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FOR SOCIAL WORKERS
2023–2024

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Tel: 800-232-4238 (within the U.S.)
916-783-4238 (outside the U.S.)
Fax: 916-783-6067
Email: Info@NetCE.com
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# *Imminent Death and Loss*

## 1 Clinical Clock Hour

### *Audience*
This course is designed for members of the interprofessional team, including social workers, physicians, physician assistants, nurse practitioners, nurses, marriage and family therapists, and other members seeking to enhance their knowledge of palliative care.

### *Course Objective*
The purpose of this course is to bridge the gap in knowledge of palliative care at the time of imminent death and in skills necessary to support patients and families in the moments before death.

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

1. Develop a strategy for providing care to patients and their families over the last days and hours of life.
2. Support appropriate grief and mourning.
3. Discuss how culture impacts end of life care and death.

### *Faculty*
**Lori L. Alexander, MTPW, ELS, MWC**, is President of Editorial Rx, Inc., which provides medical writing and editing services on a wide variety of clinical topics and in a range of media. A medical writer and editor for more than 30 years, Ms. Alexander has written for both professional and lay audiences, with a focus on continuing education materials, medical meeting coverage, and educational resources for patients. She is the Editor Emeritus of the *American Medical Writers Association (AMWA) Journal*, the peer-review journal representing the largest association of medical communicators in the United States. (A complete biography appears at the end of this course.)

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

### *Faculty Disclosure*
Contributing faculty, Lori L. Alexander, MTPW, ELS, MWC, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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

***Division Planners***
John M. Leonard, MD
Jane C. Norman, RN, MSN, CNE, PhD
James Trent, PhD

***Senior Director of Development and Academic Affairs***
Sarah Campbell

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

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

  

## INTRODUCTION

In the last days, the goals of the healthcare team are to ensure a peaceful death for the patient and to support the family during the dying process and throughout grief and mourning. The focus for the patient is management of symptoms and emotional and spiritual ease, and the focus for the family is education to prepare them for the dying process.

## THE PATIENT'S NEEDS

During the last days, all care should be directed at comfort, and the National Comprehensive Cancer Network (NCCN) has listed several interventions for imminently dying patients (***Table 1***) [1]. The physician should minimize the number of medications by reassessing the need for each one. The symptoms that occur most commonly during the last days are pain, noisy breathing, dyspnea, and delirium, and medications to manage these symptoms should be maintained or initiated [2]. In addition, medication may be required to reduce the risk of seizures. Medications should be prescribed for the least invasive route of administration (oral or buccal mucosa), but patients may lose the ability to swallow, making a subcutaneous, transdermal, or intravenous route necessary.

Treatment of pain should continue, and knowledge of opioid pharmacology becomes critical during the last hours of life [2; 3]. The metabolites of morphine and some other opioids remain active until they are cleared through the kidneys. If urine output stops, alternative opioids, such as fentanyl or methadone, should be considered, as they have inactive metabolites [4; 5].

Anticholinergic medications can eliminate the so-called "death rattle" brought on by the build-up of secretions when the gag reflex is lost or swallowing is difficult. However, it is important to note that results of clinical trials examining various pharmacologic agents for the treatment of death rattle have so far been inconclusive [6]. Despite the lack of clear evidence, pharmacologic therapies continue to be used frequently in clinical practice [3]. Specific drugs used include scopolamine, glycopyrrolate, hyoscyamine, and atropine (***Table 2***) [2; 3; 7]. Glycopyrrolate may be preferred because it is less likely to penetrate the central nervous system and with fewer adverse effects than with other antimuscarinic agents, which can worsen delirium [3]. For patients with advanced kidney disease, the dose of glycopyrrolate should be reduced 50% (because evidence indicates that the drug accumulates in renal impairment) and hyoscine butylbromide should not be used (because of a risk of excessive drowsiness or paradoxical agitation) [4]. Some evidence suggests that treatment is more effective when given earlier; however, if the patient is alert, the dryness of the mouth and throat caused by these medications can be distressful. Repositioning the patient to one side or the other or in the semiprone position may reduce the sound. Oropharyngeal suctioning is not only often ineffective but also may disturb the patient or cause further distress for the family. Therefore, it is not recommended.

Terminal delirium occurs before death in 50% to 90% of patients. It is associated with shorter survival and complicates symptom assessment, communication, and decision making. It can be extremely distressing to caregivers and healthcare professionals alike [3]. Safety measures include protecting patients from accidents or self-injury. Reorientation strategies are of little use during the final hours of life. Education and support for families witnessing a loved one's delirium are warranted [3]. There are few randomized controlled trials on the management of terminal delirium. Agents that can be used to manage delirium include haloperidol, which is frequently the first choice for its relatively quick action [3; 8]. Other drugs may include olanzapine, chlorpromazine, levomepromazine, and benzodiazepines [3; 8]. For terminal delirium associated with agitation, benzodiazepines, including clonazepam, midazolam, diazepam, and lorazepam may be helpful [3; 8; 9]. Depending on which drug is used, administration may intravenous, subcutaneous, or rectal, and the dose can be titrated until effective.

Seizures at the end of life may be managed with high doses of benzodiazepines. Other antiepileptics such as phenytoin (administered intravenously), fosphenytoin (administered subcutaneously), or phenobarbital (60–120 mg rectally, intravenously, or intramuscularly every 10 to 20 minutes as needed) may become necessary until control is established.

A calm and peaceful environment should be maintained for the patient. Family and spiritual leaders should be allowed to carry out traditional rites and rituals associated with death.

### PALLIATIVE SEDATION

Palliative sedation may be considered when an imminently dying patient is experiencing suffering (physical, psychologic, and/or spiritual) that is refractory to the best palliative care efforts. Terminal restlessness and dyspnea have been the most common indications for palliative sedation, and thiopental and midazolam are the typical sedatives used [1; 10; 11]. For patients who have advanced kidney disease, midazolam is recommended, but the dose should be reduced because more unbound drug becomes available [1; 4]. Before beginning palliative sedation, the clinician should consult with a psychiatrist and pastoral services (if appropriate) and talk to the patient, family members, and other members of the healthcare team about the medical, emotional, and ethical issues surrounding the decision [1; 2; 9; 12; 13]. Formal informed consent should be obtained from the patient or from the healthcare proxy.

