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2021–2022
CONTINUING EDUCATION FOR COUNSELORS & THERAPISTS

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INSIDE THIS EDITION:

Racial Trauma
Ethics for Counselors
Alcohol Use Disorders
Demystifying Dissociation

American Psychological Association

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Racial Trauma: The African American Experience

Approval(s): APA, NBCC, NAADAC

This course meets the requirement for cultural competency education.

Audience
This course is designed for mental and behavioral health professionals who provide services to African American clients who have experienced racial trauma.

Course Objective
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.

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

1. Define racism and its historical and current manifestations in the United States.
2. Describe the impact of structural racism and related racial trauma on African American individuals.
3. Evaluate the adverse health and mental health impacts of racial trauma on African Americans.
4. Outline approaches to rapport building and mental health interventions best suited for African American clients who have experienced racial trauma.
5. Discuss culturally relevant approaches to promote post-traumatic growth and provide trauma-informed care.

Faculty
Tanika Johnson, EdD, MA, LPC-MHSP, LMHC, NCC, BC-TMH, CCTP, is a licensed professional counselor and contributing faculty specializing in addiction, trauma, sexual assault, human trafficking, domestic violence, crisis and behavioral health interventions, anxiety, mood disorders, perinatal disorders, obsessive-compulsive disorder, anger and impulse control, and self-management coaching. She also has experience with education consulting and serving the special education community and the exceptional needs of children, adolescents, and adults with disabilities.

Faculty Disclosure
Contributing faculty, Tanika Johnson, EdD, MA, LPC-MHSP, LMHC, NCC, BC-TMH, CCTP, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planner
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Division Planner Disclosure
The division planner has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed marriage and family therapists. #MFT-0015.

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NetCE is approved as a provider of continuing education by the California Association for Alcohol/Drug Educators. Provider Number CP40 889 H 0623.

NetCE is approved as a provider of continuing education by the California Association of DUI Treatment Programs (CADTP). Provider Number 185.

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NetCE designates this continuing education activity for 5 CE credits.

NetCE designates this continuing education activity for 1.5 NBCC clock hours.

Social Workers participating in this intermediate to advanced course will receive 5 Cultural Competence continuing education clock hours.

NetCE designates this continuing education activity for 5 continuing education hours for addiction professionals.

Individual State Behavioral Health Approvals

In addition to states that accept ASWB, NetCE is approved as a provider of continuing education by the following state boards: Alabama State Board of Social Work Examiners, Provider #0515; Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health, Provider #50-2405; Illinois Division of Professional Regulation for Social Workers, License #159.001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197.000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168.000190; Texas State Board of Social Work Examiners, Approval #3011.

About the Sponsor

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

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INTRODUCTION

African Americans have endured oppression, racism, and trauma since the founding of this country [1]. The maltreatment of slaves and former slaves (who were considered raw material or merchandise) and the legacy of racial subjugation and enslavement resulted in the eradication of fundamental human rights. The traumatic impact of African American hardships is unconcealed in the modern-day circumstances of the African American community. These effects have been termed racial trauma, defined as "events of danger related to real or perceived experience of racial discrimination, threats of harm and injury, and humiliating and shaming events, in addition to witnessing harm to other ethnoracial individuals because of real or perceived racism" [2]. While similar to post-traumatic stress disorder (PTSD), racial trauma is typically the result of ongoing, consistent exposure to race-related stress rather than a single traumatic event.

Diverse cultural views and traditions are intertwined into the foundation of life [3]. Modern society is the most globally mobile in history, and this accelerates the relocation of refugees escaping combat, food crises, violence, and oppression. Frequently, these events coexist with political unrest, ethnocentrism, and racial discrimination and intolerance. As a result, immigrants, refugees, and persons of color are at increased risk for prejudice, hatred, and discrimination. There is significant intersectionality of characteristics and personalities influencing the social landscape in the United States. Any persons who fall outside the hegemonic norms reinforced by structural forces may become an outcast.

