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COURSE #77770 — 5 CLOCK HOURS Release Date: 05/01/23 Expiration Date: 04/30/26

Counseling Patients at the End of Life

5 Clinical Clock Hours

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 physicians, nurses, physician assistants, and allied health professionals 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.

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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].

EVIDENCE-BASED PRACTICE RECOMMENDATION

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 40–41.

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 clock hour activity must be completed by April 30, 2026.

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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 40–41.
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 #71770 — 5 CLOCK HOURS Release Date: 04/01/23 Expiration Date: 03/31/26

Rural Health, Mental Health, and Social Work

5 Cultural Competency Clock Hours

Audience

This course is designed for social workers, counselors, and therapists involved in providing care to clients in rural areas.

Course Objective

The purpose of this course is to provide mental and behavioral health professionals with the knowledge and skills necessary to effectively meet the unique needs of rural clients, ultimately improving care and addressing existing disparities in health and mental health.

Learning Objectives

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

1. Define the term rural and review the demographic characteristics of those living in rural areas in the United States.
2. Identify how cultural values and norms characteristic of a rural culture can be strengths as well as limitations.
3. Discuss cultural competency and how it applies to rural communities.
4. Describe health, mental health, and social services disparities in rural areas of the United States.
5. Provide an overview of the unique health, mental health, and social work practice problems and issues experienced by various subpopulations residing in rural areas.
6. Discuss the role of and benefits of interprofessional collaboration in rural areas.
7. Describe ethical issues that emerge when working with clients in rural areas.

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.

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, 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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Designations of Credit

Social workers completing this intermediate-to-advanced course receive 5 Cultural Competency continuing education credits.

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INTRODUCTION

Individuals live in rural areas of the United States for many reasons [1]. Although there are benefits and necessities to living in rural areas, many residing in these areas experience significant health and mental health disparities and challenges in accessing services. As of 2020, about 63 million Americans live in rural areas [2]. However, to some extent, the needs of this population remain invisible and vulnerable. Rural residents have remained largely neglected in the fields of health, mental health, and social work. In a meta-analysis of literature published in the top 14 social work journals between 2004 and 2008, only 71 of the 3,004 peer-reviewed articles (2.36%) focused on rural populations [3].

There is no one definition of the term rural, and how it is defined is controversial. Some definitions focus on population density, which falls under a spatial definition classification [4; 5]. Most generally, rural has been defined as all territory, persons, and housing units not defined as urban [6]. Urban areas have a population threshold consisting of 65,000 or more people, with a density of 1,000 people per square mile [6]. The U.S. government defines rural areas as those with populations of 2,500–64,999 [5]. This dichotomous definition of urban/not urban masks the nuances of rural experiences and different levels of rurality and urbanicity [7]. Other definitions focus more on socioeconomic classification, which emphasizes geographic isolation and socioeconomic factors, such as employment and availability of and access to resources [4; 5].

More than 64% of the estimated 63 million Americans who live in rural areas resides east of the Mississippi River; 46.7% live in the South, and 10% live in the West [8]. Maine and Vermont have the greatest proportion of residents living in rural areas; California has the lowest proportion [9].

The goal of this course is to examine working in and with rural communities and the need for cultural sensitivity and competence. Health, mental health, and social work service disparities, barriers to help-seeking, and specific issues relevant to various subpopulations will be explored. Ethical issues unique to working in rural communities will also be discussed.

DEMOGRAPHIC OVERVIEW

In the United States, the largest rural population (6.8 million residents) is found in the East North Central region; this is followed by the South Atlantic (5.7 million) [10]. The five states with the largest proportion of rural residents are Vermont, Wyoming, Maine, Montana, and Mississippi [9].

Rural residents tend to be older than the average in the United States. The median age in rural areas is 51 years, compared with 45 years in urban areas [11]. In addition, 27% of rural households are headed by a senior, compared with 21% of urban households. By 2040, it is projected that 25% of the population in rural areas will be 65 years of age and older, compared with 20% in urban areas [10].

Rural residents are more likely to be married than urban residents (61.9% vs. 50.8%). There is also less mobility compared with urban populations. An estimated 65.4% of rural residents live in the same state they were born in, compared with 48.3% of their urban counterparts [11].

Rural residents tend to have achieved lower levels of education than urban residents. In rural areas, 19.5% have attained a bachelor's degree or higher, compared with 29% of those in urban areas. The digital divide is greater in rural communities; 23.8% of rural households do not have Internet access, while 17.3% of urban households do not have Internet access [11].

Residents in rural areas also tend to be of lower socioeconomic statuses. The average per capita income for rural areas is lower by $9,242 than the national average [12]. Between 2009 and 2013, 17.7% of residents in rural communities lived in poverty (vs. 15.4% for the general population) [10]. This is even more marked in southern rural areas, which have a poverty rate of 20.5%, and western areas (16.2%) [13]. In mostly rural counties, the median income is $47,020, with a poverty rate of 16.3%; in completely rural counties, the median income is $44,020, with a poverty rate of 17.2% [14]. Mostly rural counties are defined as those in which 50% to 99.9% of the population lives in rural areas; in completely rural counties, 100% of the population lives in a rural environment [14].

Rural civilian employment among persons 18 to 64 years of age is lower (67.6%) than that reported for urban residents (70%) [15]. Three major service industries together with manufacturing provide more than 70% of rural employment: education and health (25%); trade, transportation, and utilities (20%); and leisure and hospitality (11%). Manufacturing, farming, and mining have historically been the goods production focus for rural areas [16]. Rural employment was severely impacted by the 2008 recession, and rates have still not fully recovered. According to the USDA, half of the observed decline in the unemployment rate since 2010 is due to a reduction in the size of the labor force, not an increase in employment, which is partly the result of little or no population growth in rural America [17]. Regardless, employment for rural America lags below the 2007 figures. This has been further complicated by the COVID-19 pandemic. By April 2020, mainly due to COVID-19 and related pressures, rural unemployment rates reached 13.6%, a level not seen since the 1930s. As of the end of 2021, unemployment rates among rural residents had returned to pre-pandemic numbers, recovering more quickly than unemployment in metropolitan areas [16; 17].

Rural communities in the United States tend to be predominantly White and less racially and ethnically diverse. In 2020, 76% of the rural population identified as non-Hispanic White, compared with 64.1% of the general U.S. population [18]. An estimated 7.7% of the rural population is African American/Black and 9.0% are Hispanic, compared with 13.6% and 18.9%, respectively, of the general population [18]. Black Americans in rural areas tend to be clustered in the south, in areas that were historically linked to slavery, particularly in Alabama, Georgia, Mississippi, North Carolina, South Carolina, and Virginia [18]. Minority rural populations are disproportionately affected by poverty. In 2018, the poverty rate among rural Black Americans was 31.6%, and the rate among rural Native American communities is 30.9%. This compares to a rate of 13.2% among rural non-Hispanic White Americans [19].

RURAL CULTURE: STRENGTHS AND CHALLENGES

CULTURAL NORMS AND VALUES AS STRENGTHS

Culture has been conceptualized as a diversity domain, characterized by having specific value systems, norms, and social and behavioral patterns [20]. Specifically, culture refers to the values and knowledge of groups in a society; it consists of approved behaviors, norms of conduct, and value systems [21; 22]. Culture also involves attitudes and beliefs that are passed from generation to generation within a group. These patterns include language, religious beliefs, institutions, artistic expressions, ways of thinking, and patterns of social and interpersonal relations [23]. Culture can also represent worldviews—encompassing assumptions and perceptions about the world and how it works [24]. Culture has two components: the observable and the unobservable [25]. The observable include things such as language, customs, and specific practices, while the unobservable include beliefs, norms, and value systems. Culture helps to elucidate why groups of people act and respond to the environment as they do [26].

Working with clients from rural areas requires cultural competency; providers should be aware of the unique cultural differences of rural communities [27]. Some have argued that rural residents are a minority group that experiences prejudice and cultural microaggressions from the dominant culture [28]. Although there is a positive stereotype of rural life as bucolic and idyllic, there are also negative stereotypes regarding rural residents as uneducated and backward [28].

The concept of culture can encompass geographical characteristics, not just social and behavioral norms [29]. For example, there are often particular language nuances in rural cultures [29]. It is important to remember that there is tremendous diversity within rural groups, and it is vital to avoid stereotyping all rural residents by a single set of values.

One of the main cultural values among rural residents in the United States is self-reliance and autonomy [27; 29; 30]. There tends to be an attitude of individualism and Puritan work ethic; rural residents often adhere to the ideal of "pulling yourself up by your bootstraps" in challenging times [35]. These values are learned early, partially because rural residents often live far from other people and services. Geographic isolation, limited resources, and constrained finances (both personal and community) reinforce self-sufficiency as a social identity. However, providers should not assume that all rural clients will want to rely upon the legacy of self-reliance as a means of compensating for lack of services or access [30].

Family, church, and community are the traditional underpinnings of rural life [29; 31]. There is a more collectivistic approach compared with urban communities [31; 32]. Community and mutuality are shared values, and families rely on each other and their community for help [33]. Support networks are naturally occurring [34]. Rural areas are also characterized by more informal social relationships. Rural residents tend to utilize long-standing community institutions as social outlets, such as schools, churches, community clubs, and farmers' organizations [34; 36]. Neighbors, family, and friends are crucial components of one's natural support networks, particularly in times of crisis [37]. The Walsh Center for Rural Analysis reported that rural residents described their communities as having a "community spirit" and a "culture of cooperation," exhibited by residents having close ties not only to their families but with community and neighborhood associations and strong religious affiliations [35].

RURAL CHALLENGES

While self-reliance and independence are values that can assist individuals during times of crisis, they can also negatively influence health beliefs and help-seeking behaviors. Persons with this perspective seek health services only when problems are severe. This is especially true of mental health services, as mental illness is often incorrectly perceived as a problem with personal willpower [38]. Because self-reliance is a major part of the cultural rural fabric, obtaining help may be viewed as a sign of weakness and burdensome to others [7]. For this same reason, rural residents often feel that obtaining services from safety net programs is stigmatizing.

Another barrier to formal help-seeking is the core cultural value of family, community, and mutuality, which results in rural individuals relying on coping strategies that focus on self-care and informal networks rather than formal agencies [38]. Confidentiality and discretion are also important, as there is a feeling in small, rural communities that everyone is aware of everyone else's movements. Individuals may be impeded from engaging with formal services if they fear their privacy will be violated [28].

Another cultural characteristic of rural communities is their general distrust of outsiders. Because of its emphasis on family and community, rural residents are often mistrustful of people and institutions that are not part of the community. This is particularly true in rural areas that are geographically isolated, like the Appalachian area [39]. Rural areas tend to be more traditional and conservative, with an embrace of religious values [27; 29]. Those leaning toward more liberal beliefs may be ostracized by family, friends, and the community. Diversity is not easily accepted [34; 40]. However, this is only a general trend; in some rural communities, as certain industries grow, diversity is increasing [29].

Geographic and environmental characteristics also help shape specific rural cultures [29]. These features can serve as literal structural barriers that reinforce rural cultural values and norms. Geographically isolated areas are slower to incorporate technological advances, and one area that has lagged behind is telecommunications [1; 34; 40]. Rural areas often do not have the infrastructure for high-speed connections. In 2019, 63% of rural residents had broadband Internet access at home. They also go online less often, with 76% reporting that they go on the Internet at least daily, compared with 83% of urban dwellers [41]. Public transportation may not be available or easily accessible, which can impede rural residents' ability to travel to health clinics, medical appointments, and/or mental health and social services [37]. The availability of these services could also be limited due to financial constraints and workforce shortages [37]. All of these barriers reinforce cultural values of independence and autonomy. The interplay of place and culture is inextricably intertwined.

CULTURAL COMPETENCY

Cultural competence is a professional mandate in the health professions [42]. The Joint Commission has standards for cultural competence for health organizations [43]. In its Code of Ethics, the National Association of Social Workers requires that all social workers "demonstrate understanding of culture and its function in human behavior and society, recognizing the strengths that exist in all cultures" [44]. Cultural competency is a dynamic process and an ongoing journey that is informed by cultural encounters [45]. It cannot be achieved by completing a course or training; rather, cultural competence involves continual learning throughout one's professional career in four different areas [22; 46]:

- Cultural awareness
- Knowledge acquisition
- Skills development
- Inductive learning

Expanding on this paradigm, cultural awareness is a practitioner's ability to [48]:

- Identify key cultural values of the client.
- Understand how these cultural values influence the client and his/her/their environment.
- Develop skills in order to apply and implement services that are congruent to the client's value systems.
- Acknowledge that this is an inductive learning process that involves a continual journey and quest to learn about different cultural value systems and beliefs and apply them to Western intervention models.

Other related concepts are cultural humility and cultural safety. Cultural humility refers to an attitude of humbleness, acknowledging one's limitations in the cultural knowledge of groups. Practitioners who apply cultural humility readily concede that they are not experts in others' cultures and that there are aspects of culture and social experiences that they do not know. From this perspective, patients are considered teachers of the cultural norms, beliefs, and value systems of their group, while practitioners are the learners [49]. Cultural humility is a lifelong process involving reflexivity, self-evaluation, and self-critique [50].

Cultural safety focuses on a practitioner's own culture, position, and power, and how the practitioner can unconsciously control a cultural group's values and behaviors [51]. Cultural safety as a concept applies particularly well to Native and indigenous populations in rural areas [51]. The goal of cultural competence, humility, and safety is to reduce the gap between the norms and belief systems of clients from diverse cultural groups and the institutional cultural norms of service delivery agents and organizations. Ultimately, this will mitigate the disparities that exist in mental health and healthcare systems [52]. Inherent in the assumptions of cultural competency, humility, and safety is the acknowledgement that a group's core values and norms are strengths. It is important to take a strengths-based perspective versus a deficit or pathological lens.

DISPARITIES AND UTILIZATION PATTERNS IN RURAL AREAS

DEFINITION OF DISPARITIES

Health disparity can be an ambiguous term, and there is not yet a consensus definition. Very basically, health disparities are differences in health or mental health status that systematically and adversely affect less advantaged groups [53]. These inequities are often linked to historical and current unequal distribution of resources due to poverty, structural inequities, insufficient access to health care, and/or environmental barriers and threats [54]. Healthy People 2030 has defined a health disparity as [55]:

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

Health disparities are closely tied to healthcare disparities, which are defined as unequal access to services in the health or mental health service sector or differences in quality of these services to individual(s) or groups due to disadvantages and marginalization [56]. Health equity is a goal but can be a nebulous concept; therefore, health disparities are employed to measure whether the goal of health equity is being accomplished [57]. Health equity is a form of social justice in the health arena and is based on the belief that no one should be denied good health simply for being in a group that may have been or is marginalized [57].

HEALTH AND MENTAL HEALTH DISPARITIES IN RURAL COMMUNITIES

Rural health disparities exist on a global level. Worldwide, 56% of rural residents lack health insurance, compared with just 22% in urban areas [58]. In the United States, national physical and mental health outcomes have improved over the years; however, these improvements are not as large in rural communities. Today, incidences of obesity, diabetes, cancer, heart disease, and respiratory illness are all higher in rural areas than urban areas [59; 60]. For example, in 2016, the diabetes prevalence rate was 12.6% for rural U.S. communities but 9.9% in urban areas in the United States [12]. In addition, high-risk behaviors, such as not using a seat belt, tobacco use, and substance abuse, are more prevalent in rural communities [59; 60]. Furthermore, rural residents are more likely to consume calorie-dense and lower nutrient foods and are less physically active [60]. More rural residents themselves rate their health as fair to poor (19.5%), compared with urban residents (15.6%) [29].

Mortality rates are also higher in rural areas of the United States. While overall life expectancy has improved, the rural-urban gap has widened, increasing from 0.4 years in 1969 to 2 years by 2014 [12; 61]. As rurality increases, so do infant mortality rates, primarily due to sudden unexpected infant deaths and congenital anomalies [62]. There are particularly high mortality rates among Native American Indian and non-Hispanic White infants outside of metropolitan areas [62].

Rural Americans with mental health needs typically enter care later, have more serious symptoms, and require more costly and intensive treatment [63]. In 2020, 21% of adults in nonmetropolitan counties had some form of mental illness and 6% experienced serious mental illness [64]. Suicide rates have been increasing across the United States, led by areas considered less urban, with the gap in rates between less urban and urban areas widening between 1999 and 2016; furthermore, suicide with a firearm is two times higher among rural residents than those in urban areas [65; 66; 67]. While White men are at highest risk for suicide nationally, in rural areas American Indians/Alaska Natives are the most affected [65; 66]. In 2020, 5% of rural adults reported serious thoughts of suicide [64].

Substance use disorder refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes [68]. In 2020, 13% of rural adults experienced a substance use disorder [64]. Rural areas can vary on type of substance(s) abused. Residents of rural areas are more likely to experience unintentional opioid overdose deaths than those in urban areas [68].

The rate of opioid misuse and related fatalities are considered public health emergencies in the United States. The general rate of drug use in urban and rural areas are similar (10.4% and 10.9%, respectively) [69]. The rate of drug overdose deaths is greater in rural areas, with the rural overdose rate (unintentional injury) 50% higher than the urban rate [70]. Between 1999 and 2015, the rural opioid death rate quadrupled among those 18 to 25 years of age and tripled for women [70]. Socioeconomic factors, behavioral factors, and access to services contribute to these rural-urban differences. An understanding of how rural areas are different when it comes to drug use and drug overdose deaths, including opioids, can help public health professionals identify, monitor, and prioritize their response to the opioid epidemic [70]. To develop this understanding, ongoing data collection, analysis of data, and reporting of findings are critical to staying ahead of the drug crisis in public health.

