop, demographic trends indicate increasing diversification and multiculturalism in U.S. society, including rapidly growing ethnic minority populations relative to the white population; a continual influx of documented and undocumented immigrants; a growing number of individuals with various gender and sexual identities (4% to 17% of the total population); an unprecedented increase in the older American population; and a vast number of Americans with disabilities (57 million individuals) [41; 42; 43; 44; 45; 46]. This has profound implications for counselors, as culture (in a general sense) influences every aspect of our lives, including our social and

psychologic reality [47]. Consequently, it is inevitable that counselors will work with more clients and settings than they are familiar or comfortable with. It is therefore advisable that counselors take into account cultural context and their clients' sociocultural identity when entering into a counseling relationship. Richmond writes that "counselors and clients are both emotionally invested in 'right living' issues. Since no therapy is value free, clients face the dilemma of finding a therapist with values similar to their own or having their values challenged. Therapists face the ethical issue of clarifying their own values and determining how to make them known" [66].

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

MULTICULTURALISM IN RESEARCH

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

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

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

DEBATES WITHIN MULTICULTURALISM/ DIVERSITY AND ETHICS

Much of the traditional ethical systems and philosophies that have influenced the United States stems from Christian-based and scientific empiricism [48]. Positivism assumes there is one universal that can be counted or measured. In addition, it postulates that reality is objective and value-free [48]. This positivistic approach to ethics was challenged by Joseph Fletcher in 1966 when he published *Situation Ethics*. He challenged the assumption made by many scholars in the 20th century that one resolved ethical dilemmas by turning to universally accepted principles. His work caused a paradigm shift from a universal approach to ethics to deconstructing it and developing a constructivist, contextual approach [48]. Consequently, in situation ethics, one takes the context (including culture and diversity) into account.

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

INFUSING DIVERSITY INTO THE ETHICAL DECISION-MAKING MODELS

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

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

Step 1: Interpreting the Situation through Awareness

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

Step 2: Formulating an Ethical Decision

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

Step 3: Weighing Competing, Nonmoral Values

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

Step 4: Implementing Action Plan

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

MULTICULTURALISM/DIVERSITY AND THE ACA CODE OF ETHICS

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

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

MULTICULTURALISM/DIVERSITY AND THE NBCC CODE OF ETHICS

Directive 7 of the NBCC Code of Ethics states, "Counselors shall demonstrate multicultural counseling competence in practice. Counselors will not use counseling techniques or engage in any professional activities that discriminate against or show hostility toward individuals or groups based on gender, ethnicity, race, national origin, sex, sexual orientation, disability, religion, or any other legally prohibited basis" [58]. In addition to a working knowledge of a client's cultural norms, the counselor should have an understanding of the effect that discrimination and oversimplification have on various social groups.

Furthermore, Directive 66 states, "Prior to the use of a test or assessment with a client, counselors shall seek information about a test's normative groups and limitations of use that may affect the administration or interpretation of results" [58]. It has been noted that many assessments, standardized tests, and techniques were normalized based on research with white, middle class populations. This includes psychologic test procedures and instruments in addition to educational or career assessment tools. Sociocultural norms and biases should be accounted for when interpreting results.

In order to avoid perpetuating cultural disparities in research and care, the NBCC also requires that research conducted with under-represented groups must take into consideration their historical, diverse, and multicultural experiences, and only use techniques and approaches based on appropriate, established, clinically sound theories.

ONLINE COUNSELING

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

LIMITATIONS OF ONLINE COUNSELING

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

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

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

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

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

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

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

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

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

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

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

ONLINE COMMUNICATIONS AND DISTANCE COUNSELING: A SOCIOCULTURAL CONTEXT

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

Race, Culture, and Ethnicity

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

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

Individuals from high-context cultures may require more social context in order to understand the meanings of the communication [79]. E-mail is a technology that can be viewed as more amenable to individuals from low-context cultures [79]. E-mails are perceived as a quick, easy way to communicate, in which the focus is on words to convey both content and meaning [79]. However, this form of communication can place ethnic minorities or individuals from other cultures at a disadvantage. Some experts recommend that when using technology in education and, by extension, counseling, the facilitator should attempt to increase contextual cues [82]. Counselors may choose to provide biographical information about themselves and encourage brief introductions from everyone in an online support group [82]. This process of setting up rich contextual cues will assist in building rapport as well.

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

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

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

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

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

Gender

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

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

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

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

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

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

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

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

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

ETHICAL AND LEGAL ISSUES

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

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

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

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

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

ACA CODE OF ETHICS AND DISTANCE COUNSELING

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

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

Information Privacy and Confidentiality

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

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

Distance Counseling, Technology, and Social Media

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

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

- **Records and web maintenance**: Laws and statutes regarding electronic record storage dictate how counselors maintain and secure client files and personal information. Clients should be informed about the security measures and encryption used in their database. If transaction records are archived, counselors should disclose how long these are kept. A distance counselor's licensure and professional certification board information should be linked on their website or personal page, and these links should be regularly updated.
- **Social media**: Counselors must maintain separate personal and professional social media profiles and/or web pages. Disclosure of confidential information on public social media or web pages must be avoided. Clients' Internet presence should remain private (even publicly shared information) unless a counselor receives consent.

NBCC STANDARDS FOR THE PROVISION OF TELEMENTAL HEALTH SERVICES

In its most recent revision of its Code of Ethics, the NBCC added a section addressing telemental health. This section replaces the previous policy for the provision of distance professional services issued by the NBCC in 2016. The following standards are from the 2023 NBCC Code of Ethics [58].

91. Counselors shall provide only those telemental health services for which they are qualified by education and experience.

92. Counselors shall carefully adhere to legal requirements when providing telemental health services. This requirement includes legal regulations from the State(s) in which the counselor and client are located. Counselors shall document relevant State requirements in the relevant client record(s).

93. Counselors shall ensure that the electronic means used in providing telemental health services are in compliance with current Federal and State laws and regulatory standards concerning telemental health service.

94. Counselors shall ensure that all electronic technology communications with clients are encrypted and secure.

95. Counselors shall maintain records of all clinical contacts with telemental health service clients.

96. Counselors shall set clear expectations and boundaries with telemental health service recipients about the type(s) and timing of communications that will be included in service provision. These expectations and boundaries shall be communicated in writing in disclosure documents provided to clients.

97. Counselors shall provide written information to all telemental health clients regarding the protection of client records, accounts and related passwords, electronic communications, and client identity. This information should include a description of the nature of all communication security measures that are used by the counselor, including any risks or limitations related to the provision of telemental health services.

98. Counselors shall communicate information regarding security to clients who receive telemental health services. Telemental health service clients shall be informed of the potential risks of telemental health communications, including warnings about transmitting private information when using a public access computer or one that is on a shared network.

99. Counselors shall screen potential telemental health service clients to determine whether such services are appropriate. These considerations shall be documented in the client's record.

    Counselors shall advise telemental health services clients that they must be intentional about protecting their privacy and confidentiality, including advice concerning viewing employer policies relating to the possible prohibitions concerning the use of work computer systems for personal communications, and not using "auto-remember" usernames and passwords.

100. During the screening or intake process, Counselors shall provide potential clients with a detailed written description of the telemental health counseling process and service provision. This information shall be specific to the identified service delivery type, and include relevant considerations for that particular client. These considerations shall include: the appropriateness of telemental health counseling in relation to the specific goal; the format of service delivery; the electronic equipment requirements such as the need for a computer with certain capabilities; the limitations of confidentiality; privacy concerns; the possibility of technological failure; anticipated response time to electronic communication; alternate service delivery processes; and, any additional considerations necessary to assist the potential client in reaching a determination about the appropriateness of the telemental health service delivery format for their needs. Counselors shall discuss this information throughout the service delivery process to ensure that this method satisfies the anticipated goals. The counselor will document such information and the discussion of alternative service options and referrals in the client's record.

101. Counselors shall prevent the distribution of confidential telemental health client information to unauthorized individuals. Counselors shall discuss actions the client may take to reduce the possibility that such confidential information is sent to unauthorized individuals in error.

102. Counselors shall provide clients of telemental health services with information concerning their professional preparation and/or credentials related to telemental health, and identify the relevant credentialing organization websites.

103. Counselors, either prior to or during the initial session, shall inform clients of the purposes, goals, procedures, limitations, and potential risks and benefits of telemental health services and techniques. Counselors also shall provide information about rights and responsibilities as appropriate to the telemental health service. Counselors also shall discuss with clients the associated challenges that may occur when communicating through telemental health means, including those associated with privacy and confidentiality.

104. In the event that the client of telemental health services is a minor or is unable to provide legal consent, the counselor shall obtain a legal guardian's consent prior to the provision of services unless otherwise required by State law. Counselors shall retain documentation indicating the legal guardian's identity and consent in the client's file.

105. Counselors will provide clients of telemental health services with specific written procedures regarding emergency assistance situations related to a client. This information shall include the identification of emergency responders near the client's location. Counselors shall take reasonable steps to secure referrals for recipients when needed for emergencies. Counselors shall provide information to clients concerning the importance of identifying personal contacts in the event of identified emergency situations, and shall ask clients to identify such contacts. Counselors also shall identify to the clients the circumstances in which the counselor will communicate with emergency contacts, and the information that will be shared with emergency contacts.

106. Counselors shall develop written procedures for verifying the identity of each telemental health client, their current location, and readiness to proceed at the beginning of each contact. Examples of verification include the use of code words, phrases, or inquiries, such as "Is this a good time to proceed?".

107. Counselors shall limit use of client information obtained through social media sources (e.g., Facebook, LinkedIn, Twitter) in accordance with established practice procedures provided to the client at the initiation of services and as adopted through the ongoing informed consent process.

108. Counselors shall retain telemental health service records for a minimum of five (5) years unless applicable State laws require additional time. Counselors shall limit the use of such client records to those permitted by law and professional standards, and as specified by the agreement terms with the respective telemental health services client.

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

INTERPROFESSIONAL COLLABORATION AND ETHICS

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

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

There is a difference between the traditional model of professional ethics and interprofessional ethics [139]. The traditional model revolves around a single profession's unique code of ethics, which addresses the specific profession's roles, expertise, core values, and ethical behaviors. Each professional's code of ethics demands the practitioner's loyalty and commitment to the values, specialty, and expertise [139]. On the other hand, interprofessional ethics emphasizes the relationship and interactions of practitioners from different professions and the unique ethical issues that emerge from working with a diverse team (e.g., interpersonal conflict, misuse of power, respect) [139]. Practitioners in an interprofessional setting should engage in collective interprofessional ethics work, which is defined as "the effort cooperating professionals put into collectively developing themselves as good practitioners, collectively seeing ethical aspects of situations, collectively working out the right course of action, and collectively justifying who they are and what they do" [140].

CONCLUSION

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

RESOURCES

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

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

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

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

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

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

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

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

National Board for Certified Counselors: Ethics Policies and Procedures
https://www.nbcc.org/Ethics

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

APPENDIX: THE ACA CODE OF ETHICS

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

SECTION A: THE COUNSELING RELATIONSHIP

Introduction

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

A.1. Client Welfare

A.1.a. Primary Responsibility

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

A.1.b. Records and Documentation

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

A.1.c. Counseling Plans

Counselors and their clients work jointly in devising counseling plans that offer reasonable promise of success and are consistent with the abilities, temperament, developmental level, and circumstances of clients. Counselors and clients regularly review and revise counseling plans to assess their continued viability and effectiveness, respecting clients' freedom of choice.

A.1.d. Support Network Involvement

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

A.2. Informed Consent in the Counseling Relationship

A.2.a. Informed Consent

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

A.2.b. Types of Information Needed

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

A.2.c. Developmental and Cultural Sensitivity

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

A.2.d. Inability to Give Consent

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

A.2.e. Mandated Clients

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

A.3. Clients Served by Others

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

A.4. Avoiding Harm and Imposing Values

A.4.a. Avoiding Harm

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

A.4.b. Personal Values

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

A.5. Prohibited Noncounseling Roles and Relationships

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

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

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

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

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

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

A.5.d. Friends or Family Members

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

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

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

A.6. Managing and Maintaining Boundaries and Professional Relationships

A.6.a. Previous Relationships

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

A.6.b. Extending Counseling Boundaries

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

A.6.c. Documenting Boundary Extensions

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

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

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

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

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

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

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

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

A.7.a. Advocacy

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

A.7.b. Confidentiality and Advocacy

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

A.8. Multiple Clients

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

A.9. Group Work

A.9.a. Screening

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

A.9.b. Protecting Clients

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

A.10. Fees and Business Practices

A.10.a. Self-Referral

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

A.10.b. Unacceptable Business Practices

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

A.10.c. Establishing Fees

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

A.10.d. Nonpayment of Fees

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

A.10.e. Bartering

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

A.10.f. Receiving Gifts

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

A.11. Termination and Referral

A.11.a. Competence within Termination and Referral

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

A.11.b. Values within Termination and Referral

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

A.11.c. Appropriate Termination

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

A.11.d. Appropriate Transfer of Services

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

A.12. Abandonment and Client Neglect

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

SECTION B: CONFIDENTIALITY AND PRIVACY

Introduction

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

B.1. Respecting Client Rights

B.1.a. Multicultural/Diversity Considerations

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

B.1.b. Respect for Privacy

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

B.1.c. Respect for Confidentiality

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

B.1.d. Explanation of Limitations

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

B.2. Exceptions

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

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

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

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

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

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

B.2.d. Court-Ordered Disclosure

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

B.2.e. Minimal Disclosure

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

B.3. Information Shared with Others

B.3.a. Subordinates

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

B.3.b. Interdisciplinary Teams

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

B.3.c. Confidential Settings

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

B.3.d. Third-Party Payers

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

B.3.e. Transmitting Confidential Information

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

B.3.f. Deceased Clients

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

B.4. Groups and Families

B.4.a. Group Work

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

B.4.b. Couples and Family Counseling

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

B.5. Clients Lacking Capacity to Give Informed Consent

B.5.a. Responsibility to Clients

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

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

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

B.5.c. Release of Confidential Information

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

B.6. Records and Documentation

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

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

B.6.b. Confidentiality of Records and Documentation

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

B.6.c. Permission to Record

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

B.6.d. Permission to Observe

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

B.6.e. Client Access

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

B.6.f. Assistance with Records

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

B.6.g. Disclosure or Transfer

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

B.6.h. Storage and Disposal After Termination

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

B.6.i. Reasonable Precautions

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

B.7. Case Consultation

B.7.a. Respect for Privacy

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

B.7.b. Disclosure of Confidential Information

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

SECTION C: PROFESSIONAL RESPONSIBILITY

Introduction

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

C.1. Knowledge of and Compliance with Standards

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

C.2. Professional Competence

C.2.a. Boundaries of Competence

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

C.2.b. New Specialty Areas of Practice

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

C.2.c. Qualified for Employment

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

C.2.d. Monitor Effectiveness

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

C.2.e. Consultations on Ethical Obligations

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

C.2.f. Continuing Education

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

C.2.g. Impairment

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

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

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

C.3. Advertising and Soliciting Clients

C.3.a. Accurate Advertising

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

C.3.b. Testimonials

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

C.3.c. Statements by Others

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

C.3.d. Recruiting Through Employment

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

C.3.e. Products and Training Advertisements

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

C.3.f. Promoting to Those Served

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

C.4. Professional Qualifications

C.4.a. Accurate Representation

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

C.4.b. Credentials

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

C.4.c. Educational Degrees

Counselors clearly differentiate between earned and honorary degrees.

C.4.d. Implying Doctoral-Level Competence

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

C.4.e. Accreditation Status

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

C.4.f. Professional Membership

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

C.5. Nondiscrimination

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

C.6. Public Responsibility

C.6.a. Sexual Harassment

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

C.6.b. Reports to Third Parties

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

C.6.c. Media Presentations

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

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

C.6.d. Exploitation of Others

Counselors do not exploit others in their professional relationships.

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

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

C.7. Treatment Modalities

C.7.a. Scientific Basis for Treatment

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

C.7.b. Development and Innovation

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

C.7.c. Harmful Practices

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

C.8. Responsibility to Other Professionals

C.8.a. Personal Public Statements

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

SECTION D: RELATIONSHIPS WITH OTHER PROFESSIONALS

Introduction

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

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

D.1.a. Different Approaches

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

D.1.b. Forming Relationships

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

D.1.c. Interdisciplinary Teamwork

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

D.1.d. Establishing Professional and Ethical Obligations

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

D.1.e. Confidentiality

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

D.1.f. Personnel Selection and Assignment

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

D.1.g. Employer Policies

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

D.1.h. Negative Conditions

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

D.1.i. Protection From Punitive Action

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

D.2. Provision of Consultation Services

D.2.a. Consultant Competency

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

D.2.b. Informed Consent in Formal Consultation

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

SECTION E: EVALUATION, ASSESSMENT, AND INTERPRETATION

Introduction

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

E.1. General

E.1.a. Assessment

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

E.1.b. Client Welfare

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

E.2. Competence to Use and Interpret Assessment Instruments

E.2.a. Limits of Competence

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

E.2.b. Appropriate Use

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

E.2.c. Decisions Based on Results

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

E.3. Informed Consent in Assessment

E.3.a. Explanation to Clients

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

E.3.b. Recipients of Results

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

E.4. Release of Data to Qualified Personnel

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

E.5. Diagnosis of Mental Disorders

E.5.a. Proper Diagnosis

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

E.5.b. Cultural Sensitivity

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

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

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

E.5.d. Refraining From Diagnosis

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

E.6. Instrument Selection

E.6.a. Appropriateness of Instruments

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

E.6.b. Referral Information

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

E.7. Conditions of Assessment Administration

E.7.a. Administration Conditions

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

E.7.b. Provision of Favorable Conditions

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

E.7.c. Technological Administration

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

E.7.d. Unsupervised Assessments

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

E.8. Multicultural Issues/Diversity in Assessment

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

E.9. Scoring and Interpretation of Assessments

E.9.a. Reporting

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

E.9.b. Instruments with Insufficient Empirical Data

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

E.9.c. Assessment Services

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

E.10. Assessment Security

Counselors maintain the integrity and security of tests and assessments consistent with legal and contractual obligations. Counselors do not appropriate, reproduce, or modify published assessments or parts thereof without acknowledgment and permission from the publisher.

E.11. Obsolete Assessment and Outdated Results

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

E.12. Assessment Construction

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

E.13. Forensic Evaluation: Evaluation for Legal Proceedings

E.13.a. Primary Obligations

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

E.13.b. Consent for Evaluation

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

E.13.c. Client Evaluation Prohibited

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

E.13.d. Avoid Potentially Harmful Relationships

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

SECTION F: SUPERVISION, TRAINING, AND TEACHING

Introduction

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

F.1. Counselor Supervision and Client Welfare

F.1.a. Client Welfare

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

F.1.b. Counselor Credentials

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

F.1.c. Informed Consent and Client Rights

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

F.2. Counselor Supervision Competence

F.2.a. Supervisor Preparation

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

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

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

F.2.c. Online Supervision

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

F.3. Supervisory Relationship

F.3.a. Extending Conventional Supervisory Relationships

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

F.3.b. Sexual Relationships

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

F.3.c. Sexual Harassment

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

F.3.d. Friends or Family Members

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

F.4. Supervisor Responsibilities

F.4.a. Informed Consent for Supervision

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

F.4.b. Emergencies and Absences

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

F.4.c. Standards for Supervisees

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

F.4.d. Termination of the Supervisory Relationship

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

F.5. Student and Supervisee Responsibilities

F.5.a. Ethical Responsibilities

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

F.5.b. Impairment

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

F.5.c. Professional Disclosure

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

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

F.6.a. Evaluation

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

F.6.b. Gatekeeping and Remediation

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

F.6.c. Counseling for Supervisees

If supervisees request counseling, the supervisor assists the supervisee in identifying appropriate services. Supervisors do not provide counseling services to supervisees. Supervisors address interpersonal competencies in terms of the impact of these issues on clients, the supervisory relationship, and professional functioning.

F.6.d. Endorsements

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

F.7. Responsibilities of Counselor Educators

F.7.a. Counselor Educators

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

F.7.b. Counselor Educator Competence

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

F.7.c. Infusing Multicultural Issues/Diversity

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

F.7.d. Integration of Study and Practice

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

F.7.e. Teaching Ethics

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

F.7.f. Use of Case Examples

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

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

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

F.7.h. Innovative Theories and Techniques

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

F.7.i. Field Placements

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

F.8. Student Welfare

F.8.a. Program Information and Orientation

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

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

8. Student and supervisor evaluation and dismissal policies and procedures; and
9. Up-to-date employment prospects for graduates.

F.8.b. Student Career Advising

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

F.8.c. Self-Growth Experiences

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

F.8.d. Addressing Personal Concerns

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

F.9. Evaluation and Remediation

F.9.a. Evaluation of Students

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

F.9.b. Limitations

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

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

F.9.c. Counseling for Students

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

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

F.10.a. Sexual or Romantic Relationships

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

F.10.b. Sexual Harassment

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

F.10.c. Relationships with Former Students

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

F.10.d. Nonacademic Relationships

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

F.10.e. Counseling Services

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

F.10.f. Extending Educator-Student Boundaries

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

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

F.11.a. Faculty Diversity

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

F.11.b. Student Diversity

Counselor educators actively attempt to recruit and retain a diverse student body. Counselor educators demonstrate commitment to multicultural/diversity competence by recognizing and valuing the diverse cultures and types of abilities that students bring to the training experience. Counselor educators provide appropriate accommodations that enhance and support diverse student well-being and academic performance.

F.11.c. Multicultural/Diversity Competence

Counselor educators actively infuse multicultural/diversity competency in their training and supervision practices. They actively train students to gain awareness, knowledge, and skills in the competencies of multicultural practice.

SECTION G: RESEARCH AND PUBLICATION

Introduction

Counselors who conduct research are encouraged to contribute to the knowledge base of the profession and promote a clearer understanding of the conditions that lead to a healthy and more just society. Counselors support the efforts of researchers by participating fully and willingly whenever possible. Counselors minimize bias and respect diversity in designing and implementing research.

G.1. Research Responsibilities

G.1.a. Conducting Research

Counselors plan, design, conduct, and report research in a manner that is consistent with pertinent ethical principles, federal and state laws, host institutional regulations, and scientific standards governing research.

G.1.b. Confidentiality in Research

Counselors are responsible for understanding and adhering to state, federal, agency, or institutional policies or applicable guidelines regarding confidentiality in their research practices.

G.1.c. Independent Researchers

When counselors conduct independent research and do not have access to an institutional review board, they are bound to the same ethical principles and federal and state laws pertaining to the review of their plan, design, conduct, and reporting of research.

G.1.d. Deviation From Standard Practice

Counselors seek consultation and observe stringent safeguards to protect the rights of research participants when research indicates that a deviation from standard or acceptable practices may be necessary.

G.1.e. Precautions to Avoid Injury

Counselors who conduct research are responsible for their participants' welfare throughout the research process and should take reasonable precautions to avoid causing emotional, physical, or social harm to participants.

G.1.f. Principal Researcher Responsibility

The ultimate responsibility for ethical research practice lies with the principal researcher. All others involved in the research activities share ethical obligations and responsibility for their own actions.

G.2. Rights of Research Participants

G.2.a. Informed Consent in Research

Individuals have the right to decline requests to become research participants. In seeking consent, counselors use language that:

1. Accurately explains the purpose and procedures to be followed;
2. Identifies any procedures that are experimental or relatively untried;
3. Describes any attendant discomforts, risks, and potential power differentials between researchers and participants;
4. Describes any benefits or changes in individuals or organizations that might reasonably be expected;
5. Discloses appropriate alternative procedures that would be advantageous for participants;
6. Offers to answer any inquiries concerning the procedures;
7. Describes any limitations on confidentiality;
8. Describes the format and potential target audiences for the dissemination of research findings; and
9. Instructs participants that they are free to withdraw their consent and discontinue participation in the project at any time, without penalty.

G.2.b. Student/Supervisee Participation

Researchers who involve students or supervisees in research make clear to them that the decision regarding participation in research activities does not affect their academic standing or supervisory relationship. Students or supervisees who choose not to participate in research are provided with an appropriate alternative to fulfill their academic or clinical requirements.