| INTERVENTIONS FOR PATIENTS WHO ARE IMMINENTLY DYING |
|---|
| Intensify ongoing care. |
| Try to ensure privacy (if not at home, arrange for private room if possible). |
| Discontinue diagnostic tests. |
| Reposition for comfort as appropriate. |
| Avoid unnecessary needle sticks. |
| Provide mouth care (e.g., hydrogen peroxide/water solution). |
| Treat for urinary retention and fecal impaction. |
| Ensure access to medication even when oral route is not available. |
| Prepare to meet request for organ donation and autopsy. |
| Allow patient and family uninterrupted time together. |
| Ensure the patient and family understand the signs and symptoms of imminent death and are supported through the dying process. |
| Offer anticipatory bereavement support. |
| Provide support to children and grandchildren. |
| Encourage visits by children if consistent with family values. |
| Support culturally meaningful rituals. |
| Facilitate around-the-clock family presence. |
| Ensure that caregivers understand and will honor advance directives. |
| Provide respectful space for families. |
| Facilitate closure. |
| *Source: [1]* *Table 1* |

| TREATMENT OF EXCESSIVE RESPIRATORY SECRETIONS CAUSING "DEATH RATTLE" | |
|---|---|
| **Drug** | **Dose** |
| Scopolamine (transdermal patch) | One (1.5-mg) patch applied behind the ear and changed every 72 hours<br>Onset of action may be delayed several hours, so other anticholinergic treatment should be provided until effective. |
| Glycopyrrolate | 0.2–0.4 mg SC, repeat at 30 minutes, then every 4 to 6 hours, as needed; or 0.6–1.2 mg/day CSCI |
| Hyoscyamine | 0.4 mg SC, repeat at 30 minutes, then every 2 to 4 hours, as needed; or 0.6–1.2 mg/day CSCI |
| Atropine | 0.4–0.8 mg SC, repeat every 2 to 4 hours |
| CSCI = continuous subcutaneous infusion, SC = subcutaneously. | |
| *Source: [8]* | *Table 2* |

## PHYSICIAN-ASSISTED DEATH

Physician-assisted death, or hastened death, is defined as active euthanasia (direct administration of a lethal agent with a merciful intent) or assisted death (aiding a patient in ending his or her life at the request of the patient) [2]. The following are not considered to be physician-assisted death: carrying out a patient's wishes to refuse treatment, withdrawal of treatment, and the use of high-dose opioids with the intent to relieve pain.

The American Medical Association Code of Ethics explicitly states, "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks" [14]. Position statements against the use of physician-assisted death have been issued by many other professional organizations, including the National Hospice and Palliative Care Organization and the American Academy of Hospice and

  

Palliative Medicine (AAHPM) [15; 16]. The AAHPM states that their position is one of "studied neutrality" [15]. The basis for these declarations is that appropriate hospice care is an effective choice for providing comfort to dying patients.

In 2010, in a first-of-its-kind comprehensive consensus statement, the Heart Rhythm Society in collaboration with the major cardiology, geriatrics, and palliative care societies, emphasized that deactivation of implantable cardioverter-defibrillators is neither euthanasia nor physician-assisted death [17]. The organizations urged clinicians to respect the right of patients to request deactivation.

The NCCN guidelines recommend that physicians explore requests for assisted death and explain to the patient the distinctions among assisted death, treatment withdrawal, and aggressive symptom management [1]. Some states have enacted assisted death statutes. State laws vary, and knowledge of your local statutes is necessary.

## THE FAMILY'S NEEDS

Ongoing communication with family members is essential to ensure their well-being as their loved one dies. The healthcare team should discuss what will happen over the course of dying so the family can be better prepared for symptoms such as altered breathing patterns and sounds, terminal delirium, and unconsciousness [1; 3; 18]. The family should be reassured that what they may think the patient is experiencing is not the patient's actual reality.

The altered breathing patterns that are present as death is imminent are distressful for family members, as they believe that the patient is experiencing a sense of suffocation. Also distressful to family is the sound of the death rattle. The healthcare team should assure family that these signs do not indicate that the patient is suffering and explain that additional therapy will not be of benefit.

Families often misinterpret the early signs of terminal delirium as signs of uncontrollable pain. However, if pain has been adequately managed throughout the delivery of palliative care, such pain will not begin during the last hours. As the patient slips in and out of consciousness, family members may become increasingly distressed about not being able to communicate anymore with their loved one. Although it is unknown what a dying patient can hear, other experiences in medicine suggest that awareness may be greater than the ability to respond. Family members should be encouraged to continue talking with their loved one to help them attain a sense of closure.

Despite the best efforts to prepare the family, reactions are unpredictable when death occurs. The clinician should take time to answer questions from family members, including children, and perhaps provide information on the physiologic events associated with death [2]. For family members who were not present during the death, the clinician should describe the event, while reassuring them that the patient died peacefully.

Many experts believe that people can handle grief better if they spend time with a loved one immediately after death. Family members should be allowed to touch, hold, and kiss their loved one as they feel comfortable. The healthcare team should respect the needs of the family to conduct personal, cultural, or religious traditions, rites, and rituals.

## GRIEF, MOURNING, AND BEREAVEMENT

Palliative care extends beyond the patient's death, with the focus shifting to support of the family during bereavement and mourning. Although the terms "grief," "mourning," and "bereavement" are often used interchangeably, their definitions are different. Grief is a normal reaction to a loss; mourning is the process by which individuals adjust to the loss; and bereavement is the period of time during which grief and mourning occur [2; 19]. Psychosocial support of the family is essential throughout the duration of palliative care and can help to decrease the risks of morbidity, substance abuse, and mortality that have been found among spouses and other loved ones of patients who have died [18].


The National Hospice and Palliative Care Organization recommends that patient and family/caregiver feelings, strengths, goals, and needs related to loss, grief, and bereavement be assessed. Then, interventions should be developed based on the assessment and are incorporated into the interdisciplinary plan of care.

(https://www.nhpco.org/regulatory-and-quality/quality. Last accessed October 22, 2021.)

**Strength of Recommendation/Level of Evidence**: Expert Opinion/Consensus Statement

### GRIEF

Grief comprises a range of feelings, thoughts, and behaviors that fall in the realm of the physical, emotional, and social domains [2]. Individuals may have trouble sleeping, changes in appetite, or other physical symptoms or illness. Emotions can include sadness, anxiety, guilt, and anger. Return to work, activities with friends, and taking care of family can be beneficial.

Grief counseling for the family and patient should begin when the patient is alive, with a focus on life meaning and the contributions from the patient's family. An understanding of the mediators of the grief response can help physicians and other members of the healthcare team recognize the family members who may be at increased risk for adapting poorly to the loss [20]. These mediators are:

- Nature of attachment (how close and/or dependent the individual was with regard to the patient)
- Mode of death (the suddenness of the death)
- Historical antecedents (how the individual has handled loss in the past)
- Personality variables (factors related to age, gender, ability to express feelings)
- Social factors (availability of social support, involvement in ethnic and religious groups)
- Changes and concurrent stressors (number of other stressors in the individual's life, coping styles)

Clinical assessment should be carried out for individuals at risk of complicated grief. Distinguishing between grief and depression can be challenging, as many signs and symptoms are similar. However, the hallmarks of depression are constant and unremitting feelings of worthlessness, hopelessness, helplessness, anhedonia, and suicidal ideation [8].

### MOURNING

Satisfactory adaptation to loss depends on "tasks" of mourning [20]. Previous research referred to "stages" of mourning, but the term "task" is now used because the stages were not clear-cut and were not always followed in the same order. The tasks include:

- Accepting the reality of the loss
- Experiencing the pain of the loss
- Adjusting to the environment in which the deceased is missing (external, internal, and spiritual adjustments)
- Finding a way to remember the deceased while moving forward with life

After the patient's death, members of the palliative care team should encourage the family to talk about the patient, as this promotes acceptance of the death. Explaining that a wide range of emotions is normal during the mourning process can help family members understand that experiencing these emotions is a necessary aspect of grieving. Frequent contact with family members after the loved one's death can ensure that the family is adjusting to the loss. Referrals for psychosocial and spiritual interventions should be made as early as possible to optimize their efficacy.