In the past few decades, the manufacture and abuse of methamphetamine in the United States has gained increased attention. The admissions rates for treatment of methamphetamine-related disorders have ballooned alarmingly in some areas, particularly in rural or frontier areas, causing public health concerns. National reports of methamphetamine use have shown an increase since 2014. Regional use of methamphetamine continues to vary widely, with the highest rates in the West and Midwest, and a strong presence in the Southeast, with rural areas being the most severely impacted. According to a 2020 report, the Northeast, an area previously not a major market for methamphetamine, had seen a recent increase in use rates [71]. The higher use of methamphetamine in Western states is also reflected by the number of persons under its influence who come into contact with law enforcement.

Methamphetamine users in rural areas, especially areas designated as frontier regions, are likely to experience great difficulty in accessing medical, psychiatric, or substance abuse services. Even self-help groups are likely to be nonexistent in these areas, and when they are available, the degree of anonymity in a 12-step group in a small town may be compromised. The nearest available small city often serves as the population center for the region. Social services in these cities may be overwhelmed by numbers of transient persons from the surrounding rural areas needing services in addition to the inhabitants of the city [72].

CONTRIBUTING FACTORS TO DISPARITIES IN RURAL COMMUNITIES

It is difficult to isolate a single contributing factor to health and care disparities. There are multiple factors, and they work in conjunction to affect rural health inequities [73]. The following sections will provide a snapshot of individual/family, community, systemic/institutional, and societal/cultural factors that contribute to and perpetuate rural health disparities.

Individual/Family-Level Factors

Demographic factors, such as education level and personal and household income, play a role in health and mental health disparities; this is mainly related to lack of access to resources [58]. As noted, rural areas tend to have a higher unemployment rate, lower median household income, higher poverty rate, and higher uninsured rate [12]. Each one of these factors can contribute to lack of access to health and mental health services. Even when access is available, travel and time off of work may be more difficult for rural clients.

Rural men are more likely than urban inhabitants to subscribe to gender role stereotypes that support self-reliance; therefore, they are less likely to seek help for health and mental health concerns [74]. As discussed, rural communities are tightly knit, with a high level of social proximity, which results in low levels of anonymity [7]. Further, rural families have been shown more likely to attach stigma to mental health disorders, including depression, compared with their urban counterparts [75]. Being circumspect and avoiding stigma can be challenging in small communities, where movements, activities, and visitors are public knowledge [76].

Community-Level Factors

Demographic and physical characteristics, availability of resources, and the social and economic environment of the community also play a role in maintaining health disparities. For example, some rural communities are considered food deserts, defined as areas in which one must travel more than 10 miles to a supermarket to obtain fresh foods at affordable prices [77]. These areas lack easy access to fresh produce; instead, dollar stores and convenience stores are the most common sources of groceries for rural families. Food deserts are linked to poor health outcomes, including obesity and chronic illness [78; 79]. It is estimated that a total of 23.5 million people in the United States reside in food deserts, and urban and rural areas are affected [77]. In total, 2.3 million individuals reside in rural communities that are classified as low income and food deserts [77]. Studies have shown that simply opening grocery stores/supermarkets in food deserts does not ameliorate the issue, because rural residents may continue to purchase groceries at dollar or convenience stores if their transportation options are limited or if it is less expensive [78; 80]. Schools and government workplaces are potential sources of food for low-income rural residents; farmers' markets have also begun to accept Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and vouchers from the Farmers' Market Nutrition Program [81]. Typically, a combination of policies and environmental interventions is used in order to meet the food needs of rural residents.

Lack of access to public transportation in rural communities also affects rural health. Health and mental health clinics are often located at a distance. Public transportation options are limited or nonexistent, and missing work can be a financial burden, particularly for those who require regular, long-term appointments [82]. Transportation times can be longer than appointment times, making it difficult to convince rural residents that the help is worth the trouble.

Where there are shortages in trained professionals, development and support for community educational training and resources are also lacking. As a result, the health and mental health literacy in rural communities is often low, which contributes to a lack of interest in seeking formal help. At least one study has identified a gender divide, with rural men less likely to have good understanding of depression compared with rural women [83]. In this study, depression literacy did not predict the perceived need to seek formal help. When participants did seek help, they tended to prefer to seek a religious leader, perhaps because they viewed such help-seeking less stigmatizing.

Systemic/Institutional Level Factors

Rural health disparities can be partially attributed to chronic staffing shortages in the health, mental health, and social services sectors in rural areas. A chief characteristic of the rural health workforce is one of maldistribution. In most of the country, health professionals concentrate in urban areas, creating an insufficient supply and unequal distribution of primary healthcare providers [84; 85]. Per 10,000 population, there are 5.3 primary care physicians, 6.5 nurse practitioners, and 2.9 dentists, compared with 79, 81, and 43, respectively, in urban areas [86]. The difference is even more marked among behavioral health professions. Per 10,000 population, there are 0.3 psychiatrists, 1.6 psychologists, 5.8 social workers, and 8.8 counselors in rural areas. In urban areas, there are 1.3 psychiatrists, 4.0 psychologists, 9.6 social workers, and 13.1 counselors per 10,000 population [86]. This disparity is expected to grow as a result of demographic changes, insurance coverage expansions, and a decline in the primary care physician workforce [86; 87]. Specialists and subspecialists are particularly limited in rural areas, as they tend to concentrate in areas with larger population bases, where they have enough demand for their services to be economically viable [88; 89]. Rural counties are also historically disadvantaged in terms of mental health services [90]. According to the Centers for Disease Control and Prevention, more than 85 million Americans live in areas with an insufficient number of mental health providers; this shortage is particularly severe among low-income rural communities [91]. Patients in rural care settings are also more likely to be given pharmacotherapy for psychiatric illness due to a shortage of professionals qualified to provide psychotherapy.

Lower population density also means fewer social service programs in rural areas, which results in the attraction of fewer social workers [92]. The Council on Social Work Education (CSWE) conducted a study in 2017 to better understand the landscape of new social work graduates entering the workforce. Online surveys were sent to newly graduated social workers from 84 different social work programs. Of the graduates holding a master's degree in Social Work (MSW), only 7.2% were practicing social work in rural communities; 25.9% took jobs in large cities (i.e., 1 million population or greater) [93]. In a smaller descriptive study examining 115 social work students' career plans and views of rural social work practice, 70% of respondents preferred to practice social work in an urban or near an urban area [94]. This finding is interesting in light of the fact that more than half reported residing in a rural community at the time of their high school graduation. These social work students expressed concerns with lower salaries and professional and personal opportunities if they were to practice in rural areas.

Overall, an array of factors contributes to the shortage of professionals in rural areas, including [95]:

- Challenges recruiting and retaining newly graduated professionals to small, rural communities
- Lower salaries
- Geographic and social isolation
- Retirement/aging of current providers
- Unwillingness to accept new patients by providers who are seeking to lighten workloads

For social workers and other mental health professionals who work in rural areas, burnout is common and affects agencies' ability to retain practitioners. A survey study examining factors related to job satisfaction and burnout among social workers in rural areas found that, in general, participants were moderately satisfied with their jobs. Not surprisingly, those with higher salaries and who had been at their workplaces longer tended to report higher levels of satisfaction. Higher levels of burnout were predicted by older age, non-White race (particularly Black race), and employment in child welfare agencies [96].

In a qualitative study about older adults' access to primary care physicians in rural areas, researchers found an implicit social contract between physicians and patients [97]. Rural physicians expected patients to be "easy" and not bother them with minor complaints. If the patient adheres to the contract, he or she can expect to be readily seen by the physician. However, many participants complained about difficulty in scheduling appointments and feeling unwelcome.

Societal and Cultural Level Factors

On a macro level, structural barriers contribute to health and mental health disparities. While the Affordable Care Act has increased the number of individuals with health insurance, rural residents may still find that co-pays are too financially restrictive when accessing care or services. Smaller agencies and businesses (with fewer than 50 employees) may not be able to attain full reimbursement, and in rural communities, smaller agencies and private companies are more common [98]. During the COVID-19 pandemic, Medicaid expanded coverage for telehealth services, but after the national health crisis is lifted in 2023, coverage will again be limited (and vary by state) [99].

One of the challenges in rural areas is the likelihood of cultural norms of self-reliance and stoicism impeding help-seeking. Self-care is generally not a priority, and when symptoms emerge, rural residents are more likely to use home-based remedies. In many cases, a physician is only contacted in the event of serious symptoms and after other avenues have been exhausted (i.e., at the last minute) [100]. There is cultural pride in being independent and being hard working. Taking time to take care of oneself is often seen as a luxury, especially in light of personal financial stress [29]. In a study with women in rural Appalachia, depressive symptoms of low energy, apathy, and low mood were considered at odds with cultural values of self-sufficiency. The women reported carrying on because they had little or no support in working or child and family care [101]. "Keeping going" had a moral and cultural undertone.

SPECIAL POPULATIONS IN RURAL COMMUNITIES

CHILDREN AND ADOLESCENTS

In the rural United States, there are 13.4 million children younger than 18 years of age [102]. The child poverty rate is lower among rural children than urban children (18.9% vs. 22.3%). However, more rural children (7.3%) are uninsured than urban children (6.3%) [102]. Just as there are health disparities among adults in rural and urban areas, health disparities also exist for children. Rural children are more likely to have a body mass index (BMI) greater than the 85th percentile than urban children [103]. In a study of 186 rural children, 37% were overweight or obese and 43% of the families were at risk for food insecurity. Not surprisingly, families who were at risk for food insecurity were more likely to have children who were obese [104].

Adverse childhood experiences (ACEs) are defined as potentially traumatic experiences that affect an individual during childhood (before 18 years of age). These experiences place individuals at risk for future health and mental health issues and risky behaviors in adulthood [105]. ACEs include witnessing family abuse and/or community violence, experiencing a family member attempting or dying by suicide, and experiencing child abuse and/or neglect. It can also encompass adverse family challenges, such as parental divorce, substance use, and parental incarceration [105]. Rural children have higher exposure rates to ACEs compared with urban children [106]. In general, regardless of where they live, children with more than four ACEs are more likely to live below the poverty line [106].

Higher levels of poverty, substance use disorder, unemployment, and other stressors are risk factors for child maltreatment. According to the Fourth National Incidence Study of Child Abuse and Neglect, children in rural communities have a higher incidence of maltreatment compared with their urban counterparts [107]. Another national study found that the rate of child maltreatment was 1.7 times higher in rural areas than urban areas [108]. However, a 2020 systematic review presented mixed findings regarding rural/urban differences in child maltreatment rates [109]. In this analysis, only five studies that showed that rural communities had higher incidences of child maltreatment. In terms post-identification, rural children are 1.18 times more likely than urban children to be discharged from foster care [110].

Adolescents in rural areas are more likely to report tobacco, alcohol, and cocaine use compared to their urban counterparts. They are also more likely to binge drink and to drive under the influence [103]. In general, rurality is associated with higher adolescent mortality related to unintentional injuries and suicide [103].

Chronic school absenteeism is also high in rural areas. Almost half of preschool children in an Appalachian school setting missed 10% or more of their school year. This then was related to fewer gains in literacy during the school year [111].

Rural adolescent girls are more likely than their urban counterparts to become pregnant and to elect to continue their pregnancy and keep their child. Birth rates for rural communities are approximately one-third higher than urban areas [112]. More than urban women, rural women's first adolescent pregnancies are more likely to be unplanned and to result in a live birth [113]. This disparity was particularly marked among Black rural women [113]. Mortality rates are higher for rural children than urban children regardless of gender and racial/ethnic minority group.

WOMEN

In a large-scale study, analyzing data from 12,600 mothers in Maine, rural mothers tended to be younger than urban mothers, and 10% of all rural patients who gave birth were adolescents, compared with 6.2% of urban patients [114]. Rural mothers were more likely to smoke prior to and during their pregnancies and had higher BMIs prior to pregnancy. These women were less likely to have higher education or to be married and more likely to reside in households with lower incomes [114]. Given these social determinants and overall rural health disparities, it is not surprising that maternal health disparities are a concern in rural communities. Compared with urban women, rural women had a 9% increased probability of mortality and severe maternal morbidity (i.e., a risky condition that requires a life-saving procedure during or immediately following childbirth) [115].

Infant mortality rates are also 6% higher in rural areas compared with small and medium urban areas and 20% higher compared with large urban counties [116]. Neonatal deaths, defined as the death of an infant during the first 28 days of life, are also 8% higher in rural communities compared with urban areas [116].

Pregnant rural women may experience challenges accessing regular prenatal care and hospitals with obstetric units. Increasingly, rural hospital obstetric units are closing due to budget cuts and low reimbursement rates as well as challenges retaining staff [117]. Rural counties without a hospital with an obstetric unit and that are not located near an urban area have higher rates of out-of-hospital births, births in non-obstetric hospital units (e.g., emergency departments), and preterm births [118]. In a qualitative study exploring reasons rural women delay obtaining prenatal care, rural women reported lack of support or encouragement for prenatal care from family members (specifically, mothers) and the community [119]. Other women in the community often feel that doing without these services is the norm for rural women.

Rural and urban women who are vulnerable to high-risk pregnancies have similar life stressors (e.g., financial limitations) that impede seeking prenatal care. However, rural women who have two or more barriers are 2.85 less likely to have a regular source of prenatal care than urban women with comparable barriers [120]. Individual and community barriers, such as lack of insurance, transportation logistics, difficulty locating a physician/provider, and lack of affordable prenatal health services, are also considerations. Finally, structural issues often result in poor continuity of care.

Poverty, early parenthood, lack of education, and sparse resources can place women at risk of intimate partner violence, particularly in rural areas characterized by more conservative, patriarchal values that reinforce male dominance [121]. It has been postulated that traditional values may make attitudes toward intimate partner violence more tolerant. However, a large national study found that lifetime intimate partner violence victimization rates in rural areas (26.7% in women, 15.5% in men) are similar to the prevalence found among men and women in non-rural areas [122]. There is some evidence that intimate partner homicide rates may be higher in rural areas than in urban or suburban locales [123; 124].

Substance use disorders and unemployment are more common among intimate partner violence perpetrators in rural areas [123]. Poverty in rural areas is also associated with an increased risk for intimate partner violence victimization and perpetration for both men and women [125]. It has been suggested that intimate partner violence in rural areas may be more chronic and severe and may result in worse psychosocial and physical health outcomes. Residents of rural areas are less likely to support government involvement in intimate partner violence prevention and intervention than urban residents [123]. Although the rates are similar, the risk factors, effects, and needs of rural victims are unique. For example, research indicates that rural women live three times further from their nearest intimate partner violence resource than urban women. In addition, domestic violence programs serving rural communities offer fewer services for a greater geographic area than urban programs [126].

OLDER ADULTS

Overall, a greater proportion of the rural population (20%) is 65 years of age and older than the proportion in urban areas (16%) [127]. Approximately 75% of rural older adults live with someone in a household; very few (1.4%) elderly rural residents live in skilled nursing facilities [128]. Older rural adults experience similar challenges as other rural residents, but their experiences may be exacerbated by impaired mobility, frailty, and limited income. Food security and transportation are key issues.

Food insecurity is defined as adjusting the amount and quality of food one eats in response to limited financial or physical resources [129]. Persons with food insecurity may resort to consuming calorie-dense foods high in fat and sugar, which tend to be less expensive. As discussed, some also rely on convenience stores that are closer to their homes to obtain groceries; these stores generally do not supply fresh fruits and vegetables. Food insecurity is linked to social determinants and contributes to higher incidences of obesity, diabetes, and chronic illness [129; 130].

Food insecurity and transportation challenges are related. Rural areas in the United States have limited and unreliable public transportation, especially in areas with poor roads and more extreme weather conditions. In general, life expectancy exceeds driving expectancy by 6 years for women and 10 years for men [131]. Older adults want to retain their ability to drive and related independence, but this is made more difficult in rural areas [132]. For rural older adults who can still drive, they are twice as likely as urban older adults to be hurt or die on the road because of the longer driving distances and poorer road conditions [133].

Although Medicaid will pay for transportation needs for non-emergency health services, there are variations in Medicaid coverage in different states [134]. Therefore, some older adults will be unable to obtain healthcare services because of lack of transportation. It is estimated that 3.6 million Americans fall in this category, especially women, rural residents, those with mobility issues, and those with multiple chronic conditions [135]. Other transportation options, such as ride shares (e.g., Uber, Lyft) may be cost-prohibitive and or unavailable in some rural areas [131].

GENDER AND SEXUAL MINORITIES

Approximately 3% to 5% of those who live in rural communities in the United States identify as gender and/or sexual minorities [136]. The gender and sexual minorities umbrella encompasses lesbian, gay, bisexual, transgender, queer/questioning, intersex/intergender, asexual/ally (LGBTQIA) people as well as less well-recognized groups, including non-binary, aromantic, two-spirited, and gender-fluid persons.

The rural context may have significant influence on an individual's sexual identity development. Rural communities have been characterized as more conservative and religious, and thereby more heterocentric [137]. By extension, this often results in less supportive attitudes toward LGBT+ individuals and more discriminatory policies and laws [136]. Because rural communities tend to be small in population and tightly knit, there is greater likelihood that anti-LGBT+ attitudes and behaviors will affect residents. For example, parishioners in a worship service are often also the same people one interacts with at work, at grocery stores, and in healthcare settings [136].

However, there is some evidence of a shift in attitudes in rural areas. In a 2015 study, nearly 80% of rural participants were supportive/accepting of same-sex marriages; gender, educational level, and relationship status did not appear to affect attitudes [138]. In a survey study of 113 rural primary care providers, 54.8% had received education aimed at LGBT+ health and 88% believed that health education targeted to LGBT+ patients should be a required part of the training curricula. However, as religiosity increased, favorable attitudes toward LGBT+ persons declined [139].

