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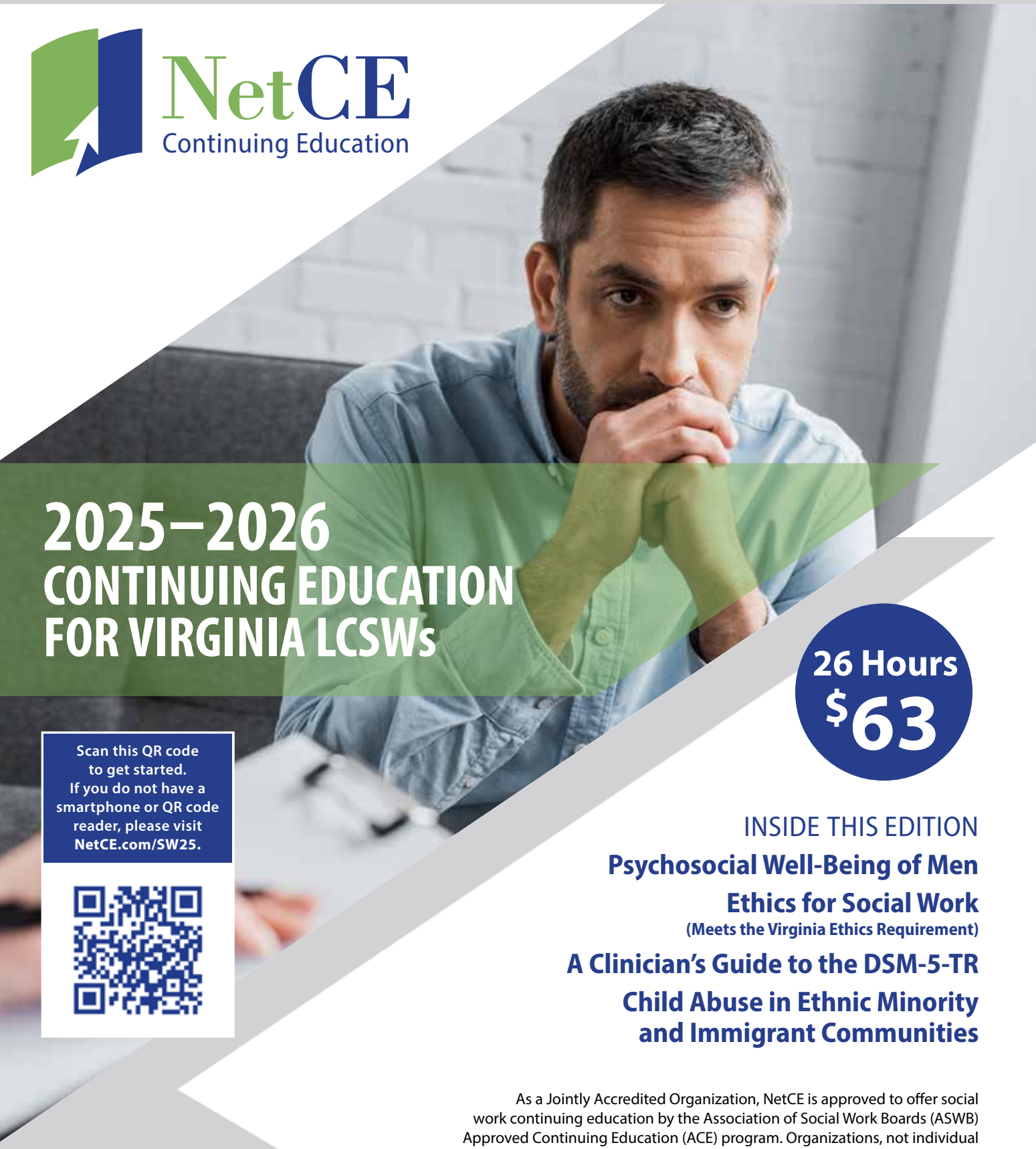

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Psychosocial Well-Being of Men

1 Clinical Continuing Education Credit

Audience
This course is designed for behavioral health professionals, physicians, physician assistants, and nurses, seeking to enhance their knowledge of issues related to men's psychosocial well-being.

Course Objective
The purpose of this course is to provide health and mental healthcare professionals with necessary information regarding psychosocial conditions and issues that affect men in order to facilitate more effective diagnosis, treatment, and care.

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

1. Describe the impact of stress and anger on men.
2. Outline the presentation and approaches to treatment for substance use disorder in men.
3. Describe the diagnosis and treatment of depression in male patients.

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. 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.

John M. Leonard, MD, Professor of Medicine Emeritus, Vanderbilt University School of Medicine, completed his post-graduate clinical training at the Yale and Vanderbilt University Medical Centers before joining the Vanderbilt faculty in 1974. He is a clinician-educator and for many years served as director of residency training and student educational programs for the Vanderbilt University Department of Medicine. Over a career span of 40 years, Dr. Leonard conducted an active practice of general internal medicine and an inpatient consulting practice of infectious diseases.

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, John M. Leonard, MD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Alice Yick Flanagan, PhD, MSW

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INTRODUCTION

Psychosocial well-being is important to men, and many conditions or situations can disrupt the sense of well-being. Among the more common factors that can have a negative effect on well-being for both sexes are everyday stressors (positive as well as negative), personal conflicts, traumatic events, and depression. In general, men lack the social support and interpersonal relationships that help women to cope with stresses [1]. Because of this, men differ in their ability to handle stress, with many men resorting to anger, violence, and substance misuse to deal with stress or depression [2; 3]. As a result, stress/anger, substance misuse, and depression are among the psychosocial conditions with the most serious health implications for men. Most men will not seek help for psychosocial disorders and may not recognize the symptoms of depression [3; 4; 5]. Thus, it is important for healthcare providers to address psychosocial well-being and potential threats to well-being as part of routine health evaluations of men.

STRESS/ANGER

Stress and anger have long been associated with negative health consequences. Most of the earlier research focused on the effects of stress and hostility on coronary heart disease, and additional research has found a link between hostility and a more rapid decline in lung function in older men [6; 7; 8]. Appropriate expression of anger has been suggested as a way to improve health, and controlling anger has been shown to promote well-being in older individuals [9].

Safety is also of concern, as anger has been associated with an increased incidence of injuries and violence. In one study, higher levels of anger (at a given moment) were associated with an increased risk of injury, especially in men [10]. In that study, nearly 32% of individuals who had been injured reported having some degree of irritability before the injury.

Men are the usual perpetrators of intimate partner violence causing injury, and these men tend to be younger (18 to 35 years of age), to be from a racial/ethnic minority population, and to have low socioeconomic status [11; 12]. Substance misuse and unemployment are also associated with such violence [11]. However, identifying a perpetrator of intimate partner violence in a clinical setting is difficult [12]. It is important to remember that men can also be victims of intimate partner violence, and this is especially true for men who have sex with men (MSM) [13].

Although the U.S. Preventive Services Task Force (USPSTF) found insufficient evidence for or against routine screening for intimate partner violence (including child abuse and elder abuse), a survey of patients within a private family practice network showed that 97% of respondents believed that physicians should ask patients about family stress and conflict [14; 15]. The survey sample included women who had been physically hurt by intimate partner violence as well as men who had admitted perpetrating such injury. These findings support early studies that indicated patient preference for clinicians to ask questions about physical and sexual abuse [16]. The American Academy of Family Physicians (AAFP) notes that family physicians have the opportunity to provide early intervention in family violence through routine screening and identification of abuse; thus, physicians should be alert for the presence of family violence in virtually every patient encounter [17]. It seems reasonable and appropriate for clinicians to include within routine health assessments of men questions about feelings of anger and frustration and urges to strike family members [11; 13]. Suggestions for strategies that focus on anger management and conflict resolution may be helpful, especially for adolescents and young men [13].

SUBSTANCE MISUSE

As noted, substance misuse is higher among men than among women in all age categories, and men are more likely to have psychosocial problems related to the misuse [2; 11]. Although the rate of alcohol misuse is highest among younger men, men older than 65 years of age are of special concern because they are much more likely than women to be "problem" drinkers and to misuse a wide range of illicit as well as prescription drugs [11]. As the general population ages, the misuse of illicit drugs is expected to increase [18]. Adding to this problem is the low rate of screening for alcohol misuse in the older population and the secrecy of many men about drug use [18; 19].

Additional concerns are the use of anabolic steroids among adolescents and young adult men and the use of methamphetamine among MSM. Use of anabolic steroids begins during the teenage years in approximately 25% of cases, and about 10% of all users are teenagers [20]. The prevalence of methamphetamine use among MSM is approximately 10% to 20%, a rate that is 10 times higher than that in the general population [21].

Several professional organizations, including the USPSTF, recommend screening and behavioral counseling intervention to reduce alcohol misuse [22]. However, reported rates of screening have been low [23]. Several screening instruments have been developed, and they vary in the number of questions, the populations for which they are best suited, and their usefulness in specific situations; no one tool is perfect [24; 25; 26; 27]. The CAGE questionnaire, which includes four questions, is best for detecting alcohol dependency and is easy and quick to perform [24; 25]. However, the test may not detect low, but risky, levels of drinking [11; 28]. The Alcohol Use Disorders Identification Test (AUDIT) is the most accurate for detecting problem drinking [23; 26].

Screening in the older population is especially important, as low levels of alcohol use can cause morbidity due to age-related physiologic changes, comorbidities, and the use of prescription medications [29]. Screening tools developed specifically for older individuals should be used, such as the geriatric version of the Michigan Alcohol Screening Test (MAST) or the Alcohol-Related Problems Survey (ARPS) [29; 30; 31]. Clinicians should also ask specific questions about drug use.

A medical history is also helpful, and a family history of alcoholism is a risk factor [23]. Clues to a problem with alcohol can be provided by such symptoms as amnesic episodes, mood swings, chronic fatigue, gastrointestinal symptoms, anxiety, and excessive sweating [23]. Several physical findings can suggest that a patient has a problem with alcohol or drugs, including [23; 28]:

- Mild tremor
- Unsteady gait
- Tachycardia
- Odor of alcohol or marijuana
- Enlarged, tender liver
- Nasal irritation (cocaine use)
- Conjunctival irritation (marijuana use)
- Excessive use of aftershave or mouthwash
- Signs of chronic obstructive pulmonary disease, hepatitis B or C, or HIV infection

Signs that should raise a "red flag" about substance misuse are frequent absences from work or school, history of frequent trauma or accidental injuries, depression or anxiety, other substance misuse, labile hypertension, sexual dysfunction, sleep disorders, poor nutrition, gastrointestinal symptoms, and interpersonal conflicts [11; 23; 28].

Clinicians should provide brief interventions, such as short counseling strategies, for men who are identified to have at-risk drinking. These interventions have been shown to be effective [23; 28; 32]. Alcoholism and drug addiction are best treated by an addiction medicine specialist or through an inpatient or outpatient program [28]. Primary care providers should have referrals for counseling and treatment readily available, as well as resources on support groups, such as Alcoholics Anonymous and Narcotics Anonymous.

To help healthcare professionals carry out the appropriate diagnosis and treatment of patients with alcohol problems, the National Institutes on Alcoholism and Alcohol Abuse (NIAAA) developed the publication Core Resource on Alcohol, which features an updated guideline on screening and brief intervention. These resources are available on the NIAAA website at https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol.

DEPRESSION

Depression is often regarded as a "woman's disease" because it is diagnosed more frequently in women than men. However, researchers and the health community at large now realize that depression is of serious concern in men and is underdiagnosed [2; 33]. According to data from 2020, the prevalence of major depressive episode was 6.2% among men and 10.5% among women [34].

Despite the lower rates of depression in men compared with women, the rate of completed suicide is nearly four times higher for men (25.8 vs. 7.1 per 100,000) [35]. Suicide is a leading cause of death for men in many age groups and across all racial/ethnic populations, except for the Black population [35]. There is some evidence that loneliness, while experienced by both men and women with depression, may be a stronger predictor of suicidal ideation among younger men than other demographic groups [36]. Researchers have hypothesized that feeling understood and loneliness likely function as serial mediators rather than as parallel mediators. In essence, the positive effect of disclosure of distress and feeling understood on depression and suicidality scores may be explained through loneliness measures [37].

The underdiagnosis of depression in men involves clinician-related and patient-related factors. Clinicians' lack of appropriate training and discomfort with dealing with depression contribute to a low rate of diagnosis, estimated to be about 50% [38; 39]. In addition, no screening instrument for suicide risk has been shown to reliably detect suicide risk in primary care populations [40]. This is unfortunate, as primary care providers appear to be in a position to intervene. As many as 83% of people who died by suicide had contact with their primary care physician in the year before death, with approximately 20% seeing their physician one day before death [38; 41]. In addition, 50% to 66% of individuals who committed suicide saw their primary care physician within one month of their death, with 10% to 40% committing suicide within one week of the visit [40]. Thus, better recognition of depression and suicide risk by primary care providers may help reduce suicide rates.

Many patient-related factors in the underdiagnosis of depression are primarily related to gender issues, including [2; 3; 33; 38; 42; 43]:

- Reluctance of men to seek help
- Lack of men's recognition of the symptoms of depression
- Hesitancy of men to express emotions
- Tendency for men to see depression as a weakness
- Men's misconceptions about mental illness and its treatment

DIAGNOSIS

Because men are less likely to express their emotions, they may recognize and discuss only the physical symptoms of depression, making diagnosis a challenge [3; 5; 42]. A carefully taken history can elicit information about risk factors, which include a family history of depression, the use of some medications (beta blockers, histamine H2-receptor antagonists, benzodiazepines, and methyldopa), chronic illness or other comorbidity, lack of social support, recent life stressor, and single marital status [11; 44]. Substance misuse frequently occurs concomitantly with depression, more often in men than women, but the direction of the causal relationship is not clear [3; 44].

Many of the symptoms of depression reported by women are the same for men: depressed mood, changes in appetite and sleep habits, problems with concentration, and an inability to find pleasure in once pleasurable activities [3]. It has been proposed that the symptoms of depression in men represent a male depressive syndrome, characterized by such symptoms as irritability, acting-out, aggression, low tolerance of stress, low impulse control, tendency to blame others, and a greater willingness to take risk [2; 3; 38; 42]. Men with depression may thus present with a very different symptom profile [33].

Identification of suicide risk is an essential component of the evaluation of patients with depression. Many of the risk factors for suicide are similar to those for depression; when the circumstances surrounding completed suicides were reviewed, the following were found to be factors [35]:

- Loss of a partner (through death or other means)
- Loss of job
- History of mental illness
- Depressed mood
- Previous suicide attempts
- Physical health problems
- Intimate partner problem
- Preceding or impending crisis (within two weeks)
- Financial problem

Clinicians should ask questions to determine the duration of symptoms and explore possible triggers of depression [33]. Because of their lack of experience with discussing emotions, many men may be uncomfortable with open-ended questions such as, "How do you feel?"; rather, discussing emotions in situational contexts can help men better express what they are feeling and why [42]. It may also be helpful to de-emphasize the negative connotation of depression and frame questions within the overall context of health and well-being [18].

TREATMENT OPTIONS

The treatment approach will depend on the severity of symptoms and the patient's preference. In general, a combination of psychotherapy and pharmacologic management provides the best results for most men [33; 44]. Potential psychotherapy approaches include cognitive behavior therapy and interpersonal psychotherapy [3; 11; 33]. First-line pharmacologic treatment involves the use of selective serotonin reuptake inhibitors, such as paroxetine, sertraline, and fluoxetine [11]. This treatment approach has efficacy rates of 30% to 70% [33]. Clinicians should emphasize the importance of taking the medication as prescribed, as it may be two to four weeks before a benefit is evident [33]. Depression that is associated with chronic illness is often seen as an inevitable consequence of the disease, but the depression should be treated. Frequently, the treatment improves the overall outcome [44].

To improve outcomes for men with depression, it is crucial to address the underlying gender-related factors that contribute to underdiagnosis and undertreatment, including reducing stigma, promoting help-seeking and early intervention, and considerations of gender-specific factors when developing treatment plans.

CONCLUSION

The psychosocial well-being of men is a multifaceted issue that requires comprehensive attention from healthcare providers. Stress, anger, substance misuse, and depression are significant factors that can adversely affect men's health, often leading to severe consequences such as violence and suicide. Despite the challenges in diagnosis and treatment, particularly due to societal norms and personal reluctance, it is crucial for clinicians to incorporate routine screenings and interventions into their practice. By addressing these issues with sensitivity and providing appropriate resources and support, healthcare professionals can play a pivotal role in improving the mental health and overall well-being of men.

Customer Information/Answer Sheet/Evaluation are located on pages 101–104.

TEST QUESTIONS
#93780 PSYCHOSOCIAL WELL-BEING OF MEN

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 hour activity must be completed by March 31, 2028.

1. What is a common factor that negatively affects the psychosocial well-being of men?
- A) *Age*
- B) *Friendship*
- C) *Disordered eating*
- D) *Everyday stressors*

2. Which of the following statements regarding intimate partner violence is TRUE?
- A) *Men are the usual perpetrators of intimate partner violence causing injury.*
- B) *Male perpetrators of intimate partner violence tend to be older (45 to 65 years of age).*
- C) *Men are not usually victims of intimate partner violence, especially MSM.*
- D) *Identifying a perpetrator of intimate partner violence in a clinical setting is generally simple.*

3. Which age group of men is most likely to misuse alcohol?
- A) *Adolescents*
- B) *Young adults*
- C) *Older men (65 years of age or older)*
- D) *Middle-aged men*

4. The prevalence of methamphetamine use among MSM is approximately 10% to 20%, a rate that is 10 times higher than that in the general population.
- A) *True*
- B) *False*

5. What is the most accurate tool for detecting problem drinking?
- A) *AUDIT*
- B) *MAST*
- C) *ARPS*
- D) *CAGE questionnaire*

6. In the United States, suicide is a leading cause of death for men in many age groups and across all racial/ethnic populations, EXCEPT:
- A) *Asian men*
- B) *Black men*
- C) *White men*
- D) *Native American/Alaska Native men*

7. Which of the following is a patient-related factor in the underdiagnosis of depression in men?
- A) *Frequent medical check-ups*
- B) *Availability of mental health resources*
- C) *Men's reluctance to express emotions*
- D) *High awareness of mental health issues*

8. Which of the following is a risk factor for depression in men?
- A) *Stable employment*
- B) *High social support*
- C) *Single marital status*
- D) *Regular physical activity*

9. What is a characteristic symptom of male depressive syndrome?
- A) *Increased appetite*
- B) *Low impulse control*
- C) *High tolerance of stress*
- D) *Decreased risk-taking behavior*

10. Which treatment approach is generally most effective for men with depression?
- A) *Psychotherapy alone*
- B) *Lifestyle changes only*
- C) *Pharmacologic management alone*
- D) *Combination of psychotherapy and pharmacologic management*

Be sure to transfer your answers to the Answer Sheet located on page 102.
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PLEASE NOTE: Your postmark or facsimile date will be used as your test completion date.

Ethics for Social Work

6 Social Work Ethics* Continuing Education Credits

Audience
This intermediate to advanced course is designed for social workers and related professionals required to complete ethics continuing education.

Course Objective
The purpose of this course is to increase the social work professional's knowledge base about ethical theories, principles, and the application of these principles to social work practice. A historical context of ethics in social work and in the larger context of the helping professions, such as nursing and other human service areas, will be explored. The course will also examine the specific components of the National Association of Social Workers (NASW) Code of Ethics, ethical theories, ethical decision-making processes, the psychological context of moral development, and multiculturalism and ethics.

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

1. Discuss the historical context of ethics in social work and the emergence of the National Association of Social Workers (NASW) Code of Ethics.
2. Define common terms such as ethics, morality, ethical dilemmas, and ethical principles.
3. Identify the purpose and functions of the NASW Code of Ethics.
4. Differentiate between deontologic, teleologic, motivist, natural law, transcultural ethical, and ethical relativism theories.
5. Discuss the relationship between ethical theories and the NASW Code of Ethics.
6. Identify the different ethical decision-making models.
7. Discuss the psychologic context of ethical decision making by applying Lawrence Kohlberg's theory of moral development.
8. Discuss ethical issues that emerge with social work practice under managed care systems.

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

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

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

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

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***This course does not meet the ethics requirements for Georgia, Kentucky, or Wisconsin.**
Please see page 100 for additional information.

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Sarah Campbell

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INTRODUCTION

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

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

members; unify, advise, and protect existing members; help resolve ethics issues; protect those that the profession serves; and help establish and distinguish an organization, agency, and its members.

HISTORICAL CONTEXT OF SOCIAL WORK ETHICS

Two events in the 20th century served as catalysts to facilitate the codifying principles and behaviors that protected the rights of research participants. This set the context for establishing codes of ethics in human service arenas, including social work. One event was the atrocities exposed during the Nuremberg trials in Germany in 1945 and 1946. Another significant event occurred in the United States when, in 1932, the Public Health Service initiated a syphilis study on 399 African American men from Tuskegee, Alabama. The goal of the study was to observe the men over a period of time to examine how the disease progressed in African Americans. When the study began, there was no cure; however, 15 years into the study, penicillin was discovered to be a cure for syphilis. The research participants were never informed, and treatment was withheld in spite of the fact that by the end of the experiment in 1972, 128 men had died either from the disease or related complications [1].

These two events triggered the realization that an organized standard of ethics was needed. Values of self-determination, voluntary consent, and informed consent needed to be upheld. In 1966, the Public Health Services established ethical regulations for medical research. In 1974, the National Commission for the Protection of Human Subjects was created by public law. Finally, in 1979, the commission published *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. The commission recommended that all institutions receiving federal research funding establish institutional review boards. Today, these boards, made up of researchers and lay people, review social science research proposals to ensure that they meet ethical standards for protecting the rights of the potential subjects. In 1991, the "Common Rule" or the federal policy about protecting human research participants was published [72]. In 2011, revisions to the Common Rule were introduced to provide additional protections for human research participants and lesson researcher burden [73].

In 1973, the first edition of the *Hastings Center Studies* pointed out the problems and the needs that would become paramount in developing healthcare research projects. Remarkable advances were projected in the areas of organ transplantation, human experimentation, prenatal diagnosis of genetic disease, the prolongation of life, and control of human behavior. All of these had the potential to produce difficult problems, thus requiring scientific knowledge to be matched by ethical insight. This report laid the foundation for other disciplines to develop their own ethics guidelines.

The federal government, private philanthropists and foundations, universities, professional schools, and committed professionals moved quickly to address these questions. A plethora of codes of ethical behaviors and guidelines have been set forth by many human service disciplines. The specific code of ethics developed for each profession is guided by the overall value system of that profession. Codes of ethics serve to bring about greater public confidence to the profession, and it helps the practitioner and the profession resist environmental pressures [20].

Table 1 provides a summary of codes of ethics commonly utilized by mental health professionals, counselors, marriage and family therapists, social workers, and other helping practitioners [2].

PHILOSOPHICAL HISTORY OF ETHICS

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

Modernism

The term modernism refers to an era during which scholars were encouraged to shift from a basis of metaphysics to rationalism in analyzing the world and reality [3]. In a modernist world, it is believed that human reason can determine truth on all subjects [3; 74]. Practitioners who are rational and autonomous take personal responsibility to behave in an ethical manner [74]. Just as science evolved from being religion- or faith-based, modernists sought to understand social phenomena by explicating universal ethical laws [3].

Modernist philosophy argues that all individuals are similar and individual rights are supreme [4; 74]. This philosophy has permeated much of biomedical ethics, and as such, each of the four ethical principles that form the backbone of ethical codes—autonomy, beneficence, nonmaleficence, and justice—should be universally adhered to and applied [5]. Utilitarian ethical principles, rationalism, and evidence-based scientific applications are at the heart of modernism [94].

One of the main criticisms of modernism as applied to ethics is that moral uncertainty exists when it comes to making ethical decisions, and ethical decision-making cannot always be laid out in a rational and linear manner [45]. Furthermore, the modernist perspective reinforces hierarchy, with the practitioner designated the expert and the client designated novice or student, which can diminish client self-determination [45].

Postmodernism

Postmodernism is a reaction to the belief that there is "rational scientific control over the natural and social worlds" [3]. Postmodernism is characterized by diversity, pluralism, and questioning the belief that there are objective laws or principles guiding behavior [3; 95]. This perspective recognizes that knowledge is not error free and the world is characterized by fluidity [45]. Postmodernists argue that ethical principles should take into account historical and social contexts to understand individuals' behaviors [4]. According to this view, the concepts of "right" and "good" are seen as social constructs influenced by historical and current social forces [45]. This philosophical climate emphasizes situational ethics in which there are no black and white rules about principles of good and bad. Ultimately, a set of universal ethical principles cannot be easily applied [3].

Since 2015, there has been increasing discussion regarding the apparent shift to postmodernism in the ethical landscape [94; 95]. In part spurred by the political environment in the United States during this period, the concept of a universal set of ethical principles appeared to be challenged; instead, ethical relativism appeared to move to the forefront. The growing use of social media and the Internet helped to present a highly individualized set of "truths" (or "alternative facts") [94].

Today, ethical codes and practices are also influenced by critical theory. Critical theorists focus on eliminating inequities and marginalization [74]. Ethics from this perspective explores the role of power and power inequalities, exploring who or what defines truth and whose voices are represented [74]. Reality is a socially and culturally shared experience and is shaped and navigated by both the practitioner and client [96]. Therefore, ethics is not a top-down experience, whereby ethical rules are unilaterally imposed. Rather, handling and negotiation of ethical challenges should be a collaboration [96].

HISTORICAL EVOLUTION OF ETHICS IN SOCIAL WORK

Reamer provides an excellent synopsis of the historical climate in social work that set the stage for the evolution of ethical norms, principles, and standards [6]. He identifies four stages in the profession's history: the morality period, the values period, the ethical theory and decision-making period, and the ethical standards and risk management period. He argues that from the early conception of the field, social work focused primarily on the client's values and eventually matured and shifted to wrestling with complex ethical dilemmas. The culmination of this maturation is reflected in the field's third code of ethics, ratified by the National Association for Social Work (NASW) in 1996. The following is a brief overview of each historical period in social work [6].

Morality Period

In the late 1800s, social work was concerned primarily with the morality of the poor [6]. Organized relief focused on pauperism and efforts to lift the poor out of their "shiftless" and "wayward" behaviors and habits. Poverty was attributed to internal personality traits. By the early 1900s, with the settlement house movement, social work ideology was moving away from attributing social problems to the individual and focused instead on causative environmental factors. However, an emphasis remained on the morality of social change and reform as focus shifted from the personal to the social [6;

97]. Consequently, a social worker's ethical obligation was to promote social justice and reform.

Values Period

Although social work is a value-based profession, it was not until the 1920s that there was some inclination to explore the role of values and ethics, but the majority of the work did not appear until the 1950s. After the Flexner Report (published in 1915) stated that social work could not be considered a profession until it had a code of ethics, Mary Richmond began developing the first experimental code of ethics for caseworkers in 1920 [7]. However, it was not until 1947, after many years of discussion and debate, that the Delegate Conference of the American Association of Social Workers adopted a code of ethics. Finally, in 1966, the NASW released a comprehensive ethical code [98]. In addition, several social work journals published articles on ethics and the core values of respect of persons, valuing individuals' capacity for change, client self-determination, client empowerment, individual worth and dignity, commitment to social change, and social justice. Unlike previously, this period was marked by exploration of the field's values and practitioners' personal values rather than an emphasis on client morality [6].

To this day, many argue that social work as a profession is "among the most value based of all professions" [46]. The core values laid out by the NASW Code of Ethics lay the foundation of the mission of social work [46].

Period of Ethical Theory and Decision Making

In the 1970s, a new field of applied and professional ethics emerged, which had a dominant role in medical ethics. This new field emerged during a social and political climate that begged for answers to philosophical questions. For example, there were debates about welfare rights, prisoners' rights, and healthcare issues such as organ transplants, abortion, and end-of-life decisions. In addition, the public wrestled with the scandal of Watergate. Amidst the social climate of the 1970s, social work paid more attention to the topic of ethics as there were an increasing number of allegations of professionals' unethical behavior and malpractice litigations [46].

In the 1980s, social workers continued to further explore the profession's values. Drawing on ideas from philosophy and the newer field of applied ethics, social work literature focused on ethical theories, ethical decision making, and ethical challenges confronted in direct practice such as client self-determination, informed consent, and the relationships among practitioners [6].

Ethical Standards and Risk Management Period

In 1996, the NASW revised its Code of Ethics for Social Workers to include a section on core values and ethical standards. The revised Code offered new guidelines to improve service and enhance social workers' self-protection in an increasingly diverse and litigious society.

Digital Period

In the 2010s, a fifth period—the digital period—was introduced. This period is characterized by an increasing reliance on technology in social work and the related impact on the ethical landscape [75]. Social workers today should consider the impact of the Internet, social media, and smartphones on the micro, mezzo, and macro levels [75].

Contemporary Issues

To meet the needs of the changing multicultural landscape, in 2008, the NASW Delegate Assembly revised the Code of Ethics to include cultural competency and social diversity [47]. Social work professionals should maintain professional knowledge regarding diversity, oppression, and marginalization as they relate to the different dimensions of diversity (e.g., race, culture, ethnicity, age, religion, ability, immigration status, gender/sexual identity, political affiliations) [47].

In view of the growing role of technology in clients' lives and on the provision of social work services, the 2017 revision of the NASW Code of Ethics made the inclusion of guidelines for the ethical use of technology its major focus [8]. Social work professionals should consider the role of technology in ensuring informed consent, competence, conflicts of interest, privacy/confidentiality, and professional relationships and boundaries. In addition, in 2017 the NASW, in conjunction with the Association of Social Work Boards, the Council on Social Work Education, and the Clinical Social Work Association, published specific guidance in its publication *Standards on Technology and Social Work Practice* [71]. In 2021, the NASW Delegate Assembly approved revisions to the NASW Code of Ethics, adding self-care as one of the purposes of the code and revising language and expanding the scope of the discussion of cultural competence [8]. A review of these most recent changes is available at https://www.socialworkers.org/LinkClick.aspx?fileticket=UyXb_VQ35QA%3D&portalid=0.

DEVELOPMENT OF THE CODES OF ETHICS IN SOCIAL WORK

As noted, the first informal code of ethics targeted to caseworkers was developed by Mary Richmond in 1920 [7]. In 1955, the American Association of Group Workers, American Association of Psychiatric Social Workers, American Association of Social Workers, Association of the Study of Community Organization, National Association of School Social Workers, and the Social Work Research Group consolidated to form the NASW. In 1960, the NASW formulated and approved their first Code of Ethics [75].

It consisted of 14 general and idealistic statements that described social workers' responsibilities and obligations to the field [7]. In 1979, this Code of Ethics was revised, and the second iteration consisted of a ten-page document that described social workers' conduct and their responsibility to their clients, colleagues, professional field, and society. It was

the first time that it was explicitly stated that social workers needed to abide by any disciplinary rulings based on the code. In 1990, another revision was made. This third iteration eliminated the prohibition against soliciting colleagues' clients and added a statement that prevented social work professionals from exploiting relationships with clients for personal advantage or accepting anything for making a referral. In 1993, the fourth iteration included two additional amendments—social workers' responsibility to impaired clients and the prohibition against dual relationships [7].

There were many criticisms of these different iterations. Some argued that the previous codes applied to direct service professionals and less so to supervisors, administrators, or educators. Others argued that the previous codes focused on work with individual clients and did not deal with groups and/or families. Finally, issues that were becoming increasingly relevant such as confidentiality, technology, sexual harassment, managed care, cultural sensitivity and competence were not at all addressed in the previous code [7]. Consequently, the NASW set out to again revise the Code of Ethics, and in 1994, formed a committee of social work leaders, educators, professionals, and experts in ethics to develop a new code. It was finally approved by the Delegate Assembly in 1996 and went into effect on January 1, 1997 [7]. In 2008, the code was amended to include additional contemporary issues, specifically gender identity or expression and immigration status. In 2017, the code was revised substantially, with a focus on issues related to the use of technology [8; 76]. An additional revision was completed in 2021 (as discussed). The current Code of Ethics is considered to be one of the most comprehensive ethical standards in NASW history. It will be examined in greater detail in various sections throughout the course.

COMMON TERMS USED IN THE DISCUSSION OF ETHICS

VALUES

Frequently, the terms values and ethics are employed interchangeably; however, the terms are not synonymous. Values are beliefs, attitudes, or preferred conceptions about what is good or desirable that provide direction for daily living. They stem from our personal, societal, and agency values. Rokeach has argued that values may be organized into two categories: terminal values and instrumental values [9]. Terminal values describe the desired end-goal for a person's life; they are identified as: happiness, inner harmony, wisdom, salvation, equality, freedom, pleasure, true friendship, mature love, self-respect, social recognition, family security, national security, a sense of accomplishment, a world of beauty, a world at peace, a comfortable life, and an exciting life. Instrumental values are those that help a person to achieve their desired terminal values, such as love, cheerfulness, politeness, responsibility, honesty, self-control, independence, intellect, broad-mindedness, obedience, capability, courage, imagination, logic, ambition, cleanliness, helpfulness, and forgiveness. Ultimately, all of these types of values influence how a person will behave. Not all individuals will identify with all of these values; most will have a few terminal values that are important to them. When there is conflict or tension between values, such as politeness and honesty, individuals will begin to prioritize [9; 69].

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

Values in the NASW Code of Ethics

The NASW Code of Ethics identifies six core values (***Table 2***) [8].

The value of service has been the core of the social work field throughout history. At the heart of this value is giving—the giving of oneself to others to contribute to society [77]. The primary goals of the social worker are to help people in need, to advocate, and to link clients to services [7]. However, a social worker's commitment to this value is tested when presented with a client who may not be able to afford services. The code encourages *pro bono* work.

The value of social justice is integral to the field. The American settlement house movement started in the United States in the late 1800s, a time when there was a large influx of immigrants arriving. Settlement houses sought to improve urban conditions and promote social and economic reform [12]. Social justice, therefore, emphasizes social work's commitment to eradicating oppression and discrimination and promoting cultural diversity and sensitivity [7; 41]. Social workers are dedicated to advocating for equity for all people [77].

The value of dignity and worth of the person aims to promote a client's self-determination and autonomy. Respecting and valuing of all people is at the crux of this value [77]. However, social workers can face conflict with this value when, for example, a client is repeatedly abused by her spouse yet returns to him after each incident. Often, promoting self-determination and client autonomy may not be consistent with the professional's view of what is perceived as the best option.

The value of importance of human relationships spans across all different types of situations in social work. It involves not only the client's individual relationships with his/her family or other individuals, but also the social worker's interactions with communities, organizations, and other helping professionals to strengthen connections as well [7]. For this to occur, social workers should emphasize clear communication and working through differences [77].

CORE VALUES EMBODIED IN THE NASW CODE OF ETHICS	
Values	**Definitions of Values**
Service	Provision of assistance, resources, benefits, and service in order for individuals to achieve their potential
Social justice	The ideal in which every individual in society has equal access to rights, opportunities, social benefits, and protection
Dignity and worth of the person	Placing the individual in high esteem and valuing individual differences
Importance of human relationships	Valuing and appreciating the interaction, connections, and exchange that exists in the social worker and client relationship, which creates a positive working relationship
Integrity	Trustworthiness and adherence to moral principles
Competence	Having the skills and abilities to work with clients effectively
Source: [8]	*Table 2*

The value of integrity is essential to building relationships with clients and other professionals. The social work professional must be truthful to the client and colleagues in what he/she can provide or what he/she will or will not disclose [7].

Finally, the value of competence reinforces the belief that social workers should only practice in areas in which they have the requisite knowledge and abilities. Professionals can only help if they have the proper tools and skills to utilize them effectively. Social workers must also improve their knowledge and abilities so they can further assist clients and contribute to the advancement of their profession [7; 8; 11]. Growth and continual learning are lifelong endeavors for social workers and ensure they can most effectively serve clients and communities [77].

ETHICS

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

An ethical dilemma presents itself when a social worker must make a choice between two mutually exclusive courses of action. The action may involve the choice of two positives or the choice of avoiding two harms. If one side of the dilemma is more valuable or positive than the other side, then there is no dilemma because the choice will lean toward the side that is more desirable [15]. The process of making the choice is the ethical decision-making process.

Ethical decision making is influenced by the ethical principles to which individuals adhere. Ethical principles are expressions that reflect humans' obligations or duties [10]. These principles of correct conduct in a given situation originated from debates and discussions in ancient times and became the theoretical framework upon which we base our actions as individuals and societies. Most prominently, it was the Bible and Greek philosophers, such as Plato and Aristotle, who created most of the familiar ethics and morals in use today.

The following are general ethical principles that social work professionals recognize [10]:

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

Based on these ethical principles, professions develop ethical codes that embody the values of the profession and guide behaviors of members. Of course, codes of ethics do not guarantee ethical practice [99]. They do not always provide clear direction, and in some cases, the tenets of the codes are in direct conflict with each other.

It is also important to note that codes of ethics should be dynamic, reflecting the changing social and cultural climate. If the codes are not revised periodically, they can become obsolete [99].

NASW CODE OF ETHICS

The NASW Code of Ethics is the ethical code most widely used by social workers in the United States. It is divided into four sections [8]:

I. Preamble – Summarizes the mission of social work and the six core values of the profession. The mission of social work is "to enhance human well-being and help meet the basic needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" [8]. The six core values are:

- Service
- Social justice
- Dignity and worth of the person
- Importance of human relationships
- Integrity
- Competence

II. Purpose of the NASW Code of Ethics – Provides an overview of the purpose and functions of the Code. This section identifies the Code's six major aims [8]:

1. Identifies core values on which social work's mission is based
2. Summarizes broad ethical principles that reflect the profession's core values and establishes a set of specific ethical standards that should be used to guide social work practice
3. Helps social workers identify relevant considerations when professional obligations conflict or ethical uncertainties arise
4. Provides ethical standards to which the general public can hold the social work profession accountable
5. Socializes practitioners new to the field to social work's mission, values, ethical principles, and ethical standards
6. Articulates standards that the social work profession itself can use to assess whether social workers have engaged in unethical conduct

III. Ethical Principles – Presents six broad principles that can be drawn from the six core values stated in the preamble [8]:

1. Social workers' primary goal is to help people in need and to address social problems (drawn from core value of service).
2. Social workers challenge social injustice (drawn from core value of social justice).
3. Social workers respect the inherent dignity and worth of the person (drawn from the core value of dignity and worth of the person).
4. Social workers recognize the central importance of human relationships (drawn from the core value of importance of human relationships).
5. Social workers behave in a trustworthy manner (drawn from the core value of integrity).
6. Social workers practice within their areas of competence and develop and enhance their professional expertise (drawn from core value of competence).

IV. Ethical Standards – This section includes specific principles clustered around six major categories, which include the following [8]:

1. Ethical responsibilities to clients
2. Ethical responsibilities to colleagues
3. Ethical responsibilities to practice settings
4. Ethical responsibilities as professionals
5. Ethical responsibilities to the social work profession
6. Ethical responsibilities to the broader society

The Code of Ethics are aspirational in that the values, principles, and standards reflect the ideals that social workers should strive toward [100]. For each of these six professional arenas, ethical principles are highlighted. To view the full code, visit https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English.

ILLUSTRATIVE EXAMPLE

Client A, a Chinese immigrant man 85 years of age, is brought to the hospital's emergency department by ambulance after his wife found him lying on the floor after a fall. Because Client A and his wife speak limited English, Chinese-speaking hospital staff is located to help with interpreting.

After testing is complete, the emergency room physician diagnoses Client A with aortic dissection. The client must make a decision of whether to proceed with surgery, which has significant risks. He is informed that he has only a slight chance of recovery given his age. He is also informed he must make a decision immediately. Client A and his wife say they cannot make a decision without consulting with their children, who are in transit to the hospital but still a few hours away.

The treating physicians are pressuring the client to make a decision, as the window for success is short. A white social worker visits the couple. She knows that Asian culture is very family oriented and highly collectivistic. She indicates to the physicians that, in this case, decision-making will not necessarily revolve around self-autonomy.

In this case, the social worker is operating under the value of promoting the dignity and worth of the person, which is at the heart of social work. This value is reflected in NASW Ethical Standard: 1.02: Self-Determination. Another important ethical consideration stems from the Standard: 1.05: Cultural Awareness and Social Diversity. Western values emphasizing autonomy are not necessarily paramount for all clients. In Client A's case, given his collectivistic cultural orientation, family decision-making is vital. Before making any decisions or recommendations, the social worker also addresses her own level of competence, which reflects Standard 1.04: Competence.

ETHICAL THEORIES

Ethical theories provide a framework that can be used to determine the principles that might decide whether an action is ethical. Ethical theories do not solve ethical dilemmas; instead, they are a lens through which to analyze them [78]. These ethical systems are each made up of principles, precepts, and rules that form a specific theoretical framework, providing general strategies for defining the ethical actions to be taken in any given situation.

In its most general and rudimentary categorization, ethics can be classified into three different headings: deontologic (i.e., mandatory) ethics, teleologic (i.e., aspirational or consequential) ethics, or virtue ethics [16]. When a social worker wears a mandatory ethics lens, he/she views the world in terms of polar opposites, in which one must make a choice between two behaviors. On the other hand, those who adopt aspirational ethics assume that there are a host of variables that play a role in benefiting the client's welfare [16]. Those who adhere to virtue ethics assume that the moral character of the social worker or even the social service agency will drive ethical behavior and decisions [48]. For all ethical decision-making models, there is an underlying ethical theory that drives the model. Therefore, it is important to understand the various ethical theories.

DEONTOLOGIC ETHICAL THEORIES

Deontologic theories concentrate on considering absolutes, definitives, and imperatives [7; 79]. Deontologic theories may also be referred to as fundamentalism or ethical rationalism [17]. According to this perspective, ethical behavior is based on objective rules an individual follows in order to fulfill his/her obligation to society, the profession, the community, clients, and/or employers [48; 80; 101]. Persons adhering to this perspective ask: What rules apply? What are the duties or obligations that provide the framework for ethical behavior [102; 103; 104]? The deontologic theorist would argue that values such as self-determination and confidentiality are absolute and definitive, and they must prevail whatever the circumstances (i.e., universally applicable) [17]. Other underlying principles include beneficence, non-maleficence, and justice [103]. An action is deemed right or wrong according to whether it follows pre-established criteria known as imperatives. An imperative in our language is viewed as a "must do," a rule, an absolute, or a black-and-white issue. This is an ethic based upon duty, linked to absolute truths set down by specific philosophical schools of thought. As long as the principles dictated by these imperatives are met with dutiful compliance, one is said to be acting ethically.