G.2.c. Client Participation

Counselors conducting research involving clients make clear in the informed consent process that clients are free to choose whether to participate in research activities. Counselors take necessary precautions to protect clients from adverse consequences of declining or withdrawing from participation.

G.2.d. Confidentiality of Information

Information obtained about research participants during the course of research is confidential. Procedures are implemented to protect confidentiality.

G.2.e. Persons Not Capable of Giving Informed Consent

When a research participant is not capable of giving informed consent, counselors provide an appropriate explanation to, obtain agreement for participation from, and obtain the appropriate consent of a legally authorized person.

G.2.f. Commitments to Participants

Counselors take reasonable measures to honor all commitments to research participants.

G.2.g. Explanations After Data Collection

After data are collected, counselors provide participants with full clarification of the nature of the study to remove any misconceptions participants might have regarding the research. Where scientific or human values justify delaying or withholding information, counselors take reasonable measures to avoid causing harm.

G.2.h. Informing Sponsors

Counselors inform sponsors, institutions, and publication channels regarding research procedures and outcomes. Counselors ensure that appropriate bodies and authorities are given pertinent information and acknowledgment.

G.2.i. Research Records Custodian

As appropriate, researchers prepare and disseminate to an identified colleague or records custodian a plan for the transfer of research data in the case of their incapacitation, retirement, or death.

G.3. Managing and Maintaining Boundaries

G.3.a. Extending Researcher-Participant Boundaries

Researchers consider the risks and benefits of extending current research relationships beyond conventional parameters. When a nonresearch interaction between the researcher and the research participant may be potentially beneficial, the researcher must document, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the research participant. Such interactions should be initiated with appropriate consent of the research participant. Where unintentional harm occurs to the research participant, the researcher must show evidence of an attempt to remedy such harm.

G.3.b. Relationships with Research Participants

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

G.3.c. Sexual Harassment and Research Participants

Researchers do not condone or subject research participants to sexual harassment.

G.4. Reporting Results

G.4.a. Accurate Results

Counselors plan, conduct, and report research accurately. Counselors do not engage in misleading or fraudulent research, distort data, misrepresent data, or deliberately bias their results. They describe the extent to which results are applicable for diverse populations.

G.4.b. Obligation to Report Unfavorable Results

Counselors report the results of any research of professional value. Results that reflect unfavorably on institutions, programs, services, prevailing opinions, or vested interests are not withheld.

G.4.c. Reporting Errors

If counselors discover significant errors in their published research, they take reasonable steps to correct such errors in a correction erratum or through other appropriate publication means.

G.4.d. Identity of Participants

Counselors who supply data, aid in the research of another person, report research results, or make original data available take due care to disguise the identity of respective participants in the absence of specific authorization from the participants to do otherwise. In situations where participants self-identify their involvement in research studies, researchers take active steps to ensure that data are adapted/changed to protect the identity and welfare of all parties and that discussion of results does not cause harm to participants.

G.4.e. Replication Studies

Counselors are obligated to make available sufficient original research information to qualified professionals who may wish to replicate or extend the study.

G.5. Publications and Presentations

G.5.a. Use of Case Examples

The use of participants', clients', students', or supervisees' information for the purpose of case examples in a presentation or publication is permissible only when (a) participants, clients, students, or supervisees have reviewed the material and agreed to its presentation or publication or (b) the information has been sufficiently modified to obscure identity.

G.5.b. Plagiarism

Counselors do not plagiarize; that is, they do not present another person's work as their own.

G.5.c. Acknowledging Previous Work

In publications and presentations, counselors acknowledge and give recognition to previous work on the topic by others or self.

G.5.d. Contributors

Counselors give credit through joint authorship, acknowledgment, footnote statements, or other appropriate means to those who have contributed significantly to research or concept development in accordance with such contributions. The principal contributor is listed first, and minor technical or professional contributions are acknowledged in notes or introductory statements.

G.5.e. Agreement of Contributors

Counselors who conduct joint research with colleagues or students/supervisors establish agreements in advance regarding allocation of tasks, publication credit, and types of acknowledgment that will be received.

G.5.f. Student Research

Manuscripts or professional presentations in any medium that are substantially based on a student's course papers, projects, dissertations, or theses are used only with the student's permission and list the student as lead author.

G.5.g. Duplicate Submissions

Counselors submit manuscripts for consideration to only one journal at a time. Manuscripts that are published in whole or in substantial part in one journal or published work are not submitted for publication to another publisher without acknowledgment and permission from the original publisher.

G.5.h. Professional Review

Counselors who review material submitted for publication, research, or other scholarly purposes respect the confidentiality and proprietary rights of those who submitted it. Counselors make publication decisions based on valid and defensible standards. Counselors review article submissions in a timely manner and based on their scope and competency in research methodologies. Counselors who serve as reviewers at the request of editors or publishers make every effort to only review materials that are within their scope of competency and avoid personal biases.

SECTION H: DISTANCE COUNSELING, TECHNOLOGY, AND SOCIAL MEDIA

Introduction

Counselors understand that the profession of counseling may no longer be limited to in-person, face-to-face interactions. Counselors actively attempt to understand the evolving nature of the profession with regard to distance counseling, technology, and social media and how such resources may be used to better serve their clients. Counselors strive to become knowledgeable about these resources. Counselors understand the additional concerns related to the use of distance counseling, technology, and social media and make every attempt to protect confidentiality and meet any legal and ethical requirements for the use of such resources.

H.1. Knowledge and Legal Considerations

H.1.a. Knowledge and Competency

Counselors who engage in the use of distance counseling, technology, and/or social media develop knowledge and skills regarding related technical, ethical, and legal considerations (e.g., special certifications, additional course work).

H.1.b. Laws and Statutes

Counselors who engage in the use of distance counseling, technology, and social media within their counseling practice understand that they may be subject to laws and regulations of both the counselor's practicing location and the client's place of residence. Counselors ensure that their clients are aware of pertinent legal rights and limitations governing the practice of counseling across state lines or international boundaries.

H.2. Informed Consent and Security

H.2.a. Informed Consent and Disclosure

Clients have the freedom to choose whether to use distance counseling, social media, and/or technology within the counseling process. In addition to the usual and customary protocol of informed consent between counselor and client for face-to-face counseling, the following issues, unique to the use of distance counseling, technology, and/or social media, are addressed in the informed consent process:

- Distance counseling credentials, physical location of practice, and contact information;
- Risks and benefits of engaging in the use of distance counseling, technology, and/or social media;
- Possibility of technology failure and alternate methods of service delivery;
- Anticipated response time;
- Emergency procedures to follow when the counselor is not available;

- Time zone differences;
- Cultural and/or language differences that may affect delivery of services;
- Possible denial of insurance benefits; and
- Social media policy.

H.2.b. Confidentiality Maintained by the Counselor

Counselors acknowledge the limitations of maintaining the confidentiality of electronic records and transmissions. They inform clients that individuals might have authorized or unauthorized access to such records or transmissions (e.g., colleagues, supervisors, employees, information technologists).

H.2.c. Acknowledgment of Limitations

Counselors inform clients about the inherent limits of confidentiality when using technology. Counselors urge clients to be aware of authorized and/or unauthorized access to information disclosed using this medium in the counseling process.

H.2.d. Security

Counselors use current encryption standards within their websites and/or technology-based communications that meet applicable legal requirements. Counselors take reasonable precautions to ensure the confidentiality of information transmitted through any electronic means.

H.3. Client Verification

Counselors who engage in the use of distance counseling, technology, and/or social media to interact with clients take steps to verify the client's identity at the beginning and throughout the therapeutic process. Verification can include, but is not limited to, using code words, numbers, graphics, or other nondescript identifiers.

H.4. Distance Counseling Relationship

H.4.a. Benefits and Limitations

Counselors inform clients of the benefits and limitations of using technology applications in the provision of counseling services. Such technologies include, but are not limited to, computer hardware and/or software, telephones and applications, social media and Internet-based applications and other audio and/or video communication, or data storage devices or media.

H.4.b. Professional Boundaries in Distance Counseling

Counselors understand the necessity of maintaining a professional relationship with their clients. Counselors discuss and establish professional boundaries with clients regarding the appropriate use and/or application of technology and the limitations of its use within the counseling relationship (e.g., lack of confidentiality, times when not appropriate to use).

H.4.c. Technology-Assisted Services

When providing technology-assisted services, counselors make reasonable efforts to determine that clients are intellectually, emotionally, physically, linguistically, and functionally capable of using the application and that the application is appropriate for the needs of the client. Counselors verify that clients understand the purpose and operation of technology applications and follow up with clients to correct possible misconceptions, discover appropriate use, and assess subsequent steps.

H.4.d. Effectiveness of Services

When distance counseling services are deemed ineffective by the counselor or client, counselors consider delivering services face-to-face. If the counselor is not able to provide face-to-face services (e.g., lives in another state), the counselor assists the client in identifying appropriate services.

H.4.e. Access

Counselors provide information to clients regarding reasonable access to pertinent applications when providing technology-assisted services.

H.4.f. Communication Differences in Electronic Media

Counselors consider the differences between face-to-face and electronic communication (nonverbal and verbal cues) and how these may affect the counseling process. Counselors educate clients on how to prevent and address potential misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically.

H.5. Records and Web Maintenance

H.5.a. Records

Counselors maintain electronic records in accordance with relevant laws and statutes. Counselors inform clients on how records are maintained electronically. This includes, but is not limited to, the type of encryption and security assigned to the records, and if/for how long archival storage of transaction records is maintained.

H.5.b. Client Rights

Counselors who offer distance counseling services and/or maintain a professional website provide electronic links to relevant licensure and professional certification boards to protect consumer and client rights and address ethical concerns.

H.5.c. Electronic Links

Counselors regularly ensure that electronic links are working and are professionally appropriate.

H.5.d. Multicultural and Disability Considerations

Counselors who maintain websites provide accessibility to persons with disabilities. They provide translation capabilities for clients who have a different primary language, when feasible. Counselors acknowledge the imperfect nature of such translations and accessibilities.

H.6. Social Media

H.6.a. Virtual Professional Presence

In cases where counselors wish to maintain a professional and personal presence for social media use, separate professional and personal web pages and profiles are created to clearly distinguish between the two kinds of virtual presence.

H.6.b. Social Media as Part of Informed Consent

Counselors clearly explain to their clients, as part of the informed consent procedure, the benefits, limitations, and boundaries of the use of social media.

H.6.c. Client Virtual Presence

Counselors respect the privacy of their clients' presence on social media unless given consent to view such information.

H.6.d. Use of Public Social Media

Counselors take precautions to avoid disclosing confidential information through public social media.

SECTION I: RESOLVING ETHICAL ISSUES

Introduction

Professional counselors behave in an ethical and legal manner. They are aware that client welfare and trust in the profession depend on a high level of professional conduct. They hold other counselors to the same standards and are willing to take appropriate action to ensure that standards are upheld. Counselors strive to resolve ethical dilemmas with direct and open communication among all parties involved and seek consultation with colleagues and supervisors when necessary. Counselors incorporate ethical practice into their daily professional work and engage in ongoing professional development regarding current topics in ethical and legal issues in counseling. Counselors become familiar with the ACA Policy and Procedures for Processing Complaints of Ethical Violations and use it as a reference for assisting in the enforcement of the *ACA Code of Ethics*.

I.1. Standards and the Law

I.1.a. Knowledge

Counselors know and understand the *ACA Code of Ethics* and other applicable ethics codes from professional organizations or certification and licensure bodies of which they are members. Lack of knowledge or misunderstanding of an ethical responsibility is not a defense against a charge of unethical conduct.

I.1.b. Ethical Decision Making

When counselors are faced with an ethical dilemma, they use and document, as appropriate, an ethical decision-making model that may include, but is not limited to, consultation; consideration of relevant ethical standards, principles, and laws; generation of potential courses of action; deliberation of risks and benefits; and selection of an objective decision based on the circumstances and welfare of all involved.

I.1.c. Conflicts Between Ethics and Laws

If ethical responsibilities conflict with the law, regulations, and/or other governing legal authority, counselors make known their commitment to the *ACA Code of Ethics* and take steps to resolve the conflict. If the conflict cannot be resolved using this approach, counselors, acting in the best interest of the client, may adhere to the requirements of the law, regulations, and/or other governing legal authority.

I.2. Suspected Violations

I.2.a. Informal Resolution

When counselors have reason to believe that another counselor is violating or has violated an ethical standard and substantial harm has not occurred, they attempt to first resolve the issue informally with the other counselor if feasible, provided such action does not violate confidentiality rights that may be involved.

I.2.b. Reporting Ethical Violations

If an apparent violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution or is not resolved properly, counselors take further action depending on the situation. Such action may include referral to state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or appropriate institutional authorities. The confidentiality rights of clients should be considered in all actions. This standard does not apply when counselors have been retained to review the work of another counselor whose professional conduct is in question (e.g., consultation, expert testimony).

I.2.c. Consultation

When uncertain about whether a particular situation or course of action may be in violation of the *ACA Code of Ethics*, counselors consult with other counselors who are knowledgeable about ethics and the *ACA Code of Ethics*, with colleagues, or with appropriate authorities, such as the ACA Ethics and Professional Standards Department.

I.2.d. Organizational Conflicts

If the demands of an organization with which counselors are affiliated pose a conflict with the *ACA Code of Ethics*, counselors specify the nature of such conflicts and express to their supervisors or other responsible officials their commitment to the *ACA Code of Ethics* and, when possible, work through the appropriate channels to address the situation.

I.2.e. Unwarranted Complaints

Counselors do not initiate, participate in, or encourage the filing of ethics complaints that are retaliatory in nature or are made with reckless disregard or willful ignorance of facts that would disprove the allegation.

I.2.f. Unfair Discrimination Against Complainants and Respondents

Counselors do not deny individuals employment, advancement, admission to academic or other programs, tenure, or promotion based solely on their having made or their being the subject of an ethics complaint. This does not preclude taking action based on the outcome of such proceedings or considering other appropriate information.

I.3. Cooperation with Ethics Committees

Counselors assist in the process of enforcing the *ACA Code of Ethics*. Counselors cooperate with investigations, proceedings, and requirements of the ACA Ethics Committee or ethics committees of other duly constituted associations or boards having jurisdiction over those charged with a violation.

Customer Information/Answer Sheet/Evaluation insert located between pages 64–65.

TEST QUESTIONS
#77723 ETHICS FOR COUNSELORS

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

This 6 clock hour activity must be completed by April 30, 2025.

1. Virtue ethics is an ancient ethical system attributed to
- A) *Aristotle.*
- B) *Hippocrates.*
- C) *St. Augustine.*
- D) *St. Thomas Aquinas.*

2. Which of the following historical events reinforced the need for codified standards of ethics?
- A) *The Watergate trial*
- B) *The Belmont Report*
- C) *The guidance counseling movement*
- D) *Medical experiments conducted on Jewish people during the Nazi regime and on children at Willowbrook State School*

3. The Tuskegee experiment is one of the most publicized research projects referred to in ethical discussion today. It involved
- A) *children with intellectual disability being given hepatitis by injection.*
- B) *elderly patients with chronic illness who were injected with live cancer cells.*
- C) *penicillin treatment withheld from African American test subjects with syphilis.*
- D) *affluent children given Nutrasweet in their Coca-Cola with a control group receiving regular Coca-Cola.*

4. All of the following are reasons ethical codes are developed, EXCEPT:
- A) *To protect clients and professionals*
- B) *To provide guidance for ethical decision making*
- C) *To grant professional immunity from legal action when ethics violations occur*
- D) *To help to establish an organization by differentiating itself from similar institutions*

5. Which philosophical viewpoint is characterized by diversity and pluralism?
- A) *Modernism*
- B) *Postmodernism*
- C) *Morality period*
- D) *Aesthetic value orientation*

6. Courage, cleanliness, and cheerfulness are examples of
- A) *morals.*
- B) *terminal values.*
- C) *ethical principles.*
- D) *instrumental values.*

7. Ethics may best be defined as
- A) *what is considered moral.*
- B) *Aristotle's philosophical concept.*
- C) *beliefs about what is correct or proper behavior.*
- D) *the only right action as determined by the institution one works for.*

8. Morality is best defined as
- A) *ethics.*
- B) *views on sexual behavior.*
- C) *the attitude of counselors.*
- D) *the judgment or evaluation of ethical principles based on social, cultural, and religious norms.*

9. What constitutes an ethical dilemma?
- A) *When the guiding principle of autonomy is violated*
- B) *Cognitive dissonance experienced by the professional*
- C) *When a professional witnesses another practicing paternalism*
- D) *When a choice must be made between two mutually exclusive courses of action*

10. Ethical principles are best defined as
- A) *expressions of morality.*
- B) *statements that reflect values of society.*
- C) *ideas that provide direction for daily living.*
- D) *expressions that reflect people's obligations or duties.*

11. The ethical principle of competency is the duty to
- A) *tell the truth.*
- B) *only practice in areas of expertise.*
- C) *enter into challenging relationships.*
- D) *try to solve problems faster than other counselors.*

12. Which of the following is NOT one of the nine sections included in the ACA Code of Ethics?
- A) *Resolving Ethical Issues*
- B) *Institutional Assumptions*
- C) *Professional Responsibility*
- D) *Confidentiality and Privacy*

13. Deontologic ethics is
- A) *the principle that all people are not of equal value.*
- B) *okay with lying if it is seen to be in the client's best interest.*
- C) *based upon the principle that people should always be treated as means to an end.*
- D) *a system of ethical decision making that stands on absolute truths and unwavering principles.*

14. Which of the following is considered a teleologic ethical theory?
- A) *Utilitarianism*
- B) *Theologic ethics*
- C) *Mandatory ethics*
- D) *All of the above*

15. Which of the following is NOT a component of decision analyses?
- A) *Calculating the expected value*
- B) *Creating the pathways of the decision*
- C) *Listing the pros or cons of the various decisions*
- D) *Identifying the perspectives of the ethical theories*

16. What is the main focus of the Ethical Principles Screen developed by Loewenberg and Dolgoff?
- A) *It is a screening method that allows for self-reflection and implicit argumentation.*
- B) *It is a method that focuses on a hierarchy of ethical principles to evaluate the potential course of action for ethical dilemmas.*
- C) *It assists counselors to identify his/her values and personal beliefs to set the context of ethical decision making.*
- D) *It lists out all the general ethical principles and asks the professional to identify the most meaningful to apply to the ethical dilemma.*

17. Lawrence Kohlberg identifies two important correlates of his six stages of moral development. One of these is that
- A) *everyone goes through each stage in a different order.*
- B) *every person can understand each stage of moral development.*
- C) *a person at one stage can understand any stage below him or her, but cannot understand more than one stage above.*
- D) *after a person progresses through a stage, he or she no longer understand the stage below, but can understand one stage above.*

18. Lawrence Kohlberg presumes there are six stages of moral development. A person making a stage 5 decision uses which of the following justifications?
- A) *"If I do not make that decision, I will be punished."*
- B) *"If I make that decision, I will be rewarded and other people will help me."*
- C) *"Others whom I care about will be pleased if I do this because they have taught me that this is what a good person does."*
- D) *"This decision will contribute to social well-being, and, as members of a society, we have an obligation to every other member."*

19. Which of the following ethical conflicts may be a concern in a managed care environment?
- A) *Distributive justice*
- B) *Client confidentiality*
- C) *Fiduciary relationships with clients vs. agencies*
- D) *All of the above*

20. According to Manhal-Baugus, the two main ethical issues in online counseling are privacy/confidentiality and
- A) *justice.*
- B) *beneficence.*
- C) *multiculturalism.*
- D) *principles of establishing online relationships.*

Be sure to transfer your answers to the Answer Sheet located between pages 64–65.
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.

Psychedelic Medicine and Interventional Psychiatry

Approval(s): APA, NBCC, NAADAC

Audience

The course is designed for all members of the interprofessional team, including mental health professionals, physicians, physician assistants, and nurses, involved in caring for patients with mental disorders resistant to traditional treatment approaches.

Course Objective

The purpose of this course is to provide medical and mental health professionals with the knowledge and skills necessary to effectively treat mental disorders using emerging psychedelic and interventional techniques.

Learning Objectives

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

1. Outline factors that have contributed to the rise in interest in psychedelic and interventional psychiatry.
2. Define terms related to the discussion of psychedelic and interventional psychiatry.
3. Discuss the history of psychedelics in medical care.
4. Evaluate factors that may impact the provision of psychedelic or interventional psychiatry techniques, including stigma, setting, and culture.
5. Outline the role of psilocybin and ketamine in psychiatric care.
6. Describe how MDMA and ibogaine may impact mental health.
7. Review the clinical effects of kratom, LSD, and mescaline.
8. Discuss the potential clinical role of nitrous oxide, ayahuasca, and dimethyltryptamine (DMT).
9. Describe how psychedelics may be incorporated into the treatment of mental health disorders, including treatment-resistant depression, post-traumatic stress disorder, and substance use disorders.
10. Identify interventional approaches that may be used in the treatment of mental health disorders.

Faculty

Mark S. Gold, MD, DFASAM, DLFAPA, is a teacher of the year, translational researcher, author, mentor, and inventor best known for his work on the brain systems underlying the effects of opiate drugs, cocaine, and food. Dr. Gold was a Professor, Eminent Scholar, Distinguished Professor, Distinguished Alumni Professor, Chairman, and Emeritus Eminent Scholar during his 25 years at the University of Florida. He was a Founding Director of the McKnight Brain Institute and a pioneering neuroscience-addiction researcher funded by the NIH-NIDA-Pharma, whose work helped to de-stigmatize addictions and mainstream addiction education and treatment. He also developed and taught courses and training programs at the University of Florida for undergraduates and medical students. (A complete biography appears at the end of this course.)

Faculty Disclosure

Contributing faculty, Mark S. Gold, MD, DFASAM, DLFAPA, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planners

Alice Yick Flanagan, PhD, MSW
James Trent, PhD

Senior Director of Development and Academic Affairs

Sarah Campbell

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

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This course is considered self-study by the New York State Board of Marriage and Family Therapy.

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NetCE designates this continuing education activity for 10 CE credits.

NetCE designates this continuing education activity for 3 NBCC clock hours.

NetCE designates this continuing education activity for 10 continuing education hours for addiction professionals.

Individual State Behavioral Health Approvals

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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

A new and intense interest in psychedelic drugs and interventional medicine is occurring now in the United States and worldwide, as scientists are exploring and discovering innovative ways to treat challenging psychiatric problems, including treatment-resistant depression, suicidal major depressive disorder, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), and substance use disorders, as well as multiple other psychiatric problems that have largely been impervious to traditional treatment. Psychedelic medicine refers to the use of drugs that are hallucinogenic and/or anesthetic and that have a unique action on the brain. These approaches may be used only in research situations or may be in current and active use as treatments. In contrast, interventional psychiatry refers to the use of brain-stimulating therapies to treat severe psychiatric disorders. These therapies include electroconvulsive therapy (ECT), repetitive transcranial magnetic stimulation (rTMS), vagus nerve stimulation (VNS), and deep brain stimulation (DBS). As with psychedelic medicine, interventional medicine may be used to provide relief for patients with multiple major and previously unremitting severe psychiatric disorders, although there is still much to learn about these therapies. This course will provide an overview of both of these forms of treatment, with an emphasis on psychedelic medicine.

Today, psychedelics like N, N-dimethyltryptamine (DMT), psilocybin, 3,4-methylenedioxymethamphetamine (MDMA), and lysergic acid diethylamide (LSD) are being explored to treat various psychiatric disorders. Trials of these drugs are in different stages, and the timeline for U.S. Food and Drug Administration (FDA) approval is not always obvious. While ketamine was approved in 2020, most experts believe the first psychedelic approval will come in 2024, likely for PTSD rather than treatment-resistant depression, even though treatment with psilocybin was found to relieve symptoms of major depressive disorder for at least one year for some patients in a 2022 Johns Hopkins study [1]. The safety and efficacy of MDMA-assisted therapy is currently under Phase 3 investigation, but concerns remain regarding efficacy and potential adverse effects. As of 2022, the Multidisciplinary Association of Psychedelic Studies (MAPS) is sponsoring MAPP2, the second of two Phase 3 trials to support FDA approval of MDMA as a breakthrough-designated therapy for the estimated 9 million adults in the United States who experience PTSD each year. In MAPS's first Phase 3 study, 88% of participants with severe PTSD experienced a clinically significant reduction in PTSD diagnostic scores two months after their third session of MDMA-assisted therapy, compared with 60% of placebo participants. Additionally, 67% of participants in the MDMA group no longer met the criteria for PTSD two months after the sessions, compared with 32% of participants in the placebo group [2].