The coming out process can be challenging under normal circumstances, but it may be even more challenging in the rural context. Because maintaining privacy can be challenging, individuals may find it difficult or impossible to avoid coming out to the entire community or to avoid scrutiny and stigmatization [136]. In some cases, they may feel ostracized in their places of worship and spiritually excommunicated [137]. Older rural LGBT+ individuals report higher levels of guardedness about their sexual orientation with people in their social networks compared with their urban counterparts [140]. Rural communities tend to have very limited LGBT+-friendly spaces (e.g., bars, clubs, bookstores, coffee shops), so LGBT+ individuals may feel that they do not have the support to come out or that their environment does not affirm their identity. Because of the discrimination, rejection, and ostracism they face, LGBT+ individuals may experience greater minority stress, which is associated with an increased risk for various health and mental health issues. For example, transgender and gender non-conforming individuals living in rural communities experience greater levels of social anxiety compared to urban individuals who have greater social supports (a protective factor) [141].

VETERANS

Approximately 5 million veterans live in rural areas of the United States, representing about 25% of the total veteran population [142]. Historically, the U.S. military has focused recruiting efforts in Southern rural areas [143]. Rural veterans tend to be older than urban veterans, a reflection of rural populations in general. Given that this population skews older, it is not surprising that about 27.8% of rural veterans served in the Vietnam War [142]. In addition, 9.7% of rural veterans served in Iraq and Afghanistan [144]. Because the median age of rural veterans is 65 years, this population also has a higher rate of chronic medical conditions, such as hypertension, diabetes, and obesity [142; 144]. Similar to the general health and mental health trends in rural areas, rural veterans are more likely than urban veterans to have a diagnosed psychiatric condition (e.g., post-traumatic stress disorder [PTSD], anxiety disorders, depression, substance use disorders) and are at an increased risk of suicide [143; 145]. Veterans from very rural areas tend to smoke more than their urban counterparts, perhaps due to the higher rates of under- or unemployment and lack of specialized smoking cessation services [146]. More rural veterans than urban veterans are enrolled in the Veterans Affairs (VA) healthcare system (57% vs. 37%); however, rural residents often have to travel greater distances to access VA health services [144].

As a group, rural veterans are marked by low income (57% earn less than $35,000 annually) and economic instability [144]. Therefore, housing affordability, accessibility, and availability can be a challenge [147]. The lower household incomes and higher rates of substance use disorders and mental illness seem like they would increase the risk of homelessness, but rural veterans actually have lower rates of homelessness compared with urban veterans [148]. This has been attributed, in part, to the supportive environment and accessibility of informal networks in rural communities [148]. It may also be that homelessness is exhibited differently in rural areas. For example, rural veterans might reside with family members or friends for a period of time or live in tents or vehicles [148]. The ability to live in vehicles, tents, and non-residential structures without law enforcement intervention is also increased in rural areas. In a study with 151 homeless male veterans in Nebraska, those living in micropolitans (i.e., areas with population of at least 10,000 but less than 50,000) were more likely to be unmarried, transient, and living in transitional housing [149]. They were also more likely to access health services and spend less time traveling to these services.

INTERPROFESSIONAL COLLABORATION IN THE RURAL CONTEXT

The biomedical model is the traditional foundation of the U.S. healthcare system. This model is considered individualistic and perhaps even paternalistic. U.S. healthcare providers tend to work in silos and decision-making is one-sided [150]. In rural communities, services for health, mental health, and social work are often inadequate to meet the needs of the population due to provider shortages and lack of facilities. In this setting, interprofessional and interdisciplinary collaborations are increasingly vital and an essential means to address the complex and multifaceted needs of rural communities [151]. When working in an interprofessional context, practitioners will learn about each other's roles, work within a team, and develop and enhance community networks so a streamlined referral system can easily be accessed [151; 152]. Interprofessional collaboration deviates from the silo model and shifts to a team perspective.

DEFINITION AND CHARACTERISTICS

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/patients and their families to improve health, mental health, social, and/or family outcomes [153]. Providers come together and view and discuss the same client problem from different lenses, which can ultimately produce more innovative solutions [152]. The client is not excluded from the process; rather, there is shared decision making among all team members, with the objective to improve client outcome [153]. Key elements of interpersonal collaboration include [150; 152; 153; 154]:

- Coordination
- Shared knowledge and skills
- Sharing of resources
- Understanding of each team member's roles and competencies
- Autonomy
- Mutual trust and respect of each members' professional roles, identity, and culture
- Building relationships
- Communication
- Responsibility
- Accountability
- Patient-centeredness

POSITIVE OUTCOMES

There are many benefits of interprofessional collaboration at each system level. On a micro or individual level, clients experience [154; 155; 156]:

- Reduced patient mortality
- Increased patient safety
- Increased patient satisfaction
- Improved health outcomes
- Improved quality of life

Practitioners experience professional benefits, including [154; 156; 157]:

- Increased job satisfaction
- Greater equality of status between practitioners
- Improved working relationships within teams, reducing team conflict
- Increased staff retention
- Greater creativity to come up with innovative solutions

On an organizational level, agencies, organizations, and hospitals should expect to see [150; 154; 156]:

- Reduction of medical errors
- Decreased length of hospital stays
- Improved care coordination and continuity
- More holistic services
- Improved efficiency
- Decreased adverse events
- Reduction of cost of care
- Lessened financial/budget constraints
- Improved use of specialty care and services

On macro or societal level, interprofessional collaboration has been linked to improved outcomes in areas of infectious diseases, epidemics, and humanitarian efforts by the World Health Organization [150].

CHALLENGES FACILITATING INTERPROFESSIONAL COLLABORATION

Most practitioners would agree that interprofessional collaboration is vital. However, there are challenges in promoting this approach. Most commonly, this includes [152; 158]:

- Lack of clear leadership
- Lack of understanding of different providers' roles
- Limited time and resources

- Different professional values and traditions among the various disciplines
- Time and effort required to develop an interprofessional collaborative climate

In order to facilitate interprofessional collaboration, providers should develop the following skills and competencies [159; 160; 161; 162]:

- Enhanced communication (e.g., giving constructive feedback, listening, facilitating positive discussions, keeping all parties informed, asking for input)
- Team building (e.g., building consensus, talking and resolving conflict)
- Developing effective relationships across providers in different disciplines
- Joint problem-solving
- Implementing stages of change models
- Sharing expertise and knowledge and, in turn, learning what each member contributes or could contribute and the discipline-specific processes and procedures
- Developing trust and interdependence

Professionals can convey an understanding of the roles and responsibilities of each member of the interprofessional team by discussing and clarifying roles while recognizing limitations within each discipline.

ETHICAL ISSUES AND STANDARDS OF PRACTICE IN RURAL COMMUNITIES

The characteristics, values, and norms of rural communities and the culture of rurality influence how ethical standards are applied and emphasized. Most clearly, this applies to the ethical values of confidentiality, distributive justice, fidelity, and autonomy [163]. Rurality can affect how these ethical principles are applied in the day-to-day practice of rural practitioners.

CONFIDENTIALITY AND PRIVACY

As discussed, the smaller population size and tightly knit formal and informal social networks of rural communities can make for open and permeable boundaries, potentially negatively affecting practitioner-client confidentiality. Consider the following scenario [164]:

> A pastor of a rural church also serves as a chaplain of a rural hospital. He sees two patients who are scheduled for surgery for the following week; these patients are also congregants. The surgeon is also a member of the church. At a weekly service, the pastor calls for prayer and divine guidance for the surgeon and the two patients by name.

Does this violate privacy and HIPAA regulations? The pastor may believe that the importance of community support and prayer are far more vital than statutory regulations. Are there legal or ethical ramifications?

As discussed, clients may fear that living in small communities can compromise their desire for privacy and confidentiality. The disclosure of sensitive health or mental health information to friends or family can be stigmatizing. If a rural community resident seeks counseling because they are experiencing depression, other residents may see their vehicle parked outside the counselor's office and ask questions or gossip [165]. Agency supervisors may also be concerned with confidentiality in hiring and staffing and information that could accidentally be released in different spheres of life (e.g., church, work, grocery stores) [166].

The acquisition of third-hand information and how it is used in the clinical setting is another important issue in rural communities. Because most members of the community are familiar with each other, practitioners may obtain third-hand information through community gossip or through living in the community. Even if this information appears to be vital therapeutic information, the question of whether it can or should be used remains [167]. For example, a counselor might notice that his client is entering a local bar when, in their last session, the client had indicated that she was no longer drinking. Should the counselor then bring this observation into the next session? The management of information requires a careful, deliberate maneuvering to ensure that professional and personal boundaries are not blurred [167].

DUAL RELATIONSHIPS

This leads to the issue of dual relationships, which are defined as situations in which a professional has more than one role in a client's life (e.g., a financial, sexual, personal, and/or religious relationship). This is frowned upon and can rise to the level of an ethical violation because of the potentially coercive nature of the relationship resulting from the inherent power dynamics between the practitioner and the client [165]. Dual relationships have been identified as the top ethical challenge for social workers, counselors, and therapists working in a rural community [168]. However, dual relationships can be almost impossible to avoid. In a qualitative study with 10 social work research participants in a rural Alaskan community, participants reported difficulty avoiding dual relationships because their social, personal, and family lives often inevitably overlapped with clients' lives in a rural community with only one school, church, mechanic, and medical office [164; 167]. Because of the overlapping roles, it was difficult for practitioners to maintain a professional identity and distance. Rural practitioners may feel they are always on call, even when they are not working. Attempting to maintain professional distance may be perceived as unfriendly and unhelpful. Practitioners' personal lives are often on community display or part of community discussions, and this information may be used in part to evaluate their credibility and trustworthiness [167].

Experts have identified steps that can be taken to mitigate the challenges of dual relationships in rural communities [169]. Referring clients to non-local agencies that offer telehealth options can help. Another option is to employ the strong, naturally occurring helping relationships that exist in the community to meet client needs. However, this has its drawbacks, specifically potential lack of confidentiality. Finally, practitioners can offer to exchange services with practitioners in other rural communities via telehealth technology [169].

DISTRIBUTIVE JUSTICE

Because residents of rural communities often have limited financial and transportation resources, practitioners may struggle with the ethical principle of distributive justice, which emphasizes the role of fairness in the distribution of services [170]. A practitioner might be unsure if referring a client to services is the correct step, knowing that the client has no health insurance and would have to travel long distances to access the service [163]. Practitioners should also have boundaries surrounding in-kind payment for services [164].

COMPETENCE

The limited number of providers in rural areas can raise questions about competence. In professional ethical codes, competence is defined as a practitioner's knowledge, skills, and training and the importance of continuous education for professional development. It also encompasses the need to practice within one's professional competence. In its Code of Ethics, the National Association of Social Workers defines competence as a value requiring social workers to practice within their areas of competence and to continue to expand their professional knowledge and skills [44]. The American Counseling Association's Code of Ethics prescribes the same value and principle [171[. The issue that arises when the number of available practitioners is limited is balancing the need to limit practice to areas of competence but also meet the needs of an underserved population [172]. Is providing potentially incompetent care more detrimental than providing no care? In addition, coworkers and supervisors may be reticent to report incompetent care or ethical violations because it would further exacerbate the existing practitioner shortage. This can then be perpetuated, and professional silence might become the accepted norm [168]. If a practitioner feels he/she is not sufficiently trained in a particular area, it is common practice to refer a client to a specialist, but this may not be an easy solution in rural communities. Finally, practitioners do not have the same access to supervision, ethics committees, and trained ethics consultants to attain advice, consultation, and direction [163].

CONCLUSION

Rural populations are a vulnerable and marginalized population. They are often neglected, perhaps in part because many practitioners are trained in urban areas. Consequently, the professional lens is often urban-centered, with practice and research biased toward an urban perspective [3]. This compounds already inadequate services in rural communities. Practitioners who work in rural communities should be cognizant of the rural culture. Just as when practitioners work with any minority groups, it is important to recognize and appreciate the array of strengths that come with rural residents' unique cultural values and norms. Yet, when describing rural communities as "individualistic," "self-reliant" or "having rich informal support networks," it is important to remember that these are merely categorizations—they do not capture the multilayered and heterogeneous complexities of each rural community. As such, there is no universal practice template. What is clear is that all clients need to feel safe. Studies indicate that when vulnerable and marginalized clients feel that their cultural differences are pathologized, they feel unsafe and are more likely to prematurely terminate services [47].

The health, mental health, and social service disparities that exist in rural communities are the result of multiple factors, one of which is related to service delivery. Because of the low population density of many rural areas, health, mental health and social service availability is limited [92]. Although interprofessional collaboration is key in mitigating the challenges of providing services in rural areas, developing such relationships can be time consuming and, at times, fraught with interpersonal tension and conflict. The use of technology and telehealth services is recommended to help overcome challenges in rural access to services.

Customer Information/Answer Sheet/Evaluation insert located between pages 40–41.

TEST QUESTIONS

#71770 RURAL HEALTH, MENTAL HEALTH, AND SOCIAL WORK

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 clock hour activity must be completed by March 31, 2026.

1. **Which of the following is among the top five states with the largest proportion of rural residents?**
   - *A) Texas*
   - *B) Vermont*
   - *C) California*
   - *D) South Dakota*

2. **Rural residents are more likely than urban residents to**
   - *A) be single.*
   - *B) have Internet access.*
   - *C) have completed college.*
   - *D) live in the same state in which they were born.*

3. **All of the following industries are major employers in rural areas, EXCEPT:**
   - *A) Manufacturing*
   - *B) Entertainment*
   - *C) Education and health*
   - *D) Leisure and hospitality*

4. **Which of the following is considered an unobservable component of culture?**
   - *A) Customs*
   - *B) Language*
   - *C) Value systems*
   - *D) Specific practices*

5. **Which of the following statements regarding rural culture is FALSE?**
   - *A) Support networks are naturally occurring.*
   - *B) Rural areas are characterized by more formal social relationships.*
   - *C) There is a more collectivistic approach compared with urban communities.*
   - *D) Family, church, and community are the traditional underpinnings of rural life.*

6. **Because self-reliance is a major part of the cultural rural fabric, obtaining help may be viewed as a sign of weakness and burdensome to others.**
   - *A) True*
   - *B) False*

7. **Cultural competence involves continual learning throughout one's professional career in what four areas?**
   - *A) Cultural humility, cultural curiosity, appropriation, and formal learning*
   - *B) Cultural cooperation, conductive learning, self-critique, and skill acquisition*
   - *C) Cultural awareness, knowledge acquisition, skills development, and inductive learning*
   - *D) Knowledge development, cultural exploration, cultural safety, and interprofessional collaboration*

8. **Health disparities are often linked to historical and current unequal distribution of resources due to**
   - *A) poverty.*
   - *B) structural inequities.*
   - *C) insufficient access to health care.*
   - *D) All of the above*

9. **The incidences of all of the following conditions are higher in rural areas, EXCEPT:**
   - *A) Obesity*
   - *B) Cancer*
   - *C) Respiratory illness*
   - *D) Infectious diseases*

10. **Rural Americans with mental health needs typically enter care later, have more serious symptoms, and require more costly and intensive treatment.**
    - *A) True*
    - *B) False*

11. **In 2020, what percentage of rural residents experienced a substance use disorder?**
    A) *1.3%*
    B) *13%*
    C) *27%*
    D) *43%*

12. **Rural families have been shown less likely to attach stigma to mental health disorders, including depression, compared with their urban counterparts.**
    A) *True*
    B) *False*

13. **Food deserts**
    A) *lack access to processed foods.*
    B) *often rely on supermarkets as the most common sources of groceries.*
    C) *are linked to poor health outcomes, including obesity and chronic illness.*
    D) *are defined as areas in which one must travel more than 100 miles to a supermarket to obtain fresh foods at affordable prices.*

14. **Which of the following statements regarding provider shortages in rural areas is TRUE?**
    A) *Specialists and subspecialists tend to concentrate in areas with larger population bases.*
    B) *Medical clinician shortages are extensive, but behavioral health professional shortages are less likely in rural areas.*
    C) *Patients in rural care settings are more likely to be given psychotherapy for psychiatric illness due to a shortage of prescribers.*
    D) *The rural-urban provider disparity is expected to decrease as a result of demographic changes and insurance coverage expansions.*

15. **All of the following factors contribute to the shortage of professionals in rural areas, EXCEPT:**
    A) *Lower salaries*
    B) *Geographic and social isolation*
    C) *Acceptance of all new patients by providers seeking to establish their practices*
    D) *Challenges recruiting and retaining newly graduated professionals to small, rural communities*

16. **One of the challenges in rural areas is the likelihood of cultural norms of self-reliance and stoicism impeding help-seeking.**
    A) *True*
    B) *False*

17. **Which of the following statements regarding rural children is FALSE?**
    A) *More rural children are uninsured than urban children.*
    B) *The child poverty rate is higher among rural children than urban children.*
    C) *Rural children have higher exposure rates to adverse childhood experiences compared with urban children.*
    D) *Rural children are more likely to have a body mass index (BMI) greater than the 85th percentile than urban children.*

18. **Adolescents in rural areas are more likely than their urban counterparts to report**
    A) *cocaine use.*
    B) *tobacco use.*
    C) *binge drinking.*
    D) *All of the above*

19. **All of the following contribute to lack of adequate prenatal care in rural regions, EXCEPT:**
    A) *Poor continuity of care*
    B) *Transportation logistics*
    C) *Difficulty locating a physician/provider*
    D) *Excessive community pressure to obtain care*

20. **Elderly adults in rural areas**
    A) *are more likely to live in skilled nursing facilities.*
    B) *are more likely to live in a household with someone.*
    C) *experience less food insecurity than those in urban areas.*
    D) *tend to have fewer issues with transportation than urban elderly persons.*