The precepts in the deontologic system of ethical decision making stand on moral rules and unwavering principles. No matter what situation presents itself, the purest deontologic decision maker would stand fast by a hierarchy of maxims. These are as follows [18; 103]:

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

Social work professionals making ethical decisions under the deontologic ethical system see all situations within a similar context regardless of time, location, or people. It does not take into account the context of specific cultures and societies [17; 78]. The terminology used in this system of beliefs is similar to that found in the legal justice system.

One of the most significant features of deontologic ethics is found in John Rawls' *Theory of Justice*, which states that every person of equal ability has a right to equal use and application of liberty. However, certain liberties may be at competition with one another. There are also some principles within the same ethical theoretical system that can conflict with one another. An example of this conflict might involve a decision over allocation of scarce resources. Under the principle of justice, all people should receive equal resources (benefits), but allocation can easily become an ethical dilemma when those resources are scarce.

A framework of legislated supportive precepts, such as the NASW Code of Ethics, serves social work professionals by protecting them in their ethical practice. However, even these systems of thought will not clearly define the right answer in every situation. Most professionals will not apply the concept of the means justifies the end if the end outcome is harmful to the patient, client, or others in their social group. When duties and obligations conflict, few will follow a pure deontologic pathway because most people do consider the consequences of their actions in the decision-making process.

Theologic Ethical Theory

A well-known deontologic ethical theory is based upon religious beliefs and is known as the theologic ethical theory. The principles of this theory promote a *summum bonum*, or highest good, derived from divine inspiration. A very familiar principle is to do unto others as you would have them do unto you, which guides this system of beliefs.

Categorical Imperative

Another deontologic ethical principle is Immanuel Kant's categorical imperative. Kant believed that rather than divine inspiration, individuals possess a special, inborn sense that reveals ethical truth to them and causes persons to act in the proper manner. Some of the enduring ethical principles originating from Kant will become more familiar as the principles associated with bioethics are discussed. These include individual rights, self-determination, keeping promises, privacy, personal responsibility, dignity, and sanctity of life.

TELEOLOGIC ETHICAL THEORIES

Telos is a Greek word meaning end, and the teleologic ethical theories (or consequential ethics) are outcome-based theories [105]. It is not the motive or intention that causes one to act ethically, but the underlying goal and consequences of the act [7; 79]. If the action causes a positive effect, it is said to be ethical. So here, the end justifies the means. From this perspective, the question is: What are the possible good and bad outcomes? What would be the most or least harmful [101; 102; 104; 105]? Teleological theories focus more on societal effects of actions, while deontological theories emphasize effects on the individual [103]. Therefore, deontological theories may be more patient-centered.

The founder of modern utilitarian ethics, Jeremy Bentham, introduced in *An Introduction to the Principles of Morals and Legislation* the principle of utility for the evaluation of appropriate actions [12; 13]. The rightness or wrongness of a selected action is decided according to whether the action would maximize a positive outcome, that is, whether the action would bring less pain and more pleasure to the most people. Bentham quantifies the amount of pain and pleasure created from actions in a moral utilitarian calculus that examines the rightness or wrongness of the selected actions in terms of seven factors: intensity, duration, certainty, propinquity or remoteness, fecundity, purity, and extent [12; 13; 14].

Utilitarianism

Utilitarianism is the most well-known teleologic ethical theory. This is the principle that follows the outcome-based belief of actions that provide the greatest good for the greatest number of people [49; 80; 106]. In other words, the rights of individuals may be relegated in order to benefit the greatest number of people. Social laws in the United States are based upon this principle. The individual interests are secondary to the interest of the group at large. There are two types of utilitarianism: act utilitarianism and rule utilitarianism [106]. In act utilitarianism, a person's situation determines whether an act is right or wrong. In rule utilitarianism, a person's past experiences influence one to greatest good. There are no rules to the game; each situation presents a different set of circumstances. This is currently referred to as situational ethics. This situational ethics precept would say that if the act or decision results in happiness or goodness for the person or persons affected, it would be ethically right.

Individuals may choose the utilitarian system of ethics over another because it fulfills their own need for happiness, in which they have a personal interest. It avoids the many rules and regulations that may cause a person to feel lack of control. In Western society, the rule of utility is whatever leads to an end of happiness fits the situation.

One of the limitations of utilitarianism is its application to decision making in social work. In developing social policies for a nation of people based upon the principle of doing the greatest good for the greatest number, several questions arise. Who decides what is good or best for the greatest number: society, government, or the individual? For the rest of the people, are they to receive some of the benefits, or is it an all or nothing concept? How does "good" become quantified in social work?

Existentialism

One modern teleologic ethical theory is existentialism. In its pure form, no one is bound by external standards, codes of ethics, laws, or traditions. Individual free will, personal responsibility, and human experience are paramount. This perspective assumes that a person is highly aware and sensitive and has the capacity to reflect on his or her personal responsibility, freedom, pressures experienced by others, and practical constraints of a situation [50]. Existentialism lends itself to social work because one of the tenets is that every person should be allowed to experience all the world has to offer. A critique of the existential ethical theory is that because it is so intensely personal, it can be difficult for others to follow the reasoning of a social worker, making proof of the ethical decision-making process a concern.

Pragmatism

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

VIRTUE ETHICS

Virtue ethics is based on the belief that moral character is the foundation for ethical decision making. Virtues, such as integrity, wisdom, compassion, courage, truthfulness, and modesty, will guide ethical behavior [48; 51; 67; 79; 101]. According to Aristotle, there are two categories of virtues: intellectual and moral. Intellectual virtues include wisdom, understanding, and prudence; moral virtues encompass liberality and temperance [107].

This perspective does not emphasize rules or the motivations or outcomes of an action. Instead, it focuses on the individual's personality traits or character. Professionals with this perspective ask themselves what a good practitioner would do in light of an ethical dilemma [104]? Virtues relevant to the practice of social work include openness, care, compassion, honesty, empathy, patience, gratitude, humility, hopefulness, courage, fair mindedness, and diligence [52]. Virtue ethics theorists argue that primary and continuing social work education should focus on character formation in addition to social work competencies and skills in order for practitioners to develop crucial virtues to become a good person [51; 53]. In reality, social workers simultaneously employ multiple ethical theories. In doing so, they mitigate the limitations inherent in using only one primary ethical theory. Ethical dilemmas may be analyzed using all three major ethical theories [54]. The deontologic framework assists social workers to consider their absolute principles and obligations, for example, through the use of the NASW Code of Ethics. The utilitarian framework offers a cost and benefit analysis of certain actions taken, and virtue ethics provides an opportunity for the social worker to reflect on his/her character, motives, and the type of social worker he/she wants to be [54].

RELATIONAL ETHICS

A relational model of ethics focuses on the network of relationships and social connections rather than universal absolutes, as humans are embedded in a social web [81; 82; 108]. Cooperation and care are key in relational ethics. Gilligan's ethics of care is an example of relational ethics. At the heart of relational or care ethics is consideration of the care responsibilities of a practitioner [104].

In summary, ethical dilemmas may be analyzed using all three major ethical theories [54]. The deontologic framework assists social workers to consider their absolute principles and obligations, for example, through the use of the NASW Code of Ethics. The utilitarian framework offers a cost and benefit analysis of certain actions taken, and virtue ethics provides an opportunity for the social worker to reflect on his/her character, motives, and the type of social worker he/she wants to be [54]. Traditionally, social work has focused mainly on deontological and utilitarianism as the dominant ethical paradigms [109].

PRACTICAL APPLICATION OF ETHICAL THEORY

It is important to remember that ethical theories are just that—theories. They do not provide absolute solutions to ethical dilemmas nor do they guarantee moral actions in a given situation. They do provide a framework for ethical behavior and decision making when adjoined to professional codes of ethics and to the critical information we obtain from the clients and families. In other words, theories serve as lenses to how we approach ethical dilemmas, solve problems, create assessments, and evaluate interventions.

RELATIONSHIP BETWEEN ETHICAL THEORIES AND THE NASW CODE OF ETHICS

The 1990 NASW Code of Ethics was classified as deontologic because it contained three ethics statements that were more rule-based [21]. The most recent NASW Code of Ethics also has a deontologic style because it also includes the responsibility of the social work professional to understand the ethical statements instead of merely inscribing the ethical statements as a prescriptive rule [21]. It has been noted that the values set forth in the NASW Code of Ethics are deontologic in nature, but frequently, social workers will use teleologic reasoning to make their decisions when confronted with ethical dilemmas [7].

RELATIONSHIP BETWEEN ETHICAL THEORIES AND PROFESSIONAL PRACTICE

As discussed, professional ethical codes define a particular organization's values and create boundaries that members must abide. In practice, most social work professionals adopt a combination of ethics that agree with personal and client values and prioritize these values based on the situation or application, while at the same time adhering to professional codes of ethics. This often occurs naturally, without giving much thought to the theories that the various values are derived from. One study found that social work professionals tend to adhere to deontologic ethical principles; however, in their day-to-day practice, they utilize a utilitarian approach [55].

Ethics inform all aspects of practice, not just the resolution of dilemmas. It is important to remember that ethical obligations and repercussions differ somewhat between applications. Ethics used in research are abstract and do not necessarily take into account a unique client situation; however, when performing an assessment to guide a real-world intervention, values must be evaluated and prioritized to help clients achieve specific goals [43]. Most practitioners would agree that personal value systems must be flexible in order to accommodate the needs of the individual client-system (e.g., clients from differing cultures, elderly clients, clients with substance abuse disorders, groups).

Of course, certain values, such as respect, should always be a high priority. It has been shown that respect is a fundamental value in social work and that demonstrating respect toward clients (in a variety of ways) can lead to better outcomes [44].

It is also important to understand that each objective's or each intervention's outcomes can be evaluated using different theoretical lenses or outlooks. A social worker can compare the outcomes of similar cases against the intervention being evaluated, but practitioners may judge the outcome differently based on their personal values and ethics. Bloom argues that deontologic (i.e., absolutist) ethics are "fairytale-like and unsuited to the real world" because they promote an all or nothing attitude during evaluation and an unrealistic expectation of perfection [43]. On the other hand, teleologic (i.e., consequential) ethics allow for acceptance of varying degrees of success and for outcomes to be gauged by a variety of measures. If the goals of an agreed upon intervention plan are not 100% achieved, the absolutist social worker will deem the intervention a failure, but the practitioner using consequential ethics will view the achieved positives and eliminated problems of an intervention, individually, as successes.

Although the all or nothing approach may have some merit and may work for a given objective (i.e., target) or intervention, there are instances where even a fraction of improvement is very desirable. Bloom gives the example of an elderly man that is extremely angry and resentful at being moved into a nursing home due to lack of social contacts/support [43]. Ensuring anger reduction is important, but because it may be unlikely that his anger will ever dissipate completely, clinicians should identify another acceptable outcome. By comparing his case to other similar cases or research studies, a social worker can identify an average and the range of decrease in anger and resentment among many individuals and use that to set an intervention goal, which can either be a percentage of improvement or a reduction on a 10-point scale [43]. The goal may be a 30% reduction in anger or going from a 9 to a 6 on a 10-point scale.

If there is only a 10% reduction in anger during the intervention period, and the goal was not reached, the evaluation can reach several conclusions. Practitioners with an absolutist ideology might contend that the intervention failed because the goal was not realized. This presents a separate ethical issue: whether to continue the intervention despite a lack of documented improvement with an extremely difficult client (and at the potential expense of helping another client). However, during the course of the intervention, a social worker with a consequentialist ideology may decide that 10% is all that is realistically achievable for the client; additionally, they can note other specific positives and eliminated negatives achieved as individual successes, even if the overall goal was not reached. This social worker may decide it best to terminate the intervention, having the belief that the client has stabilized to an appropriate level for the given situation (i.e., the client's anger level is within the normal range, or the improvement is outside the range but further anger reduction is unlikely). This allows the social worker to produce the greatest good for a greater number (e.g., to help another recent nursing home resident with anger and resentment issues).

Ethics also play a large role in the ongoing and dynamic client assessment process. Bloom outlines six particular ethical considerations for social work [43]:

- "Demonstrable help" must be provided to the client in the context of the social setting.
- There is a burden on the practitioner to prove that no harm was done to the client-system. If either the client or the social context is significantly harmed as a result of the intervention, the intervention is unethical.
- If harm is caused, the social worker has an ethical obligation to reevaluate the intervention plan; this includes physical, psychologic, and/or social harm. Deterioration detection is a vital component of the dynamic, multidimensional assessment. Clients that are "acting out" or that are not following the agreed upon objectives are providing the practitioner additional information that can be used to modify the assessment (e.g., if self-reflection causes client distress, gather progress information from other sources).
- The client must be directly involved in the assessment process. Objectives/targets and the intervention goal(s) must be agreed upon so they can proceed unimpeded. Practitioners should restate the clients' goals so there is clear understanding by both parties.
- Confidentiality is paramount. Informed consent should be used to gather information useful to all parties while harming none.
- Culture-, income-, education-, sexual orientation-, and gender-specific assessment are vital to predict how the client will perform their objectives, reduce the dropout rate, and increase cost-effectiveness.

These same ethical considerations, with minor alterations, can and should be applied to research settings [43]. They can also be used to solve ethical dilemmas.

Case Study

Now let us see how a social worker might take one of these theories and translate it to a reasoning process in the ethical dilemma presented [15].

Child A, diagnosed with attachment disorder, has been seeing a caseworker twice weekly since entering the agency program eight months ago. The program works with emotionally disturbed children 6 to 12 years of age. She lives in a group home with her sister, Child B, who is 3 years of age, and three other children. The sisters have been in the group home for two years, and parental rights are in the process of being terminated. Each child has her own worker.

Both Child A's and Child B's caseworkers have been asked to make independent recommendations regarding whether the sisters should be placed together or whether each sibling should be placed separately. Both workers are aware that a recommendation to keep the siblings together will reduce their chances for adoption, particularly for Child B. In other words, Child B is the more desirable candidate for adoption if she is alone [22].

Child A's caseworker's primary responsibility is to Child A, but also has a responsibility to avoid harm to the third party, Child B. What should Child A's caseworker do?

Child A's caseworker used a teleologic approach, weighing the goods and harms of two decision options. After applying the teleologic approach, the caseworker sees that the cumulative good of keeping the siblings together surpasses the cumulative good of separating them. Similarly, the total harm of separating them outweighs the harm of keeping them together. The caseworker decides to keep the siblings together until a single adoptive home is available for both sisters.

Discussion

Practitioners should employ ethical theories to reflect upon the ethical decisions they make [79]. In the case of Child A, because the case worker used a teleologic approach, he/she might assess the consequences of the decision and if the decision adheres to the values of social justice and well-being [79]. If the social worker had based the decision on virtue ethics, he/she might assess if the decision reflects the values and attributes he/she strives to embody as a social worker. If the social worker had based the decision on relational ethics, specifically an ethics of care perspective, he/she might explore whether the decision promoted the importance of social relationships, receptiveness, and responsibility [79].

ETHICAL DECISION-MAKING FRAMEWORKS

Whenever the social worker-client relationship is established, a moral relationship exists. Moral reasoning is required to reach ethically sound decisions. This is a skill, not an inherent gift, and moral reasoning must be practiced so that it becomes a natural part of any social work professional's life.

The decision-making frameworks presented in this section are decision analyses. A decision analysis is a step-by-step procedure breaking down the decision into manageable components so one can trace the sequence of events that might be the consequence of selecting one course of action over another [23]. All ethical decision-making models include the steps of identifying the problem, identifying alternatives, consulting with others, and implementing and evaluating the decision [99]. Decision analysis frameworks provide an objective analysis in order to help practitioners make the best possible decision in a given situation, build logic and rationality into a decision-making process that is primarily intuitive, and lay the potential outcomes for various decision paths [23]. These frameworks are helpful when rules are not clearly defined or if there are multiple sets of competing rules [83]. They are also attempts to shift the process of moral decision making from the arena of the personal and subjective to the arena of an intellectual process, characterized by rigor and systematization [24]. Ethical decision-making models are helpful tools to stimulate discussion but do not guarantee with absolute certainty that the decisions are infallible [78]. They can be particularly helpful for novice practitioners to organize the information that surfaces when an ethical dilemma emerges [110]. The models assist in providing a linear series of steps to make an informed decision in order to reduce the likelihood of making a truncated decision [110].

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

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

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

It is important to remember that following an ethical decision making framework step-by-step does not mean that the final decision is the only or best option. Instead it represents a "good enough" choice, given the reality of the situation [83]. A "good enough" perspective does not connote mediocrity; rather, it represents a rational choice, with the ultimate goal of striving for excellence [84].

DECISION-MAKING MODELS FOR ETHICAL DILEMMAS

Congress ETHIC Model

The ETHIC model framework was developed by E.P. Congress to take into consideration social work values, the NASW Code of Ethics, and social work professional contexts (***Table 3***) [7]. The first step in the ETHIC model is to examine relevant personal, societal, agency and professional values [7]. Social work professionals should identify all the different values that impinge on their worldviews—their own personal values, the agency in which they operate, the client's values and belief systems, and the discipline's values. Secondly, they should think about what ethical standard of the NASW Code applies to the situation, as well as the relevant laws and case decisions.

Next, social work professionals should hypothesize about the possible consequences of different decisions. They may use the teleologic approach, listing the pros and cons for different scenarios. By doing this, they can identify who will benefit and who will be harmed in view of the most vulnerable clients. The final step is to consult with supervisors and colleagues about the most ethical choice.

Kenyon's Ethical Decision-Making Model

Kenyon has adapted an ethical decision-making model from Corey, Corey, and Callanan and from Loewenberg and Dolgoff (***Table 4***) [10]. The first step in Kenyon's decision-making model is to describe the issue [10]. Social work professionals should be able to describe the ethical issue or dilemma, specifically, by identifying who is involved and what their involvement is, what the relevant situational features are, and what type of issue it is. Next, they should consider all available ethical guidelines; professional standards, laws, and regulations; relevant societal and community values; and personal values relevant to the issue.

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

CONGRESS'S ETHIC MODEL

Examine
Think
Hypothesize
Identify
Consult

Source: [7] *Table 3*

KENYON'S ETHICAL DECISION-MAKING MODEL

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

Source: [10] *Table 4*

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

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

In both Kenyon's and Congress's ethical decision-making frameworks, there are five fundamental components to this cognitive process. They encompass naming the dilemma, sorting the issues, solving the problem, and evaluating and reflecting [8; 10].

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

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

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

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

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

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

- Review the ramifications of the decision.
- Review the process of making the decision. For example, ask yourself if you would do it in the same way the next time and if the appropriate people were involved.
- Ask whether the decision should become policy or if more cases and data are needed before that step should occur.
- Learn from successes and errors.
- Be prepared to review the decision at a later time if the facts or issues change.

It is important to remember that Kenyon's and Congress's ethical decision-making frameworks are based on a rational model for ethical decision making. One of the criticisms of rational decision-making models is that they do not take into account diversity issues [27].

Ethical Principles Screen

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

Collaborative Model for Ethical Decision Making

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

- Identify the parties involved in the ethical dilemma.
- Define the viewpoints and worldviews of the parties involved.

- Use group work and formulate a solution in which all parties are satisfied.
- Identify and implement each individual's proposed recommendations for a solution.

I CARE Acronym

The I CARE Model was formulated on the NASW Code of Ethics along with several other decision-making models specifically for work with transgender clients [111]. It consists of [111]:

- **I**dentification: Identify the ethical values and principles that emerge given the dilemma.
- **C**onsultation: Seek information from literature and other professionals to become familiar with the issues at hand, the psychosocial needs of the client population, and one's own implicit biases.
- **A**ction: Formulate action steps and evaluate the benefits and limitations of the action steps (and benefits and consequences of not taking certain action steps).
- **R**ebuttal: Identify counterpoints to the arguments.
- **E**valuation: Evaluate or assess the outcomes of decision while documenting rationale.

LIMITATIONS OF ETHICAL DECISION-MAKING FRAMEWORKS

One of the criticisms of ethical decision-making frameworks is that they portray decision making in a linear progression, and in real life, such prescriptive models do not capture what professionals do [30]. In essence, these frameworks stem from a positivist approach. Positivism values objectivity and rationality. In subjectivity, one's values, feelings, and emotions are detached from scientific inquiry. Research has indicated that practitioners having these linear ethical decision frameworks in their knowledge base do not necessarily translate them into ethical practice. Consequently, Betan argues for a hermeneutic approach to ethical decision making. The person making the decision is not a detached observer; rather, the individual is inextricably part of the process. Betan maintains that this is vital because "ethics is rooted in regards to human life, and when confronting an ethical circumstance, one calls into service a personal sense of what it is to be human. Thus, one cannot intervene in human affairs without being an active participant in defining dimensions of human conduct and human worth" [30]. In one qualitative study, counselors were asked to walk through their ethical decision-making processes [85]. The researchers found that the counselors did not necessarily follow the steps outlined in various decision-making models. Instead, they tended to make a quick and automatic decision based on their experiences, their personal values and worldviews, and their professional responsibilities. This does not necessarily mean that professionals should discard the linear approaches to ethical decision making. Rather, professionals should work toward understanding how the principles fit within the therapeutic context as well as the larger cultural context. Furthermore, some maintain that even if practitioners follow a decision-making model, they are often prone to rationalizing their decisions despite ethical violations [110]. Another criticism is that ethical decision-making models are difficult to implement. When an ethical issue arises, decisions are often made rapidly, and as such, going through numerous steps may seem burdensome and inefficient [56]. Many ethical decision-making models also fail to take into account diversity and culture [112].

ETHICAL SELF-REFLECTION

Mattison challenges social work professionals to not only use decision-making models to infuse logic and rationality to the decision-making process, but to also incorporate a more reflexive phase [24]. Practitioners frequently overestimate their own levels of competence, which places them at risk in making errors. Self-reflection is vital to combat this tendency. This involves objective and direct observation and evaluation of one's own thought processes [86]. In many ways, Mattison's assertion is similar to Betan's call for integrating a hermeneutic perspective to ethical decision making. This is referred to as ethical self-reflection. The process is to learn more about oneself as a decision maker or to better understand the lens one wears to make decisions [24]. It is impossible to remove one's character, conscience, personal philosophy, attitudes, and biases from the decision-making process [31]. Just as social work emphasizes the person-in-situation perspective in working and advocating for clients, so too should the person-in-situation perspective be employed in increasing self-awareness as a decision maker in ethical situations [24]. The person-in-environment perspective argues that to understand human behavior, one must understand the context of the environment that colors, shapes, and influences behavior. Therefore, the social worker must engage in an active process by considering how their individual level (e.g., prior socialization, cultural values and orientations, personal philosophy, worldview), the client's domain (e.g., values, world views, beliefs), organizational context (i.e., organizational or agency culture, policies), professional context (i.e., values of the social work profession), and societal context (i.e., societal norms) all play a role in influencing moral decision making [24].

Chechak offers an alternative view regarding the role of personal values in self-reflection and evaluation [63]. He asserts that because social workers chose the profession, their personal values and worldviews should conform to the Code of Ethics and its underlying values—the standards should not be reinterpreted to align with separate personal values.

A qualitative study with social work students found they tended to place higher importance on the principle of self-determination over beneficence when confronted with an ethical dilemma, resulting in tension and conflict [57]. The researchers argue that students tend to be more familiar with the principle of self-determination, and as a result, they automatically resort to it. To combat this reflex, reflectivity to identify biases and values and how they influence ethical action is key. Social work agencies should ensure that reflection is incorporated into professional development on ethics to provide social workers an opportunity to apply ethical decision making to real-life case scenarios [57]. Supervision is also key in facilitating self-awareness and reflection when making ethical decisions [113].

PSYCHOLOGICAL CONTEXT OF MORAL DECISION MAKING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Since Kohlberg formulated his theory, several theorists have revised or reinvented it. James Rest used Kohlberg's theory as a basis for his Schema Theory [58]. Schema Theory consists of three domains: personal interest schema, maintaining norms schema, and postconventional schema [59]. The personal interest schema focuses on the individual experiencing the moral dilemma and how he/she should evaluate the personal gain or loss. During this period, there is almost no thought about the ultimate ethical decision or how it will impact society [59]. The maintaining norms schema is based on law and order. In this phase, a person will make an ethical decision based on laws and recognizing that disruption and disorder will occur if laws are not adhered to [59]. The post conventional schema is the most advanced type of moral reasoning in Schema Theory. It stresses shared ideals that are open to the evaluation by the community. Consensus building, due process, and safeguarding rights of all members in society are emphasized [59].

Kohlberg's theory of moral development and followers of Kohlberg's theory have been criticized for being androcentric. In other words, his moral dilemmas capture male moral development and not necessarily female moral development. Gilligan, backed by her research, argues that men and women have different ways of conceptualizing morality, and therefore, the decisions made will be different [33]. This does not necessarily mean that one conceptualization is better than the other. Brown and Gilligan maintain that men have a morality of justice while women have a morality of care [34]. This is particularly relevant in social work because the field has a predominance of female social workers. This longing for relatedness and connectedness results in a "feminine" ethic of care, and it is this that guides female professionals' ethical decision making [35]. In other words, the decision-making process includes both a rational-cognitive component as well as a personal-emotive one. The social worker's "feminine" ethic of care involves a dynamic process of balancing objectivity, systematization, and rationality to reflect upon the moral dilemma, without forsaking the affective component [35]. Since Gilligan's work, scholars have discussed care ethics and mature care, which encompasses a relational care but also reflective examination of the self. In other words, ethics of care involves the care of others as well as self [60]. From this perspective, an ethical professional is one who cares for the needs of others, but also recognizes his/her own needs. Furthermore, ethics of care is not restricted to women; rather, some argue care is essential to morality [61]. Ultimately, the goal is not to elevate one form of moral development as the scientific standard; rather, it is crucial to view female ethics of care as complementing the standard theories of moral development.

MANAGED CARE AND ETHICS

Managed care has changed the climate in the provision of health and mental health services, and a range of practitioners have been affected, including social workers. In part due to negative public perception, there has been a shift away from the term "managed care" and toward terms such as "behavioral health," "integrated behavioral health," and "behavioral mental health" to refer to managed mental health care [87]. This shift acknowledges that mental health issues are complex and involve physical, psychologic, and emotional components [88]. So, more coordinated and integrated services should ultimately benefit the consumer [87; 88]. This section is not meant to be an exhaustive discussion of how managed care or integrated behavioral health has impacted ethical practice, but it is meant to provide an overview of the ethical issues raised in a managed care climate that are complex and multifaceted.

Managed care is a system designed by healthcare insurance companies to curb the increasing costs of health care [62; 89]. A third party (utilization reviewer) reviews treatment plans and progress and has the authority to approve further treatment or to terminate treatment [16; 89]. In addition, certain types of interventions are reimbursable while other types of care are not [36]. Furthermore, professionals have to learn new ways to decrease costs and improving the efficacy of manpower and these skills may include learning to use computer technology for documentation, empirical validation of interventions, and business strategies to increase profit margins [62].

The ethical concerns in managed care revolve around the issue of whether a social worker or practitioner should continue to provide services outside the parameter of the managed care contract [16]. Is early termination of services deemed on a probability that payment will not be obtained? In a cost-benefit analysis, what is the role of the client? How does the ethical principle of beneficence come into play? Certain diagnoses will be deemed reimbursable by the managed care organization. Is it beneficial for the client if a different diagnosis is given in order for services to continue [114]?

At the core, it is the ethical conflict of distributive justice versus injustice [37]. Distributive justice stresses the role of fairness in the distribution of services and states that, at minimum, a basic level of care should be provided. However, the principle of distributive justice may be compromised when services are allocated based on fixed criteria and not on individuals' needs [37]. Situations will then emerge in which the utilization reviewer indicates that the client is not approved for more services, and the social worker may find him or herself unable to provide services that are still necessary. In this case, it is suggested that social workers utilize their roles as advocates to encourage and coach their clients to go through grievance procedures for more services from their managed care provider [37]. One of the consequences of ethical conflict between a client's need for services and the environmental pressure of financial constraints is moral distress [63]. Moral distress is the psychologic tension produced when practitioners know the right thing to do but cannot behave accordingly given environmental and organization constraints [64]. A survey of 591 social workers found that those who perceived they had higher levels of competence with managed care experienced lower levels of emotional exhaustion [62].

Another ethical issue emerging within social work practice in a managed care environment is that of the social worker's fiduciary relationship with the agency versus a fiduciary relationship with the client [37; 70]. Each relationship has competing sets of loyalties and responsibilities. First, the social worker has a fiduciary relationship to the managed care company. The responsibility to the agency is to keep expenditures within budget. Yet, there is also the social worker's obligation to the client's best interests and needs [37]. Galambos argues that while the NASW Code of Ethics emphasizes both the importance of the social worker's obligation to their agency and the ethical principle of respect for the inherent dignity and worth of the person, the client's welfare is paramount. One way of managing this conflict is for social workers to be involved in the advocacy and development of policies that allow some leeway for clients who may require additional services.

Confidentiality, which is founded on respect and dignity, is of paramount importance to the therapeutic relationship. However, managed care systems also present challenges to the ethical issue of client confidentiality, as they often request that clients' records be submitted for review and approval of services [38; 114]. Accessible electronic health records further complicate this issue [88]. Consequently, social workers and other practitioners should explain up front and provide disclosure statements that establish the limits to confidentiality, what types of information must be shared, how this information is communicated, treatment options, billing arrangements, and other information [38; 39]. Knowing that other staff members may obtain sensitive information can influence the extent to which sensitive information is included in notes [88].

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

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

DIVERSITY AND MULTICULTURALISM: ETHICAL ISSUES

It has been argued that ethical principles may not be easily applied to different cultural contexts. The majority of established ethical principles and codes have been formulated within a Western context; therefore, these ethical principles may have been formulated without consideration for linguistic, cultural, and socioeconomic differences. Harper argues that a cultural context must be taken into account because many of these groups constitute vulnerable populations and may be at risk of exploitation [17]. In this course, an inclusive definition of diversity is utilized, encompassing age, race, ethnicity, culture, immigration status, ability, educational level, religion, gender, sexual orientation, gender identity or expression, and socioeconomic status, to match the increasing diversity of contemporary American society [40; 68].

DEBATES WITHIN MULTICULTURALISM/ DIVERSITY AND ETHICS

Much of the traditional ethical systems and philosophies that have influenced the United States stems from Christian-based and scientific empiricism [42]. Positivism assumes there is one universal that can be counted or measured. In addition, it postulates that reality is objective and value-free [42]. This positivistic approach to ethics was challenged by Joseph Fletcher in 1966 when he published Situation Ethics. He challenged the assumption made by many scholars in the 20th century that one resolved ethical dilemmas by turning to universally accepted principles. His work caused a paradigm shift from a universal approach to ethics to deconstructing it and developing a constructivist, contextual approach [42]. In situation ethics, one takes the context (including culture and diversity) into account.

Others argue that a postmodernist perspective is beneficial when working with clients from diverse cultures [65]. This approach argues for cultural relativism, maintaining that there is no reference point to which to compare cultural norms [65].

In our multicultural society, definitions of "good" or "bad" will inevitably vary from group to group. One of the struggles when dealing with multiculturalism and diversity issues while developing ethical guidelines is the question of how to develop one ethical guideline that can fully apply to the many diverse groups in our society. Strictly speaking, multiculturalism promotes the idea that all cultural groups be treated with respect and equality [19; 68]. The complexity of defining multiculturalism and diversity is influenced by the tremendous differences within a group in addition to the differences between groups. Certainly religion, nationality, socioeconomic status, education, acculturation, and different political affiliations all contribute to this within-group diversity. To make matters even more complex, multiculturalism and diversity within a society are dynamic rather than static, as are the words used to describe problems [44]. For example, the term "vulnerable populations" has long been used in social work research and practice. However, in the past few years experts have begun to argue that the term undermines the social work value "respecting the dignity and worth of the person," as it may convey a lack of ability to make decisions [90].

Consequently, the questions that arise in this debate are: Should ethical guidelines be based on the uniqueness of groups, taking into account distinct values, norms, and belief systems? Or should ethical guidelines be developed based on the assumption that all human beings are alike [44]? Some experts have argued that the underlying values of many of the professional codes of ethics in the United States mirror "Americanness," essentially overemphasizing autonomy and individualism [66]. If clients ultimately want to be treated with dignity and respect, then honoring dignity may be more important than honoring autonomy [66].

INFUSING DIVERSITY INTO THE ETHICAL DECISION-MAKING MODELS

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

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

Step 1: Interpreting the Situation through Awareness

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

Step 2: Formulating an Ethical Decision

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

Step 3: Weighing Competing, Nonmoral Values

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

Step 4: Implementing Action Plan

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

SELF-CARE AND THE NASW CODE OF ETHICS

Self-care is at the heart of social work practice [115]. If social workers do not prioritize their own wellness, compassion fatigue, burnout, and secondary traumatization can result, which leads to higher attrition rates and can harm clients.

Before the 2021 revisions to the NASW Code of Ethics, there was only implicit reference to self-care [116]. In an effort to clarify the importance of this issue, new language about self-care was added to the Purpose and Ethical Principle sections of the Code of Ethics [116]. The Purpose section now includes the following language [8]:

> Professional self-care is paramount for competent and ethical social work practice. Professional demands, challenging workplace climates, and exposure to trauma warrant that social workers maintain personal and professional health, safety, and integrity. Social work organizations, agencies, and educational institutions are encouraged to promote organizational policies, practices, and materials to support social workers' self-care.

MULTICULTURALISM/DIVERSITY AND THE NASW CODE OF ETHICS

In the 2017 NASW Code of Ethics, references to cultural competence were changed to cultural awareness [8; 91]. However, the 2021 update reverts back to the language of cultural competence, as it connotes the inclusion of culturally informed practice and cultural awareness. The concept of cultural humility has also been added to the standard [116].

Standard 1.05, which is titled "Cultural Competence" reads [8]:

(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.

The 2021 Code of Ethics, with its emphasis on cultural competence, calls for understanding and demonstration through knowledge.

TECHNOLOGY AND THE NASW CODE OF ETHICS

Today, social workers use a variety of technologies in their daily practice with clients, families, stakeholders, and colleagues. These technologies include e-mail, social networks, videoconferencing, smartphones, blogs, and electronic records [92; 93]. The 2017 revision of the NASW Code of Ethics included many changes and new standards that reflect the role of technology in social work; these remain in place with the 2021 revision. However, it is important to note that all of the ethical standards outlined in the NASW Code of Ethics apply to social workers who use technology with clients. Social work professionals should consider how the ethical principles and standards apply to technologic tools and interactions. For example, the NASW Code of Ethics includes five ethical standards regarding technology and informed consent [8]:

1.03 Informed Consent

(e) Social workers should discuss with clients the social workers' policies concerning the use of technology in the provision of professional services.

(f) Social workers who use technology to provide social work services should obtain informed consent from the individuals using these services during the initial screening or interview and prior to initiating services. Social workers should assess clients' capacity to provide informed consent and, when using technology to communicate, verify the identity and location of clients.

(g) Social workers who use technology to provide social work services should assess the clients' suitability and capacity for electronic and remote services. Social workers should consider the clients' intellectual, emotional, and physical ability to use technology to receive services and the clients' ability to understand the potential benefits, risks, and limitations of such services. If clients do not wish to use services provided through technology, social workers should help them identify alternate methods of service.

(h) Social workers should obtain clients' informed consent before making audio or video recordings of clients or permitting observation of service provision by a third party.

(i) Social workers should obtain client consent before conducting an electronic search on the client. Exceptions may arise when the search is for purposes of protecting the client or other people from serious, foreseeable, and imminent harm, or for other compelling professional reasons.

The 2021 updates include expanded language on the use of technology in social work practice. Standard 1.05: Cultural Competence requires social workers to have a commitment to prevent barriers to effective technology use [117].

INTERPROFESSIONAL COLLABORATION AND ETHICS

Interprofessional collaboration is defined as a partnership or network of providers who work in a concerted and coordinated effort on a common goal for clients and their families to improve health, mental health, and social and/or family outcomes [118]. It involves the interaction of two or more disciplines or professions who work collaboratively with the client on an identified issue [119]. Providers come together to discuss and address the same client problem from different lenses, which can ultimately produce more inventive and effective solutions [120]. The client/patient is not excluded from the process; rather, shared decision making by all team members advances the goal of improving client/patient outcome(s) [118].

Interprofessional collaborations have been touted for multiple reasons. Positive outcomes have been demonstrated on individual and organizational levels. For example, on the client level, reduced mortality, increased safety and satisfaction, and improved health outcomes and quality of life have been demonstrated [121; 122; 123]. Practitioners also experience benefits, including increased job satisfaction, staff retention, improved working relationships, and more innovative solutions to problems [121; 123; 124].

There is a difference between the traditional model of professional ethics and interprofessional ethics [125]. The traditional model revolves around a single profession's unique code of ethics, which addresses the specific profession's roles, expertise, core values, and ethical behaviors. Each professional's code of ethics demands the practitioner's loyalty and commitment to the values, specialty, and expertise [125]. On the other hand, interprofessional ethics emphasizes the relationship and interactions of practitioners from different professions and the unique ethical issues that emerge from working with a diverse team (e.g., interpersonal conflict, misuse of power, respect) [125]. Practitioners in an interprofessional setting should engage in collective interprofessional ethics work, which is defined as "the effort cooperating professionals put into collectively developing themselves as good practitioners, collectively seeing ethical aspects of situations, collectively working out the right course of action, and collectively justifying who they are and what they do" [126].

Standard 2.03 in the NASW Code of Ethics states [8]:

(a) Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established.

(b) Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels. If the disagreement cannot be resolved, social workers should pursue other avenues to address their concerns consistent with client well-being.

Because interprofessional team members come from different disciplines, there may be divergent views on how to handle ethical dilemmas. This is a challenge and can result in friction among the team. Practitioners should communicate openly about each members' roles, expertise, and responsibilities in client care and decision-making processes [99]. It is also important to delineate who will be involved in the informed consent process, documentation, and record keeping. Most importantly, practitioners should not act outside the scope of their practice and licensing and regulatory requirements.

CONCLUSION

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

RESOURCES

Social workers play an important role in advocacy and education. To be more effective, social work professionals may need additional resources. The following are some resources, including organizations and articles about ethics in general and specifically in social work.

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

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

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

National Association of Social Workers
https://www.socialworkers.org

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

https://www.socialworkers.org/About/Ethics/Ethics-Education-and-Resources/Ethics-Consultations

Social Work Today
https://www.socialworktoday.com/eye_on_ethics_index.shtml

The New Social Worker
https://www.socialworker.com/feature-articles/ethics-articles

Standards on Technology and Social Work Practice
https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/Standards-for-Technology-in-Social-Work-Practice

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

Customer Information/Answer Sheet/Evaluation are located on pages 101–104.

TEST QUESTIONS
#77233 ETHICS FOR 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 6 hour activity must be completed by June 30, 2026.