For those categorized as outcasts, the sociocultural landscape adds to trauma [3]. Racism embedded in social and legal structures of the United States reinforces racial trauma. In order to grasp the intricacies of trauma and the evolution of its social and cultural framework, an adaptable and all-inclusive model, examining sociocultural factors, is essential for improving diagnosis and treatment.

RACISM: A BASIC OVERVIEW

Very basically, racism is defined as prejudice, discrimination, or antagonism directed against a person or people on the basis of their membership in a minority or marginalized racial or ethnic group. This is often (but not always) paired with a belief that certain racial groups have characteristics that make them inherently superior or inferior.

In America, racism continues to be a widespread problem on the individual, cultural, and institutional levels [4]. Racial slurs, exclusion, and degradation are examples of individual and cultural racism and reflect an attitude of superiority. Institutional racism (also referred to as systemic racism) is defined as racism that is codified in a society's laws and institutions and is rooted in cultural stances that are strengthened through tokenism, discrimination, promotion of ethnic majorities in employment settings, segregation, and suppression. Historically, this has included slavery, Jim Crow laws, disenfranchisement, criminal justice racism, and unethical and damaging research practices (e.g., the Tuskegee Study). More recently, racism in the United States has largely (but not completely) switched from explicit acts to more implicit ones. Examples of implicit racism include:

- Microaggression in the form of experiencing low-quality customer service due to an individual's race
- Conditional housing contracts and discrimination in selling or renting homes in specific areas of a community
- Application of laws and stricter sentencing disproportionately to communities of color

Of course, all forms and levels of racism have long-term effects for victims, bystanders, and society in general.

RESPONSES TO RACISM: TRAUMA AND RESILIENCE

The relationship between racism and related adverse physical and psychological effects has been extensively studied and reveals the degree to which African Americans have been at risk due to exposure to stressful life events and persistent trauma, defined as a response to exceedingly harmful events and occurrences in real life and to a universe in which individuals are consistently injured.

Persistent trauma, including oppression and exposure to racism, has unequivocally affected African American's psychological and physical well-being, with end outcomes fluctuating from somatic complaints, depression, and anxiety to post-traumatic stress reactions [1]. Despite the increased risk, a great number of African Americans exhibit psychological resilience rather than psychological distress.

Resilience corresponds to universal protective factors; it is not specific to race or culture. It is a process that evolves throughout a person's lifetime and unfolds from circumstance to circumstance. It is also variable, and an individual can experience and express resilience differently to an identical stressor over time [1]. The development of resilience requires exposure to adversity and positive adaptation. Adversity is any suffering related to unfortunate conditions or events, and traumatic experiences. Positive adaptation is defined as behaviorally manifested social competency or accomplishments in overcoming biologic, psychological, and social challenges throughout a person's life. Resilience corresponds to universal protective factors; it is not specific to race or culture. Hopefulness, inquisitiveness, elevated levels of energy, and the skill to detach and intellectualize problems combined with self-assurance, positive affect, self-efficacy, self-esteem, optimistic emotions, spirituality, and extraversion shield an individual from potentially harmful trauma and promote resilience.

Cultural factors are the cornerstone of understanding resiliency. Cultural socialization and social support networks are facets of African American culture that are protective against psychosomatic stress. Similarly, ideas that foster cultural pride, heritage, and history promote resilience and have generally been correlated with enhanced academic achievement, racial identity development, and positive intellectual and socioemotional results.

Studies show that firsthand knowledge or experiences of trauma increase the likelihood of a resilient reaction [1]. This provides a reasonable rationale for African Americans and other minorities exhibiting more resilience than White Americans.

WHITE PRIVILEGE

Rebecca C. Hong, author of *Black Dignity/White Fragility: An Extended Review*, emphasizes DiAngelo's analysis of the social construction of race in America, with its earliest roots emerging with the historical and inhumane acts of colonization, slavery, imprisonment, and systemic injustice [5]. These events, originating from racial prejudice and a belief in white superiority and embraced and preserved by institutions and creeds, have reaped benefits at the expense of manipulating and persecuting minorities. Hong argues that racism is profoundly embedded in the structure of our society and has permitted Caucasian Americans to have collective and institutional power and privilege over minorities. Labeling and accepting this power and white privilege allows for a genuine acknowledgement of whiteness as a position and status that has justified beliefs in white supremacy.