When effective, psychedelic medicine is analogous to a "resetting" of the brain. It is somewhat like when a computer runs awry, and nothing of many actions that the user tries improves the situation. In frustration, the user shuts off the machine, but when the device is turned back on, everything works perfectly. The machine has reset itself. Similarly, psychedelic drugs, when effective, may aid the brain in a sort of resetting. Depending on the individual and the drug, the person may find they have marked improvements in symptoms of depression, PTSD, addiction, or other severe psychiatric problem.

As a result of today's research renaissance on psychedelic drugs, there is a new era of hope for people with major psychiatric disorders who have been largely unresponsive to traditional treatments.

One concern about psychedelic medicine is that many of the drugs may induce hallucinations, even in the low doses used for depression. Mental health professionals who prescribe or administer the drugs will need to ensure patients are monitored adequately. In some cases, the person receiving the drug is hospitalized, but in others, the drug is administered and changes observed in an office setting.

Ketamine's efficacy and protocols to ensure safety have resulted in thousands of patients being treated and reporting excellent responses for treatment-resistant depression. However, the ideal drug would provide the benefits without the hallucinatory side effects. In one unique experiment with mice, researchers effectively blocked 5-HT2A, the serotonin-detecting receptor, and this action appeared to stop mice being administered psilocybin from hallucinating ("tripping"). The antidepressant effects were unaltered in this study, as evidenced by the mice resuming consumption of sugar water, an act they had abandoned while depressed [5]. This is an area of great interest, with the potential that the hallucinations induced by psychedelic drugs could be blocked and increase the acceptability of these agents in the general treatment of depression.

Of course, there are many who believe that the psychedelic trip itself, hallucinations and all, is the crucial experience that allows people to experience psychic relief. These individuals believe that eliminating the crucial experience of hallucination would essentially block the full efficacy of the drug. This issue is likely to continue to be discussed and debated as the science advances.

Psychedelic drugs are often divided into two categories: classic and non-classic or dissociative. The classic psychedelics are usually derived from naturally occurring compounds and include such drugs as psilocybin, LSD, and DMT, an active component of ayahuasca, an increasingly popular sacramental drink originating from South America. The dissociative psychedelics are typically newer analogs and include ketamine, phencyclidine (PCP), MDMA, mescaline, *Salvia divinorum*, and dextromethorphan (DXM). While considered drugs of abuse, most agents being tested in psychedelic medicine clinical trials are not self-administered by laboratory animals, the usual test for abuse and dependence liability. If anything, hallucinogens tend to lose their ability to produce changes in the person over time and with regular use. These drugs are all variations on tryptamine, and while they may increase dopamine, they tend to do this through an indirect mechanism.

In their 1979 publication, Grinspoon, Grinspoon, and Bakalar define a classic psychedelic drug as [6]:

> A drug which, without causing physical addiction, craving, major physiological disturbances, delirium, disorientation, or amnesia, more or less reliably produces thought, mood, and perceptual changes otherwise rarely experienced except in dreams, contemplative and religious exaltation, flashes of vivid involuntary memory, and acute psychosis.

While the classic versus non-classic designation is of interest to researchers, it is likely not an important distinction for prescribers or patients.

THE IMPORTANCE OF PSYCHEDELIC AND INTERVENTIONAL MEDICINE

There are multiple reasons health and mental health professionals would benefit from education about both psychedelic and interventional medicine. Psychedelic medicine is a multi-billion-dollar industry and is rapidly growing. It is likely that many healthcare professionals will become involved with these approaches as they enter more widespread use.

Many people in the United States suffer from severe depression, and suicide is a public health problem. In 2020, 21,570 people in the United States died from homicide, a significant increase from the number just one year earlier [7]. However, it did not come close to the suicide rate. In 2020, 45,855 people in the United States died from suicide. The annual U.S. suicide rate increased 30% between 2000 and 2020 [7]. As such, depression and suicide are major health problems in the United States today, and approaches to reverse depression rapidly and safely are greatly needed.

It is also important to consider the frustration of many patients with treatment-resistant depression and other disorders, many of whom have turned to cannabis to obtain relief. The majority of states have enacted laws approving medical marijuana, although its efficacy in the treatment of PTSD, depression, and other psychiatric disorders is often lacking [8]. Patients are clearly open to seeking help wherever it may be, whether evidence and healthcare professionals support the approaches. As such, it is vital that clinicians be aware of and knowledgeable regarding novel uses of psychedelic drugs and interventional psychiatry to best serve their patients.

Academic experts, universities, and medical groups continue to research psychedelic medicine, with exciting major breakthroughs in the treatment of depression/anxiety at the end of life and providing relief to patients with treatment-resistant depression, PTSD, and other disorders that most psychiatrists consider difficult to treat. This research will be detailed later in this course.

TREATMENT-RESISTANT DEPRESSION AND THE RISK OF SUICIDE

As noted, the suicide rate in the United States is more than twice as high as the homicide rate [7]. In 2019, suicide was the second leading cause of death for people 10 to 34 years of age and the tenth leading cause of death across all age groups (***Table 1***). Overall, suicide accounts for 1.7% of all deaths in the United States. Although official national statistics are not compiled on attempted suicide (i.e., nonfatal actions), it is estimated that 1.2 million adults (18 years of age and older) attempted suicide in 2020 [9]. Overall, there are roughly 25 attempts for every death by suicide; this ratio changes to 100 to 200:1 for the young and 4:1 for the elderly [9].

People with depression may experience suicidal ideation and behaviors, which can subsequently lead to suicide completions. As illustrated by ***Figure 1***, in 2020, adults 18 to 25 years of age had the highest risk for a major depressive episode, followed by those 25 to 49 years of age. In addition, individuals of two or more races had the highest risk for depression (15.9%), followed by White individuals (9.5%).

Suicidal behaviors are a major problem in the United States, as depicted in the converging circles shown in ***Figure 2***. This figure demonstrates that 12.2 million adults seriously considered suicide in 2020, represented by the outer circle, while 3.2 million adults made suicide plans, and 1.2 million adults attempted suicide. Of those adults who attempted suicide in 2020, 920,000 had made a suicide plan; 285,000 adults had made no such plan prior to the attempt [10; 12].

Clearly, action is needed to help address depression and suicide in the United States, and psychedelic and interventional medicine may have a role.

POOR RESPONSE TO ANTIDEPRESSANTS

When they were first introduced, the monoamine oxide (MAO) inhibitors and tricyclic antidepressants were perceived as wonder drugs for depression. However, MAO inhibitors require strict dietary constraints, and both drug classes are associated with multiple troubling side effects. In contrast, when selective serotonin reuptake inhibitors (SSRIs) were introduced, they were much easier to prescribe and expanded treatment approaches to include primary care. Unfortunately, for many patients, SSRIs did not help as much as expected—or indeed at all, in some cases. Today, it is clear that non- or under-response to pharmacotherapy for major depression is far more common than was realized at the time. For example, researchers have found that antidepressants are ineffective for at least one-third of individuals who take them [2]. Suboptimal responses are also common. Many patients for whom the drugs do not work will recalibrate their expectations and accept the treatment response as the best they can hope to achieve. Treatment discontinuation is common among frustrated patients.

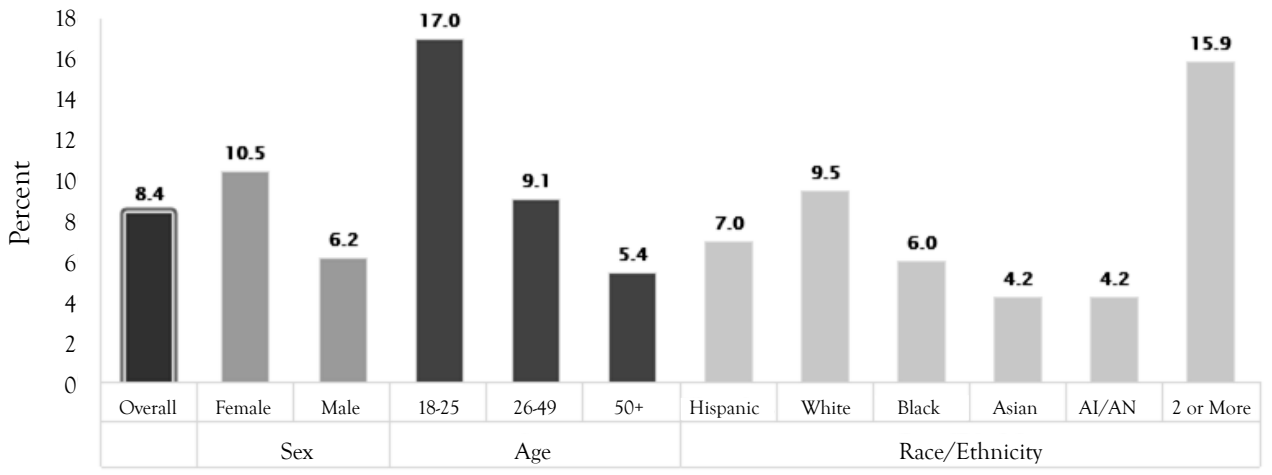
It is also important to note that even when antidepressants actually are efficacious, it usually takes at least three or four weeks for the drug to begin to take effect. Tricyclic antidepressants, MAO inhibitors, SSRIs, and serotonin and norepinephrine reuptake inhibitors (SNRIs) all share this issue of a delayed onset of action. Psychiatrists and neuroscientists have been unable to develop faster-acting medications for depression to date. This means that many people with severe depression could take an antidepressant very faithfully for weeks without any relief. These patients may give up hope and halt treatment or try again with another antidepressant or medication combination.

LEADING CAUSE OF DEATH IN THE UNITED STATES FOR SELECT AGE GROUPS, 2019							
Rank	Age (in Years)						
	10–14	15–24	25–34	35–44	45–54	55–64	All Ages
1	Unintentional injury (778)	Unintentional injury (11,755)	Unintentional injury (24,516)	Unintentional injury (24,070)	Malignant neoplasms (35,587)	Malignant neoplasms (111,765)	Heart disease (659,041)
2	Suicide (534)	Suicide (5,954)	Suicide (8,059)	Malignant neoplasms (10,695)	Heart disease (31,138)	Heart disease (80,837)	Malignant neoplasms (599,601)
3	Malignant neoplasms (404)	Homicide (4,774)	Homicide (5,341)	Heart disease (10,499)	Unintentional injury (23,359)	Unintentional injury (24,892)	Unintentional injury (173,040)
4	Homicide (191)	Malignant neoplasms (1,388)	Malignant neoplasms (3,577)	Suicide (7,525)	Liver disease (8,098)	CLRD (18,743)	CLRD (156,979)
5	Congenital anomalies (189)	Heart disease (872)	Heart disease (3,495)	Homicide (3,446)	Suicide (8,012)	Diabetes (15,508)	Stroke (150,005)
6	Heart disease (87)	Congenital anomalies (390)	Liver disease (1,112)	Liver disease (3,417)	Diabetes (6,348)	Liver disease (14,385)	Alzheimer disease (121,499)
7	CLRD (81)	Diabetes (248)	Diabetes (887)	Diabetes (2,228)	Stroke (5,153)	Stroke (12,931)	Diabetes (87,647)
8	Influenza/ pneumonia (71)	Influenza/ pneumonia (175)	Stroke (585)	Stroke (1,741)	CLRD (3,592)	Suicide (8,238)	Nephritis (51,565)
9	Stroke (48)	CLRD (168)	Complicated pregnancy (532)	Influenza/ pneumonia (951)	Nephritis (2,269)	Nephritis (5,857)	Influenza/ pneumonia (49,783)
10	Benign neoplasms (35)	Stroke (158)	HIV (486)	Septicemia (812)	Septicemia (2,176)	Septicemia (5,672)	Suicide (47,511)
CLRD = chronic lower respiratory disease, HIV = human immunodeficiency disease.							
Source: [10]							*Table 1*

As with any pharmacotherapy, antidepressants have many possible adverse effects, including weight gain, anorgasmia, sluggishness, anxiety, insomnia, and suicidal ideation. As such, a patient may experience no improvements in depression symptoms while also developing adverse drug effects. This is not the end of consequences; discontinuation symptoms are also a concern. Antidepressant discontinuation symptoms can be very challenging. For example, abruptly ending fluoxetine can cause nightmares, vomiting, and irritability. In most cases, patients who no longer wish to take an antidepressant should taper off the drug on a defined schedule [3].

To recap, patients may take antidepressants for months without significant improvements in depression symptoms while also experiencing side effects, and when they stop taking these ineffective drugs, they suffer more side effects unless they carefully taper off. In contrast, some psychedelic drugs have the potential to provide relief in a few sessions, with lasting efficacy over months or even years, although further research is needed. This contrast is the main reason that so many mental health professionals and patients are intrigued about the possibilities of psychedelic medicine, particularly for more difficult cases.

PAST YEAR PREVALENCE OF MAJOR DEPRESSIVE EPISODE AMONG U.S. ADULTS, 2020

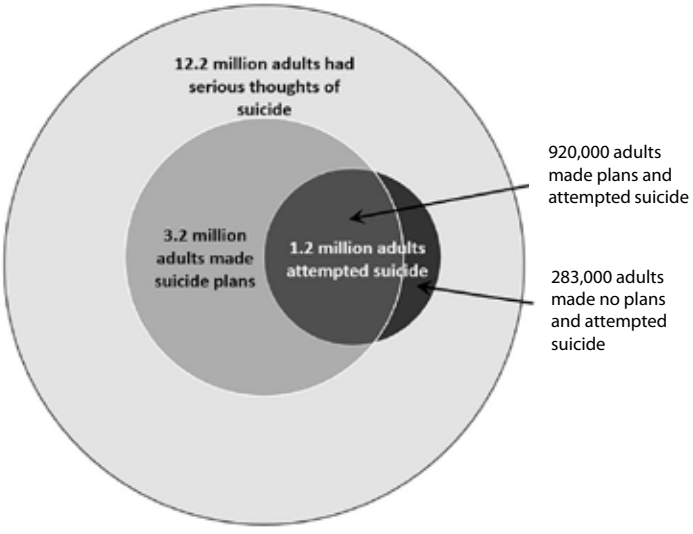


AI/AN = American Indian/Alaska Native

Source: [11]

Figure 1

SUICIDAL BEHAVIORS IN THE UNITED STATES, 2020



Source: [10; 12; 14]

Figure 2

It is not clear why antidepressants work for some patients and not for others. Some have hypothesized it may be related to the size and shape of a person's neurons, which can vary considerably [3]. Another possible contributing factor is the similar mechanisms of action among the different classes of antidepressants. These agents increase blood levels of serotonin, dopamine, or norepinephrine. In contrast, some psychedelic drugs, such as ketamine, are *N*-methyl-D-aspartate (NMDA)/glutamate receptor antagonists. This represents a completely different target for antidepressant mechanism of action and also a novel approach to treating depression.

There is also some evidence that ketamine can reverse suicidality or depression after a single dose, which suggests that the drug reverses a neurochemical deficit that is close to the problem. Ketamine and psychedelic drugs are effective at promoting plasticity, reconnections, and healing within the brain, a feat beyond the capabilities of traditional antidepressants or most other drugs. Researchers have found that neuroplastic changes, specifically atrophy of neurons in the prefrontal cortex, are an underlying etiology of depression and other mood disorders. The extent to which these drugs, and ketamine in particular, are able to promote structural and functional plasticity in the prefrontal cortex is believed to underlie the fast-acting antidepressant properties [4]. Other drugs, such as LSD and DMT, may stimulate the formulation of synapses [4]. Psychedelic drugs may also create new connections within the brain, although much more research is needed to understand how and why these drugs may be effective in treating serious psychiatric disorders in some who have heretofore not proven responsive to traditionally effective treatments.

A GROWING MARKET

Certainly, psychedelic medicine is regarded as a major and burgeoning healthcare market. Data Bridge Market Research has estimated that the market for psychedelic drugs will more than triple, from about $2 billion in 2019 to nearly $7 billion by 2027 [13]. Other estimates are even more favorable; a report from Research and Markets anticipates a market of $10.75 billion in psychedelic drugs by 2027 [13]. In a post-COVID world in which the numbers of people with reported depression have increased by as much as three times, potentially effective treatment options should not be ignored.

It has been estimated that at least 50,000 therapists will be needed by 2031 to provide psychedelic-assisted therapy to patients, and as a result, some organizations have already begun to increase their hiring. The key types of therapies used will be cognitive-behavioral therapy (CBT), acceptance and commitment therapy (ACT), or other types of therapy adapted to psychedelic treatment [15].

The current high interest in psychedelic medicine may stimulate pharmaceutical companies to research and develop novel drug treatments for major psychiatric problems beyond the traditional classes of drugs that solely target serotonin, norepinephrine, and dopamine, which would be yet another positive consequence.

CONSUMER INTEREST

At the same time that the federal government has somewhat loosened its tight reins on psychedelic medicine and researchers and medical professionals have begun to explore the use of these agents, there has been a dramatic increase in interest among consumers in Schedule I drugs, particularly in cannabis, but also in psilocybin and other psychedelic drugs. As of 2022, 37 states as well as the District of Columbia and four U.S. territories allow the medical use of cannabis ("medical marijuana") [16]. (Note that medical use of cannabis is a bit of a misnomer, as prescribers generally have little or no involvement with patients who take the drug and it has not attained FDA approval for any condition.) In addition, the U.S. House of Representatives passed a bill to decriminalize cannabis use in 2022 [17]. In addition, 18 states, the District of Columbia, and 2 U.S. territories have legalized the recreational use of cannabis for adults [18]. This followed several years of decriminalization at the local and state levels. While cannabis is not considered a psychedelic drug, its shift toward decriminalization and medicinal use is a sign that a similar path may be beginning for other Schedule I drugs with potential psychiatric benefit. Further, in states that allow medical or recreational use of cannabis for adults, the federal government has largely backed away from taking any punitive measures against individuals who use the drug, even though cannabis remains illegal at a federal level.

This movement may already be advancing with psychedelic drugs. This began with the decriminalization of psilocybin in Denver, Colorado, in 2019, followed by Oakland and Santa Cruz, California. In 2021, the city of Cambridge, Massachusetts, passed a law decriminalizing all "entheogenic plants," which includes the drugs ayahuasca, ibogaine, and psilocybin [19]. As of 2022, the largest city to decriminalize psilocybin is Seattle, Washington [19]. In 2020, the state of Oregon approved the use of psilocybin by consumers [20]. Also in 2020, the District of Columbia decriminalized the use of psilocybin mushrooms as well as other substances found in peyote and ayahuasca [20]. Other states are considering taking similar actions. In 2021, Health Canada, the premier health agency in Canada, approved trials of MDMA-assisted therapy for the treatment of PTSD [15]. It is important to note that it can be dangerous for psilocybin and other psychedelic drugs to be used by individuals who do not understand its risks. As popularity and interest in the medical use of these agents increases, clinicians have a responsibility to educate themselves and their patients about the safe and appropriate use of psychedelics.

A major factor in the popularity of psychedelic drugs is frustration resulting from unrelenting depression, anxiety, chronic pain, or other health and mental health conditions. Some patients may have already tried cannabis to address these conditions, with varying levels of success.

PSYCHEDELIC PSYCHIATRY TRAINING PROGRAMS
Hopkins-Yale-NYU https://medicine.yale.edu/news-article/grant-supports-development-of-training-for-psychiatrists-in-psychedelic-medicine
MAPS https://mapspublicbenefit.com/training
Mount Sinai https://icahn.mssm.edu/research/center-psychedelic-psychotherapy-trauma-research/training-education
Source: Compiled by Author — *Table 2*

GROWING BODY OF RESEARCH FROM RESPECTED ACADEMIC AND PHYSICIAN LEADERS

Although researchers have historically chosen to avoid or been blocked from researching psychedelics because of bans by the federal government, this has changed in the past few decades. For example, in 2006, Johns Hopkins Medicine began their research on psychedelic medicine, subsequently producing more than 80 peer-reviewed clinical studies by 2020 [21]. A new home for the Center for Psychedelic and Consciousness Research was created in 2020, the first such establishment in the United States [21]. Private donors provided funding to launch the Center, and since its opening, the Center has also received federal funding for research. In addition, Yale, Massachusetts General Hospital/Harvard, and other psychiatric and research excellence centers are studying psychedelic medications as treatment options for serious psychiatric disorders.

In addition, training programs focusing on psychedelic psychiatry are being established (***Table 2***). Johns Hopkins, New York University, and Yale are collaborating to create a psychedelics-psychiatrist program funded by a grant facilitated by Heffter Research Institute [22].

DEFINITIONS

Clear definitions of the concepts related to psychedelic drugs and interventional psychiatry are helpful. The following is a glossary of terms used throughout this course.

Classic psychedelic: Refers to older hallucinogenic drugs, such as psilocybin and LSD. These agents are often derived from natural sources.

Deep brain stimulation: With the use of implanted electrodes, the brain is stimulated to treat such psychiatric problems as treatment-resistant depression.

Electroconvulsive therapy (ECT): Stimulation of the brain causing a seizure. This therapy is administered under sedation and is used to help patients with severe psychiatric diagnoses.

Hallucinogen: Drug that may cause the user to experience visual, auditory, or other types of hallucinations.

Neuromodulation therapy: The use of noninvasive or invasive means to stimulate the brain in order to treat serious psychiatric problems.

Psychedelic medicine: The use of mind-altering (typically but not always hallucinogenic or dissociative) drugs by mental health professionals to improve or even provide remission from severe psychiatric problems, such as depression, PTSD, anxiety, and substance use disorders.

Set: Refers to the patient's mindset. For example, a person who is anxious and fearful is less likely to have a positive experience with psychedelic medicine than a person who has an open and positive outlook.

Setting: Refers to the overall ambiance in which psychedelic medicine is administered. A pleasant atmosphere that makes the individual feel safe is best.

Transcranial magnetic stimulation: A noninvasive form of therapy that uses large magnets external to the patient to stimulate the brain.

Vagus nerve stimulation: Invasive stimulation of the vagus nerve in order to treat serious, treatment-resistant psychiatric diagnoses.

PONDERING PSYCHEDELICS

More than 50 years have passed since the federal Controlled Substances Act first criminalized the use of psychedelics in the United States in 1970. The initial use (and misuse) of psychedelic drugs in that era was primarily associated with Timothy Leary, a Harvard professor who promoted the nonmedical use of LSD, a practice subsequently adopted by the amorphous "hippie" counterculture movement of the 1960s and 1970s. Dr. Leary was famously noted as advising his followers to "turn on, tune in, and drop out," scandalizing much of the conservative population of the time. Numerous events led to Leary's loss of reputation, academic standing, and position, but his impact during this period was indisputable. In response to this movement, drugs such as LSD, DMT, psilocybin, and mescaline were all placed in the Schedule I drugs category under the Controlled Substances Act 1970 (***Table 3***).

PSYCHEDELIC DRUG SCHEDULING	
Drug	**Schedule**
Ayahuasca/DMT	I
Ibogaine	I
Ketamine	III
Kratom	Not scheduled
LSD	I
Mescaline	I
Nitrous oxide	Not scheduled
Psilocybin	I
MDMA ("Molly," "Ecstasy")	I
Source: [23]	*Table 3*

The categorization of psychedelics as Schedule I drugs immediately halted intense scientific research on psychedelics, which had begun in the 1950s. This prohibition on psychedelic drug research significantly delayed advances in medical knowledge on the therapeutic uses of these agents. While much of the focus at that time was on Timothy Leary and the counterculture's recreational LSD use, some researchers had demonstrated beneficial effects with psychedelic medicine in end-of-life care as well as in the treatment of addiction and other severe psychiatric problems [24].

This research did not restart in the United States in any meaningful way until the 21st century. In this new wave of research, researchers in Phase 2 and 3 clinical trials of psychedelic medications have found the possibility of remission in diverse psychiatric populations (including in patients with PTSD, depression, eating disorders, and substance use disorders) as well as reduction in end-of-life anxiety and despair in those with terminal diagnoses [25]. At the same time, researchers have explored the use of older drugs (e.g., nitrous oxide, ketamine) to treat unrelenting psychiatric disorders.