1. The field of bioethics came into existence because
- A) *issues of day-to-day practices were raised and standards of care were needed.*
- B) *scientific advances made it possible for patients to trust completely in their doctor's judgment, leaving no need for their own voice to be heard.*
- C) *there was a need to talk about how research and healthcare decisions and regulations could be made, who could make them, and what their long-term implications would be.*
- D) *All of the above*

2. Which of the following historical events reinforced the need for a codified standard of ethics?
- A) *The Watergate trials*
- B) *Stanley Milgram's experiments in which research subjects were electrically shocked*
- C) *Medical experiments conducted on the Jewish people during the Nazi regime and on black men with syphilis in Tuskegee, Alabama*
- D) *The early 1800s, when social workers attributed moral characteristics to issues of poverty and consequently blamed clients for their circumstances*

3. The Tuskegee human experiment is one of the most publicized research projects used in ethical discussion today. It involved
- A) *children with intellectual disability being given hepatitis by injection.*
- B) *elderly patients with chronic illness who were injected with live cancer cells.*
- C) *penicillin treatment withheld from African American test subjects with syphilis.*
- D) *affluent children given Nutrasweet in their Coca-Cola with a control group receiving regular Coca-Cola.*

4. Which philosophical viewpoint is characterized by diversity and pluralism?
- A) *Modernism*
- B) *Postmodernism*
- C) *Morality period*
- D) *Aesthetic value orientation*

5. Values are beliefs, attitudes, or preferred conceptions about what is good or desirable that provide direction for daily living.
- A) *True*
- B) *False*

6. Social justice is defined as the provision of assistance, resources, benefits, and service in order for individuals to achieve their potential.
- A) *True*
- B) *False*

7. Ethics may best be defined as
- A) *what is considered moral.*
- B) *Aristotle's philosophical concept.*
- C) *beliefs about what is correct or proper behavior.*
- D) *the only right action as determined by the institution one works for.*

8. Morality is best defined as
- A) *views on sexual behavior.*
- B) *the attitude of employees working in a social service agency.*
- C) *the judgment or evaluation of ethical principles based on social, cultural, and religious norms.*
- D) *None of the above*

9. What constitutes an ethical dilemma?
- A) *When the guiding principle of autonomy is violated*
- B) *Cognitive dissonance experienced by the professional*
- C) *When a professional witnesses another practicing paternalism*
- D) *When a choice must be made between two mutually exclusive courses of action*

10. Ethical principles are defined as
- A) *expressions of morality.*
- B) *codified standards to uphold.*
- C) *statements that reflect values of society.*
- D) *expressions that reflect humans' obligations or duties.*

11. Respect for persons is the duty to honor others, their rights, and their responsibilities.
A) *True*
B) *False*

12. What code of ethics is most widely used in the field of social work in the United States?
A) *NASW Code of Ethics*
B) *National Organization for Human Services Ethics of Human Services*
C) *American Counseling Association Code of Ethics and Standards of Practice*
D) *Association for Counselor Education and Supervision Ethical Guidelines for Counseling Supervisors*

13. Which of the following is NOT one of the four sections included in the current NASW Code of Ethics used by social workers?
A) *Purpose*
B) *Preamble*
C) *Ethical Standards*
D) *Institutional Assumptions*

14. What is one of the purposes of the current NASW Code of Ethics?
A) *Maintain confidentiality*
B) *Ensure cultural sensitivity*
C) *Identify the major social work values*
D) *Distinguish between extraordinary and ordinary care measures*

15. Which is NOT one of the six categories of ethical standards in the NASW Code of Ethics?
A) *Ethical responsibilities to colleagues*
B) *Ethical responsibilities as professionals*
C) *Ethical responsibilities to the broader society*
D) *Ethical responsibilities to state and federal government*

16. In its most general and rudimentary categorization, ethics can be classified into three different headings: deontologic, teleologic, or virtue.
A) *True*
B) *False*

17. Deontologic ethics is
A) *the principle that all people are not of equal value.*
B) *okay with lying if it is seen to be in the client's best interest.*
C) *based upon the principle that people should always be treated as means to an end.*
D) *a system of ethical decision making that stands on absolute truths and unwavering principles.*

18. Social work professionals making ethical decisions under the deontologic ethical system see all situations from different contexts affected by time, location, or people.
A) *True*
B) *False*

19. Existentialism is considered what type of ethical theory?
A) *Teleologic*
B) *Mandatory*
C) *Deontologic*
D) *All of the above*

20. To the pragmatist, whatever is practical and useful is considered best for both the people who are problem solving and those who are being assisted.
A) *True*
B) *False*

21. Which type of ethical theory does the current NASW Code of Ethics most closely resemble?
A) *Pragmatism*
B) *Existentialism*
C) *Utilitarianism*
D) *Deontologic ethical theory*

22. In practice, most social work professionals strictly adhere to their professional codes of ethics, with little or no focus on personal and client values.
A) *True*
B) *False*

23. According to Bloom, if either the client or the social context is significantly harmed as a result of the intervention, an intervention is considered unethical.
A) *True*
B) *False*

24. Implicit argumentation involves an internal dialogue, whereby the practitioner talks and listens to him/herself.
A) *True*
B) *False*

25. Which of the following is NOT a component of decision analyses?
A) *Calculating the expected value*
B) *Creating the pathways of the decision*
C) *Listing the pros or cons of the various decisions*
D) *Identifying the perspectives of the ethical theories*

Test questions continue on next page ➞

26. The first step in Kenyon's decision-making model is to resolve the conflicts.
- A) *True*
- B) *False*

27. Naming the dilemma involves identifying the values in conflict.
- A) *True*
- B) *False*

28. What is the main focus of the Ethical Principles Screen developed by Loewenberg and Dolgoff?
- A) *It is a screening method that allows for self-reflection and implicit argumentation.*
- B) *It assists the social work practitioner to identify his/her values and personal beliefs to set the context of ethical decision making.*
- C) *It is a method that focuses on a hierarchy of ethical principles to evaluate the potential course of action for ethical dilemmas.*
- D) *It lists out all the general ethical principles and asks the professional to identify the most meaningful to apply to the ethical dilemma.*

29. The purpose of ethical self-reflection is to learn more about oneself as a decision maker or to better understand the lens one wears to make decisions.
- A) *True*
- B) *False*

30. Lawrence Kohlberg identifies two important correlates of his six stages of moral development. One of these is that
- A) *everyone goes through each stage in a different order.*
- B) *every person can understand each stage of moral development.*
- C) *a person at one stage can understand any stage below him, but cannot understand more than one stage above.*
- D) *once a person progresses through a stage, they no longer understand the stage below, but can understand one stage above.*

31. Lawrence Kohlberg presumes there are six stages of moral development that people go through. A person making a stage 5 decision uses the following justification:
- A) *"If I do not make that decision, I will be punished."*
- B) *"If I make that decision, I will be rewarded and other people will help me."*
- C) *"Others whom I care about will be pleased if I do this because they have taught me that this is what a good person does."*
- D) *"This decision will contribute to social well-being, and, as members of a society, we have an obligation to every other member."*

32. Schema Theory consists of three domains: modernism, postmoderism, and multiculturalism.
- A) *True*
- B) *False*

33. The ethical concerns in managed care revolve around the issue of whether a social worker or practitioner should continue to provide services outside the parameter of the managed care contract.
- A) *True*
- B) *False*

34. How might the ethical principle of confidentiality be compromised in a managed care system?
- A) *Distributive justice cannot be upheld.*
- B) *A client's records are shared with the managed care operating organization without disclosure to the client.*
- C) *The social worker has a fiduciary relationship with the managed care operating organization and values this more than the relationship with the client.*
- D) *None of the above*

35. One of the struggles when dealing with multiculturalism and diversity issues while developing ethical guidelines is the question of how to develop one ethical guideline that can fully apply to the many diverse groups in our society.
- A) *True*
- B) *False*

Be sure to transfer your answers to the Answer Sheet located on page 102.
DO NOT send these test pages to NetCE. Retain them for your records.
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A Clinician's Guide to the DSM-5-TR

9 Clinical Continuing Education Credits

Audience
This course is designed for social workers, marriage and family therapists, mental health counselors, and other ancillary behavioral health staff.

Course Objective
The purpose of this course is to provide clinicians with the most up-to-date information on the DSM-5-TR, relative to the previous edition (DSM-5), including diagnostic criteria needed to assess the presence of various disorders.

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

1. Describe the history of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).
2. Explain the structural and organizational changes made in the *Diagnostic and Statistical Manual of Mental Disorder*s, fifth edition, text revision (DSM-5-TR).
3. Identify psychiatric diagnoses that are newly included in DSM-5-TR.
4. Identify changes to psychiatric diagnoses made in the transition from DSM-5 to DSM-5-TR, including the recategorization, renaming, and modification of criteria.
5. List psychiatric disorders and the criteria recommended for further study by the DSM-5-TR.
6. Describe the controversies and criticisms arising from the publication of DSM-5-TR and the alternative diagnostic systems proposed in place of DSM-5-TR.

Faculty
Meriah Ward, DNP, FNP-BC, PMHNP-BC, is a highly accomplished healthcare professional with a Doctor of Nursing Practice (DNP) degree and dual certifications as a Family Nurse Practitioner (FNP-BC) and Psychiatric-Mental Health Nurse Practitioner (PMHNP-BC). They currently serve as a nurse practitioner at Advance Community Health in Raleigh, North Carolina, while holding the adjunct professor position at Old Dominion University's advanced practice registered nursing family nurse practitioner program. In addition to their clinical roles, Dr. Ward is a contract content creator for Continuing Medical Education (CME) and a healthcare advisor for Vance-Granville Community College's medical assistant program.

Dr. Ward has authored numerous continuing education courses on a wide range of topics, including HIV, Type 2 Diabetes (T2D), Pre-Exposure Prophylaxis (PrEP), neurodivergence, and substance use disorder (SUD). Their work primarily addresses healthcare disparities in underserved communities and explores the relationship between social determinants of health and health outcomes. Within the organization, Dr. Ward also serves as a clinical informaticist, actively involved in quality improvement projects to enhance patient care, improve outcomes, and increase provider satisfaction. Dr. Ward completed the MSN, DNP, and Post-Graduate Certificate (PGC) at Old Dominion University in 2020, 2021, and 2024, respectively. They identify as non-binary and use they/them pronouns, and their personal experience as an autistic individual informs their perspective on neurodivergence in healthcare.

Faculty Disclosure
Contributing faculty, Meriah Ward, DNP, FNP-BC, PMHNP-BC, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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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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COURSE OVERVIEW

With the development of the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, text revision (DSM-5-TR), professionals who work with people who have mental health diagnoses will be responsible for learning and understanding the changes that have taken place in the new diagnostic manual [1]. The transition from using the previous edition of DSM-5 to the new DSM-5-TR presents a challenge for any clinician [1; 2]. Given the extent of the changes that have occurred for DSM-5, reading through DSM-5-TR and piecing together these changes should be quick but done thoroughly.

This course provides clinicians with the most up-to-date information on DSM-5-TR, relative to the previous edition, DSM-5, including diagnostic criteria needed to assess the presence of various disorders. This course will not only present newly classified disorders and identify those that have been removed or reclassified but will also illuminate any changes to diagnostic criteria for disorders in the previous manual and continue to be defined as disorders in DSM-5-TR. The course will cover the development process used by the DSM-5-TR task force in deciding the diagnostic system's new structure and removing the multiaxial system. Alternative diagnostic systems proposed in place of DSM-5-TR will also be described.

This course is designed for social workers, psychologists, marriage and family therapists, mental health counselors, occupational therapists, nurses, advanced practice registered nurses, and other ancillary behavioral health staff. Summary tables are provided to assist with understanding the significant changes that have taken place. Without a strong understanding of these changes, clinicians may be more prone to making psychiatric diagnoses based on out-of-date criteria, or they may make a diagnosis that no longer formally exists (e.g., Asperger syndrome). This knowledge will benefit treatment in various settings, whether addressing psychiatric symptoms directly or understanding the impact of the symptoms on other aspects of the person's functioning. This course concludes with a discussion of the controversies and criticisms that arose with the publication of DSM-5-TR and the alternative diagnostic systems that have recently been proposed instead of DSM-5-TR.

HISTORY OF THE DSM

The DSM aims to provide a common language for clinicians, a tool for researchers, a bridge between research and clinical work, and a textbook of information for students and educators. The DSM also provides a coding system for statistics, insurance, and administrative processes [3]. However, despite being commonly referred to by the media as the "bible" of psychiatry, the DSM is a constantly changing manual that has undergone extensive revision over time. Publication of the fifth edition, text revision of the DSM, known as the DSM-5-TR, is the culmination of many decades of research and countless arguments for how such a diagnostic manual should be structured. To understand the advances of DSM-5-TR, it is also essential to know the history of the DSM and how it has changed over the years. Understanding this is also relevant to understanding current controversies with the DSM-5-TR. Clinicians must possess this knowledge to function within their specific scope of practice and ethical guidelines and provide best practices to clients [4; 5; 6].

Before the development of a comprehensive diagnostic system, there was little agreement on categories of psychological disorders or what disorders were psychological versus medical. The first large-scale attempt at generating mental health diagnoses was published in the 1840s, and it was primarily an attempt to obtain statistical data through the census and consisted of a single diagnosis of idiocy/insanity. Following this, in 1917, to better standardize the classification of mental disorders across mental hospitals, the American Psychiatric Association (APA) developed a standard nomenclature for some psychological disorders that would be included in the *American Medical Association's Standard Classified Nomenclature of Disease*. Although this was an essential step in the direction of identifying standardized psychological diagnoses, it was limited in that it did little to distinguish between psychological and medical disorders, and it was primarily focused on the most severe disorders that were seen in inpatient units.

Following World War II, to better classify and distinguish the presentations of psychological disorders in service veterans, the U.S. Army, Veterans Administration, and World Health Organization (WHO) worked to incorporate a section for mental disorders into the sixth edition of the International Classification of Disease (ICD), which was published in 1949. In 1952, the APA published a manual solely focused on mental health diagnoses called the *Diagnostic and Statistical Manual: Mental Disorders* [7]. This volume is now referred to as DSM-I and was an essential development in the progress of diagnostic structure because it was heavily focused on clinical utility and provided additional descriptions of disorders beyond what was available in the ICD-6. Importantly, DSM-I was also more extensive than previous attempts at classifying psychiatric conditions and listed 106 mental disorders ranging from neurosis to personality disturbance.

Although DSM-I was a significant advancement, it was still limited in many ways, particularly by the lack of a consistent and agreed-upon definition for mental illness. As an example, homosexuality was listed in DSM-I as a sociopathic personality diagnosis, which reflected more on the social traditions at the time of DSM-I than on the actual psychological aspects of homosexuality. By the 1960s, many viewed the concept of mental illness as a myth or as a way for society to exert control over those who might deviate from societal norms [8; 9]. In 1968, in conjunction with the development of the ICD-7, the

APA published a revision of the manual DSM-II [10]. This revision was like DSM-I in many ways, and it increased the number of psychological diagnoses to 182 disorders. DSM-II also no longer made use of the term reaction, which was used throughout much of DSM-I to indicate that all mental disorders were reactions to environmental factors [11]. For example, there was a section on schizophrenic reaction, which implied that psychotic symptoms arose from environmental stressors such as insufficient mothering. DSM-II was still heavily influenced by psychodynamic theory, and disorders such as neurosis and homosexuality continued to appear in the manual. In 1974, during the seventh printing of DSM-II, homosexuality was removed from the DSM, following controversy over the diagnosis and over data indicating that there were few differences in the psychological adjustment between heterosexual and homosexual men [12].

In the mid-1970s, the DSM came under scrutiny by clinicians who questioned the DSM's utility from both a clinical and a research perspective. Spitzer and Fleiss published a highly influential paper indicating that DSM-II diagnoses were unreliable, meaning that they did not yield consistent results across diagnosticians and settings [13]. A vital aspect of a diagnosis involves consistent communication between clinicians about the diagnosis, and a diagnostic system that yields unreliable results across most diagnostic categories is a significant problem. Thus, in 1974, only a few years after the publication of DSM-II, the decision was made to revise the DSM again, with Robert Spitzer as the chairman of the DSM-III task force. The primary goals for DSM-III were to make the DSM more consistent with the ICD, standardize diagnostic practices between the United States and other countries, and improve the standardization and validity of diagnoses. To make these improvements, the methods for establishing the diagnostic criteria for a disorder were changed. In previous versions of the DSM, diagnoses consisted of brief and sometimes vague descriptions of the disorder, with many descriptions being heavily influenced by theory rather than observable factors. In DSM-III, diagnoses were structured using the research diagnostic criteria and the Feighner criteria, which were published scientific reports for how a psychiatric diagnostic system should be structured [14; 15]. It was here that many DSM diagnoses, like their current descriptions, began to fully appear, with the inclusion of diagnostic categories such as anxiety and affective disorders, schizophrenia, and antisocial personality disorder. When published in 1980, DSM-III contained 265 mental health diagnoses, which was a significant increase from DSM-II [16]. In addition to including more explicit diagnostic criteria, DSM-III introduced a multiaxial system that allowed for multiple facets of diagnosis and the notation of medical diagnoses, acknowledging that mental and physical health problems often co-occur. The multiaxial system also allowed attention to be given to more chronic disorders, with Axis II diagnoses including mental retardation and personality disorders. Finally, DSM-III also included more textual descriptions of theoretically neutral disorders dispensed with previous theoretically driven diagnoses. Many of these changes resulted in DSM-III being a far more reliable tool than DSM-II and facilitated better communication among professionals about the disorders they were treating.

DSM-III was revised in 1987 to DSM-III-R, and these changes primarily involved restructuring and renaming some diagnostic categories and removing certain controversial disorders, such as premenstrual dysphoric disorder [17]. The number of diagnostic categories in DSM-III-R increased to 292 diagnoses. In 1994, the fourth version of the DSM was published (DSM-IV) [18]. The task force for DSM-IV, chaired by Allen Frances, aimed to integrate more empirical evidence into the diagnostic system than had DSM-III [3; 19]. DSM-IV had extensive reviews of the existing literature and multicenter field trials that established diagnostic reliability rates and relevance to clinical practice. In addition to increasing the number of psychological disorders to 297, DSM-IV also added a criterion to many disorders that required the disorder to result in "clinically significant distress." In 2000, DSM-IV was updated with changes primarily involving text revisions and finalizing the five-axis multiaxial system (DSM-IV-TR) [20]. The purpose of including the multiaxial system was to encourage clinicians to think about the interaction among psychological, medical, and social factors and to distinguish between acute and chronic psychological disorders.

Nineteen years elapsed between the publication of DSM-IV and the release of DSM-5. The revision process for DSM-5 began in 1999 and was a long one that involved substantial efforts by many key leaders in the field of psychopathology, considerable debate about what changes should or should not be made to diagnostic categories and criteria, and extensive field-testing of diagnoses for reliability [21]. In coordination with large health institutions, such as the National Institute of Mental Health and the World Health Organization, the APA began in 1999 to evaluate the strengths and weaknesses of DSM-IV. David Kupfer and Darrel Regier chaired the DSM-5 task force of 28 people, with 6 to 12 task force members assigned to each work group. Each work group was responsible for meeting in person and communicating frequently throughout the year to determine the changes that should be made for each assigned category (e.g., mood disorders, eating disorders, personality disorders). These work groups then drafted proposals for changes to each area, which were posted on the APA DSM-5 website (http://www.dsm5.org) for public evaluation and commentary. Field trials for potential DSM-5 diagnostic criteria began in 2011 to establish inter-rater reliability for all diagnoses. In December 2012, the APA Board of Trustees voted to approve DSM-5, published in May 2013. However, it is essential to remember that the DSM is a constantly evolving manual.

The DSM-5 was released in 2013, and nearly a decade later received a text revision, colloquially known as the DSM-5-TR [1]. The development of the DSM-5-TR involved over 200 experts, including many who had worked on the DSM-5, and took approximately three years to complete [22]. The revision process incorporated three main components: the original DSM-5 diagnostic criteria and text, updates made through an iterative revision process overseen by the DSM Steering Committee, and a comprehensive text update managed by the Revision Subcommittee. The DSM-5-TR introduced several changes, including a new diagnosis (prolonged grief disorder), clarifications to existing diagnostic criteria, updated terminology, and comprehensive text revisions [1]. Additionally, four cross-cutting review groups focused on culture, sex and gender, suicide, and forensic issues, while a Work Group on Ethnoracial Equity and Inclusion ensured appropriate attention to risk factors such as racism and discrimination [23]. The revision aimed to reflect current scientific literature, address inconsistencies, and improve the manual's utility for clinicians and researchers.

OVERVIEW OF CHANGES MADE IN THE DSM-5-TR

COMPREHENSIVE TEXT REVISION AND ADDITION OF NEW DIAGNOSTIC ENTITIES

The comprehensive text revision in the DSM-5-TR represents a significant update to the descriptive content for most mental disorders compared to the DSM-5. This revision focused on several key areas [1]:

- **Prevalence**: Updated information on how common each disorder is in the population, based on newer epidemiological studies conducted since the DSM-5 was published in 2013.
- **Risk and prognostic factors**: Revised details on factors that may increase the risk of developing a disorder or influence its course and outcome. It incorporates new research findings on genetic, environmental, and developmental factors.
- **Culture-related diagnostic issues**: Expanded information on how cultural factors may impact mental disorders' presentation, diagnosis, and understanding across different populations. This reflects an increased emphasis on cultural competence in mental health care.
- **Sex- and gender-related diagnostic issues**: Updated content on how biological sex and gender identity may influence the manifestation and prevalence of disorders. It incorporates newer understandings of gender diversity and its relationship to mental health.
- **Association with suicidal thoughts or behavior**: Enhanced information on the relationship between specific disorders and suicide risk, reflecting the critical importance of suicide prevention in mental health care.
- **Comorbidity**: Revised details on how different disorders commonly co-occur, which is crucial for comprehensive diagnosis and treatment planning.

The extensive text revisions in the DSM-5-TR serve several vital purposes. They incorporate the latest research findings and clinical knowledge accumulated since the DSM-5 was published in 2013, providing clinicians with more up-to-date and nuanced information to aid in accurate diagnosis and treatment planning. These revisions reflect evolving understandings of how factors like culture, gender, and comorbidity impact mental health, aligning the manual more closely with current best practices in mental health care [24; 25]. This emphasis on cultural competence, gender-affirming care, and comprehensive assessment of suicide risk represents a significant advancement in the field. Additionally, the updated text helps researchers by providing revised frameworks for studying mental disorders and their various dimensions. By addressing these critical areas, the DSM-5-TR aims to enhance the clinical utility of the manual and ensure it reflects the most current knowledge in the field of mental health by focusing on these areas; the DSM-5-TR aims to enhance the clinical utility of the manual and ensure it reflects current knowledge in the field of mental health. This comprehensive revision underscores the dynamic nature of psychiatric diagnosis and the ongoing efforts to refine our understanding of mental disorders.

The DSM-5-TR also added several new diagnostic entities and symptom codes (***Table 1***) [1].

CLARIFICATIONS AND MODIFICATIONS

The DSM-5-TR included clarifying modifications to the diagnostic criteria for more than 70 disorders [1]. These modifications were primarily aimed at improving clarity and reducing ambiguity in the criteria sets rather than fundamentally changing the conceptual definitions of the disorders. Here is a description of these changes:

- **Nature of the changes**: The modifications were mostly minor clarifications to wording, designed to resolve ambiguities or inconsistencies in the original DSM-5 criteria.
- **Purpose**: These changes were intended to enhance the reliability and validity of diagnoses by making the criteria more precise and more accessible to interpret consistently across clinicians.
- **Scope**: The modifications affected a wide range of disorders across multiple categories in the DSM, indicating a comprehensive review of the manual.

NEW DIAGNOSTIC ENTRIES IN DSM-5-TR		
Diagnostic Entity	**Description**	**Key Features**
Prolonged grief disorder	Prolonged grief disorder (PGD) is characterized by a persistent, intense longing for or preoccupation with a deceased loved one, accompanied by significant emotional distress and functional impairment lasting at least 12 months after the loss (6 months for children and adolescents). PGD is distinct from normal grief and other disorders like depression or PTSD. Its inclusion in the DSM-5-TR aims to improve the recognition and treatment of maladaptive grief responses.	1. Intense yearning for the deceased or preoccupation with thoughts/memories of them 2. At least 3 of 8 additional symptoms, such as: • Identity disruption • Disbelief about the death • Avoidance of reminders • Intense emotional pain • Difficulty reintegrating into life • Emotional numbness • Feeling life is meaningless • Intense loneliness 3. The symptoms cause clinically significant distress or impairment. 4. The grief reaction exceeds cultural, social, or religious norms. 5. The symptoms are not better explained by another mental disorder.
Unspecified mood disorder	Unspecified mood disorder is used for presentations that include symptoms characteristic of mood disorders but do not meet the full criteria for any specific mood disorder in either the bipolar or depressive categories. This diagnosis is applied when the clinician chooses not to specify the reason that the criteria are not met for a specific mood disorder, or when there is insufficient information to make a more specific diagnosis. This category is particularly useful in clinical situations where immediate treatment decisions need to be made, but the full diagnostic picture is not yet clear, such as in emergency room settings.	1. The presence of mood disorder symptoms that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. 2. The symptoms do not meet the full criteria for any specific bipolar or depressive disorder. 3. It allows clinicians to avoid prematurely choosing between bipolar disorder and depressive disorder when the presentation is unclear or information is limited. 4. It provides a diagnostic option for cases where it is challenging to determine whether the appropriate diagnostic class is bipolar or depressive, especially when irritable mood or agitation predominates. 5. The diagnosis can serve as a temporary placeholder until more information becomes available to make a more specific diagnosis.
Stimulant-induced mild neurocognitive disorder	Stimulant-induced mild neurocognitive disorder is characterized by persistent cognitive deficits resulting from stimulant use, particularly cocaine and amphetamine-type substances. The cognitive impairments are not severe enough to interfere significantly with independence in everyday activities but are severe enough to require more significant mental effort, use of compensatory strategies, or accommodation. This diagnosis was added to the existing types of substance-induced mild neurocognitive disorders (such as those induced by alcohol, inhalants, and sedatives) in recognition of the growing evidence that chronic stimulant use can lead to persistent cognitive impairments, even after cessation of use.	1. Evidence of cognitive decline from a previous level of performance in one or more cognitive domains (e.g., complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition). 2. The cognitive deficits do not occur exclusively during the course of delirium and persist beyond the usual duration of intoxication and acute withdrawal. 3. There is evidence from the history, physical examination, or laboratory findings that the deficits are etiologically related to the persisting effects of stimulant use. 4. The deficits cause mild interference in independence in everyday activities. 5. The deficits are not better explained by another mental disorder.

Table 1 continues on next page.

NEW DIAGNOSTIC ENTRIES IN DSM-5-TR (*Continued*)		
Diagnostic Entity	**Description**	**Key Features**
No diagnosis or condition	The DSM-5-TR introduced a new code for "no diagnosis or condition" to address situations where a clinician needs to indicate that no mental disorder or condition is present. The code for "no diagnosis or condition" allows clinicians to document that a comprehensive diagnostic evaluation was conducted explicitly, but no mental disorder or condition warranting clinical attention was found. This code helps improve the accuracy of clinical documentation and provides a straightforward way to communicate that a mental health evaluation was conducted with a finding of no diagnosable condition. It is beneficial in contexts where the absence of a diagnosis needs to be formally recorded.	1. An individual undergoes a mental health assessment but does not meet the criteria or any mental disorder. 2. A clinician must indicate the absence of a mental health diagnosis for administrative or billing purposes. 3. There is a need to document that a thorough evaluation was performed, even though no diagnosis was made. 4. To differentiate between cases where no disorder is present versus cases with insufficient information to diagnose.
Suicidal behavior	The DSM-5-TR defines suicidal behavior as "potentially self-injurious behavior with at least some intent to die as a result of the action."	1. Current suicidal behavior (initial encounter) 2. Current suicidal behavior (subsequent encounter) 3. History of suicidal behavior
Nonsuicidal self-injury (NSSI)	NSSI is defined as intentionally inflicting damage to one's body that will "likely induce bleeding, bruising or pain."	1. Current nonsuicidal self-injury 2. History of nonsuicidal self-injury
These new codes serve several important purposes: 1. They allow clinicians to document these behaviors without requiring other mental health diagnoses. 2. They help improve the accuracy of clinical documentation and risk assessment. 3. They facilitate better tracking and research on suicidal behavior and self-injury. 4. They encourage clinicians to assess these behaviors in routine clinical practice. The inclusion of these codes in the DSM-5-TR aims to draw attention to these critical issues in mental health care and improve the overall assessment and treatment of individuals at risk for suicide or self-harm.		
Source: [1]		*Table 1*

- **Process**: These changes underwent a formal review process, including approval by the DSM Steering Committee, the APA Board of Trustees, and the APA Assembly.
- **Clinical impact**: While these modifications do not fundamentally alter the disorders, they may lead to more accurate and consistent diagnoses in clinical practice.
- **Examples**: Typical clarifications might involve specifying time frames more precisely, clarifying the meaning of specific terms, or providing more detailed descriptions of symptoms.
- **Importance for clinicians**: These changes underscore the need for mental health professionals to stay updated with the latest version of the DSM to ensure they are using the most current and accurate diagnostic criteria.
- **Research implications**: Clear criteria can produce more consistent research results across different studies and settings.

It is important to note that while these modifications are significant for ensuring diagnostic accuracy, they are not as substantial as adding new disorders or significant revisions to existing ones. Clinicians are encouraged to review the specific changes relevant to their practice areas.

UPDATED TERMINOLOGY

The DSM-5-TR incorporated updated terminology throughout the manual in its comprehensive revision process. This update in terminology serves several important purposes:

- **Reflecting current scientific understanding**: The updated terminology aligns with the latest research and clinical understanding of mental disorders, ensuring that the language used is consistent with contemporary knowledge in the field.
- **Reducing stigma**: Some terms were updated to use less stigmatizing language, crucial in promoting a more compassionate and understanding approach to mental health.
- **Improving clarity and precision**: The revised terminology aims to provide more accurate and specific descriptions of symptoms and disorders, facilitating better communication among clinicians and researchers.
- **Enhancing cultural sensitivity**: The updates include more culturally sensitive language to describe various aspects of mental health, including sexual orientation, gender identity, and cultural experiences.

The DSM-5-TR incorporates several important terminology updates to reflect current scientific understanding and promote more sensitive, accurate language. Throughout the text, "neuroleptic medications" have been replaced with "antipsychotic medications or other dopamine receptor blocking agents," providing a more precise description of these drugs' mechanisms. In sections on gender dysphoria, "desired gender" has been updated to "experienced gender," acknowledging individuals' lived experiences better. The language surrounding substance use disorders has been revised to reduce stigma and align with the understanding of addiction as a medical condition. Terminology related to neurodevelopmental disorders has been updated to reflect current research and clinical practice. Additionally, the manual refines language used to describe cultural factors in mental health, emphasizing the importance of cultural competence in diagnosis and treatment. These changes demonstrate the ongoing effort to keep the DSM-5-TR relevant, accurate, and sensitive. The manual aims to improve communication among professionals, enhance diagnostic accuracy, and foster a more nuanced understanding of mental health conditions by adopting more precise, less stigmatizing, and culturally appropriate language.

ICD-10-CM CODE UPDATES

The DSM-5-TR incorporated several updates to ICD-10-CM codes to align with the latest changes in diagnostic classifications [1]. Critical updates to the ICD-10-CM codes in the DSM-5-TR include the following.

New Codes Added

- Prolonged grief disorder was added with the code F43.8.
- New symptom codes were introduced for:
  - Suicidal behavior (R45.851)
  - Nonsuicidal self-injury (R45.88)
- Codes for homelessness were expanded:
  - Sheltered homelessness (Z59.01)
  - Unsheltered homelessness (Z59.02)

Code Modifications

- Unspecified depressive disorder was changed from F32.9 to F32.A.
- Food insecurity now has a specific code, Z59.41, previously part of a broader category.
- Lack of safe drinking water received its code Z58.6.
- Personal history of self-harm was split into:
  - Personal history of suicidal behavior (Z91.51)
  - Personal history of nonsuicidal self-injury (Z91.52)

Ongoing Updates

The APA updates ICD-10-CM codes in response to broader medical coding system changes [22]. For example, in September 2023, Parkinson disease received an updated code G20.C and inadequate housing changed from Z59.1 to Z59.10.

It is important to note that these coding updates are part of an ongoing process. The DSM-5-TR aims to maintain alignment with the ICD-10-CM, the official coding system used in the United States for diagnostic and billing purposes.

Clinicians should regularly check for the most current coding updates, as they can affect diagnosis documentation and insurance reimbursement. The APA provides resources for staying informed about these changes, including periodic updates on their website.

FOCUS ON CULTURE, RACISM, AND DISCRIMINATION

The DSM-5-TR addressed culture, racism, and discrimination, representing a notable shift from the DSM-5 [1; 2].

Work Group on Ethnoracial Equity and Inclusion

A dedicated Work Group on Ethnoracial Equity and Inclusion was established to review the entire manual for the first time in DSM history. This group, composed of ten diverse mental health practitioners, ensured appropriate attention was given to risk factors such as racism and discrimination and that non-stigmatizing language was used throughout the text. This was a significant departure from the DSM-5, which had no comprehensive review process focused on these issues.

Updated Terminology

The DSM-5-TR adopted a more inclusive and precise language than its predecessor. For example, "racialized" replaced "race/racial" to highlight the socially constructed nature of race. "Ethnoracial" was used for U.S. Census categories, and terms like "minority" and "non-White" were avoided. "Latinx" replaced "Latino/Latina" for gender inclusivity. These changes reflect a more nuanced understanding of cultural and racial identities than the DSM-5.

Expanded Cultural Formulation

The DSM-5-TR built upon the Cultural Formulation Interview (CFI) introduced in DSM-5 and provides more comprehensive guidance on assessing cultural factors in diagnosis and treatment planning. This expansion aims to improve clinicians' ability to consider cultural context in their assessments.

Prevalence and Risk Factors

The DSM-5-TR focused on ensuring that reported differences in disorder prevalence among ethnic groups were based on reliable studies with sufficient sample sizes. It also provided context to avoid misinterpreting these differences as genetic rather than social or environmental. This represents a more critical approach to epidemiological data than in the DSM-5.

Misdiagnosis Risk

The manual explicitly highlighted the risk of misdiagnosis when evaluating individuals from socially oppressed ethnoracial groups. This acknowledgment of potential bias in diagnosis was not as prominently featured in the DSM-5.

Social Determinants of Health

There was increased recognition of how social status, including experiences of racism and discrimination, can impact mental health outcomes. This reflects a broader understanding of mental health that goes beyond the more individualistic focus of the DSM-5.

Structural Factors

The DSM-5-TR accelerated the inclusion of structural factors in the concept of culture, particularly in response to calls for social justice following events like George Floyd's death. This represents a more explicit acknowledgment of systemic issues affecting mental health than was present in the DSM-5.

These changes collectively represent a significant shift towards a more culturally informed, socially aware, and inclusive approach to mental health diagnosis and treatment compared to the DSM-5. The DSM-5-TR aims to provide clinicians with better tools to understand and address the complex interplay between culture, social structures, and mental health.

ITERATIVE REVISION PROCESS

The DSM-5-TR incorporates an iterative revision process that allows for ongoing updates and improvements to the diagnostic manual [1]. This approach represents a significant shift from previous editions of the DSM, enabling more responsive and timely updates based on emerging research and clinical evidence.

Key Features of the Iterative Revision Process

Continuous Updates

Unlike previous versions that remained static between significant revisions, the DSM-5-TR is designed to be updated incrementally. This allows for more frequent incorporation of new scientific findings and clinical insights.

DSM Steering Committee

The iterative revision process is overseen by the DSM Steering Committee, which evaluates proposals for changes and updates to the manual. This committee plays a crucial role in maintaining the DSM's scientific integrity and clinical utility.

Proposal Submission

Mental health professionals can submit change proposals through the APA's DSM web portal. The Steering Committee and relevant Review Committees rigorously evaluate these proposals.

Public Comment Period

After preliminary approval, proposed changes are posted on the DSM-5 website for public comment. This allows for broader input from the psychiatric community before final decisions are made.

Scope of Changes

The iterative revision process allows for various updates, as discussed below and throughout this course.

Text Updates

Comprehensive revisions to the descriptive text accompanying each disorder, based on literature reviews covering the past decade.

Criteria Clarifications

Minor adjustments to diagnostic criteria for clarity or consistency.

New Diagnostic Entities

Addition of new disorders or specifiers, such as prolonged grief disorder in the DSM-5-TR.

Terminology Updates

Language changes to reflect current understanding and promote non-stigmatizing descriptions.

Impact on Clinical Practice

This iterative approach ensures that clinicians have access to the most up-to-date diagnostic guidelines and information. It allows for more rapid incorporation of scientific advances, potentially improving diagnostic accuracy and treatment outcomes.

Future Outlook

The iterative revision process is expected to continue, with future updates identified by decimal points (e.g., DSM-5.1, DSM-5.2). This model aims to balance the need for stability in diagnostic practice with the imperative to incorporate new scientific knowledge promptly. By adopting this iterative revision process, the DSM-5-TR represents a more dynamic and responsive approach to psychiatric diagnosis, reflecting the evolving nature of mental health research and practice.

CRITERIA CLARIFICATIONS

The DSM-5-TR included clarifying modifications to the diagnostic criteria for more than 70 disorders. These modifications improved clarity and reduced ambiguity in the criteria sets without fundamentally changing the conceptual definitions of the disorders. The main goal was to enhance the reliability and validity of diagnoses by making the criteria more precise and more accessible to interpret consistently across clinicians.

The modifications affected a wide range of disorders across multiple categories in the DSM, indicating a comprehensive review of the manual. Most modifications were minor clarifications to wording designed to resolve ambiguities or inconsistencies in the original DSM-5 criteria. These changes underwent a formal review process, including approval by the DSM Steering Committee, the APA Board of Trustees, and the APA Assembly. Examples of clarifications include:

- Autism Spectrum Disorder: Criterion A was revised to require that all three deficits be present, stating "as manifested by all of the following."
- Major Depressive Disorder: Criterion D was revised to allow diagnosis of MDD whether the current episode includes psychotic symptoms, if there was at least one major depressive episode without concurrent symptoms of another mental disorder in the patient's lifetime.
- Manic Episode: The severity specifiers were revised in order to be consistent with the diagnostic criteria.

While these modifications do not fundamentally alter the disorders, they may lead to more accurate and consistent diagnoses in clinical practice. Clear criteria can produce more consistent research results across different studies and settings. These clarifications underscore the ongoing effort to improve the precision and utility of the DSM for both clinical and research purposes. They reflect the dynamic nature of psychiatric diagnosis and the importance of continually refining diagnostic criteria based on clinical experience and emerging research.

NEWLY CLASSIFIED DIAGNOSES IN THE DSM-5-TR

PROLONGED GRIEF DISORDER

The development and inclusion of prolonged grief disorder (PGD) in the DSM-5-TR represents a significant milestone in the field of mental health and bereavement research. Historically, research on pathological grief reactions dates to the 1990s, with various terms and criteria sets proposed over the years, including "complicated grief" and "persistent complex bereavement disorder" [26]. The concept of prolonged grief as a distinct disorder has been debated for decades among researchers and clinicians. Numerous studies have demonstrated that a small but significant portion of bereaved individuals experience persistent, intense grief that impairs their functioning, showing that prolonged grief is distinct from other mental health conditions like depression and post-traumatic stress disorder.

The proposal to include PGD was submitted to the APA nearly two decades ago and underwent extensive review and debate within the psychiatric community. Officially included in the DSM-5-TR published in March 2022, PGD replaced the previous persistent complex bereavement disorder, which had appeared in the DSM-5's Section III (Conditions for Further Study). The DSM-5-TR defines PGD as persistent yearning or longing for the deceased or preoccupation with thoughts of the deceased, along with several other symptoms lasting at least 12 months for adults and six months for children [1]. The symptoms must cause clinically significant distress or impairment and exceed cultural, religious, or age-appropriate norms.

However, the inclusion of PGD has sparked debate within the psychiatric community. Some critics argue that it pathologizes normal grief, while others contend that it is necessary to identify and treat those experiencing severe, persistent grief reactions [26]. The inclusion of PGD in the DSM-5-TR also aligns with its recognition in the ICD-11, although there are some differences in specific criteria. Overall, the incorporation of PGD reflects a growing acknowledgment of prolonged, impairing grief as a distinct clinical entity, aiming to improve diagnosis and treatment for individuals suffering from severe grief reactions while recognizing the need for careful differentiation from normal grieving processes.

Prolonged grief disorder was newly added to the DSM-5-TR as a formal diagnosis in the category of Trauma- and Stressor-Related Disorders. Here are the critical points about PGD and its diagnostic requirements in the DSM-5-TR [1]:

- **Definition**: PGD is characterized as a maladaptive grief reaction that persists for an extended period after the death of someone with whom the bereaved had a close relationship.
- **Time criteria (Criterion A)**:
  - For adults: At least 12 months must have passed since the death
  - For children and adolescents: At least six months must have passed since the death
- **Core symptoms (Criterion B)**: The person must experience at least one of the following nearly every day for at least the last month:
  - Intense yearning/longing for the deceased person
  - Preoccupation with thoughts or memories of the deceased person (for children/adolescents, this may focus on the circumstances of the death)
- **Additional symptoms (Criterion C)**: At least three of the following eight symptoms must be present nearly every day for at least the last month:
  - Identity disruption (feeling as though part of oneself has died)
  - Marked sense of disbelief about the death
  - Avoidance of reminders that the person is dead
  - Intense emotional pain related to the death
  - Difficulty moving on with life
  - Emotional numbness
  - Feeling that life is meaningless
  - Intense loneliness
- **Functional impairment (Criterion D)**: The disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- **Cultural considerations (Criterion E)**: The duration and severity of the grief reaction must clearly exceed expected social, cultural, or religious norms for the individual's culture and context.
- **Differential diagnosis (Criterion F)**: The symptoms are not better explained by another mental disorder.

The inclusion of PGD in the DSM-5-TR aims to improve the recognition and treatment of maladaptive grief responses, particularly in the context of increased deaths due to the COVID-19 pandemic. However, its inclusion has also sparked some controversy in the psychiatric community, with debates about the potential medicalization of normal grief processes.

UNSPECIFIED MOOD DISORDER

The development and inclusion of unspecified mood disorder in the DSM-5-TR represents a vital update aimed at addressing a gap in diagnostic options [1]. This category was added to provide clinicians with a diagnostic option when it is challenging to distinguish between unipolar and bipolar presentations, particularly in cases where irritable mood or agitation predominates. Historically, this category was unintentionally removed from the DSM-5 when the mood disorders diagnostic class was eliminated in favor of separate bipolar and depressive disorder classifications. The inclusion of unspecified mood disorder allows clinicians to avoid prematurely choosing between bipolar disorder and depressive disorder, which can have significant implications for treatment and long-term patient outcomes.

The unspecified mood disorder category also enhances compatibility with other diagnostic systems, such as ICD-10-CM and ICD-11, which include similar classifications. Due to the absence of a mood disorders grouping in the DSM-5-TR, unspecified mood disorder is located within both the depressive disorders and the bipolar disorders chapters. It applies to presentations with symptoms characteristic of a mood disorder that cause clinically significant distress or impairment but do not meet the full criteria for any specific mood disorder. This category serves as a diagnostic placeholder when there is insufficient information to make a more specific diagnosis, with the expectation that a more precise diagnosis may be made later as more information becomes available. Overall, including unspecified mood disorder reflects an effort to provide clinicians with greater flexibility in diagnosis, particularly in complex or unclear cases, while aligning the manual more closely with other diagnostic systems.

STIMULANT-INDUCED MILD NEUROCOGNITIVE DISORDER

The development and inclusion of stimulant-induced mild neurocognitive disorder in the DSM-5-TR represents an essential update to the classification of substance-induced cognitive impairments [1]. Historically, the DSM-IV included a category for persisting dementia resulting from four substance classes: alcohol, sedatives/hypnotics/anxiolytics, inhalants, and other/unknown substances [18]. The DSM-5 replaced this single dementia category with major and mild neurocognitive disorders for these same substance classes [2]. A growing literature on stimulant-induced neurocognitive impairments supported the existence of persistent cognitive deficits resulting from stimulant use, with studies demonstrating that these deficits, while not severe enough to interfere with independence in daily activities, were significant enough to require more tremendous mental effort, compensatory strategies, or accommodation.

In the DSM-5-TR, cocaine-induced mild neurocognitive disorder and amphetamine-type substance–induced mild neurocognitive disorder were added to acknowledge the increasing evidence that chronic stimulant use can lead to lasting cognitive impairments, even after cessation of use [1]. This inclusion provides a diagnostic category for clinicians to capture the cognitive effects of stimulant use accurately. While specific diagnostic criteria are not detailed in the search results, it likely follows the general structure for substance-induced disorders, requiring evidence of cognitive decline that is etiologically related to stimulant use. The inclusion of this disorder allows for better recognition and potential treatment of cognitive impairments associated with stimulant use. It may facilitate research into the long-term effects of such substances on cognitive functioning. Overall, this addition aligns stimulant-induced cognitive impairments with other recognized substance-induced neurocognitive disorders in the DSM, reflecting an ongoing effort to refine and update the manual based on emerging research and clinical observations in substance-related disorders.