Recognition of white privilege and self-awareness elevates racial dialogue past complicity with the overall political, economic, and social system that persists as a structure [5]. The mainstream political, economic, and social systems, originally created to support Caucasian Americans, are represented in the American entertainment industry, professional sports, government, and education. Systems and structures have historically focused on whiteness as the standard or norm. Hong asserts that [5]:

> When talking to white people about race, DiAngelo exposes common "color-blind" statements, such as "I was taught to treat everyone the same" and "So-and-so just happens to be black, but that has nothing to do with what I'm about to tell you," or "color-celebrate" claims that show they are free of racism, such as "I have people of color in my family" and "I was on a mission in Africa."

These types of statements come from a place of denial—denial of structural advantages offered to White persons and denial of the different experiences and realities of various races and ethnicities [5]. These expressions display a limited understanding of how profoundly socialized whiteness is and the deep-rooted racism that persists in society. This impedes the possibility of having vital inter-racial conversations about race and the personal, interpersonal, cultural, historical, and structural analysis required to challenge the larger system [5]. In challenging the current racial paradigm, Caucasian Americans are encouraged to respond to feedback regarding uninformed racist attitudes, behaviors, and beliefs with humility, interest, gratitude, and a position to listen, reflect, apologize, believe, process, and seek more clarity and understanding. Hong states that acknowledging white privilege [5]:

> ...is centered on openness and humility and holds the ability to transform individuals and systems that have benefited from systemic racism. It places the onus on white people to educate themselves, be uncomfortable, discuss their own internalized racial superiority, and invest effort in interrupting their own white fragility. DiAngelo recognizes that in order to break from perpetuating racial inequality, white people need to have courage to break from white solidarity, a system that has afforded them unearned privileges, and be accountable for their own racial growth. This is not the responsibility or burden of people of color.

IMPACT OF STRUCTURAL RACISM

As discussed, racism has been identified as a system of advantage instituted by race [6]. Institutional racism permits those in power and who are empowered to regulate the social, economic, and legal outcomes of African Americans and other minorities. By focusing on structural racism, one can recognize the outside forces that require African Americans to develop resilience while highlighting the significance of sustained social justice efforts in eliminating conditions that negatively affect minority populations.

HISTORICAL BACKGROUND

The modern civil rights movement was spurred largely by Jim Crow laws in the South and reactions to legal challenges to segregation and institutional racism. In 1954, the Supreme Court, in the case of Brown v. Board of Education, banned segregated public education facilities at the state level. Many Caucasian Americans had difficulty assimilating this new reality and endorsed institutional practices that restricted the upward mobility of African Americans, such as housing restrictions, educational barriers, and open violence. In 1956, more than 100 congressmen signed a manifesto committing to doing anything they could to prevent desegregation of public schools. Civil rights activists, including most prominently Dr. Martin Luther King, Jr., reacted to this increasing social discontent by promoting and inspiring Americans to live peacefully and amicably with each other. Activists passionately advocated for a society that would develop advantageous conditions for African Americans and all oppressed people.

On August 28, 1963, during the March on Washington for Jobs and Freedom, Dr. King delivered his famous "I Have a Dream" speech, which argued for an end to racial discrimination in America and advocated for civil and economic rights [6]. Dr. King envisioned the world as being a place that embraced racial unity of all ethnicities and races, and one in which all are treated honorably, respectfully, and fairly. Although King's dream of racial harmony is supported lawfully on a national level through the Civil Rights Act of 1964, the effects of institutional racism persist. African Americans remain at increased risk of impoverishment, incarceration, and unwarranted force and homicide by law enforcement compared with Caucasian Americans and most other racial minorities.

RESILIENCE

Resilience is best defined as a vital practice of sustaining positive adaptation and successful coping strategies upon encountering adversity [6]. Academic literature on African American resilience has historically concentrated on the manner in which African American single mothers and children show strength, social networks that promote resilience for African American boys and men, and how resilience correlates to race, love, and nonresident father involvement. Another area of research has been on the prominence of religion for African Americans in conjunction with the strengths of Black communities. Historically, religious involvement and prayer have been symbols of African American resilience; this remains largely true today.