### BEREAVEMENT

Bereavement support should begin immediately with a handwritten condolence note from the clinician. Such notes have been found to provide comfort to the family [21; 22]. The physician should emphasize the personal strengths of the family that will help them cope with the loss and should offer help with specific issues. Attendance at the patient's funeral, if possible, is also appropriate.

How bereavement services are provided through a hospice/palliative care program vary. Programs usually involve contacting the family at regular intervals to provide resources on grieving, coping strategies, professional services, and support groups [1; 9]. When notes are sent, family members should be invited to contact the physician or other members of the healthcare team with questions. Notes are especially beneficial at the time of the first holidays without the patient, significant days for the family (patient's birthday, spouse's birthday), and the anniversary of the patient's death. Bereavement services should extend for at least one year after the patient's death, but a longer period may be necessary [9; 18].

## CULTURAL CONSIDERATIONS

Cultural sensitivity consists of promoting trust and mutual respect for cultural differences between providers and patients [23]. In end-of-life care, an understanding of cultural differences in beliefs about grieving is necessary. In Western culture, grieving is expected to be time-limited, and extended grieving can be considered pathologic [24]. However, in other cultures, extended periods of grieving are socially sanctioned.

Cultural groups adhere to culturally laden beliefs about death rituals, death symbols, language, gender roles, advanced care planning, end-of-life directives, and bereavement and grief. As a result, a provider's level of cultural competence will influence how he or she interacts with patients and family members during the end of life, ultimately influencing how patients and families perceive the end-of-life experience [25]. In traditional Asian families, for example, the eldest son may be designated to make key health and end-of-life decisions [26]. Various cultural groups will have specific norms about the expression of emotion during funerals. White Protestant individuals, for example, may value stoicism, while the Chinese equate the amount of wailing to the amount of respect paid to the deceased [27]. Crying that involves shaking of the body is considered cathartic and a normal reaction in some cultures [28].

  

It is also important to consider intersectionality in discussions of cultural competence. Individuals do not belong in one category in terms of their identity. Often, patients have overlapping identities (e.g., sex/gender, socioeconomic status, religion, class, sexual orientation, racial/ethnic minority group). This contributes to discrimination and marginalization, which influences how one experiences death and dying [29]. Some experts assert that the word "competence" in cultural competence is a misnomer, because it implies that providers can obtain a "rational mastery and application of knowledge" [30]. End-of-life care planning is complex, and cultural competence entails being reflective and accessing one's intuition.

## CONCLUSION

When patients and their families are confronted with a terminal illness and issues of death and dying, it is undoubtedly a time of grief and stress. Although patients and families require support during this period, practitioners may be uncomfortable witnessing grief, as it may raise personal issues about their own mortality. Palliative care eases the burden of suffering experienced by patients approaching life's end and provides for grief counseling and bereavement services for a family adjusting to loss.

## FACULTY BIOGRAPHIES

**Lori L. Alexander, MTPW, ELS, MWC**, is President of Editorial Rx, Inc., which provides medical writing and editing services on a wide variety of clinical topics and in a range of media. A medical writer and editor for more than 30 years, Ms. Alexander has written for both professional and lay audiences, with a focus on continuing education materials, medical meeting coverage, and educational resources for patients. She is the Editor Emeritus of the *American Medical Writers Association (AMWA) Journal*, the peer-review journal representing the largest association of medical communicators in the United States. Ms. Alexander earned a Master's degree in technical and professional writing, with a concentration in medical writing, at Northeastern University, Boston. She has also earned certification as a life sciences editor and as a medical writer.

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

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

**Customer Information/Answer Sheet/Evaluation insert located between pages 36–37.**

## TEST QUESTIONS
## #97500 IMMINENT DEATH AND LOSS

*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 1 clock hour activity must be completed by October 31, 2024.***

**1. Which of the following measures are appropriate for managing the so-called "death rattle?"**
- A) *Oropharyngeal suction*
- B) *Laying the patient supine*
- C) *Anticholinergic medications*
- D) *All of the above*

**2. Terminal delirium**
- A) *is associated with longer survival.*
- B) *can be extremely distressing to caregivers.*
- C) *occurs before death in 5% to 9% of patients.*
- D) *can clarify symptom assessment and communication.*

**3. Palliative sedation should**
- A) *never be carried out.*
- B) *be initiated as soon as a patient requests it.*
- C) *be considered when the family asks to relieve the patient's suffering.*
- D) *be considered after consultation with a psychiatrist and pastoral services, if appropriate.*

**4. Which of the following is considered to be physician-assisted death?**
- A) *Using high-dose opioids to relieve pain*
- B) *Administration of a lethal agent with a merciful intent*
- C) *Deactivation of an implantable cardioverter-defibrillator*
- D) *All of the above*

**5. Families often misinterpret the early signs of terminal delirium as signs of**
- A) *healing.*
- B) *suffocation.*
- C) *uncontrollable pain.*
- D) *emergence from sedation.*

**6. Which of the following is TRUE of the family's needs immediately following death?**
- A) *Family members should be allowed to touch, hold, and kiss their loved one as they feel comfortable.*
- B) *The healthcare team should respect the needs of the family to conduct personal, cultural, or religious traditions, rites, and rituals.*
- C) *For family members who were not present during the death, the clinician should describe the event while reassuring them that the patient died peacefully.*
- D) *All of the above*

**7. Which of the following is TRUE regarding grief, mourning, and bereavement?**
- A) *Grief counseling should begin when the patient is alive.*
- B) *Mourning is composed of sequential stages that occur in order.*
- C) *The physician's attendance at the patient's funeral would be inappropriate.*
- D) *The healthcare team should extend bereavement services for no more than one month after the death of the patient.*

**8. All of the following are mediators of grief, EXCEPT:**
- A) *Mode of death*
- B) *Personality variables*
- C) *Nature of attachment*
- D) *Quality of health care*

  

**9. Which of the following is a task of mourning?**

A) *Accepting the reality of the loss*
B) *Experiencing the pain of the loss*
C) *Adjusting to the environment in which the deceased is missing*
D) *All of the above*

**10. Which of the following statements regarding cultural considerations at the end of life is TRUE?**

A) *Extended grieving is considered pathologic in all cultures.*
B) *In Chinese culture, stoicism during bereavement is valued.*
C) *End-of-life care planning is complex, and cultural competence entails being reflective and accessing one's intuition.*
D) *A provider's level of cultural competence will not typically influence how patients and families perceive the end-of-life experience.*

Be sure to transfer your answers to the Answer Sheet located between pages 36–37.
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.***

# *Implicit Bias in Health Care*

**New York Social Workers, you can skip this course and still receive 12 hours of continuing education.**

3 Clinical Clock Hours

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

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

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

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

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

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

***Division Planners***
John M. Leonard, MD
Randall L. Allen, PharmD

***Senior Director of Development and Academic Affairs***
Sarah Campbell

***Division Planners/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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## INTRODUCTION

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

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

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

## DEFINITIONS OF IMPLICIT BIAS AND OTHER TERMINOLOGIES

### IMPLICIT VS. EXPLICIT BIAS

In a sociocultural context, biases are generally defined as negative evaluations of a particular social group relative to another group. Explicit biases are conscious, whereby an individual is fully aware of his/her attitudes and there may be intentional behaviors related to these attitudes [5]. For example, an individual may openly endorse a belief that women are weak and men are strong. This bias is fully conscious and is made explicitly known. The individual's ideas may then be reflected in his/her work as a manager.