The diagnostic criteria for stimulant-induced mild neurocognitive disorder are as follows [1]:

- Evidence of modest cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on (Criterion A):
  - Concern about a mild decline in cognitive function, expressed by the individual, a knowledgeable informant, or the clinician.
  - A modest impairment in cognitive performance, documented by objective cognitive assessment.
- The cognitive deficits do not interfere with independence in everyday activities. However, greater effort, compensatory strategies, or accommodation may be required to maintain independence (Criterion B).
- The cognitive deficits do not occur exclusively in the context of delirium (Criterion C).
- The cognitive deficits are not better explained by another mental disorder (Criterion D).

Additionally, the clinician should specify the etiological subtype if possible (e.g., due to Alzheimer disease, vascular disease, traumatic brain injury, etc.). The presence or absence of behavioral disturbances should be noted. For some etiological subtypes, the level of certainty of the diagnosis (possible or probable) can be specified.

It is important to note that while these criteria help identify mild neurocognitive disorder, clinical judgment and comprehensive assessment are crucial for accurate diagnosis.

NO DIAGNOSIS OR CONDITION

Including a code for "no diagnosis or condition" in the DSM-5-TR represents an essential addition to the manual, addressing a longstanding need in clinical practice and documentation [1]. This new code allows clinicians to indicate that a comprehensive diagnostic evaluation was conducted explicitly, but no mental disorder or condition warranting clinical attention was found. The development of this code stemmed from the recognition that there are situations where individuals undergo mental health assessments but do not meet the criteria for any mental disorder. Nevertheless, there was previously no standardized way to document this outcome.

The addition of this code serves several vital purposes in clinical practice. It clearly communicates that a thorough evaluation was performed, even when no diagnosis was made. This is particularly useful in contexts where the absence of a diagnosis needs to be formally recorded, such as in administrative or billing processes. The code also helps differentiate between cases where no disorder is present versus cases with insufficient information to diagnose. Furthermore, it can be valuable in research settings, allowing for more accurate categorization of study participants. Including this code in the DSM-5-TR reflects the manual's ongoing efforts to improve the accuracy and utility of clinical documentation in mental health care, providing clinicians with a more comprehensive set of tools for describing the outcomes of their diagnostic assessments.

CASE STUDY

Case Presentation

Sarah, a 32-year-old woman, was referred to the outpatient psychiatric clinic by her primary care physician due to persistent depressive symptoms and difficulty functioning in daily life.

Background

Fifteen months ago, Sarah's mother died suddenly from a heart attack at age 58. Sarah and her mother had been extremely close, speaking daily and seeing each other multiple times per week. Sarah described her mother as her "best friend" and primary source of emotional support.

Symptoms

Since her mother's death, Sarah has experienced:

- Intense yearning and longing for her mother daily
- Preoccupation with thoughts and memories of her mother
- Difficulty accepting the reality of the loss
- Avoidance of places and activities that remind her of her mother

- A sense that life is meaningless without her mother
- Emotional numbness and detachment from others
- Bitterness and anger about the loss
- Difficulty engaging in work and social activities

These symptoms have persisted without significant improvement for over a year since the loss. Sarah reports that the intensity of her grief feels just as strong now as it did immediately after her mother's death.

Functional Impairment

Sarah's work performance has declined significantly. She has been reprimanded for excessive absences and missed deadlines. Her social relationships have deteriorated as she isolates herself and avoids social gatherings. Sarah has also neglected her physical health, skipping meals and doctor's appointments.

Previous Treatment

Sarah attended three grief counseling sessions shortly after her mother's death but found them unhelpful and discontinued. She has been taking an SSRI antidepressant prescribed by her primary care doctor for the past six months with minimal effect on her symptoms.

Diagnosis

Based on the persistent and impairing nature of Sarah's grief symptoms more than 12 months after her loss, she meets the criteria for prolonged grief disorder. Her symptoms go beyond customary cultural and religious norms for grief and are causing significant functional impairment.

Treatment Plan

A comprehensive treatment approach is recommended, including:

- Prolonged grief disorder-specific psychotherapy (e.g., complicated grief therapy)
- Continued antidepressant medication with potential adjustment
- Behavioral activation to increase engagement in meaningful activities
- Grief support group to reduce isolation

The goals are to help Sarah process her grief, find ways to maintain a healthy connection to her mother's memory, and gradually re-engage in life. Regular monitoring of suicidal ideation is also warranted, given the elevated suicide risk associated with prolonged grief.

SYMPTOM CODE UPDATES: PRESENCE/HISTORY OF SUICIDAL BEHAVIOR AND NSSI

PRESENCE/HISTORY OF SUICIDAL BEHAVIOR

The DSM-5-TR introduced significant changes regarding the documentation of suicidal behavior by adding new symptom codes to indicate both the presence and history of suicidal behavior [1]. This addition was part of a broader effort to improve the assessment and documentation of suicide risk in clinical practice. The DSM-5 had already included a Suicide Risk section in the text for most disorders to emphasize the importance of suicide risk assessment during clinical evaluations [2]. In the DSM-5-TR, these sections were expanded and renamed "Association with Suicidal Thoughts or Behavior."

The new symptom codes for suicidal behavior were added to the chapter "Other Conditions That May Be a Focus of Clinical Attention" in the DSM-5-TR. These codes allow clinicians to document current suicidal behavior (for both initial and subsequent encounters) as well as a history of suicidal behavior. Including these codes serves several important purposes: it helps improve the accuracy of clinical documentation, facilitates better tracking and research on suicidal behavior, and encourages clinicians to assess for these behaviors as part of routine clinical practice. Importantly, these codes can be used without requiring any other mental health diagnosis, recognizing that suicidal behavior can occur in various contexts. This change reflects a growing recognition of the need to address suicidal behavior as a distinct clinical concern, separate from, but often related to, other mental health conditions.

NSSI

The DSM-5-TR introduced new symptom codes for nonsuicidal self-injury (NSSI), representing a significant update in the documentation and recognition of this clinically meaningful behavior [1]. This addition was part of a broader effort to improve the assessment and documentation of self-harming behaviors in clinical practice. The inclusion of these codes allows clinicians to document both current nonsuicidal self-injury and a history of nonsuicidal self-injury.

The new symptom codes for NSSI were added to the "Other Conditions That May Be a Focus of Clinical Attention" chapter in the DSM-5-TR. These codes serve several important purposes: they help improve the accuracy of clinical documentation, facilitate better tracking and research on self-injurious behaviors, and encourage clinicians to assess for these behaviors as part of routine clinical practice. Importantly, these codes can be used without requiring any other mental health diagnosis, recognizing that NSSI can occur in various contexts and may not always be associated with a specific mental disorder. This change reflects a growing recognition of the need to address self-injurious behaviors as distinct clinical concerns, separate from, but often related to, other mental health conditions.

Including these codes in the DSM-5-TR aims to draw attention to the importance of assessing and documenting NSSI, potentially leading to improved identification and treatment of individuals engaging in these behaviors.

DISORDERS RECOMMENDED FOR FURTHER STUDY

Section III Conditions for Further Study in the DSM serves several important purposes:

- **Research promotion**: This section includes proposed diagnostic categories and criteria sets that require further research before they can be considered official diagnoses in the main sections of the DSM. The DSM encourages and stimulates additional research to validate these proposed disorders by including these conditions.
- **Provisional recognition**: This provides provisional recognition for conditions with some empirical support but is not well-established enough to be included in formal diagnoses. This allows clinicians and researchers to have a common language for discussing these potential disorders.
- **Clinical utility testing**: Including these conditions allows for testing their clinical utility in real-world settings. Clinicians can use these proposed criteria sets and provide feedback on their usefulness and validity.
- **Future development**: This section serves as a developmental ground for future additions to the main diagnostic categories in subsequent DSM editions.
- **Addressing emerging issues**: This allows the DSM to be responsive to emerging mental health issues and new research findings without prematurely including them as official diagnoses.
- **Continuity and evolution**: It bridges current diagnostic practices and potential future directions in psychiatric nosology.
- **Transparency**: The DSM demonstrates transparency in developing new diagnostic categories by including these proposed disorders.
- **Flexibility**: This section allows for more flexibility in considering new diagnostic entities compared to the more established categories in the main sections of the manual.

Thus, the Conditions for Further Study section plays a crucial role in the ongoing development and refinement of psychiatric diagnosis, balancing the need for diagnostic stability with the importance of incorporating new research findings and clinical observations.

ATTENUATED PSYCHOSIS SYNDROME

Attenuated psychosis syndrome (APS) is characterized by the presence of attenuated (less severe) psychotic symptoms that do not meet the full criteria for a psychotic disorder. These symptoms typically include delusions, hallucinations, or disorganized speech in a milder form, with relatively intact reality testing.

The inclusion of APS in the DSM aims to identify individuals who may be at high risk for developing a full psychotic disorder, particularly schizophrenia. To meet the criteria for APS, symptoms must have begun or worsened in the past year, be present at least once per week in the last month, and cause distress or disability to the individual [1]. Notably, the symptoms should not be better explained by another mental disorder or substance use. The concept of APS has sparked debate in the psychiatric community, with some arguing for its potential in early intervention and prevention of psychosis. In contrast, others express concerns about potential overdiagnosis and stigmatization. As research continues, the status of APS may evolve in future editions of the DSM.

Proposed Criteria for APS

- At least one of the following symptoms is present and is of sufficient severity or frequency to warrant clinical attention:
  - Attenuated delusions
  - Attenuated hallucinations
  - Attenuated disorganized speech
- Symptom(s) must have been present at least once per week for the past month.
- Symptom(s) must have begun or worsened in the past year.
- Symptom(s) is sufficiently distressing and disabling to the individual to warrant clinical attention.
- Symptom(s) is not better explained by another mental disorder, including a depressive or bipolar disorder with psychotic features, and is not attributable to the physiological effects of a substance or another medical condition.
- Criteria for any psychotic disorder have never been met.

DEPRESSIVE EPISODES WITH SHORT-DURATION HYPOMANIA

Depressive episodes with short-duration hypomania is a condition included in the Conditions for Further Study section of the DSM-5-TR, indicating that more research is needed before it can be considered an official diagnosis. This proposed disorder is characterized by individuals who experience major depressive episodes along with brief periods of hypomania that last less than four days. These short hypomanic episodes

do not meet the current DSM criteria for bipolar II disorder, which requires hypomanic episodes to last at least four consecutive days.

The inclusion of this condition in the DSM-5-TR reflects growing recognition that shorter periods of hypomania may be clinically significant and more common than previously thought. Research suggests that individuals with depressive episodes and short-duration hypomania may represent a distinct clinical group that falls on a spectrum between unipolar depression and bipolar II disorder. These patients often experience mood instability, increased energy levels, and changes in behavior during their brief hypomanic periods, which can impact their overall functioning and treatment needs. The study of this condition aims to improve diagnostic accuracy and potentially lead to more appropriate treatment strategies for individuals who may be currently misdiagnosed with unipolar depression. However, there is ongoing debate in the psychiatric community about the optimal duration criterion for hypomania and the potential implications of broadening the bipolar spectrum.

Proposed Criteria for Depressive Episodes with Short-Duration Hypomania

Lifetime experience of at least one major depressive episode meeting the following criteria [1]:

- Five (or more) of the following criteria have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) a depressed mood or (2) loss of interest or pleasure. (Note: Do not include symptoms clearly attributable to a medical condition.):
  - Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (Note: It can be an irritable mood in children and adolescents.)
  - Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation)
  - Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly daily (Note: In children, consider failure to make expected weight gain.)
  - Insomnia or hypersomnia nearly every day
  - Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
  - Fatigue or loss of energy nearly every day
  - Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
  - Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
  - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not attributable to the physiological effects of a substance or another medical condition.
- The disturbance is not better explained by schizoaffective disorder. It is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorders.

At least two lifetime episodes of hypomanic periods that involve the required criterion symptoms below but are of insufficient duration (at least two days but less than four consecutive days) to meet the criteria for a hypomanic episode. The criterion symptoms are as follows [1]:

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy.
- During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree:
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
  - More talkative than usual or pressured to keep talking
  - Flight of ideas or subjective experience that thoughts are racing
  - Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed
  - Increase goal-directed activity (socially, at work or school, or sexually) or psychomotor agitation

  - Excessive involvement in activities with a high potential for painful consequences (e.g., the individual engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
- The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
- The disturbance in mood and the change in functioning are observable by others.
- The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
- The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment).

CAFFEINE USE DISORDER

Caffeine use disorder (CUD) is a condition included in the DSM-5-TR under the Conditions for Further Study section, indicating that more research is needed before it can be considered an official diagnosis. The proposed criteria for CUD are like other substance use disorders but with a more conservative threshold to prevent overdiagnosis, given the prevalence of nonproblematic caffeine use in the general population. For a potential CUD diagnosis, an individual must endorse at least three criteria [1]:

- A persistent desire or unsuccessful effort to control caffeine use
- Continued use despite harm
- Withdrawal symptoms

Research suggests that CUD may affect a significant portion of caffeine consumers, with one study finding that 8% of a sample of U.S. adults met the proposed DSM-5 criteria [2]. Individuals meeting these criteria tend to consume more caffeine, are often younger, and are more likely to be cigarette smokers. They may experience caffeine-related functional impairment, poorer sleep, and greater levels of depression, anxiety, and stress. Symptoms of CUD can include anxiety, insomnia, and other issues that interfere with daily life. While caffeine is widely consumed and generally considered safe, CUD highlights that, for some individuals, caffeine use can become problematic and may require clinical attention. However, more research is needed to fully understand this condition's prevalence, severity, and clinical significance before it can be officially recognized as a disorder in future editions of the DSM.

Proposed Criteria for CUD

A problematic pattern of caffeine use leading to clinically significant impairment or distress, as manifested by at least three of the following criteria occurring within a 12-month period [1]:

- A persistent desire or unsuccessful efforts to cut down or control caffeine use.
- Continued caffeine use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by caffeine.
- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for caffeine
  - Caffeine (or a closely related substance) is taken to relieve or avoid withdrawal symptoms
- Caffeine is often taken in larger amounts or over a longer period than was intended.
- Recurrent caffeine use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated tardiness or absences from work or school related to caffeine use or withdrawal).
- Continued caffeine use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of caffeine (e.g., arguments with spouse about consequences of use, medical problems, cost).
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of caffeine to achieve the desired effect
  - Markedly diminished effect with continued use of the same amount of caffeine
- A great deal of time is spent on activities necessary to obtain caffeine, use caffeine, or recover from its effects.
- Craving or a strong desire or urge to use caffeine.

INTERNET GAMING DISORDER

Internet gaming disorder (IGD) is a condition included in the Conditions for Further Study section of the DSM-5-TR, indicating that more research is needed before it can be considered an official diagnosis [1]. The DSM-5 defines IGD as "a pattern of excessive and prolonged Internet gaming that results in a cluster of cognitive and behavioral symptoms, including progressive loss of control over gaming, tolerance, and withdrawal symptoms, analogous to the symptoms of substance use disorders" [1]. To meet the criteria for IGD, an individual must experience five or more of nine specified symptoms within a year, such as preoccupation with gaming, withdrawal symptoms when gaming is taken away, and loss of interest in other activities.

The inclusion of IGD in the DSM-5 reflects growing concern about the potential negative impacts of excessive online gaming, particularly among young people. Research suggests that individuals with IGD may experience significant impairment in various areas of life, including academic performance, social relationships, and mental health. However, the prevalence of IGD appears to be relatively low, with studies estimating that between 0.3% and 1.0% of the general population might qualify for a potential diagnosis. The condition criteria focus on Internet games and do not include general Internet use, online gambling, or social media use. While IGD's inclusion in the DSM-5 has stimulated further research and clinical attention, debate continues in the scientific community about whether gaming addiction should be classified as a distinct mental disorder. As research in this area progresses, our understanding of IGD and its potential impacts on mental health may evolve.

Proposed Criteria for IGD

Persistent and recurrent use of the Internet to engage in games, often with other players, leading to clinically significant impairment or distress as indicated by five (or more) of the following in a 12-month period [1]:

- Preoccupation with Internet games. (The individual thinks about previous gaming activity or anticipates playing the next game; Internet gaming becomes the dominant activity in daily life.) Note: This disorder is distinct from Internet gambling, which is included under gambling disorder.
- Withdrawal symptoms when Internet gaming is taken away. (These symptoms are typically described as irritability, anxiety, or sadness, but there are no physical signs of pharmacological withdrawal.)
- Tolerance—the need to spend increasing amounts of time engaged in Internet games.
- Unsuccessful attempts to control the participation in Internet games.
- Loss of interests in previous hobbies and entertainment as a result of, and with the exception of, Internet games.
- Continued excessive use of Internet games despite knowledge of psychosocial problems.
- Has deceived family members, therapists, or others regarding the amount of Internet gaming.
- Use of Internet games to escape or relieve a negative mood (e.g., feelings of helplessness, guilt, anxiety).
- Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of participation in Internet games.

Note: Only nongambling Internet games are included in this disorder. Use of the Internet for required activities in a business or profession is not included; nor is the disorder intended to include other recreational or social Internet use. Similarly, sexual Internet sites are excluded.

Internet gaming disorder can be mild, moderate, or severe depending on the degree of disruption of normal activities. Individuals with less severe Internet gaming disorder may exhibit fewer symptoms and less disruption of their lives. Those with severe Internet gaming disorder will have more hours spent on the computer and more severe loss of relationships or career or school opportunities.

NEUROBEHAVIORAL DISORDER ASSOCIATED WITH PRENATAL ALCOHOL EXPOSURE

Neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE) is a condition included in the DSM-5-TR under the Conditions for Further Study section [1]. It is characterized by a pattern of impairments in neurocognition, self-regulation, and adaptive functioning resulting from prenatal alcohol exposure. To meet the diagnostic criteria for ND-PAE, there must be confirmed prenatal alcohol exposure, along with evidence of impaired neurocognitive functioning, self-regulation, and adaptive functioning. Symptoms typically manifest in childhood and lead to significant distress or impairment in social, academic, or other important areas of functioning [1].

Individuals with ND-PAE may experience cognitive deficits, such as planning, attention, learning, and memory difficulties. Behavioral regulation issues, including mood or behavioral regulation problems, attention deficits, and impulse control challenges, can also arise. Additionally, these individuals may face difficulties in adaptive functioning, including social communication and interaction problems and impaired daily living skills. Estimates suggest that 2-5% of children in the United States may have a fetal alcohol spectrum disorder (FASD), with ND-PAE being a subset of this group [22]. Diagnosis requires confirmation of prenatal alcohol exposure and a comprehensive assessment of neurocognitive, behavioral, and adaptive functioning. Treatment typically involves a multidisciplinary approach that includes educational interventions, behavioral therapies, and sometimes medication for specific symptoms. While ND-PAE is a lifelong condition, early intervention and appropriate support can improve outcomes significantly. Notably, the only way to prevent ND-PAE is to avoid alcohol consumption during pregnancy. This condition represents an effort to capture better the range of effects that prenatal alcohol exposure can have on a child's development and functioning, extending beyond the physical features associated with fetal alcohol syndrome [1].

Proposed Criteria for ND-PAE

- More than minimal exposure to alcohol during gestation, including prior to pregnancy recognition. Confirmation of gestational exposure to alcohol may be obtained from maternal self-report of alcohol use in pregnancy, medical or other records, or clinical observation.
- Impaired neurocognitive functioning as manifested by one or more of the following:
  - Impairment in global intellectual performance (i.e., IQ of 70 or below, or a standard score of 70 or below on a comprehensive developmental assessment)
  - Impairment in executive functioning (e.g., poor planning and organization; inflexibility; difficulty with behavioral inhibition)
  - Impairment in learning (e.g., lower academic achievement than expected for intellectual level; specific learning disability)
  - Memory impairment (e.g., problems remembering information learned recently; repeatedly making the same mistakes; difficulty remembering lengthy verbal instructions)
  - Impairment in visual-spatial reasoning (e.g., disorganized or poorly planned drawings or constructions; problems differentiating left from right)
- Impaired self-regulation as manifested by one or more of the following:
  - Impairment in mood or behavioral regulation (e.g., mood lability; negative affect or irritability; frequent behavioral outbursts)
  - Attention deficit (e.g., difficulty shifting attention; difficulty sustaining mental effort)
  - Impairment in impulse control (e.g., difficulty waiting turn; difficulty complying with rules)
- Impairment in adaptive functioning as manifested by two or more of the following, including at least one of the first two criteria:
  - Communication deficit (e.g., delayed acquisition of language; difficulty understanding spoken language)
  - Impairment in social communication and interaction (e.g., overly friendly with strangers; difficulty reading social cues; difficulty understanding social consequences)
  - Impairment in daily living skills (e.g., delayed toileting, feeding, or bathing; difficulty managing daily schedule)
  - Impairment in motor skills (e.g., poor fine motor development; delayed attainment of gross motor milestones or ongoing deficits in gross motor function; deficits in coordination and balance)
- Onset of the disorder (symptoms in Criteria B, C, and D) occurs in childhood.
- The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.
- The disorder is not better explained by the direct physiological effects associated with postnatal use of a substance (e.g., a medication, alcohol, or other drugs), a general medical condition (e.g., traumatic brain injury, delirium, dementia), another known teratogen (e.g., fetal hydantoin syndrome), a genetic condition (e.g., Williams syndrome, Down syndrome, Cornelia de Lange syndrome), or environmental neglect.

SUICIDAL BEHAVIOR DISORDER

Suicidal behavior disorder (SBD) was introduced in the DSM-5 as a condition for further study, indicating that more research was needed before it could be considered for inclusion as an official diagnosis [2]. SBD is characterized by a self-initiated sequence of behaviors believed at the time of initiation to cause one's death, occurring within the last 24 months. The proposal aimed to improve the recognition, documentation, and treatment of suicidal behavior as a distinct clinical concern, separate from, but often related to, other mental health conditions.

The inclusion of SBD in the DSM-5 sparked debate in the psychiatric community [2]. Proponents argued that it could enhance research, improve communication during clinical hand-offs, and maintain focus on suicidal behavior as a significant clinical concern. Critics, however, raised concerns about the potential over-medicalization of behavior and increased liability for mental health professionals. Research on SBD over the past decade has primarily focused on its clinical utility in predicting future suicide risk, its association with related disorders, the development of psychometric measures, its pathophysiology, and potential interventions. However, studies have shown that the clinical utility of SBD for predicting future suicide risk is limited. In the DSM-5-TR, published in 2022, SBD was not included as a formal diagnosis. Instead, new symptom codes were added to indicate current suicidal behavior and history of suicidal behavior, allowing clinicians to document these behaviors without requiring any other mental health diagnosis. This change reflects ongoing efforts to improve the assessment and documentation of suicide risk in clinical practice while acknowledging the complexities involved in classifying suicidal behavior as a distinct disorder.

Proposed Criteria for SBD

- Within the last 24 months, the individual has made a suicide attempt. Note: A suicide attempt is a self-initiated sequence of behaviors by an individual who, at the time of initiation, expected that the set of actions would lead to his or her own death. (The "time of initiation" is the time when a behavior took place that involved applying the method.)
- The act does not meet criteria for nonsuicidal self-injury—that is, it does not involve self-injury directed to the surface of the body undertaken to induce relief from a negative feeling/cognitive state or to achieve a positive mood state.
- The diagnosis is not applied to suicidal ideation or to preparatory acts.
- The act was not initiated during a state of delirium or confusion.
- The act was not undertaken solely for a political or religious objective.
- Specify if:
  - Current: not more than 12 months since the last attempt
  - In early remission: 12 to 24 months since the last attempt

NONSUICIDAL SELF-INJURY

Nonsuicidal self-injury disorder (NSSID) is a condition included in the Conditions for Further Study section of the DSM-5-TR, indicating that more research is needed before it can be considered an official diagnosis [1]. NSSID is characterized by deliberate self-inflicted damage to the surface of one's body without suicidal intent. To meet the diagnostic criteria, an individual must have engaged in self-injury for at least five days within the past year, with the expectation that the injury will lead to minor or moderate physical harm. The behavior is typically associated with interpersonal difficulties or negative feelings and thoughts, such as depression, anxiety, or self-criticism. Individuals with NSSID often report engaging in self-injury to obtain relief from negative emotions, to resolve interpersonal difficulties, or to induce positive feelings.

Studies have shown that individuals meeting NSSID criteria often experience more severe psychopathology and impairment compared to those who self-injure but do not meet full criteria. NSSID can occur both independently and comorbidly with other mental health conditions, such as depression, anxiety disorders, and borderline personality disorder. Including NSSID in the DSM-5-TR aims to improve the recognition and treatment of clinically significant self-injurious behaviors while stimulating further research to understand this condition better. However, there is ongoing debate regarding the optimal diagnostic criteria, particularly concerning the frequency threshold and the potential risk of pathologizing behaviors that may be transient or part of normal development, especially in adolescents [1].

Proposed Criteria for NSSID

- In the last year, the individual has, on five or more days, engaged in intentional self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising, or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (i.e., there is no suicidal intent).

  Note: The absence of suicidal intent has either been stated by the individual or can be inferred by the individual's repeated engagement in a behavior that the individual knows, or has learned, is not likely to result in death.
- The individual engages in the self-injurious behavior with one or more of the following expectations:
  - To obtain relief from a negative feeling or cognitive state
  - To resolve an interpersonal difficulty
  - To induce a positive feeling state

Note: The desired relief or response is experienced during or shortly after the self-injury, and the individual may display patterns of behavior suggesting a dependence on repeatedly engaging in it.

- The intentional self-injury is associated with at least one of the following:
  - Interpersonal difficulties or negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act
  - Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to control
  - Thinking about self-injury that occurs frequently, even when it is not acted upon
- The behavior is not socially sanctioned (e.g., body piercing, tattooing, part of a religious or cultural ritual) and is not restricted to picking a scab or nail biting.
- The behavior or its consequences cause clinically significant distress or interference in interpersonal, academic, or other important areas of functioning.
- The behavior does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In individuals with a neurodevelopmental disorder, the behavior is not part of a pattern of repetitive stereotypies. The behavior is not better explained by another mental disorder or medical condition (e.g., psychotic disorder, autism spectrum disorder, intellectual developmental

disorder [intellectual disability], Lesch-Nyhan syndrome, stereotypic movement disorder with self-injury, trichotillomania [hair-pulling disorder], excoriation [skin-picking disorder]).

CRITICISMS AND CONTROVERSIES WITH THE DSM-5-TR

The DSM-5-TR has faced several criticisms and controversies [1].

ADDITION OF PROLONGED GRIEF DISORDER

The inclusion of prolonged grief disorder has been one of the most controversial changes. Critics argue that it may pathologize normal grief reactions, potentially leading to overdiagnosis and unnecessary treatment. Some concerns defining grief as a disorder after just one year (or six months in children) may not account for cultural variations in grieving processes.

MEDICALIZATION OF NORMAL HUMAN EXPERIENCES

Some mental health professionals worry that the DSM-5-TR continues the trend of medicalizing typical human experiences. This concern extends beyond just grief to other areas of human distress that may be inappropriately labeled as disorders.

POTENTIAL FOR OVERDIAGNOSIS AND OVERTREATMENT

With the addition of new disorders and modifications to existing criteria, there are concerns about potential overdiagnosis and subsequent overtreatment, particularly with psychiatric medications.

CULTURAL SENSITIVITY AND BIAS

Despite efforts to improve cultural sensitivity, some critics argue that the DSM-5-TR still does not adequately account for cultural variations in the expression of mental distress.

VALIDITY AND RELIABILITY OF DIAGNOSES

There are ongoing debates about the validity and reliability of specific diagnoses, with some arguing that the categorical approach to mental disorders does not accurately reflect the complexity and dimensionality of mental health.

INFLUENCE OF PHARMACEUTICAL INDUSTRY

Some critics raise concerns about the potential influence of the pharmaceutical industry on diagnostic criteria, suggesting that new or broadened diagnoses might benefit drug companies.

LACK OF BIOMARKERS

Like its predecessors, the DSM-5-TR relies primarily on observable symptoms rather than biological markers. Given advancements in neuroscience and genetics, some argue that this approach is outdated.

DIMENSIONAL VS. CATEGORICAL APPROACH

There is ongoing debate about whether a dimensional approach to mental health (as proposed by alternative systems like the RDoC) might be more appropriate than the DSM's categorical approach.

FINANCIAL CONFLICT OF INTEREST

Some critics argue that the APA, which publishes the DSM, has a financial conflict of interest that may influence decisions about what to include in the manual.

These controversies highlight the ongoing challenges in developing a comprehensive and universally accepted system for diagnosing mental disorders. They also underscore the importance of continued research and debate in mental health.

ALTERNATIVE DIAGNOSTIC APPROACHES

The criticisms against the DSM-5 and the DSM-5-TR highlight that although the DSM is the most comprehensive and widely utilized diagnostic system currently available, it is not necessarily the only or the best system to classify and diagnose mental disorders. Along these lines, there have been advances in the generation of new diagnostic systems or approaches in recent years.

HIERARCHICAL TAXONOMY OF PSYCHOPATHY (HiTOP)

The Hierarchical Taxonomy of Psychopathology (HiTOP) represents a significant departure from the traditional categorical approach of the DSM-5-TR. While the DSM-5-TR relies on discrete diagnostic categories mainly determined by expert consensus, HiTOP adopts a dimensional, data-driven approach to classifying mental health problems [27]. HiTOP organizes psychopathology into a hierarchical structure, ranging from broad, general dimensions to more specific symptoms, based on empirical evidence from large-scale studies. This dimensional approach addresses several DSM limitations, including arbitrary boundaries between normality and pathology, high comorbidity rates, within-disorder heterogeneity, and diagnostic instability.

One of the critical differences between HiTOP and the DSM-5-TR is how they conceptualize mental health problems. The DSM-5-TR views disorders as distinct categories with clear boundaries, while HiTOP sees them as existing on continua of severity. For example, where the DSM-5-TR might diagnose social anxiety disorder as a discrete condition, HiTOP would place an individual on a spectrum of social anxiety, ranging from mild discomfort to severe impairment. This dimensional approach allows for more nuanced assessment and potentially more tailored treatment planning. Additionally, HiTOP's hierarchical structure explicitly accounts for comorbidity by

grouping related syndromes, whereas the DSM-5-TR's categorical approach often results in multiple, seemingly separate diagnoses for a single individual. While HiTOP shows promise in addressing some of the DSM-5-TR's limitations, it is still a work in progress and faces widespread clinical implementation and acceptance challenges.

RESEARCH DOMAIN CRITERIA (RDoC)

The Research Domain Criteria (RDoC) framework and the DSM-5-TR represent two distinct approaches to understanding and classifying mental health disorders. While the DSM-5-TR is a categorical system primarily designed for clinical diagnosis, RDoC is a dimensional, research-oriented framework that aims to integrate multiple levels of information to understand the fundamental mechanisms underlying mental health and illness [28]. The DSM-5-TR provides specific diagnostic criteria for mental disorders, organized into distinct categories, and is widely used by clinicians for diagnosis and treatment planning. In contrast, RDoC does not provide diagnostic categories but focuses on examining functional dimensions of behavior across a spectrum from normal to abnormal.

One of the critical differences between RDoC and DSM-5-TR lies in their underlying philosophies and goals. The DSM-5-TR aims to provide a common language for clinicians and researchers, facilitating communication and standardizing diagnoses. It is based on observable symptoms and clinical presentation. RDoC, on the other hand, was developed to address limitations in the current diagnostic systems by focusing on neurobiology and behavioral dimensions that cut across traditional diagnostic boundaries. RDoC organizes research into five main domains (negative valence systems, positive valence systems, cognitive systems, social processes, and arousal/regulatory systems), each of which can be studied at various levels of analysis, from genes to self-report. While the DSM-5-TR is immediately applicable in clinical settings, RDoC is primarily a research framework aimed at advancing our understanding of the biological and psychological mechanisms underlying mental health disorders, with the long-term goal of informing future diagnostic systems and treatment approaches.

NETWORK ANALYSIS APPROACH

The Network Analysis Approach represents a significant shift in how mental disorders are conceptualized and studied, with implications for the DSM-5-TR and future iterations of diagnostic manuals [29]. Unlike the traditional DSM approach, which views mental disorders as discrete categories caused by underlying latent variables, the Network Analysis Approach posits that mental disorders are complex systems of interacting symptoms. This approach focuses on how symptoms directly influence each other rather than being caused by an underlying disorder. For example, insomnia might lead to fatigue, which could then cause concentration problems.

Network analysis offers a new perspective on comorbidity, suggesting that disorders co-occur because of shared symptoms that bridge different symptom networks. While the DSM-5-TR still essentially uses a categorical approach to diagnosis, network analysis aligns more closely with dimensional models of psychopathology, which are gaining traction in psychiatric research. This approach allows for a more personalized understanding of an individual's symptom patterns, potentially leading to more tailored treatment approaches than those based on broad DSM categories.

Studies using network analysis have provided insights into the structure of various DSM disorders, including depression, anxiety, and PTSD, potentially informing future revisions of the manual. The network approach suggests that targeting central symptoms in a network might be more effective than treating all symptoms equally, which could influence how DSM disorders are conceptualized and treated. While not directly incorporated into the DSM-5-TR, network analysis can be seen as complementary to current diagnostic practices, offering additional insights into the structure and dynamics of mental disorders. As network analysis gains more empirical support, it may influence future revisions of the DSM, potentially leading to more dynamic and interconnected models of mental disorders.

TRANSDIAGNOSTIC APPROACHES

Transdiagnostic approaches represent a shift from the traditional categorical diagnostic system used in the DSM-5-TR, instead focusing on standard processes and factors that cut across multiple disorders [30]. While the DSM-5-TR maintains a categorical approach to diagnosis, it has incorporated some transdiagnostic elements, reflecting the growing recognition of shared features across disorders. For example, the DSM-5-TR includes dimensional assessments and cross-cutting symptom measures that can be applied across diagnostic categories. Additionally, the manual's text revisions have emphasized common risk factors, comorbidities, and overlapping symptoms between disorders.

The transdiagnostic perspective aligns with emerging research, suggesting that many mental health conditions share underlying psychological and biological mechanisms. This approach aims to identify core processes that contribute to developing and maintaining various disorders, potentially leading to more efficient and effective treatments. While the DSM-5-TR does not fully embrace a transdiagnostic framework, its updates reflect a growing awareness of the limitations of strict categorical diagnoses. The inclusion of dimensional assessments and the emphasis on comorbidity in the DSM-5-TR can be seen as steps toward a more nuanced understanding of mental health that aligns with transdiagnostic principles. However, the fundamental structure of the DSM-5-TR remains rooted in discrete diagnostic categories, highlighting the ongoing tension between categorical and dimensional approaches to understanding and treating mental health disorders.

CLINICAL STAGING MODELS

Clinical staging models represent an alternative approach to psychiatric diagnosis and treatment that has gained attention in recent years [31]. However, they are not formally incorporated into the DSM-5-TR. These models aim to identify where individuals lie along a continuum of illness, from at-risk to chronic and severe conditions. Unlike the categorical approach of the DSM-5-TR, clinical staging models emphasize the progression and extension of mental disorders over time. They propose that mental health problems develop through a series of stages, each with distinct clinical and neurobiological features.

While the DSM-5-TR maintains a primarily categorical approach to diagnosis, it does acknowledge the potential utility of dimensional assessments and cross-cutting symptom measures, which align somewhat with the principles of clinical staging. The DSM-5-TR's emphasis on early identification and intervention for mental health problems also resonates with the goals of clinical staging models. However, the DSM-5-TR does not formally adopt a staging framework for any disorders. Some researchers argue that integrating clinical staging models into future revisions of the DSM could enhance its clinical utility, particularly for youth mental health and early intervention services. These models could potentially bridge the gap between categorical diagnoses and the complex, often overlapping presentations seen in clinical practice. As research in this area progresses, future editions of the DSM may incorporate more elements of clinical staging, particularly if evidence continues to support its utility in improving treatment selection and understanding patterns of illness progression.

PERSONALIZED DIAGNOSIS

Personalized diagnosis represents a shift away from the categorical approach used in the DSM-5-TR towards a more individualized understanding of mental health conditions [31]. While the DSM-5-TR provides standardized diagnostic criteria for mental disorders, personalized diagnosis aims to tailor the diagnostic process to everyone's unique biological, psychological, and social characteristics.

The DSM-5-TR relies on symptom-based criteria to categorize mental disorders, which allows for consistency in diagnosis across clinicians and settings. However, this approach has been criticized for not fully capturing the complexity and heterogeneity of mental health presentations. In contrast, personalized diagnosis incorporates a broader range of data, including genetic information, biomarkers, environmental factors, and individual life experiences. This approach often utilizes advanced technologies like machine learning to predict individual outcomes and treatment responses. While the DSM-5-TR has made some moves towards dimensionality, such as including severity specifiers and cross-cutting symptom measures, personalized diagnosis goes further by considering the unique combination of factors that contribute to an individual's mental health status. This approach aligns with the growing understanding that mental disorders are complex and multifaceted, influenced by a variety of interacting factors. However, while personalized diagnosis holds promise for improving treatment outcomes and understanding individual variations in mental health, it is still an evolving field. The DSM-5-TR remains the standard for clinical diagnosis in many settings due to its established reliability and utility in professional communication. As research in personalized diagnosis advances, it may increasingly complement and potentially reshape traditional diagnostic approaches in future iterations of diagnostic manuals.

CULTURAL FORMULATIONS

The DSM-5-TR continues and expands upon the emphasis on cultural considerations in psychiatric diagnosis introduced in previous editions. The manual includes a dedicated chapter titled "Culture and Psychiatric Diagnosis" in Section III, which provides comprehensive guidance on integrating cultural concepts into clinical practice. This chapter introduces the Cultural Formulation Interview (CFI), a semi-structured interview guide designed to help clinicians systematically assess cultural factors that may impact a patient's mental health presentation, diagnosis, and treatment.

The CFI consists of 16 questions that explore the patient's cultural identity, explanatory models of illness, psychosocial stressors, cultural features of the patient-clinician relationship, and overall cultural assessment. Additionally, the DSM-5-TR includes 12 supplementary modules to the CFI that allow for more in-depth exploration of specific cultural domains such as explanatory models, level of functioning, social network, and cultural identity. These tools aim to enhance cultural competence in clinical practice and improve the accuracy and relevance of psychiatric diagnoses across diverse populations.

Throughout the manual, each disorder includes sections on "Culture-Related Diagnostic Issues" and "Sex- and Gender-Related Diagnostic Issues," which have been updated to reflect current research and understanding of how cultural and gender factors may influence the presentation, prevalence, and course of mental disorders. The DSM-5-TR also emphasizes the importance of considering the impact of racism, discrimination, and other social determinants of mental health in assessment and diagnosis. This comprehensive approach to cultural formulation in the DSM-5-TR represents a significant step towards more culturally sensitive and accurate psychiatric diagnosis and treatment planning.

DSM-6: WHAT TO EXPECT

While the exact DSM-6 release date has not been officially announced, based on historical patterns, it is anticipated to be released sometime between 2023 and 2028. The development of a new DSM edition is a complex process involving extensive research, expert input, and rigorous review, which can impact the release timeline. The DSM-6 is expected to build upon the foundations laid by its predecessors, incorporating the latest research findings and clinical insights further to improve the diagnosis and treatment of mental disorders. Some potential areas of focus for updates and changes in the DSM-6 may include:

- Refinement of diagnostic criteria for existing disorders, aiming to enhance the validity and reliability of psychiatric diagnoses.
- Introducing new disorders or reclassification of existing ones based on emerging research and clinical evidence.
- Updates to reflect advancements in neuroscience and our understanding of the biological basis of mental disorders.
- Further emphasis on dimensional approaches to diagnosis, allowing for a more nuanced assessment of symptom severity and presentation.
- Incorporation of cultural and social factors in diagnostic criteria, recognizing the impact of diverse backgrounds on mental health.
- Potential revisions to specific disorder categories such as autism spectrum disorders, neurocognitive disorders, and substance use disorders.
- Integration of new technologies and digital health considerations in diagnostic processes.

The DSM-6 will likely continue aligning with the International Classification of Diseases (ICD) to ensure consistency in coding and diagnostic practices across different healthcare systems. This alignment facilitates effective communication between healthcare providers and supports research efforts globally. As with previous editions, the development of DSM-6 will involve collaboration among numerous experts and professionals in the field. The APA typically forms various work groups and task forces to review current literature, conduct field trials, and propose revisions. This process ensures a comprehensive and rigorous approach to updating the manual. It is important to note that while these potential changes are based on current trends and expectations in psychiatry, the specific details of DSM-6 revisions will only be confirmed upon its official release. Mental health professionals, researchers, and stakeholders in the field should stay informed about updates from the APA regarding the development and eventual release of DSM-6.

CONCLUSION

The DSM-5-TR represents a significant update to the DSM-5, incorporating new research findings and clinical insights accumulated since 2013. Fundamental changes include adding new diagnostic entities like prolonged grief disorder, clarifying existing diagnostic criteria for over 70 disorders, updating terminology, and comprehensive text revisions. The manual also introduced new symptom codes for suicidal behavior and nonsuicidal self-injury and placed increased emphasis on cultural sensitivity and addressing issues related to racism and discrimination.

In the future, the DSM is expected to continue evolving as a "living document" that can be updated on an ongoing basis rather than at set intervals. The APA has implemented a continuous improvement model, allowing for empirically driven changes as new research emerges. This approach keeps the manual current with the latest scientific understanding of mental disorders.

Future editions of the DSM may incorporate more dimensional approaches to diagnosis, further integration of biological and neuroscience findings, and potentially closer alignment with other frameworks like the RDoC project. There is also an ongoing effort to improve the manual's utility for clinicians and researchers while addressing concerns about heterogeneity within diagnoses and comorbidity.

As the field of psychiatry advances, the DSM will likely continue to face challenges in balancing categorical and dimensional approaches to mental disorders, incorporating new research findings, and maintaining clinical utility. The development of DSM-6, which may be a decade away, will involve extensive collaboration among experts and stakeholders to address these challenges and further refine the classification and diagnosis of mental disorders.

Customer Information/Answer Sheet/Evaluation are located on pages 101–104.

TEST QUESTIONS
#76760 A CLINICIAN'S GUIDE TO DSM-5-TR

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 9 clock hour activity must be completed by December 31, 2027.