Although resilience has been highlighted as a response to racism, this should not imply that society should be content with the current situation. Instead, society should strive to advance social justice for all Americans, minimizing the need for resilience to racial trauma. Racial discrimination and structural racism adversely impact the individual, family, and collective welfare of minorities, and social justice endeavors have the power to improve the standard of living for these populations.

Structural racism expressed through adverse interactions with law enforcement, mass incarceration, and impoverishment results in dissatisfaction, resentment, anguish, and decreased well-being and longevity [6]. These negative effects should be explored and understood as they relate to clients' experiences and possible trauma exposures. [6].

HOUSING AND POVERTY

Even with the enactment of the Civil Rights Act of 1964 banning housing discrimination, African Americans continue to experience greater rates of poor housing or being unhoused. In the United States, homeownership is considered a main component of economic improvement. However, residential segregation and a racially segmented housing market continue [42]. Unequal access to home loans and the consistent devaluation of homes in Black neighborhoods combine to "constrict the ability of African Americans to build equity and accumulate wealth through homeownership" [42].

African Americans are more likely to be in a lower socioeconomic status than Caucasian Americans, as defined by education, salary, and employment. Low socioeconomic status has been substantially linked to a greater risk for mental health disorders. Even when modified by educational attainment, the unemployment rate for African Americans is substantially greater than their Caucasian counterparts. Employed African Americans are more likely to be in the lowest-paying economic sector.

IMMIGRATION AND MIGRATION

Nearly 42 million people in the United States, or 13.2%, identify as Black and an additional 1% identifies as multiracial [8]. In America, the Black population consists of both African Americans, who often have deep roots in America tracing back to slavery, and African, Hispanic, and Caribbean immigrants [7]. As such, immigration and migration can significantly impact the Black population.

Immigrant and migrant communities have historically and continue to experience oppression and social and legal challenges; these challenges should be addressed by all Americans [9]. The issue of immigration/migration is linked to the concept of who is able to define the character and future of America. Specifically, the racist conception of America as a finished product reflecting Caucasian ideals is damaging to those who do not fit into this ideal. Instead, it is helpful in addressing immigration and racism to think of the country as a culturally diverse, unfinished project. In order to achieve success, African American individuals build unified affiliations, coalitions, and alliances with other individuals and work to build a new world. Coalition building with immigrant communities involves focusing on self-awareness and social justice, with the goal of improving conditions for all people. This is considered the anti-racist approach to immigration.

POLICING AND INCARCERATION

Perhaps the most prominent display of racism today is the disproportionate use of force and deaths experienced at the hands of law enforcement. In response, social movements have advocated for law enforcement to treat African Americans with the equal dignity and respect as all Americans. The eradication of structural inequality would alter conditions that increase the risks to physical and psychological security for this population. African Americans are also excessively represented at all levels of the judicial system. They are more inclined to be detained, incarcerated, and sentenced to stricter terms than Caucasian Americans For example, African American adults are 5.9 times as likely their White counterparts to be incarcerated [43]. Racial and ethnic disparities are more marked in men but occur across the spectrum of sex/gender expression. Mass incarceration impacts both the individual and his or her family.

According to the Sentencing Project, "the rise of mass incarceration begins with disproportionate levels of police contact with African Americans. This is striking in particular for drug offenses, which are committed at roughly equal rates across races" [43]. Although drug use rates are roughly the same across race/ethnicities, Black persons are much more likely to be arrested on drugs charges. In 2010, African American individuals were 3.7 times more likely to arrested on cannabis possession charges than White individuals, despite similar usage rates [43].

Interaction with police is also increased among African Americans. While Black drivers are somewhat more likely than White drivers to experience a traffic stop, they are significantly more likely to be searched and arrested [43]. When they are arrested, African Americans are more likely to be denied bail, to have their case taken to trial, and to be more strictly sentenced.