FitzGerald and Hurst assert that there are cases in which implicit cognitive processes are involved in biases and conscious availability, controllability, and mental resources are not [6]. The term "implicit bias" refers to the unconscious attitudes and evaluations held by individuals. These individuals do not necessarily endorse the bias, but the embedded beliefs/attitudes can negatively affect their behaviors [2; 7; 8; 9]. Some have asserted that the cognitive processes that dictate implicit and explicit biases are separate and independent [9].

Implicit biases can start as early as 3 years of age. As children age, they may begin to become more egalitarian in what they explicitly endorse, but their implicit biases may not necessarily change in accordance to these outward expressions [10]. Because implicit biases occur on the subconscious or unconscious level, particular social attributes (e.g., skin color) can quietly and insidiously affect perceptions and behaviors [11]. According to Georgetown University's National Center on Cultural Competency, social characteristics that can trigger implicit biases include [12]:

- Age
- Disability
- Education
- English language proficiency and fluency
- Ethnicity
- Health status
- Disease/diagnosis (e.g., HIV/AIDS)
- Insurance
- Obesity
- Race
- Socioeconomic status
- Sexual orientation, gender identity, or gender expression
- Skin tone
- Substance use

An alternative way of conceptualizing implicit bias is that an unconscious evaluation is only negative if it has further adverse consequences on a group that is already disadvantaged or produces inequities [6; 13]. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages [13].

When the concept of implicit bias was introduced in the 1990s, it was thought that implicit biases could be directly linked to behavior. Despite the decades of empirical research, many questions, controversies, and debates remain about the dynamics and pathways of implicit biases [2].

## OTHER COMMON TERMINOLOGIES

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

### Cultural Competence

Cultural competence is broadly defined as practitioners' knowledge of and ability to apply cultural information and appreciation of a different group's cultural and belief systems to their work [14]. It is a dynamic process, meaning that there is no endpoint to the journey to becoming culturally aware, sensitive, and competent. Some have argued that cultural curiosity is a vital aspect of this approach.

### Cultural Humility

Cultural humility refers to an attitude of humbleness, acknowledging one's limitations in the cultural knowledge of groups. Practitioners who apply cultural humility readily concede that they are not experts in others' cultures and that there are aspects of culture and social experiences that they do not know. From this perspective, patients are considered teachers of the cultural norms, beliefs, and value systems of their group, while practitioners are the learners [15]. Cultural humility is a lifelong process involving reflexivity, self-evaluation, and self-critique [16].

### Discrimination

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

### Diversity

Diversity "encompasses differences in and among societal groups based on race, ethnicity, gender, age, physical/mental abilities, religion, sexual orientation, and other distinguishing characteristics" [20]. Diversity is often conceptualized into singular dimensions as opposed to multiple and intersecting diversity factors [21].

### Intersectionality

Intersectionality is a term to describe the multiple facets of identity, including race, gender, sexual orientation, religion, sex, and age. These facets are not mutually exclusive, and the meanings that are ascribed to these identities are inter-related and interact to create a whole [22].

  

**Prejudice**

Prejudice is a generally negative feeling, attitude, or stereotype against members of a group [23]. It is important not to equate prejudice and racism, although the two concepts are related. All humans have prejudices, but not all individuals are racist. The popular definition is that "prejudice plus power equals racism" [23]. Prejudice stems from the process of ascribing every member of a group with the same attribute [24].

**Race**

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

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

**Racism**

Racism is the "systematic subordination of members of targeted racial groups who have relatively little social power...by members of the agent racial group who have relatively more social power" [29]. Racism is perpetuated and reinforced by social values, norms, and institutions.

There is some controversy regarding whether unconscious (implicit) racism exists. Experts assert that images embedded in our unconscious are the result of socialization and personal observations, and negative attributes may be unconsciously applied to racial minority groups [30]. These implicit attributes affect individuals' thoughts and behaviors without a conscious awareness.

Structural racism refers to the laws, policies, and institutional norms and ideologies that systematically reinforce inequities resulting in differential access to services such as health care, education, employment, and housing for racial and ethnic minorities [31; 32].

## MEASUREMENT OF IMPLICIT BIAS: A FOCUS ON THE IAT

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

**interactive activity**

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

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

The IAT is not without controversy. One of the debates involves whether IAT scores focus on a cognitive state or if they reflect a personality trait. If it is the latter, the IAT's value as a diagnostic screening tool is diminished [37]. There is also concern with its validity in specific arenas, including jury selection and hiring [37]. Some also maintain that the IAT is sensitive to social context and may not accurately predict behavior [37]. Essentially, a high IAT score reflecting implicit biases does not necessarily link to discriminating behaviors, and correlation should not imply causation. A meta-analysis involving 87,418 research participants found no evidence that changes in implicit biases affected explicit behaviors [38].

### EXTENT OF IMPLICIT BIASES AND RISK FACTORS

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

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

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

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

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

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

## THEORETIC EXPLANATIONS AND CONTROVERSIES

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

### SOCIAL PSYCHOLOGICAL AND COGNITIVE THEORETICAL FRAMEWORKS

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

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

  

[51]. When a heuristic is activated, an implicit memory or bias may be triggered simultaneously [47]. This is also known as the dual-process model of information processing [50].

### BEHAVIORAL OR FUNCTIONAL PERSPECTIVES

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

### NEUROSCIENTIFIC PERSPECTIVES

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

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

### STRUCTURAL OR CRITICAL THEORY

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

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

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

## CONSEQUENCES OF IMPLICIT BIASES

### HEALTH DISPARITIES

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

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

As noted, in 2003, the Institute of Medicine implicated implicit bias in the development and continued health disparities in the United States [1]. Despite progress made to lessen the gaps among different groups, health disparities continue to exist. One example is racial disparities in life expectancy among Black and White individuals in the United States. Life expectancy for Black men is 4.4 years lower than White men; for Black women, it is 2.9 years lower compared with White women [63]. Hypertension, diabetes, and obesity are more prevalent in non-Hispanic Black populations compared with non-Hispanic White groups (25%, 49%, and 59% higher, respectively) [64]. In one study, African American and Latina women were more likely to experience cesarean deliveries than their White counterparts, even after controlling for medically necessary procedures [65]. This places African American and Latina women at greater risk of infection and maternal mortality.