21. **Rural areas are characterized by less supportive attitudes toward LGBT+ individuals and more discriminatory policies and laws.**
    A) *True*
    B) *False*

Test questions continue on next page →

22. **Compared with urban individuals, transgender and gender non-conforming individuals living in rural communities experience**
    - A) *greater levels of social anxiety.*
    - B) *a less stressful coming-out process.*
    - C) *more supportive community spaces.*
    - D) *tend to spend more time building supportive social networks.*

23. **Which of the following statements regarding rural military veterans is TRUE?**
    - A) *Rural veterans tend to be younger than urban veterans.*
    - B) *About 2.7% of rural veterans served in the Vietnam War.*
    - C) *Historically, the U.S. military has focused recruiting efforts in Midwestern rural areas.*
    - D) *Rural veterans are more likely than urban veterans to have a diagnosed psychiatric condition.*

24. **Which of the following is a key element of interpersonal collaboration?**
    - A) *Coordination*
    - B) *Gatekeeping resources*
    - C) *Working independently*
    - D) *Professional-centeredness*

25. **On a micro level, interprofessional collaboration can result in**
    - A) *increased job satisfaction.*
    - B) *reduced patient mortality.*
    - C) *decreased length of hospital stays.*
    - D) *improved use of specialty care and services.*

26. **The smaller population size and tightly knit formal and informal social networks of rural communities can make for open and permeable boundaries, potentially negatively affecting practitioner-client confidentiality.**
    - A) *True*
    - B) *False*

27. **The top ethical challenge for social workers, counselors, and therapists working in a rural community is**
    - A) *confidentiality.*
    - B) *client autonomy.*
    - C) *dual relationships.*
    - D) *working within one's competencies.*

28. **In order to mitigate the challenges of dual relationships, practitioners can**
    - A) *referring clients to non-local agencies that offer telehealth options.*
    - B) *employ the strong, naturally occurring helping relationships that exist in the community.*
    - C) *offer to exchange services with practitioners in other rural communities via telehealth technology.*
    - D) *All of the above*

29. **Because residents of rural communities often have strong support systems in place, practitioners may struggle with the ethical principle of distributive justice.**
    - A) *True*
    - B) *False*

30. **All of the following challenge practitioners' ability to limit practice to areas of competence, EXCEPT:**
    - A) *Staffing shortages*
    - B) *Proliferation of subspecialists*
    - C) *A norm of professional silence*
    - D) *Lack of access to supervision, ethics committees, and trained ethics consultants*

Be sure to transfer your answers to the Answer Sheet located between pages 40–41.
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 #77041 — 6 CLOCK HOURS Release Date: 12/01/21 Expiration Date: 11/30/24

Setting Ethical Limits: For Caring and Competent Professionals

6 Ethics Clock Hours

Audience

This course is designed for social workers, counselors, and marriage and family therapists in all practice settings.

Course Objective

The purpose of this course is to educate helping professionals on how to provide compassionate care ethically to those they serve without causing burnout.

Learning Objectives

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

1. Define professional competence.
2. Describe the importance of cultural competence.
3. Outline components of the therapeutic relationship.
4. Define empathy and describe the difference between empathy and sympathy.
5. Identify compassion fatigue, vicarious trauma, and burnout and describe their impact on mental health professionals.
6. Define transference and countertransference and discuss their implications for the mental health professional.
7. Identify the functions of professional boundaries in the therapeutic relationship and multiple relationships.
8. Discuss the guidance on giving and receiving gifts provided by professional ethics codes.
9. Discuss the legal and ethical considerations of providing distance therapy.

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.

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Division Planners/Director Disclosure

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Social workers completing this intermediate-to-advanced course receive 6 Ethics continuing education credits.

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INTRODUCTION

Counselors can make a significant, positive impact in the lives of those with whom they work, and the practice of therapy can be highly rewarding and gratifying. However, it can also be emotionally demanding, challenging, and stressful. Counselors are at risk for occupational stress from a variety of sources, including [1]:

- The demands of clinical and professional responsibility
- The challenges of managing the client/counselor relationship
- The role characteristics that make counselors prone to burnout (e.g., high level of involvement)
- Vulnerability to vicarious traumatization
- The changing standards and business demands of the profession (e.g., increased documentation requirements, increased intrusion of legal/business concerns into therapeutic practice)
- The intersection of personal and professional demands

Healthy boundaries are a critical component of self-care. Setting boundaries can help counselors manage occupational stressors and maintain the delicate balance between their personal and professional lives. Boundaries also demonstrate competency in clinical practice and help counselors avoid ethical conflicts [2].

Please note, throughout this course the term "counselor" is used to refer to any professional providing mental health and/or social services to clients, unless otherwise noted.

COMPETENCE

Professional associations representing the various fields of clinical practice have codes of ethics that provide principles and standards to guide and protect both the mental health professional and the individuals with whom they work. For example, the American Psychological Association (APA), the American Counseling Association (ACA), the National Association of Social Workers (NASW), the National Board of Certified Counselors (NBCC), and the National Certification Commission for Addiction Professionals (NCCAP) each has an ethics code created to identify core values, inform ethical practice, support professional responsibility and accountability, and ensure competency among its members [3; 4; 5; 6; 7].

Competency is defined as "the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects" [8]. It is the scope of the professional's practice. According to the ethics codes of the APA, the ACA, and the NASW, members are to practice only within their boundaries of competence [3; 4; 5].

APA'S ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT

2.01 Boundaries of Competence

(a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.

(b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.03 Maintaining Competence

Psychologists undertake ongoing efforts to develop and maintain their competence.

2014 ACA CODE OF ETHICS

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.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.

CODE OF ETHICS OF THE NASW

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

(d) Social workers who use technology in the provision of social work services should ensure that they have the necessary knowledge and skills to provide such services in a competent manner. This includes an understanding of the special communication challenges when using technology and the ability to implement strategies to address these challenges.

(e) Social workers who use technology in providing social work services should comply with the laws governing technology and social work practice in the jurisdiction in which they are regulated and located and, as applicable, in the jurisdiction in which the client is located.

CULTURAL COMPETENCE

A general (aspirational) principle articulated in the APA's ethics code addresses respect for people's rights and dignity. The principle states, in part, that [3]:

> Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

CODE OF ETHICS OF THE NASW

1.05 Cultural Competence

(a) Social workers should demonstrate understanding of culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should demonstrate knowledge that guides practice with clients of various cultures and be able to demonstrate skills in the provision of culturally informed services that empower marginalized individuals and groups. Social workers must take action against oppression, racism, discrimination, and inequities, and acknowledge personal privilege.

(c) Social workers should demonstrate awareness and cultural humility by engaging in critical self-reflection (understanding their own bias and engaging in self-correction), recognizing clients as experts of their own culture, committing to lifelong learning, and holding institutions accountable for advancing cultural humility.

(d) Social workers should obtain education about and demonstrate understanding of the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability.

(e) Social workers who provide electronic social work services should be aware of cultural and socioeconomic differences among clients' use of and access to electronic technology and seek to prevent such potential barriers. Social workers should assess cultural, environmental, economic, mental or physical ability, linguistic, and other issues that may affect the delivery or use of these services.

Although counselors are not expected to know about every nuance of each culture they serve, it is important to be open to learning about diverse cultural backgrounds in order to provide empathic, competent care. It is also important to be aware of culture-specific religious or spiritual practices that are regarded as healing forces in the client's world. Achieving this awareness may involve researching the client's culture and inquiring about their culture-specific healing practices in a manner that respects the client's dignity and privacy [3]. It is always the professional's goal to do no harm. As previously stated, professionals must "try to eliminate the effect on their work of [their] biases" and address them outside the therapeutic time with a trusted colleague or supervisor [3].

CHARACTERISTICS OF A CULTURALLY COMPETENT COUNSELOR

Three characteristics of a culturally competent counselor have been described. First, a culturally competent counselor is actively engaged in the process of becoming aware of his or her assumptions about human behavior, values, biases, preconceived notions, and personal limitations [9]. This is an ongoing process of self-discovery that requires the willingness to address any issues that may arise. For example, because the concept of boundaries varies across cultures, therapeutic elements related to boundaries should be modified to adapt to this variance. The expectation of confidentiality also varies, so the counselor should not assume that confidentiality is implicitly restricted to the counselor and client. In many cultures, confidentiality is neither expected nor therapeutic [10]. Being culturally competent also requires vigilance and an understanding that referral to another counselor might be necessary in some circumstances (i.e., when working with a particular client is beyond the counselor's boundaries of competence) [9].

Next, a culturally competent counselor actively attempts to understand the worldview of a culturally different client by employing empathy and avoiding negative judgments [9]. This involves becoming familiar with the culture, subculture, and political history of the client when these differ from those of the counselor. This yields valuable rewards and is useful in avoiding the common therapeutic blunder of overgeneralization [10]. For example, knowing the client's ethnicity, political affiliation in their country of origin, religious beliefs, and expectations of gender roles all contribute to providing the counselor a more precise framework from which therapy can be applied. Clients usually recognize and appreciate the counselor's attempts to learn about their culture, which can enhance the therapeutic alliance [10]. It is also important to recognize that the client is part of a larger cultural system that may include family members, societal elders, or others of significance to the client. These others can impact the client's therapy, with positive or negative outcomes, depending on whether they are enlisted as therapeutic allies or alienated [10].

Last, a culturally competent counselor actively develops and practices appropriate, relevant, and sensitive intervention strategies and skills when working with culturally different clients. In order to keep abreast of new interventions and strategies, the counselor may need to acquire additional education, training, and supervised experience (***Resources***) [9].

Common issues in the therapeutic relationship (e.g., gifts, touch, eye contact, medication compliance, choice of vocabulary) are all influenced by culture. Rather than adhere to a rigid theoretical approach to dealing with these issues, it is best to seek out their cultural meaning on a case-by-case basis. Enlist the expertise of a "cultural informant" if one is available. This person is generally from the same culture as the client, is not an active participant in the therapy, and functions as a consultant to the professional by interpreting or identifying culture-specific issues. The therapeutic paradigm should be flexible. The degree of active intervention by the mental health professional, definition of therapeutic goals, techniques used, and outcome measures should all be modified to reflect cultural differences in the therapy. Also, transference and countertransference interactions influenced by culture will occur and require that professionals become familiar with the types of culturally influenced reactions that can occur in therapy. Phenomena such as cultural stereotyping often occur even when the counselor and client share the same ethno-cultural background [10].

THE THERAPEUTIC RELATIONSHIP

Many situations that occur in the counseling office are not written about in text books or taught in a classroom setting. Counselors learn through hands-on experience, intuition, ongoing supervision, and continuing education. One constant is the therapeutic relationship. Every therapeutic relationship is built on trust and rapport. Counselors teach their clients what a healthy relationship is through the compassionate care and limit setting that occurs within the therapeutic context. Counselors model acceptable behavior in the office so their clients are equipped to emulate and apply that behavior in the outside world. In many cases, counselors are teaching self-regulation to clients who are learning how to control impulses or regulate behavior in order to improve their connection to other people.

Bandura has described self-regulation as a self-governing system that is divided into three major subfunctions [11]:

- Self-observation: We monitor our performance and observe ourselves and our behavior. This provides us with the information we need to set performance standards and evaluate our progress toward them.
- Judgment: We evaluate our performance against our standards, situational circumstances, and valuation of our activities. In the therapeutic setting, the counselor sets the standard of how to interact by setting limits and upholding professional ethics. The client then compares the counselor's (i.e., "the expert's") modeled behavior with what they already have learned about relationship patterns and dynamics (i.e., referential comparisons).
- Self-response: If the client perceives that he or she has done well in comparison to the counselor's standard, the client gives him- or herself a rewarding self-response. The counselor should reinforce this response by delivering positive reinforcement and affirmation for the newly learned behavior. For example, if the client arrives to therapy habitually late and then makes an effort to arrive on time, the counselor can remark, "I notice that you are working hard to arrive on time for session. That is great." The counselor's positive reinforcement and acknowledgment can have a positive impact on the client's self-satisfaction and self-esteem.

According to Rogers, "individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behavior" [12]. To facilitate a growth-promoting climate for the client, the counselor should accept, care for, and prize the client. This is what Rogers refers to as "unconditional positive regard," and it allows the client to experience whatever immediate feeling is going on (e.g., confusion, resentment, fear, anger, courage) knowing that the professional accepts it unconditionally [12]. In addition to unconditional positive regard, a growth-promoting therapeutic relationship also includes congruence and empathy.

CONGRUENCE

Trust is built and sustained over time through consistent limits that are maintained within the sacred space of each therapeutic hour. When a counselor is observed as consistent and congruent, the client notices. Being authentic is part of being compassionate and empathic. Clients know when a counselor's words and actions do not match. These actions can be overt, such as cutting short the therapeutic time or going over the time allotted. They also can be subtle, as when leaked out and expressed through a stressed vocal tone, facial expression, or other body language indicator (e.g., arms folded across the chest). To the highly aware client, these actions can result in a loss of trust.

Nevertheless, counselors are not perfect and can err from time to time. This is why it is important for counselors to be self-aware, acknowledge when their words and actions do not match, and discuss that within the therapeutic relationship. If a client notices one of these cues of incongruence and expresses it to the counselor, it is essential that the counselor listen openly and validate the client's experience. Any defensiveness on the part of the counselor will decrease relationship trust. Conversely, this admission of human failure can actually build a stronger bond of trust. Clients see that counselors are, like themselves, human and imperfect. This presents an opportunity for clients to learn and then model this type of integrity in their own relationships. "Congruence for the therapist means that he (or she) need not always appear in a good light, always understanding, wise, or strong" [12]. It means that the therapist is his or her actual self during encounters with clients. Without façade, he or she openly has the feelings and attitudes that are flowing at the moment [12]. The counselor's being oneself and expressing oneself openly frees him or her of many encumbrances and artificialities and makes it possible for the client to come in touch with another human being as directly as possible [12]. As discussed, this involves self-observation and self-awareness on the counselor's part.

This does not mean that counselors burden clients with overt expression of all their feelings. Nor does it mean that counselors disclose their total self to clients. It means that the counselor is transparent to the client so that the client can see him or her within the context of the therapeutic relationship [13]. It also means avoiding the temptation to present a façade or hide behind a mask of professionalism, or to assume a confessional-professional attitude. It is not easy to achieve such a reality, as it involves "the difficult task of being acquainted with the flow of experiencing going on within oneself, a flow marked especially by complexity and continuous change" [12].

EMPATHY

There is great power in empathy. It breaks down resistance and allows clients to feel safe and able to explore their feelings and thoughts. It is a potent and positive force for change [12]. Empathy serves our basic desire for connection and emotional joining [14]. Empathy may be defined as the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another. It is a deeper kind of listening in which the counselor senses accurately the feelings and personal meanings that the client is experiencing and communicates this understanding to the client [12]. Empathy is not parroting back the client's words or reflecting only the content of those words. It entails capturing the nuances and implications of what the client is saying, and reflecting this back to the client for their consideration using clear, simply connotative language in as few words as possible [15]. Counselors also can show empathy in nonverbal ways to their clients by, for example, looking concerned, being attentive, leaning forward, and maintaining eye contact [15].

Empathy is a multi-level process of relating to others. It encompasses both an emotive experience and a cognitive one. It includes an intellectual component (namely, understanding the cognitive basis for the client's feelings), and it implies the ability to detach oneself from the client's feelings in order to maintain objectivity [16]. While engaged in empathic listening, mental health professionals should remain responsive to feedback and alter their perspective or understanding of the client as they acquire more information [16]. Empathy may be summarized by the ability to [17]:

- See the world as others see it.
- Be nonjudgmental.
- Understand another person's feelings.
- Communicate your understanding of that person's feelings.

Empathy should not be confused with sympathy, which may be defined as an affinity, association, or relationship between persons wherein whatever affects one similarly affects the other. Compared with empathy, sympathy is a superficial demonstration of care. With sympathy, you feel sorry for the client; with empathy, you feel the client's pain. Although a counselor can get caught up in the client's feelings, he or she should always strive to empathically understand what the client is experiencing while maintaining emotional detachment. This potentially provides a broader perspective that extends beyond the client's situational distress. Mental health professionals want to employ the best tools in order to affect change in their clients without causing harm, and empathy surpasses sympathy in terms of effectiveness. Research has validated the importance of empathy, unconditional positive regard, and congruence for achieving an effective therapeutic relationship [18].

Compassion-focused therapy is a rapidly growing, evidence-based form of psychotherapy that pursues the alleviation of human suffering through psychological science and engaged action [19]. According to Gilbert, the following are attributes of compassion-focused therapy [20]:

- Sensitivity: Responsive to distress and needs; able to recognize and distinguish the feelings and needs of the client.
- Sympathy: Being emotionally moved by the feelings and distress of the client. In the therapeutic relationship, the client experiences the counselor as being emotionally engaged with their story as opposed to being emotionally passive or distant.
- Distress tolerance: Able to contain, stay with, and tolerate complex and high levels of emotion, rather than avoid, fearfully divert from, close down, contradict, invalidate, or deny them. The client experiences the counselor as able to contain her/his own emotions and the client's emotions.
- Empathy: Working to understand the meanings, functions, and origins of another person's inner world so that one can see it from her/his point of view. Empathy takes effort in a way that sympathy does not.
- Nonjudgment: Not condemning, criticizing, shaming, or rejecting. It does not mean nonpreference. For example, nonjudgment is important in Buddhist psychology, which emphasizes experiencing the moment "as it is." This does not mean an absence of preferences.

Empathic Boundaries

Counselors strive to achieve empathy with their clients while maintaining boundaries that protect their own energies. Professionals should "sense the client's private world as if it were [their] own, without ever losing the 'as if' quality," and while not becoming entangled with their perception of the client [12; 21]. It takes work to maintain a healthy distance emotionally while feeling and intuiting what the client is saying.