ACCESS TO HEALTH AND MENTAL HEALTH CARE

Individual and systemic racism have resulted in considerable disparities in the rates of access to health and mental health care (including diagnosis, prevention, and treatment) for African Americans, and these gaps adversely impact community health. Historically, slavery, sharecropping, and segregation, as well as other forms of race-based exclusion from health care, education, and social and economic resources, have contributed to disparities in the African American community. Institutional racism is represented in American medical education, medical practice, and scientific studies, all factors that continue to affect the community. Studies reveal that African American or Black patients are [7]:

- More likely to obtain mental health treatment in emergency and hospital settings
- Misdiagnosed or diagnosed at dispropor-tionately higher rates with schizophrenia and other psychotic disorders
- Less likely to be provided antidepressant therapy, even after controlling for insurance and financial conditions

This, along with decreased rates of access to mental health treatment for African Americans, adversely affects physical and mental health and diminishes relationships with the mental health community [7].

Some African Americans view the healthcare system as a racist institution [3]. In general, this has been attributed to a general mistrust of societal institutions [39]. At times, individual experiences or family recollections of racism experienced in health care contribute, and in America, there is a history of damaging racism in health care (e.g., the well-known Tuskegee study of untreated syphilis in African American men, the nonconsensual harvesting of cells from Henrietta Lacks for medical research). These historical examples highlight the racial inequities entrenched in American research studies and healthcare systems and emphasize the historical disregard of patient consent and privacy for African Americans. Family and community pressure is another consideration. In one study, African American patients with PTSD refused to access treatment due to shame and fear of family or cultural disapproval [40].

In order to enhance the lives of African American patients, mental health practitioners should strive for an understanding of historical, sociocultural, and individual issues that influence the treatments offered to this population. To this end, and to help alleviate racial and cultural prejudices, mental health providers should:

- Re-evaluate professional practices to determine whether these practices relate to the fundamental values of African American culture, such as family, kinship, community, and spirituality.
- Analyze how apparent racial discrimination may cause hypervigilance, anxiety, or depressive symptoms among African Americans.
- Understand and acknowledge personal biases in treatment and bear in mind that African Americans may feel rejected or disregarded by mental health practitioners who misinterpret expressions of emotion by this population.
- Seek out and learn about the experiences of the local African American community.
- Unite with community organizations and leaders to understand more about the range of African American cultures within the community and opportunities to work in partnership.
- Actively listen and genuinely assess every relationship to develop and improve alliances with patients.
- Accurately screen and follow through with quality assessments that employ a biopsychosocial model.
- Maintain talk therapy as a top priority of treatment models from the beginning and offer consistency in treatment.

HEALTH AND MENTAL HEALTH OUTCOMES

As mentioned, racism, racial bias, and discrimination have been linked to poor physical and mental health outcomes among minorities [10]. Institutional racism is a key social determinant of health, along with educational attainment, housing opportunities, accessible employment, health care, and environment, each of which can negatively impact health.

Implicit bias remains a significant issue in health and mental health care. While implicit bias is distinct from racism, the two concepts can overlap. Implicit bias is very basically defined as unconscious or pre-reflective attribution of qualities (usually stereotypes) to a member of a group. These biases affect one's understanding, actions, and decisions and can be related to racial profiling. For example, young African American men are often presumed to be criminals or delinquents, with providers and authorities assuming they are involved in illegal behavior and unlawful activity. These biases can affect the type of care and treatment offered.

In any client who has experienced trauma, acute stress reactions and/or PTSD should be considered. The actual incidence of race-related PTSD is unclear. Of course, an isolated violent event can be a triggering event for PTSD, but vicarious experiences and racial microaggressions are also contributing factors. This extended and persistent trauma is often referred to as complex trauma. Research indicates that minorities have higher rates of PTSD and experience more severe symptoms than Caucasian Americans [11]. Discrimination contributes to these disparities.

The multifaceted trauma experienced by African Americans impacts extended families, with many generations impacted by impoverishment, physical and sexual abuse, domestic and community violence, separation from family and re-victimization by others, mental health disorders, substance use disorders, and adverse interactions with government entities. This type of collective trauma, experienced over time and across generations, has been termed historical trauma. Typically, complex traumas start in early childhood and can disturb numerous facets of development and sense of self.