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

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

## CLINICAL DECISIONS AND PROVIDER-PATIENT INTERACTIONS

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

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

## PATIENTS' PERCEPTIONS OF CARE

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

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

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

  

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

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

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

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

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

## DEVELOPMENTAL MODEL TO RECOGNIZING AND REDUCING IMPLICIT BIAS

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

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

## CREATING A SAFE ENVIRONMENT

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

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

When implicit bias interventions or assessments are planned, facilitators should be open, approachable, non-threatening, and knowledgeable; this will help create a safe and inclusive learning environment [77]. The principles of respect, integrity, and confidentiality should be communicated [77]. Facilitators who demonstrate attunement, authenticity, and power-sharing foster positive and productive dialogues about subjects such as race and identity [76]. Attunement is the capacity of an individual to tacitly comprehend the lived experiences of others, using their perspectives to provide an alternative viewpoint for others. Attunement does not involve requiring others to talk about their experiences if they are not emotionally ready [76]. Authenticity involves being honest and transparent with one's own position in a racialized social structure and sharing one's own experiences, feelings, and views. Being authentic also means being vulnerable [76]. Finally, power-sharing entails redistributing power in the learning environment. The education environment is typically hierarchical, with an expert holding more power than students or participants. Furthermore, other students may hold more power by virtue of being more comfortable speaking/interacting [76]. Ultimately, promoting a safe space lays a foundation for safely and effectively implementing implicit bias awareness and reduction interventions.

## STRATEGIES TO PROMOTE AWARENESS OF IMPLICIT BIAS

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

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

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

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

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

## INTERVENTIONS TO REDUCE IMPLICIT BIASES

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

### PERSPECTIVE TAKING

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

  

interactive activity

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

**Think Out Loud Podcast**
Young Black people share their experiences growing up in Portland, Oregon.
https://www.opb.org/article/2020/10/30/young-black-people-share-their-experiences-growing-up-in-portland

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

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

## EMPATHY INTERVENTIONS

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

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

## INDIVIDUATION

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

## MINDFULNESS

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

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

An approach to mindfulness using the acronym STOPP has been developed as a practical exercise to engage in mindfulness in any moment. STOPP is an acronym for [88]:

- Stop
- Take a breath
- Observe
- Pull back
- Practice

interactive activity

Visit the following website to view a short, animated video on the STOPP technique. After viewing the video, consider how you can incorporate the technique into your work.
https://www.youtube.com/watch?v=tStXi7f7Vgk

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

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

## COUNTER-STEREOTYPICAL IMAGING

Counter-stereotypical imaging approaches involve presenting an image, idea, or construct that is counter to the oversimplified stereotypes typically held regarding members of a specific group. In one study, participants were asked to imagine either a strong woman (the experimental condition) or a gender-neutral event (the control condition) [92]. Researchers found that participants in the experimental condition exhibited lower levels of implicit gender bias. Similarly, exposure to female leaders was found to reduce implicit gender bias [93]. Whether via increased contact with stigmatized groups to contradict prevailing stereotypes or simply exposure to counter-stereotypical imaging, it is possible to unlearn associations underlying various implicit biases. If the social environment is important in priming positive evaluations, having more positive visual images of members in stigmatized groups can help reduce implicit biases [94]. Some have suggested that even just hanging photos and having computer screensavers reflecting positive images of various social groups could help to reduce negative associations [94].

## EFFECTIVENESS OF IMPLICIT BIAS INTERVENTIONS

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

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

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

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

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

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

  

## ROLE OF INTERPROFESSIONAL COLLABORATION AND PRACTICE AND IMPLICIT BIASES

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

One of the core features of ICP is sharing—professionals from different disciplines share their philosophies, values, perspectives, data, and strategies for planning of interventions [97]. ICP also involves the sharing of roles, responsibilities, decision making, and power [98]. Everyone on the team employs their expertise, knowledge, and skills, working collectively on a shared, patient-centered goal or outcome [98; 99].

Another feature of ICP is interdependency. Instead of working in an autonomous manner, each team member's contributions are valued and maximized, which ultimately leads to synergy [97]. At the heart of this are two other key features: mutual trust/respect and communication [99]. In order to share responsibilities, the differing roles and expertise are respected.

Experts have recommended that a structural or critical theoretical perspective be integrated into core competencies in healthcare education to teach students about implicit bias, racism, and health disparities [100]. This includes [100]:

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

Adopting approaches from the fields of education, gender studies, sociology, psychology, and race/ethnic studies can help build curricula that represent a variety of disciplines [78]. Students can learn about and discuss implicit bias and its impact, not simply from a health outcomes perspective but holistically. Skills in problem-solving, communication, leadership, and teamwork should be included, so students can effect positive social change [78].

## CONCLUSION

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

## RESOURCES

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

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

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

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

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

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

**Unconscious Bias Project**
https://unconsciousbiasproject.org

**MINDFULNESS RESOURCES**

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

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

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

## FACULTY BIOGRAPHY

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

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

**Customer Information/Answer Sheet/Evaluation insert located between pages 36–37.**

  

## TEST QUESTIONS
## #97000 IMPLICIT BIAS IN HEALTH CARE

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

***This 3 clock hour activity must be completed by August 31, 2024.***

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

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

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

**4. How might critical theory or a structural perspective be integrated into the values and ethics of interprofessional collaboration and practice?**
- A) *Advocate for more neurologic imaging studies to examine how implicit bias affects the brain.*
- B) *Analyze how patients' health and well-being may reflect structural vulnerabilities driven in large part by social, cultural, economic, and institutional forces.*
- C) *The ethical responsibility is to advocate for policies that perpetuate and reinforce implicit biases.*
- D) *The role of health professionals is to focus less on the unconscious and instead emphasize explicit bias as the behaviors.*

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

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

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

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

*Test questions continue on next page* ➞

**9. Mr. A, a social worker, attempts to record personal information about his patients and not simply social characteristics. For example, he writes, "Patient is an elderly Hispanic woman, age 79 years. She lives with her daughter and is an avid pianist." What is this an example of?**

*A) STOP*
*B) Priming*
*C) Power-sharing*
*D) Individuation*

**10. All of the following are concerns with research conducted to examine the effectiveness of implicit bias reduction interventions, EXCEPT:**

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

Be sure to transfer your answers to the Answer Sheet located between pages 36–37.
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.***

  

# 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.

***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.

***Accreditations & Approvals***
As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. Regulatory boards are the final authority on courses accepted for continuing education credit.

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

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

***Designations of Credit***

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

***Individual State Behavioral Health Approvals***

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

***About the Sponsor***

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

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

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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 non-metropolitan 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 36–37.**

## 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 36–37.
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.***

  

# 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.

***Division Planner***
Alice Yick Flanagan, PhD, MSW

***Senior Director of Development and Academic Affairs***
Sarah Campbell

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

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

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

***Designations of Credit***

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

***Individual State Behavioral Health Approvals***

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

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- Return your Customer Information/Answer Sheet/Evaluation and payment to NetCE by mail or fax, or complete online at **www.NetCE.com/SW23B**.
- A full Works Cited list is available online at www.NetCE.com.

  

## 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

**Customer Information/Answer Sheet/Evaluation insert located between pages 36–37.**

  

## 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*

*Test questions continue on next page* ➞

**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*

**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.*

*Test questions continue on next page* ➜

**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 36–37.
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 36–37.
We encourage you to **GO GREEN**. Access your courses **online** or download as an **eBook** to save paper and **receive a discount** or sign up for **One Year of Unlimited Online CE starting at only $85!** Additional titles are also available.
**www.NetCE.com**

## THE BISEXUAL CLIENT: TRAUMA-FOCUSED CARE

**#71501 • 5 Clock Hours**

**Book By Mail – $38 • ONLINE – $30**

**Purpose**: The purpose of this course is to provide members of the interdisciplinary healthcare team with the knowledge and resources necessary to improve the care provided to bisexual or sexually fluid individuals.
**Faculty**: Jamie Marich, PhD, LPCC-S, REAT, RYT-500, RMT
**Audience**: This course is designed for behavioral and mental health professionals of any kind who work with clients on a regular basis or who teach/supervise those working with clients who identify as bisexual or non-binary.