1. Which new diagnosis was added to the DSM-5-TR?
- A) *Chronic fatigue syndrome*
- B) *Internet gaming disorder*
- C) *Prolonged grief disorder*
- D) *Misophonia*

2. How many disorder criteria sets were modified for clarification in the DSM-5-TR?
- A) *More than 50*
- B) *More than 70*
- C) *About 20*
- D) *More than 100*

3. Which of the following is NOT a new symptom code added in the DSM-5-TR?
- A) *Suicidal behavior*
- B) *Nonsuicidal self-injury (NSSI)*
- C) *Panic attacks*
- D) *No diagnosis or condition*

4. What term replaced "desired gender" in the Gender Dysphoria chapter of the DSM-5-TR?
- A) *Preferred gender*
- B) *Chosen gender*
- C) *Identified gender*
- D) *Experienced gender*

5. Which group was formed to review references to ethnicity and race in the DSM-5-TR?
- A) *Cultural Competence Committee*
- B) *Ethnoracial Equity and Inclusion Work Group*
- C) *Diversity in Diagnosis Task Force*
- D) *Race and Ethnicity Review Board*

6. Caffeine use disorder is included in the DSM-5-TR as
- A) *a fully recognized diagnostic category.*
- B) *a condition for further study.*
- C) *a subtype of stimulant use disorder.*
- D) *It is not included at all.*

7. Which of the following symptom codes were added to the DSM-5-TR?
- A) *Codes for current suicide behavior only*
- B) *Codes for a history of NSSI only*
- C) *Codes for both current and historical suicidal behavior and NSSI*
- D) *No new codes were added.*

8. Which of the following best describes a fundamental difference between the Hierarchical Taxonomy of Psychopathology (HiTOP) approach and the DSM-5-TR?
- A) *HiTOP uses categorical diagnoses, while the DSM-5-TR uses dimensional ratings.*
- B) *HiTOP organizes symptoms into dimensional spectra, while DSM-5-TR primarily uses discrete categories.*
- C) *HiTOP is based on expert consensus, while DSM-5-TR is based on factor analysis.*
- D) *HiTOP includes more mental disorders than DSM-5-TR.*

9. In the DSM-5-TR, Internet gaming disorder (IGD) is
- A) *a fully recognized diagnostic category.*
- B) *a condition for further study.*
- C) *a subtype of stimulant use disorder.*
- D) *not included at all.*

10. Approximately how many mental disorders were cataloged in the DSM-II (1968 edition)?
- A) *25 disorders*
- B) *265 disorders*
- C) *182 disorders*
- D) *300 disorders*

11. According to the DSM-5-TR, when should the diagnosis of unspecified mood disorder be used?
- A) *When symptoms meet the criteria for either bipolar disorder or major depressive disorder*
- B) *Only in emergency department settings where there is limited time for assessment*
- C) *When a patient has been previously diagnosed with a specific mood disorder but is currently in remission*
- D) *When symptoms do not meet the full criteria for any specific mood disorder, and it is difficult to choose between unspecified bipolar and unspecified depressive disorder*

12. Why did the DSM-5-TR update its terminology?
- A) *To align with new diagnostic categories*
- B) *To reflect current preferred usage and promote inclusivity*
- C) *To simplify the language for non-professionals*
- D) *To match terminology used in the ICD-11*

13. The DSM-5-TR introduced a new diagnostic option of no diagnosis or condition. What was the primary reason for this addition?
- A) *To reduce overdiagnosis of mental disorders*
- B) *To provide a billing code for insurance purposes*
- C) *To acknowledge that not all distress requires a mental disorder diagnosis*
- D) *To replace the "diagnosis deferred" option from previous editions*

14. What ICD-10 code was added in the DSM-5-TR for prolonged grief disorder?
- A) *F43.20*
- B) *F43.81*
- C) *F43.8*
- D) *Z63.4*

15. What is the primary purpose of the Cultural Formulation Interview (CFI) in the DSM-5-TR?
- A) *To diagnose culture-bound syndromes*
- B) *To assess language proficiency in non-native English speakers*
- C) *To gather culturally relevant information to inform diagnosis and treatment planning*
- D) *To determine a patient's racial and ethnic background*

16. Which of the following best describes the criticism regarding biomarkers in the DSM-5-TR?
- A) *The DSM-5-TR includes too many biomarkers, leading to overdiagnosis.*
- B) *The lack of reliable biomarkers in the DSM-5-TR undermines its validity as a diagnostic tool.*
- C) *The DSM-5-TR relies too heavily on biomarkers, ignoring psychological factors.*
- D) *Biomarkers in the DSM-5-TR are not specific enough to differentiate between disorders.*

17. Which of the following is included in Section III of the DSM-5-TR?
- A) *Alternative DSM-5 model for personality disorders*
- B) *Cultural Formulation Interview*
- C) *Dimensional approach to diagnosis*
- D) *All of the above*

18. Nonsuicidal self-injury disorder (NSSID) is included in DSM-5-TR under
- A) *Disruptive, Impulse-Control, and Conduct Disorders.*
- B) *Neurodevelopmental disorders.*
- C) *Suicidal Self-Injury Disorder.*
- D) *Conditions for Further Study.*

19. Attenuated psychosis syndrome (APS) is included in the DSM-5-TR as a condition for further study. How can identifying APS potentially help in the management of psychotic disorders?
- A) *By allowing for immediate diagnosis and treatment of schizophrenia*
- B) *By enabling early intervention before full psychotic symptoms develop*
- C) *By preventing all cases of APS from progressing to psychosis*
- D) *By replacing the need for antipsychotic medications*

20. Which of the following best describes a key difference between the Research Domain Criteria (RDoC) approach and the DSM-5-TR?
- A) *RDoC uses categorical diagnoses, while the DSM-5-TR uses dimensional ratings.*
- B) *RDoC organizes symptoms into dimensional spectra, while the DSM-5-TR primarily uses discrete categories.*
- C) *RDoC is based on expert consensus, while the DSM-5-TR is based on factor analysis.*
- D) *RDoC includes more mental disorders than the DSM-5-TR.*

21. What was the primary goal of developing the DSM-5-TR?
- A) *To completely restructure mental health diagnoses*
- B) *To provide updated information based on new research since DSM-5*
- C) *To eliminate all previous diagnostic categories*
- D) *To reduce the number of mental health diagnoses*

22. When was the first large-scale attempt at generating mental health diagnoses published?
- A) *1917*
- B) *1840s*
- C) *1952*
- D) *1968*

Test questions continue on next page ➞

23. Which of the following best describes the iterative revision process in DSM-5-TR?
- A) *Updates occur only every 20 years*
- B) *Changes can only be made by the APA board*
- C) *Allows for ongoing updates based on emerging research*
- D) *Requires complete manual revision for any changes*

24. What is the primary characteristic of prolonged grief disorder in adults?
- A) *Symptoms lasting at least 6 months*
- B) *Symptoms lasting at least 12 months*
- C) *Symptoms lasting at least 18 months*
- D) *Symptoms lasting at least 24 months*

25. How many symptoms from the additional criteria must be present for a prolonged grief disorder diagnosis?
- A) *At least one*
- B) *At least two*
- C) *At least three*
- D) *At least four*

26. Which new diagnostic code was added in DSM-5-TR for individuals with no mental health diagnosis?
- A) *Caffeine use disorder*
- B) *No diagnosis or condition*
- C) *Autism spectrum disorder*
- D) *Mood disorder with hypomania*

27. What is the minimum duration required for hypomanic episodes in depressive episodes with short-duration hypomania?
- A) *One day*
- B) *Two days*
- C) *Three days*
- D) *Four days*

28. How many criteria must be met for a potential caffeine use disorder diagnosis?
- A) *Two criteria*
- B) *Three criteria*
- C) *Four criteria*
- D) *Five criteria*

29. What is the minimum number of symptoms required for Internet gaming disorder diagnosis?
- A) *Three symptoms*
- B) *Four symptoms*
- C) *Five symptoms*
- D) *Six symptoms*

30. Which of the following is a core symptom of prolonged grief disorder?
- A) *Sleep disturbance*
- B) *Intense yearning for the deceased*
- C) *Weight loss*
- D) *Panic attacks*

31. What is the primary focus of the HiTOP diagnostic approach?
- A) *Categorical classification*
- B) *Dimensional, data-driven approach*
- C) *Expert consensus only*
- D) *Cultural factors exclusively*

32. How many domains does the Research Domain Criteria (RDoC) framework organize research into?
- A) *Three domains*
- B) *Four domains*
- C) *Five domains*
- D) *Six domains*

33. What is the key feature of the Network Analysis Approach to mental disorders?
- A) *Views disorders as discrete categories*
- B) *Focuses on underlying latent variables*
- C) *Views symptoms as directly influencing each other*
- D) *Emphasizes cultural factors only*

34. When was the DSM-III published?
- A) *1968*
- B) *1974*
- C) *1980*
- D) *1987*

35. What was a significant change in DSM-III compared to previous versions?
- A) *Removal of all diagnostic criteria*
- B) *Introduction of the multiaxial system*
- C) *Elimination of all personality disorders*
- D) *Focus on theoretical approaches only*

36. How many disorders were included in DSM-II?
- A) *106 disorders*
- B) *182 disorders*
- C) *265 disorders*
- D) *297 disorders*

37. What is the primary purpose of the Cultural Formulation Interview in DSM-5-TR?
- A) *To diagnose specific cultural disorders*
- B) *To systematically assess cultural factors affecting mental health*
- C) *To determine treatment duration*
- D) *To evaluate medication effectiveness*

38. Which of the following is a key feature of the Clinical Staging Models approach?
- A) *Categorical diagnosis only*
- B) *Focus on progression of mental disorders over time*
- C) *Exclusive use of biological markers*
- D) *Rejection of all traditional diagnoses*

39. What is the minimum number of days of self-injury required within the past year for a diagnosis of nonsuicidal self-injury disorder?
- A) *Three days*
- B) *Four days*
- C) *Five days*
- D) *Six days*

40. Which of the following best describes the DSM-5-TR's approach to suicidal behavior?
- A) *Requires specific medication protocols*
- B) *Added new symptom codes for documentation*
- C) *Eliminated all previous suicide-related criteria*
- D) *Focuses only on prevention strategies*

41. What is a key characteristic of stimulant-induced mild neurocognitive disorder?
- A) *Severe interference with daily activities*
- B) *Complete loss of cognitive function*
- C) *Requires more mental effort but maintains independence*
- D) *Only occurs during active stimulant use*

42. How many questions are included in the Cultural Formulation Interview?
- A) *12 questions*
- B) *14 questions*
- C) *16 questions*
- D) *18 questions*

43. What is the primary focus of the Personalized Diagnosis approach?
- A) *Standardized diagnostic criteria only*
- B) *Categorical classification*
- C) *Individual biological, psychological, and social characteristics*
- D) *Cultural factors exclusively*

44. Which of the following is a proposed criteria for the diagnosis of Internet gaming disorder?
- A) *Gaming exclusively for monetary gain*
- B) *Gaming only during specific hours*
- C) *Persistent and recurrent use of Internet games*
- D) *Playing only specific types of games*

45. What is the minimum duration of symptoms required for prolonged grief disorder in children?
- A) *3 months*
- B) *6 months*
- C) *9 months*
- D) *12 months*

46. How many work groups were involved in the DSM-5-TR development process?
- A) *5*
- B) *8*
- C) *10*
- D) *12*

47. What is a key feature of the Transdiagnostic Approach to diagnosis of metal disorders?
- A) *Focus on discrete diagnostic categories*
- B) *Emphasis on standard processes across multiple disorders*
- C) *Exclusive use of biological markers*
- D) *Rejection of all psychological factors*

48. When did the revision process for DSM-5 begin?
- A) *1995*
- B) *1997*
- C) *1999*
- D) *2001*

49. What is the primary purpose of the no diagnosis or condition code in DSM-5-TR?
- A) *To indicate incomplete evaluations*
- B) *To document that a thorough evaluation found no mental disorder*
- C) *To replace all other diagnostic codes*
- D) *To indicate treatment failure*

50. Which of the following best describes the DSM-5-TR's approach to cultural considerations?
- A) *Eliminated all cultural considerations*
- B) *Added comprehensive cultural assessment guidance*
- C) *Limited cultural factors to specific disorders*
- D) *Focused only on Western cultural perspectives*

Be sure to transfer your answers to the Answer Sheet located on page 102.
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.

Child Abuse in Ethnic Minority and Immigrant Communities

10 Cultural Continuing Education Credits

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

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

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

1. Describe the historical emergence of child abuse and neglect.
2. Identify federal policies in the United States to address child abuse and neglect.
3. Define child abuse and neglect.
4. Outline the international prevalence of child abuse and neglect and variations in defining child maltreatment.
5. Discuss the impact of child abuse and neglect in the United States and Canada, particularly among ethnic minority groups.
6. Analyze how race, ethnicity, and culture impacts ethnic minority families' parenting styles and disciplining.
7. Identify the role of ecologic factors on the risk for child abuse and neglect.
8. Describe cultural theoretical frameworks to guide practice.
9. Discuss child abuse assessment, intervention, and training that consist of culturally sensitive best practice values.
10. Identify self-care issues and practices for practitioners working with child abuse cases.

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 can be found online at NetCE.com.)

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
Ronald Runciman, MD
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Margaret Donohue, PhD

Senior Director of Development and Academic Affairs
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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.

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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 10 Cultural continuing education credits.

Individual State Behavioral Health Approvals
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INTRODUCTION

The United States' demographic landscape is diverse and multicultural, and minority and immigrant children are projected to constitute a significant population of the school systems in the United States in the near future. In 2022, for example, 49% of the children in the United States were non-Hispanic White [8]. In 2020, non-Hispanic White children younger than 18 years of age constituted 71.6% of minor-age population [3]. Hispanic children constituted 25.5% in 2020, and it is projected they will grow to 31.9% by 2060 [3]. In 2018, the District of Columbia, Hawaii, Washington, New Mexico, and California are the states/territories that had the largest number of non-White children younger than 15 years of age [1].

As of 2019, an estimated 26% of children younger than 18 years of age in the United States (18 million) reside with at least one immigrant parent [195]. This group tends toward lower socioeconomic statuses, and as of 2021, the poverty rates for Black and Hispanic children were 27.3% and 22.4%, respectively, both of which were significantly greater than the poverty rate (8.8%) of non-Hispanic White children [8]. Almost 75% of racial and ethnic minority children live in poverty, and African American and Hispanic children are twice as likely as White children to experience food insecurity [12].

The process of immigration involves uprooting from the familiar—leaving one's homeland, family, friends, work, lifestyle, and in some cases, even value systems behind [4]. The adaptation process for immigrants often entails social, psychologic, and economic stressors. Many require new skills to navigate a new social and cultural system. Furthermore, immigrant families may be isolated, and isolation, along with the stressors, increases these families' vulnerability to child maltreatment and other problems [2]. Many immigrant families are reluctant to seek or accept formal assistance from medical and social service institutions given past experiences with oppression, fear of being deported, and general distrust of authority figures [2].

Despite these trends, the literature examining child abuse in immigrant and ethnic minority families is quite minimal when compared to the larger picture of child abuse/maltreatment research. In a meta-analysis of articles published between 1999 and 2002 on child abuse in America, researchers found that only 12% of the studies focused on ethnicity [5]. Of the 489 articles that did examine ethnicity, 52.3% found ethnicity to have a statistically significant effect on child abuse and help seeking, which emphasizes the importance of considering the role of ethnicity in child abuse and neglect.

Racial minority children are also over-represented in the child welfare system [48]. For example, in 2019, African American children constituted 14% of the child population in the United States, but they represented 23% of the foster care population [23]. In 2020, a total of 3.9 million reports came in to child welfare agencies in the United States. These

reports represented 7.1 million children. Black children were twice as likely as White children to be represented in these reports [37]. After initial screening, Black children are two to five times more likely than White children to have their cases screened in for further investigation [297].

Finally, when addressing child abuse with racial and ethnic minority families, practitioners should be knowledgeable about various cultures, values, and belief systems in order to formulate interventions that are culturally sensitive and competent [2].

HISTORICAL OVERVIEW OF CHILD WELFARE AND PROTECTIVE SERVICES

HISTORICAL VIEWS OF CHILDREN

The notion of childhood in Europe during the Middle Ages was very different from contemporary Western views. Childhood was not necessarily viewed as a distinct stage of the life cycle; rather, children were viewed as miniature adults [6; 352]. Childhood was a time to teach skills to prepare children for being adults [352]. It was not until the 15th and 16th centuries, with the rise of the middle class, that childhood began to be considered a separate developmental stage [6]. John Locke, for example, argued that a child's mind was a blank slate, prime for being shaped by experiences [352]. Many Renaissance scholars argued that children had their own unique needs, which were distinct from adults; however, this perspective was primarily held by the upper middle class [7].

A dualistic perspective about children emerged during the Reformation in the 16th century. Children were viewed as God's creatures, to be loved and protected, but also as sinful humans [353]. As a result, parents, teachers, preachers, and adults who were responsible for the moral upbringing and socialization of children were encouraged to use strict discipline to correct the evilness that was part of their human nature [353].

By the mid-19th century, a romantic perspective emerged and children began to be seen as the "torchbearers" of the future [7]. There was much emphasis on education, training, and the overall nurturance of children. The increase in industrialization and urbanization of the early 20th century resulted in heightened crime, poverty, and social disorganization, all of which affected children. As a consequence, social reforms targeted to children, such as child labor restrictions and compulsory education laws, began to emerge [93]. Massachusetts was the first state to pass a child labor law in 1851, which propounded that children younger than 15 years of age were required to attend school for at least three months out of the year in order to remain working in factories [352]. During the middle of the 20th century, there was increased emphasis on the rights of children, in part because of the grassroots movements advocating for the rights of disenfranchised populations [93]. In 1938, for example, President Franklin Roosevelt signed the Fair Labor Standards Act, which addressed child labor [352].

HISTORY OF CHILD ABUSE AND NEGLECT

The terms "child abuse," "child neglect," and "child maltreatment" are relatively new terms despite the fact that this social problem has existed through the ages. Records have documented cruelty to children by adults throughout the ages and across societies. Physical abuse has historically been justified because it was believed that severe physical punishment was necessary to discipline, to rid the child of his or her evil nature, and to educate children [9].

Sexual abuse of children, particularly incest (i.e., sex between family members), is very much a taboo. As early as the 16th century in England there have been concerted efforts to protect children from sexual abuse. For example, boys were protected from forced sodomy, and girls younger than 10 years of age were protected from forcible rape [9]. In the late 1890s, Sigmund Freud began seeing patients, many of whom were women and described memories of sexual abuse during their childhoods. Freud dismissed these as fantasies rooted in female psychopathology [192]. Freud's speculations contributed to later concerns about the reliability of sexual abuse reports [192]. As late as the 1920s, sexual abuse of children was described as an assault committed by "strangers" and the victim was perceived as a "temptress" rather than an innocent child [9].

The Massachusetts Adoption of Children Act of 1851 was the precursor of the modern U.S. foster care system [29]. In accordance with this Act, judges are required to determine if adoptive parents are fit to raise a child [29]. Between 1850 and 1919, the foster care movement was prominent in the United States, and it was within this landscape that the first child abuse case arose [29].

The first public case of child abuse in the United States that garnered widespread interest took place in 1866 in New York City. The child, Mary Ellen Wilson, was 10 years of age and lived with foster parents [10]. Neighbors became concerned that she was being mistreated; however, her foster parents refused to change their behaviors and said they could treat the child as they wished [9]. Because there were no agencies established to protect children specifically, Henry Berge, founder of the Society for the Prevention of Cruelty to Animals, intervened on her behalf [10]. He argued that she was a member of the animal kingdom and deserved protection. The case received much publicity, and as a result, the New York Society for the Prevention of Cruelty to Children was formed in 1874 [10]. By 1919, all but three states had juvenile courts. However, many of these nongovernmental agencies could not sustain themselves during the Depression [193]. Today, every state has a child protective services (CPS) system in place.

In 1946, a pediatric radiologist by the name of John Caffey published an article that talked about six young children he had seen with unexplained subdural hematoma and leg and arm fractures [193]. Although Caffey never used the word "abuse," it was implied, and this article generated some interest among physicians.

In 1962, Kempe and Heller published a study titled *The Battered-Child Syndrome*, in which they argued that battered-child syndrome consisted of traumatic injuries to the head and long bones, most commonly in children younger than 3 years of age and perpetrated by parents [11]. This is considered a seminal article in the child abuse field as it alerted both the general public and the academic community to the problem of child abuse [9].

Child abuse and neglect are now considered significant social problems with deleterious consequences. As noted, a system has been implemented in all 50 states to ensure the safety of children, with laws defining what constitutes abuse and neglect and mandated reporters of abuse.

LEGISLATIVE RESPONSES IN THE UNITED STATES

There is some evidence of legal protection for children dating back to colonial America. For example, in 1642 in Massachusetts, there was a law that gave local magistrates the power to remove children from homes where parents were not "training up" their children [193]. In Georgia in 1735, an orphan girl was removed from a home where she was being abused sexually [193].

For the most part, in the 19th and early part of the 20th century, child protection responses were led by nongovernmental agencies [193]. Beginning in 1912, the federal government began to be involved. For example, the Children's Bureau was created, and the Sheppard-Towner Act was implemented to provide federal funds to health services for mothers and children [193].

The first major federal response can be traced to President Roosevelt's New Deal. A federal program for child welfare services was approved under the Social Security Act in 1935 [13]. The Federal Government provided grants-in-aid to states to assist in the development of state child welfare agencies and programs to deliver services to protect children. Over the years, the federal government has continued the funding, with the expectation that states will match the funds [13].

In the 1950s, there was an emphasis on maintaining children in their own families, referred to as child permanency, as studies demonstrated the negative effects of separating children from families for extended periods of time. The notion of child permanency is based on the belief that the family is paramount, the parent and child dyad is crucial for child development, and family stability has long-term positive impacts on children [14]. Ultimately, CPS must remove children from homes in some cases, and before this time, many children were in the custody of the state, without having any sense of permanency [14]. The emphasis on child permanency resulted in a move away from foster care placement and toward working with families to provide services to strengthen the family system.

In 1974, the Child Abuse Prevention and Treatment Act (CAPTA) was authorized under the Title XX Social Services Program. This federal legislation was targeted at states' responses to child maltreatment and focused on prevention, investigation, prosecution, and the delivery of a range of social services targeted to child abuse and neglect. It also encouraged demonstration research projects to examine how best to prevent child maltreatment and to evaluate various child abuse and neglect services [15; 16; 17]. This act was most recently re-amended in 2003 by the Keeping Children and Families Safe Act [17].

In 1978, the Indian Child Welfare Act (ICWA) was added to CAPTA to protect Native American children in the child welfare system [15]. Congress observed that Native American children removed from their homes were often placed in non-Native American homes. Furthermore, the mainstream judicial and social work systems were not familiar with traditional Native American value systems regarding childrearing and socialization, which resulted in labeling these homes dysfunctional [18]. The emphasis of the ICWA is on reunification of the child with the family; if a child is removed, efforts should be focused on helping the family resolve issues that triggered removal [19]. Ultimately, this act was intended to help maintain the integrity of the Native American nations, cultures, and families [18]. The ICWA has been criticized for being inadequately funded, for the lack of tribal involvement, and for reverse discrimination [194].

In 1980, the Adoption Assistance and Child Welfare Act was enacted. This act emphasized that foster care was not a permanent service; rather, it was crucial to reunite families by providing services to strengthen the family system [14]. This was a federal response to three main problems in child welfare at that time: an anti-family bias, causing children to be removed from their families without exploring other options; lack of individualized case planning based on each child; and a bias in federal funding incentives toward placing children in foster care versus returning children to homes or adoption [15]. This was further expanded by the Adoption and Safe Families Act (ASFA) of 1997 [16]. This act stressed time limits for foster care, reunification of the child with the family, and better linkage between child welfare services and other supportive services [14; 16].

The United States has continued to pass legislation to protect children. In 2007 and 2008, several states enhanced the review process for child fatalities [234]. During this period, Maryland, Missouri, Washington, California, Delaware, Maine, and Maryland passed legislation requiring a specific and systematic child fatality review process [234]. On a national level, CAPTA was reauthorized in 2010, which assists states to continue to provide services to identify and prevent child abuse and neglect [280].

In 2014, the Preventing Sex Trafficking and Strengthening Families Act was signed into law [240]. This law ensures that states implement mechanisms for reporting and collecting data on sex trafficking and identifying children who may be at risk of becoming victims of sex trafficking [240]. It also strengthens existing laws related to adoption incentives and the provision of services to foster parents [240].

In 2015, the Justice for Victims of Trafficking Act was enacted with the goal of providing grants to organizations and programs that deliver services for victims of child pornography and domestic child human trafficking and training for law enforcement officers, child welfare, and healthcare providers in order to better identify child human trafficking victims [279]. In addition, CAPTA modified the Comprehensive Addiction and Recovery Act of 2016 to include a provision for states to develop safety plans for the follow-up care of infants affected by substance abuse, withdrawal symptoms, or fetal alcohol syndrome [280]. In 2018, the Family First Prevention Services Act allowed federal funding for services for families whose children were at risk of being removed, including the provision of mental health, substance abuse, and parenting enhancement skills services [45]. Beginning in 2020, human resource employees working in a business with five or more employees are considered mandated reporters under the Child Abuse and Neglect Reporting Act [51]. In 2023, support for kinship caregivers was enhanced. Family kinship caregivers (e.g., grandparents, aunts, uncles) can more easily step in to provide foster care for children. They are still required to undergo regulatory screening and an application process; however, the process is simplified. In addition, kinship caregivers and given the same level of financial assistance as other foster care parents [354].

DEFINITIONS AND TYPES OF CHILD ABUSE AND NEGLECT

The federal definition of child abuse is formally established by CAPTA, which states that child abuse is any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act that presents an imminent risk of serious harm [20]. A child (in this case defined as an individual younger than 18 years of age) victim of trafficking is also considered a victim of child abuse/neglect [20].

FORMS OF CHILD ABUSE AND NEGLECT

There are several acts that may be considered abusive, and knowledge of what constitutes abuse is necessary for all healthcare providers and mandated reporters. In this section, specific behaviors that may be considered abuse and/or neglect will be reviewed.

Physical Abuse

Physical abuse injuries can range from minor bruises and lacerations to more severe neurologic trauma and even death. Physical abuse is one of the most easily identifiable forms of abuse and the type most commonly seen by healthcare professionals. Physical injuries that may be indicative of abuse include bruises, welts, burns, fractures, abdominal injuries, lacerations/abrasions, and central nervous system trauma [187].

Bruises and welts are of concern, particularly those appearing on:

- The face, lips, mouth, ears, eyes, neck, or head
- The trunk, back, buttocks, thighs, or extremities
- Multiple body surfaces

Patterns such as shapes of the article (a cord, belt buckle, teeth, or hand) used to inflict the bruise or welt should be noted. Cigar or cigarette burns are common, and they will often appear on the child's soles, palms, back, or buttocks. Patterned burns that resemble shapes of appliances, such as irons, burners, or grills, are of particular concern.

Fractures that result from abuse might be found on the child's skull, ribs, nose, or any facial structure. These may be multiple or spiral fractures at various stages of healing. When examining patients, note bruises on the abdominal wall; any intestinal perforation; ruptured liver or spleen; and blood vessel, kidney, bladder, or pancreatic injury, especially if accounts for cause do not make sense. Look for signs of abrasions on the child's wrists, ankles, neck, or torso. Lacerations might also appear on the child's lips, ears, eyes, mouth, or genitalia. If violent shaking or trauma occurred, the child might experience a subdural hematoma [187].

Sexual Abuse/Exploitation

Sexual abuse is defined by CAPTA as, "the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children" [20]. Child sexual abuse can be committed by a stranger or an individual known to the child. Sexual abuse may be manifested in many different ways, including [21; 196]:

- Verbal: Obscene phone calls or talking about sexual acts for the purpose of sexually arousing the adult perpetrator
- Voyeurism: Watching a child get dressed or encouraging the child to masturbate while the perpetrator watches
- Commercial sexual exploitation and child prostitution: Involving the child in sexual acts for monetary profit
- Child pornography: Taking photos of a child in sexually explicit poses or acts

- Exhibitionism: Exposing an adult's genitals to a child or forcing a child to observe the adult or other children in sexual acts
- Molestation: Touching, fondling, or kissing the child in a provocative manner; for example, fondling the child's genital area or long, lingering kisses
- Sexual penetration: The penetration of part of the perpetrator's body (e.g., finger, penis, tongue) into the child's body (e.g., mouth, vagina, anus)
- Rape: May involve sexual intercourse, sodomy, or penetration with a foreign object without the victim's consent, and may include violence or the threat of violence. This definition is wide in scope and does not necessarily involve physical touching, contact, or physical force. Instead, it encompasses sexual intent against an individual's will. It also takes into consideration consent, as some cannot consent due to their age, disability, fear of harm, and/or state of consciousness or intoxication.

Neglect

Due to the ambiguity of definitions of neglect, the Study of National Incidence and Prevalence of Child Abuse and Neglect has attempted to standardize the definition [20; 22]. According to the study, neglect may include [20; 22]:

- Failure to provide adequate food, clothing, shelter, hygiene, supervision, education, and protection
- Refusal and/or delay in medical attention and care (i.e., failure to provide needed medical attention as recommended by a healthcare professional or failure to seek timely and appropriate medical care for a health problem)
- Abandonment, characterized by desertion of a child without arranging adequate care and supervision (e.g., children who are not claimed within two days or who are left alone with no supervision and without any information about their parents'/caretakers' whereabouts)
- Expulsion or blatant refusals of custody on the part of parent/caretaker, such as ordering a child to leave the home without adequate arrangement of care by others
- Inadequate supervision (i.e., child is left unsupervised or inadequately supervised for extended periods of time)

Emotional Abuse

The following behaviors constitute emotional abuse and neglect [20; 22]:

- Verbal abuse: Belittling or making pejorative statements in front of the child, which results in a loss or negative impact on the child's self-esteem or self-worth
- Inadequate nurturance/affection: Inattention to the child's needs for affection and emotional support
- Witnessing domestic violence: Chronic spousal abuse in homes where the child witnesses the violence
- Substance and/or alcohol abuse: The parent/caretaker is aware of the child's substance misuse problem but chooses not to intervene or allows the behavior to continue
- Refusal or delay of psychologic care: Failure or delay in obtaining services for child's emotional, mental, or behavioral impairments
- Permitted chronic truancy: The child averages at least five days per month of school absence, and the parent/guardian does not intervene
- Failure to enroll: Failure to enroll or register a child of mandatory school age or causing the child to remain at home for nonlegitimate reasons
- Failure to access special education services: Refusal or failure to obtain recommended services or treatment for remedial or special education for a child's diagnosed learning disability

Parental Substance Abuse

Parental substance abuse falls into the category of child abuse and neglect in certain states [20]. This might include prenatal exposure due to the mother's use of an illegal substance, the manufacture of illegal substances in the presence of a child, or using substances that negatively affect caregiving abilities [20].

There has been some debate of whether exposing children to secondhand smoke is considered child abuse [241]. Some experts argue that if parents are informed by healthcare providers that the secondhand smoke is contributing to a child's illness (e.g., asthma, bronchitis) but do not make any attempts to protect the child from the smoke, it could be classified as child abuse [241].

Abandonment

In some states, abandonment is considered to be a type of child abuse or neglect [20]. CAPTA defines abandonment as, "when the parent's identity or whereabouts are unknown, the child has been left by the parent in circumstances in which the child suffers serious harm, or the parent has failed to maintain contact with the child or to provide reasonable support for a specified period of time" [20].

Trafficking

As noted, children who are the victim of trafficking are also considered child abuse victims [280]. Forms of child trafficking include forced labor, conscription, and sex trafficking. The 2015 Justice for Victims of Trafficking Act includes an amendment to CAPTA. In accordance with this amendment, states can track sex trafficking victim data. This was again expanded in 2016 to collect and report data related to infants with prenatal substance exposure. In 2018, there was a total of 27,709 infants reported in the category.

AN INTERNATIONAL PERSPECTIVE

When considering the implications of ethnicity and culture as they relate to child abuse, it is important to have an understanding of the global impact and experience of the problem. Particularly, there is controversy regarding whether various social problems are or should be considered child abuse and/or neglect.

INTERNATIONAL PREVALENCE OF CHILD ABUSE AND NEGLECT

Worldwide, it is estimated that approximately 80% of children between 1 and 14 years of age have experienced physical punishment and/or psychological aggression by a caregiver in the past month [239]. This was exacerbated during the coronavirus disease (COVID-19) pandemic due to increased economic stress and social isolation as well as decreased services to families [355]. A systematic study involving 14,360 children found a physical abuse rate of 18% and a psychological rate of 39% during the pandemic. Researchers found a strong relationship between unemployment and physical child abuse [356].

In terms of sexual abuse, one in 10 girls younger than 18 years of age are believed to have experienced forced intercourse and other sexual acts [282]. In addition, estimates indicate that as many as 275 million (one in seven) children worldwide witness violence in the home. In a meta-analysis, 26.6% of children were found to have experienced physical abuse, 26% neglect, 19.6% emotional abuse, and 8.7% sexual abuse [283].

In some countries, child abuse and fatalities are the result of gender inequality and discrimination [24]. The United Nations Children's Fund (UNICEF) estimates there are 50 million unregistered births every year, and in some countries, particularly in some parts of South Asia, infants who are murdered within days of their birth are registered as stillbirths [25; 26]. Girls are often the victims of infanticide because they are viewed as an economic liability. In India, for example, high dowry payments can make girls a financial burden for parents [242]. In China, the ratio of male to female infants is 117 to 100, an imbalance that is attributed to female infanticide [27]. China also leads the world in reports of cleft-related infanticides [245]. In some countries, girls are targeted even before they are born. Gender-specific feticide (whereby a fetus is aborted based on a sex determination test indicating the child would be a girl) is relatively common in some countries, such as China and India. In India, it is estimated that 10 million female fetuses have been illegally aborted [243].

In addition, female genital mutilation/cutting (FGM/C) is a common practice in some areas of the world, predominantly in Africa. In a Ghanaian study, the overall prevalence was 11.7%, but FGM/C trends varied significantly by region [281]. It is estimated that between 100 and 140 million girls and women in the world have experienced FGM/C [244]. A study conducted in Mali, in western Africa, almost three-quarters of the women with daughters had at least one daughter who had FGM/C [357]. Women who never read a newspaper or magazine were twice as likely to have a daughter who experienced FGM/C compared with those who read a newspaper/magazine at least once per week.

Ritual servitude is another potential form of child abuse or endangerment. In parts of Africa, mainly Ghana, Togo, and Benin, daughters younger than 10 years of age (due to their "virgin" status) are given to the priests in shrines in order to atone for sins and crimes of their dead ancestors [235]. These girls are generally expected to engage in sexual activity with the priest and elders.

Other independent studies support the UN's assertion that child abuse and neglect are common. In 2013–2014, there were 40,844 substantiated cases of child abuse and neglect in Australia [28]. A study of Iranian students 11 to 18 years of age found that more than one-third (38.5%) had experienced physical violence at home that resulted in mild-to-severe injury [30].

In a study of South African women between 15 and 49 years of age, approximately 21% disclosed having been forced to engage in sexual intercourse before the age of 15 years by a male relative [31]. One complication to obtaining data and an understanding of the extent of child sexual abuse is sanctioned forms, such as child marriages. Some countries and cultures are associated with high rates of child marriage [316].

INTERNATIONAL DEFINITIONS OF CHILD MALTREATMENT

In Western industrialized countries, it is typical to subdivide abuse and neglect into different categories, such as physical abuse, neglect, sexual abuse, and emotional abuse. All of these acts are forms of psychologic trauma and may have lifelong consequences. However, the categorization of certain social issues, such as child labor, FGM/C, honor killing, and child prostitution and trafficking, has been debated as they are not easily placed into an established abuse category [32]. The difficulty in reaching a consensus in this debate stems from several factors, including acceptability of behaviors that occur in a complex, multifaceted cultural context; variations in beliefs about childrearing and socialization; and lack of a universal method to measure child abuse and neglect [32; 316]. All of these factors reflect the competing paradigms regarding universal rights and respect for cultural differences [236].

In some developing countries, the proliferation of poverty, gender inequality, political instability, and violence make it difficult to focus solely on child abuse and neglect, as these social problems are often intertwined with the issues of child welfare and protection [33]. Furthermore, social, cultural, and religious norms may hinder the ability of government or

social organizations to fully implement protective policies. For example, androcentric cultural norms are deeply embedded in many countries, and to challenge the established patriarchal ideology would mean to challenge gender inequality and the structures that support this norm [33].

Female Genital Mutilation/Cutting

It is beyond the scope of this course to resolve the complex questions of culture and child abuse or to uphold one position over the other. This becomes very clear in the case of FGM/C. FGM/C generally refers to the cultural practice of cutting away a part of or all of a girl's external genitalia for a variety of cultural and social reasons [25]. However, some groups participate in ritual cutting or piercing of female genitalia that does not result in the removal of tissue. The motivation or goal does not appear to be to intentionally harm the child (although the procedure often does); rather, this practice is reflective of a set of prescribed, deeply rooted cultural norms. In some cultures, FGM/C acts as a social mechanism to control female sexuality. In other cultures, FGM/C is a ritual to initiate girls into womanhood [25]. The World Health Organization categorizes the various practices of FGM/C into four major types [34]:

- Clitoridectomy: Partial or total removal of the clitoris and, rarely, the prepuce (the fold of skin surrounding the clitoris)
- Excision: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora
- Infibulation: Narrowing of the vaginal opening (often to the width of a match-stick) through the creation of a covering seal formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris
- Other: All other harmful procedures to the female genitalia for non-medical purposes (e.g., pricking, piercing, incising, scraping, and cauterizing the genital area)

Prevalence rates of FGM/C are difficult to ascertain. Rates of recorded FGM/C are highest in Africa, where the pooled prevalence in one study was 56% [358]. One study found that rates ranged from 1% in Uganda to 98% of the female population in Somalia [284]. The highest rates of FGM/C are in Somalia [317]. It is estimated that, as of 2011, 500,000 immigrant women and girls in the European Union, Norway, and Switzerland in 2011 had experienced FGM/C [285]. There is some evidence that FGM/C rates are higher in rural areas (compared with urban areas) and in households with lower incomes [318; 358]. Furthermore, a family history of FGM/C and Muslim faith are strong predictors [358]. Some countries (e.g., the United Kingdom) have laws in place making FGM/C illegal or traveling to another country for the purpose of performing FGM [284]. In some cases, physicians may be required to report FGM cases, regardless of the woman's/girl's age [284].

The question of whether FGM/C is child abuse remains. Some experts maintain that traditional cultural practices that may be unfamiliar should not necessarily be labeled as abusive [35]. In FGM/C cases, the adults do not explicitly intend to harm or punish the child; rather, the practice promotes cultural identity [35]. Similarly, male circumcision is a cultural ritual that marks a rite of passage for boys, and it is not considered abusive [36]. On the other hand, the literature demonstrates the host of negative short- and long-term repercussions associated with FGM/C, including severe scarring, infections, obstruction of urine and/or menstrual blood, infertility, postpartum hemorrhage, and death [246; 318]. Adverse psychologic effects, such as post-traumatic stress disorder, are also possible [246]. If a girl's parents are cognizant of the adverse consequences of the procedure, then is it considered abuse? Can and should culture be utilized to rationalize the use of practices that are shown to have adverse physical and psychologic consequences?

In some countries, such as Spain, FGM/C is a crime of injury [237]. Furthermore, instances in which healthcare professionals are aware of FGM/C or situations where a girl is at risk and do not intervene are considered crimes of omission, punishable by prison. The complex interaction of culture and values and the issue of rights is at the root of FGM/C. If countries implement strict control measures for FGM/C, this can have a strong impact on families. Surveillance and monitoring mechanisms, such as mandatory gynecologic exams for minors, can have negative effects on individuals' rights and dignity [237]. Clearly, the issue is complex and multiple questions arise.

Childhood Conscription

It is difficult to measure the prevalence of child conscription, but UNICEF estimates that more than 105,000 children were recruited to serve in conflict between 2005 and 2022 [359]. Child soldiers may be responsible for digging trenches, radio communication, performing guard duty, setting land mines, manufacturing bombs, and front-line fighting [247]. The majority of these child soldiers are 15 to 18 years of age, but some are as young as 7 years [238]. In one study with a sample of 330 former child soldiers of Uganda, the mean age was 10.8 years [238]. Of these children, 41.8% served as front-line soldiers and 99.7% were recruited by force. Isolation, witnessing violence, and forced killings are mechanisms used to control and indoctrinate child soldiers [286]. The atrocities these children witness and experience are beyond comprehension. Bayer, Klasen, and Adam conducted a study that included 169 former Ugandan and Congolese child soldiers who were on average 15.3 years of age at the time of the study [38]. Almost all (92.9%) reported witnessing a shooting, 89% witnessed someone being wounded, and 84% witnessed someone being seriously beaten. A total of 54% reported having killed someone, and 27.8% reported being forced to engage in sexual activity [38]. The experience of conscription among children produces emotional and psychologic trauma and a host of cognitive and behavioral problems [39]. In the

Ugandan study, 33% of the children were diagnosed with current post-traumatic stress disorder, 36% were diagnosed with current major depressive disorder, and 19% had both [238]. In one study of 19 child soldiers, 18 had volunteered for service in the army and one had been abducted. Some of the children tried to run away or disobey, which resulted in beatings and imprisonment. In some cases, they were told to commit suicide. Although most of the children volunteered into the army, their participation became involuntary. Some also reported that they received educational and supportive services that they may not have otherwise obtained [39]. In one study of child soldiers in Colombia, the majority (83%) stated they joined an illegal armed group voluntarily, with 18% citing financial motivations [287]. If child soldiers escape and attempt to reintegrate back into their communities, they often face ostracism, ridicule, and a host of mental health issues [288].

Again, the issue of child conscription being defined as a form of child abuse is debated. The definition of childhood and adulthood varies tremendously across different cultures in the international community [40]. Although child soldiers are clearly victims, they may be viewed and treated as perpetrators when they return home [319]. Consequently, it raises questions regarding the extent of protection that should be provided, to whom protection should be provided, and how the rights and autonomy of the individual can be achieved.