Too much sympathy, or working with empathy without proper boundaries in the therapeutic relationship, drains the counselor of energy and leads to burnout. In a study of 216 hospice care nurses from 22 hospice facilities across Florida, it was found that trauma, anxiety, life demands, and excessive empathy (leading to blurred professional boundaries) were key determinants of compassion fatigue risk [22]. In other words, there can be too much of a good thing. In order to motivate client change, there should be a limit to the use of empathy in therapy. Empathy is but one tool that a compassionate mental health professional can use to ensure client growth.

THE COSTS OF CARING

Humans need humans and heal best with compassionate care. However, mental health professionals must guard against caring too much. While hearing about and sharing the joyous parts of a client's life is wonderful, most therapeutic work involves listening to a client's emotional pain, which can take its toll on even the most seasoned professional.

STRESS

Stress is a warning sign that indicates that self-care needs to be increased. Stress tells you that something is not right. It is like the "check engine" light on your car's dashboard, which, if ignored, can lead to major engine malfunction. Stress that is left unchecked or poorly managed is known to contribute to high blood pressure, heart disease, obesity, diabetes, and suicide [23]. Stress reminds us that we are human and that we have limits. The symptoms of stress include [23]:

- Headaches, muscle tension, neck or back pain
- Upset stomach
- Dry mouth
- Chest pains, rapid heartbeat
- Difficulty falling or staying asleep
- Fatigue
- Loss of appetite or overeating "comfort foods"
- Increased frequency of colds
- Lack of concentration or focus
- Memory problems or forgetfulness
- Jitters, irritability, short temper
- Anxiety

Other warning signs that more self-care is needed include outbursts, depression, anxiety, and lowered tolerance to frustration. Fatigue, whether physical, emotional, mental, or spiritual, can lead to reactivity and poor judgment. Little or no self-care can contribute to burnout, illness, and even addiction. It can also leave the professional vulnerable to crossing or violating boundaries.

A counselor's job is stressful for many reasons, including working in isolation; shouldering the burden of a client's depression, anxiety, apathy, and suicidality; witnessing slow, gradual progress in the therapeutic process; and managing increasing administrative demands (e.g., insurance claims, documentation). These demands can often lead to increased stress and frustration for the counselor.

Self-care includes stress management and vice versa. Self-care should be part of your preventative wellness routine, not instituted only when signs of illness or breakdown are already occurring. Activities that one recommends to clients to decrease their stress will also work for professionals. This includes healthy eating, time management, relaxation techniques, adequate sleep, and maintaining hobbies and outside interests.

COMPASSION FATIGUE, VICARIOUS TRAUMA, AND BURNOUT

When work-related stress is combined with a lack of self-care and support, more serious stress reactions can occur. Compassion fatigue can develop when a mental health professional cares too much or carries too much material [24]. Chronic day-to-day exposure to clients and their distress (e.g., sexual and physical abuse, military combat, community disaster) can be emotionally taxing for the helping professional and can result in compassion fatigue, vicarious trauma, or, ultimately, professional burnout [24; 25]. Vicarious trauma describes a profound shift in worldview that occurs in helping professionals when they work with clients who have experienced trauma; the professional's fundamental beliefs about the world are altered by repeated exposure to traumatic material. Burnout describes the physical and emotional exhaustion that helping professionals can experience when they have low job satisfaction and feel powerless and overwhelmed at work. It is not the same as being depressed or overworked. It is a subtle process in which an individual is gradually caught in a state of mental fatigue and is completely drained of all energy. However, burnout does not necessarily indicate a change in worldview or a loss of the ability to feel compassion for others [26; 27; 28].

The chronic use of empathy combined with day-to-day bureaucratic hurdles (e.g., agency stress, billing difficulties, balancing clinical work with administrative work) can generate the experience of compassion fatigue [29; 30]. This type of listening and exposure can take its toll on mental health professionals, particularly when combined with the need to maintain strong limits and boundaries both inside and outside the office. Yet, no matter how well-defined the boundaries are, there will be times when the professional will be affected by listening to what the client has lived through in order to survive; it can be very difficult to hear. This is why peer supervision is necessary. The professional benefits from having a place to offload and receive support following an intense client session in order to mitigate the risk of negative consequences, such as post-traumatic stress disorder, which can be an indirect response to clients' suffering. Compassion fatigue can also cause professionals to lose touch with their own empathy. Strong emotions, as evoked by traumatic material, may strain the empathic ability of the therapist [31]. Symptoms of compassion fatigue result in a loss of interest toward holding empathic response to others due to feeling overwhelmed and burdened by the client's trauma and illnesses. Caregivers with compassion fatigue may develop a preoccupation with re-experiencing clients' trauma; they can develop signs of persistent arousal and anxiety as a result of this secondary trauma. Examples of this arousal can include difficulty falling or staying asleep, irritability or outbursts of anger, and/or exaggerated startle responses. Most importantly, these caregivers ultimately experience a reduced capacity for or interest in being empathic toward the suffering of others [32]. Overlap can occur between compassion fatigue, vicarious trauma, and burnout, with the mental health professional experiencing more than one emotional state.

Some causes of burnout and compassion fatigue can result in part from the personality characteristics of the professional (e.g., perfectionism, overinvolvement with clients) [33]. Because burnout is largely identified in young, highly educated, ambitious professionals, many consider the conflict between an individual's expectations and reality as one of the main characteristics of burnout [27]. Additionally, the professional's attitudes, beliefs, and assumptions can have an impact on performance (e.g., "I must get all my clients better'') and may lead to irritation, a sense of failure, or burnout. Some attitudinal issues are specific to particular client groups (e.g., people who get hostile or perpetrators of sexual assault) or to particular elements of the therapy process (e.g., "I must be available for all of my clients all the time'') [34]. In order to prevent or decrease cases of burnout, compassion fatigue, and vicarious traumatization among professionals, it is important that they receive education on the signs and symptoms of each and that they have access to an open and supportive environment in which to discuss them.

MITIGATING THE COSTS OF CARING

Disengage

As noted, counselors are at increased risk for compassion fatigue, burnout, and/or vicarious trauma when the majority of their caseload involves trauma cases; when there is a lack of balance between work, rest, and play; and when there is a lack of attention to spiritual needs. To reduce their risk, counselors should learn to let go and leave work at work—they should learn to disengage. Disengagement can lower or prevent compassion stress by allowing counselors to distance themselves from the ongoing misery of clients between sessions. The ability to disengage demands a conscious, rational effort to recognize that one must "let go" of the thoughts, feelings, and sensations associated with client sessions in order to live one's own life. Disengagement is the recognition of the importance of self-care and of the need to carry out a deliberate program of self-care [30]. When counselors employ self-care, they model for their clients what mental health looks like. When clients know that counselors have done their own therapeutic or healing work, it instills in them a sense of hope. They see results that indicate the process can work for them, too.

Seek Support

Research indicates that encouraging peer support groups, providing education on the impact of client traumas on mental health professionals, diversifying caseloads, encouraging respite and relaxation, and encouraging a sense of spirituality and wellness are several means of providing support for at-risk professionals [35]. Counselors can be more resilient, accomplish more, and feel more worthwhile when they have close, supportive relationships. Support acts as a buffer against the effects of stress and burnout [36]. Counselors with a larger sense of meaning and connection who practice self-care and work in collaboration with others are less likely to experience vicarious traumatization [37; 38].

Set Self-Care Boundaries

In addition to setting and maintaining boundaries with clients, counselors also should set and maintain self-care boundaries to avoid burnout. When setting self-care boundaries, counselors may consider some of the following habits [39; 40]:

- Leave work at the office. Avoid conducting research, making telephone calls, and catching up on record keeping at home. Set office hours, publish them on your answering machine, and adhere to those hours.
- Have a procedure for after-hours emergency calls. For example, many counselors instruct clients to call the nearest hospital or go to the local emergency room. Other offices may have an on-call clinician dedicated to responding to emergency calls. The important thing is that there be a clear policy in place for after-hours calls and that clients are aware of and understand the policy.
- Do not skip meals to see an extra client. Include regularly scheduled breaks as part of each work day.
- Schedule and take vacations. Do not check your messages while on vacation. Ask another counselor to see clients in cases of emergency. Most clients can tolerate their counselor's absence for a week or two.
- Live a well-rounded life beyond the office. Make time for friends and family and engage in interests that renew you.
- Educate yourself about trauma and its effects. If you are a supervisor, consider using instruments that measure stress with supervisees. The Maslach Burnout Inventory (MBI) and the Professional Quality of Life (ProQOL) scale should be administered on a regular basis to assess both organizational and individual risk of burnout and trauma-related conditions in high-risk settings.
- Increase your capacity for awareness, containment, presence, and integration. Awareness can be encouraged through meditation, visualization, yoga, journal keeping, art, other creative activities, and personal psychotherapy. Containment abilities can be built through self-care efforts and a balanced life that includes time spent in activities unrelated to work.

Mental health professionals should strive to maintain a balance between giving and getting, between stress and calm, and between work and home. These stand in clear contrast to the overload, understaffing, over-commitment, and other imbalances of burnout. To give and give until there is nothing left to give means that the professional has failed to replenish his or her resources [28].

Practice Mindfulness

Helping professionals often feel like they have to fix others or have all the answers. This is a faulty cognition. Oftentimes, the most healing and powerful act a counselor can do is being in the moment with the client, holding the space for his or her feelings and thoughts. Mindfulness practice can facilitate this. The practice of mindfulness (i.e., present-focused attending to ongoing shifts in mind, body, and the surrounding world), integrated into daily life, can help counselors to develop enhanced patience, presence, and compassion [41]. It can help counselors to stay calmly focused and grounded, which allows them to be less reactive and engage with greater equanimity [41].

One study investigated how the use of dialectical behavioral therapy (DBT) in working with young, self-harming women with borderline personality disorder affected the occupational stress and levels of burnout among psychiatric professionals [42]. DBT was stressful in terms of learning demands, but it decreased the experience of stress in actual treatment of clients. Participants felt that mindfulness training, which was one aspect of DBT, improved their handling of work stressors not related to DBT [42]. Counselors were better able to accept feelings of frustration, cope with stress, and be more patient and relaxed [42]. Mindfulness has been found to decrease stress, increase concentration, and increase the counselor's ability to detach from the client's material. It also assists a counselor's empathy and boundary setting [43]. Mindfulness, attention, empathy, and counseling self-efficacy have been found to be significantly related to one another [43].

One study explored the impact of Buddhist mindfulness (meditation) practice on the attitude, work, and lived experience of counselors and their self-reported experiences of working with clients [44]. Findings suggest that a long-term mindfulness meditation practice can positively impact counselors' ability to distinguish their own experiences from their clients' experiences, can enrich clarity in their work with clients and may help them develop self-insight [44]. Mindfulness may also help to increase patience, intentionality, gratitude, and body awareness [45]. It is an excellent tool for caring, compassionate professionals to use to maintain their own energies and support their clients' growth.

Expand Your Professional World

Symptoms of burnout or compassion fatigue can be signs of a need to grow professionally. This might mean branching out from individual therapy sessions to include group therapy, teaching at local colleges, supervising other professionals, developing continuing education units, or providing consultations. In some instances, it might mean changing careers or exploring other ways to use your licensure and experience.

TRANSFERENCE AND COUNTERTRANSFERENCE

The term transference was coined by Freud to describe the way that clients "transfer" feelings about important persons in their lives onto their counselor. As Freud said, "a whole series of psychological experiences are revived, not as belonging to the past but applying to the person of the physician at the present moment" [46]. The client's formative dynamics are recreated in the therapeutic relationship, allowing clients to discover unfounded or outmoded assumptions about others that do not serve them well, potentially leading to lasting positive change [47]. Part of the counselor's work is to "take" or "accept" the transferences that unfold in the service of understanding the client's experience and, eventually, offer interpretations that link the here-and-now experience in session to events in the client's past [48]. The intense, seemingly irrational emotional reaction a client may have toward the counselor should be recognized as resulting from projective identification of the client's own conflicts and issues. It is important to guard against taking these reactions too personally or acting on the emotions in inappropriate ways [49]. Therapists' emotional reactions to their patients (countertransference) impact both the treatment process and the outcome of psychotherapy.

REFLECTION

It also is important to be reflective rather than reactive in words and actions. Use of the mindfulness technique can help counselors to become reflective rather than reactive and can help counselors unhook from any triggering material and maintain appropriate limits and boundaries. Reflection demands a reasonable level of awareness of one's thoughts and feelings and a sound grasp of whether they deviate from good professional behavior. Reflection includes [51]:

- A questioning attitude towards one's own feelings and motives
- The recognition that we all have blind spots
- An understanding that staff are affected by clients
- An understanding that clients are affected by staff behavior
- A recognition that clients often have strong feelings toward staff

Clients are more accepting of transference interpretations in an environment of empathy. Transference interpretation is most effective when the road has been paved with a series of empathic, validating, and supportive interventions that create a holding environment for the client [52].

Freud believed transference to be universal, with the possibility of occurring in the counselor as well as the client. He described this "countertransference" as "the unconscious counter reaction to the client's transference, indicative of the therapist's own unresolved intrapsychic conflicts" [53]. Freud felt that countertransference could interfere with successful treatment [47]. Since the 1950s, the view of countertransference has evolved. It is no longer believed to be an impediment to treatment. Instead, it is viewed as providing important information that the professional can use in helping the client [47].

Empathy allows the counselor to experience and thus know what the client is experiencing. Countertransference emerges when the client's transference reactions touch the counselor in an unresolved area, resulting in conflictual and irrational internal reactions [54]. Good indicators of countertransference are feelings of irritability, anger, or sadness that seem to arise from nowhere. Countertransference frequently originates in counselors' unresolved conflicts related to family issues, needs, and values; therapy-specific areas (e.g., termination, performance issues); and cultural issues [55]. When feelings have intensity or when they persist, this is an indicator for future work and healing.

The counselor's work is to bear the client's transferences and interpret them. When the counselor refuses the transference, there is often a mutual projective identification going on, in which both counselor and client project part of themselves onto the other. Refusal may also mean that one of the counselor's own blind spots has been engaged. As Shapiro explains, "a rough edge of our character has been 'hooked' by a bit of what the patient is struggling with, and we act out a bit of countertransference evoked in us by the transference" [56]. In a group therapy setting, family dynamic re-enactments can emerge as transferences. Managing these complex dynamics can raise the counselor's anxiety and mobilize his or her defenses, compromising a usually thoughtful stance. When counselors experience intense reactions in trauma groups that pull them out of the present moment, they should investigate whether they are responding to traumatic content, personal unresolved issues, or individual or collective transference [57]. Counselors who find themselves ruminating about a previous session's content, a client's welfare, or their own issues should talk with a trusted, objective colleague. Countertransference issues for the mental health professional should be resolved apart from the therapeutic environment to avoid burdening and potentially harming clients [53]. One study of countertransference found that therapists' self-reported disengaged feelings over a treatment period adversely impacted the effect of transference work for all patients, but especially for patients with a history of poor, nonmutual, complicated relationships [50].

SELF-AWARENESS

Problems arise when the professional lacks awareness or refuses to devote the necessary time to process the personal emotions and thoughts that arise within the therapeutic relationship. Feelings of anger, grief, jealousy, shame, injustice, trauma, and even attraction can, when they touch a wound from the past, trigger reactions within even experienced professionals. Clients' experiences can replicate the professional's past relationships and trigger emotions that have not been worked on or addressed. If this occurs, the professional can, without disrupting the client's session, make a mental note of the feelings. This allows the professional to attend to the present moment. After the client's session has ended, the professional can arrange to talk to a colleague or supervisor for processing. If the countertransference continues, it may be necessary for the professional to seek counseling. Self-awareness helps the professional to reflect back to the client's true emotions. It also is an important component of training, development, and effectiveness [58]. Mental health professionals need to possess certain values, qualities, and sensitivities, and should be open-minded and have an awareness of their comfort levels, values, biases, and prejudices [59].

As stated in the ethics codes of the ACA [4]:

> Therapists are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors. They 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 their values are inconsistent with the client's goals. They refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner. When they become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance and determine whether they should limit, suspend, or terminate their work-related duties.

BOUNDARIES AND LIMITS

Generally speaking, a boundary indicates where one area ends and another begins. It indicates what is "out of bounds" and acts to constrain, constrict, and limit. In the therapeutic relationship, a boundary delineates the "edge" of appropriate behaviors and helps to rule in and out what is acceptable, although the same behaviors might be acceptable or even desirable in other relationships [60; 61]. Boundaries have important functions in the therapeutic relationship, helping to build trust, empower and protect clients, and protect the professional.

BUILDING TRUST

An inherent power differential exists in the therapeutic relationship between the client, who is placed in a position of vulnerability as she or he seeks help, and the practitioner, who is placed in a position of power because of her or his professional status and expertise [61]. When the client sees the counselor sitting in a chair, with a diploma or licensure on the wall, it can be intimidating. To help mitigate these feelings with the client, it is important to maintain a sense of professionalism while working to build trust and rapport. Part of that professionalism includes setting limits and explaining what they are in the context of therapy.

The familiarity, trust, and intensity of the therapeutic relationship create a powerful potential for abuse that underscores the need for careful attention to the ethical aspects of professional care [61]. Trust is the cornerstone of the therapeutic relationship, and counselors have the responsibility to respect and safeguard the client's right to privacy and confidentiality [4]. Clients have expressed what they believe to be essential conditions for the development of trust in the therapeutic relationship. These include that the clinician [62]:

- Is perceived as available and accessible
- Tries to understand by listening and caring
- Behaves in a professional manner (evidenced by attributes such as honesty in all interactions)
- Maintains confidentiality
- Relates to the client as another adult person rather than as an "expert"
- Remains calm and does not over-react to the issue under discussion

Only when satisfied that the clinician is sufficiently experienced, professional, flexible, and empathic can a foundation for therapy be laid. Clients acknowledge that this takes time and that the trustworthiness of the therapeutic relationship may be tested. If the relationship is perceived to be wanting, clients indicate that they would have difficulty continuing it [62].