Another interesting avenue of research has been in the field of addiction medicine. There is some evidence that certain psychedelic drugs, particularly psilocybin, may act as a sort of "anti-gateway drug." Years ago, there was a belief that some (or all) drugs were "gateway drugs," leading inevitably to taking other drugs; for example, this perspective holds that people who smoked marijuana would eventually progress to using "harder" drugs, injecting heroin or other opioids. This theory has largely been discredited and devalued. In fact, several studies have indicated that persons who use hallucinogens are less likely to progress to harder drugs. In one study, researchers used data from nearly 250,000 respondents from the National Survey on Drug Use and Health over the period 2015–2019. Respondents were asked about their past use of classic psychedelics, and these results were then compared to their later abuse (or non-use) of opioids. Individuals who had used psilocybin ("magic mushrooms") in the past had a significantly lower rate (30% lower than average) of opioid misuse and abuse later. This finding was not replicated with other psychedelic drugs [26]. An earlier study using National Survey on Drug Use and Health data for the period 2008–2013 found that past use of classic psychedelics decreased the risk for past-year opioid dependence by 27% and of opioid abuse by 40% [27].

Both of these studies relied on individuals reporting on their past use of psychedelic drugs, and there are multiple possible issues with this type of retrospective reporting. But the idea that past use of drugs such as psilocybin could be protective against opioid misuse and dependence in the future is promising, given the ongoing opioid epidemic in the United States.

A BRIEF HISTORY OF PSYCHEDELICS

It is unclear how long the various psychedelic substances have been used worldwide, but it is safe to say that some have been used for thousands of years in religious and tribal ceremonies. The earliest known written record of the use of psilocybin mushrooms appeared in the Florentine Codex, a manuscript of ethnographic research of Mesoamerica, particularly of Mexico and the Aztecs, compiled between 1529 and 1579. Psilocybin, mescaline, and ayahuasca (a concoction often brewed in a tea and that includes the psychedelic chemical DMT) have all been used in religious ceremonies in indigenous societies in South and Central America for centuries. The hallucinogenic effects of some plants and fungi also have been known by indigenous cultures and were deliberately exploited by humans for thousands of years. Fungi, particularly some types of mushrooms, are the principal source of naturally occurring psychedelics. Historically, the mushroom extract psilocybin has been used as a psychedelic agent for religious and spiritual ceremonies and as a therapeutic option for neuropsychiatric conditions [28].

Early Days of LSD

Modern pharmaceutical research on psychedelics started in earnest in 1930s Basel, Switzerland, with research chemist Albert Hofmann. Seeking to create a synthetic alkaloid to the ergot fungus, he developed LSD-25 in 1938. The uses of the drug were not immediately obvious, so it sat on a shelf for five years until Hofmann decided to repeat his synthesis of the chemical. Despite his care, Hofmann accidentally contaminated himself with the drug and thereafter experienced highly unusual sensations as well as dizziness. He described his experience as [29]:

> I lay down and sank into a not unpleasant intoxicated-like condition, characterized by an extremely stimulated imagination. In a dreamlike state, with eyes closed (I found the daylight to be unpleasantly glaring), I perceived an uninterrupted stream of fantastic pictures, extraordinary shapes with intense, kaleidoscopic play of colors. After some two hours, this condition faded away.

Hofmann decided to experiment on himself with what he believed to be a very low dose of LSD, but the dose was high enough for him to experience what he perceived to be demonic possession and other lurid sensations. His physician was called and only noted that Hofmann had extremely dilated pupils, with normal blood pressure and vital signs. When Hofmann related his experiences to his colleagues, they were dubious that he had measured correctly, but to be safe, they took even lower doses. Each experienced what were later referred to as psychedelic mind "trips" [29].

In 1947, Sandoz began marketing and distributing LSD, under the brand name Delysid, as a possible psychiatric drug to treat neurosis, alcoholism, criminal behavior, and schizophrenia. In addition, LSD-25 was also used to treat autism and verbal misbehavior [28; 30]. In his book, Hofmann described how LSD helped provide relief to people who were dying of cancer and in severe pain for whom major analgesics were ineffective. He hypothesized that the analgesic effect was not inherent to the drug but was a result of patients dissociating from their bodies such that physical pain no longer affected them [29].

However, early studies on LSD did not always inform patients about the potential risks. For example, in some cases, patients with schizophrenia were given LSD and not told about the possible risk for a psychotic break [31]. Patients at the Addiction Research Center in Lexington, Kentucky, were often given the drug without being told what it was or the possible effects. Researchers who believed in the importance of "set and setting" (the patient's mindset and the setting where the drug was administered) were more likely to inform patients about possible risks and benefits. The 1962 Kefauver-Harris Amendments required that all patients provide informed consent for therapeutic interventions and research participation. Despite this, the "informed consent" of the 1960s was not as comprehensive as informed consent today. Some have posited that the primary goal was to release researchers from legal responsibility rather than to provide ensure the safety of patients and prospective subjects of clinical trials [31].

For about a decade, Hofmann and Sandoz believed that LSD might provide breakthroughs in psychiatry. However, with the major social change of the 1960s, characterized by protests for social change and against the Vietnam War and increasingly liberal attitudes regarding drugs among young people, the focus shifted to recreational rather than medical use of LSD, and in 1965, Sandoz stopped manufacture and marketing of LSD. In 1966, Sandoz gave their remaining supplies to the National Institute of Mental Health [31].

Early Days of Psilocybin

In 1957, Hofmann received a sample of dried *Psilocybe mexicana* mushrooms from a mycologist in Huautla de Jiménez in Oaxaca, Mexico. The mycologist, R. Gordon Wasson, had received a sample of the mushrooms and information regarding the sacred rituals of the Mazatec people from a curandera to whom he promised secrecy; this promise was obviously not kept, and Wasson's actions resulted in retaliation against the indigenous woman who he betrayed [138]. Hofmann used paper chromatography to separate the various components of whole extracts of mushrooms and ingested each separated fraction. The active fraction was then chemically characterized, crystallized, and named psilocybin. In 1958, Hofmann and his colleagues subsequently elucidated the structure and synthesis of psilocybin and psilocin, a minor component of the extract that is a dephosphorylated form of psilocybin. In the 1960s, Sandoz Pharmaceuticals began to distribute Indocybin, a psychotherapeutic drug in pill form, containing 2-mg psilocybin. This period also saw research focusing on psilocybin as a probe for brain function and recidivism and as an entheogen used by religious people (divinity students).

During this era, psilocybin, LSD, mescaline, and other psychedelics were used by some individuals with psychiatric diseases, and they were also used extensively by some psychiatrists to treat patients before the drugs were categorized as Schedule I of the U.N. Convention on Drugs in 1967, which preceded the Controlled Substances Act in the United States. Today, the medical value of hallucinogens is being tested in rigorous trials in settings such as Roland Griffith's Johns Hopkins research program. The experts from the psilocybin research group at Johns Hopkins University have described the importance of trained psychedelic therapists and other components of a psychedelic treatment session to optimize patient safety in hallucinogen research [32].

CONSIDERING PSYCHEDELIC-ASSISTED PSYCHOTHERAPY AS A TREATMENT OPTION

For most mental health professionals, the idea of psychedelic-assisted psychotherapy is a major paradigm shift and leap from current practices of providing pharmacotherapy or psychotherapy to individuals or groups. At the same time, it may represent a new opportunity to combine the talents and skills of therapists with the proven benefits of a psychedelic drug. Combined psychotherapy/pharmacotherapy is the treatment of choice for most patients with mental health disorders, so interprofessional collaboration is a typical (and vital) part of treatment. Psychedelic medicine requires that diverse disciplines collaborate closely and communicate to clearly ensure that the therapy is safely and effectively administered.

LEGAL AND REGULATORY BARRIERS

Today, the federal government has provided limited permission or even grants to study Schedule I drugs and their possible role in the treatment of patients. Outside of these limited cases, researchers find it difficult to obtain the needed drug for testing purposes. To avoid legal and regulatory issues, a good amount of research is performed outside of the United States.

"SET" AND "SETTING" IN PSYCHOTHERAPY-ASSISTED PSYCHEDELIC TREATMENT

Since the 1960s, therapists have noted that the response to psychedelic drugs is impacted by the patient's mindset as well as the setting where the psychedelic drug is administered. For example, if the person feels confident that the experience will be a positive one, then this "set" is considered more conducive to a good experience while under the influence of a psychedelic drug compared with when persons are extremely apprehensive and fearful beforehand. By extension, if patients are in an office setting with a therapist or other practitioner with whom they feel safe, the outcome is generally better than in those who feel unsafe. Research has shown a better outcome with patients receiving psychedelics in a therapeutic setting versus receiving the drug while undergoing a positron emission tomography (PET) scan [33]. These researchers stated [33]:

> The finding that the PET environment was strongly associated with anxious reactions could be partially explained by the perceived atmosphere. Whereas non-PET experiments were mostly conducted in laboratory rooms that were furnished in an aesthetically pleasing way, the environment at the PET center was much more clinical and "antiseptic" (i.e., lots of technical equipment, white walls, personnel in white lab coats). Our results are therefore in support of current safety guidelines, which recommend avoiding "cold" and overly clinical environments in human hallucinogen research in order to reduce the risk of anxious reactions.

Another element of setting, and one that is also used to enhance set, is the use of music while the patient undergoes therapy with psychedelic medicine. Johns Hopkins has developed a "psilocybin playlist" lasting nearly eight hours that is used for patients who are undergoing treatment with psilocybin [34].

In many cases, psychedelic therapy is administered after a therapeutic session. Psychotherapy is often also provided during the course of the drug's effects and at integration sessions that occur after the drug was given to help the patient to give meaning and context for the experience [35]. This provision of multiple hours of psychotherapy over a short period of time can translate to higher costs. This scenario might be less appealing to insurance carriers than traditional therapies (e.g., antidepressants or other drugs), but this is yet to be seen.

It should also be noted that in some areas, there are clear manualized approaches to treating patients that carefully consider both set and setting; this is particularly the case for MDMA in the treatment of PTSD. However, these approaches are yet to be developed for most other psychedelic drugs. Again, this field offers burgeoning opportunities for psychiatrists, psychologists, primary care providers, and other mental health practitioners.

ADVISING PATIENTS CONSIDERING PSYCHEDELIC MEDICINE

Some patients will approach their primary care providers to discuss the possibility of seeking care at a ketamine or MDMA (or other) clinic. It is important not to dismiss these treatment options out of hand. Instead, it may be best to ask the patients the following questions to help assess if the option would be helpful and if the facility is set up to provide optimal care:

- Who is the expert or experts running this clinic? What experience(s) make this person or team experts? What outcome data are provided?
- Does the patient have a severe and intractable diagnosis, such as treatment-resistant depression, substance use disorder, or PTSD? If not, then conventional medicine is still best.
- Does the clinic ensure professional observation after the drug is administered? This is always advisable in case the patient experiences adverse events.
- How soon after a drug is administered are patients discharged from the facility? Minimal times (e.g., 15 minutes) are not long enough to ensure safety.
- Does the facility offer psychotherapy before, during, and after the drug is administered? Combining psychotherapy with psychedelic medicine is the proven best practice.
- Is there a required follow-up?
- Are the costs for treatments clearly delineated? If not, patients should request, in writing, an estimate of total costs. Psychedelic medicine is likely not covered by health insurance and may be costly. Also, the cost may fluctuate significantly from one clinic to another.
- Has the patient experienced a psychotic break in the past or does the patient have first-degree relatives with a history of psychosis? Psychedelics have the potential to trigger an underlying predisposition for psychosis, although it can be temporary. Still, even a short-term psychotic break is a terrifying experience.

ADDRESSING STIGMA

For many people, including some clinicians, the phrase "psychedelic medicine" evokes images of free love, 1960s counterculture, and recreational intoxication. In reality, these therapies typically look much more pedestrian, consisting of a patient sitting or lying on a couch while a clinician guides the person through the experience in order to treat their severe psychiatric disorder. Although many of the drugs described in this course can and do induce hallucinations, subjects have reported that these experiences were integral and allowed them to resolve psychiatric issues that have been resistant to traditional treatments and that have significant impact on their lives. If further studies continue to bear these findings out, it would be unwise to ignore the benefits that may accrue.

EMERGING PSYCHEDELIC TREATMENTS

The key psychedelic drugs actively being researched and/or currently in use today include psilocybin, ketamine, MDMA, ibogaine, kratom, LSD, mescaline, and ayahuasca (***Table 4***). In addition, nitrous oxide, a gas used for many years by dentists as both an anesthesia and analgesic for patients undergoing painful procedures, has also been found effective as a treatment for some psychiatric disorders.

PSILOCYBIN

Beginning in the 2010s, psilocybin has been undergoing an era of increased research attention, and this compound remains under active investigation. Psilocybin occurs in nature in hundreds of species of mushrooms as 4-phosphoryloxy-*N*,*N*-dimethyltryptamine. However, when used by researchers, the drug is nearly always a chemically synthesized compound to maintain a standard dosage as well as the purity of the drug. In 2020, COMPASS Pathways announced that it had gained a patent in the United States for COMP360, its form of synthetically derived psilocybin [15].

According to a 2022 report from the Associated Press, some states, even in conservative areas (e.g., Utah), have approved studying psilocybin as a treatment. This movement has largely been driven by increasing rates of treatment-resistant PTSD among military veterans [36].

Psilocybin was first studied during the 1960s to establish its psychopharmacologic profile; it was found to be active orally at around 10 mg, with more potent effects at higher doses, with a four- to six-hour duration. Psilocybin is rapidly metabolized to psilocin, a full agonist at serotonin 5-HT1A/2A/2C receptors, with 5-HT2A receptor activation directly correlated with human hallucinogenic activity. Time to onset of effect is usually within 20 to 30 minutes of ingestion. As a drug, it is about 20 times stronger than mescaline but much less potent than LSD [37].

In animal studies of the use of psilocybin, a link has been identified between reduced prefrontal mGluR2 function and both impaired executive function and alcohol craving. Psilocybin also restored healthy mGluR2 expression and reduced relapse behavior in mice [38]. Mice and humans do not always respond equivalently, but this finding may explain why psilocybin is effective in treating induced alcoholism in mice and provides an interesting research avenue in the investigation of psilocybin as a treatment for alcohol use disorder in humans, because relapse is a significant problem; even when a patient has abstained from alcohol for years, the underlying craving remains. If this craving could be reduced or altogether eliminated, this could revolutionize substance use disorder treatment.

In a study at King's College London, researchers studied the effects of psilocybin on the emotional and cognitive functions in healthy subjects in a Phase 1 randomized double-blind controlled study with 89 subjects (average age: 36.1 years). Subjects were randomized to receive placebo or 10 mg or 25 mg of psilocybin. Therapists were available to the subjects throughout the sessions. Six subjects at a time received the drug. The study showed that there were no short- or long-term adverse effects to the emotional processing or cognitive functioning of the subjects [39]. In this study, 70% of the subjects who received 25-mg psilocybin experienced visual hallucinations, compared with 60% of those who received 10-mg psilocybin and 6.9% of those who received placebo. The second most common treatment-emergent adverse event was illusion, which was experienced by 60% of subjects receiving 25-mg psilocybin and 63.3% of those receiving 10-mg psilocybin; 13.8% of those receiving placebo reported experiencing this effect. Other treatment-emergent adverse events reported more commonly among the treatment groups included mood alteration, headache, fatigue, and euphoric mood, all of which were lower or altogether non-existent in the placebo group. Also absent in the placebo group were auditory and tactile hallucinations [39]. The researchers concluded [39]:

> This study demonstrated the feasibility of one-to-one psychological support from specially trained therapists during [the] simultaneous administration of psilocybin in a supervised clinical setting in healthy volunteers. A single dose of psilocybin 10 mg or 25 mg elicited no serious adverse effects and did not appear to produce any clinically relevant detrimental short- or long-term effects, compared with placebo, in cognitive or social functioning or emotional regulation in this study in health volunteers.

MAJOR PSYCHEDELIC RESEARCH CENTERS IN THE UNITED STATES

Johns Hopkins Center for Psychedelic and Consciousness Research
https://hopkinspsychedelic.org

National Institutes of Health Funding
https://pubmed.ncbi.nlm.nih.gov/34624734

Yale University
https://medicine.yale.edu/psychiatry/education/residency/interest/psychedelic_science_group

Mount Sinai
https://www.mountsinai.org/about/newsroom/2021/mount-sinai-health-system-launches-center-for-psychedelic-research

Stanford University
https://med.stanford.edu/spsg.html

University of California, San Francisco
https://neuroscape.ucsf.edu/psychedelics

Duke University
https://dukepsychedelics.org

University of Texas at Austin
https://dellmed.utexas.edu/units/center-for-psychedelic-research-and-therapy

Washington University in St. Louis (WUSTL)
https://healthymind.wustl.edu/items/washington-universitys-program-in-psychedelic-research

Harvard/Massachusetts General Hospital
https://www.massgeneral.org/psychiatry/treatments-and-services/center-for-the-neuroscience-of-psychedelics

Source: Compiled by Author *Table 4*

In studies using psilocybin, the most common adverse reactions were found to be headache, nausea, and hypertension, and events were considered to be equivalent to those found with the use of SSRIs [40]. However, it should also be noted that the subjects in psilocybin clinical trials are usually screened for a family history of schizophrenia, major depression with psychotic features, high risk for suicide, and severe personality disorders before inclusion [40].

Another study at Johns Hopkins evaluated the efficacy and safety of psilocybin for the treatment of major depressive disorder. In this randomized study, 24 patients 21 to 75 years of age with moderate-to-severe unipolar depression were randomized to either immediate or delayed treatment. Subjects were administered two doses of psilocybin along with supportive psychotherapy. Researchers found a greater than 50% reduction in depressive symptoms, as measured by the GRID-Hamilton Depression Rating Scale (GRID-HAMD), in the treatment group. Before initiating psilocybin therapy, subjects first received six to eight hours of preparation with trained facilitators. The psilocybin was administered at doses of 20 mg/70 kg and 30 mg/70 kg, about two weeks apart, while subjects were in a comfortable room supervised by two facilitators. There were also follow-up counseling sessions [1]. The mean scores on the GRID-HAMD decreased from an average of 22.8 at the pretreatment level to 8.7 at 1 week, 8.9 at 4 weeks, 9.3 at 3 months, 7.0 at 6 months, and 7.7 at 12 months. These data indicate that the psilocybin provided persistent relief to many patients [1].

In a 2018 British study, 26 patients, 20 of whom were diagnosed with severe treatment-resistant depression, were administered separate doses of 10- and 25-mg psilocybin one week apart; administration took place in a supportive setting. Nineteen subjects completed the treatment process, including psychological support, and all of the completers reported improved symptoms based on Quick Inventory of Depressive Symptoms (QIDS-SR16) and HAM-D scores. Four patients experienced remission of their depression at week five. Many completers continued to benefit from treatment at three months and six months. Suicidality scores among the patients also significantly fell within the two weeks after treatment [41].

Not all researchers have offered a ringing endorsement of the use of psilocybin. A 2021 study studied 59 patients with moderate-to-severe major depressive disorder. The subjects were administered either two doses of 25-mg psilocybin three weeks apart plus placebo (30 patients) over six weeks, or they were given escitalopram (an SSRI) for six weeks (29 patients). All the patients also received psychological assistance. No significant differences were noted in depression symptoms between the two groups, and the researchers concluded that further studies with larger populations were needed. Even the adverse events in the two groups were somewhat similar; the most common adverse effect in both groups over the course of the study was headache, followed by nausea [42]. Even in this study, psilocybin was about as effective as antidepressant therapy. This is remarkable, in that this new treatment is about as effective as the established criterion standard treatment for major depressive disorder.

Although studies have supported the hypothesis that psilocybin provided under research conditions by physicians has a positive effect on depressive symptoms, until recently, the mechanism by which this improvement has occurred was largely unknown. However, in a study of 16 individuals with treatment-resistant depression, researchers used functional magnetic resonance imaging (fMRI) to assess functional brain changes both at baseline and one day after the study group received 25-mg psilocybin. The researchers found brain network modularity was reduced within just one day after the psilocybin was administered [43]. In a second study by the same researchers, 59 patients with major depressive disorder were randomized to either two doses of 25-mg psilocybin three weeks apart plus six weeks of daily placebo or to six weeks of 10- to 20-mg escitalopram per day plus 1-mg psilocybin (an ineffective dose). In this study, 29 subjects were in the escitalopram arm, although the group ultimately decreased to 21 subjects (28% dropout rate). The 30 patients in the psilocybin group decreased to 22 subjects (27% dropout rate) [43]. The researchers noted that [43]:

> It is plausible that this putative liberating effect of psilocybin on cortical activity occurs via its direct agonist action on cortical 5-HT2A receptors, dysregulating activity in regions rich in their expression. We surmise that chronic escitalopram does not have the effect on brain modularity due to its more generalized action on the serotonin system and predominant action on inhibitory postsynaptic 5-HT1A receptors, which are richly expressed in limbic circuity.

The researchers found that the antidepressant effect of the psilocybin was sustained and rapid and that it also corresponded with decreases in fMRI brain network modularity. This indicates that the antidepressant effect of psilocybin, when it works, is linked with a global increase in brain network integration. In contrast, the response to the escitalopram was mild and caused no changes to the brain network [43].

KETAMINE

Ketamine is a derivative of phencyclidine (PCP), which itself was originally developed as an anesthetic. However, the major adverse effects of PCP, such as aggression, psychosis, and dysphoria, made it an undesirable and unacceptable anesthetic choice [44]. In contrast, ketamine was effective as an anesthetic and had few adverse effects. PCP subsequently became a drug of abuse.

While ketamine has been used in operative analgesia for decades, it has also become a drug of abuse and misuse [45]. Most notoriously, ketamine became known as a "date-rape drug," because it was administered in drinks to unknowing victims who were subsequently sexually assaulted by their predators. Because ketamine causes amnesia, victims have little or no memory of what occurred to them, although they often experienced after-effects, such as pain. As a result of this growing criminal use, Congress passed the Drug-Induced Rape Prevention and Punishment Act of 1996. During this period and the decade following, there was increased awareness of the dangers of ketamine and other drugs that were used in a similar manner, such as flunitrazepam (Rohypnol) and gamma hydroxybutyric acid (GHB) [46]. As a result, ketamine developed a stigma, and this negative view may persist in many minds.

Ketamine is a Schedule III drug that is a combination of s-ketamine (esketamine) and r-ketamine (arketamine). In 2019, the use of esketamine as a nasal spray (brand name Spravato) was approved by the FDA for the treatment of treatment-resistant depression. Since then, it has also been approved to treat suicidal depression. However, it should be noted that this nasal spray formulation is not available at most pharmacies; instead, it is provided solely through a restricted distribution system. The FDA also requires that patients be overseen for a minimum of two hours after treatment, in order to allow sufficient time to identify and address and adverse reactions that develop in patients. (It is not clear if all ketamine clinics adhere to this provision.)

EVIDENCE-BASED PRACTICE RECOMMENDATION

For patients with major depressive disorder who have not responded to several adequate pharmacologic trials, the Department of Veterans Affairs suggests ketamine or esketamine as an option for augmentation.

(https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFinal508.pdf. Last accessed July 8, 2022.)

Strength of Recommendation: Weak for

After treatment with ketamine, patients should not leave the facility until they are cleared to do so by a healthcare provider and they should also be cautioned to avoid driving or using heavy equipment until the following day. In addition, patients are not allowed to take the nasal spray home, because it may only be used in the medical office while under the supervision of qualified staff members [47].

Intravenous ketamine has been used off-label for treatment-resistant depression by some clinicians, and ketamine clinics are established in many parts of the United States, although their fees vary widely. The effects of intravenously administered ketamine may last for hours, days, or even weeks in some patients. Some believe that intravenous ketamine is significantly more effective than its intranasal form because it includes both the s and r forms of the drug.