Child Labor

Child labor is defined by the International Labour Organization (ILO) as economic labor performed by a child younger than the minimum age specified for the type of work as defined by the nation (generally 15 years in the United States) and that is thus likely to impede education and/or development [188]. It is important to note the difference between child labor and child work. Child work has been defined as activities supervised by an adult that promote the development and growth of the child. Child labor does not benefit the child [41]. Essentially, child work is not considered harmful while child labor is [42].

Child labor is deeply entrenched in cultural and social norms. Early child apprenticeship is common, and parents approve these informal apprenticeships to instill a strong work ethic and, in some cases, to help perpetuate the family business [360]. Ultimately, the goal is to help improve family finances. It is also connected to gender role norms. Girls typically go into domestic work, while boys go into fishing, carpentry, or work on farms [360]. Finally, child labor is deeply rooted in poverty, the infrastructure and political stability of the country, and market forces [41]. It is also entrenched in power structures reinforced by institutional norms that perpetuate a master-servant relationship (i.e., the child laborer is considered property of the owner). The owner/adult often uses corporal punishment or abusive behaviors to instill fear in child laborers [320]. A study of child labor in the Pakistani carpet industry found that 68% of cases were attributed to poverty [289]. Often, the families did not have an adult wage laborer to provide for the family. However, some have argued that this work/labor dichotomy is too simplistic. The delineation of harmful or nonharmful work activities and range of work, and by extension the categorization of certain labor as abuse, remains a debated issue [42]. In general, forced labor and the implication of children in illicit activities are recognized as harmful [188]. However, the health consequences of child labor tend to be ambiguous, particularly if one uses the categories of hazardous and non-hazardous work [321]. For example, eradicating forms of child labor on health-related grounds may cause significant economic hardship to families, especially if the child brings in necessary income. Child labor is not a homogenous phenomenon [322].

It is difficult to estimate the scope of child labor; however, the ILO reports there are 17.2 million children worldwide engaged in paid or unpaid domestic work [248]. It has been predicted that the COVID-19 pandemic will trigger an increase in child labor [323].

A qualitative study explored the lived realities of Ghanaian children trafficked for labor to a fishing village in Lake Volta [249]. This fishing village received international attention for the extensive amount of child torture and death. One rescued child reported [249]:

> When we went to the fishing village, we fished day and night, rain or shine. We were asked to dive when the net is trapped. Every day was a fishing day. There was no time set aside for sleeping. We could be called at midnight to go fishing.

Child Trafficking

Child trafficking has also been examined as a possible type of child abuse. The United Nations has defined human trafficking as [43]:

> The recruitment, transportation, transfer, harbouring, or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation includes, at a minimum, the exploitation or the prostitution or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude, or the removal of organs.

Obtaining a true understanding of the scope of child trafficking is challenging. Trafficking is a secret activity. Further, there is no universal definition or central database to monitor reports and convictions. Existing institutional corruption can also contribute to its invisibility [324]. Children are sold or kidnapped for a multitude of reasons, including labor, sexual

abuse, commercial exploitation, domestic servitude, and illicit adoption [44]. Trafficking of children may be intra-regional (e.g., children from rural areas trafficked to urban areas) or inter-regional (e.g., children trafficked from one country to another) [233]. With the widespread use of Internet technology and social networking sites, chatrooms, and Internet video and voiceover communication, young children and adolescents may be trafficked after having interacted with a perpetrator on the Internet [233]. Migrant children are also at risk of being trafficked. With the migration crisis in Europe and the amount of transience, it is estimated that there are 10,000 unaccounted-for migrant children [290].

According to UNICEF, girls as young as 13 years of age, mainly from Asia and Eastern Europe, are trafficked as "mail-order brides" into Western Europe and North America. Children are also trafficked in West and Central Africa, mainly for domestic work but also for sexual exploitation and commercial labor. Nearly 90% of these trafficked domestic workers are girls. Furthermore, thousands of infants and children from Central and South America are trafficked for adoption in North America and Europe every year [25]. There have also been reports of "baby factories" in West Africa, particularly Nigeria. Young women are trafficked to produce children, and the infants are then sold for adoption. Because of the stigma of infertility among African couples, many adopt illegally [291]. In other instances, the infants are raised to a certain age then trafficked [291]. In the United States, in 2021, the National Center for Missing and Exploited Children reported that they received 17,200 cases of child sex trafficking [361]. Among those who had run away, about 17% had become sex trafficking victims. The causes of child trafficking are rooted in the political, economic, and social instabilities in many countries. In many cases, the act also reflects the gender inequalities inherent in the countries' institutional and cultural norms [44].

Like child abuse, child trafficking results in consequences to the community and the individual, which ultimately undermine child development. For example, children who are trafficked for sexual exploitation experience physical and sexual abuse, resulting in long-term psychologic trauma [324]. Several factors make children particularly vulnerable to sexual trafficking, including the cultural myth that having sex with a virgin can cure human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and the increased popularity of Internet-based child pornography and child sex tourism [25]. According to data from the 2019 National Child Abuse and Neglect Data System, substance use, living in a group home, having a disability, and residing in more rural areas predicted child sex trafficking [362]. If victims of child trafficking are rescued, reintegration back into the community is a challenge given the stigmatization [46]. Clearly there are adverse consequences to human trafficking, and the consequences may be compounded in childhood. However, questions remain regarding the categorization of this act as child abuse.

All of these social issues are complex and multifaceted. Professionals cannot simply take on a completely relativistic stance and justify all cultural practices as unharmful in the name of culture [46]. Simultaneously, it is important for professionals to avoid jumping to the conclusion that a cultural practice is deviant, bizarre, or abusive because it is outside of their own cultural experiences or beliefs.

CHILD ABUSE IN THE UNITED STATES AND CANADA

A study of adults in the United States indicated that 14% recalled experiencing physical abuse during childhood [47]. In 2022, there were 4.27 million referrals to CPS agencies in the United States [250]. The majority (70%) of these reports were made by professionals. Girls tended to be victims at a slightly higher rate (8.2 cases per 1,000 children) than boys (7.1 cases per 1,000 children) [250]. The most common perpetrators were parents (76%); specifically, mothers were more often perpetrators compared with fathers (37.4% vs. 24.5%) [250].

As of 2022, 7.7% of children in the United States have been victims of abuse and/or neglect [250]. This is the unique rate, meaning it counts each child only once regardless of the number of reports of abuse/neglect. By far, the most common type of abuse reported in the United States is neglect, which accounts for 74.3% of reported cases. This is followed by physical abuse (17%), and sexual abuse (10.6%) [250].

There is some evidence that child abuse is on the decline in the United States. Between 2018 and 2022, the overall child maltreatment rate declined slightly from 9.4 to 7.7 per 1,000 children [250]. Approximately 1,990 children died of abuse and neglect in the United States in 2022 [250].

The accuracy of these statistical findings has been debated, with some attributing the change to a decrease in reporting, different standards for reporting, and changes in federal and state funding that have impacted child maltreatment services. One study hypothesized that the decrease in child sexual abuse cases was related to caseworkers' increased caseload size and inability to follow up adequately [50]. However, this hypothesis was not supported by analysis of data from the National Child Abuse and Neglect Data System. The researchers concluded that child sexual abuse may actually be declining. There has also been a decline in teenage suicide, juvenile delinquency, and teenage pregnancy, all of which are proxy indicators to child abuse [49]. However, it appears that cases of child neglect have increased. Compared to 1990, cases of substantiated neglect were up by 14% in 2003 [49]. The causes of the apparent decline in the prevalence of child physical abuse and the concurrent increase in child neglect have not been determined.

CHILD MALTREATMENT RATES BY RACE[a]	
Race	**Maltreatment Rate (Per 1,000 Children)**
African American	12.1
Native American	14.3
Hispanic	7.0
Non-Hispanic white	6.6
Asian American	1.3
[a]The rates reported are for data from 2022.	
Source: [250]	*Table 1*

Research has shown that racial and ethnic minority children (particularly African American, Native American, and Hispanic children) have higher rates of reported child maltreatment compared to their White counterparts (***Table 1***) [250]. Studies examining prevalence of child sexual abuse in ethnic minority groups have yielded mixed results. These mixed results may be due to variations in definitions and methodologies used in the study of child abuse [52]. One study found that Latino and non-Latino children experienced rates of sexual abuse at 7.4% and 8.8%, respectively [52]. Another study found higher rates of child sexual abuse among African American children compared to Latinos [52]. However, there does appear to be one consistent trend: reported child sexual abuse tends to be lower in Asian countries as well as among Asian American families in the United States compared to the general population. It has been speculated that traditional norms about sexual activity or Asian cultural values such as filial piety, harmony, and collectivistic orientation impede Asian and Asian American children from reporting such abuse [52].

Overall, children of color are more likely than White children to be over-represented in child abuse and neglect reports in many Western countries, including the United States, and this has been identified as racial disproportionality [53; 251; 252; 325]. Aboriginal and First Nation children in Australia and Canada and African American children in the United States are over-represented in the child welfare system. For example, among African American children from birth to 18 years of age, the overall prevalence rate of child maltreatment is 21%; for White children, the rate is 11% [252; 292]. Some argue that the racial disproportionality exists at the reporting phase, while other data indicate it exists at the substantiation stage [251]. It is estimated that before turning 18 years of age, 37.4% of all children in the United States will have experienced a Child Protective Services investigation; however, the rate is significantly higher for Black children (53%) [297]. Black children are also reported to be three times more likely to have their maltreatment case substantiated and be placed in foster care than White children [363].

Not only are children of color over-represented, there is also indication they may move through the system differently in terms of length of placement, type of placement (e.g., greater use of kinship foster care), and services offered (e.g., less provision of mental health services) [197]. This trend has also been reported in Canada. In a large scale study of Aboriginal and non-Aboriginal families in Canada, Aboriginal children were over-represented at all phases of the child welfare system (first reports leading to investigations, substantiated reports, cases being kept open longer, and more frequent placement in out-of-home care) [54]. In another Canadian study, Aboriginal, Black, and Latino children were 1.77 times more likely to be involved in child abuse investigations compared to White children [55]. A 2019 study found that the rate of investigations for First Nations children was three times higher than that for White counterparts in Ontario, Canada [326]. In the United States, Native American Indian families had lower reunification rates compared with White families; however, Hispanic families have higher reunification rates [327].

Several factors might account for this disparity. It is possible that reporters, such as teachers, social workers, counselors, and other community workers, may be biased in the reporting of abuse [252; 328]. There is some empirical indication that although ethnic minority children are less likely to be viewed as being at risk for child abuse, case workers may be more likely to view a case that is under investigation as constituting abuse when an ethnic minority child is involved [53; 56]. Some experts argue that professionals have their own "professional ethnocentrism," whereby having been trained within the dominant culture's values, they see individuals from immigrant and cultural groups as being exotic, aberrant, or pathologic [46]. This perspective is also called the cultural deficit lens, which assumes that other cultures and their norms fall "short" and need correcting [198; 328]. In a series of focus groups conducted with community members, legal professionals, and caseworkers from communities in which there are a disproportionate amount of African American children being removed from their homes, caseworkers admitted they often used the benchmarks of appropriate parenting based upon their own experiences. Furthermore, some caseworkers admitted being fearful of going into unsafe neighborhoods; as a result, they tended to bypass some of the normal investigative procedures and simply remove the child [57]. Some choices may also be made based on stereotypes or behaviors outside of perceived norms [58]. For example, biases may lead professionals to believe rescuing a child from an "unhealthy" environment is better than placing the child with his or her large network of extended kin because of the misperception that such a network is "chaotic" [58; 328]. Related to biases, it is also possible that there is a disparity of services and resources allocated to racial and ethnic minority families, which then augments the risks for child maltreatment [252]. Practitioners' biases about kinship networks are not solely to blame; agency policies also tend to exclude willing caregivers from extended kinship networks from stepping in to care for children about to be removed [57].

Another bias may stem from practitioners' reductionistic perspectives about child safety and what factors are responsible for placing children at risk. In a study of the over-representation of Aboriginal children in Canada's child welfare system, researchers found it was not necessarily race or poverty of the case that influenced the decision making outcome of the case [199]. Rather, it was other factors, such as substandard housing, parental substance abuse, and domestic violence, that predicted child protection decisions among practitioners. It is possible that child protective workers tend to identify individual causes (e.g., parental substance abuse, child's race, caregiver characteristics) more than structural causes (e.g., lack of access to resources). Whether biases exist on an individual level or on an agency level, it is important that the desire to help is tempered by a consideration of the role of cultural bias or racist attitudes in negatively affecting the helping process [58; 328].

On the other hand, some professionals, particularly those from the same ethnic group as the family they are working with, may deny or overlook instances of abuse because the family is very much like their own family and upbringing [46]. Professionals who adopt a cultural relativism perspective are hesitant to make judgments, believing that all cultures and their practices are equally valid [198]. It is also possible for practitioners to overlook abusive behaviors in an attempt to be culturally sensitive and avoid being called racist [59].

It is possible that there are more ethnic minority children in the child welfare system because the risk factors they are exposed to are greater. Immigrant and ethnic minority families, for example, are more likely to be poor, unemployed, and live in single-parent homes, all of which are risk factors for child abuse [251]. They may also reside in neighborhoods that are characterized as more socially disorganized. When neighborhoods have lower levels of cohesion and order, families cannot rely on neighbors for assistance, which increases stress [252]. In a study of Aboriginal children in Canada, researchers found that the over-representation of Aboriginal children in the child welfare system was related to poverty, parental use of alcoholism, and lack of housing [54]. In another study using an existing dataset from Texas' National Child Abuse and Neglect Data System, financial challenges, inadequate housing, and substance abuse among caregivers were the strongest predictors to foster care placement among African American children [293]. It has been argued that the experience of colonization and oppression exacerbate these environmental stressors. In Canada, the government attempted to assimilate many Aboriginal tribes by removing young children and placing them in Christian schools, causing devastating upheaval. These schools were in existence for more than 100 years, with the last school closing in 1996 [54]. A focus group study found that complex and interwoven factors of poverty, the breakdown of the traditional community and more supportive networks, and the disintegration of families all contribute to the disproportionate number of racial minority children, particularly African American children, being removed from their homes [57].

Some have argued that, because of this connection, there should be more social services available in these neighborhoods to serve as a buffer against child abuse. In one study, researchers found that African American families who reside in areas close to mental health services had lower rates of child neglect [294]. Closer proximity to substances abuse services or poverty services was not associated with improvements in child abuse or neglect rates.

It has also been suggested that practitioners make more "false positive" identifications of child maltreatment when working with immigrant and ethnic minority families [46]. False positives can result from a lack of familiarity with cultural beliefs, norms, and practices, or it can stem from professional ethnocentrism [46]. For example, some cultural groups have restrictions on hair cutting or bathing that could lead professionals to report child neglect if they are not familiar with the cultural practices [46]. In addition, differing beliefs about sleeping arrangements with young children could lead to allegations of sexual abuse. In a study with mothers from the United States and Guatemala, American mothers tended to move their infants out of their room by 3 to 6 months of age, while Guatemalan infants generally stayed in the parents' room much longer, up to their second year in life [60].

Not only are there disparities in the proportion of minority children entering the child welfare system, but there is evidence that suggests that their length of placement is longer than their White counterparts [197]. African American and Hispanic children are also more likely to be placed with kin compared to White children [197]. Although kin foster placement can be highly beneficial, there has been some evidence that there may be unfair treatment to kinship foster care parents, with these families receiving less financial support or services compared to other foster care parents [197].

In summary, families from racial and ethnic minority groups are often expected to conform to the norms and dominant culture in which they live; yet, many desire to raise their children to appreciate and continue to perpetuate their cultural traditions. Unfortunately, misunderstandings of certain cultural practices can lead to inaccurate reports of child maltreatment.

The questions that arise about the role of culture and child abuse and neglect are complex and multifaceted [59]:

- Can culture be a legitimate explanation for abuse?
- What is considered culturally acceptable and not acceptable as child discipline?
- What are reasonable cultural explanations for behaviors, and when do they override the rights of the child?

These questions do not have simple answers, and the goal of this course is not necessarily to provide quick, easy answers, but rather to raise practitioners' awareness of the range of issues. Furthermore, these explanations should not be viewed as mutually exclusive, but synergistically, contributing to an understanding of this very complicated issue [294].

CULTURE, RACE, AND ETHNICITY

CULTURE

Culture refers to the values and knowledge of groups in a society; it consists of approved behaviors, norms of conduct, and value systems [61; 62]. Culture 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 [63]. Culture can also represent worldviews, encompassing assumptions and perceptions about the world and how it works [64]. Culture helps to elucidate the reasons groups of people act as they do and respond to the environment as they do [65]. Culture is also shared among individuals in the same group across generations. It is the common ground that evokes certain feelings and ideas [200].

Kluckhohn and Strodtbeck proposed five different dimensions that comprise a worldview [66]:

- Human nature: How individuals view human nature
- Humans and nature: How individuals view themselves in relation to nature
- Time: How individuals view the past, present, and future
- Activity: How individuals view "doing" and "being"
- Relational: How individuals view social relations such as family and other social networks

Culture is not static; it is not merely inherited nor are groups of people passive recipients of culture. Rather, "culture and people negotiate and interact, thus transforming and developing each other. It is a process of continuous modification" [67].

Dividing cultural items into two categories, surface and deep structures, can assist in achieving cultural sensitivity [68]. Surface cultural dimensions include tangible and observable aspects, such as food, language, music, art, and clothing. Deep cultural dimensions, which are more difficult to identify and appreciate, include psychologic, historical, sociopolitical, and social forces [68].

RACE

The term "race" is linked to biology and is partially defined by physical markers such as hair color, skin color, and facial features. Race may also be used to describe groups of people connected to a common origin or lineage [69]. The association of race with lineage is often used to explain why people are physically and culturally different [69]. Ultimately, value judgements are often associated with race and these differences [70]. Race has social, political, and economic ramifications, as it plays a role in stereotypes, discrimination, social arrangements of different groups, and access to various societal resources [70]. When skin color is used to identify culture, it may not be an accurate measure [71].

ETHNICITY

In some ways, the term "ethnicity" refers to both culture and race [69]. Some have argued that the defining characteristic of an ethnic group is a subjective feeling of belonging. Ethnicity is closely related to culture, as ethnic groups often share common cultural traits that differentiate them from other groups [72]. However, ethnicity is now seen as more than just culture; rather, it is a category involving a group's socially constructed identity, at times based on class, politics, and sociopolitical factors [72].

IMPACT OF CULTURE ON CHILDREARING

PARENTING STYLES AND SOCIALIZATION

Just as there are multitudes of parents, there is a vast array of different parenting styles and socialization goals. Generally, the goal of many parents is to socialize their children to become self-reliant, productive, and responsible adults. How one accomplishes these goals is influenced by cultural norms. One example is the authoritarian parenting style, which is characterized by an emphasis on controlling the child's behaviors based on absolute standards, obedience, and respect for authority [73]. In Western societies, an authoritarian parenting style is regarded more negatively, and some believe it to be associated with negative outcomes such as poor self-esteem, poor academic achievement, and greater levels of aggressive behaviors [74]. In Western cultures, such as the United States, values focusing on individualism and autonomy often promote childrearing strategies that encourage children to explore their environment more independently.

The issue of immigration and acculturation will inevitably influence immigrants' parenting behaviors, as values in the host country may compete with established cultural belief systems. Part of the acculturation process involves adaptation and coping. In general, studies have shown that as immigrant parents reside longer in the United States, they become less authoritative and have more open communication with their children. There is more negotiation between parent and child, and fathers become more involved in parenting [201]. However, this does not necessarily mean that traditional cultural beliefs and values disappear.

Asian parenting styles have also been described as authoritarian; yet, the authoritarian style is equated with parental concern, caring, and love in many Asian cultures [74; 75]. Asian cultures also emphasize relational socialization goals, such as obeying elders and parents, maintaining harmony, and caring for others [202; 329]. Many Asian parents emphasize the importance of moral training that aligns with Confucian principles, in some cases using authoritarian parenting styles (including physical punishment, guilt, and shame) [329]. As a result, Asian authoritarian parenting styles include harmony while focusing on achievement that will bring honor to the family. The parent/child relationship is predicated on hierarchal relationships and is not typically characterized as warm. Instead, parenting in many Asian homes reflects on key cultural norms that promote interdependence, social harmony, and respect [364]. Some studies have found a positive relationship between authoritarian parenting and outcomes; for example, authoritarian parenting styles were correlated with higher academic achievement in a study of Chinese students [76; 253]. One study with 251 parents found that Chinese mothers tend to be more psychologically controlling of their children compared to both White and African American mothers [254]. The Chinese mothers' sense of worth was dependent on their children's performance, which may explain this tendency.

This concept may also be more fully understood if it is examined from the perspective of collectivistic cultures. Again, these are global themes and there is tremendous diversity within all cultural groups. In many collectivistic cultures, the goal is to promote harmony and relegate individual needs to that of the larger collective group (i.e., family and community) [77]. Chinese parents, for example, are charged with training their children to be cooperative, to respect their parents and elders, to learn self-control, and to value the needs of the group, all of which conform to Confucian principles [74; 78]. In Chinese culture, then, it is believed that parents who do not discipline their children effectively are abusive [74]. Affectionate and highly expressive behaviors among Asian parents are not the predominant parenting styles because a major lesson for children is the value of self-control; highly expressive and emotive behaviors are considered inappropriate [78]. However, the perception of Asian American authoritative parenting may be rooted in a comparison to White/European American parenting styles in the United States. In one study, the most common parenting style among Chinese parents was a supportive style [295].

The level of adherence to authoritative parenting styles may also depend on the level of acculturation. In a qualitative study with 20 highly educated Korean parents from middle to upper-middle socioeconomic brackets, the parents described trying to strive for Western norms of autonomy and individuality in their parenting, wanting to promote their children's sense of freedom in exploring the world around them [255]. However, they do limit freedom when it comes to academic achievement [296].

In Japan, some parents strive for the *mimamor* approach, which means "watching and caring" [365]. Generally, the Japanese believe that it is the parent's responsibility to nurture a child, and therefore, parenting is very child-centric. Children all have potential, and the goal is to respect the wish of the child and help them reach their potential. Therefore, it is crucial for parents to watch attentively to see how they can nurture the child's innate skills [365].

Just as there is heterogeneity within specific groups, there are obviously marked differences within collectivistic cultures. Studies that show that indulgent parenting styles (high degree of parental affection, acceptance, and emotional expressiveness) in some collectivistic countries, such as Spain and Italy, yield similar results in terms of children's level of self-esteem and adjustment compared to children socialized in Asia [79]. Similarly, in Hispanic/Latino groups, which are also characterized as collectivistic, childrearing practices have been described as very nurturing and permissive, with more emphasis on interdependence versus independence [80].

These seemingly contradictory findings about collectivistic cultures may be partially explained by the diversity within collectivistic cultures; some researchers subdivide these cultures into two categories: horizontal and vertical [81]. Horizontal collectivistic cultures emphasize egalitarian relationships, while vertical collectivistic cultures focus on relationships within a hierarchical structure.

However, it is also likely that divergent cultural values may contribute to differences in parenting styles in collectivistic cultures. It has been proposed that *machismo* influences parenting styles in Hispanic/Latino cultures. *Machismo* refers to a set of ideals placed upon Hispanic/Latino men, including physical strength, virility, and bravery [82]. Men are often considered to be dominant figures in the family structure [83]. This *machismo* attitude may promote rigid gender role expectations and misogyny [83]. It is also speculated that *machismo* adherence may influence more authoritarian parenting and punitive disciplining styles in Hispanic/Latino cultures. In one study of 150 Hispanic, African American, and White parents, *machismo* significantly predicted use of physical punishment by fathers regardless of ethnicity [84]. This supported an earlier study of Guyanese parents in which parents who were less nurturing and who tended to use more physical punishment were associated with *machismo* ideals [83].

More recently, the stereotypical portrayal of *machismo* and its effect on Mexican fathers' parenting has been questioned. For example, the positive dimensions of *machismo*, known as *caballerismo*, consist of dignity, honor, respect, and the role of men as providers. These values can lead to greater involvement of fathers with their children in Mexican families. In one study, Mexican children whose fathers who had higher levels of *caballerismo* reported greater positive father involvement [203].

However, other studies have conflicted with these findings [204]. It is important to remember that no simplistic cultural generalizations can be made when working with culturally diverse groups.

The concept of raising children to be *tranquilo*, *obediente*, *y respetuoso* (calm, obedient, and respectful toward adults) also underlies much of childrearing among Hispanic/Latino families [85]. In Mexican families, a well-educated child has been taught to treat others with courtesy and respect [80]. As a horizontal collectivistic culture, Hispanic/Latino families highly value respect because it accords worth to individuals regardless of their social hierarchy [82]. It has been said that Hispanic/Latino parents are more likely to make unilateral decisions on the behalf of their children and the children are expected to conform to their parents' decisions in part because of the emphasis on respect [86]. In focus groups with Dominican and Puerto Rican mothers and their adolescent children, Guilamo-Ramos and colleagues found that mothers expected their children to obey them, which was expressed through cultural values revolving around respect [86]. However, this does not mean their parenting practices were harsh; rather, the children knew they were loved, but the mothers acknowledged that "tough love" was used. These ideals may be retained, in part or entirely, in Hispanic American families.

The historical legacy and the pervasiveness of racism and discrimination in the United States has led many African American families to view parenting and childrearing as preparing their children to cope, manage, and succeed in an often oppressive and hostile environment [87; 88]. In a 2001 case study of two middle-class African American families, the theme of racial socialization was a key component in childrearing [89]. Racial socialization refers to the process of raising children to be healthy adults acting in a prosocial manner in a society that has a negative view of African Americans [89]. Some experts argue that this is a prominent dimension of childrearing for African American families regardless of socioeconomic class [89]. In a 2014 study with African American parents of adolescents (12 to 14 years of age), the parents reported desiring to verbally communicate with their children. For more serious situations, they tended to exhibit a firm use of disciplinary tactics [256]. It is speculated that African American parents are attuned to racism displayed by the police toward African American adolescents, and consequently, they desire to eliminate negative and perceived antisocial behaviors [256]. In families concerned with racial socialization, demanding children's respect, obedience, and proper behavior in both the public and private arenas is essential [87]. Respect is highly valued because it involves exhibiting honor to elders and authority figures and acknowledging their wisdom and past experiences. This is consistent with literature that underscores the role of elders and other responsible adults in socializing children [88]. It has also been postulated that the emphasis of respect and the use of more authoritarian parenting styles among African Americans in part stems from their experiences with racial discrimination. Focus groups with low-income African American mothers found that the women tempered their "tough love" with demonstrative caring [205]. Teaching children early on to obey their parents and to change seemingly innocent behaviors rapidly is a means to protect their children from harm [206]. In a 2010 study, African American mothers expressed concerns about spoiling their children, even as infants. They also adhered to stronger beliefs about using punishment compared to the White mother participants [207].

Raising children so they are familiar with African American historical roots and kinship ties is also an important dimension in African American families [88]. The literature has consistently documented the importance of family in African American culture. This includes not only the immediate family unit but the extended family system [90]. The extended family plays a central role in childrearing [91]. During financially difficult times, Caribbean families adhere to a concept referred to as child fostering, whereby extended family members or fictive kin step in to rear children. This allows a family member to leave the area or country to look for employment without worrying about leaving children behind. The parent who leaves is not totally absent; he or she generally continues to maintain contact and provide financial support [92].

DISCIPLINE AND CORPORAL PUNISHMENT

Discipline is a set of rules, norms, and consequences established in a family system to regulate children's behaviors with the overall objective of teaching children to act in a prosocial manner and to become responsible adults [94]. Discipline methods are much debated, particularly if physical or corporal punishment is used. Corporal punishment has been defined as punishment that inflicts physical pain [95]. Legally, it has been defined as comprising "reasonable force" [208]. Corporal punishment is legally banned in 63 countries; however, it is still viewed as a common form of violence against children [366]. Worldwide, it is estimated that two-thirds of children between 2 and 4 years of age are spanked [367].

It is estimated that 71% to 99% of parents in the United States use physical punishment during the course of a child's life [96]. A 2019 study found the past-year spanking rate was 37% for children younger than 18 years of age, supporting several studies reporting a decrease in spanking between 1988 and 2011 [330]. The researchers argued that this decline may be attributed to the increasing public education and awareness promotions in the United States about the negative effects of corporal punishment. Most commonly this involves spanking. Spanking is defined as using an open hand to hit a child on the buttocks or other parts without leaving a bruise or causing physical harm [97]. However, regional differences in the acceptance of corporal punishment have been documented in the United States [368]. Respondents were asked about how much they agree that children sometimes need a good spanking.

Between 1986 to 2016, generally, there was a general decline of acceptance of the statement among those from non-southern states, particularly among those from higher socioeconomic levels. However, this was not the case of individuals from southern states, regardless of socioeconomic distribution [368].

Professionals generally do not advocate the use of spanking. In a survey of psychologists, 86% felt that one should never recommend spanking to a parent, and more than 75% felt it was unethical for professionals to recommend spanking [298]. Despite practitioners, educators, and scholars advocating against the use of corporal punishment, 94% of parents of toddlers still spank [208]. In a study of 2,573 African American, Mexican American, and White low-income mothers with toddlers, 34% of the participants with children 1 year of age indicated that they or someone in the household had spanked their child within the last week [209]. This number increased to 49% for those with children 2 or 3 years of age. African American children were spanked significantly more than the White and Mexican American children, and there were no differences in frequency of spanking between White and more acculturated Mexican American families.

The decision of whether or not to spank is controversial and is associated with moral and cultural undertones. Some argue for no spanking at all, maintaining that it constitutes physical violence; others argue that it is an effective means to discipline [97]. Three perspectives on spanking have been identified [97]. The first perspective is pro-corporal punishment and embraces the belief that spanking is a necessary part of childrearing in order to teach and train children about positive behaviors. For example, some studies have found that spanking has the positive effect of gaining immediate results in cases with significant detrimental outcomes [208]. The second perspective is anti-corporal punishment. Those who fall into this category believe that violence ultimately begets violence and that harmful results will occur from spanking; they equate corporal punishment with physical abuse [210]. Some countries, such as Sweden, Germany, and Cyprus, have outlawed the use of corporal punishment and consider it abusive [95; 98]. The third view is the conditional corporal punishment perspective, which advocates that it is too simplistic to make a blanketed statement about the use of spanking being positive or negative. Rather, the effects are contingent on a range of factors, such as frequency, context, intensity, and other parent-child variables, such as how the parent delivers the response and how the child understands the response [97; 210]. It is important to note that healthcare workers with higher scores in terms of approval of corporal punishment have been found to be less likely to perceive and report child abuse [99].

In general, studies have found several patterns regarding attitudes toward corporal punishment. Within the United States, regional differences play a role. Individuals from the South tend to approve of the use of physical punishment, while persons in the Northeast are least likely to approve of spanking [100; 330]. Age and education are also predictors. Older adults and those with lower education levels tend to endorse the use of physical punishment compared to their younger and more educated counterparts [101; 102]. Religion also impacts attitudes toward corporal punishment. Christian individuals who take a literal interpretation of the Bible, particularly evangelical and fundamentalist Protestants, are more likely to support corporal punishment [103]. In general, persons who identify as members of a conservative religious organization are more likely to approve of corporal punishment [100]. In a national study, researchers found that more than one-third of conservative Protestants strongly agreed that spanking is an appropriate form of discipline. Younger age and higher educational attainment were correlated with decreased likelihood to endorse corporal punishment [299].

There is also variation across countries. Strong support for corporal punishment has been documented in Russia, Jamaica, and Barbados [98]. In one cross-cultural study, university students in Asian countries tended to approve of corporal punishment at greater levels than students from European universities [98]. In China, many believe that corporal punishment is acceptable and that beating a child is not antithetical to a display of love [300]. Countries with higher levels of economic insecurity and inequality have been associated with more frequent use of violent discipline strategies [331].

Effects on Children

Regardless of intent, corporal punishment has effects on the children who experience it, some of which have long-term consequences. Although a clear causal relationship between corporal punishment and the emergence of antisocial or problem behavior in children and adolescents has not been clearly established, there is some evidence of correlation. In a 2023 systematic analysis involving 34 studies that examined for associations between maternal spanking or corporal punishment and outcomes for children younger than 6 years of age, researchers found that in 94% of the studies, there were significant relationships between maternal spanking and corporal punishment practices with a decline in the child's behavior and development, either currently or at a later time [369]. In a large meta-analysis of corporal punishment and outcomes, use of physical discipline techniques was associated with one desirable outcome (immediate compliance), six undesirable outcomes in childhood (moral internalization, aggression, delinquent and antisocial behavior, quality of parent-child relationship, mental health issues, and victim of physical abuse), and four adverse outcomes in adulthood (aggression, criminal or antisocial behavior, mental health issues, and perpetrator of family abuse) [104]. Research has linked spanking and physical abuse victimization, with spanking tied to adverse outcomes [301]. In a quantitative study, researchers found that women who justified husbands hitting their wives were more likely to approve of corporal punishment for children and their children were more likely to have experienced psychologic and

physical violence [257]. An analysis concluded that corporal punishment has a relationship with children's initial antisocial behavior and with changes in antisocial behavior [105]. Some speculate that when parents use more aggressive discipline, children are less likely to learn empathy, which can lead to future antisocial and aggressive behaviors [302]. Overall, research findings show that spanking has negative effects on cognitive and social/emotional development that can result in long-term developmental consequences [370].

No evidence was found for differences in the effect of corporal punishment across racial groups. In a related study, parental use of corporal punishment was associated with an increase in children's externalizing behavior problems [106]. It is important to note that in all of these studies there was not proof of cause in the relationships. A study of university students from 19 different countries found that settings in which the rate of corporal punishment experienced by university students is high tend to be settings in which the rate of students assaulting and injuring a dating partner is also high [107].

African American/Caribbean Families

Some studies have found that African American parents use spanking, harsh disciplining methods, and physical punishment more frequently than White Americans, although more research is necessary to compare discipline techniques among ethnic minority populations [91; 104; 108; 371]. In many African American families, discipline is viewed as a teaching method and is believed to be a part of the group's cultural norms [91]. In one survey of African American parenting approaches, participants continually reiterated the necessity and essentialness of discipline in childrearing [91]. They maintained that disciplining constitutes proper childrearing; however, many acknowledged that physical punishment as disciplining is not aligned with the dominant (White) values of childrearing. Endorsement of physical punishment was not believed to be child abuse among this group of participants [91]. This is consistent with Deater-Deckard, Dodge, Bates, and Pettit's argument that African Americans' use of corporal punishment is a cultural norm and is implemented with control used to socialize children versus corporal punishment used in an emotional and impulsive manner [211]. The key is that corporal punishment is not utilized impulsively, stemming from anger and frustration. However, this was not supported by a 2011 study with 453 White, Latino, and African American couples with children 3 to 7 years of age, which did not find that African American parents used corporal punishment with less emotionality or impulsivity compared to Latino and White parents [212].

In a qualitative study of 18 African American women 18 to 49 years of age, researchers explored the use of corporal punishment and its perceived effectiveness [213]. These women indicated that corporal punishment was an expression of love, with the aim of teaching respect and promoting the child's safety, and was also considered crucial for teaching life lessons necessary for survival. It was generally used as a last resort when other disciplining tactics were not effective. In addition, within the context of African Americans' experiences with oppression and racism, corporal punishment is seen as a way of teaching children to survive in a racist environment [332]. In one study, Black parents in focus groups indicated that the changing social climate is one in which they are judged if they discipline their children in public [372]. They stated that someone will immediately interfere with their disciplining efforts. Therefore, they feel that they have to avoid disciplining their children in public or even in private, due to fears of outside (e.g., school) involvement.

Studies of African American families and disciplining patterns do not all make linear, definitive conclusions that harsh physical punishment is the sole disciplinary tactic used. In a survey study of 176 low-income African American, Latino American, and White mothers, researchers found that preferred parenting strategies were more similar than different among the three groups [109]. Mothers from all three ethnic groups preferred praising their children as their first disciplinary strategy, followed by ignoring a behavior and spanking. Overall, the mothers did not favor using harsh and punitive childrearing methods. Other studies examining the disciplinary patterns and practices of African American parents found that African American parents preferred to use rational means, such as discussions or lecturing, to physical discipline [87; 110].

Metaparenting involves a systematic type of parental thinking (involving evaluation, reflection, and anticipation) to help guide children back to positive behaviors. In one study, African Americans reported more metaparenting compared with White/European American parents [303]. In addition, African Americans and Mexican Americans tended to use reflection more.

Some experts propose that families who experience high levels of stress will use more punitive and harsh disciplinary strategies, in part because childrearing and caregiving are perceived to be arduous [111]. Due to multiple stressors that commonly occur in African American families, including single parenthood, racism/oppression, and socioeconomic factors, it is possible that this group is more prone to using harsh discipline. In a longitudinal study of 139 African American mothers, researchers found that perceived discrimination predicted health and depressive symptoms, which then decreased parenting practices characterized by high levels of involvement, vigilance, warmth, and nurturance [112].

Harsh disciplining has been documented in Caribbean cultures as well. Flogging is a common disciplinary strategy used for misbehaving Jamaican children [113]. Caribbean immigrant families in the United States are over-represented in child abuse cases, and many of these parents do not understand why their parental authority is being undermined when the cases

are brought forth [113]. Some have speculated that the use of harsh discipline stems from the oppressive legacy of slavery, during which time cruelties and violence were rampant [113].

It has been speculated that African cultural beliefs about respect for elders and the role of education in training children into responsible adults facilitate the acceptability of corporal punishment [114]. In some African countries, such as Botswana and Kenya, caning is a common disciplinary practice even within the school setting [114; 214]. In Kenya, caning was banned in 2001, but many teachers still used it in the school setting in order to gain immediate compliance. In one study, teachers reported they felt that students misbehaved more since the ban [214].

Certain disciplining tactics are intertwined with cultural beliefs about childrearing and the symbolism attached to certain disciplining methods. In West African families, for example, suppositories of ginger root and/or pepper have also been used as forms of punishment, particularly to reduce sexually promiscuous behaviors [35]. For example, a girl who is perceived to be sexually promiscuous may be punished by inserting suppositories in her vagina, which then can result in pain and various infections [35].

Hispanic Families

Some studies have shown that Hispanic families use less corporal disciplining tactics. In focus groups, Latino participants indicated that individuals their country of origin were generally more socially accepting in their attitudes toward the use of harsh punishment and disciplining tactics than in the United States [372]. In a qualitative study with Latino mothers, many stated that they prefer not to spank but rather to first use discussion and reasoning [373]. Some have also maintained that *familismo*, the cultural value of the emphasis of the family and sacrificing for the family, is believed to influence this tendency [209]. Because of the collective values of family support and collectivism, there is less need for the use of physical punishments like spanking [258]. Caregivers' attitudes of *machismo* correlated with experiences of moderate-to-severe forms of physical punishment in a quantitative study with 736 racially/ethnically diverse undergraduate students [333].

Hispanic cultures are unique, and there are tremendous variations within the general Hispanic group. Acculturation also plays a role in these variations. In a large-scale survey study comparing foreign-born and native-born Hispanic parents, foreign-born parents were less likely to employ corporal punishment compared to their native-born Hispanic counterparts [258]. Using language as a variable to measure acculturation, Hispanic participants who answered written questions in English were less likely to respond favorably to physical punishment compared with those who responded in Spanish [332].

Native American Families

Children are considered gifts from the Creator, and Native Americans believe that parents are the guardians of this gift and must teach their children respect and to honor their elders and tribal community [215]. In Native American cultures, the extended family unit is very involved in childrearing and disciplining. As oral historians and torchbearers of cultural traditions and wisdom, grandparents and other elders in Native American families often help with the socialization of children [216]. Furthermore, elders are viewed as the oral historians, who can help pass on traditions and wisdom through storytelling [216]. In one study, Native American parents who received more support from each other and others were less likely to use corporal punishment than those with little or no support [259].

In many Native American cultures, parents and extended family adhere to a belief in noninterference when disciplining and childrearing. This is based on a deep belief in fate and maintenance of harmony and peace within the family. Young children, such as infants and toddlers, are rarely disciplined because it is believed they are unable to discern right and wrong; older siblings often use scare tactics to divert younger children's attention from engaging in misbehavior [115]. Children's misbehaviors are not ignored; rather, the goal of discipline is to teach the lessons of life, using stories, and modeling [215]. In qualitative interviews with Native American families, many parents identified the role of providing structure, rules, and guidelines to teach prosocial behaviors. They avoided using physical punishment for disciplining, instead implementing or removing rewards or privileges [374]. As children get older, particularly during adolescence, same-sex siblings and cousins employ physical disciplining or directed verbal sarcasm. However, adult caretakers then "fend off" these "hurtful" words or behaviors. By "fending off" the discipline, caretakers demonstrate that the offending child is still loved [115]. This influential role of extended family members is supported by one study that indicated family, rather than peer group, was most influential in deterring the use of illicit substances in Native American adolescents [116]. It appears the boundaries between peers and family members are more nebulous in Native American families.

Asian/Asian American Families

There is a common Vietnamese proverb that roughly translates to: "When we love our children, we give them a beating; when we hate our children, we give them sweet words" [117]. This idea that corporal punishment is a reflection of a parent's love is shared by many Asian cultures. Asian children are viewed as extensions of their parents, with the goal of bringing honor and pride to their families. As such, Asian children are expected to be obedient to their parents [117]. This unquestioning obedience is the foundation of parenting in many Asian cultures. Disciplinary practices commonly used among White Americans include time-outs and lecturing; however, this is not commonly practiced in Asian families.

Asian parents frequently use physical disciplining, such as spanking with a hand or object [217]. In Singapore, caning is a prevalent and highly acceptable form of discipline [119]. Caning is often inflicted on a child's arm, palm, or buttocks. When used on these parts of the body, the wounds are often innocuous, but on other parts of the body or face, it may be extremely dangerous [119]. In a quantitative Chinese study, approximately half of parents reported having used corporal punishment in the past six months [334]. Mothers were more likely to use corporal punishment than fathers. Parents who had experienced corporal punishment as children were more likely to employ corporal punishment as parents. Verbal disciplining strategies may also be used, usually focusing on how the child shamed the family [217]. A survey of 89 mothers from Taiwan and Hong Kong found that the majority (91.4%) would use "power assertion," characterized as demanding immediate compliance. Some Asian cultures (e.g., Chinese, Korean) also use psychological control such as guilt induction, love withdrawal, and shaming to instill moral values and to teach children from right and wrong [375].