THE VALUE OF FLEXIBILITY

Rigid boundaries can negatively reinforce the power differential that exists between the client and the counselor. Rigid boundaries may serve the fears and needs of counselors who are new to the profession and/or concerned with the implications of boundary violations. However, rigid boundaries can lead to harm for the client who perceives that the "rules" are more important than his or her welfare. While rigidity and remoteness on the counselor's part may help ensure that boundaries are intact, they do not accurately reflect the intended role of boundaries in clinical practice. Boundaries should never imply coldness or aloofness. As stated, clients value flexibility, caring, and understanding. Within conditions that create a climate of safety, flexible boundaries can accommodate individual differences among clients and counselors and allow them to interact with warmth, empathy, and spontaneity [63]. Firm, intractable boundaries may be a comfort to the helping professional; however, fixed rules cannot capture the complex reality of the therapeutic relationship [61].

EMPOWERING AND PROTECTING THE CLIENT

Boundaries and effective limit setting in sessions help to empower and protect clients by teaching and reinforcing the skills they need to become healthy. Boundaries set the parameters and expectations of therapy, so it is important to articulate them in such a way that each client's understanding of them is clear. Counselors should constantly and actively make judgements about where to draw lines that are in the client's best interests [64].

Boundaries begin the moment a client enters the room. Indicate which chair is yours and where it is acceptable for the client to sit. Take note of where your seat is in relation to the door should an emergency arise. Be sure to maintain an appropriate amount of space between yourself and the client. Too much space can feel impersonal and too little can feel invasive. Consider the décor of the setting. Clients may become distracted by the counselor's personal artifacts and family photographs and may place their focus on the counselor rather than on their own therapeutic work. Some clients with poor boundaries may become preoccupied with the counselor's family, which can become a source of transference.

Clients often enter therapy with a history of prior boundary violations (e.g., childhood sexual abuse, domestic violence, inappropriate boundary crossings with another professional) that leave them with persisting feelings and confusion regarding roles and boundaries in subsequent intimate relationships [65]. Consequently, they may test the boundaries as children do. The counselor should recognize these boundary dilemmas and manage them by reiterating the boundaries calmly and clearly [64]. The counselor must also set and maintain boundaries even if the client threatens self-harm or flight from therapy. This can be extremely challenging when faced with a client's primitively motivated, intense demands. However, counselors should recall that one description of the tasks with clients with primitive tendencies is to resist reinforcing primitive strivings and to foster and encourage adult strivings [66]. Winnicott refers to this as a "holding relationship," wherein the counselor acts as a "container" for the strong emotional storms of the client. The act of holding helps reassure the client that the clinician is there to help the client retain control and, if necessary, assume control on his or her behalf [67].

Due to the potential issues and challenges that the client brings to therapy (e.g., cognitive deficits, substance abuse/addictions, memory issues, personality disordered manipulations), it is important to maintain a record of instances when the articulated boundaries and limits have been ignored or violated. For example, a client is habitually late, despite knowing that it is unacceptable to arrive more than 10 minutes late to session. The first instance of a late arrival might simply warrant a reminder of the 10-minute limit, whereas repeated instances would require that the limit be enforced. The clinician who overidentifies with a client might experience a need to do things for the client rather than help the client learn to do things for him- or herself. While this behavior may appear relatively harmless, it suggests overinvolvement with a client and potential boundary problems [68]. Such behavior inhibits the client's ability to learn personal responsibility and how to resolve conflict [69]. It also may impede the reflective and investigative character of an effective helping process [39]. Mental health professionals should take reasonable steps to minimize harm to clients where it is foreseeable and unavoidable [3; 4]. They also should facilitate client growth and development in ways that foster the interest and welfare of the client and promote the formation of healthy relationships [4].

PROTECTING THE PROFESSIONAL

As stated, professional associations that represent the various fields of clinical practice have codes of ethics that provide principles and standards to guide and protect the professional and the individuals with whom they work [3; 4; 5; 6; 7]. Client welfare and trust in the helping professions depend on a high level of professional conduct [3; 4]. Professional values, such as managing and maintaining appropriate boundaries, are an important way of living out an ethical commitment [4].

Some situations in therapy are clear with regard to boundaries (e.g., no sexual relationships with clients). Other situations may be not as clear or may be ambiguous (e.g., receiving gifts from clients). When faced with such situations, professionals should engage in an ethical decision-making process that includes an evaluation of the context of the situation and collaboration with the client to make decisions that promote the client's growth and development [4]. Supervision and colleague support also may be necessary to reach the best decision. Such a process helps clinicians maintain justice and equity and avoid implications of favoritism in dealing with all of their clients [70].

Professionals who deliver services in nontraditional settings, such as those who have home-based practices, face unique challenges related to boundaries and limit setting. As with office-based therapy, some situations cannot be prepared for and will need to be addressed in the moment. While delivering services in nontraditional settings may benefit some clients, when working in homes or residences, the professional is advised to emphasize informed consent, particularly with regard to therapeutic boundaries. Whenever possible, the impact of crossing boundaries on therapy and on the therapeutic relationship should be considered ahead of time [71].

BOUNDARY CROSSINGS AND VIOLATIONS

A boundary crossing is a departure from commonly accepted practices that could potentially benefit clients; a boundary violation is a serious breach that results in harm to clients and is therefore unethical [72]. Professional risk factors for boundary violations include [73]:

- The professional's own life crises or illness
- A tendency to idealize a "special" client, make exceptions for the client, or an inability to set limits with the client
- Engaging in early boundary incursions and crossings or feeling provoked to do so
- Feeling solely responsible for the client's life
- Feeling unable to discuss the case with anyone due to guilt, shame, or the fear of having one's failings acknowledged
- Realization that the client has assumed management of his or her own case

Denial about the possibility of boundary problems (i.e., "This couldn't happen to me") also plays a significant role in the persistence of the problem [73]. Lack of self-care and self-awareness also can leave the mental health professional vulnerable to boundary crossings and/or violations.

Whatever the reason the professional has to cross a boundary, it is of utmost importance to ensure that it will not harm the client. Each boundary crossing should be taken seriously, weighed carefully in consultation with a supervisor or trusted colleague, well-documented, and evaluated on a case-by-case basis. Intentional crossings should be implemented with two things in mind: the welfare of the client and therapeutic effectiveness. Boundary crossing, like any other intervention, should be part of a well-constructed and clearly articulated treatment plan that takes into consideration the client's problem, personality, situation, history, and culture as well as the therapeutic setting and context [74]. Boundary crossings with certain clients (e.g., those with borderline personality disorder or acute paranoia) are not usually recommended. Effective therapy with such clients often requires well-defined boundaries of time and space and a clearly structured therapeutic environment. Dual or multiple relationships, which always entail boundary crossing, impose the same criteria on the professional. Even when such relationships are unplanned and unavoidable, the welfare of the client and clinical effectiveness will always be the paramount concerns [74].

Some counselors may consider a boundary crossing when it provides a better firsthand sense of the broader clinical context of their client, such as visiting the home of a client that is ailing, bedridden, or dying; accompanying a client to a medically critical but dreaded procedure; joining a client/architect on a tour of her latest construction; escorting a client to visit the gravesite of a deceased loved one; or attending a client's wedding [74]. Many mental health professionals will not cross these boundaries and will insist that therapy occur only in the office. Each professional should operate according to the parameters with which he or she is comfortable. As stated, the best interests of the client, including client confidentiality, and the impact to therapy should be of paramount importance when considering whether to cross a boundary.

To be in the best position to make sound decisions regarding boundary crossings, mental health professionals should develop an approach that is grounded in ethics; stay abreast of evolving legislation, case law, ethical standards, research, theory, and practice guidelines; consider the relevant contexts for each client; engage in critical thinking and personal responsibility; and, when a mistake is made or a boundary decision has led to trouble, use all available resources to determine the best course of action to respond to the problem [75]. The risk management strategy also should include discussions with supervisors, colleagues, and the client. Each step should be documented and should include supervisory recommendations and client discussion regarding the benefits versus the risks of such actions. Although minor boundary violations may initially appear innocuous, they may represent the foundation for eventual exploitation of the client. If basic treatment boundaries are violated and the client is harmed, the professional may be sued, charged with ethical violations, and lose his/her license [76].

MULTIPLE RELATIONSHIPS

Examples of multiple relationships include being both a client's counselor and friend; entering into a teacher/student relationship; becoming sexually involved with a current or former client; bartering services with a client; or being a client's supervisor. Even when entering into a multiple relationship seems to offer the possibility of a better connection to a client, it is not recommended. Multiple relationships can cause confusion and a blurring of boundaries and risk exploitation of the client.

The issue of multiple relationships is addressed by the codes of ethics of mental health professions. According to the APA's ethics code [3]:

> A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person. A psychologist refrains from entering into a multiple relationship if the multiple relationships could reasonably be expected to impair the psychologist's objectivity, competence or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

The ethics code of the NASW (standard 1.06 Conflicts of Interest) defines dual or multiple relationships as occurring "when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively." [5]. It also states that "social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries" [5]. The code further states that it is the professional's responsibility to "be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment" and that counselors should "inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible" [5]. In some instances, this may require "termination of the professional relationship with proper referral of the client" [5].

The ACA ethics code states that [4]:

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

Mental health professionals who practice in small, rural communities face special problems in maintaining neutrality, fostering client separateness, protecting confidentiality, and managing past, current, or future personal relationships with clients [77]. Whether the practice is located in a small town or a big city, there will be times when counselors and clients will encounter one another outside the office. To ignore a client who is reaching out in a social setting may cause the client harm. However, it also is important to avoid violating the client's privacy. The best way to minimize the potential awkwardness of such an encounter is to prepare ahead of time. For example, a counselor might incorporate a conversation about such an encounter into the initial evaluation process by telling the client: "If I happen to be at a store or a restaurant and see you, I won't say hello because I respect your confidentiality and want to protect your privacy. However, if you want to smile or say hello to me, I will respond in kind." Explain to the client that the conversation or acknowledgment must be brief to prevent any violation of the client's privacy. After an encounter in public, address the event in your next session, discuss any feelings the client had about the encounter, and note the discussion in the client record. Such an encounter would not fall under the category of dual/multiple relationships unless, for example, the counselor and client went grocery shopping at the same time every week and interacted each time. In this instance, the counselor is advised to change his or her shopping day and/or time in order to avoid risking loss of client confidentiality.

BOUNDARY VIOLATIONS WITHIN MULTIPLE RELATIONSHIPS

Mental health professionals are forbidden to exploit any person over whom they have supervisory, evaluative, or other similar authority. This includes clients/patients, students, supervisees, research participants, and employees [3; 4]. Professional ethics codes outline specific instances of behaviors and actions (some that are expressly prohibited) that have exploitative potential, including [3; 4; 5]:

- Bartering with clients
- Sexual relationships with students or supervisees
- Sexual intimacies with current or former clients
- Sexual intimacies with relatives/significant others of current therapy clients
- Therapy with former sexual partners or partners of a romantic relationship
- Romantic interactions or relationships with current clients, their romantic partners, or their family members, including electronic interactions or relationships
- Physical contact with clients (e.g., cradling or caressing)

There are times when a client has an emotional session and hugs the counselor unexpectedly before leaving the office. This physical contact should be noted in the client's record along with what precipitated it. It should be revisited with the client at the next session, with this discussion recorded in the client's record. While you may prefer no physical contact, you can try to respond positively to the desire for closeness. For example, make personal contact with your hand as you hold the client at a distance, make eye contact, and tell the client that while physical reaching out is positive and welcome, you cannot allow it [12].

The ACA ethics code prohibits sexual and/or romantic counselor/client interactions or relationships with former clients, their romantic partners, or their family members for a period of five years following the last professional contact. This prohibition applies to both in-person and electronic interactions or relationships [4]. The APA ethics code indicates that this period should be "at least two years after cessation or termination of therapy," and that "psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances" [3]. Mental health professionals who choose to engage in relationships with former clients have the burden of demonstrating that there has been no exploitation, in light of all relevant factors [3]. Factors to consider include the amount of time passed since termination of therapy; the client's personal history and mental status; the likelihood of an adverse impact on the client; and statements or actions made by the counselor during therapy suggesting or inviting a possible sexual or romantic relationship with the client [3].

Standards regarding sexual relationships and physical contact also are addressed by the NASW ethics code [5]:

1.09 Sexual Relationships

(a) Social workers should under no circumstances engage in sexual activities, inappropriate sexual communications through the use of technology or in person, or sexual contact with current clients, whether such contact is consensual or forced.

(b) Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers—not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(d) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.

1.10 Physical Contact

Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

The safest course of action is to continue to maintain established boundaries and limits indefinitely after therapy ends. In addition to the noted relevant factors, counselors should keep in mind that the client may return for further treatment. If the counselor has become involved in a business or social relationship with a former client, he or she deprives the client of the opportunity to return for additional treatment. It is vital to be mindful of the potential to exploit the client's vulnerability in a post-termination relationship [78].

Mental health professionals who find themselves attracted to a client should seek supervision around this issue. It is normal for feelings to develop in any type of relational context. It is not the feelings of attraction that are the problem, but rather actions taken. Mental health professionals should never act on these feelings, but instead discuss them with a trusted supervisor or colleague, exploring the possibility of countertransference as well as the potential trigger for the attraction. If the attraction causes intense feelings, it is advisable to seek personal therapy. If the feelings interfere with one's ability to treat a client, the client should be transferred to another professional, and work with the client terminated.

GIFTS

It is not unusual during the course of therapy for a client to present a counselor with a token of appreciation or a holiday gift, and receiving gifts from clients is not strictly prohibited by professional ethics codes. Instead, the ethics codes advise professionals to consider a variety of factors when deciding whether to accept a client's gift.

Section A.10.f (Receiving Gifts) of the 2014 ACA Code of Ethics states that [4]:

> 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.

The National Board for Certified Counselors Code of Ethics: Directive #4 provides similar guidance to its members [6]:

> National certified counselors (NCCs) shall not accept gifts from clients except in cases when it is culturally appropriate or therapeutically relevant because of the potential confusion that may arise. NCCs shall consider the value of the gift and the effect on the therapeutic relationship when contemplating acceptance. This consideration shall be documented in the client's record.

In the code of ethics of the Association for Addiction Professionals, Principle I-40: The Counseling Relationship states that [7]:

> Addiction professionals recognize that clients may wish to show appreciation for services by offering gifts. Providers shall 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.

As noted in these excerpts, the effect on the therapeutic relationship should be a primary consideration when considering whether to accept a gift. Gifts can mean many things and also can fulfill social functions. The counselor's task is to identify the contextual meaning of the gift and determine when the gift is not merely a gift. To do so, the counselor must draw out from the client information to discern the possibility of a metaphorical or culturally significant meaning for the gift giving [79]. Counselors should consider the client's motivation for gift-giving as well as the status of the therapeutic relationship. Gifts that may seem intended to manipulate the counselor are probably best refused, whereas rejection of a gift intended to convey a client's appreciation may harm the relationship [80].

If the counselor is most comfortable with a "no-gift policy," it is best that the policy be discussed at the beginning of therapy. To wait until a client is presenting a gift to state that it is your policy to decline gifts may harm the client and damage the therapeutic relationship. Clear communication, both written and spoken, of the policy with clients as they enter therapy may help avert difficult later interactions around gifts. If clients have an understanding as they begin therapy what the counselor's approach will be, misunderstandings may be avoided [81]. While restrictive guidelines might be unhelpful, confusion surrounding gifts seems to be exacerbated by a lack of professional discussion about the topic [82].

Many professionals try to keep gifts "alive" throughout client sessions. This often involves putting the gift "on hold" (including decisions about acceptance and rejection) until the best moment for exploration with the client occurs. This allows that gifts given during therapy (where possible) remain part of therapy (i.e., they stay in the room and are available for future sessions) [82]. When considering whether to discuss the gift as part of therapy, the counselor should evaluate pertinent factors, such as the client's time in therapy, the context and frequency of gifts, and client dynamics. While not all gifts warrant full discussion (e.g., those given to show appreciation or of modest financial value), some, such as repeated or expensive gifts, do. Although counselors should be careful not to make too much of a gift, especially those that clients at least initially see as being given simply as a way to say thank you, such conversations may enable both members of the dyad to attain greater insight into the gift's intention and meaning and thereby prove helpful to the continued therapy work [83].

Gifts can range from physical objects, to symbols or gestures. As stated, consider 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 [4; 5; 7]. If there are concerns about any of these factors, it may be best to explore the intent of the gift in session. If a gift is deemed inappropriate, the counselor is advised to decline to accept it. In these cases, counselors should express appreciation for the thought and gesture, explain why they are unable to accept the gift, return it with kindness, and note the encounter in the client's record.

Professionals who work with children have unique challenges regarding gifts. Rejecting a child's gift or trying to explain a "no-gift policy" can cause the child to feel confused or rejected; children do not have the same levels of cognition and understanding that adults have. For play counselors, potential compromises include incorporating the gift into the other materials and toys in the playroom or directly sharing the gift with the child [83]. An important factor affecting the decision to accept a gift is the kind of gift presented by the child. Artwork or something created by the child is an extension of the child and therefore can be viewed as an extension of emotional giving. Accepting non-purchased items (e.g., a flower picked by a child or a child's drawing) would be acceptable in most cases [84].