## PROMOTING THE HEALTH OF GENDER AND SEXUAL MINORITIES


**#71793 • 5 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


**#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.

## FRONTOTEMPORAL DEMENTIA


**#76102 • 2 Clock Hours**

**Book By Mail – $23 • ONLINE – $15**

**Purpose**: Understanding the epidemiology, pathology, clinical features, diagnostic process, genetics, symptom treatment/management, role of brain autopsy, and current research provides a foundation for the care of patients with FTD and support for their families. The purpose of this course is to provide mental health professionals with current information on frontotemporal dementia (FTD).
**Faculty**: Ellen Steinbart, RN, MA; Lauren E. Evans, MSW
**Audience**: This course is designed for mental and behavioral health professionals who may intervene to support patients with frontotemporal dementia and their families.
**Special Approval**: This course meets the Illinois requirement for dementia education.

## 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**

**Purpose**: The purpose of this course is to provide behavioral and mental health professionals with an appreciation of the impact of depression and suicide on patient health as well as the skills necessary to identify and intervene for patients at risk for suicide.
**Faculty**: Mark Rose, BS, MA
**Audience**: This course is designed for social workers, therapists, counselors, and other professionals who may identify persons at risk for suicide and intervene to prevent or manage suicidality.
**Special Approval**: This course is designed to meet requirements for suicide assessment and prevention education.

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

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

# Course Availability List *(Cont'd)*

## 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

MA Mandate

**#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 Massachusetts requirement for 2 hours of anti-racism and 1 hour of anti-discrimination education.

## THE INTERSECTION OF PAIN AND CULTURE

Pain Mgmt

**#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.
**Special Approval**: This course meets the District of Columbia and Michigan requirements for pain management education.

## COUNSELING PATIENTS AT THE END OF LIFE

NEW!

**#77770 • 5 Clock Hours**

**Book By Mail – $38 • ONLINE – $30**

**Purpose**: The purpose of this course is to provide counselors, therapists, social workers, and other mental health professionals with the knowledge and strategies necessary to best assist patients to seek and receive optimal end-of-life care.
**Faculty**: Lisa Hutchison, LMHC
**Audience**: This course is designed for all members of the interprofessional team responsible for supporting patients at the end of life.

## 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.

## 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

MI Mandate

**#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.
**Special Approval**: This course fulfills the Michigan requirement for training in identifying victims of human trafficking.

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

# Course Availability List *(Cont'd)*

## MENTAL HEALTH ISSUES COMMON TO VETERANS AND THEIR FAMILIES

**#96342 • 2 Clock Hours**

**Book By Mail – $23 • ONLINE – $15**

**Purpose**: The purpose of this course is to provide health and mental health professionals with an appreciation of the impact of military service on patient health as well as the skills necessary to effectively identify and intervene for these patients.
**Faculty**: Alice Yick Flanagan, PhD, MSW; Mark Rose, BS, MA, LP
**Audience**: This course is designed for physicians, nurses, psychologists, social workers, therapists, counselors, and other healthcare professionals who may treat veterans or their family members.

## METHAMPHETAMINE USE DISORDER


**#96954 • 5 Clock Hours**

**Book By Mail – $38 • ONLINE – $30**

**Purpose**: Methamphetamine use has risen alarmingly, reaching epidemic proportions in some regions. The purpose of this course is to provide a current, evidence-based overview of methamphetamine abuse and dependence and its treatment in order to allow healthcare professionals to more effectively identify, treat, or refer patients who use methamphetamine.
**Faculty**: Mark Rose, BS, MA, LP
**Audience**: This course is designed for health and mental health professionals who are involved in the evaluation or treatment of persons who use methamphetamine.

## CULTURAL COMPETENCE: AN OVERVIEW


**#97430 • 2 Clock Hours**

**Book By Mail – $23 • ONLINE – $15**

**Purpose**: The purpose of this course is to provide members of the interprofessional healthcare team with the knowledge, skills, and strategies necessary to provide culturally competent and responsive care to all patients.
**Faculty**: Alice Yick Flanagan, PhD, MSW
**Audience**: This course is designed for all members of the interprofessional healthcare team.
**Special Approval**: This course meets the requirement for cultural competency education.

## CANNABINOID OVERVIEW


**#98010 • 3 Clock Hours**

**Book By Mail – $26 • ONLINE – $18**

**Purpose**: The purpose of this course is to provide healthcare professionals in all practice settings the knowledge necessary to increase their understanding of the various cannabinoids.
**Faculty**: Chelsey McIntyre, PharmD
**Audience**: This course is designed for healthcare professionals whose patients are taking or are interested in taking cannabinoid products.
**Additional Approval**: AACN Synergy CERP Category A

## COMMONLY ABUSED SUPPLEMENTS


**#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


**#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.

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

# Social Worker Continuing Education Requirements by State

| State | Approval Accepted by Board | Hours Allowed by Home Study |
|---|---|---|
| Alabama | #0515 | 20✶, ♦ |
| Alaska | ASWB | 45✶, ❖, ♦ |
| Arizona | ASWB | 30✶, ❖ |
| Arkansas | Approved | 15✶ |
| California | ASWB | 36✶, ♦ |
| Colorado | Approved | 40 (Coursework) |
| Connecticut | ASWB | 6❖, ♦ |
| Delaware | ASWB | LCSW 40✶, ♦; LMSW 30✶, ♦; LBSW 20✶, ♦ |
| District of Columbia | ASWB | 12✶, ♦ |
| Florida | #50-2405 | 30✶, ♦ |
| Georgia | ASWB | 10✪ |
| Hawaii | ASWB | 45✶ |
| Idaho | ASWB | 20✶ |
| Illinois | #159.001094 | 15✶, ❖, ♦ |
| Indiana | ASWB | 40✶ |
| Iowa | ASWB | 27✶, ♦ |
| Kansas | Accepted by Board | 40✶, ♦ |
| Kentucky | ASWB | LCSW, CSW 27⧫, ♦; LSW 12⧫, ♦ |
| Louisiana | Accepted by Board | 20✶, ♦ Before 8/31/2023; 10✶, ♦ After 8/31/2023 |
| Maine | Accepted by Board | 10✶, ♦ |
| Maryland | ASWB | LCSW, LCSW-C 20✶, ♦; LBSW 15✶, ♦ |
| Massachusetts | ASWB | LICSW 30♦; LCSW 20♦; LSW 15♦; LSWA 10♦ |
| Michigan | ASWB | 22.5✶, ♦ |
| Minnesota | ASWB | 20✶, ♦ |
| Mississippi | ASWB | 20✶, ♦, ❖ |
| Missouri | ASWB | 30✶, ♦, ❖ |
| Montana | Accepted by Board of Scope of Practice | 20♦ |
| Nebraska | ASWB | 20✶ |
| Nevada | ASWB | LASW, LSW 30✶, ❖, ♦; LISW, LCSW 36✶, ❖, ♦ |
| New Hampshire | ASWB | 20✶, ♦ |
| New Jersey | NASW-NJ | LCSW 40✶, ❖, ♦; LSW 30✶, ❖, ♦; CSW 20✶, ❖, ♦ |
| New Mexico | ASWB | 30♦, ❖ |
| New York | SW-0033 | 12♦ |
| North Carolina | ASWB | 20✶ |
| North Dakota | ASWB | 10✶ |
| Ohio | ASWB | LISW 30♦, ✶; LSW 30✶; SWA 15✶ |
| Oklahoma | ASWB | 8✶ |
| Oregon | ASWB | LCSW 40♦, ✶, ❖; LMSW 30♦, ✶, ❖; RBSW 20♦, ✶, ❖ |
| Pennsylvania | ASWB | 30✶, ♦ |
| Rhode Island | ASWB | 8✶, ❖ |
| South Carolina | ASWB | 40♦ |
| South Dakota | ASWB | 30 |
| Tennessee | Accepted by Board | LCSW, LAPSW 15✶, ♦; LMSW 12✶, ♦; LBSW 9✶, ♦ |
| Texas | Accepted by Board | 30✶, ❖, ♦ |
| Utah | ASWB | LCSW 15✶, ♦; CSW, SSW 8✶, ♦ |
| Vermont | ASWB | LICSW 5✶; LMSW None |
| Virginia | ASWB | LCSW 30✶; LBSW, LMSW 15✶ |
| Washington | ASWB | SWIs, SWAs 26✶, ♦; SWIA, SWAAs 18✶ |
| West Virginia | ASWB | 20✶, ♦ |
| Wisconsin | ASWB | 26✪ |
| Wyoming | ASWB | 45✶, ♦ |