Some researchers have found that the mental state of the patient (set) prior to receiving treatment with ketamine may affect the outcome of treatment. In a 2019 study, 31 patients with major depressive disorder were treated with ketamine infusions. Researchers used multiple instruments to measure the mental state of subjects prior to and after receiving treatment, including the Montgomery-Asberg Depression Rating Scale (MADRS) and the Beck Hopelessness Scale. In this study, 17 subjects (55%) responded to the ketamine, while 14 (45%) had no response [48]. Non-responders had significantly higher rates on anxiety scales than responders. The researchers stated [48]:

> The present study showed for the first time that non-responders had more anxiety-related experiences induced by the first ketamine infusion than responders confirming our initial hypothesis of significantly different subjective experiences as a function of treatment response. Specifically, we found that it was the extent of ketamine-induced anxiety that was negatively predictive of a treatment response after a series of six infusions on average.

They also noted that providing a calm treatment environment to patients might be sufficient to reduce anxiety levels in patients to improve outcomes. This is the goal of treatment providers as well as researchers who emphasize the importance of set (mindset) and setting, as discussed. In this study, there was no follow-up after the last infusion, which may also have improved efficacy [48].

In another study of 30 individuals with PTSD of a median duration of 15 years, half of subjects were randomized to a ketamine group and half were assigned to a midazolam (a benzodiazepine) group. The subjects received six infusions over the course of two weeks of either ketamine (0.5 mg/kg) or midazolam (0.045 mg/kg). The subjects were evaluated with the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) at baseline and also at the end of treatment [49].

The average CAPS-5 total scores following the infusions were 11.88 points lower among the subjects in the ketamine group compared with the midazolam group. About two-thirds of the ketamine subjects (67%) responded to the treatment, versus only 20% of treatment responders in the midazolam group. The median time to loss of treatment following the two-week ketamine treatment period was 27.5 days. However, in outlier cases, two subjects still had not lost their response; improvements continued at 50 days and 102 days since the last infusion. The ketamine group experienced a major reduction in symptoms of depression as well as in clinical ratings of global psychiatric illness severity. The researchers concluded that the findings from this study support the assertion that "repeated ketamine infusions are safe and generally well tolerated among individuals with chronic PTSD, with only transient emergence of psychoactive and hemodynamic side effects" [49].

In a French study, ketamine was explored as a treatment for individuals with severe suicidal ideation in a double-blind randomized clinical trial. In this six-study report, published in 2022, 156 patients were given either a 40-minute infusion of ketamine or placebo (saline solution). The administration was repeated 24 hours later. The groups were also divided into subjects with bipolar disorder, depressive disorder, and other diagnoses. Of patients in the ketamine group, 93.1% had a past history of the commission of a suicidal act, as did 86.6% of the subjects in the placebo arm [50].

On day 3, nearly two-thirds (63%) of the patients in the ketamine group achieved full remission from suicidal thoughts. In contrast, 31.6% of the patients in the placebo group were in remission. In nearly 44% of the ketamine subjects, remission occurred within two hours after the first infusion, compared with 7.3% of the placebo group. Ketamine was particularly effective in the bipolar group, while its effect was not significant in the group with major depressive or other psychiatric disorders. The researchers speculated that ketamine might provide an analgesic kind of effect to mental pain [50].

MDMA

In the past and even to date, MDMA (also referred to as "Ecstasy" or "Molly") has been largely a drug of abuse. According to the National Institute on Drug Abuse, about 2.6 million people in the United States 12 years of age and older reported past-year use of MDMA in 2020 [51]. The drug was originally developed by Merck in 1912, and in the 1970s, it was found to be useful in combination with psychotherapy [52]. However, because of considerable active abuse of the drug in the United States, in 1985, MDMA was categorized as a Schedule I drug under the Controlled Substances Act in an emergency ban, and consequently research on this drug largely halted until the 2010s [53].

Today, researchers have demonstrated the efficacy of combination psychotherapy and MDMA in treating PTSD. The FDA has granted "breakthrough therapy" permission for MDMA therapeutic treatment, largely as a result of the findings of several small studies. Clinicians who use MDMA-assisted psychotherapy to treat individuals with PTSD have access to a manual outlining best practices for this therapeutic use. In the 2017 revision of this manual, the following explanation is given [54]:

> The basic premise of this treatment approach is that the therapeutic effect is not due simply to the physiological effects of the medicine; rather, it is the result of an interaction between the effects of the medicine, the therapeutic setting, and the mindsets of the participant and the therapists. MDMA produces an experience that appears to temporarily reduce fear, increase the range of positive emotions toward self and others, and increase interpersonal trust without clouding the sensorium or inhibiting access to emotions. MDMA may catalyze therapeutic processing by allowing participants to stay emotionally engaged while revisiting traumatic experiences without being overwhelmed by anxiety or other painful emotions. Frequently, participants are able to experience and express fear, anger, and grief as part of the therapeutic process with less likelihood of either feeling overwhelmed by these emotions or of avoiding them by dissociation or emotional numbing. In addition, MDMA can enable a heightened state of empathic rapport that facilitates the therapeutic process and allows for a corrective experience of secure attachment and collaboration with the therapists.

In six double-blind, randomized clinical studies conducted between 2004 and 2017, 72 subjects are administered 75–125 mg of MDMA in two or three sessions, comparing these results with 31 patients who received placebo; all the patients had diagnosed PTSD. The drug was administered following 90-minute sessions of psychotherapy and three to four therapy sessions were also provided during follow-up after MDMA therapy [55].

Members of the treatment group reported significantly reduced scores on the CAPS-5 compared with the control group. In addition, after two sessions, 54.2% of those who received MDMA no longer met the criteria for PTSD—they were in remission. In contrast, only 22.6% of the control group experienced remission. The researchers noted that "MDMA-assisted psychotherapy was efficacious and well tolerated in a large sample of adults with PTSD" [55].

In another randomized, double-blind, placebo-controlled phase 3 clinical trial with 90 individuals with severe PTSD, the subjects received manualized therapy with either MDMA or placebo. Three preparatory sessions occurred before the administration of the drug, and there were nine integrative therapy sessions afterwards. Subjects in the MDMA treatment group experienced a significant decrease in CAPS-5 (-24.4) scores compared with placebo subjects (-13.9). Scores on the Sheehan Disability Scale (SDS) also significantly improved in the MDMA subjects compared with the placebo subjects [56]. The researchers noted [56]:

> Given that PTSD is a strong predictor of disability in both veterans and community populations, it is promising to note that the robust reduction in PTSD and depressive symptoms identified here is complemented by a significant improvement in SDS score (for example, work and/or school, social and family functioning). Approximately 4.7 million U.S. veterans report a service-related disability, costing the U.S. government approximately $73 billion per year. Identification of a PTSD treatment that could improve social and family functioning and ameliorate impairment across a broad range of environmental contexts could provide major medical cost savings, in addition to improving the quality of life for veterans and others affected by this disorder.

Because major problems with sleep quality are common among patients with PTSD, some researchers have studied the effects of MDMA-assisted psychotherapy to determine its effects on sleep disorder. In a series of four studies with 63 subjects at sites in the United States, Canada, and Israel, subjects were randomized to two or three sessions of MDMA-assisted psychotherapy or to a control group. PTSD symptoms were assessed with the CAPS-IV, and the Pittsburgh Sleep Quality Index (PSQI) was used to measure changes in sleep quality. At the conclusion of the study, the CAPS-IV severity scores had decreased by 34 points in the MDMA group, compared with a decrease of 12.4 points for the control group. In addition, sleep quality improved significantly in the experimental group compared with the control group. In the treatment group, 53.2% of subjects reported a PSQI score drop of 3 or more points, compared with 12.5% in the control group [57].

Although there appears to be a benefit for MDMA therapy in the management of PTSD, especially for patients who have failed other therapies, the durability of this affect has been questioned. One study indicated improvement may be persistent for a considerable period of time for some subjects. In a study involving 107 subjects with PTSD, individuals were administered either two or three doses of MDMA (75–125 mg) during blinded or open-label therapy sessions. The subject's PTSD symptoms were evaluated 1 to 2 months after the last MDMA session and again after 12 months. The researchers reported that at the 12-month follow-up time, nearly all (97.6%)

of the subjects said they had benefited from the treatment, and 53.2% reported large benefits that had lasted or even increased. A minority of subjects reported unfavorable results; 8.4% reported harms. However, in 86% of these cases (six of seven subjects), the harms were rated as a 3 or less on a 5-point scale. There were no reports of severe harm, and all the subjects who reported harm also reported one or more benefits. The most common harm reported was worsened mood (3.6%) [58]. The researchers noted that, "Overall findings from the present analyses support MDMA-assisted psychotherapy as an efficacious treatment for PTSD with symptom improvements that were sustained at 1 to 3.8 years post-treatment. These findings corroborate and expand preliminary results from the first phase 2 trial of this treatment" [58].

IBOGAINE

Largely derived from the Western African shrub *Tabernanthe iboga,* ibogaine has been explored as a possible treatment for opioid use disorder, although there are many caveats to be considered, including the fact that ibogaine is a Schedule I drug. Given the current climate surrounding opioid misuse and use disorder in the United States, possible treatment options are a major focus. According to the Centers for Disease Control and Prevention, more than 70% of drug overdoses in the United States in 2019 were related to opioid use [59]. Ibogaine apparently acts to eliminate craving for opioids and rapidly detoxifies individuals with opioid dependence, although much further study with larger populations is needed. Most people who seek treatment with ibogaine have opioid use disorder, but some have been dependent on stimulants such as cocaine.

The anti-addictive capabilities of ibogaine were first noted by Howard Lotsof in 1962 as a result of his own experience with the drug as well as reports from others. Lotsof, a man in recovery from heroin use disorder from New York City who unexpectedly found relief and remission with ibogaine, subsequently actively and tirelessly lobbied researchers to study the drug. He eventually succeeded, and multiple researchers using both animal and human studies have demonstrated ibogaine's apparent ability to induce recovery in some persons struggling with substance use disorders [60; 61].

Metabolism of ibogaine is purportedly mediated by the p450 cytochrome enzyme CY2D6. Because of genetic differences, an estimated 10% of persons of European heritage (predominantly White Americans in the United States) lack the necessary gene to synthesize this enzyme. Among this group, including the many individuals who do not realize they lack this gene, administration of ibogaine can result in plasma levels as much as twice as high as those in persons with the gene. As a precaution, a test dose of the drug may be given to subjects to assess the response. Another option is genotype screening of subjects who seek treatment with ibogaine, to ensure safety and to aid in treatment decisions [62].

Although it provides insufficient data from which to draw major conclusions, a study of the use of ibogaine in two adults with opioid use disorder is interesting. The experiences of one of the patients are described here, although it should be noted that both patients have remained abstinent for several years [62]. The first patient developed an opioid use disorder secondary to pain from chronic pancreatitis. His physician was concerned about potential misuse and weaned the patient off opioids; however, the patient began taking large quantities of oxycodone tablets he purchased illegally. As the substance use disorder progressed, this patient was actively resistant to conventional treatment despite clear physical and psychosocial consequences. Eventually, he agreed to experimental treatment with ibogaine.

The patient was screened with an electrocardiogram prior to treatment and administered a test dose of ibogaine. During the first four days of treatment, he was administered oxycodone (legally obtained via prescription). The opioid doses were steadily titrated down and on day 4, all opioid medications stopped. During this same period, the patient was given increasing doses of ibogaine. On day 4, the patient was given a "flood dose" of both iboga and ibogaine (variations of the same drug). Between treatments, diazepam was given to support sleep and assuage anxiety. Treatment lasted for six days, and the patient remained at the clinic for a total of eight days. At three-year follow-up, the patient had remained abstinent from opioids, as indicated by negative drug screens. Interestingly, after the flood dose of ibogaine, the client also reported that his chronic pain issues ended, and they have not recurred [62]. The reasons for this finding are unknown.

In a study of 14 individuals with opioid use disorder, subjects were given staggered doses of 200-mg ibogaine capsules at two different clinics. Because ibogaine is a stimulant, most patients were given benzodiazepines or sleep aids so they could attain sufficient hours of sleep. The first dose administered was a test dose given when the patient was in a withdrawal state from opioids; then, a larger dose of up to 600 mg of ibogaine was given one to four hours later. This was followed by smaller dosages of 200 mg given at 20-minute intervals until ended by the provider. The subjects were interviewed pretreatment, immediately post-treatment, and 12 months later. The outcome was that 12 of the 14 subjects (85.7%) had either a marked reduction in opioid use or ended use of the drug altogether [61].

In a larger study of 191 adults wishing to detoxify from opioids or cocaine, a single dose of ibogaine was administered during a medically supervised period of detoxification. According to the researchers, the goals of the study were to safely detoxify the subjects from opioids or cocaine, to provide motivational counseling, and to refer the patients to aftercare and 12-step programs [63]. All subjects received a physical examination, and a medical history was taken. Laboratory tests were administered, as were electrocardiograms. The subjects were drug tested at the beginning of the program, and all tested positive

for either opioids or cocaine. A licensed therapist worked with the subjects during and after ibogaine was administered. The average age of subjects was 36 years, and all were habitual users. The subjects were given one dose oral (gel capsule) ibogaine 8–12 mg/kg. In this study, the most common adverse effect was headache, reported by 7% of the subjects; orthostatic hypotension occurred in 5% of the subjects. About 2% of adverse events were considered to be moderately severe.

After the ibogaine was administered, its effects began about 30 to 45 minutes later. According to the researchers [63]:

> Sensory and perceptual changes included reports of visual images, changes in the quality and rate of thinking, and heightened sensitivity to sound. Most subjects reported a dream-like experience lasting between four and eight hours, after which there was an abrupt change in the sensory experience to a more quiet period of deep introspection.

Approximately 92% of subjects reported benefits from the experience. They also reported that both drug craving and depression symptoms improved with doses of 500–1,000 mg. One shortcoming of this study, however, was a lack of follow-up. It would be especially helpful to know if these individuals remained abstinent 6 to 12 months later. Unfortunately, this was not among the goals of the researchers [63].

Ibogaine is difficult to obtain in the United States, and travel to other countries to obtain treatment has been reported, which can be very costly. Assuming that ibogaine were to be equal in efficacy to clonidine or lofexidine for detoxification from opioids or acute discontinuation, it is still unclear what long-term effects or level of continued abstinence can be expected. Naltrexone (Vivitrol) following detoxification might be facilitated. But, data supporting the use of suboxone and methadone in reducing overdoses, deaths, and emergency department visits are clear, including both short- and long-term outcomes. It is important to compare ibogaine to buprenorphine or methadone treatment, just as psilocybin was compared to SSRI therapy [64].

KRATOM

Kratom is a drug derived from *Mitragyna speciosa*, an evergreen tree native to Southeast Asia, where it has been used for generations, largely by locals who chew on the leaves or brew it into a tea and reportedly use the drug for an energizing purpose (e.g., to facilitate longer work periods), much as Americans use caffeine. Kratom is used by consumers in the United States as a drug of abuse and, less commonly, to manage depression. As of 2022, the drug is not scheduled by the U.S. Drug Enforcement Administration (DEA), although the DEA did consider categorizing kratom constituents mitragynine and 7-hydroxymitragynine under Schedule I in 2016. This effort was met with considerable resistance and was abandoned. As such, the product remains available locally in smoke and "head" shops, although many purchase the drug over the Internet. Kratom is banned in six states, including Arkansas, Indiana, Tennessee, Vermont, Wisconsin, and most recently in Alabama [65].

Experts exploring the potential psychiatric uses of kratom have expressed optimism. According to McCurdy, kratom "seems to have mood lifting and elevating properties in addition to its ability to seem to move people off of hardcore opiates" [66]. Although the drug is traditionally used as a stimulant, it has a sedative or opioid-like effects in very high doses. It has been hypothesized that kratom might have a role in the treatment of opioid use disorder, although much more study is needed.

It is important to note that kratom products available in the United States are very different from those that are used by people in their native environments. For example, the kratom used in Southeast Asia is almost always derived from fresh leaves, while in the United States, the products are freeze-dried leaves, concentrated extracts, or liquid "energy shots." As a result of these differences, concentrations and adulteration are concerns. Some individuals in the West who consume kratom products have displayed blood serum levels of mitragynine (the key alkaloid in kratom) 100 to 1,000 times higher than in those found in consumers in Southeast Asia [67].

Another issue is one of purity. In an analysis of eight samples of the drug, researchers found that all the samples tested positive for varying levels of *Mitragyna,* ranging from 3.9–62.1 mg/g, which is a wide range that could significantly alter efficacy and toxicity [68]. In addition, six of the samples tested positive for fungi and bacteria. Most (seven) of the samples were positive for significant levels of toxic heavy metals, including nickel, lead, and chromium. The presence of lead was particularly troubling, as lead has many potentially toxic effects, particularly in terms of potential problematic neurologic effects in children and young adults as well as a variety of cognitive, developmental, immunologic, renal, and cardiovascular effects [68]. Although this study did not find evidence of *Salmonella* contamination, in 2018, a *Salmonella* outbreak originating from kratom products was reported to affect 199 people spanning 41 states [69]. It is clear that the purity of kratom purchased in the United States is highly questionable, largely because there are no federal constraints on its production by the FDA or other federal agencies. Healthcare professionals who know or suspect that their patients are using kratom may wish to warn them about these findings.

LSD

As discussed, LSD is a compound synthesized from ergot. It is usually administered as an oral solution. LSD takes effect within 20 to 40 minutes after ingestion, and its effects may last for up to 12 hours. Flashbacks may also occur with this drug, defined as a feeling of re-experiencing an event or emotion that occurred during the course of the LSD "trip." LSD is about 2,000 times more potent than mescaline [37].

Prior to the Controlled Substances Act passage in 1970, there were numerous research studies on LSD as a treatment for depression, substance use disorder, and other psychiatric diagnoses, although some of these studies were not scientifically rigorous by today's standards. Fewer studies on LSD are published today, but several merit some attention. For example, a 2022 study assessed the impact of LSD on stressed mice [70]. Anxious mice were administered low doses of LSD for seven days, during which their anxiety levels decreased. In addition, researchers found that the mice given LSD showed signs of increased production of new dendritic spines, a sign of brain plasticity. The researchers also found that the LSD increased the production of serotonin in the treated mice, in a somewhat similar manner to SSRI antidepressants [70].

In an earlier study of the effects of LSD on humans with life-threatening diseases, 8 of the 12 subjects were given 200 mcg of LSD and a control group was given 20 mcg, an insufficient dose to generate significant response. After the initial blinded study was unmasked, the control group subjects were also given 200 mcg of LSD. All subjects had a score of higher than 40 on the state or trait scale of the Spielberger State-Trait Anxiety Inventory before the study. In addition, half the subjects had diagnosed generalized anxiety disorder. A therapist was present for two sessions conducted two to three weeks apart. The experimental sessions lasted eight hours, and patients left only to use the restroom [71]. Subjects who received the 200-mcg dose of LSD displayed a decrease in anxiety as measured by multiple instruments, and this decrease persisted at the 12-month follow-up evaluation. Overall, the subjects experienced a 78% drop in anxiety scores and a 67% increase in quality of life scores after one year. They also reported better access to and control of their own emotions [72].

While this research is interesting and points to areas for future research, it remains to be seen if LSD (or a similar compound) will ever be in clinical use for anxiety and depression. In addition to overcoming stigma and issues with adverse effects, significant additional research on efficacy is necessary.

MESCALINE

3,4,5-trimethoxyphenethylamine, also known as mescaline, is a psychedelic drug that is mainly found in *Lophophora williamsii*, or the peyote cactus. Its effects upon ingestion are similar to the effects found with LSD or psilocybin, including hallucinations and euphoria [37]. The drug is known to have been used for thousands of years for these and perceived spiritual or medical effects; archaeologists have found evidence of this drug in Texas dating back 5,700 years [73]. Today, it is a Schedule I drug, but it may be used legally in religious ceremonies of the Native American Church. Mescaline has been suggested as a potentially effective treatment for a variety of mental health conditions, including depression, OCD, anxiety, and substance use disorder; however, research has yet to be conducted to support these claims.

The average dose of mescaline ranges from 20–500 mg, and the duration of action is about 10 to 12 hours. Individuals suffering from mescaline toxicity (typically seen with doses of 20 mg/kg or greater) may experience tachycardia, hypertension, seizures, hyperthermia, respiratory depression, and rarely death [73]. Concomitant use of mescaline with stimulant drugs (e.g., nicotine, cocaine, ephedrine, amphetamines) may increase the risk of adverse central nervous system effects.

In a survey of 452 individuals who reported using mescaline, researchers found that the drug was usually used once per year or less frequently, and only 9% of users reported a craving for mescaline. About 50% of users reported established psychiatric diagnoses, including anxiety and depression, and of this group, more than 65% reported that these problems improved after taking mescaline [74]. Clinical studies are necessary to confirm or refute these findings.

In another analysis of these data, nearly 50% of respondents reported their experience with mescaline was either the most meaningful experience of their lives or in the top five most meaningful experiences. Respondents who said they had experienced improvement in psychiatric problems were significantly more likely to also report experiencing mystical/spiritual experiences and psychological insight [75].

NITROUS OXIDE

Nitrous oxide (chemical formula N_2O) is a component familiar to many, as it is commonly used today to facilitate comfort and address anxiety in dental settings. Historically, it has been used in both dental and medical interventions. The origins of nitrous oxide are attributed to Joseph Priestley's discovery in 1772, who referred to it as "dephlogisticated nitrous air" [76]. Anesthetic use of nitrous oxide was discovered by a dentist in 1844, and it was used for this purpose almost solely until the 1980s. The first research into the use of nitrous oxide for neuropsychiatric purposes was published between 1920 and 1950, and in the early 1980s, low-dose titration of nitrous oxide was introduced into medical practice as a possible adjunct to the treatment of psychiatric disorders, including substance use disorders [77]. Before then, it was limited to use as an anesthetic or for analgesia during childbirth. In 1994, the term psychotropic analgesic nitrous oxide was introduced in order to better distinguish anesthetic and nonanesthetic preparations [77].

The anxiolytic action of nitrous oxide is believed to be due to binding at select gamma-aminobutyric acid (GABA) receptors, an action similar to the benzodiazepines [78]. The mild analgesic effect appears to be linked to the endogenous opioid receptor system, as experimental studies have shown that the introduction of opioid receptor antagonists to the brain decreases the analgesic efficacy of nitrous oxide [79].

The route of administration is inhalation via a mask secured to the patient's nose. In the dental setting, the concentration of nitrous oxide is 25% to 50% (usually 30% to 40%) nitrous oxide with oxygen. When utilized in obstetrics, a fixed 50%

concentration with oxygen is used [77]. Onset of action can occur in as quickly as 30 seconds, with the peak effects seen in five minutes or less. Unlike the benzodiazepine medications, nitrous oxide is not metabolized in the body. It is eliminated via respiration within minutes after 100% oxygen is inhaled at the conclusion of the intervention [78]. Repeated doses could be problematic, as extended use of nitrous oxide has been linked to vitamin B12 deficiency [76]. As such, serum vitamin B12 level may need to be measured before and after treatment.

Nitrous oxide has been demonstrated to improve the condition of individuals with treatment-resistant depression. A study of 20 subjects with treatment-resistant depression were randomly placed in either a nitrous oxide treatment group (10 subjects) or placebo group (10 subjects). The nitrous oxide group inhaled 50% nitrous oxide/50% oxygen, and the placebo group received 50% nitrogen/50% oxygen. There were two sessions one week apart. At the end of the study, four patients (40%) had a decrease in symptoms of depression and three patients (30%) experienced full remission. In contrast, one patient improved after receiving the placebo (10%) and none of the placebo patients remitted from their depression. The improvements in the nitrous oxide group were rapid, occurring in some cases within as little as two hours of receiving the drug [80]. Adverse events were mild and included nausea and vomiting, headache, and dizziness/lightheadedness. At the time of the second session, some patients in the treatment group experienced a carryover effect from the first week's treatment, as evidenced by sustained improvements in their scores on the Hamilton Depression Rating Scale (HDRS-21).