Clients with personality disorders present unique challenges regarding the issue of gifts. Generally, these clients exhibit manipulation, poor boundaries, and fixed or rigid patterns of relating, and gift giving can be a feature of the clinical picture for such clients. Accepting a gift from such a client may reinforce patterns of manipulative or self-debasing behaviors that are symptomatic of the problematic levels of functioning. In such instances, counselors should discern which course of action is truly in the client's best interests [79].

Often, a small token may be given or received at the termination of therapy for a long-term client. A touchstone that has meaning for the client, such as a meditation CD, book, or greeting card, is appropriate. As with all gifts, the gift and the context in which the gift was given or received should be noted in the client's record, along with your own intent and how you think the client perceived the gift.

THE GIFT OF SELF-DISCLOSURE

Self-disclosure can be considered another type of gift; however, it is best saved for a special occasion, shared deliberately, and always with the client's welfare first and foremost in mind. Self-disclosure is useful when it benefits the client, not the counselor. Although self-disclosure may cause no problems in therapy, it may intrude on the client's psychic space or replace a client's rich and clinically useful fantasy with dry fact, stripped of meaningful affect [73].

Humanistic theorists openly embrace counselor self-disclosure, asserting that such interventions demonstrate counselors' genuineness and positive regard for clients [85]. It is not surprising that professionals with behavioral and cognitive orientations view professional self-disclosures positively, especially when these interventions are intended to serve as a model for client self-disclosure [86]. And there will be times that self-disclosure is helpful in therapy. For example, it may serve as a vehicle for transmitting feminist values, equalizing power in the therapy relationship, facilitating client growth, fostering a sense of solidarity between counselor and client, helping clients view their own situations with less shame, encouraging clients' feelings of liberation, and acknowledging the importance of the real relationship between counselor and client. It also may enable clients to make informed decisions about whether or not they choose to work with a counselor [86].

According to one study, the content areas clinical social workers felt most comfortable self-disclosing about were loneliness, relationship status, aging, and other developmental issues of adulthood. Many talked freely about their marital status, the composition of their families, their parenting, their education, and their work. The most significant content area for sharing was grief work around significant losses either through separation, divorce, or death [87]. In these cases, counselor self-disclosure can help clients feel less alone and can normalize an emotional experience. It can give a client hope to learn that a trusted counselor has gone through the same situation.

Cautions Regarding Self-Disclosure

The power differential in the therapeutic relationship gives the professional access to a great deal of information about the client, which is transmitted in a one-way direction from client to counselor. Occasionally, a client will ask personal questions of the counselor. The questions may arise simply out of curiosity, but they also may arise when a client is attempting to gain a feeling of control, as seen in individuals with personality disorders. Personal questions also may signal a client's wish to avoid feeling uncomfortable with emerging feelings/thoughts. Acknowledging and showing compassion for the client's curiosity while maintaining professional boundaries will satisfy most clients. While it is normal for clients to be curious, it is important to remind them that they are the focus of session. Gently redirect the conversation with comments such as, "Let's get back to you," or "What were you thinking or feeling before you asked me about myself?" It is important that professionals keep their sharing limited, even when the client asks for them to self-disclose.

No matter how on guard one is, there will be times when personal information makes its way to clients. Accidental self-disclosures may include extra-therapeutic encounters, slips of the tongue, or public notices of events or lectures. Personal aspects of the counselor's life may come to light if he or she calls a client by another client's name, a newspaper prints an obituary of the counselor's spouse, or the counselor is seen entering a place of worship [88]. Most clients who learn a bit of personal information about their counselor will mention it only to express care or concern, as when they learn of a death. Clients are generally satisfied with a brief acknowledgement of the disclosure and an appreciation for the client's expressed feelings about it.

As stated, mental health professionals' primary concern is to avoid burdening or overwhelming clients. Professionals should generally avoid using disclosures that are for their own needs, that remove the focus from the client, that interfere with the flow of the session, that burden or confuse the client, that are intrusive, that blur the boundaries between the professional and client, or that contaminate transference [86].

TECHNOLOGY AND DISTANCE THERAPY

We live in a rapidly changing world, especially where technology is concerned. In the past, therapy was offered only through in-person interaction in an office setting. Then, gradually, some professionals began to offer telephone sessions. Today, counseling is offered through video conferencing and online message boards, and paper client records are being replaced with electronic records. Competent counseling includes maintaining the knowledge and skills required to understand and properly use treatment tools, including technology, while adhering to the ethical code of one's profession.

The APA has created guidelines to address the developing area of psychologic service provision commonly known as telepsychology [89]. The APA defines telepsychology as the "provision of psychological services using telecommunication technologies. Telecommunication technologies include, but are not limited to, telephone, mobile devices, interactive videoconferencing, email, chat, text, and Internet (e.g., self-help websites, blogs, and social media)" [89]. The APA guidelines are informed by its ethics code and record-keeping guidelines as well as its guidelines on multicultural training, research, and practice. The guidelines allow that telecommunication technologies may either augment traditional in-person services or be used as stand-alone services. The guidelines also acknowledge that telepsychology involves "consideration of legal requirements, ethical standards, telecommunication technologies, intra- and interagency policies, and other external constraints, as well as the demands of the particular professional context" [89]. When one set of considerations may suggest a different course of action than another, the professional should balance them appropriately, with the aid of the guidelines [89]. The complete guidelines are available online at https://www.apa.org/practice/guidelines/telepsychology.

The 2014 ACA Code of Ethics also addresses distance counseling, technology, and social media. It states [4]:

> 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.

The ACA code also addresses legal considerations, informed consent and disclosure, confidentiality, security, and multicultural and disability considerations as they relate to technology.

The NBCC recognizes that distance counseling presents unique ethical challenges to professional counselors; related technology continues to advance and be used by more professionals; and that the use of technology by professionals continues to evolve. In light of this information, the NBCC revised its Internet counseling policy and developed the NBCC Policy Regarding the Provision of Distance Professional Services [90]. This policy replaces previous editions.

The revised policy includes use of the term "distance professional services" to include other types of professional services that are being used more in distance formats. The policy addresses telephone-, email-, chat-, video-, and social network-based distance professional services that may be conducted with individuals, couples, families, or group members. The policy also identifies specific actions that NCCs should take when providing distance services. The policy supplements the directives identified in the NBCC Code of Ethics [6; 90]. The policy is available at https://www.nbcc.org/Assets/Ethics/NBCCPolicyRegardingPracticeofDistanceCounselingBoard.pdf.

According to the NASW ethics code, social work services assisted by technology "include any social work services that involve the use of computers, mobile or landline telephones, tablets, video technology, or other electronic digital technologies [that] includes the use of various electronic or digital platforms, such as the Internet, online social media, chat rooms, text messaging, e-mail and emerging digital applications" [5]. Professionals are advised to "keep apprised of emerging technological developments that may be used in social work practice and how various ethical standards apply to them" [5]. In general, the ethical standards articulated in the NASW

Code of Ethics are "applicable to all interactions, relationships, or communications, whether they occur in person or with the use of technology" [5]. Professionals who are involved in discoverable (by the client) "electronic communication with groups based on race, ethnicity, language, sexual orientation, gender identity or expression, mental or physical ability, religion, immigration status, and other personal affiliations may affect their ability to work effectively with particular clients" [5].

Professionals interested in providing online interventions also should consider the potential for boundary confusion, inappropriate dual relationships, or harm to clients [5]. For example, instant message systems can alert clients each time the professional is online, allowing the client to send chat requests. Clients might access a professional's personal webpage or sign onto online discussion groups to which the professional also belongs. Some may continue to send the professional emails after the termination of the relationship. E-counselors should consider their response to such ongoing contact. Potentially more seriously, clients may use the Internet to harass or stalk current or former counselors [91]. The best way to prevent potential problems is to discuss the boundaries with clients during the initial assessment. Being up front and clear with clients about limits and policies regarding the use of technology and social networking is recommended [92].

Miscommunication is a commonplace occurrence in the online world. Even the simplest things (e.g., punctuation marks) can be misinterpreted. Studies reveal that 7% of any message is conveyed through words, 38% through certain vocal elements, and 55% through nonverbal elements (e.g., facial expressions, gestures, posture) [93]. Some technology-based forms of communication can result in the loss of important nonverbal and vocal cues, leading to an increased risk for miscommunication between client and counselor. Interactive communication, such as texting and email, involves the loss of nonverbal social cues that provide valuable contextual information and interpretation of meaning. Loss of these physical social cues may also increase the client's tendency to project personal psychologic material onto the blankness of the communication. While this may be helpful in some forms of psychotherapeutic interventions and it may offer advantages over in-person communication, it also presents a potential risk for increased miscommunication [91].

The compassionate professional strives to communicate nonverbally to clients that he or she is listening to and in the moment with the client. Physical cues, such as nodding and eye contact, have been shown to be positively associated with the degree that clients feel the counselor is respectful and genuine [94; 95]. Much attention also is paid to the voice, as it carries the verbal message and people often believe the voice to be a more reliable indicator of one's true feelings [96]. Because research exploring how empathy is experienced in an online environment is minimal, counselors should check with their clients to determine if the empathy is being transmitted in their text-based communications [12].

No matter what type of counseling is offered, a thorough initial evaluation should be completed to assess whether a client is appropriate for distance counseling. Practicing within recommended guidelines does not release counselors from the personal responsibility to be aware of, and to independently evaluate, the variety of ethical issues involved in the practice of online therapy [91]. Certain clients (e.g., those with suicidal, homicidal, or substance abuse history, clients with personality disorders) would not be suited to online therapy.

LEGAL AND ETHICAL CONSIDERATIONS

The challenges of online therapy lead to legal and ethical concerns associated with the delivery of mental health services via the Internet. Those opposed to online or distance therapy worry about licensure issues related to doing therapy across jurisdictional boundaries, legal responsibility in the event of a crisis, and the appropriateness of client anonymity [97].

Providing services across state lines is one of the biggest unresolved issues. Although communication technologies allow counselors to reach clients anywhere, state licensing laws generally do not permit out-of-state counselors to provide services via these methods. Some states offer guest licensure provisions, but most states require that the counselor hold a license in his or her own state and in the client's state. Providing distance therapy within one's own state is simpler, and it allows mental health professionals to reach people who would not otherwise have access to services (e.g., rural residents, people with certain disabilities) as well as those who want to receive services from home. To confidently provide distance services [98]:

- Abide by all applicable licensing requirements and professional standards of care.
- Understand the technology being used.
- Periodically check your state legislature's website for the latest telehealth laws and regulations.
- Check for a board policy statement that provides guidance on telepractice.
- Check whether your state licensing board has issued policies related to telepractice.
- Confirm that telehealth services (both in-state and across jurisdictional lines) are covered under your malpractice policy.

The COVID-19 public health emergency increased demand for mental and behavioral health services while driving most of those services to telehealth platforms. In response to this, in 2020, the APA led a campaign to maximize the availability of telepsychology services [99]. In March 2020, the federal government designated psychologists as critical, essential workers, and the Centers for Medicare and Medicaid Services (CMS) improved access to care for Medicare beneficiaries. CMS issued further guidance to waive key telehealth requirements. Because the new legislation cannot supersede state licensing laws (e.g., those that prohibit psychologists from using telehealth to provide services across state lines), the APA drafted letters to governors in all 50 states urging them to temporarily suspend state licensing laws and regulations regarding telepsychology services to ensure continuity of care. Within weeks of receiving the APA letter [99]:

- 12 states issued executive orders calling for expansion of telehealth service rates.
- 14 states issued executive orders allowing patients to receive telehealth services in their own homes.
- 16 states temporarily lifted licensing requirements.
- 22 states either expanded their policies for out-of-state providers to temporarily practice in their states or instituted emergency expedited registration for out-of-state providers.

SOCIAL MEDIA

With the advent of social media, clients can now search for and find the Facebook or Twitter page of their counselor, if one exists. Counselors who accept a client's "friend request" are in essence agreeing that the counselor and client are now friends, creating a multiple relationship. As discussed, when clients have access to their counselor's social media sites, both intentional and unintentional self-disclosures can occur. Modern social networking systems (e.g., Facebook, Instagram) exemplify intentional self-disclosure without a particular client focus. In contrast, Internet search engines (e.g., Google, LexisNexis) may allow unintended disclosure of personal details of the professional's life. Professionals should be aware and cognizant of social media involvement, including what information is public. Many sites offer ways to post minimal information if a connection to other professionals is desired. Avoid posting a profile photo that includes your family or other personal details, as these are public [88].

CONCLUSION

Competent counselors are well-educated and well-versed in the ethics of their profession. They understand that trust is built over time in the therapeutic relationship, with the help of limits and boundaries, and that it is reinforced by empathic response. Competent, compassionate professionals are both self- and other-aware and able to seek appropriate supervision and consultation when necessary. They establish self-care boundaries in order to protect their own compassionate, empathic response as well as their physical, emotional, and spiritual well-being. This enables counselors to most effectively help their clients.

RESOURCES

Administration for Community Living
Diversity and Cultural Competency
https://www.acl.gov/programs/strengthening-aging-and-disability-networks/diversity-and-cultural-competency

Office of Minority Health
Cultural and Linguistic Competency
https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6

Health Resources and Services Administration
Culture, Language and Health Literacy
https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy

APA Ethical Principles of Psychologists and Code of Conduct
https://www.apa.org/ethics/code

ACA Code of Ethics
https://www.counseling.org/resources/aca-code-of-ethics.pdf

NAADAC Code of Ethics
https://www.naadac.org/code-of-ethics

NBCC Code of Ethics
https://www.nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf

NASW Code of Ethics
https://www.socialworkers.org/About/Ethics/Code-of-Ethics

Substance Abuse and Mental Health Services Administration Cultural Competence
https://www.samhsa.gov/capt/applying-strategic-prevention/cultural-competence

HelpGuide: Benefits of Mindfulness
https://www.helpguide.org/harvard/benefits-of-mindfulness.htm

Mindfulnet.org
http://www.mindfulnet.org

Plum Village Mindfulness Practice Center
https://plumvillage.org/mindfulness-practice

An excerpt from the California Board of Behavioral Sciences Statutes and Regulations Relating to the Practice of Clinical Social Work is available at https://www.netce.com/coursemedia/2293/extra-ca-regulations__CA.2293.pdf

Customer Information/Answer Sheet/Evaluation insert located between pages 40–41.

TEST QUESTIONS

#77041 SETTING ETHICAL LIMITS: FOR CARING AND COMPETENT PROFESSIONALS

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 November 30, 2024.

---

1. **Competency is defined as the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected results.**
   A) *True*
   B) *False*

2. **According to the American Counseling Association's (ACA's) Code of Ethics, the boundaries of competence are based on all of the following, EXCEPT:**
   A) *Education*
   B) *Sensitivity*
   C) *Supervised experience*
   D) *Appropriate professional experience*

3. **According to the Code of Ethics of the National Association of Social Workers (NASW), social workers should only use intervention approaches that are new to them after**
   A) *engaging in appropriate study.*
   B) *receiving appropriate training.*
   C) *engaging in consultation with and supervision from people competent in the technique.*
   D) *All of the above*

4. **According to the American Psychological Association (APA), cultural competence is a part of its principle addressing respect for people's rights and dignity.**
   A) *True*
   B) *False*

5. **Which of the following is NOT one of the three characteristics of a culturally competent counselor?**
   A) *Actively attempts to understand the worldview of a culturally different client*
   B) *Actively seeks consultation and supervision from a person within one's own cultural community*
   C) *Actively develops and practices appropriate, relevant, and sensitive intervention strategies and skills when working with culturally different clients*
   D) *Actively engages in the process of becoming aware of his/her assumptions about human behavior, values, biases, preconceived notions, and personal limitations*

6. **Because the concept of boundaries does not vary across cultures, therapeutic elements related to boundaries do not need to be modified.**
   A) *True*
   B) *False*

7. **A cultural informant**
   A) *is not an active participant in the therapy.*
   B) *is generally from the same culture as the client.*
   C) *functions as a consultant by interpreting and identifying culture-specific issues.*
   D) *All of the above*

8. **Counselors model acceptable behavior in the office so their clients are equipped to emulate and apply that behavior in the outside world.**
   A) *True*
   B) *False*

9. **Which of the following is NOT one of the major sub-functions of self-regulation, as defined by Bandura?**
   A) *Judgment*
   B) *Self-response*
   C) *Self-observation*
   D) *Cultural competence*

Test questions continue on next page →

10. **In the counselor-client relationship, unconditional positive regard means that the counselor should accept, care for, and prize the client.**
    A) *True*
    B) *False*

11. **A growth-promoting therapeutic relationship consists of all of the following, EXCEPT:**
    A) *Empathy*
    B) *Congruence*
    C) *Negative reinforcement*
    D) *Unconditional positive regard*

12. **Which of the following best describes the concept of empathy?**
    A) *Repeating back a client's words*
    B) *Reflecting only the content of a client's words*
    C) *An affinity, association, or relationship between persons wherein whatever affects one similarly affects the other*
    D) *Understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another*

13. **While engaged in empathic listening, counselors should**
    A) *remain judgmental.*
    B) *not respond to feedback.*
    C) *keep a distance from the experiences being expressed by the client.*
    D) *alter their perspective of the client as they acquire more information.*

14. **Which of the following is one of the attributes of compassion-focused therapy?**
    A) *Empathy*
    B) *Sensitivity*
    C) *Nonjudgment*
    D) *All of the above*

15. **Working with empathy without proper boundaries in the therapeutic relationship leads to burnout.**
    A) *True*
    B) *False*

16. **Which of the following is a symptom of stress?**
    A) *Fatigue*
    B) *Sleep problems*
    C) *Loss of concentration or focus*
    D) *All of the above*

17. **Vicarious trauma is defined as**
    A) *a state of mental fatigue.*
    B) *being depressed or overworked.*
    C) *a profound shift in worldview that occurs following work with clients who have experienced trauma.*
    D) *the physical and emotional exhaustion that results from low job satisfaction and feeling powerless and overwhelmed at work.*

18. **Which of the following statements regarding burnout is TRUE?**
    A) *Causes of burnout are purely organizational.*
    B) *Burnout is largely identified in older professionals with lower levels of education.*
    C) *The conflict between expectations and reality is one of the main characteristics of burnout.*
    D) *Working with less difficult client groups (e.g., marriage counseling) is associated with higher levels of burnout.*

19. **All of the following are examples of setting healthy self-care boundaries, EXCEPT:**
    A) *Leave work at the office.*
    B) *Always be available for clients.*
    C) *Live a well-rounded life outside the office.*
    D) *Educate yourself about trauma and the effects.*

20. **The term transference describes the way clients "transfer" feelings about important persons in their lives onto their counselors.**
    A) *True*
    B) *False*

21. **Reflection demands a reasonable level of awareness of one's thoughts and feelings and a sound grasp of whether they deviate from good professional behavior.**
    A) *True*
    B) *False*

22. **Clients are more accepting of transference interpretations in an environment of**
    A) *empathy.*
    B) *judgment.*
    C) *group therapy.*
    D) *vicarious trauma.*

23. **In the therapeutic relationship, a boundary**
    A) *helps to determine what is acceptable.*
    B) *delineates the "edge" of appropriate behaviors.*
    C) *clearly defines what is appropriate with every client at every time.*
    D) *Both A and B*

24. Which of the following clinician attributes has been identified by clients as essential for the development of trust in the therapeutic relationship?