✶ Special mandate: Ethics

❖ Special mandate: Cultural Competence

♦ Additional requirements: Please go to www.NetCE.com/ce-requirements for more information.

⧫ Ethics must be completed through an approved provider.

✪ Ethics must be live participatory.

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

  

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# Customer Information

**(Incomplete information may delay processing.)**

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SW23B

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

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**(916) 783-6067**
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**(800) 232-4238**
Email us
**help@NetCE.com**

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**www.NetCE.com/SW23B**

Last Name First Name MI

State License # Exp.

State Additional License # Exp.

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

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

**Complete before April 30, 2024, pay**
**$40**

**Complete after April 30, 2024, pay**
**$50**

## ENCLOSED SPECIAL OFFER: 15 CLOCK HOURS

***Complete all four courses or any combination of these four courses for a maximum payment of $40 (or pay the individual course price).***

| ✓ | Course # | Course Title / Clock Hours | Price |
|---|---|---|---|
| | 97500 | Imminent Death and Loss / 1 Clock Hour | $15 |
| | 97000 | Implicit Bias in Health Care / 3 Clock Hours | $18 |
| | 71770 | Rural Health, Mental Health, and Social Work / 5 Clock Hours | $30 |
| | 77041 | Setting Ethical Limits: For Caring and Competent Professionals / 6 Clock Hours | $36 |

### Additional Courses Available by Mail (ACCESS ONLINE FOR A DISCOUNT!)

**Payment must accompany this form. To order by phone, please have your credit card ready.**

| ✓ | Course # | Course Title / Clock Hours | Price |
|---|---|---|---|
| ☐ | 71501 | The Bisexual Client: Trauma-Focused Care / 5 | $38 |
| ☐ | 71793 | Promoting the Health of Gender & Sexual Minorities / 5 | $38 |
| ☐ | 71943 | Providing Care to Asian Immigrants / 10 | $68 |
| ☐ | 76102 | Frontotemporal Dementia / 2 | $23 |
| ☐ | 76222 | Borderline Personality Disorder / 15 | $98 |
| ☐ | 76442 | Suicide Assessment and Prevention / 6 | $44 |
| ☐ | 76690 | Anxiety Disorders in Older Adults / 3 | $26 |
| ☐ | 76863 | Clinical Supervision: A Person-Centered Approach / 10 | $68 |
| ☐ | 76920 | Racial Trauma: The African American Experience / 5 | $38 |
| ☐ | 77032 | The Intersection of Pain and Culture / 5 | $38 |
| ☐ | 77770 | Counseling Patients at the End of Life / 5 | $38 |
| ☐ | 96213 | Attention Deficit Hyperactivity Disorder / 5 | $38 |
| ☐ | 96274 | Sexual Addiction / 5 | $38 |
| ☐ | 96313 | Human Trafficking and Exploitation / 5 | $38 |
| ☐ | 96342 | Mental Health Issues Common to Veterans / 2 | $23 |
| ☐ | 96954 | Methamphetamine Use Disorder / 5 | $38 |
| ☐ | 97430 | Cultural Competence: An Overview / 2 | $23 |
| ☐ | 98010 | Cannabinoid Overview / 3 | $26 |
| ☐ | 98020 | Commonly Abused Supplements / 2 | $23 |
| ☐ | 98394 | Herbal Medications: An Evidence Based Review / 10 | $68 |

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

*Please print name (as shown on credit card)*

Credit card #

Expiration date / Security code

*Security code is last three numbers in the signature area on back of credit card or four numbers above the account number on front of AmEx cards.*

Signature

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

Special Offer (before April 30, 2024) $40
$50 (after April 30, 2024)
**I would like my certificates mailed for an additional $6**
Additional Courses
Subtotal
Expedited Delivery
**Grand Total**

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

SW23B

# Answer Sheet

(Completion of this form is mandatory)

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

**Please note the following:**

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

## #97500 IMMINENT DEATH AND LOSS—1 CLOCK HOUR

Please refer to pages 8–9.

*Expiration Date: 10/31/24*

*May be taken individually for $15*

| | A | B | C | D | | A | B | C | D |
|---|---|---|---|---|---|---|---|---|---|
| 1. | ❍ | ❍ | ❍ | ❍ | 6. | ❍ | ❍ | ❍ | ❍ |
| 2. | ❍ | ❍ | ❍ | ❍ | 7. | ❍ | ❍ | ❍ | ❍ |
| 3. | ❍ | ❍ | ❍ | ❍ | 8. | ❍ | ❍ | ❍ | ❍ |
| 4. | ❍ | ❍ | ❍ | ❍ | 9. | ❍ | ❍ | ❍ | ❍ |
| 5. | ❍ | ❍ | ❍ | ❍ | 10. | ❍ | ❍ | ❍ | ❍ |

## #97000 IMPLICIT BIAS IN HEALTH CARE—3 CLOCK HOURS

Please refer to pages 23–24.

*Expiration Date: 08/31/24*

*May be taken individually for $18*

| | A | B | C | D | | A | B | C | D |
|---|---|---|---|---|---|---|---|---|---|
| 1. | ❍ | ❍ | ❍ | ❍ | 6. | ❍ | ❍ | ❍ | ❍ |
| 2. | ❍ | ❍ | ❍ | ❍ | 7. | ❍ | ❍ | ❍ | ❍ |
| 3. | ❍ | ❍ | ❍ | ❍ | 8. | ❍ | ❍ | ❍ | ❍ |
| 4. | ❍ | ❍ | ❍ | ❍ | 9. | ❍ | ❍ | ❍ | ❍ |
| 5. | ❍ | ❍ | ❍ | ❍ | 10. | ❍ | ❍ | ❍ | ❍ |

## #71770 RURAL HEALTH, MENTAL HEALTH, AND SOCIAL WORK—5 CLOCK HOURS

Please refer to pages 40–42.