A separate study was undertaken to determine whether a single solution of 25% nitrous oxide would be as beneficial as a 50% solution. This study included 24 subjects with treatment-resistant depression who were randomly placed in one of three groups. Each group received either 50% nitrous oxide therapy, 25% nitrous oxide therapy, or placebo each month; each patient had the opportunity to receive all three treatments. At the end of the study, 55% of the subjects reported improvement in at least half of their symptoms, while 40% reported full remission [81]. Of interest, the 25% nitrous oxide solution had about the same level of efficacy in reducing depression as the 50% solution; however, there were significantly lower levels of adverse events in the 25% group. For example, 21% of those who had received 50% nitrous oxide concentration reported nausea; this decreased to 5% in the group that received 25% concentration. Further, the incidences of headache and dizziness were 17% and 13%, respectively, in the 50% concentration group, while the rates were 10% and 0% in the 25% group [82]. The study made it clear that with nitrous oxide, a 25% solution administered over one hour could improve treatment-resistant depression. Most of the study patients had failed an average of 4.5 antidepressants before the study, so the results were significant for a group in need of additional treatment options.

AYAHUASCA/DIMETHYLTRYPTAMINE (DMT)

Ayahuasca is a brew derived from the leaves of *Psychotria viridis*, a shrub found in Amazonian South America, and which contains DMT, a hallucinogenic alkaloid. The brew is also made with the *Banisteriopsis caapi* vine, the bark of which contains ingredients that act as MAO inhibitors.

In a Brazilian study involving 29 subjects with treatment-resistant depression, patients were randomized to receive a dose of either ayahuasca or placebo. Subjects were evaluated on the MADRS at the following points: baseline, day 1, day 2, and day 7 after dosing. They found MADRS scores were significantly lower in the ayahuasca group at all points and all individuals in this group experienced improvements. In contrast, 27% of patients in the placebo group developed worse depression symptoms. However, ayahuasca sickens many people, and most of the subjects who were given this substance felt nauseous and 57% vomited [83].

In another small Brazilian study, six subjects with recurrent major depressive disorder (without psychotic symptoms) were assessed for response to ayahuasca therapy. All individuals were inpatients at a psychiatric unit and were not taking any psychiatric or recreational drugs. The ayahuasca used by the volunteers was plant-based and refrigerated before the study, and each person drank 120–200 mg [84]. All subjects experienced decreases in depression symptoms on days 1 and day 7 of treatment. There were significant decreases in the Brief Psychiatric Rating Scale (BPRS), indicating improvements in both depression and anxiety. There were also statistically significant decreases in scores on the HAM-D and the MADRS. For example, on day 1, there was a 62% decrease on the HAM-D, and a 72% decrease by day 7. On day 14, however, depression symptoms increased. Similar changes were seen with the MADRS scores [84]. About half the volunteers did vomit; however, vomiting did not appear to impact the efficacy of the drug [84]. If ayahuasca is to be considered as a therapeutic option, a way to counteract the emetic effects and make the drug more tolerable to patients is necessary. To date, experts have hypothesized that antiemetic drugs might interfere with the action of ayahuasca.

Another problem with the scientific study of ayahuasca is that the effects of the drug depend on the concoction and there are no standardized dosages. If the drug could be provided in a synthesized form, it would become easier to evaluate and study in patients with depression and other disorders. In Barker's report on DMT, he states [85]:

> While ayahuasca obviously holds promise in many social, cultural, and therapeutic paradigms, including treatment of addiction, anxiety, and depression in psychiatry and many other possible applications, it is, nonetheless, a complex mixture of perhaps thousands of compounds.

DMT has been identified in additional substances. The Sonoran Desert toad (*Bufo alvarius*), native to Texas, California, and Mexico, excretes a venom when threatened that contains a naturally occurring form of DMT. This venom, which can be made into crystals and smoked, is popular for inducing psychedelic trips among recreational users. However, this venom is unsafe, and some have died after smoking it. Further, harvesting this venom has reduced the population of the toad in some areas. Overall, experts recommend that people not attempt to capture the toads or harvest the venom [86].

DIAGNOSES AND PSYCHEDELIC MEDICINE

This section will outline the possible role of psychedelics in the management of specific psychiatric diagnoses, including diagnoses not previously discussed. It is important to remember that most of these uses are investigational.

TREATMENT-RESISTANT DEPRESSION AND SUICIDE

Depression and suicidal depression are major problems in the United States. As noted, at least 30% of persons with depression do not respond to psychotherapy and/or medication. Psilocybin has proven effective at providing breakthroughs with treatment-resistant depression as well as in treating suicidal depression [41; 42]. Nasal spray esketamine (Spravato) is FDA-approved as an adjunct treatment in addition to a conventional antidepressant for treatment-resistant depression and/or major depressive disorder with suicidal ideation or behavior [87]. The nasal spray formulation of esketamine is administered in two sprays (28 mg) per device. The recommended dosage for adults with treatment-resistant depression is 56 mg on day 1, then 56 – 84 mg twice per week for four weeks, reducing to once per week for the next four weeks, and then once weekly or once every two weeks thereafter. This drug is only administered under medical supervision, and patients should remain under observation for at least two hours following administration.

There are concerns regarding misuse, excessive sedation, and diversion, and a Risk Evaluation and Mitigation Strategy (REMS) has been established. The full document is available online at https://www.accessdata.fda.gov/drugsatfda_docs/rems/Spravato_2022_01_03_REMS_Document.pdf.

PTSD

MDMA and ketamine are well on their way to being proven safe and effective in the treatment of PTSD, and further studies on other psychedelics are likely to provide even more breakthrough information. According to the National Center for PTSD, an estimated 12 million adults in the United States have PTSD in a given year; 8% of women and 4% of men develop PTSD in their lifetime [88]. However, PTSD is very difficult to treat with medications and psychotherapy.

The usual dosage of ketamine for the treatment of persistent PTSD is 0.5 mg/kg given via a 40-minute IV infusion. The regimen typically consists of multiple sessions per week for two to four weeks [89].

In the research setting, MDMA for PTSD is typically given during or immediately preceding a psychotherapy session. The usual dose is 75–125 mg in a single dose [90]. As a Schedule I drug, MDMA is only used in clinical trials and research settings.

SUBSTANCE USE DISORDERS

To date, psychedelic drugs such as ibogaine have not been proven effective in treating opioid use disorder and may not compare well to existing and approved treatments. However, limited studies have shown decreased substance use after administration of psilocybin and ketamine. A 2014 open-label pilot study married a 15-week smoking cessation program with several doses of psilocybin. This study included 15 smokers who were considered psychiatrically healthy adults who had smoked an average of 19 cigarettes per day for an average of 31 years [91]. Psilocybin was administered during the 5th, 7th, and 13th week of the study. During the first four weekly meetings, cognitive-behavioral therapy was provided as was preparation for receiving psilocybin. A target quit date was set to occur with the first dosage of psilocybin during week five, when the subjects were given 20 mg/70 kg of psilocybin. Weekly meetings continued, and then on the seventh week, a higher dose of 30 mg/70 kg was given. During the 13th week, the higher dose of psilocybin was made optional for the subjects. Before the psilocybin was administered, subjects noted their motivational statement for smoking cessation. The subjects also participated in a guided imagery exercise at the end of the first psilocybin session [91]. At six-month follow-up, 80% of the former smokers (12 of 15) were abstinent from tobacco, as verified by breath and urine tests. This was a much higher abstinence rate than seen with traditional smoking cessation programs [91].

The researchers returned to their subjects later, reporting on smoking abstinence at 12 months and over the long term, with an average of 30 months after the study. They found that at the 12-month point, 67% were abstinent from smoking. At the long-term point, 60% were still smoking-abstinent, an excellent success rate [92].

In an older study of single versus repeated sessions of ketamine-assisted psychotherapy in 59 subjects who had detoxified from heroin, subjects were divided into two groups. The subjects in the first group received two addiction counseling sessions with ketamine, followed by two ketamine-assisted psychotherapy sessions, with sessions held at monthly intervals. The subjects in the second group received two addiction counseling sessions without ketamine and one ketamine therapy session. At the one-year follow-up point, 50% of subjects in the first group were still abstinent from heroin, versus 22.2% of subjects

in the second group. The researchers concluded that three sessions in the ketamine-assisted psychotherapy program was more effective in promoting abstinence from heroin than one session followed by counseling [93]. There are also emerging data showing positive effects in alcohol use disorders and other substance use disorders.

It is important to keep in mind comparable efficacy. For opioid use disorder, it is vital to know both short- and long-term safety and efficacy comparisons to the standard of care (medication-assisted treatment plus therapy). Also consider that psychedelics will not be proved safe and effective by a professional consensus but rather by the FDA. It may be that psychoactive substances are legalized much in the same fashion cannabis has, but whether they are approved for clinical use will depend on the outcomes of Phase 2 and 3 FDA-qualifying clinical trials and safety and comparable efficacy trials. As of 2022, these trials are ongoing.

ANXIETY AND DEPRESSION RELATED TO LIFE-THREATENING DIAGNOSES

As discussed, research has demonstrated that psilocybin can be effective in improving mood and quality of life of patients with terminal cancer diagnoses. This aspect of cancer care has been largely overlooked and undertreated. Agrawal notes that, "Oncologists are well-equipped to fight the physical threats of cancer with powerful, yet sometimes imperfect tools including chemotherapy, radiation, and surgery, but they often feel helpless when it comes to treating the intense psychological agony many patients experience" [94]. A seminal study published in 2016 explored the use of a modest dose of psilocybin given to patients with terminal cancer under the supervision of trained therapists. The findings demonstrated that more than 80% of 51 patients who had received life-threatening cancer diagnoses and who subsequently developed depression or anxiety experienced significant and sustained improvements in mood and quality of life six months after taking psilocybin. In addition to feeling calmer and happier, the participants reported forging a closer connection with their friends and family [95]. This study demonstrated the careful and controlled use of psilocybin might be a safe and effective treatment for existential anxiety and despair that often accompany advanced-stage cancers. In addition, in limited studies, LSD has been found to significantly decrease anxiety levels in patients with life-threatening diseases.

Oncology and palliative care specialties have been associated with relatively high burnout rates, at least in part from seeing the psychological distress of patients with potentially terminal diagnoses. In this setting, any therapy that can improve patients' experiences and mood would be beneficial, and initial results of research incorporating psilocybin, LSD, and other psychedelics has been positive [94]. Agrawal further states [94]:

> I have never witnessed the sort of dramatic response to any medical intervention as I have with some patients through psychedelic-assisted therapy. It is not a magic bullet or cure for a cancer patient's suffering—and it won't change their prognosis or life expectancy. But it could be a spark that begins their healing journey, helping them come to terms with their most difficult fears.

The use of psychedelic medications in end-of-life care is logical and should be tested compared to the standard treatment (counseling) in randomized, blind clinical trials and other investigations to facilitate FDA approval.

OBSESSIVE-COMPULSIVE DISORDER

OCD can be an extremely debilitating disorder that is often difficult to treat. In a 2006 study of nine subjects with treatment-resistant OCD who were treated with psilocybin, the subjects experienced a significant decrease (range 23% to 100%) in OCD symptoms. One of the subjects experienced an issue with temporary hypertension. These are positive findings; however, it is obviously a very small study and additional research would be needed to replicate findings in a larger and more diverse group [96].

Other researchers have discussed the potential for the use of ketamine and esketamine in treating OCD [97]. In a 2013 randomized, double-blind, placebo-controlled, crossover study of drug-free adults with OCD, subjects were given two 40-minute intravenous infusions, one of saline and one of ketamine (0.5 mg/kg), spaced at least one week apart [98]. Individuals who received ketamine reported significant improvement in obsessions (measured by OCD visual analog scale) during the infusion compared with those given placebo. One-week post-infusion, 50% of those who had received ketamine met the criteria for treatment response (defined as a 35% or greater reduction in Yale-Brown Obsessive-Compulsive Scale scores); no subjects receiving placebo displayed treatment response after one week. The authors of this study concluded that "rapid anti-OCD effects from a single intravenous dose of ketamine can persist for at least one week in some patients with constant intrusive thoughts" [98]. However, other studies have found no effect on OCD symptoms [99]. Solid evidence is lacking and requires greater and more rigorous research.

SOCIAL ANXIETY IN PATIENTS WITH AUTISM

In a study of 12 adults with autism and issues with severe social anxiety, subjects were randomized to receive either MDMA (75 mg or 125 mg) or placebo during the course of two 8-hour psychotherapy sessions. The MDMA was administered after a guided progressive muscle relaxation exercise. The experimental sessions were held one month apart and separated by three nondrug sessions of psychotherapy. The patients were provided with as few sensory interruptions as possible, such as soft lights, noise abatement, and fidget objects to help them with self-regulation through repeated actions (i.e., "stimming")

[100]. On the Leibowitz Social Anxiety Scale, the MDMA group experienced a significantly greater improvement in social anxiety scores compared with the placebo group. Improvements persisted at six-month follow-up. The researchers said of the follow-up, "social anxiety remained the same or continued to improve slightly for most participants in the MDMA group after completing the active treatment phase" [100].

Social anxiety disorder is relatively common among the general population; about 12% suffer from this disorder at some point in their lives [101]. If it is determined to be an effective treatment, MDMA-assisted psychotherapy could be an option for these patients who have not responded to traditional psychotherapy or pharmacotherapy.

ANOREXIA NERVOSA

Anorexia nervosa is a severe eating disorder characterized by restriction of energy intake relative to an individual's requirements, typically resulting in low body weight and malnutrition. It is notoriously difficult to treat and has a high mortality rate. Experts have continued to search for more effective treatment options for this population.

In one study, the authors treated 15 patients (23 to 42 years of age) with treatment-resistant anorexia nervosa with infusions of 20 mg/hour of ketamine over 10 hours. The subjects were also given 20 mg twice per day of nalmefene. The subjects showed a marked decreased in scores on compulsion. Before the ketamine was administered, the average scores were 44.0; after treatment, mean compulsion scores dropped to 27.0. Nine of the subjects (60%) showed remission after two to nine ketamine infusions over the course of five days to three weeks [102]. The authors reported the following details on three specific patients [102]:

> Patient 4 increased her weight after three treatments but agreed to more in the hope that her compulsion score would come down further. After a year in follow-up with a normal weight, she then started work and remained in a stable state while followed-up for nine months.
>
> Patient 5 was a married woman and reached a normal weight after five treatments. As an outpatient, her periods returned and she had a successful pregnancy. Patient 6 had a long history of alternating anorexia and bulimia. After four treatments and despite only a small fall in compulsion score, she became able to control her eating and her weight. She held a responsible job with no relapse during two years of follow-up.

In a 2020 study with only one subject, the researchers treated a patient, 29 years of age, who had developed anorexia nervosa at 14.5 years of age and had been unable to attain remission. The researchers prescribed a ketogenic diet along with intravenous ketamine infusions. (A ketogenic diet was chosen because it had proven in the past to prevent starvation, a real risk with anorexia.) The patient sustained complete recovery and continued her ketogenic diet while maintaining a normal weight [103]. After three months, the woman remained on the ketogenic diet and reported feeling significantly better but still suffered from anorexic compulsions. At that time, she was sent for ketamine infusions. The patient reported that within one hour of her first infusion the "anorexic voice" inside her was decreasing and she felt more like herself. The patient had three more infusions over the next 14 days. After the fourth infusion, the patient stated [103]:

> I know this sounds ridiculous, but I am no longer anorexic. I had so many rules I didn't even know them. But they are gone. I can exercise because it feels good. It isn't that I have to. I can stop when I want to.

Because this study had two potentially essential factors (ketamine and the ketogenic diet), it is unclear if either or both are responsible for the single patient's improvements. As is the case for many of these novel treatments, additional research is warranted.

CLUSTER HEADACHES

Cluster headaches, which affect less than 1% of adults, are considered to be the most painful of all headaches and can last for a week or longer, potentially becoming a chronic health issue [104]. Traditional treatment approaches include triptan medications and oxygen therapy. Understandably, most sufferers seek quick relief and would prefer to never experience another attack.

In one report, the authors interviewed 53 people with cluster headaches who had self-medicated with psilocybin or LSD. (This is not recommended or considered safe.) Of 26 patients who used psilocybin, 22 said the drug successfully aborted their headache attacks. Of five people who said they used LSD to treat their headaches, four reported experiencing remission [105]. Based on these findings, the authors recommend further study of psychedelics as a possible treatment for cluster headaches. It is important to remember that self-reports are no basis for concluding that psilocybin or LSD is effective at improving a cluster headache condition. There is a current clinical trial underway examining the role of LSD as a possible treatment for cluster headaches [106].

In another study of 77 patients with treatment-resistant migraines or new daily headaches, all of whom had failed aggressive outpatient and inpatient treatment, patients were infused with ketamine. According to the researchers, the mean headache pain rating at the start of the study was 7.1; this fell to 3.8 upon discharge. Most of the patients responded well to the ketamine. Researchers concluded [107]:

> Pending higher level evidence and given that ketamine is generally well-tolerated, ketamine may be considered a reasonable acute treatment for well-selected headache patients for whom standard therapies are either ineffective or medically contraindicated.

OTHER DISORDERS

Some psychiatric disorders, particularly those with psychotic features such as schizophrenia, schizophreniform disorder, brief psychotic disorder, schizoaffective disorder, and delusional disorder, should certainly not be treated with psychedelic drugs. It is unclear if other psychiatric conditions would be amenable to psychedelic treatment. This can only be determined by clinical trials that administer these drugs under scientific rigor and with a sufficiently high number of patients. Many of the studies published to date have included very small numbers of patients, though this is largely because of necessity. It may have been that few individuals with the disorder could be recruited into a trial consisting of experimental treatment with a psychedelic drug. As the knowledge base grows based on clinical trials, it is hoped that it will become increasingly more feasible to test psychedelics on patients with a multitude of psychiatric disorders, particularly for those individuals whose conditions have been challenging to treat.

INTERVENTIONAL PSYCHIATRY: BRAIN STIMULATION THERAPIES

Electroconvulsive therapy has been in use for nearly a century and continues to be used in psychiatric treatment today. Newer forms of brain stimulation are increasing popular options for patients—or likely will be soon at major medical centers, including rTMS, VNS, and DBS. New brain mapping techniques may help eliminate the need for more invasive procedures. Interventional psychiatry represents an opportunity to help patients who otherwise have found no relief from pharmacotherapy and standard treatments [108].

For health professionals interested in the latest techniques on neuromodulation to aid patients with refractory psychiatric disorders, interventional psychiatry may be the answer. In order for physicians to effectively enter this field, experts recommend an additional year of training with an emphasis on interventional psychiatry.

ELECTROCONVULSIVE THERAPY

ECT has been used to treat depression, bipolar disorder, schizophrenia, and other psychiatric diagnoses for many years, starting in the first half of the 20th century. The goal of ECT is to induce a seizure through applied electric shocks. The procedure was initially introduced in the late 1930s in Italy, and in the 1940s through the 1960s, ECT became popular in the United States as a mainstream treatment [109]. However, early treatments did not provide anesthesia and sometimes led to physical and psychological trauma [110]. Physicians later learned that significantly milder shocks could achieve the same goals.

Today, the procedure is used rarely for treatment-resistant depression and major depression with suicidal ideation or behaviors, as well as for schizophrenia and schizoaffective disorder. A team of professionals are involved, including a psychiatrist, a neurologist, an anesthesiologist, and a nurse [110]. Some believe that ECT should be used before psychedelics or newer brain intervention therapies are attempted, although agreement on this subject is not universal. It should also be noted that there is some residual fear/concern of ECT itself that persists among many patients (and some healthcare professionals), largely because ECT was historically traumatic. However, ECT has proven highly effective at treating both major depressive disorder and suicidal depression. About 100,000 patients receive ECT each year, and most of them are residents in psychiatric hospitals or psychiatric units of hospitals [111].

The National Institute for Health and Care Excellence recommends clinicians consider electroconvulsive therapy (ECT) for the treatment of severe depression if the person chooses ECT in preference to other treatments based on their past experience of ECT and what has previously worked for them OR a rapid response is needed (e.g., if the depression is life-threatening) OR other treatments have been unsuccessful.

(https://www.nice.org.uk/guidance/ng222. Last accessed July 8, 2022.)

Level of Evidence: Expert Opinion/Consensus Statement

The modern use of ECT consists of [112]:

> induction of brief general anesthesia (typically lasting less than 10 minutes), pharmacologic muscle relaxation, and continuous monitoring of oxygen saturation, blood pressure, and heart rate, and rhythm. An electrical charge is delivered to the brain through scalp electrodes, which results in a generalized seizure typically lasting for 20 to 60 seconds. Most patients receive between 6 and 12 treatments spaced over a period of 2 to 4 weeks as an initial course of treatment.

Patients who receive ECT may have mild-to-moderate cognitive side effects that generally resolve within days or weeks after the course of treatment has ended [112]. Improvement in depressive symptoms is apparent as soon as the third treatment, and remission rates may be as high as 60% among patients with treatment-resistant depression [113].

In a study of 31 patients with major depressive disorder who received ECT treatment, neurocognitive function was assessed with multiple tests, such as the MATRICS Consensus Cognitive Battery, the Everyday Memory Questionnaire, and the MADRS. These instruments were used before ECT, six weeks after ECT, and six months after the procedure. There was a significant decrease in depression scores six weeks and six months after ECT. Patients also exhibited significantly improved neurocognitive abilities six weeks subsequent to the ECT; these improvements were maintained at six months. The researchers concluded that improvements in depression and stability of subjectively reported memory function indicate that the antidepressant effects of ECT do not occur at the expense of cognitive function [114].

A Swedish analysis of 254,906 sessions of ECT conducted with 16,681 individuals between 2012 and 2019 found that fewer than 1% of individuals suffered broken teeth incurred as a result of their treatment. More specifically, the rate was 0.3% per individual, and there were no differences found between patients by age, gender, or diagnosis, although the dental fracture group had a greater number of treatments. Despite the low rate, bite guards and muscle relaxants are recommended to be used as a safety precaution during treatment with ECT [115].

In a 2021 survey of 192 ECT physician practitioners in the United States, 30% of the survey respondents had graduated from one of 12 residency programs in the United States. Several barriers to ECT programs were identified, stigma against ECT on the part of patients and problems with patient transportation, because patients cannot drive themselves home after treatment [116]. With regard to starting a new ECT program, barriers included lack of well-trained ECT practitioners, lack of institutional support or interest in leading the initiative, and insufficient physical space at the facility. The highest concentration of ECT providers were based in New England, and the lowest concentration was in the southern central region of the United States. Overall, the researchers were able to identify a variety of institution-related barriers (e.g., finances, bureaucracy, stigma, lack of understanding) that prevent enthusiastic adoption of this intervention. As a result, although ECT potentially could provide relief to many patients with treatment-resistant depression and other disorders, it may not be an option for many patients who live remotely from centers that offer this service.

In a 2018 study, a MarketScan database of more than 47 million patients was analyzed to determine the incidence of ECT. Of about 1 million patients with a mood disorder, 2,471 (0.25%) had received ECT. Individuals who had received ECT were five times more likely to have additional comorbid psychiatric disorders and twice as likely to have comorbid substance use disorder [117]. Whether ECT should be used more frequently is beyond the scope of this course, but it is important to understand that is can be an effective treatment even though it remains rarely used.

TRANSCRANIAL MAGNETIC STIMULATION (TMS)

TMS, a noninvasive form of neural modulation, was initially developed in the 1980s. Later, it was discovered that repeated sessions of TMS (rTMS) were more effective than a single treatment. In 2008, the FDA approved rTMS to treat major depressive disorder; in 2018, it was approved to treat OCD [118]. Trials are also investigating the efficacy of rTMS in the treatment of substance use disorders with alcohol, opioids, cannabis, tobacco, methamphetamine, and cocaine [119]. The procedure is also used to treat patients with neurologic disorders, including Parkinson disease, multiple sclerosis, and stroke [120].

An increasingly popular procedure in the United States and other Western countries, rTMS is available at major medical centers throughout the country. This procedure uses large magnets to stimulate the neurons in the prefrontal cortex of the brain. An electromagnetic coil is placed on the patient's forehead at the site of the left prefrontal cortex, an area of the brain that often displays reduced activity in persons with severe and refractory depression. Nonpainful electromagnetic pulses pass through the skin and to the brain. There is no anesthesia needed or given with this procedure, and the only potential adverse effects are headache and minor discomfort in the scalp.