Maintaining harmony within interpersonal relationships and respecting one's elders are paramount in Asian hierarchal family structures [77]. The Korean proverb *mae ga yak ida* (translated as "spare the rod and spoil the child") is commonly adhered to by many Korean families [126]. Another common Korean term is *sarangeei mae*, which translates to "whip of love," implying that parents whip their children out of love [118]. In general, Asian immigrants tend to believe only very severe physical punishment resulting in obvious injuries (e.g., fractures) constitutes child abuse [126].

Acculturation level can affect beliefs about disciplining. In a study with first-generation Korean Americans, parents viewed disciplinary tactics such as spanking and withholding affection as consistent with the Korean culture, and using time-outs, giving and removing privileges, and the use of sticker charts as American styles of discipline [218]. However, the longer the parents lived in the United States, the more likely they were to incorporate American disciplining techniques [218].

CULTURE AND PERCEPTION OF CHILD ABUSE

Defining child abuse and child maltreatment is a complex matter. Hutchinson notes [120]:

> Both the sociocultural and social labeling perspectives challenge the sovereign role of professionals in providing the definition of child maltreatment. The sociocultural approach points to the varying expectations of caregivers across cultures and over time and cautions that the definitions of child maltreatment need to reflect cultural norms.

In most countries, sexual abuse is considered the most severe form of abuse. Most cultural groups limit or avoid talk about sex and sexuality; for children to discuss sexual acts is considered immoral. For example, African American girls live in a culture that stresses persevering and overcoming challenges and may feel that their sexual abuse is not a legitimate cause of complaint [219]. Other cultures may consider girls who are no longer virgins to be "ruined" or "spoiled," with the blame for this change falling to the girl regardless of circumstances [219]. Sexual abuse destroys children's innocence. Some experts and laypersons have expressed the belief that sexual abuse can facilitate hypersexualization, particularly among girl victims [304]. In a 2019 study with Vietnamese American students, the majority of participants did not believe that sexual abuse perpetrators could be relatives and felt that schools and homes were safe places. They also tended to believe that boys could not be victims of sexual abuse [335].

Abuse that involves physical aggression is also frequently viewed as abuse. In a study involving participants from the United States, Ghana, and Nigeria, the vast majority (95% to 100%) agreed that behaviors that involved a physical component and resulted in physical injury and pain (e.g., punching, kicking, burning a child with a hot object) were child abuse [260]. However, there is less agreement regarding the categorization of emotional and psychologic abuse and neglect. It becomes clear that definitions of child abuse are influenced by culture, race, and ethnicity. In one study of perceptions of child abuse among White, Chinese, and Filipino Americans, findings showed there were racial and ethnic differences in definitions [121]. In this study, White participants were more likely to rate behaviors as forms of abuse, particularly physical and emotional maltreatment, and to identify severe abuse, while the Chinese American and Filipino American participants were more concerned about parental sexual values and parental drug abuse and were more likely to view these behaviors as abusive. These differences may be attributed in part to the importance of parents' socialization of children in Asian cultures.

In a 2017 study in Beijing, participants tended to feel that the criteria for child abuse should focus on intent to harm and the severity of the harm being inflicted. They did not believe that biologic parents could abuse a child, only strangers [300]. In another survey study of 401 residents in public housing in Singapore, while more severe forms of physical punishment and physical neglect were considered to be child abuse, minor forms of physical punishment and emotional abuse were more likely to be viewed as acceptable [122]. Similarly, in a telephone survey of 1,001 Chinese participants residing in Hong Kong, the majority (80%) identified physical abuse as child abuse but often did not categorize psychologic abuse and neglect as child abuse [123]. By far, younger and more educated participants were more likely to view a behavior as abusive [123].

In a study of Korean mothers, participants generally felt that child abuse was a result of a parent's love toward a child [124]. As in other studies, education played a role. Mothers with higher levels of education tended to have more negative attitudes toward child abuse. Korean immigrant mothers who felt they had experienced discrimination as immigrants were more likely to approve of the use of corporal punishment [124].

A study with urban Native Americans found that the participants had very strong views regarding the classification of child neglect [220]. Overall, Native American parents rated the majority of the vignettes as violating standards of appropriate child care. In this study, the most serious style of neglect was identified as "unwholesome circumstances," such as parental substance abuse or parents' sexual behaviors and value systems. Emotional abuse is also controversial. In one study, many Chinese parents would not agree that parental control strategies that rely on psychological manipulation (e.g., withdrawing affection and love to help train children to improve school performance) would constitute as emotional abuse; those from Western societies were more likely to identify such parental behaviors as abuse [376].

It is also important to examine cultural differences in professionals' perceptions and attitudes toward child abuse, as these differences can affect reporting patterns. In a study of 80 Korean American pastors, participants stated that they were familiar with the child abuse reporting laws and felt that these laws were important to protect children [125]. However, when presented with various vignettes describing different types of maltreatment, the majority reported that they would recommend the family for pastoral counseling rather than reporting the incidents to child protective agencies. The majority (83%) also felt that the child abuse laws were at odds with childrearing practices in Korean culture.

In a survey of health visitors in England, participants were asked to rank various behaviors according to the extent of which they could be considered child neglect [127]. The top signs of child abuse included violence against the child, the family deliberately excluding the child, the child left unsupervised or a young child attending to other young children, a home environment marked by criticism, signs of human or animal excrement, an unsafe environment, a child who was not well nourished, and unmet medical needs.

ECOLOGIC FACTORS

Some experts have advocated for the consideration of the range of social and psychologic dimensions that contribute to social problems, including child abuse and neglect. Ecologic theory is a conceptual framework used to examine a social problem within a multi-level context: the individual, family, neighborhood, and community contexts, and sociopolitical and sociocultural structures [128]. Garbarino, who has applied the ecologic model to child abuse, argues [129]:

> The overarching hypothesis generated by an ecologic analysis of child abuse is that destructive organism-environment adaptions are "permitted" by ideologic support for the use of physical force and by naturally occurring and socially engineered support systems that inadequately monitor deviance and fail to encourage effective parenting.

Ecologic theory organizes the various factors that may affect child maltreatment into four levels: macrosystem, exosystem, microsystem, and ontologic levels. It emphasizes that there is no single pathway that precipitates child abuse and neglect. The strength of ecologic theory is that it has the ability to examine many variables, exploring both their direct and indirect influences on child abuse and neglect [221].

MACROSYSTEM

The macrosystem level of ecologic theory includes the broad social and cultural values that affect the individual. Cultural norms about the justification of force or violence used to support conditions that lead to child abuse fall into this category. Norms regarding the use of social and/or mental health services were also found to predict later child neglect [377]. The lack of a consensus among professionals regarding a definitive definition of child abuse, neglect, and maltreatment can also play a role in confusing the identification, reporting, and criminal prosecution of child abuse cases [130]. Stereotypical cultural depictions can confuse definitions and perceptions of child abuse. For example, children may be simultaneously infantilized and hypersexualized. In racialized perceptions, African American girls may be viewed as "bad," overly sexual, or immoral, which can negatively affect reports of and responses to sexual abuse [337]. Overall societal attitudes about children and appropriate behavior can also affect parenting and discipline [131]. For example, if parents adhere to the cultural belief that children are the property of parents, this can breed child maltreatment [129]. Using the ecologic model to examine child maltreatment in Korea, the following macro factors were identified [222]:

- Alcohol drinking culture, particularly the mother's consumption of alcohol
- Views about corporal punishment, particularly a technique known as the "cane of love" (sarangui mae)
- Family adherence to Confucianism regarding parent-child relationships

Of course, the ecologic model is not meant to be deterministic or reductionistic. Cultural attitudes alone are not necessarily sufficient to lead to child maltreatment. However, coupled with a variety of other parental factors, such as lack of social support and inability to cope with the social stress, macrosystem issues can contribute to child maltreatment [129].

EXOSYSTEM

The influence of formal and informal social structures, such as work, peer groups, support groups, friendships, school settings, community, and neighborhoods, on larger social problems and individual behaviors is referred to as the exosystem level. As an example, some argue that a neighborhood's social organization (or lack thereof) contributes to child abuse. When neighborhoods have high rates of poverty, there are often co-occurring effects, such as high residential turnover, crime, and violence, which result in higher levels of disorganization and general decline [252]. The amount of drug use in a community or city, for example, can also impact child abuse [305]. Greater availability of drugs in a neighborhood is associated with higher reported incidences of physical child abuse and neglect.

Individuals in these communities may have more difficulty trusting and collaborating with each other, which may correspond with higher rates of victimization and violence [132]. Neighborhoods with few resources to support parents and children may experience higher incidences of child maltreatment [132]. Some experts argue that parents experience more stressors and challenges, a risk factor for child maltreatment, when raising children in impoverished neighborhood communities due to the disorder and instability impinging upon the family system.

The COVID-19 pandemic exacerbated family stressors, which contributed to the rise of child maltreatment during this period. Research indicates that 20% of parents employed more discipline on their children during the pandemic; nearly 25% reported yelling at their children more, and 26.7% disclosed that they emotionally neglected their children. Parents experiencing more financial stress also reported an increase in parent-child physical and verbal conflicts [338]. Overall, high stress levels stemming from economic hardship/deprivation and social isolation have been positively associated with all forms of child maltreatment [377].

As a second example, school systems are also considered part of the exosystem. Studies have shown that the school environment can serve as a protective buffer against the negative repercussions of child abuse. When children believe the adults in school are caring, they have positive self-esteem and self-concept, which may have been damaged by the abuse [133]. Teachers are also on the frontlines to witness children's behavior on a day-to-day basis, and when they witness behaviors or symptoms that are consistent with child abuse, how do they react?

MICROSYSTEM

The microsystem level refers to the family unit or the immediate context of the child. This level includes the physical characteristics of the immediate family, interactions within the family system, and the child's perception of the familial environment [131]. Families characterized by greater relational stress, marital discord, poor communication, and conflict are more vulnerable to child neglect [261; 339; 377]. In a Vietnamese study, a single-parent household was a strong correlate to different types of child maltreatment [378]. In a systematic study about child sex trafficking, a variety of household characteristics, including single-parent household, unrelated male member (e.g., boyfriend) of the household, households with a previous history of domestic violence, and financial hardship, were also correlated with risk of child sex trafficking [362]. A review of empirical studies that examined ecologic factors and child abuse/maltreatment concluded that there is no provable relationship between family structure and child abuse, but there are other studies that show a correlation between shorter intervals between births and child neglect [134; 261]. Inconsistencies in data collection and small sample sizes may have contributed to conflicting results.

Parental unemployment has also been linked to child abuse, likely a result of financial strain on a family. However, unemployment can also allow parents to spend more time with their children and enhance their quality time [306]. In the future, more studies are needed to examine these variables.

Other studies have shown a correlation between a family's socioeconomic status and child abuse; specifically, families from lower socioeconomic brackets are more likely to use force when parenting [135; 307]. It is believed economic conditions affect the quality of parent-child relationships due to the increased number of external and extenuating life stressors. Coupled with families' lack of knowledge of child development and parenting skills, this could contribute to child abuse [130]. It is possible that not having sufficient parenting skills can result in parenting stress and resultant child abuse [307].

ONTOLOGIC LEVEL

The ontologic level refers to the factors inherent to the individual (developmental history, skill level, behavior patterns, and personality structure). Risk factors in this level that contribute to child abuse include parental substance abuse, depression, low educational levels, and experiences of interpersonal violence [130; 261]. Parental/caregiver individual factors, such as substance use disorder and history of intimate partner violence, are among the strongest factors predicting child maltreatment [377]. In addition, parents' own childhood and early adult development can play a role in the perpetration of child abuse, causing the abuse to appear intergenerational [131; 377]. Other ontologic risk factors include the child's age, coping skills, temperament, and personality. In one study, the greatest predictors of child neglect were related to parental factors, such as a history of antisocial behaviors, criminal offense, mental illnesses, and childhood abuse [308]. A study of children 11 to 17 years of age in Pakistan found that child maltreatment was correlated with the child's age, birth order, parental education, and maternal age [339]. A child's multiracial identity, disability diagnosis, experiences with substance abuse, and prior maltreatment are also ontological factors correlated with child sex trafficking [362].

Utilizing an ecologic model to discuss child abuse shifts the problem from being solely a parent-child issue to the true etiology and consequences of child abuse. It is important to note that the ecologic model is transactional; each level influences the others [129]. When examined in this manner, it is clear to see that child abuse is a multifaceted social problem, with ripple effects on multiple layers.

CULTURALLY RELEVANT THEORETICAL FRAMEWORKS

Cultural relevance or sensitivity is defined as behaviors, attitudes, and policies that are aligned or harmonious with a group's belief and value systems and that ultimately enable agencies, communities, practitioners, policymakers, and researchers to work effectively in a cross-cultural situation [136]. Cultural sensitivity entails the "ethic or moral imperative to value and respect the beliefs, norms, and practices of the people to be served" [137]. Culturally competent practice theories take into account how the social environment intersects at all levels [138]. Overall, cultural competence, awareness, and sensitivity are fluid processes. Each time a new patient enters a relationship with a provider, it is important to set a respectful tone and use the encounter as an opportunity to learn about his or her culture [262]. In this section, several theories will be highlighted and very briefly reviewed. It is not meant to be an exhaustive listing of all culturally relevant theories for practitioners when dealing with child abuse in ethnic minority and immigrant families. The application of these theories for child abuse assessments and interventions will be discussed in depth later in this course.

It can be argued that ecologic theory may be utilized to guide interventions when working with child abuse in immigrant families because cultural competency involves a multisystemic approach [139].

LEININGER'S CULTURE CARE THEORY

Madeline Leininger, a nursing scholar, developed a theory for transcultural nursing in the 1950s as nurses' patient populations became more diverse [140]. Leininger argues that care is the essence of nursing, and care is inevitably linked to culture [141]. Because patients are cultural beings, the goal, according to Leininger, is to provide culturally sensitive and relevant care to individuals and families that is acceptable and consistent with the individual's/group's cultural beliefs and value systems [141; 263]. This theory emphasizes holism, or the idea that the whole is greater than the sum of the parts. According to the culture care theory, effective caring involves taking a range of factors into account, including the patient's religious and spiritual beliefs, language, cultural health beliefs, sociocultural milieu, and social, political, and economic environment [140; 142]. Cultural care promotes the use of culturally derived acts to support an individual or group. Health is then culturally defined by the individual or group [140].

AIRHIHENBUWA'S PEN-3 MODEL

The PEN-3 model was originally developed by Airhihenbuwa for use to guide HIV prevention programs in Africa. Since then, the model has been used to understand cancer, diabetes, smoking, nutrition, domestic violence, and other social problems [264]. The PEN-3 model is a theoretical framework that places a social problem within a cultural context; culturally relevant health education and interventions can then be formulated [143].

The PEN-3 model has three interrelated dimensions, each with three components. The three primary dimensions are cultural identity, relationships, and cultural empowerment [143; 144].

Cultural Identity

The cultural identity dimension is based on three components: persons, extended family, and neighborhoods and their roles in health education and interventions. As part of this category, healthcare professionals are asked to evaluate how individuals, extended family networks, and the community may be supportive or resistant toward the health education and intervention activities.

Relationships and Expectations

The concept of relationships and expectations explores the perceptions of the targeted audience for the health education and intervention programs. Identifying factors that enable and nurture health behaviors is the main task in this dimension.

Cultural Empowerment

Cultural empowerment entails examining the positive, existential, and negative components of the culture combined to empower individuals to adopt healthy behaviors. Positive behaviors involve beliefs or activities that assist in lessening the problem. Existential (neutral) behaviors are practices with no adverse health consequence. Finally, negative behaviors are beliefs and practices that are harmful and should be altered [143].

KLEINMAN'S CULTURAL EXPLANATORY MODEL

Kleinman, a cross-cultural psychiatrist and researcher, argues that health behaviors are enmeshed in a cultural context [145]. How individuals make decisions about health, how they experience particular social problems and associated symptoms, and how and where they ultimately seek help are influenced by three sectors: lay/popular, folk, and professional [145].

Lay/Popular Sector

In many cultures, the lay/popular sector is typically the first avenue to seek help when individuals experience a problem. This sector is comprised of friends, family members, and the community. The information available in this section is typically founded on general knowledge and wisdom. Self-treatment and family care generally fall under this heading [146].

Folk Sector

An individual's cultural and social beliefs and value systems about health, illness, and healing are referred to as the folk sector. Religious practitioners and indigenous healers also fall into this category [145; 146].

Professional Sector

The professional sector is closely aligned with Western approaches to health and illness. This sector involves professionals and healthcare providers who are considered "legitimate" in Western society [146].

STRENGTHS-BASED PERSPECTIVE

The strengths-based perspective focuses on moving away from a client's deficits and emphasizing untapped strengths, competencies, and capabilities [147]. This perspective is based on the belief that all people have the capability for positive growth and change. Empowering individuals may assist them in accessing internal and external resources.

The central premises of the strengths-based perspective are [148]:

- The individual is viewed as the expert.
- The individual is the facilitator of change.
- The hierarchal power relationship between the individual and the practitioner should be minimized.
- Individuals should be provided the opportunity to reach self-identified goals and obtain new skills.
- Healthcare professionals should work with community stakeholders to change existing resource allocations.

The strengths-based perspective emerged as a result of the tendency in many disciplines to pathologize and blame the victim [148]. The concept of "blaming the victim" was first identified in 1976 [149]. This concept recognized that social problems in America are often blamed on victims' characteristics and value systems. In taking such an approach, practitioners working with families and children with trauma and abuse histories can help their clients to realize that they are survivors and they have "survival stories" [223]. Furthermore, acknowledging clients' strengths can build rapport [340]. Resiliency, hope, and survival are emphasized. The child and the family's environment and culture are viewed in a positive manner. The goal is to create positive experiences of cultural safety, tease out protective factors to promote child and family well-being, and offer pathways for services [379].

A common theme in these theoretical frameworks is the view that an individual's culture should be at the forefront when conducting assessments and formulating interventions. For example, some experts assert that the strengths perspective is suitable in working with Muslim patients in fostering hope and delivering services that incorporate social and multicultural dimensions aligned with religious value systems [265]. Instead of making Western interventions fit into the individual's cultural context, these frameworks emphasize a biculturalization approach for assessments and interventions. The biculturalization of assessments and interventions involves [150]:

- Identifying cultural values and beliefs to be incorporated into assessment and interventions
- Ensuring that interventions are congruent with the individual's and family's cultural norms
- Identifying indigenous interventions that can be incorporated into Western interventions
- Formulating a plan that promotes an individual's values and belief systems
- Explaining to the individual (and family) that the Western-based intervention will not negate the client's value systems but can work in harmony with indigenous interventions

CHILD ABUSE ASSESSMENT AND INTERVENTIONS

ASSESSMENT

Assessment for child abuse and neglect involves the systematic collection of data and being able to assess accurately and competently with professional judgment [266]. Information should be obtained regarding the primary reason for the visit, the family health history, the child's health history, the history of illnesses, the parents' attitudes toward discipline, and the child's pattern of nutrition, sleep, and diet [189].

It is important for professionals to ask questions in a nonjudgmental manner. A nonconfrontational manner is important to ensure the parent or caregiver does not feel accused [267]. The practitioner can inform the parent/caregiver of his or her duty to explore the concerns [267]. An environment where support and concern facilitate an open, trusting relationship between the parent and the practitioner must be created. Practitioners should reinforce the idea that parents are the experts on their culture and child [341]. By providing such an environment, the parent has the opportunity to voice concerns and ask for help [189]. Questions that convey concern and can provide valuable information to the professional include, "Who helps you care for your children?" or "How do you discipline your children?" [189]. Healthcare professionals should discuss how disciplining strategies might be influenced by cultural beliefs and norms and avoid using stigmatizing language [341]. It may be necessary to interview the child and parent separately; however, by spending some time with the child and parent together, practitioners can observe interactions and communication. Finally, it is vital to remember that risk and safety are on a continuum and not necessarily dichotomous entities (e.g., safe vs. not safe) [266].

When screening and assessing children and youths who may have experienced a form of child maltreatment, a trauma-informed approach is beneficial. This approach shifts any blame from the victim, allowing the individual to tell their story in their own words and timing. A nonjudgmental first step is to simply ask: "What happened to you?" [380].

It is also important to remember that many immigrant families and their children may not be proficient in speaking English. The assessment interview is too important for individuals to struggle to convey information in a language with which they are not proficient [224]. Families and children appear more competent and less depressed and anxious and are able to provide more details when they are speaking their native language. So, it is vital that the practitioner can speak the same language as the parent and child whenever possible. If that is not possible, a well-trained professional interpreter is necessary. However, the use of an interpreter should always be discussed with the family [341].

Accuracy in record taking is also important as it ensures continuity of care and serves to enhance risk management [268]. Be sure to record the date and time of the visit, sources of any information, and the date, time, and location of the alleged abuse or assault [190]. When talking to the child, the practitioner should use developmentally appropriate language that will be easily understood. Leading questions should be avoided [190]. Asking the following questions may be helpful when interacting with children [190]:

- Do you know why you are here today?
- Can you tell me what happened?
- How did it begin?
- What happened next?
- Where did this happen?
- Have you been hurt lately?

Because studies have demonstrated a correlation between child abuse and domestic violence, there is a need for dual screening for both types of family violence [191].

Assessment guided by a strengths-based perspective focuses on an individual's or family's strengths, coping strategies, and resiliencies. This is particularly crucial when assessing racial and ethnic minorities, as they are often depicted in a negative light in society [151]. As part of the assessment process, practitioners may ask individuals involved in family violence the following questions [152]:

- What do you believe is working well for you now?
- What difficulties are you experiencing now?
- What in your life gives you strength or a sense of meaning?
- What role does your family play in your life?
- How have you dealt with this experience in the past?

The goal is to give individuals the opportunity to tell their stories and frame their experiences from their own point of view. Patient-centered communication is crucial. The stories patients tell are personal and intimate, and they should have the opportunity to invite the practitioner into their lives instead of having entry demanded [309]. It is also key for the practitioner to avoid the use of jargon, which reinforces distance between the two parties.

Assessment guided by ecologic theory will address all four levels. At the exosystem level, it is important to explore how migration or immigration experience has affected the family system, childrearing, and coping ability. Immigration and migration, depending upon the circumstances, can infuse hope and new dreams with the vision of building a better life for oneself and family members. Or, it can be an experience fraught with loss, as existing social networks and supports are left behind [153].

When assessing immigrants, healthcare professionals should consider incorporating the following assessment questions of the individual and/or family [153]:

- Why did you immigrate?
- Are you a legal immigrant?
- Who was left behind? Who plans to emigrate?
- What regrets or disappointments resulted from the immigration?
- How are you coping and adjusting to your new environment? Are some having more difficulties than others? If so, who?

Exploring immigration experience and status is crucial. In a research study involving immigrant parents in New York City who had a recent experience (within the previous five years) with child protective services, participants consistently indicated there was a lack of caseworker knowledge of the family's immigration status [154]. This lack of knowledge had serious implications, because it affected the families' ability to access services and to meet the mandated service plans, which then delayed reunification with their child [154]. For example, one family was mandated to attend a series of psychologic evaluations, parent education training, and other services [154]. However, the caseworker was not aware that the family had immigrated illegally and therefore was not eligible for free services. After several months of attendance, the family was told that they would have to pay for these services, which they could not afford. Similarly, participants in another focus group reported that interventions are often proposed without any sense of families' understanding of the requirements or ability to access the recommended services (i.e., ability to access transportation) [57]. "Cookie cutter" interventions are made without a comprehensive assessment of families' resources; these interventions are certainly not tailored to the unique needs of the families' social realities [57].

A technique referred to as "photovoice" has been studied, whereby research participants take photographs to express their thoughts and concerns about the child welfare system [225]. Using photovoice, a 2009 study found that the philosophies of the child welfare system were often dissonant with the belief systems of parents from minority cultural groups. Refugee parents stated that resettlement and adjustment to a new country was extremely challenging, with many living in high-crime and poverty-ridden areas. As a result of their dangerous living situations, they found themselves having stricter disciplinary practices to protect their children from harm. However, they felt that the social workers they encountered judged them harshly and undermined their parenting styles. They described how they needed support services and assistance rather than the social workers' negative evaluations of how they were raising their children [225].

Assessments guided by Leininger's, Airhihenbuwa's, or Kleinman's theoretical frameworks infuse the notion of culture into all aspects of planning. For example, the folk sector of Kleinman's cultural explanatory model focuses on the cultural group's social value systems about health and healing. When ethnic minority and/or immigrant families come to practitioners for child abuse, it is necessary to momentarily put aside any established conceptualization of abuse. It is important to hear from the individual or family what circumstances brought the family to the child protective system. Questions about parenting, childrearing, and disciplining must be asked. Many immigrant families come from countries where state involvement in family affairs is minimal and may have traditional cultural beliefs about parental disciplining [154].

Identifying Harmful Practices in an Ethnically Diverse Population

It is simply not feasible to ask practitioners to be informed and familiar with every cultural practice and nuance. However, it is also unethical for practitioners to explain away certain practices in the name of culture. So, how then do practitioners determine the best course of action? A model has been created to assist practitioners in conceptualizing cultural practices along a continuum [35]. On one end of the continuum there are beneficial practices, of which the practitioner should promote the continuation. On the opposite end of the continuum lie harmful practices that must cease and should be prevented by the practitioner [35]. At the center of the continuum, there are neutral practices. These are behaviors that practitioners should learn more about in order to strengthen their cultural competency. There are also potentially harmful behaviors, which are not fully understood or recognized as abusive. In these cases, practitioners should engage in a dialogue with the family to evaluate the potential negative outcomes. It may then be necessary for the practitioner to educate the family. This framework is aligned with the PEN-3 model.

INTERVENTIONS AND BEST PRACTICES

It is not surprising that greater cultural competence is correlated with patient retention and satisfaction. Using a sample of 1,305 participants from a statewide family preservation program, patients who perceived higher cultural competence among their providers had higher goal attainment and satisfaction with services [269]. Developing and delivering interventions that are culturally competent is a process and "should never be treated as a one-time initiative or as an after-thought" [139]. Building rapport with families and children is important. It is vital to keep in mind that immigrant families and children are often anxious and fearful, particularly with mainstream Western social and health services. A few strategies can help put the family at ease [224]:

- Snacks: When children are hungry, thirsty, or tired, they are less likely to talk or remember details. However, snacks should not be used as rewards for responses provided.
- Familiar ethnic objects: Familiar pictures, books, magazines, and/or toys will reassure immigrant parents and children and make them feel more welcomed.
- Non-uniformed officials: If the police must be involved in the interviews or sessions, they should be dressed in plain clothes to avoid scaring the family/child.

Building alliances and collaborative relationships with the community and other agencies and organizations is also key. Four tasks have been identified as beneficial for organizations and practitioners in order to build strong working relationships with stakeholders in ethnic communities. It is recommended that healthcare professionals should [155; 156; 157]:

- Develop a knowledge base about the demographics, values, norms, and cultural practices of ethnic minority groups. Case discussions about real life cases involving immigrant families can facilitate practitioners learning about new cultures. As part of practitioners' professional development, cultural experts may be invited to discuss real life cases of immigrant families. Of course, families should always be contacted to ask for permission, ensuring that confidentiality will be protected.
- Build relationships with stakeholders in ethnic minority communities. For example, practitioners can represent an organization or agency by attending events where immigrants and community leaders are present to begin developing relationships and alliances.
- Facilitate opportunities for practitioners and organizations to discuss stereotypes and generalizations regarding ethnic and cultural groups. For example, discussion during training workshops may reveal that practitioners hold preconceived notions that African American men are absent or marginally present in their families' lives.

It is important to consider the possibility of stereotypes becoming self-fulfilling prophecy. In this example, if child welfare agencies ignore African American men as decision-makers, the men may feel as if they do not contribute in a positive manner to society. Such stereotypes should be identified and challenged.

- Form alliances with diverse communities. Many ethnic minority communities have "hidden" resources, in the sense that organizations are not familiar with the informal support networks. For example, in the African American community, churches, kinship groups, self-help groups, and voluntary associations are rich resources.

Cultural brokers are mediators or intermediaries serving as bridges between practitioners and clients/patients. They can facilitate understanding of the individual's cultural heritage as well as typically Western paradigms of health and mental health to those who find the concepts foreign [158; 341]. Cultural brokers are not usually trained in the area of health and mental health issues. In the context of this course, cultural brokers may be members of ethnic minority communities who could serve as "cultural consultants" [156]. As such, cultural brokers may be utilized in a variety of ways when dealing with individuals of a specific cultural group. Elders in ethnic minority communities could be solicited to help plan community education events sponsored by organizations or agencies. Because in many cultures, elders' experiences and wisdom are valued, the community may more readily accept events promoted by this group [155]. Cultural brokers can also assist as interpreters or translators. English language proficiency is a major barrier to accessing services for many ethnic minority patients. Because of the complexities of child abuse, it is recommended that professional interpreters be used to assist in translating communications. Cultural brokers may also be ideal for helping to translate written information and contributing to the graphic design of brochures to ensure they are culturally meaningful. Finally, cultural brokers can help in laying a foundation for practitioners from agencies to enter into the ethnic community. This may be a needed link to the "hidden" informal support networks.

INTERPROFESSIONAL COLLABORATION

Interprofessional collaboration is defined as a partnership or network of providers who work in a concerted and coordinated effort for the common goal of improving patients' health, mental health, and social and/or family outcomes [342]. Positive outcomes have been demonstrated on the individual and organizational levels with interprofessional collaboration [343; 344; 345]. Because child abuse and maltreatment is complex and multifaceted, it makes sense for service providers to collaborate in order to increase access to services and reduce costs [381]. However, implementing and promoting this approach can be challenging. For example, child welfare workers rarely engage with physicians or nurses; instead, these service providers focus primarily on investigations and the home environment. Conflicting mandates or priorities for providers from different disciplines can impede effective interprofessional collaboration [381]. But understanding the patient's health context can assist in understanding family adversities [346]. Not understanding each other's roles is another barrier.

PROFESSIONAL DEVELOPMENT

One way to support practitioners is to provide professional training and development so they have sufficient resources to handle the unique questions and issues that arise when working with diverse patients and the sensitive topic of child abuse. In reality, most individuals learn best when they have the opportunity to engage in the content and apply the information to real-life situations. Consequently, one-day training sessions may not be the most effective [270]. Coaching is one way to facilitate learning that results in sustainable change. Coaches can encourage the practitioner to question, evaluate, and reflect on specific information and can challenge the practitioner to apply new skills and reflect on their practice [270]. While organizations may not be able to offer coaching, training sessions can allocate time to ask questions that facilitate critical thinking and reflection. Agencies that invest in practitioners working in child welfare/protection by offering training, continuing education, and opportunities for professional growth will find that their staff experience less burnout and remain more committed to the agency [382].

Cultural Knowledge

Some behaviors and practices are universally unacceptable (e.g., teaching a child to steal), but other behaviors may be culturally idiosyncratic or existential behaviors (from the third dimension of the PEN-3 model). These culturally rooted behaviors are neutral, with no negative health ramifications, but may be unfamiliar to practitioners. Examples are the use of coining, cupping, and *cao gio*, all of which are practiced by many Southeast Asians. Very briefly, coining, cupping, and *cao gio* are all traditional dermabrasion therapies intended to reduce the *phong* or "wind" in the body. Coining consists of a coin or metal piece being rubbed against the client's/patient's skin in order to remove the *phong* [159; 160]. Cupping is an intervention whereby one applies warm cups to the ailing individual's skin to draw the *phong* out [161]. *Cao gio* involves rubbing an ointment comprised of various oils including camphor, menthol, and wintergreen oil onto the body [162]. A spoon edge or a coin is then used to firmly rub the ointment on the body area for about 15 to 20 minutes, until a red mark is produced [162]. Many of these cultural practices are commonly used in Africa, Latin America, the Middle East, Southern China, and Southeast Asia, and they continue to be employed by immigrants in new homelands [383]. Based on yin-yang principles, moxibustion involves putting a piece of material (e.g., yarn,

string) on the painful area of a patient's body and lighting the material on fire [347]. Healthcare professionals have at times misinterpreted marks from these therapies as being abusive. Teachers who notice red marks on their students' arms or back have attributed them to child abuse and have reported it as such [162; 347; 383].

In Hispanic culture, there is a cultural practice (*hincar*) whereby children are disciplined by kneeling on uncooked rice [347]. There is some controversy regarding whether this should be considered abusive. In Namibia, there is a common cultural practice called child fosterage, whereby a child is raised by an extended family member, but the child may also have to perform household duties [348].

Three questions may help practitioners determine whether a behavior is abusive or culturally specific [351]:

- Are the children and family members/caregivers from an ethnic group?
- Does the group have such a tradition?
- Was the family member/caregiver motivated by the tradition when he or she acted?

Healthcare providers and other professionals are increasingly becoming educated about these practices in order to understand the health beliefs that surround these practices; therefore, they may be less likely to construe the marks as evidence of abuse.

Immigration Knowledge

Practitioners working with racial and ethnic minority families require some understanding of the stages of migration for different immigrant groups and the complex issues related to immigration status. It is important to understand that not all immigrant groups are the same. The variables that influence the pre-migration stage (prior to leaving their homeland), the transit or intermediate stage (the time before settling in their new homeland, which may include detention centers or refugee camps), and the resettlement stage will vary tremendously among immigrant groups [156]. Continuing education or independent study focusing on various nations and immigrant groups may be useful. Reviewing the migration journey for these groups can provide practitioners with a basis on which to build cultural knowledge [156].

It is also important for practitioners to understand how immigration status affects the lives of their patients or clients. For example, immigration status may affect individuals' ability to access services and benefits [154; 163]. When providing care for undocumented immigrants, practitioners may need to think "outside the box" to help families access informal community networks versus the traditional public benefits [154]. Immigrant groups may also be concerned regarding potential ramifications of interacting with government agencies [163]. Therefore, a basic, high-level knowledge of local and federal laws related to immigration and language access is necessary [163]. In reality, practitioners cannot know all aspects of immigration and how it affects service delivery within the context of child welfare and protection. Therefore, cross-collaboration with service delivery experts such as advocacy groups and immigration specialists is vital [226].

Law and Ethics

Practitioners should be familiar with appropriate child welfare legislative policies and their historical foundations, particularly the laws pertaining to racial and ethnic minority groups. For example, practitioners who work with Native American families should be familiar with the ICWA. A basic understanding of this act is needed to understand the services for which Native American families are eligible [164]. It is also crucial for practitioners to understand the historical backdrop that led to the legislation, as it may help practitioners understand the reluctance to accept government assistance [164].

Training Methods

The PEN-3 model can frame training for practitioners. Using the three dimensions of the model, practitioners may be encouraged to identify specific cultural values and norms and how they support or enable health education and interventions for child abuse, parent education, and childrearing. When practitioners project their own cultural values onto the patient or client, labeling "foreign" cultures as "bad" or "good," this can cause misunderstandings [165].

PRACTITIONER STRESS WHEN WORKING WITH CHILD ABUSE CASES

Practitioners who work on child maltreatment cases can experience a tremendous amount of stress caused by the complex problems associated with child abuse and neglect cases. The organizational characteristics of child welfare agencies can also contribute to the stress experienced by practitioners. Child welfare agencies often operate on limited resources in terms of staffing and funding, which can affect services rendered. Practitioners attempting to access services may feel frustrated by seemingly overwhelming bureaucracies, which can contribute to feelings of helplessness. Mandated reporters may feel torn between the notions of family privacy and child protection [166].

Practitioners who enter the helping professions often do so because they deeply subscribe to the notion of contributing to society. Some beliefs and expectations held when child protection professionals begin their careers include [167]:

- "Family problems can be solved."
- "I can help, and families will want my help."
- "I should always understand and be empathic."

- "I will always be safe because I am offering services to those in need."
- "My work will receive support by others (e.g., colleagues, family and friends, society in general)."

Obviously, these expectations are not always met. Child protection workers who enter the field are enthusiastic at first but can end up feeling discouraged when outcomes do not meet their expectations [168].

Ongoing and continual exposure to stressors related to child abuse cases can lead to practitioners experiencing burnout, secondary trauma, and other professional issues [167]. The following section will focus on the emotional reactions practitioners may experience when working with child abuse/maltreatment cases. There will also be a discussion of supervision issues related to child abuse cases and a review of the importance of engaging in self-care strategies.

TRANSFERENCE AND COUNTERTRANSFERENCE ISSUES

Child abuse and neglect cases epitomize betrayal; adult caregivers have broken a child's trust, misused their power, and severely violated boundaries (particularly in child sexual abuse). This betrayal may induce clients or patients to unconsciously engage in dissociated re-enactments of the abusive relationships, in some cases with the practitioner [169]. Countertransference hostage syndrome refers to a situation in which the practitioner feels controlled by the patient and the events he or she is experiencing [170]. The practitioner ultimately feels silenced, with minimal options. Practitioners working with child abuse victims and families may take on various roles, being a rescuer, abuser, and victim [171]. In more serious cases such as working with child soldiers, Draijer and Van Zon observe that [271]:

> Clinicians are confronted with oppression and dissociation in and outside of psychotherapy. Relatively minor stressors can trigger classic fight, flight, or freeze reactions, manifested by severe aggression and/or regressed dissociative states...Clinicians are pulled into the reenactments of old trauma scenarios and become part of a wild therapeutic dance of approach and avoidance that can feel like war.

As a result, transference and countertransference issues may arise. Identification with child abuse victims is not uncommon. Practitioners may feel as if they are in a delicate situation, similar to victims who may feel they are always on the edge of danger [172]. Child abuse victims often feel helpless, powerless, and isolated. Because the perpetrator wields the power, the victim is frequently not in the position to defend him/herself. Being exposed to these situations and emotions, practitioners can also feel helpless and powerless. In a qualitative study exploring the lived experiences of clinicians who work with sexual abuse victims, one worker stated, "'I feel disempowered in cases where I can't do anything to help...incompetent" [272]. If these feelings are ignored and not dealt with, the practitioner can inadvertently end up abandoning the client/family on an emotional level [173]. It is not uncommon for practitioners to dissociate while listening to their clients [172]. This has negative effects on the client, and it can indicate to supervisors and employers that the practitioner is incompetent and/or negligent [173]. When a practitioner is also a survivor of child abuse, detachment may be an issue [310].

Practitioners have also reported feeling exploited and manipulated, again very much like the victims' experiences [172]. Others feel angry at the perpetrator and society for failing to protect the victim, and in turn, the practitioner is motivated to rescue the victim [384]. Furthermore, victims often view the world dualistically, as good and bad or victims and perpetrators [173]. If this is the case, the practitioner may be placed into the role of victim or perpetrator by the victim/family. If not careful, the practitioner can adopt roles in which boundaries are blurred and inappropriate promises are made, such as contacting the client or family after hours [173].

Despite the horror of child abuse cases, some clients' stories may be fascinating, arousing, or exhilarating to practitioners due to their forbidden nature [168]. Although these emotions are unconscious, they can be tremendously shocking to the practitioner if brought to consciousness, provoking feelings of shame and guilt [168].

In some instances, a practitioner may avoid talking about cases with the hope that the feelings of hopelessness or frustration will disappear. Along these same lines, they may discuss cases in supervision in a removed or theoretical manner, dissociating themselves from the feelings [173].

Boundary issues are particularly relevant in child abuse cases because trust, intimacy, and power have been violated. Boundaries are the spoken or unspoken separations of the client and the practitioner [171; 272]. The maintenance or dismissal of boundaries conveys messages regarding power, trust, and authority to clients [171]. For example, some practitioners use self-disclosure to promote rapport building. But, in child maltreatment cases, self-disclosure can be misinterpreted by victims and their families. If practitioners are not very clear regarding the overall intent of the self-disclosure or if they are unsure how it will affect the clinical process and the client, then there is possible risk of doing harm [171].

Similar transference and countertransference issues exist for practitioners working with abusers. In a qualitative study with nine professionals working with incest sexual abusers, the participants reported feelings of disgust and extreme anger and hostility [227]. For example, one therapist discussed having fantasies of punishing the abuser. Another therapist felt like physically stepping back from the client to avoid contact. Overidentification with an abuser can also occur. One practitioner talked about feeling sorry for the client, and another talked about having loving feelings toward the abuser [227].

Practitioners who are able to identify transference and countertransference issues specific to child abuse may use these dynamics both to help the client work through the trauma and to aid in their own professional development [173]. It is crucial that practitioners have the opportunity to self-reflect and identify various roles they may be adopting [171]. If countertransference issues are not recognized and addressed, the practitioner may begin acting out, leading to negative repercussions for the client or family, or the practitioner may experience secondary traumatization [173].

SECONDARY TRAUMATIZATION

The terms secondary traumatization, secondary traumatic stress, secondary victimization, vicarious traumatization, and compassion fatigue all refer to the psychologic trauma experienced by those in close contact with trauma victims. This includes, but is not limited to, families, friends, and helping practitioners, such as nurses, mental health counselors, therapists, and social workers [174]. Secondary traumatic stress is defined as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" [174]. Secondary trauma can affect practitioners' beliefs about the world, others, and self, including concepts of safety, trust, control, and intimacy [175]. It has been argued that trauma caused by another person (i.e., abuse) may be difficult for practitioners to deal with because it brings up the issue of human evilness. This may affect existing beliefs and ideals more than trauma caused by natural events (e.g., natural disasters) [175]. Seven psychologic areas may be negatively affected by trauma or secondary trauma [228]:

- Frame of reference: The need for a stable perspective to understand the world and one's experience
- Trust: The need to depend on others and their ability to care
- Esteem: The need to be validated by others
- Safety: The need to feel safe and secure
- Independence: The need to feel in control over one's own behaviors
- Power: The need to exert control over others
- Intimacy: The need to feel connected to others

In a systematic review of child protection and welfare workers, many workers reporting having lost trust in the world and in the goodness of other people [336]. In a survey study with 310 professionals who worked with clients who experienced various traumas, researchers found that 60% of the research participants indicated that their beliefs about the world changed as a result of their work, particularly to beliefs about the world being a dangerous and unjust place [229]. About 20% felt they lost a sense to the meaning of life and that they may not recover from what they heard from their clients.