As discussed, individual trauma emerges from an incident, series of incidents, or set of situations experienced by the person as physically and psychologically damaging or threatening and having long-term negative consequences on one's holistic health [3]. Providers are increasingly aware of the devastating effects of pervasive trauma beginning in childhood. In theory, a significant proportion of the population has experienced a traumatic event. For example, among women of any race seeking substance abuse treatment and community mental health services, 80% to 90% have experienced intimate partner and/or family violence and trauma, usually throughout their lifetime [3]. More than an estimated 90% of all individuals involved in the legal system requiring treatment for mental health disorders (including anxiety disorder, depressive disorders, personality disorders, substance abuse, and eating disorders) have experienced childhood emotional, physical, or sexual abuse. Taken in aggregate, it becomes clear that trauma is a public health crisis.

Research beginning in the 1990s supports the fact that traumatic events in childhood, including abuse, neglect, racism, and family dysfunction, are directly related to acute physical, mental, and behavioral health outcomes, including depression and suicide [34]. Abuse and neglect during childhood are clear adverse childhood experiences (ACEs), but other examples include witnessing family or community violence; experiencing a family member attempting or completing suicide; parental divorce; parental or guardian substance abuse; and parental incarceration [35]. When experienced in childhood, exposure to racism (e.g., discrimination, stigma, minority stress, historical trauma) is also considered an ACE. However, structural racism is also a factor in many other traditional ACEs, including birth trauma, community violence, housing instability, and poverty. As such, African American adults are more likely than the White population to have experienced ACEs [41]. Adults who experienced ACEs are at increased risk for chronic illness, impaired health, violence, arrest, and substance use disorder [36; 37].

An extensive history of injustice and hostile societal treatment has resulted in complex and collective traumas in African American communities. These trauma histories include mutual, historical encounters across generations (e.g., lynchings, slavery, police brutality, mass incarceration). Historical and modern-day encounters with racial discrimination are persistent reminders of the constant dehumanization and devaluation of African Americans.

EVIDENCE-BASED PRACTICE RECOMMENDATION

When providing mental health services for African Americans, the American Psychiatric Association recommends exploring how a patient's present experiences connect to historical trauma for a particular group or community.

(https://www.psychiatry.org/psychiatrists/cultural-competency/education/stress-and-trauma/african-americans. Last accessed May 6, 2021.)

Level of Evidence: Expert Opinion/Consensus Statement

Historical trauma narratives include public reminders of chronic mass traumas, structural inequalities, dominant cultural narratives, and public symbols, as well as family or personal stories, which may include perceived historical loss and discrimination, microaggressions, and personal trauma [10]. Of course, historical trauma is not limited to the African American community; it applies to numerous populations that have historically been ostracized and oppressed, including Asian Americans, Hispanics, Indigenous peoples, gender and sexual minorities (also referred to as lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/ally or LGBTQIA+), religious minorities, undocumented immigrants, women, and disabled persons. If an individual's cultural identity interconnects with multiple marginalized groups, then he or she may encounter many forms of historical trauma. Key terms when treating historically marginalized populations include [10]:

- Historical trauma narratives: Stories of historical trauma, including oppression, injustices, or disasters, experienced by a population.
- Contemporary reminders of historical trauma: Ongoing reminders of past trauma in the form of publicly displayed photographs and symbols as well as contexts, systems, and societal structures and individually experienced discrimination, personal traumatic experiences, and microaggressions.
- Narrative salience: The current relevance or impact of the historical trauma narrative on the individual and/or community.
- Microaggression: Historically, an everyday, subtle, and nonverbal form of discrimination. Today, the term is used to describe both verbal and nonverbal subtle forms of discrimination that can be experienced by any marginalized population.