A) Is not readily available
B) Maintains confidentiality
C) Relates to the client as an "expert"
D) Reacts strongly to every issue under discussion

25. All of the following factors indicate a history of prior boundary violations, EXCEPT:

A) Divorce
B) Domestic violence
C) Childhood sexual abuse
D) Intimate relationship with a previous counselor

26. Which of the following is a professional risk factor for boundary violations?

A) Crises in one's own life
B) Feeling solely responsible for a client's life
C) Feeling unable to discuss the case with anyone
D) All of the above

27. Boundary crossings are usually not recommended for clients with borderline personality disorder.

A) True
B) False

28. All of the following behaviors/actions have strong exploitative potential, EXCEPT:

A) Referrals
B) Bartering with clients
C) Physical contact with clients
D) Sexual relationship with supervisee

29. The safest course of action to prevent boundary violations within multiple relationships is to

A) retain clients after a romantic relationship is initiated.
B) keep meticulous notes about interactions in the client's record.
C) maintain established boundaries and limits indefinitely after therapy ends.
D) wait two years before initiating a personal or business relationship with a client.

30. When considering whether to accept a gift from a client, the primary consideration should be

A) sentimentality.
B) the monetary value of the gift.
C) your personal need for the gift.
D) the effect on the therapeutic relationship.

31. Humanistic theorists

A) openly embrace counselor self-disclosure.
B) note that self-disclosure is a sign of a narcissistic counselor.
C) assert that self-disclosure harms the counselor-client relationship.
D) argue that self-disclosure indicates counselors' negative regard for clients.

32. Professionals should generally avoid using self-disclosures that

A) clarify a point for a client.
B) contaminate transference.
C) keep the focus on the client.
D) set clear boundaries in the relationship.

33. Competent counseling includes maintaining the knowledge and skills required to understand and properly use treatment tools, including technology.

A) True
B) False

34. According to the ACA Code of Ethics, the profession of counseling is limited to in-person, face-to-face interactions.

A) True
B) False

35. Some technology-based forms of communication can result in the loss of important nonverbal and verbal cues.

A) True
B) False

Be sure to transfer your answers to the Answer Sheet located between pages 40–41.
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 #96790 — 10 CLOCK HOURS Release Date: 07/01/22 Expiration Date: 06/30/25

Psychedelic Medicine and Interventional Psychiatry

10 Clinical Clock Hours

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.

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Alice Yick Flanagan, PhD, MSW

Senior Director of Development and Academic Affairs

Sarah Campbell

Division Planner/Director Disclosure

The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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E B
EVIDENCE-BASED PRACTICE RECOMMENDATION

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the study questions and course material for better application to your daily practice.

INTRODUCTION

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 multibillion-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)

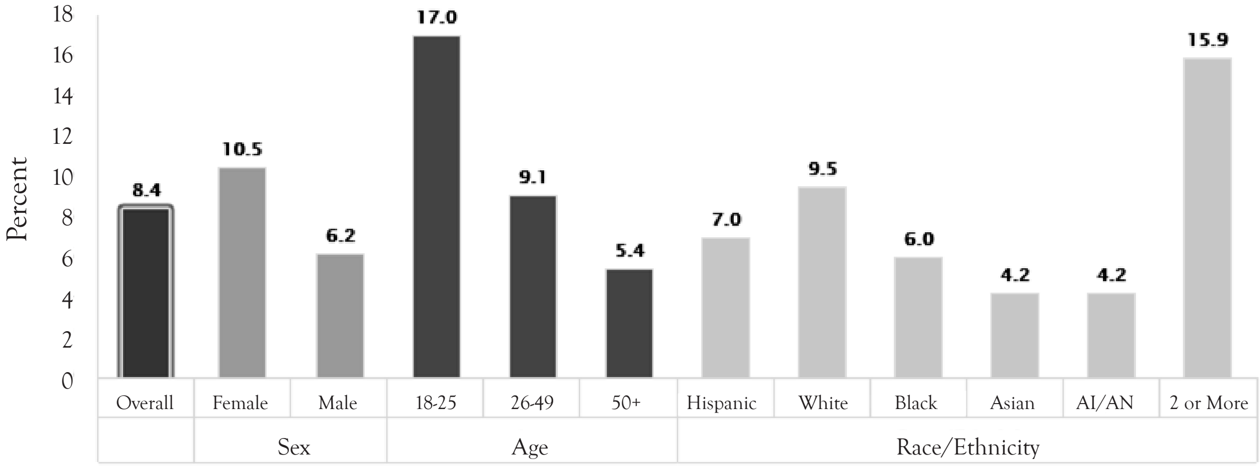
CLRD = chronic lower respiratory disease, HIV = human immunodeficiency disease.

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.

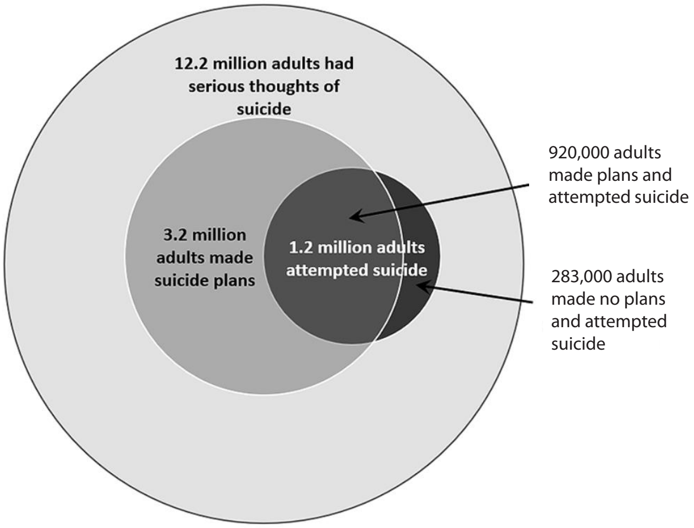
PAST YEAR PREVALENCE OF MAJOR DEPRESSIVE EPISODE AMONG U.S. ADULTS, 2020



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.)

E B
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].

EVIDENCE-BASED PRACTICE RECOMMENDATION

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 40–41.

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 clock hour activity must be completed by June 30, 2025.

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1. **Which of the following is a category of psychedelic drugs?**
   A) Classic
   B) Natural
   C) Prescription
   D) Hallucinogenic

2. **The annual U.S. suicide rate increased 30% between 2000 and 2020.**
   A) True
   B) False

3. **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.

4. **Of those adults who attempted suicide in 2020, most had made no plan prior to the attempt.**
   A) True
   B) False

5. **Even when antidepressants are efficacious, it usually takes at least three or four weeks for the drug to begin to take effect.**
   A) True
   B) False

6. **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.**
   A) True
   B) False

7. **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.

8. **Psilocybin has been legalized for consumer use in**
   A) Oregon.
   B) California.
   C) New York.
   D) New Mexico.

9. **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.

10. **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.

11. **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.*

12. **The initial use (and misuse) of psychedelic drugs in the 1960s was primarily associated with Albert Hofmann, a Swiss chemist who promoted the nonmedical use of MDMA.**
    - A) *True*
    - B) *False*

13. **Ketamine is considered a**
    - A) *Schedule I drug.*
    - B) *Schedule II drug.*
    - C) *Schedule III drug.*
    - D) *non-scheduled drug.*

14. **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.*

15. **Psilocybin, mescaline, and ayahuasca have all been used in religious ceremonies in indigenous societies in South and Central America for centuries.**
    - A) *True*
    - B) *False*

16. **LSD was first synthesized by**
    - A) *the Aztecs.*
    - B) *Timothy Leary.*
    - C) *Howard Lotsof.*
    - D) *Albert Hofmann.*

17. **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*

18. **Psychedelic medicine requires that diverse disciplines collaborate closely and communicate to clearly ensure that the therapy is safely and effectively administered.**
    - A) *True*
    - B) *False*

19. **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.*

20. **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*

21. **Psychotherapy is never provided during the course of a psychedelic drug's effects.**
    - A) *True*
    - B) *False*

22. **Psilocybin naturally occurs in**
    - A) *mushrooms.*
    - B) *toad venom.*
    - C) *the bark of certain trees.*
    - D) *the fruit of shrubs in southeast Asia.*

Test questions continue on next page ➞

23. **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.*

24. **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.**
    A) *True*
    B) *False*

25. **In studies using psilocybin, which of the following was among the most common adverse reactions?**
    A) *Anemia*
    B) *Headache*
    C) *Hypotension*
    D) *Hyperactivity*

26. **All researchers to date have offered a ringing endorsement of the use of psilocybin in the treatment of mental disorders.**
    A) *True*
    B) *False*

27. **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.*

28. **Ketamine is a derivative of lysergic acid diethylamide (LSD), which itself was originally developed as an anesthetic.**
    A) *True*
    B) *False*

29. **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.*

30. **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.**
    A) *True*
    B) *False*

31. **The effects of intravenously administered ketamine generally last minutes.**
    A) *True*
    B) *False*

32. **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.**
    A) *True*
    B) *False*

33. **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.*

34. **There is some evidence that MDMA therapy can improve problems with sleep quality common among patients with PTSD.**
    A) *True*
    B) *False*

35. **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.*

36. **Most people who seek treatment with ibogaine have alcohol use disorder, but some have been dependent on stimulants such as cocaine.**
    A) *True*
    B) *False*

37. 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.

38. Although kratom is traditionally used as a stimulant, it has sedative or opioid-like effects in very high doses.

A) True
B) False

39. Which of the following statements regarding LSD is TRUE?

A) It is a compound synthesized from Cannabis.
B) It is usually administered as an intravenous solution.
C) It is about 2,000 times more potent than mescaline.
D) It takes effect within 2 to 4 minutes after ingestion.

40. Mescaline is a psychedelic drug mainly found in *Lophophora williamsii*, or the peyote cactus.

A) True
B) False

41. Mescaline toxicity can result in

A) bradycardia.
B) hypotension.
C) hypothermia.
D) respiratory depression.

42. 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.

A) True
B) False

43. Repeated doses of nitrous oxide improve efficacy and are not associated with any untoward effects.

A) True
B) False

44. 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.

45. The most common adverse effect of ayahuasca is

A) flashbacks.
B) severe headache.
C) nausea and vomiting.
D) respiratory depression.

46. One problem with the scientific study of ayahuasca is that the effects of the drug depend on the concoction and there are no standardized dosages.

A) True
B) False

47. 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.

48. MDMA for PTSD is typically given during or immediately preceding a psychotherapy session.

A) True
B) False

49. 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.

50. 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

Test questions continue on next page →

51. Of the following disorders, which is not amenable to a possible treatment approach incorporating psychedelic agents?

A) *Schizophrenia*
B) *Anorexia nervosa*
C) *Major depressive disorder*
D) *Post-traumatic stress disorder*

52. 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.*

53. 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.*

54. 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.*

55. 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.

A) *True*
B) *False*

Be sure to transfer your answers to the Answer Sheet located between pages 40–41.
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 40–41.
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

MANAGING AND PREVENTING BURNOUT

#71464 • 4 Clock Hours

Book By Mail – $32 • ONLINE – $24

Purpose: Although work stress and burnout are present in every occupation, human service professionals, who spend their work lives attending to the needs of others, are at the highest risk. The purpose of this course is to orient the participants to the ramifications of not taking care of themselves and to promote strategies for enhancing health and well-being as individuals while working as professionals.

Faculty: Jamie Marich, PhD, LPCC-S, REAT, RYT-500, RMT

Audience: This course is designed for helping professionals of any kind, including counselors, social workers, therapists, and chemical dependency counselors, who require the tools necessary to address issues of work-life balance.

PROMOTING THE HEALTH OF GENDER AND SEXUAL MINORITIES

LGBTQ & Cultural Competency

#71793 • 5 Clock Hours

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

Cultural Competency

#71943 • 10 Clock 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.

HIV/AIDS: EPIDEMIC UPDATE FOR BEHAVIORAL HEALTH PROFESSIONALS

HIV/AIDS

#74714 • 7 Clock Hours

Book By Mail – $50 • ONLINE – $42

Purpose: In view of the already existing crisis in health care in the United States, the problems associated with providing the necessary care for persons with HIV infection or AIDS are significant. The purpose of this course is to address those problems in the discussion of epidemiology, pathophysiology, transmission, complications, treatment advancements, prevention, ethical and legal aspects of care, and workplace concerns.

Faculty: Alice Yick Flanagan, PhD, MSW;
Jane C. Norman, RN, MSN, CNE, PhD; John M. Leonard, MD

Audience: This course is designed for all behavioral health professionals, including social workers, counselors, and marriage and family therapists, who may be involved with the care of persons with HIV or AIDS.

Special Approval: This course meets the California one-time requirement for 7 hours of HIV/AIDS education.

Are you licensed in other states?
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Prices are subject to change. Visit www.NetCE.com for a list of current prices.

Course Availability List *(Cont'd)*

BORDERLINE PERSONALITY DISORDER

#76222 • 15 Clock 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 Clock 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.

ANXIETY DISORDERS IN OLDER ADULTS

#76690 • 3 Clock Hours

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.

CLINICAL SUPERVISION: A PERSON-CENTERED APPROACH

Supervision

#76863 • 10 Clock 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

Cultural Competency

#76920 • 5 Clock 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 requirement for cultural competency education.

THE INTERSECTION OF PAIN AND CULTURE

#77032 • 5 Clock Hours

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to increase clinicians' knowledge and awareness of the impact of culture on issues of pain and pain management in order to improve the provision of care and patients' quality of life.

Faculty: Alice Yick Flanagan, PhD, MSW

Audience: This course is designed for social workers, counselors, and therapists who may intervene to improve the treatment of pain in diverse patient populations.

ALZHEIMER DISEASE

#96154 • 15 Clock Hours

UPDATE

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 Clock 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.

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

Course Availability List *(Cont'd)*

SEXUAL ADDICTION

#96274 • 5 Clock 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

#96313 • 5 Clock 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.

METHAMPHETAMINE USE DISORDER

#96954 • 5 Clock 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.

OPIOID USE DISORDER

#96963 • 10 Clock Hours

Substance Abuse

Book By Mail – $68 • ONLINE – $60

Purpose: Practice guidance for opioid use disorder in primary care has not kept pace with rapid, profound changes in this area, leaving healthcare professionals with outdated and incomplete information to guide the clinical management of opioid use disorder and related morbidity. The purpose of this course is to close this gap to allow healthcare professionals to provide the best, evidence-based care to patients with opioid use disorder.

Faculty: Mark Rose, BS, MA, LP

Audience: This course is designed for medical and mental healthcare providers, including physicians, nurses, pharmacy professionals, social workers, and counselors/therapists who may be involved in identifying or treating opioid use disorder.

CULTURAL COMPETENCE: AN OVERVIEW

#97430 • 2 Clock 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.

ONLINE PROFESSIONALISM AND ETHICS

#97663 • 3 Clock Hours

Telehealth

Book By Mail – $26 • ONLINE – ~~$18~~ $10 (Thru 12/31/2023)

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

Faculty: Alice Yick Flanagan, PhD, MSW

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

Special Approval: This course meets the California one-time requirement for 3 hours of telehealth education beginning July 1, 2023.

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

Course Availability List *(Cont'd)*

COMMONLY ABUSED SUPPLEMENTS

NEW!

#98020 • 2 Clock Hours

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

UPDATE

#98394 • 10 Clock Hours

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.

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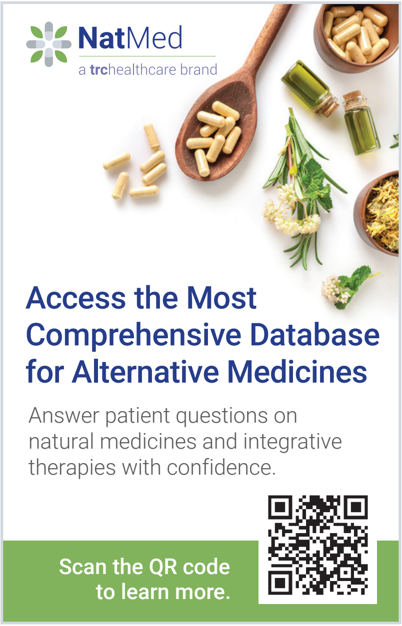

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