In a U.S. study involving 247 adults with severe treatment-resistant depression, the efficacy of rTMS in improving psychiatric symptoms was evaluated. The average age of the subjects was 43 years, and the average Patient Health Questionnaire-9 score was 21.7. The subjects received single 37-minute sessions over six weeks, up to a maximum of 30 total sessions [121]. Following rTMS therapy, there was a remission rate of 72% after three weeks, with no differences in response by sex of the subject, but age was a factor, with older individuals taking a longer time to achieve remission of their depression. In addition, remission correlated with past suicide attempts, previous

psychiatric hospitalizations, and substance use disorder, illustrating that the procedure was highly effective for individuals with severe and/or comorbid disease. In this study, there was a higher efficacy with the MagVenture device compared with the NeuroStar device.

A Dutch study randomized 14 patients with alcohol use disorder to 10 days of rTMS therapy and 16 patients to sham rTMS. The patients were subsequently evaluated for alcohol craving and alcohol use. For a period of time, subjects in the rTMS treatment group reported lower levels of alcohol craving and use than those in the control group. Differences in alcohol craving in the study group were most prevalent 3 months after treatment; at the 12-month point, there were no differences between the two groups, indicating the beneficial effects of rTMS may fade over time [122].

Because rTMS is a safe and effective FDA-approved treatment for depression, some experts have recommended turning the treatment algorithm for depression upside down, putting TMS in a first-choice position. Rather than requiring patients to undergo months of potentially ineffective antidepressant trials, starting with TMS (with an artificial intelligence component to ensure the right dose and optimal targeting) may be a better option [123]. Additional studies are underway to examine TMS and expand evidence-based access to this treatment [123].

Another form of TMS, Stanford accelerated intelligent neuromodulation therapy (also known as Stanford neuromodulation therapy or SAINT), has been associated with an extremely high success rate in patients with treatment-resistant depression. In a 2022 study, nearly 80% of 29 subjects who had been depressed for a mean period of nine years experienced remission in just four weeks. This is a much quicker response time than traditional antidepressant therapy. The difference between SAINT and other TMS procedures lay with a greater number of treatments for a shorter time frame, such as 10-minute sessions 10 times per day. These treatments are also more targeted to the patient's brain circuitry [124].

VAGUS NERVE STIMULATION

VNS is an invasive form of neuromodulation consisting of implantation of a device that sends electrical pulses to the vagus nerve of the brain. The vagus nerve (also referred to as cranial nerve X) is very long and extends from the brain into the neck, chest, and abdomen. This nerve has many effects and impacts such diverse functions as mood, digestion, blood pressure, heart rate, immune function, saliva production, and taste [125].

The first VNS event occurred in the 1880s in New York, when James Corning applied an electrical current to a carotid compression fork, believing this approach would prevent or end seizures [126]. The procedure has evolved drastically to become the sophisticated procedure used today.

In 2005, the FDA approved VNS for the management of treatment-resistant depression [127]. Since then, a transcutaneous form of VNS has been developed, eliminating the need for surgery. However, this approach was not approved by the FDA as of 2022.

Some researchers have noted that cognitive dysfunction may accompany depression and be a factor in the associated reduced work productivity. A Canadian study analyzed the cognitive performance of individuals with treatment-resistant depression subsequent to their treatment with VNS. In 14 subjects, both the learning capabilities and memory of the subjects improved significantly after one month of receiving VNS. These cognitive improvements persisted for years subsequent to treatment with VNS. After VNS, 29% of the subjects experienced remission from treatment-resistant depression after 1 month, 50% after 3 months, 57% at 12 months, and 64% at 24 months. As such, at the end of the study, nearly two-thirds of patients had recovered with VNS therapy [128]. The researchers stated [128]:

> Improvements were observed in measures of psychomotor speed, verbal fluency, attention, and executive functioning, as well as verbal and visual memory. We observed clear differences in improvement rate between cognitive measure. Memory measures, such as recall of a complex figure, as well as learning and recall of a word list, show more than 25% improvement after two months of treatment.

DEEP BRAIN STIMULATION THERAPIES

An invasive form of therapy that is used infrequently, DBS has proven effective at treating severe depression and OCD. DBS is also approved to treat some patients with severe, refractory neurologic disorders, such as epilepsy and Parkinson disease. DBS is also under investigation for the treatment of schizophrenia, Alzheimer disease, substance use disorder, and other challenging psychiatric disorders [129].

The first documented use of DBS occurred in 1948, when neurosurgeon J. Lawrence Pool implanted an electrode into the brain of a women with anorexia and depression. Results were initially positive, until the wire broke several weeks later [130]. Today, DBS involves the permanent implantation of electrodes that send regular and continuous electrical impulses to stimulate a specific part of the brain. Some describe DBS as a sort of brain pacemaker to correct imbalances, comparable to a heart pacemaker that corrects cardiac abnormalities. It should be noted that DBS is an invasive and expensive procedure that is only available to very few individuals, and it is not approved for the treatment of depression by the FDA as of 2022.

The electrodes used in DBS are made of platinum-iridium wires and nickel alloy connectors, which are enclosed in a polyurethane sheath [129]. Some patients may worry about the potential for hacking into a DBS system in today's connected world and the possibility of control over individuals, referred to as "brainjacking." This does not appear to be a problem at this time of very limited use of DBS, but it is a subject worthy of consideration in the future.

In a nationwide database of 116,890 hospitalized patients in the United States with major depressive disorder, patients receiving DBS represented 0.03% [131]. The average age of participants was 49.1 years; all were White, and 88% were female. Patients stayed in the hospital for 1 to 1.6 days. The highest rate of DBS use occurred in the southern United States, followed by the northeast and west. Patients receiving DBS either had private insurance or they were self-pay patients [131].

In a study of five patients with severe OCD who received DBS over the period 2015–2019, not only did the patients experience improvement in their OCD symptoms after DBS, but they also experienced a 53% improvement in their levels of depression (on the MADRS scale) and a 34.9% improvement on the Hamilton Anxiety Rating scales. In addition, patients also improved on the Quality of Life Enjoyment and Satisfaction Questionnaire [132]. The researchers reported anecdotal evidence of improvement as well, such as this report from one of the five patients [132]:

> Despite persistent low body mass index [BMI] of 14, she has remained out of the hospital for 29 months, the longest time period since onset of OCD and anorexia. She is working part-time as a research assistant, is active in her church, and though she wishes for further reduction in symptoms, she notes her quality of life and mood is better than prior to DBS. In addition, she no longer engages in self-injurious behaviors and no longer experiences suicidal ideation.

In another study, DBS was used to treat seven patients with treatment-resistant depression [133]. Researchers specifically targeted the bilateral habenula, which is the seat of the anti-reward system [133]. After one month, depression and anxiety symptoms had decreased by 49%, and the patients reported a dramatic improvement in their quality of life.

In a one-person study of an individual treated with DBS for treatment-resistant depression, the patient experienced continuous improvement until depressive symptoms remitted by the 22nd week. At 37 weeks, the subject was randomized to continuous treatment or discontinuation. When treatment was stopped, the patient reported increasingly worse depression and anxiety until he met rescue criteria, resulting in the resumption of treatment. The depression symptoms rapidly abated when treatment restarted [134].

CAUTIONS

Although the news about both psychedelics and brain stimulation techniques is generally positive, caution is important, particularly in the case of psychedelic drugs. Patients should be actively discouraged from trying psychedelic drugs on their own, because these drugs can trigger an underlying psychosis in individuals who would otherwise likely have remained healthy, particularly because dosage and purity of the illicit drug is unpredictable. In addition, FDA-approval processes, regulated pharmaceutical drugs rather than street drugs, and comparable efficacy can help identify the safest and most effective medication or interventional treatment for a particular patient at a particular time. In essence, buying MDMA and taking it is not the same as being administered MDMA in a PTSD clinical trial at a research institution. Today, adulteration of street drugs is of great concern, particularly with potentially lethal doses of fentanyl [135].

Patients have no idea what dosage is in a street drug and could take a suboptimal dose (to no effect) or take an excessively high dose of the drug, which could cause inadvertent harm. Importantly, patients under the influence of such drugs require supervision, lest they take actions that might be potentially dangerous to themselves or others.

For patients considered for psychedelic or interventional psychiatric options who are not proficient in English, it is important that information regarding the risks associated with the use of psychedelics and/or interventional procedures and available resources be provided in their native language, if possible. When there is an obvious disconnect in the communication process between the practitioner and patient due to the patient's lack of proficiency in the English language, an interpreter is required. Interpreters can be a valuable resource to help bridge the communication and cultural gap between patients and practitioners. Interpreters are more than passive agents who translate and transmit information back and forth from party to party. When they are enlisted and treated as part of the interdisciplinary clinical team, they serve as cultural brokers who ultimately enhance the clinical encounter. In any case in which information regarding treatment options and medication/treatment measures are being provided, the use of an interpreter should be considered. Print materials are also available in many languages, and these should be offered whenever necessary.

CONCLUSION

It is apparent that psychedelic medicine is now in a renaissance period, and this time could not have come too soon. Many people in the United States and around the world suffer from severe psychiatric disorders, including depression, PTSD, substance use disorders, anxiety disorders, OCD, anorexia nervosa, and multiple other psychiatric disorders that are not readily responsive to treatment with pharmacotherapy and/or psychotherapy [136]. In the aftermath of the COVID-19 pandemic, depressive disorders are more prevalent, and people are urgently and actively seeking effective treatments. Exploration of novel interventional and psychedelic therapies may be a path to recovery for patients with mental health disorders who have not improved on traditional approaches [137].

FACULTY BIOGRAPHY

Mark S. Gold, MD, DFASAM, DLFAPA, is a teacher of the year, translational researcher, author, mentor, and inventor best known for his work on the brain systems underlying the effects of opiate drugs, cocaine, and food. Dr. Gold was a Professor, Eminent Scholar, Distinguished Professor, Distinguished Alumni Professor, Chairman, and Emeritus Eminent Scholar during his 25 years at the University of Florida. He was a Founding Director of the McKnight Brain Institute and a pioneering neuroscience-addiction researcher funded by the NIH-NIDA-Pharma, whose work helped to de-stigmatize addictions and mainstream addiction education and treatment. He also developed and taught courses and training programs at the University of Florida for undergraduates and medical students. He continues on the Faculty of the University of Florida, Tulane, and Washington University in St Louis.

He is an author and inventor who has published more than 1,000 peer-reviewed scientific articles, 20 text books, popular-general audience books, and physician practice guidelines. Dr. Gold was co-inventor of the use of clonidine in opioid withdrawal and the dopamine hypothesis for cocaine addiction and anhedonia. Both revolutionized how neuroscientists and physicians thought about drugs of abuse, addiction, and the brain. He pioneered the use of clonidine and lofexidine, which became the first non-opioid medication-assisted therapies. His first academic appointment was at Yale University School of Medicine in 1978. Working with Dr. Herb Kleber, he advanced his noradrenergic hyperactivity theory of opioid withdrawal and the use of clonidine and lofexidine to ameliorate these signs and symptoms. During this time, Dr. Gold and Dr. Kleber also worked on rapid detoxification with naloxone and induction on to naltrexone.

Dr. Gold has been awarded many state and national awards for research and service over his long career. He has been awarded major national awards for his neuroscience research including the annual Foundations Fund Prize for the most important research in Psychiatry, the DEA 30 Years of Service Pin (2014), the American Foundation for Addiction Research's Lifetime Achievement Award (2014), the McGovern Award for Lifetime Achievement (2015) for the most important contributions to the understanding and treatment of addiction, the National Leadership Award (NAATP) from addiction treatment providers for helping understand that addiction is a disease of the brain, the DARE Lifetime Achievement Award for volunteer and prevention efforts, the Silver Anvil from the PR Society of America for anti-drug prevention ads, the PRIDE and DARE awards for his career in research and prevention (2015), and the PATH Foundation's Lifetime Achievement Award (2016) as one of the "fathers" of addiction medicine and MAT presented to him by President Obama's White House Drug Czar Michael Botticelli. He was awarded Distinguished Alumni Awards at Yale University, the University of Florida, and Washington University and the Wall of Fame at the University of Florida College of Medicine. Gold was appointed by the University President to two terms as the University's overall Distinguished Professor, allowing him to mentor students and faculty from every college and institute. The University of Florida College of Medicine's White Coat Ceremony for new medical students is named in his honor.

Since his retirement as a full-time academic in 2014, Dr. Gold has continued his teaching, mentoring, research, and writing as an Adjunct Professor in the Department of Psychiatry at Washington University and an active member of the Clinical Council at the Washington University School of Medicine's Public Health Institute. He regularly lectures at medical schools and grand rounds around the country and at international and national scientific meetings on his career and on bench-to-bedside science in eating disorders, psychiatry, obesity, and addictions. He continues on the Faculty at the University of Florida College of Medicine, Department of Psychiatry as an Emeritus Distinguished Professor. He has traveled extensively to help many states develop prevention, education, and treatment approaches to the opioid crisis.

Customer Information/Answer Sheet/Evaluation insert located between pages 64–65.

TEST QUESTIONS
#96790 PSYCHEDELIC MEDICINE AND INTERVENTIONAL PSYCHIATRY

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 10 Hour/3 NBCC Clock Hour activity must be completed by June 30, 2025.

1. Which of the following is a category of psychedelic drugs?
- A) *Classic*
- B) *Natural*
- C) *Prescription*
- D) *Hallucinogenic*

2. In the United States, suicide is the
- A) *leading cause of death.*
- B) *fifth leading cause of death.*
- C) *tenth leading cause of death.*
- D) *fifteenth leading cause of death.*

3. By 2027, Data Bridge Market Research has estimated that the market for psychedelic drugs will
- A) *remain stable.*
- B) *decrease by half.*
- C) *more than triple.*
- D) *depend on the rate of treatment-resistant depression.*

4. Psilocybin has been legalized for consumer use in
- A) *Oregon.*
- B) *California.*
- C) *New York.*
- D) *New Mexico.*

5. Deep brain stimulation consists of
- A) *invasive stimulation of the vagus nerve.*
- B) *stimulation of the brain causing a seizure.*
- C) *stimulation of the brain with the use of implanted electrodes.*
- D) *use of large magnets external to the patient to stimulate the brain.*

6. A hallucinogen is
- A) *an illicit drug of abuse in all cases.*
- B) *any substance that allows for intensified experiences.*
- C) *a drug that is used to facilitate guided imagery exercises.*
- D) *any drug that may cause the user to experience visual, auditory, or other types of hallucinations.*

7. In the context of psychedelic medicine, set refers to
- A) *the patient's mindset.*
- B) *the process of providing effective therapy.*
- C) *the environment in which therapy is provided.*
- D) *the manual of best practices established for therapy.*

8. Ketamine is considered a
- A) *Schedule I drug.*
- B) *Schedule II drug.*
- C) *Schedule III drug.*
- D) *non-scheduled drug.*

9. Which of the following statements regarding hallucinogen and other illicit drug use is TRUE?
- A) *Past use of any psychedelic drug is associated with a lower risk of opioid use disorder.*
- B) *History of cocaine or opioid misuse and abuse is a common precursor to hallucinogen use.*
- C) *A history of psychedelic use, particularly psilocybin, increases the risk of escalation to harder drug use.*
- D) *Individuals who used psilocybin in the past have a significantly lower rate of opioid misuse and abuse later.*

10. LSD was first synthesized by
- A) *the Aztecs.*
- B) *Timothy Leary.*
- C) *Howard Lotsof.*
- D) *Albert Hofmann.*

11. In the 1940s, LSD was marketed under the brand name Delysid for the treatment of
- A) *neurosis.*
- B) *alcoholism.*
- C) *schizophrenia.*
- D) *All of the above*

12. Patients who receive psychedelic therapy experience better outcomes if the therapy is administered in settings in which
- A) *they feel safe.*
- B) *they are completely alone.*
- C) *everything is new or unfamiliar.*
- D) *hallucinogenic effects are promoted by loud music and flashing colors.*

13. Which of the following is an aspect of psychedelic medicine setting that can enhance set?
- A) *Music*
- B) *Lighting*
- C) *Presence of a supportive healthcare professional*
- D) *All of the above*

14. Psilocybin naturally occurs in
- A) *mushrooms.*
- B) *toad venom.*
- C) *the bark of certain trees.*
- D) *the fruit of shrubs in southeast Asia.*

15. Which of the following statements regarding psilocybin is FALSE?
- A) *The duration of action is four to six hours.*
- B) *It is active orally at doses of around 10 mg.*
- C) *Time to onset of effect is usually within 20 to 30 minutes of ingestion.*
- D) *It is about 20 times stronger than LSD but much less potent than mescaline.*

16. In studies using psilocybin, which of the following was among the most common adverse reactions?
- A) *Anemia*
- B) *Headache*
- C) *Hypotension*
- D) *Hyperactivity*

17. The antidepressant effect of psilocybin has been found to correspond with
- A) *increased neuroplasticity.*
- B) *increased expression of serotonin.*
- C) *suppression of dopamine overproduction.*
- D) *decreases in fMRI brain network modularity.*

18. Nasal spray esketamine is approved by the FDA for the treatment of
- A) *schizophrenia.*
- B) *cluster headaches.*
- C) *opioid use disorder.*
- D) *treatment-resistant and/or suicidal depression.*

19. Researchers have demonstrated the efficacy of combination psychotherapy and MDMA in the treatment of
- A) *PTSD.*
- B) *depression.*
- C) *end-of-life anxiety.*
- D) *obsessive-compulsive disorder.*

20. Which of the following statements regarding ibogaine is TRUE?
- A) *It is a derivative of phencyclidine (PCP).*
- B) *It is FDA-approved for the treatment of opioid use disorder.*
- C) *Its metabolism is purportedly mediated by the p450 cytochrome enzyme CY2D6.*
- D) *It is easiest to obtain in the United States, and travel from other countries to obtain treatment is common.*

21. Which of the following statements regarding kratom products in the United States is TRUE?
- A) *All kratom products are considered Schedule I drugs.*
- B) *The products are typically freeze-dried leaves, concentrated extracts, or liquid "energy shots."*
- C) *Products marketed in the United States have been tested for purity and uniform concentration.*
- D) *While kratom products are available locally in smoke and "head" shops, they cannot be legally purchased over the Internet.*

Test questions continue on next page ➔

22. Mescaline toxicity can result in
- A) *bradycardia.*
- B) *hypotension.*
- C) *hypothermia.*
- D) *respiratory depression.*

23. Nitrous oxide has been demonstrated to improve the condition of individuals with
- A) *PTSD.*
- B) *psychosis.*
- C) *treatment-resistant depression.*
- D) *attention deficit Hyperactivity disorder.*

24. The most common adverse effect of ayahuasca is
- A) *flashbacks.*
- B) *severe headache.*
- C) *nausea and vomiting.*
- D) *respiratory depression.*

25. The recommended initial dose of nasal spray esketamine for adults with treatment-resistant depression is
- A) *5 mg.*
- B) *56 mg.*
- C) *150 mg.*
- D) *500 mg.*

26. Research indicates that a modest dose of psilocybin given to patients with terminal cancer under the supervision of trained therapists can improve
- A) *prognosis.*
- B) *life expectancy.*
- C) *mood and quality of life.*
- D) *tumor size and associated pain.*

27. Which of the following psychedelics has been studied for the treatment of social anxiety in persons with autism?
- A) *MDMA*
- B) *Ibogaine*
- C) *Mescaline*
- D) *Psilocybin*

28. The goal of electroconvulsive therapy (ECT) is to
- A) *stimulate the prefrontal cortex.*
- B) *provide a competing traumatic experience.*
- C) *induce a seizure through applied electric shocks.*
- D) *induce the creation of new dendrites in the brain.*

29. Which of the following statements regarding transcranial magnetic stimulation (TMS) is TRUE?
- A) *Anesthesia is required and is given with this procedure.*
- B) *This procedure uses large magnets to stimulate the neurons in the amygdala.*
- C) *The only potential side effects of TMS are headache and minor discomfort in the scalp.*
- D) *TMS consists of painful electromagnetic pulses that pass through the skin and to the brain.*

30. Deep brain stimulation
- A) *is dangerous and potentially painful.*
- B) *is the subject of intense research for the treatment of eating disorders.*
- C) *has been proven effective in amelioration of severe depression in large randomized controlled trials.*
- D) *involves the permanent implantation of electrodes that send regular and continuous electrical impulses to stimulate a specific part of the brain.*

Be sure to transfer your answers to the Answer Sheet located between pages 64–65.
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 64–65.
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 starting at only $85!** Additional titles are also available.
www.NetCE.com

THE BISEXUAL CLIENT: TRAUMA-FOCUSED CARE
#71501 • 5 APA/NAADAC Hours, 2.5 NBCC Hours

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to provide members of the interdisciplinary healthcare team with the knowledge and resources necessary to improve the care provided to bisexual or sexually fluid individuals.
Faculty: Jamie Marich, PhD, LPCC-S, REAT, RYT-500, RMT
Audience: This course is designed for behavioral and mental health professionals of any kind who work with clients on a regular basis or who teach/supervise those working with clients who identify as bisexual or non-binary.

PROMOTING THE HEALTH OF GENDER AND SEXUAL MINORITIES
#71793 • 5 APA/NAADAC Hours, 2.5 NBCC Hours

LGBTQ & Cultural Competency

Book By Mail – $38 • ONLINE – $30

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.

PROVIDING CULTURALLY RESPONSIVE CARE TO ASIAN IMMIGRANTS
#71943 • 10 APA/NAADAC Hours, 7 NBCC Hours

Book By Mail – $68 • ONLINE – $60

Purpose: The purpose of this course is to expand the level of awareness and knowledge base of practitioners in providing culturally relevant, sensitive, and responsive mental health and health services to immigrant populations, specifically Asian immigrants in the United States.
Faculty: Alice Yick Flanagan, PhD, MSW
Audience: This course is designed for social workers, therapists, mental health counselors, and other members of the interdisciplinary team who work with immigrants, particularly Asian immigrants.
Special Approval: This course meets the requirement for cultural competency education.

BORDERLINE PERSONALITY DISORDER
#76222 • 15 APA/NAADAC Hours, 6 NBCC Hours

Book By Mail – $98 • ONLINE – $90

Purpose: The purpose of this course is to provide behavioral and mental health professionals with the information necessary to assess and treat patients with borderline personality disorder effectively and safely, while minimizing their own stress level and clinic disruption these patients are capable of producing.
Faculty: Mark Rose, BS, MA, LP
Audience: This course is designed for counselors, therapists, social workers, and other mental health professionals who are involved in the care of patients with borderline personality disorder.

SUICIDE ASSESSMENT AND PREVENTION
#76442 • 6 APA/NAADAC Hours, 2.5 NBCC Hours

Book By Mail – $44 • ONLINE – $36

Suicide

Purpose: The purpose of this course is to provide behavioral and mental health professionals with an appreciation of the impact of depression and suicide on patient health as well as the skills necessary to identify and intervene for patients at risk for suicide.
Faculty: Mark Rose, BS, MA
Audience: This course is designed for social workers, therapists, counselors, and other professionals who may identify persons at risk for suicide and intervene to prevent or manage suicidality.
Special Approval: This course is designed to meet requirements for suicide assessment and prevention education. This course is approved by the State of Washington Department of Health to fulfill the requirement for Suicide Prevention training for healthcare professionals. Approval number TRNG.TG.60715375-SUIC. This course meets the Nevada requirement for 2 hours of suicide education.

ANXIETY DISORDERS IN OLDER ADULTS
#76690 • 3 APA/NAADAC Hours, 1 NBCC Hour

Book By Mail – $26 • ONLINE – $18

Purpose: Older adults are the fastest growing demographic in the world, and anxiety disorders are the most common mental disorder in this age group. The purpose of this course is to provide clinicians with the knowledge and skills necessary in order to improve the assessment and treatment of anxiety disorders in older adults.
Faculty: Beyon Miloyan, PhD
Audience: This course is designed for the benefit of a broad range of allied health professionals, including but not limited to counselors, therapists, and social workers.

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

Course Availability List *(Cont'd)*

CLINICAL SUPERVISION: A PERSON-CENTERED APPROACH

Supervision

#76863 • 10 ASWB Hours, 1.5 NBCC Hours

Book By Mail – $68 • ONLINE – $60

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

MA Mandate

#76920 • 5 APA/NAADAC Hours, 1.5 NBCC Hours

Book By Mail – $38 • ONLINE – $30

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.
Special Approval: This course meets the Massachusetts requirement for 2 hours of anti-racism and 1 hour of anti-discrimination education.