*Expiration Date: 03/31/26*

*May be taken individually for $30*

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

## #77041 SETTING ETHICAL LIMITS: FOR CARING & COMPETENT PROFESSIONALS—6 CLOCK HOURS

Please refer to pages 65–68.

*Expiration Date: 11/30/24*

*May be taken individually for $36*

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

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# Evaluation

(Completion of this form is mandatory)

SW23B

Last Name _____ First Name _____ MI _____

State _____ License # _____ Expiration Date _____

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

Compliance with Association of Social Work Boards (ASWB) standards requires that providers collect a course evaluation from the participant that includes assessment of the content, delivery method, and achievement of the individual learning objectives.

**Please read the following questions and choose the most appropriate answer for each course completed.**

1. Was the course content new or review?
2. How much time did you spend on this activity, including the questions?
3. Would you recommend this course to your peers?
4. Did the course content support the stated course objective?
5. Did the course content demonstrate the author's knowledge of the subject and the current state of scientific knowledge?
6. Was the course content free of bias?
7. Before completing this course, did you identify the necessity for education on the topic to improve your professional practice?
8. Have you achieved all of the stated learning objectives of this course?
9. Has what you think or feel about this topic changed?
10. Was this course appropriate for your education, experience, and licensure level?
11. Was the administration of the program to your satisfaction?
12. Were the materials appropriate to the subject matter?
13. Are you more confident in your ability to provide client care after completing this course?
14. Do you plan to make changes in your practice as a result of this course content?
15. If you requested assistance for a disability or a problem, was your request addressed respectfully and in a timely manner?

**#97500**
1 Clock Hour

1. ☐ New ☐ Review
2. ____ Hours
3. ☐ Yes ☐ No
4. ☐ Yes ☐ No
5. ☐ Yes ☐ No
6. ☐ Yes ☐ No
7. ☐ Yes ☐ No
8. ☐ Yes ☐ No
9. ☐ Yes ☐ No
10. ☐ Yes ☐ No
11. ☐ Yes ☐ No
12. ☐ Yes ☐ No
13. ☐ Yes ☐ No
14. ☐ Yes ☐ No
15. ☐ Yes ☐ No ☐ N/A

**#97000**
3 Clock Hours

1. ☐ New ☐ Review
2. ____ Hours
3. ☐ Yes ☐ No
4. ☐ Yes ☐ No
5. ☐ Yes ☐ No
6. ☐ Yes ☐ No
7. ☐ Yes ☐ No
8. ☐ Yes ☐ No
9. ☐ Yes ☐ No
10. ☐ Yes ☐ No
11. ☐ Yes ☐ No
12. ☐ Yes ☐ No
13. ☐ Yes ☐ No
14. ☐ Yes ☐ No
15. ☐ Yes ☐ No ☐ N/A

**#71770**
5 Clock Hours

1. ☐ New ☐ Review
2. ____ Hours
3. ☐ Yes ☐ No
4. ☐ Yes ☐ No
5. ☐ Yes ☐ No
6. ☐ Yes ☐ No
7. ☐ Yes ☐ No
8. ☐ Yes ☐ No
9. ☐ Yes ☐ No
10. ☐ Yes ☐ No
11. ☐ Yes ☐ No
12. ☐ Yes ☐ No
13. ☐ Yes ☐ No
14. ☐ Yes ☐ No
15. ☐ Yes ☐ No ☐ N/A

**#77041**
6 Clock Hours

1. ☐ New ☐ Review
2. ____ Hours
3. ☐ Yes ☐ No
4. ☐ Yes ☐ No
5. ☐ Yes ☐ No
6. ☐ Yes ☐ No
7. ☐ Yes ☐ No
8. ☐ Yes ☐ No
9. ☐ Yes ☐ No
10. ☐ Yes ☐ No
11. ☐ Yes ☐ No
12. ☐ Yes ☐ No
13. ☐ Yes ☐ No
14. ☐ Yes ☐ No
15. ☐ Yes ☐ No ☐ N/A

#97500 Imminent Death and Loss — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

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

#71770 Rural Health, Mental Health, and Social Work — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

#77041 Setting Ethical Limits: For Caring and Competent Professionals — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

Signature _____

*Signature required to receive continuing education credit.*

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# Evaluation (Continued)

SW23B

Last Name _____ First Name _____ MI _____

| CHECK THE LETTER GRADE WHICH BEST REPRESENTS EACH OF THE FOLLOWING STATEMENTS. | STRONGLY AGREE | AGREE | NEUTRAL | DISAGREE | STRONGLY DISAGREE |
|---|---|---|---|---|---|

**Learning Objectives (After completing this course, I am able to):**

**#97500 IMMINENT DEATH AND LOSS—1 CLOCK HOUR (Course expires 10/31/24)**

| | | | | | |
|---|---|---|---|---|---|
| • Develop a strategy for providing care to patients and their families over the last days and hours of life. | ☐ A | ☐ B | ☐ C | ☐ D | ☐ F |
| • Support appropriate grief and mourning. | ☐ A | ☐ B | ☐ C | ☐ D | ☐ F |
| • Discuss how culture impacts end of life care and death. | ☐ A | ☐ B | ☐ C | ☐ D | ☐ F |

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

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

**#71770 RURAL HEALTH, MENTAL HEALTH, AND SOCIAL WORK—5 CLOCK HOURS (Course expires 03/31/26)**

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

**#77041 SETTING ETHICAL LIMITS: FOR CARING AND COMPETENT PROFESSIONALS—6 CLOCK HOURS (Course expires 11/30/24)**

| | | | | | |
|---|---|---|---|---|---|
| • Define professional competence. | ☐ A | ☐ B | ☐ C | ☐ D | ☐ F |
| • Describe the importance of cultural competence. | ☐ A | ☐ B | ☐ C | ☐ D | ☐ F |
| • Outline components of the therapeutic relationship. | ☐ A | ☐ B | ☐ C | ☐ D | ☐ F |
| • Define empathy and describe the difference between empathy and sympathy. | ☐ A | ☐ B | ☐ C | ☐ D | ☐ F |
| • Identify compassion fatigue, vicarious trauma, and burnout and describe their impact on mental health professionals. | ☐ A | ☐ B | ☐ C | ☐ D | ☐ F |
| • Define transference and countertransference and discuss their implications for the mental health professional. | ☐ A | ☐ B | ☐ C | ☐ D | ☐ F |
| • Identify the functions of professional boundaries in the therapeutic relationship and multiple relationships. | ☐ A | ☐ B | ☐ C | ☐ D | ☐ F |
| • Discuss the guidance on giving and receiving gifts provided by professional ethics codes. | ☐ A | ☐ B | ☐ C | ☐ D | ☐ F |
| • Discuss the legal and ethical considerations of providing distance therapy. | ☐ A | ☐ B | ☐ C | ☐ D | ☐ F |

Signature _____

*Signature required to receive continuing education credit.*

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## To order, please visit www.NetCE.com

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

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

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

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



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