Practitioners with large caseloads of clients with a history of trauma and those who have minimal clinical experience in working with traumatized clients are vulnerable to secondary or vicarious traumatization. In these situations, it is easy to suppress one's emotions and begin distancing oneself from clients [230].

However, it is important to remember that it is not all negative. In a quantitative study with 255 social workers who work with abused children, there was a positive relationship between secondary traumatic stress and vicarious post-traumatic growth [385]. In other words, while the work was extremely stressful, there were opportunities for growth and satisfaction.

BURNOUT

Practitioners involved in child maltreatment cases are at risk for burnout. Burnout refers to the extreme stress experienced by practitioners that depletes emotional, mental, physical, and psychologic resources [176]. Signs of burnout include depression, physical and mental exhaustion, anger, cynicism, acting out, frustration, lack of productivity at work despite working longer hours, and difficulty controlling feelings [167]. A practitioner experiencing burnout often feels drained or tired and at times emotionally detached from clients [176]. Burnout can result from occupational characteristics, such as long work schedules, case overload, low staffing patterns, feelings of lacking power and control, lack of reward structures, poor management, and poor interpersonal relationships among colleagues [177; 311]. A survey study of 170 home visitors found that sense of empowerment and a positive organization climate positively affected workers' feelings of burnout [273]. A study of child welfare caseworkers showed that job stress and time pressure predicted burnout [312]. In a 2020 study, there was a positive relationship between secondary traumatic stress and burnout [349]. A sense of hope and finding meaning in one's work are mitigating factors. Supervisor and peer support, the accessibility of client services, and the caseworker-client relationship can also be protective against burnout [312]. However, these factors alone, or in combination, do not necessarily predict burnout; some practitioners may experience one or more factors but not burn out.

CONSIDERATIONS FOR CLINICAL SUPERVISION: BEST PRACTICES

Clinical supervision serves several functions, ensuring the delivery of high-quality, client-centered care [178; 179; 274]. Supervision can be delivered by self-facilitated peer groups, individual discussion with an experienced specialist who can assist with emotionally difficult cases, or individual discussion with a specialist [180].

Supervision of practitioners who work with child abuse cases has an inquisitorial nature [178]. This stems in part from the tremendous amount of follow-up necessary in child abuse cases; therefore, supervisors may assist in prioritizing cases [178; 181]. Supervision also involves monitoring practitioners' emotional well-being, especially given the distressing nature of the cases [178; 181]. In a study that examined the underlying theoretical/conceptual underpinnings of how clinical supervision is conceptualized in child welfare/protection, six different approaches emerged [278]:

- Psychodynamic perspective: The goal is to assist practitioners to identify anxieties underlying parental aggression and maintain professional boundaries. The supervisor explores how the practitioner might employ defense mechanisms in the therapeutic encounter.
- Managerial perspective: The goal is for the practitioner to identify challenging concerns regarding the case and to implement goals and plans to help the victim. Outcomes are reviewed and evaluated by the clinical supervisor.
- Critical perspective: The issue of imbalance of power is at the heart of this approach to supervision. The supervisor helps the practitioner to equalize the power relations between families and the agency and to develop a partnership with families.
- Behavior perspective: The focus of super-vision is to reduce stress for the practitioner. Because stress can trigger burnout and attrition, the supervisor helps the practitioner to create positive emotional associations within the organization.
- Systemic perspective: The supervisor helps the practitioner to understand the complexities of the workplace in order to understand how different systems levels can affect child protection practices.
- Humanistic perspective: The clinical supervisor helps the practitioner to understand their feelings and emotions and how they attribute meaning to their experiences through their emotions. Practitioners are encouraged to be reflective and to identify common thoughts and emotions.

There are several established best practice recommendations for clinical supervision of child abuse cases. Supervision should take place in an environment where practitioners feel safe to identify and label the feelings they are experiencing. Having a safe space to vent frustrations and to discuss and manage countertransference issues without feeling judged is important [350]. If supervision is delivered via a group format, the group should be small enough to allow each member the opportunity to adequately discuss his or her work and the issues that have emerged in specific cases [181]. Managers who facilitate supervision groups may feel conflicted, wanting to be a supporter while being held to the organization's mission and policies [182]. However, additional studies are needed to explore this further. It is important to ensure the members of the group are not further traumatized by hearing other members' stories. Practitioners may need to be reminded that empathic listening can exacerbate secondary traumatization [174]. Clinical supervisors help practitioners find the words to capture their experiences and feelings [168]. Furthermore, clinical supervisors should be mindful that a supervisory session can unconsciously mimic the trauma triangle of "victim/victimizer/bystander" [275]. Spiritual/religious consultants may help practitioners through grief reactions, if necessary [168]. Clinical supervisors should be aware of personal life circumstances that could negatively affect practitioners' work, for example, life crises, bereavement, and personal stressors [180]. Finally, clinical supervisors should operate from a resiliency model, with a caveat that seemingly resilient individuals should not be expected to take on all difficult cases [313].

Because of the power given to them by the state to make decisions about child abuse cases, practitioners have tremendous responsibilities. They must constantly navigate between power and compassion; therefore, in supervision, it is important to allow practitioners to explore how the issue of power emerges in their daily practice and how it affects their relationships [183].

Finally, supervisors must ensure they are engaging in self-care to avoid burnout, particularly because they model these positive behaviors to their supervisees [184]. Self-care is integral to the prevention of negative symptoms in practitioners, including burnout, secondary traumatization, and compassion fatigue. As discussed, practitioners experience the stressors associated with emotionally charged cases in addition to the normal stressors of daily life [185]. Yet practitioners may be more likely to overwork and neglect to adequately care for themselves [185; 314].

An effective self-care plan may include cognitive and stress management techniques, including relaxation techniques, meditation, biofeedback, and hypnosis [186]. Good nutrition and diet, regular physical exercise, and maintaining social and familial relationships are also important. Self-awareness and mindfulness are incorporated into many self-care plans. Self-awareness refers to knowledge about one's self, and mindfulness has been defined as one's knowledge and awareness of one's experience at and in the present moment [231]. Mindfulness-based stress reduction interventions teach individuals to attend to emotions, thoughts, and feelings as they arise and to be aware of the present moment experience [232]. Mindfulness has been found to play a mediating role in the relationship between self-care and well-being among mental health professionals [231]. Instead of practicing self-care, child welfare workers tend to engage in unhealthy behaviors to manage their stress [315].

Some argue that trauma-informed self-care is particularly pertinent for practitioners who work with patients who have experienced trauma such as child abuse [276]. The focus of trauma-informed self-care is on helping practitioners to deal with patients who have been traumatized and are learning to use strategies to mitigate stress [276]. The National Child Traumatic Stress Network has developed self-care training, which is available online at https://www.nctsn.org/resources/child-trauma-toolkit-educators.

Self-care can be described as a continuum, with proactive planning and reactive intervention on either end [176]. Self-care activities include an array of behaviors involving physical (e.g., exercise, nutrition, sleep), recreational (e.g., play activities, vacation time, hobbies), social (e.g., interaction with friends and family members), and spiritual/religious (e.g., prayer, meditation) support [176]. The concept of self-compassion has also been proposed as an integral component in self-care practice. This approach emphasizes human imperfection and may be particularly pertinent for practitioners who feel inadequate and powerless in the face of witnessing patients' adversity and trauma [277]. Practitioners should not merely consider these activities in passing but should spend some time exploring the activities in which they are engaged and whether they are practicing effective self-care [176].

Monitoring ongoing self-care is as important as promoting and developing it. To achieve this, self-care check-ins, whereby a practitioner is assigned to one of his or her peers so they can hold each other accountable to a self-care plan, may be established [184; 350]. Collegial support can also help to minimize burnout. Colleagues can help by alleviating work task stress, providing insight and comfort, and offering humor to lighten the mood [230]. Another option is for the supervisor to incorporate this monitoring into regular supervision.

When providing education to practitioners regarding self-care and secondary traumatization, it is important to avoid conveying a message of blame or weakness [166]. Along the same lines, organizations should consider whether their culture and environment may hinder practitioners from engaging in self-care activities. For example, practitioners who take vacation time or who decline to work overtime should not feel they will be perceived as less motivated than their colleagues [182]. Things like a coffee maker, relaxing photos, comfortable furniture, and soft music can provide opportunities for practitioners to take breaks after emotionally difficult meetings with clients and their families [182].

CONCLUSION

For child welfare practices to be culturally meaningful for racially and ethnically diverse families, helping professionals in all disciplines must have a clear understanding of the multifaceted nature of oppression, marginalization, and differential access to resources and how these factors affect child abuse and maltreatment [58]. The first step in this process is for diverse groups and stakeholders to identify and name the oppression and racism affecting child welfare [58]. Second, professionals must acknowledge that best practice guidelines are often influenced by Western, Eurocentric beliefs and may not be the best course of action for racial and ethnic minority families. The third step involves restoration, "whereby dominant and culturally specific peoples take mutual responsibility for child welfare services and its outcomes" [58]. The last step is relating, which consists of all parties (e.g., families, communities, professionals, other stakeholders) recognizing reconciliation as a continual journey that can only work if everyone is committed to the process [58].

Customer Information/Answer Sheet/Evaluation are located on pages 101–104.

TEST QUESTIONS
#97584 CHILD ABUSE IN ETHNIC MINORITY AND IMMIGRANT COMMUNITIES

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

This 10 hour activity must be completed by August 31, 2027.

1. **In the Middle Ages in Europe, children were viewed as**
   A) *God's creatures.*
   B) *miniature adults.*
   C) *"torchbearers" of the future.*
   D) *individuals with needs unique from adults.*

2. **The first child abuse case in the United States that garnered widespread interest involved Mary Ellen Wilson, a foster child in New York City. This case took place in**
   A) *1790.*
   B) *1866.*
   C) *1921.*
   D) *1965.*

3. **All 50 states in the United States have implemented a child protective services (CPS) system.**
   A) *True*
   B) *False*

4. **The Indian Child Welfare Act (ICWA), added to the Child Abuse Prevention and Treatment Act (CAPTA), allows**
   A) *practitioners better access to Native American children.*
   B) *Native American children to be removed from their homes and placed in non-Native American homes.*
   C) *the tribe, instead of the state courts, to address issues of child custody and welfare for Native American children.*
   D) *research projects to examine how to best integrate Native American children into the established social services framework.*

5. **Child abuse is defined at the federal level by**
   A) *child protective services.*
   B) *the Office of Child and Family Welfare.*
   C) *the Child Abuse Prevention and Treatment Act.*
   D) *the National Council on Child Abuse and Family Violence.*

6. **Which of the following injuries is NOT considered a possible indicator of physical abuse?**
   A) *Patterned burns*
   B) *Bruises on multiple body areas*
   C) *Abrasions to the knees and elbows*
   D) *Multiple or spiral fractures at various stages of healing*

7. **Child sexual abuse is categorized as exhibitionism if the act involves**
   A) *obscene phone calls.*
   B) *forcing a child to observe sexual acts.*
   C) *watching a child get dressed or undressed.*
   D) *touching, fondling, or kissing the child in a provocative manner.*

8. **Abandonment is characterized by desertion of a child without arranging adequate care and supervision.**
   A) *True*
   B) *False*

9. **A child discloses that he has not gone to school for two weeks. When questioned regarding the reason for the absences, the child states that his parents do not feel like bringing him to school. This may be reported as which type of abuse?**
   A) *Physical abuse*
   B) *Financial abuse*
   C) *Emotional abuse/neglect*
   D) *This is not an abuse case.*

10. **Parental substance abuse falls into the category of child abuse and neglect in all states.**
    A) *True*
    B) *False*

Test questions continue on next page ➞

11. Worldwide, it is estimated that approximately what percentage of children between 1 and 14 years of age have experienced physical punishment and/or psychological aggression by a caregiver in the past month?
- *A) 8%*
- *B) 30%*
- *C) 50%*
- *D) 80%*

12. The World Health Organization categorizes female genital mutilation/cutting that involves total removal of the clitoris and labia minora as
- *A) incision.*
- *B) excision.*
- *C) infibulation.*
- *D) clitoridectomy.*

13. Somalia has the highest rates of female genital mutilation/cutting (FGM/C) among all countries.
- *A) True*
- *B) False*

14. Internationally, approximately how many children were recruited to serve in conflict between 2005 and 2022?
- *A) 30,000*
- *B) 275,000*
- *C) 105,000*
- *D) 1,000,000*

15. Child labor is defined by the International Labour Organization (ILO) as economic labor performed by a child younger than the minimum age specified for the type of work as defined by the nation (generally 15 years in the United States) and that is thus likely to impede education and/or development.
- *A) True*
- *B) False*

16. Professionals cannot simply take on a completely relativistic stance and justify all cultural practices as unharmful in the name of culture
- *A) True*
- *B) False*

17. The majority of child abuse reports in the United States are made by non-professionals.
- *A) True*
- *B) False*

18. The most common type of abuse reported in the United States is
- *A) neglect.*
- *B) verbal abuse.*
- *C) sexual abuse.*
- *D) physical abuse.*

19. Compared with non-Hispanic white counterparts, ethnic minority children have
- *A) lower rates of reported child maltreatment.*
- *B) higher rates of reported child maltreatment.*
- *C) similar rates of reported child maltreatment.*
- *D) lower rates of reported neglect but higher rates of reported abuse.*

20. Asian American children have higher rates of reported child maltreatment compared to White children.
- *A) True*
- *B) False*

21. Which of the following factors might contribute to the over-representation of children of color in child abuse and neglect reports in the United States?
- *A) Reporter bias*
- *B) Lack of familiarity with cultural beliefs, norms, and practices*
- *C) Greater number of child abuse risk factors in ethnic minority communities*
- *D) All of the above*

22. It has been suggested that practitioners make more "false positive" identifications of child maltreatment when working with immigrant and ethnic minority families.
- *A) True*
- *B) False*

23. Culture refers to the values and knowledge of groups in a society; it consists of approved behaviors, norms of conduct, and value systems.
- *A) True*
- *B) False*

24. As opposed to culture, race is defined by
- A) *attitudes and beliefs that are passed down from generation to generation.*
- B) *language, religious beliefs, ways of thinking, and patterns of social relations.*
- C) *links to biology and physical markers such as hair color, skin color, and facial features.*
- D) *a group's socially constructed identity, at times based on class, politics, and sociopolitical factors.*

25. In Western society, authoritarian parenting styles are
- A) *associated with parental concern, caring, and love.*
- B) *equated with promoting individuality and autonomy.*
- C) *aligned with instilling a work ethic that leads to higher academic achievement.*
- D) *regarded more negatively and associated with negative outcomes such as poor self-esteem.*

26. What cultural orientation is marked by an emphasis on harmony and relegating individual needs to that of the larger community?
- A) *Familial culture*
- B) *Collectivist culture*
- C) *Matriarchal culture*
- D) *Individualist culture*

27. Machismo always has a negative impact on Hispanic/Latino parenting.
- A) *True*
- B) *False*

28. What does the concept of fostering in Caribbean families involve?
- A) *Socializing of children with non-related adults*
- B) *Social services placing at-risk children within their own families*
- C) *Extended family members rearing children while parents leave the area to search for employment*
- D) *All of the above*

29. Corporal punishment has been defined as
- A) *punishment that inflicts physical pain.*
- B) *discipline carried out by a patriarchal figure.*
- C) *punishment that relies on reasoning and lectures.*
- D) *discipline involving the use of shaming or publicly ridiculing.*

30. Which of the following countries has outlawed the use of corporal punishment?
- A) *Russia*
- B) *Barbados*
- C) *Germany*
- D) *The United States*

31. Strong support for corporal punishment has been documented in the United States, Sweden, and France.
- A) *True*
- B) *False*

32. In many Native American cultures, young children, such as infants and toddlers, are rarely disciplined because it is believed they are unable to discern right and wrong
- A) *True*
- B) *False*

33. In Asian cultures, corporal punishment is generally
- A) *not utilized.*
- B) *considered abusive.*
- C) *considered a reflection of parental love.*
- D) *regarded as a practice of foreign cultures.*

34. In most countries, the most severe form of abuse is identified as
- A) *neglect.*
- B) *sexual abuse.*
- C) *emotional abuse.*
- D) *physical aggression.*

35. According to ecologic theory, parental adherence to the cultural belief that children are property is part of the
- A) *exosystem.*
- B) *microsystem.*
- C) *macrosystem.*
- D) *ontologic level.*

36. A neighborhood's social organization (or lack thereof) is an microsystem factor affecting child abuse rates.
- A) *True*
- B) *False*

Test questions continue on next page ➞

37. The COVID-19 pandemic exacerbated family stressors, which contributed to the rise of child maltreatment during this period.
A) *True*
B) *False*

38. Which of the following microsystem factors has been shown to correlate to an increased risk for child maltreatment?
A) *Single-parent household*
B) *Family socioeconomic status*
C) *Multiple children in the family*
D) *All of the above*

39. Utilizing an ecologic model to discuss child abuse shifts the problem from being solely a parent-child issue to the true etiology and consequences of child abuse.
A) *True*
B) *False*

40. Which of the following is NOT a primary dimension of the PEN-3 model?
A) *Relationships*
B) *Cultural identity*
C) *Existential dilemmas*
D) *Cultural empowerment*

41. According to Kleinman's cultural explanatory model, health or mental health assistance from an indigenous healer would be categorized in which sector?
A) *Folk*
B) *Religious*
C) *Professional*
D) *Lay/popular*

42. Rapport building is a potential result of adopting a strengths-based perspective.
A) *True*
B) *False*

43. The biculturalization of assessments and interventions involves all of the following, EXCEPT:
A) *Formulating a plan that promotes a Western approach to care*
B) *Ensuring that interventions are congruent with the individual's cultural norms*
C) *Identifying cultural values and beliefs to be incorporated into assessment and interventions*
D) *Explaining to the individual that a Western-based intervention will not negate his or her value systems*

44. Healthcare professionals should discuss how disciplining strategies might be influenced by cultural beliefs and norms and avoid using stigmatizing language.
A) *True*
B) *False*

45. At the exosystem level, it is important to explore how migration or immigration experience has affected the family system, childrearing, and coping ability.
A) *True*
B) *False*

46. Cultural brokers must be trained healthcare professionals.
A) *True*
B) *False*

47. The use of professional interpreters is recommended for child abuse cases involving non-English speaking families.
A) *True*
B) *False*

48. An area for professional development for practitioners involved in the care of ethnic minority and immigrant individuals is
A) *cultural knowledge.*
B) *immigration knowledge.*
C) *legislation pertaining specifically to racial and ethnic minority groups.*
D) *All of the above*

49. Immigration status has no impact on accessing child welfare services.
A) *True*
B) *False*

50. Countertransference hostage syndrome refers to a situation in which the practitioner
A) *severely violates professional boundaries.*
B) *abandons the patient on an emotional level.*
C) *becomes overly involved with the patient and family.*
D) *feels controlled by the patient and the events he or she is experiencing.*

51. Secondary traumatic stress only affects mental health professionals.
- A) *True*
- B) *False*

52. Which of the following is NOT among the psychologic areas that may be negatively affected by trauma or secondary trauma?
- A) *Frame of reference*
- B) *Trust*
- C) *Esteem*
- D) *Kindness*

53. Burnout among child welfare workers is solely caused by occupational characteristics.
- A) *True*
- B) *False*

54. Which of the following is NOT a best practice recommendation for clinical supervision of child abuse cases?
- A) *Practitioners' emotional well-being should be monitored.*
- B) *Spiritual/religious consultants are not appropriate experts to assist with grief reactions.*
- C) *Supervision should take place in an environment where practitioners feel safe to identify the feelings they are experiencing.*
- D) *If supervision is administered via a group format, steps should be taken to ensure that group members are not further traumatized by hearing other members' stories.*

55. As practitioners involved with child abuse cases are at an increased risk for burnout, it is vital that they engage in self-care to prevent negative symptoms. An effective self-care plan includes
- A) *regular physical exercise.*
- B) *stress management techniques.*
- C) *maintenance of social relationships.*
- D) *All of the above*

Be sure to transfer your answers to the Answer Sheet located on page 102.
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.

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☐	97543	Child Abuse Identification & Reporting: The Pennsylvania Req/3	$26
☐	97664	Online Professionalism and Ethics/3	$26
☐	97914	Domestic Violence: The Kentucky Requirement/3	$26
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☐	99204	Geriatric Failure to Thrive: A Multidimensional Problem/5	$38
☐	99354	Aging and Long-Term Care/3	$26
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☐	74714	HIV/AIDS: Update for Behavioral Health Professionals/7	$50
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☐	94394	Diabetes Care and Patient Education/15	$98
☐	94424	Influenza: A Comprehensive Review/10	$68
☐	94724	HIV/AIDS: Update for Florida/1	$23
☐	94734	HIV/AIDS: Update for Washington/7	$50
☐	94974	Sexual Dysfunction in Patients with Diabetes/5	$38
☐	98773	Parkinson Disease/10	$68
☐	98884	Sleep Disorders/10	$68
☐	98904	HIV/AIDS: An Update/5	$38
MANAGEMENT			
☐	71073	Beyond Therapy: The Basics of Clinical Documentation/4	$32
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MEDICAL / SURGICAL			
☐	76831	Clinical Supervision for Mental Health Professionals in Florida/4	$132
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MEN'S HEALTH			
☐	93764	Men's Health Issues/15	$98
☐	93772	Male Sexual Dysfunction/10	$68
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PEDIATRICS			
☐	72254	Childhood Obesity: The Role of the Mental Health Prof./4	$32
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☐	76032	An Introduction to EMDR & Related Approaches in Psychotherapy/6	$44
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☐	76234	Postpartum Depression/15	$98
☐	76384	Shyness: Causes and Impact/3	$26
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☐	96984	Hallucinogens/4	$32
☐	96994	Club Drugs/3	$26
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☐	93010	Maternal Health Disparities/4	$32
☐	93032	Female Sexual Dysfunction/5	$38
☐	93093	Management of Opioid Dependency During Pregnancy/2	$23
☐	93314	Health Issues Distinctive to Women/15	$98
☐	93504	Meanings of Menopause: Cultural Considerations/5	$38

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PROMOTING THE HEALTH OF GENDER AND SEXUAL MINORITIES

#71794 • 5 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 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 all behavioral health professionals working in all practice settings.

FUNDAMENTALS OF TRAUMA PROCESSING

#76234 • 8 Hours

Book By Mail – $56 • ONLINE – $48

Purpose: The purpose of this course is to provide mental health professionals with the information necessary to assist clients to identify and process traumas that may be affecting their lives.
Faculty: Jamie Marich, PhD, LPCC-S, REAT, RYT-500, RMT
Audience: This course is designed for counselors, social workers, therapists, chemical dependency counselors, and psychologists who may encounter trauma-related disorders and their manifestations in professional settings.

SUICIDE ASSESSMENT AND PREVENTION

#76442 • 6 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, LP
Audience: This course is designed for social workers, therapists, counselors, and other healthcare professionals who may identify persons at risk for suicide and intervene to prevent or manage suicidality.
Special Approval: This course is approved by the State of Washington Department of Health to fulfill the requirement for suicide prevention training for healthcare professionals. Approval number TRNG.TG.60715375-SUIC. This course meets the South Carolina requirement for 1 hour of suicide prevention education.

ALCOHOL AND ALCOHOL USE DISORDERS

#76564 • 10 Hours

Book By Mail – $68 • ONLINE – $60

Purpose: The purpose of this course is to address the ongoing alcohol competency educational needs of practicing mental and behavioral health providers. The material will include core competencies as well as knowledge, assessment, and treatment-based competencies.
Faculty: Mark S. Gold, MD, DFASAM, DLFAPA; William S. Jacobs, MD
Audience: This course is designed for mental and behavioral allied health professionals involved in the treatment or care of patients who consume alcohol.

CLINICAL SUPERVISION: A PERSON-CENTERED APPROACH

#76864 • 10 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

#76921 • 5 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.

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Selected Course Availability List *(Cont'd)*

IMPLICIT BIAS IN HEALTH CARE

IL Mandate

#77001 • 3 Hours

Book By Mail – $26 • ONLINE – $18

Purpose: 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.
Faculty: Alice Yick Flanagan, PhD, MSW
Audience: This course is designed for the interprofessional healthcare team and professions working in all practice settings.
Special Approval: This course meets the Illinois requirement for implicit bias education.

ASSESSMENT AND MANAGEMENT OF PAIN AT THE END OF LIFE

DC, MI Mandate

#77144 • 2 Hours

Book By Mail – $23 • ONLINE – $15

Purpose: Because pain is frequently encountered in the palliative and hospice care environments, a knowledge of appropriate diagnosis and alleviation is vital to all members of the interdisciplinary team. The purpose of this course is to provide an overview of the assessment and management of pain in the end of life, focusing on the components integral to providing optimum care.
Faculty: Lori L. Alexander, MTPW, ELS, MWC
Audience: This course is designed for social workers, counselors, and other members of the healthcare team seeking to enhance their knowledge of pain management.
Special Approval: This course meets the District of Columbia and Michigan requirements for pain management education.

PROFESSIONAL BOUNDARIES IN MENTAL HEALTH CARE

NEW!

#77560 • 3 Hours

Book By Mail – $26 • ONLINE – $18

Purpose: The purpose of this course is to educate helping mental health professionals on how to provide compassionate and competent care within the boundaries of appropriate practice.
Faculty: Lisa Hutchison, LMHC
Audience: This course is designed for social workers, counselors, and marriage and family therapists in all practice settings.

INTEGRATING MINDFULNESS INTO CLINICAL PRACTICE

#78042 • 7 Hours

Book By Mail – $50 • ONLINE – $42

Purpose: The purpose of this course is to provide mental health professionals with an appreciation of the benefits of mindfulness approaches. Many therapeutic mindfulness techniques will be presented that can be safely and effectively incorporated into clinical practice.
Faculty: Jamie Marich, PhD, LPCC-S, REAT, RYT-500, RMT
Audience: This course is designed for professional clinicians, including counselors, social workers, and therapists, who work with clients on a regular basis who may benefit from the integration of mindfulness into their treatment plans.

THE ROLE OF HEALTHCARE AND SOCIAL SERVICE PROVIDERS IN ENSURING ACCESS TO LEAVE

NEW!

#91240 • 1 Hour

Book By Mail – $23 • ONLINE – $15

Purpose: The purpose of this course is to provide healthcare and social service professionals with the information necessary to guide patients and make clinical decisions regarding the needs for an extended leave from work.
Faculty: Beth Ribet, PhD, JD; Leslie Bunnage, PhD; Lisa Concoff Kronbeck, JD
Audience: This course is designed for all physicians, physician assistants, nurses, social workers, counselors, and allied healthcare professionals with patients who require or would benefit from protected leaves of absence.
Additional Approvals: AACN Synergy CERP Category C

HUMAN TRAFFICKING AND EXPLOITATION

MI Mandate

#96314 • 5 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, pharmacy professionals, therapists, mental health counselors, and other members of the interdisciplinary team who may intervene in suspected cases of human trafficking and/or exploitation.
Special Approval: This course fulfills the Michigan requirement for training in identifying victims of human trafficking.

MENTAL HEALTH ISSUES COMMON TO VETERANS AND THEIR FAMILIES

CT, WV Mandate

#96342 • 2 Hours

Book By Mail – $23 • ONLINE – $15

Purpose: The purpose of this course is to provide health and mental health professionals with an appreciation of the impact of military service on patient health as well as the skills necessary to effectively identify and intervene for these patients.
Faculty: Alice Yick Flanagan, PhD, MSW; Mark Rose, BS, MA, LP
Audience: This course is designed for physicians, nurses, psychologists, social workers, therapists, counselors, and other healthcare professionals who may treat veterans or their family members.
Special Approvals: This course is designed to meet the Connecticut requirement for 2 hours of education on mental health conditions common to veterans and family members of veterans.

This course is designed to meet the West Virginia requirement for 2 hours of education on mental health conditions common to veterans and family members of veterans.

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

Selected Course Availability List *(Cont'd)*

SEXUAL HARASSMENT PREVENTION: THE ILLINOIS REQUIREMENT

#97081 • 1 Hour

Book By Mail – $23 • ONLINE – $15

Purpose: The purpose of this course is to provide health and mental health professionals with clear knowledge of the consequences of sexual harassment and the skills to help combat harassment in the workplace.
Faculty: Lauren E. Evans, MSW
Audience: This course is designed for physicians, physician assistants, nurses, pharmacists, social workers, therapists, and all members of the interprofessional healthcare team who may act to prevent sexual harassment.
Special Approvals: This course is designed to fulfill the Illinois requirement for 1 hour of continuing education in the area of sexual harassment prevention.

IMPLICIT BIAS: THE MICHIGAN REQUIREMENT

#97441 • 2 Hours

WEBINAR – $30

Purpose: 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.
Faculty: Alice Yick Flanagan, PhD, MSW
Audience: This course is designed for the interprofessional healthcare team and professions working in all practice settings in Michigan.
Special Approval: This course meets the Michigan requirement for 2 hours of implicit bias training.

INTERCULTURAL COMPETENCE AND PATIENT-CENTERED CARE

#97510 • 4 Hours

Book By Mail – $32 • ONLINE – $24

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 requirements for cultural competence education.

CANNABINOID OVERVIEW

#98010 • 3 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.

ALTERNATIVE THERAPIES FOR DEPRESSION AND ANXIETY

#98160 • 5 Hours

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to help healthcare professionals in all practice settings increase their understanding of nutrients, lifestyle changes, complementary modalities, and herbal products that are often used by patients experiencing depression or anxiety.
Faculty: Chelsey McIntyre, PharmD
Audience: This course is designed for healthcare professionals whose patients are taking or are interested in using complementary therapies to manage symptoms of depression and/or anxiety.

ADDRESSING IMPLICIT BIAS TO IMPROVE PATIENT CARE

#24-689 • 1 Hour

WEBINAR – $15

Mandate: MI

Purpose: The purpose of this webinar is to define and explore implicit and explicit bias and to provide healthcare professionals with the knowledge and skills necessary to prevent implicit bias from negatively impacting patient care.
Audience: This course is designed for members of the interprofessional healthcare team who may intervene to identify and address implicit bias.
Additional Approvals: ABIM, ABS, ABA, ABP, ABPath
Special Approvals: This course meets the Michigan requirement for 1 hour of implicit bias training.

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	Board-Approved #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	30✶
Illinois	#159.001094	30✶, ❖, ♦
Indiana	ASWB	40✶
Iowa	ASWB	27✶, ♦
Kansas	Accepted by Board	40✶, ♦
Kentucky	ASWB	LCSW, CSW 27♠, ♦; LSW 12♠, ♦
Louisiana	Accepted by Board	10✶, ♦
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	32✶
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	Board-Approved #50-2405	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 20✶, ♦; LMSW 16✶, ♦; LBSW 12✶, ♦
Texas	Accepted by Board	30✶, ❖, ♦
Utah	ASWB	LCSW 15✶, ♦; CSW, SSW 8✶, ♦
Vermont	ASWB	LICSW 5✶; LMSW 10✶
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.

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	77233	Ethics for Social Work / 6 Hours	$36
	76760	A Clinician's Guide to the DSM-5-TR / 9 Hours	$54
	97584	Child Abuse in Ethnic Minority and Immigrant Communities / 10 Hours	$60

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✓	Course #	Course Title / Hours	Price
☐	71794	Promoting the Health of Gender & Sexual Minorities / 5	$38
☐	76234	Fundamentals of Trauma Processing / 8	$56
☐	76442	Suicide Assessment and Prevention / 6	$44
☐	76564	Alcohol and Alcohol Use Disorders / 10	$68
☐	76864	Clinical Supervision: A Person-Centered Approach / 10	$68
☐	76921	Racial Trauma: The African American Experience / 5	$38
☐	77001	Implicit Bias in Health Care / 3	$26
☐	77144	Assessment and Management of Pain at the EOL / 2	$23
☐	77560	Professional Boundaries in Mental Health Care / 3	$26
☐	78042	Integrating Mindfulness into Clinical Practice / 7	$50
☐	91240	Ensuring Access to Leave / 1	$23
☐	96314	Human Trafficking and Exploitation / 5	$38
☐	96342	Mental Health Issues Common to Veterans / 2	$23
☐	97081	Sexual Harassment Prevention: The Illinois Req. / 1	$23
☐	97441	Implicit Bias: The Michigan Req. (Webinar) / 2	$30
☐	97510	Intercultural Competence & Patient-Centered Care / 4	$32
☐	98010	Cannabinoid Overview / 3	$26
☐	98160	Alternative Therapies for Depression & Anxiety / 5	$38
☐	24-689	Addressing Implicit Bias to Improve Pt Care (Webinar) / 1	$15

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- Use pen or pencil; please refrain from using markers.
- **Information on the Customer Information form must be completed.**

#93780 PSYCHOSOCIAL WELL-BEING OF MEN—1 HOUR

Please refer to page 6.

Expiration Date: 03/31/28 — *May be taken individually for $15*

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

#77233 ETHICS FOR SOCIAL WORK—6 HOURS

Please refer to pages 30–32.

Expiration Date: 06/30/26 — *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.	❍	❍	❍	❍					

#76760 A CLINICIAN'S GUIDE TO THE DSM-5-TR—9 HOURS

Please refer to pages 56–59.

Expiration Date: 12/31/27 — *May be taken individually for $54*

	A	B	C	D		A	B	C	D		A	B	C	D		A	B	C	D		A	B	C	D
1.	❍	❍	❍	❍	11.	❍	❍	❍	❍	21.	❍	❍	❍	❍	31.	❍	❍	❍	❍	41.	❍	❍	❍	❍
2.	❍	❍	❍	❍	12.	❍	❍	❍	❍	22.	❍	❍	❍	❍	32.	❍	❍	❍	❍	42.	❍	❍	❍	❍
3.	❍	❍	❍	❍	13.	❍	❍	❍	❍	23.	❍	❍	❍	❍	33.	❍	❍	❍	❍	43.	❍	❍	❍	❍
4.	❍	❍	❍	❍	14.	❍	❍	❍	❍	24.	❍	❍	❍	❍	34.	❍	❍	❍	❍	44.	❍	❍	❍	❍
5.	❍	❍	❍	❍	15.	❍	❍	❍	❍	25.	❍	❍	❍	❍	35.	❍	❍	❍	❍	45.	❍	❍	❍	❍
6.	❍	❍	❍	❍	16.	❍	❍	❍	❍	26.	❍	❍	❍	❍	36.	❍	❍	❍	❍	46.	❍	❍	❍	❍
7.	❍	❍	❍	❍	17.	❍	❍	❍	❍	27.	❍	❍	❍	❍	37.	❍	❍	❍	❍	47.	❍	❍	❍	❍
8.	❍	❍	❍	❍	18.	❍	❍	❍	❍	28.	❍	❍	❍	❍	38.	❍	❍	❍	❍	48.	❍	❍	❍	❍
9.	❍	❍	❍	❍	19.	❍	❍	❍	❍	29.	❍	❍	❍	❍	39.	❍	❍	❍	❍	49.	❍	❍	❍	❍
10.	❍	❍	❍	❍	20.	❍	❍	❍	❍	30.	❍	❍	❍	❍	40.	❍	❍	❍	❍	50.	❍	❍	❍	❍

#97584 CHILD ABUSE IN ETHNIC MINORITY & IMMIGRANT COMMUNITIES—10 HOURS

Please refer to pages 91–95.

Expiration Date: 08/31/27 — *May be taken individually for $60*

	A	B	C	D		A	B	C	D		A	B	C	D		A	B	C	D
1.	❍	❍	❍	❍	16.	❍	❍	❍	❍	31.	❍	❍	❍	❍	46.	❍	❍	❍	❍
2.	❍	❍	❍	❍	17.	❍	❍	❍	❍	32.	❍	❍	❍	❍	47.	❍	❍	❍	❍
3.	❍	❍	❍	❍	18.	❍	❍	❍	❍	33.	❍	❍	❍	❍	48.	❍	❍	❍	❍
4.	❍	❍	❍	❍	19.	❍	❍	❍	❍	34.	❍	❍	❍	❍	49.	❍	❍	❍	❍
5.	❍	❍	❍	❍	20.	❍	❍	❍	❍	35.	❍	❍	❍	❍	50.	❍	❍	❍	❍
6.	❍	❍	❍	❍	21.	❍	❍	❍	❍	36.	❍	❍	❍	❍	51.	❍	❍	❍	❍
7.	❍	❍	❍	❍	22.	❍	❍	❍	❍	37.	❍	❍	❍	❍	52.	❍	❍	❍	❍
8.	❍	❍	❍	❍	23.	❍	❍	❍	❍	38.	❍	❍	❍	❍	53.	❍	❍	❍	❍
9.	❍	❍	❍	❍	24.	❍	❍	❍	❍	39.	❍	❍	❍	❍	54.	❍	❍	❍	❍
10.	❍	❍	❍	❍	25.	❍	❍	❍	❍	40.	❍	❍	❍	❍	55.	❍	❍	❍	❍
11.	❍	❍	❍	❍	26.	❍	❍	❍	❍	41.	❍	❍	❍	❍					
12.	❍	❍	❍	❍	27.	❍	❍	❍	❍	42.	❍	❍	❍	❍					
13.	❍	❍	❍	❍	28.	❍	❍	❍	❍	43.	❍	❍	❍	❍					
14.	❍	❍	❍	❍	29.	❍	❍	❍	❍	44.	❍	❍	❍	❍					
15.	❍	❍	❍	❍	30.	❍	❍	❍	❍	45.	❍	❍	❍	❍					

NetCE
Continuing Education

Evaluation

(Completion of this form is mandatory)

SW25

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.

This page is perforated for easy removal.

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?

#93780
Psychosocial Well-Being of Men
1 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

#77233
Ethics for Social Work
6 Hours

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

#76760
A Clinician's Guide to the DSM-5-TR
9 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

#97584
Child Abuse in Ethnic Minority and Immigrant Communities
10 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

#93780 Psychosocial Well-Being of Men — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

#77233 Ethics for Social Work — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

#76760 A Clinician's Guide to the DSM-5-TR — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

#97584 Child Abuse in Ethnic Minority and Immigrant Communities — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? _____

Signature _____

Signature required to receive continuing education credit.

NetCE Continuing Education

Evaluation *(Continued)*

SW25

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):

#93780 PSYCHOSOCIAL WELL-BEING OF MEN—1 HOUR (Course expires 03/31/28)

• Describe the impact of stress and anger on men.	☐ A	☐ B	☐ C	☐ D	☐ F
• Outline the presentation and approaches to treatment for substance use disorder in men.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe the diagnosis and treatment of depression in male patients.	☐ A	☐ B	☐ C	☐ D	☐ F

#77233 ETHICS FOR SOCIAL WORK—6 HOURS (Course expires 06/30/26)

• Discuss the historical context of ethics in social work and the emergence of the National Association of Social Workers (NASW) Code of Ethics.	☐ A	☐ B	☐ C	☐ D	☐ F
• Define common terms such as ethics, morality, ethical dilemmas, and ethical principles.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify the purpose and functions of the NASW Code of Ethics.	☐ A	☐ B	☐ C	☐ D	☐ F
• Differentiate between deontologic, teleologic, motivist, natural law, transcultural ethical, and ethical relativism theories.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss the relationship between ethical theories and the NASW Code of Ethics.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify the different ethical decision-making models.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss the psychologic context of ethical decision making by applying the Lawrence Kohlberg's theory of moral development.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss ethical issues that emerge with social work practice under managed care systems.	☐ A	☐ B	☐ C	☐ D	☐ F

#76760 A CLINICIAN'S GUIDE TO THE DSM-5-TR—9 HOURS (Course expires 12/31/27)

• Describe the history of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).	☐ A	☐ B	☐ C	☐ D	☐ F
• Explain the structural and organizational changes made in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, text revision (DSM-5-TR).	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify psychiatric diagnoses that are newly included in DSM-5-TR.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify changes to psychiatric diagnoses made in the transition from DSM-5 to DSM-5-TR, including the recategorization, renaming, and modification of criteria.	☐ A	☐ B	☐ C	☐ D	☐ F
• List psychiatric disorders and the criteria recommended for further study by the DSM-5-TR.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe the controversies and criticisms arising from the publication of DSM-5-TR and the alternative diagnostic systems proposed in place of DSM-5-TR.	☐ A	☐ B	☐ C	☐ D	☐ F

#97584 CHILD ABUSE IN ETHNIC MINORITY AND IMMIGRANT COMMUNITIES—10 HOURS (Course expires 08/31/27)

• Describe the historical emergence of child abuse and neglect.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify federal policies in the United States to address child abuse and neglect.	☐ A	☐ B	☐ C	☐ D	☐ F
• Define child abuse and neglect.	☐ A	☐ B	☐ C	☐ D	☐ F
• Outline the international prevalence of child abuse and neglect and variations in defining child maltreatment.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss the impact of child abuse and neglect in the United States and Canada, particularly among ethnic minority groups.	☐ A	☐ B	☐ C	☐ D	☐ F
• Analyze how race, ethnicity, and culture impacts ethnic minority families' parenting styles and disciplining.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify the role of ecologic factors on the risk for child abuse and neglect.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe cultural theoretical frameworks to guide practice.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss child abuse assessment, intervention, and training that consist of culturally sensitive best practice values.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify self-care issues and practices for practitioners working with child abuse cases.	☐ A	☐ B	☐ C	☐ D	☐ F

Signature _____

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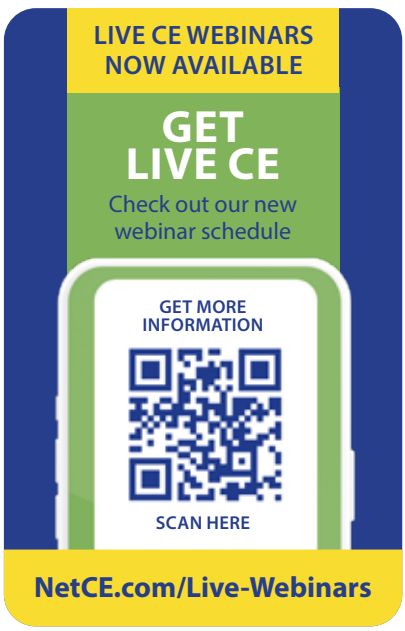

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