PROVIDING CARE TO ALASKA NATIVES

AK Mandate

#77090 • 3 ASWB/NAADAC Hours, 1 NBCC Hour

Book By Mail – $26 • ONLINE – $18

Purpose: The purpose of this course is to provide mental and behavioral health professionals with the information necessary to provide the best possible care to Alaska Natives.
Faculty: Lauren E. Evans, MSW
Audience: This course is designed for social workers, therapists, and counselors who may provide care to Alaska Natives.
Special Approval: This course meets the Alaska requirement for 3 hours of cross-cultural education activity relating to Alaskan Natives.

ASSESSMENT AND MANAGEMENT OF PAIN AT THE END OF LIFE

Pain Mgmt/ Opioids

#77143 • 2 ASWB/NAADAC Hours

Book By Mail – $23 • ONLINE – $15

Purpose: The purpose of this course is to provide an overview of the assessment and management of pain in the end of life, focusing on the components integral to providing optimum care.
Faculty: Lori L. Alexander, MTPW, ELS, MWC
Audience: This course is designed for social workers, counselors, and other members of the healthcare team seeking to enhance their knowledge of pain management.
Special Approval: This course meets the District of Columbia and Michigan requirements for pain management education.

ALZHEIMER DISEASE

#96154 • 15 APA Hours, 7.5 NBCC Hours

Book By Mail – $98 • ONLINE – $90

Purpose: In order to increase and maintain a reasonable quality of life for patients with Alzheimer disease throughout the course of the disease, caregivers must have a thorough knowledge and understanding of the disease. The purpose of this course is to provide clinicians with the skills to care for patients with Alzheimer disease in any setting as part of the interdisciplinary team.
Faculty: Joan Needham, MSEd, RNC
Audience: This course is designed for clinicians who come in contact with patients with Alzheimer disease in hospitals, long-term care facilities, home health care, and the office.

ATTENTION DEFICIT HYPERACTIVITY DISORDER

#96213 • 5 APA/NAADAC Hours, 2 NBCC Hours

Book By Mail – $38 • ONLINE – $30

Purpose: Attention deficit hyperactivity disorder (ADHD) has a significant effect on day-to-day functioning and quality of life; however, it often goes unrecognized. The purpose of this course is to educate healthcare professionals about the epidemiology, diagnosis, and management of ADHD.
Faculty: John J. Whyte, MD, MPH; Paul Ballas, DO
Audience: This course is designed for all physicians, nurses, and social work/counseling groups involved in the care of patients with attention deficit hyperactivity disorder.

SEXUAL ADDICTION

#96274 • 5 ASWB/NAADAC Hours, 2.5 NBCC Hours

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to provide healthcare professionals the information necessary to conduct a thorough sexual history and allow a clear and nonjudgmental approach to issues surrounding sexuality and sex addiction.
Faculty: Jamie Marich, PhD, LPCC-S, LICDC-CS, REAT, RYT-500, RMT
Audience: This course is designed for professional clinicians such as counselors, social workers, pastoral counselors, and nurses who would benefit from additional competence on how to assess for sexual addiction and how to make the best referral for care.

HUMAN TRAFFICKING AND EXPLOITATION

MI Mandate

#96313 • 5 APA Hours, 2.5 NBCC Hours

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to increase the level of awareness and knowledge about human trafficking and exploitation so health and mental health professionals can identify and intervene in cases of exploitation.
Faculty: Alice Yick Flanagan, PhD, MSW
Audience: This course is designed for 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.
Special Approval: This course fulfills the Michigan requirement for training in identifying victims of human trafficking.

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

Course Availability List *(Cont'd)*

MENTAL HEALTH ISSUES COMMON TO VETERANS AND THEIR FAMILIES

#96342 • 2 APA/NAADAC Hours, 1 NBCC Hour

CT, WV Mandate

Book By Mail – $23 • ONLINE – $15

Purpose: The purpose of this course is to provide health and mental health professionals with an appreciation of the impact of military service on patient health as well as the skills necessary to effectively identify and intervene for these patients.

Faculty: Alice Yick Flanagan, PhD, MSW; Mark Rose, BS, MA, LP

Audience: This course is designed for physicians, nurses, psychologists, social workers, therapists, counselors, and other healthcare professionals who may treat veterans or their family members.

Special Approvals: This course is designed to meet the Connecticut requirement for 2 hours of education on mental health conditions common to veterans and family members of veterans.

This course is designed to meet the West Virginia requirement for 2 hours of education on mental health conditions common to veterans and family members of veterans.

METHAMPHETAMINE USE DISORDER

#96954 • 5 APA/NAADAC Hours, 2 NBCC Hours

Substance Abuse

Book By Mail – $38 • ONLINE – $30

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.

CULTURAL COMPETENCE: AN OVERVIEW

#97430 • 2 APA/NAADAC Hours, 1.5 NBCC Hours

Cultural Competency

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.

Special Approval: This course meets the requirement for cultural competency education.

HUMAN TRAFFICKING AND EXPLOITATION: THE TEXAS REQUIREMENT

#97470 • 5 APA Hours, 2 NBCC Hours

TX Mandate

Book By Mail – $38 • ONLINE – $30

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 Texas physicians, nurses, social workers, pharmacy professionals, therapists, mental health counselors, and other members of the interdisciplinary team who may intervene in suspected cases of human trafficking and/or exploitation.

Special Approval: This course has been approved by the Texas Health and Human Services Commission (HHSC) to meet the requirements for human trafficking training.

COMMONLY ABUSED SUPPLEMENTS

#98020 • 2 APA Hours, .5 NBCC Hours

NEW!

Book By Mail – $23 • ONLINE – $15

Purpose: The purpose of this course is to provide healthcare professionals in all practice settings the knowledge necessary to increase their understanding of the commonly abused supplements and their adverse effects.

Faculty: Chelsey McIntyre, PharmD

Audience: This course is designed for healthcare professionals whose patients are taking or are interested in taking dietary supplements.

HERBAL MEDICATIONS: AN EVIDENCE BASED REVIEW

#98394 • 10 APA/ASWB Hours

UPDATE

Book By Mail – $68 • ONLINE – $60

Purpose: Considering the pharmacological interactions between herbal medications (HMs) and conventional medications, it is paramount to increase the awareness and knowledge of healthcare professionals about HMs. The purpose of this course is to increase healthcare professionals' awareness of the potential risks and benefits of HMs from an evidence-based perspective and promote the planned inclusion of HM use in patients' medical history. This course should allow healthcare professionals to discuss HMs in a knowledgeable and succinct manner with patients and colleagues.

Faculty: A. José Lança, MD, PhD

Audience: This course is primarily designed for physicians, pharmacists, and nurses. However, considering the widespread availability and increased use of herbal medications, other healthcare professionals, including social workers and clinical therapists, will also benefit from this course.

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

Counselor and Therapist Continuing Education Requirements by State

State	COUNSELOR	THERAPIST
	Approval Accepted/Hours by Home Study	Approval Accepted/Hours by Home Study
Alabama	APA, NBCC/10✶	NBCC/20✶, ♦
Alaska	APA, NBCC, ASWB, NAADAC/20✶	Accepted by Board/22✶, ❖, ♦
Arizona	APA, NBCC, ASWB, NAADAC/30✶, ❖, ♦	APA, NBCC, ASWB, NAADAC/30✶, ❖, ♦
Arkansas	APA, NBCC/24✶	APA, NBCC/24✶
California	APA, NBCC, ASWB/36✶, ♦	APA, NBCC, ASWB/36✶, ♦
Colorado	Accepted by Board/20 Coursework, 20 Independent learning♦	Accepted by Board/20 Coursework, 20 Independent learning♦
Connecticut	APA, NBCC, ASWB/15❖, ♦; LADC, CADC 20❖	APA, NBCC, ASWB/15❖, ♦
Delaware	APA, NBCC, ASWB, NAADAC/40	APA, NBCC, ASWB, NAADAC/40
District of Columbia	APA, NBCC, ASWB, NAADAC/40✶, ♦	APA, NBCC/15✶, ♦
Florida	#50-2405/30✶, ♦	#50-2405/30✶, ♦
Georgia	APA, NBCC, ASWB/10✪	APA, NBCC, ASWB/10✪
Hawaii	No CE Required	APA, NBCC/45✶
Idaho	APA, NBCC, ASWB/20✪	APA, NBCC, ASWB/20✪
Illinois	#197.000185/30♦	#168.000190/30♦
Indiana	APA, NBCC, ASWB, NAADAC/40✶	APA, NBCC, ASWB, NAADAC/40✶
Iowa	NBCC/40✶, ♦	NBCC/40✶, ♦
Kansas	Accepted by Board/30✶, ♦	Accepted by Board/40✶, ♦
Kentucky	NBCC/10✶, ♦	Not Approved/15
Louisiana	NBCC/10 in print & 20 online✶, ♦	Not Approved/20
Maine	APA, NBCC/55✶, ♦	APA, NBCC/55✶, ♦
Maryland	NBCC, NAADAC/10♦	NBCC, NAADAC/10♦
Massachusetts	NBCC/LMHC 15♦; LRC May Seek Board Pre-approval	May Seek Board Pre-approval/15
Michigan	No CE Required♦	No CE Required♦
Minnesota	APA, NBCC, ASWB/LPC 10; NBCC/LADC 40✶, ❖, ♦	Not Approved/7.5
Mississippi	NBCC/24✶, ♦	May Seek Board Pre-approval/6✶
Missouri	APA, NBCC, ASWB/40♦	APA, NBCC, ASWB/40♦
Montana	Accepted by Board. Must be scope of practice/20♦	Accepted by Board. Must be scope of practice/20♦
Nebraska	Accepted by Board/20✶, ♦	Accepted by Board/20✶, ♦
Nevada	Accepted by Board/20✶, ♦	Accepted by Board/20✶, ♦
New Hampshire	APA, ASWB, NBCC/20✶, ♦	APA, ASWB, NBCC/20✶, ♦
New Jersey	APA, NBCC, NAADAC, ANA/LPC, LRC 40✶, ❖; LCADC 20❖, ♦; CADC 30❖, ♦	APA, NBCC, NAADAC, ANA/20✶, ❖
New Mexico	APA, NBCC, ASWB, NAADAC40✶, ♦	APA, NBCC, ASWB, NAADAC 40✶, ♦
New York	#MHC-0021/36; 12♦	#MFT-0015/36
North Carolina	NBCC/40; APA, NAADAC/15✶	Accepted by Board/20✶
North Dakota	APA, NBCC/LAPC, LPC, LPCC 15✶	Not Approved/7.5✶
Ohio	NBCC/LPC, LPCC 30✶, ♦	30✶, ♦
Oklahoma	May Seek Board Pre-approval/10♦, ✪	May Seek Board Pre-approval/10♦
Oregon	APA, NBCC/40✶, ❖, ♦	APA, NBCC/40✶, ❖, ♦
Pennsylvania	APA, NBCC, ASWB/30✶, ♦	APA, NBCC, ASWB/30✶, ♦
Rhode Island	APA, NBCC, ASWB, NAADAC/MHC 40; NAADAC/SAC, CADC, CAADC, CCDP, CPS 40✶; NAADAC/CPRS 20✶	APA, NBCC/MFT 40
South Carolina	NBCC, NAADAC/15✶	NBCC, NAADAC/15✶
South Dakota	APA, NBCC/40✶, ♦	APA, NBCC/40✶, ♦
Tennessee	APA, NBCC/5 per year✶, ♦	APA, NBCC/5 per year✶, ♦
Texas	Accepted by Board LPC 24✶,♦; Accepted by Board, NAADAC/LCDC 40✶, ♦	Accepted by Board/30✶; MFTA/15
Utah	Accepted by Board/10✶, ♦	Accepted by Board/15✶, ♦
Vermont	APA, NBCC/28✶	APA, NBCC/10✶
Virginia	APA, NBCC, ASWB, NAADAC/20✶	APA, NBCC, ASWB, NAADAC/20✶
Washington	APA, NBCC, ASWB, NAADAC/MHC 26✶, ♦; CC, CA 12✶, ♦; CDP 40✶, ♦	APA, NBCC, ASWB, NAADAC/26✶, ♦
West Virginia	NBCC/20✶, ♦	Not Approved/15✶, ♦
Wisconsin	APA, NBCC, ASWB, NAADAC/30✶	APA, NBCC, ASWB, NAADAC/30✶
Wyoming	Accepted by Board/45✶, ♦	Accepted by Board/45✶, ♦

✶ Special mandate: Ethics

❖ Special mandate: Cultural Competence

♦ Additional requirements: Please go to www.NetCE.com/credit.php for more information.

✪ Ethics must be live participatory; home study not accepted, or must be preapproved.

Continuing Education (CE) credits for psychologists are provided through the co-sponsorship of the American Psychological Association (APA) Office of Continuing Education in Psychology (CEP). The APA CEP Office maintains responsibility for the content of the programs.

NetCE has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6361. Programs that do not qualify for NBCC credit are clearly identified. NetCE is solely responsible for all aspects of the programs.

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.

Designated courses have been approved by NetCE, as a NAADAC Approved Education Provider, for educational credits, NAADAC Provider #97847. NetCE is responsible for all aspects of their programming. Please refer to individual course details for approval information.

Why does NBCC award fewer hours than APA and NAADAC? NBCC requires 6,000 words per hour, while APA and NAADAC accept other methods to determine hours, such as pilot testing and reading level.

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(Incomplete information may delay processing.)

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(800) 232-4238

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help@NetCE.com

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Last Name _____ First Name _____ MI _____

State _____ License # _____ Exp. _____

State _____ Additional License # _____ Exp. _____

License Type (circle one): CPC / LCDC / LCPC / LPC / LPCC / CADC / MHC / MHP / RC / SAC / LMFT / MFT / MFTA / Other:

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Receive certificate(s) by:
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Complete before April 30, 2024, pay $63

Complete after April 30, 2024, pay $74

ENCLOSED SPECIAL OFFER: 26 HOURS (13 NBCC CLOCK HOURS)

Complete all four courses or any combination of these four courses for a maximum payment of $63 (or pay the individual course price).

✓	Course #	Course Title / Hours (NBCC Clock Hours)	Price
	77770	Counseling Patients at the End of Life / 5 Hours (2 NBCC Clock Hours)	$30
	76823	Incorporating Musical Strategies into Clinical Practice / 5 Hours (2 NBCC Clock Hours)	$30
	77723	Ethics for Counselors / 6 Clock Hours (6 NBCC Clock Hours)	$36
	96790	Psychedelic Medicine and Interventional Psychiatry / 10 Hours (3 NBCC Clock Hours)	$60

Additional Courses Available by Mail (ACCESS ONLINE FOR A DISCOUNT!)

Payment must accompany this form. To order by phone, please have your credit card ready.

✓	Course #	Course Title / Hours*	Price	✓	Course #	Course Title / Hours*	Price
☐	71501	The Bisexual Client: Trauma-Focused Care / 5	$38	☐	96154	Alzheimer Disease / 15	$98
☐	71793	Promoting the Health of Gender & Sexual Minorities / 5	$38	☐	96213	Attention Deficit Hyperactivity Disorder / 5	$38
☐	71943	Providing Care to Asian Immigrants / 10	$68	☐	96274	Sexual Addiction / 5	$38
☐	76222	Borderline Personality Disorder / 15	$98	☐	96313	Human Trafficking and Exploitation / 5	$38
☐	76442	Suicide Assessment and Prevention / 6	$44	☐	96342	Mental Health Issues Common to Veterans / 2	$23
☐	76690	Anxiety Disorders in Older Adults / 3	$26	☐	96954	Methamphetamine Use Disorder / 5	$38
☐	76863	Clinical Supervision: A Person-Centered Approach / 10	$68	☐	97430	Cultural Competence: An Overview / 2	$23
☐	76920	Racial Trauma: The African American Experience / 5	$38	☐	97470	Human Trafficking & Exploitation: The Texas Req. / 5	$38
☐	77090	Providing Care to Alaska Natives / 3	$26	☐	98020	Commonly Abused Supplements / 2	$23
☐	77143	Assessment & Mgmt of Pain at the End of Life / 2	$23	☐	98394	Herbal Medications: An Evidence Based Review / 10	$68

***See Course Availability List, pages 125–127 for NBCC Clock Hours.**

☐ 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 in the signature area on back of credit card or four numbers above the account number on front of AmEx cards.

Signature _____

Special Offer (before April 30, 2024)	$63
$74 (after April 30, 2024)	
I would like my certificates mailed for an additional $6	
Additional Courses	
Subtotal	
Expedited Delivery	
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.

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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**.

#77770 COUNSELING PATIENTS AT THE END OF LIFE—5 HOURS

Please refer to pages 18–20.

Expiration Date: 04/30/26 *May be taken individually for $30*

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

#76823 INCORPORATING MUSICAL STRATEGIES INTO CLINICAL PRACTICE—5 HOURS

Please refer to pages 36–38.

Expiration Date: 03/31/26 *May be taken individually for $30*

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

#77723 ETHICS FOR COUNSELORS—6 HOURS

Please refer to pages 92–93.

Expiration Date: 04/30/25 *May be taken individually for $36*

	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.	❍	❍	❍	❍

#96790 PSYCHEDELIC MEDICINE AND INTERVENTIONAL PSYCHIATRY—10 HOURS

Please refer to pages 122–124.

Expiration Date: 06/30/25 *May be taken individually for $60*

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

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Evaluation

(Completion of this form is mandatory)

CTH23

Last Name _____ First Name _____ MI _____

State _____ License # _____ Expiration Date _____

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

Compliance with APA, NBCC, and ASWB requires that providers collect a course evaluation from the participant that includes assessment of the content, delivery method, and achievement of the individual learning objectives.

Please read the following questions and choose the most appropriate answer for each course completed.

1. Was the course content new or review?
2. How much time did you spend on this activity, including the questions?
3. Would you recommend this course to your peers?
4. Did the course content support the stated course objective?
5. Did the course content demonstrate the author's knowledge of the subject and the current state of scientific knowledge?
6. Was the course content free of bias?
7. Before completing this course, did you identify the necessity for education on the topic to improve your professional practice?
8. Have you achieved all of the stated learning objectives of this course?
9. Has what you think or feel about this topic changed?
10. Was this course appropriate for your education, experience, and licensure level?
11. Was the administration of the program to your satisfaction?
12. Were the materials appropriate to the subject matter?
13. Are you more confident in your ability to provide client care after completing this course?
14. Do you plan to make changes in your practice as a result of this course content?
15. If you requested assistance for a disability or a problem, was your request addressed respectfully and in a timely manner?

#77770 5 Hours	**#76823** 5 Hours	**#77723** 6 Hours	**#96790** 10 Hours
1. ☐ New ☐ Review	1. ☐ New ☐ Review	1. ☐ New ☐ Review	1. ☐ New ☐ Review
2. ____ Hours	2. ____ Hours	2. ____ Hours	2. ____ Hours
3. ☐ Yes ☐ No	3. ☐ Yes ☐ No	3. ☐ Yes ☐ No	3. ☐ Yes ☐ No
4. ☐ Yes ☐ No	4. ☐ Yes ☐ No	4. ☐ Yes ☐ No	4. ☐ Yes ☐ No
5. ☐ Yes ☐ No	5. ☐ Yes ☐ No	5. ☐ Yes ☐ No	5. ☐ Yes ☐ No
6. ☐ Yes ☐ No	6. ☐ Yes ☐ No	6. ☐ Yes ☐ No	6. ☐ Yes ☐ No
7. ☐ Yes ☐ No	7. ☐ Yes ☐ No	7. ☐ Yes ☐ No	7. ☐ Yes ☐ No
8. ☐ Yes ☐ No	8. ☐ Yes ☐ No	8. ☐ Yes ☐ No	8. ☐ Yes ☐ No
9. ☐ Yes ☐ No	9. ☐ Yes ☐ No	9. ☐ Yes ☐ No	9. ☐ Yes ☐ No
10. ☐ Yes ☐ No	10. ☐ Yes ☐ No	10. ☐ Yes ☐ No	10. ☐ Yes ☐ No
11. ☐ Yes ☐ No	11. ☐ Yes ☐ No	11. ☐ Yes ☐ No	11. ☐ Yes ☐ No
12. ☐ Yes ☐ No	12. ☐ Yes ☐ No	12. ☐ Yes ☐ No	12. ☐ Yes ☐ No
13. ☐ Yes ☐ No	13. ☐ Yes ☐ No	13. ☐ Yes ☐ No	13. ☐ Yes ☐ No
14. ☐ Yes ☐ No	14. ☐ Yes ☐ No	14. ☐ Yes ☐ No	14. ☐ Yes ☐ No
15. ☐ Yes ☐ No ☐ N/A	15. ☐ Yes ☐ No ☐ N/A	15. ☐ Yes ☐ No ☐ N/A	15. ☐ Yes ☐ No ☐ N/A

#77770 Counseling Patients at the End of Life — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

_____

#76823 Incorporating Musical Strategies into Clinical Practice — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

_____

#77723 Ethics for Counselors — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

_____

#96790 Psychedelic Medicine and Interventional Psychiatry — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

_____

Signature _____

Signature required to receive continuing education credit.

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Evaluation (Continued)

CTH23

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):

#77770 COUNSELING PATIENTS AT THE END OF LIFE—5 HOURS (Course expires 04/30/26)

• Define palliative and end-of-life care.	☐ A	☐ B	☐ C	☐ D	☐ F
• Outline the role of health and mental health professionals in end-of-life counseling.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify psychological concerns present at the end of life.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss key components of end-of-life conversations.	☐ A	☐ B	☐ C	☐ D	☐ F
• Analyze mental health interventions that can be incorporated into end-of-life care and bereavement.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe practical, ethical, and legal issues that can arise in the provision of end-of-life care.	☐ A	☐ B	☐ C	☐ D	☐ F
• Examine the impact of culture and culturally competent care on end-of-life decisions and support.	☐ A	☐ B	☐ C	☐ D	☐ F

#76823 INCORPORATING MUSICAL STRATEGIES INTO CLINICAL PRACTICE—5 HOURS (Course expires 03/31/26)

• Discuss the historical and cultural roles of music and its impact on human healing.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe the basics of how music affects the human brain.	☐ A	☐ B	☐ C	☐ D	☐ F
• Explain the three-stage consensus treatment model.	☐ A	☐ B	☐ C	☐ D	☐ F
• Evaluate the use of musical techniques/approaches in the stabilization stage of treatment.	☐ A	☐ B	☐ C	☐ D	☐ F
• Analyze the use of musical techniques/approaches in the processing stage of treatment.	☐ A	☐ B	☐ C	☐ D	☐ F
• Outline the role of musical techniques/approaches in the reintegration stage of treatment.	☐ A	☐ B	☐ C	☐ D	☐ F

#77723 ETHICS FOR COUNSELORS—6 HOURS (Course expires 04/30/25)

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

#96790 PSYCHEDELIC MEDICINE AND INTERVENTIONAL PSYCHIATRY—10 HOURS (Course expires 06/30/25)

• Outline factors that have contributed to the rise in interest in psychedelic and interventional psychiatry.	☐ A	☐ B	☐ C	☐ D	☐ F
• Define terms related to the discussion of psychedelic and interventional psychiatry.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss the history of psychedelics in medical care.	☐ A	☐ B	☐ C	☐ D	☐ F
• Evaluate factors that may impact the provision of psychedelic or interventional psychiatry techniques, including stigma, setting, and culture.	☐ A	☐ B	☐ C	☐ D	☐ F
• Outline the role of psilocybin and ketamine in psychiatric care.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe how MDMA and ibogaine may impact mental health.	☐ A	☐ B	☐ C	☐ D	☐ F
• Review the clinical effects of kratom, LSD, and mescaline.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss the potential clinical role of nitrous oxide, ayahuasca, and dimethyltryptamine (DMT).	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe how psychedelics may be incorporated into the treatment of mental health disorders, including treatment-resistant depression, post-traumatic stress disorder, and substance use disorders.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify interventional approaches that may be used in the treatment of mental health disorders.	☐ A	☐ B	☐ C	☐ D	☐ F

Signature _____

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