The American Psychiatric Association recommends the following steps when providing services to oppressed minorities [10]:

- Use the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) to provide an assessment framework of an individual's mental health, especially as it relates to sociocultural context and history.
- Perform a Cultural Formulation Interview (CFI). This is a set of 16 questions that providers may use to obtain culturally relevant information during a mental health assessment. This instrument examines the impact of culture upon an individual's clinical presentation. The CFI identifies four domains: cultural definition of the problem; cultural perception of cause, context, and support; cultural factors affecting self-coping and past help seeking; and cultural factors affecting current help seeking.
- Consider using the CFI's 12 supplementary modules to gain additional insights into specific patient groups. Modules exist for immigrants and refugees, children and adolescents, older adults, and other special populations.
- Affirm the importance of cultural competency training for providers including (but not limited to) learning about implicit bias, microaggressions, trauma-informed care, and culturally sensitive treatment.
- Consider the cumulative and overlapping impact of historical trauma and microaggressions upon the mental health of people belonging to multiple marginalized populations, known as intersectionality.
- Emphasize self-care for all patients by encouraging healthy routines for sleep, diet, exercise, and social activities. Consider the role of self-affirmations, vicarious resilience, meditation, yoga, and other forms of traditional, alternative, or complementary care in mental health.
- Increase social supports for patients by engaging their family, social networks, and community in their care, as appropriate.
- Stay abreast of current news and events, particularly those that may affect specific marginalized patient populations. At the same time, try to be mindful to avoid information overload, which may contribute to provider burnout.
- Work with religious and spiritual leaders to provide faith-based mental health care, as appropriate.

TRAUMA- AND STRESSOR-RELATED DISORDERS

Racial trauma or race-based traumatic stress is the stressful effect or psychological distress resulting from an individual's experience with racism and discrimination [12]. Stress responses to racial trauma involve heightened vigilance and suspicion, greater sensitivity to threat, sense of a foreshortened future, and maladaptive reactions to stress (e.g., violence, drug use). Aside from stress responses, racial trauma can also lead to adverse effects on physical and mental health.

Stress is a natural, biological response (physiologic and cognitive) to circumstances identified as threats or challenges. Most stresses of daily life are manageable with appropriate coping skills and support networks. However, longstanding and extensive exposure to stressful and negative experiences, particularly without positive mitigating factors, can be harmful.

When an individual receives or foresees a threat, the brain's limbic system, or survival brain, delivers a distress signal that releases stress hormones [12]. This is the typical bodily reaction considered essential for survival. If an individual experiences chronic stress, there is a continuous stream of stress hormones and he or she remains hypervigilant to their environment. Due to the pervasiveness of racial discrimination, racial minorities usually experience this heightened stress. Systemic racism, routine racial discrimination, and the dread prior to racist incidents can cause minorities to live in a perpetual state of stress, leading to adverse physical effects such as hypertension, increased blood glucose levels, and cardiovascular disease.

In the DSM-5, several trauma- or stress-related disorders are identified, including PTSD, acute stress disorder, adjustment disorders, reactive attachment disorder, and disinhibited social engagement disorder [44]. Aside from being triggered by exposure to real or threatened violence or injury/death, these disorders are characterized by hyper-arousal, intrusion, avoidance, and negative cognition/mood symptoms.

Exposure to race-related trauma may be the originating factor in the development of an adjustment or stress disorder [12]. This effect is exacerbated by the increasing impact of multiple traumas, such as community violence, financial and/or housing insecurity, and victimization. Practitioners should take into account the adverse effects of racial trauma on their clients and use that as a mechanism for trauma-informed practice.

Many mental health practitioners fail to acknowledge racism as a trauma unless a person encounters an overt racist event (e.g., a violent hate crime) [14]. This limits the effectiveness of interventions and can damage rapport with the client. (It is also a potential failure of the practitioner to practice culturally competent care.) It is vital to recognize that a minor event can elicit traumatic responses. If asked about an overt event, minority patients may fail to report or correlate cumulative experiences of discrimination with PTSD or mental disorder symptoms. The notion of trauma as an isolated event is often insufficient for culturally diverse populations. Therefore, it is critical for practitioners and scholars to create a more thorough understanding of trauma experienced by minorities.

IMPACT OF SEX AND GENDER ON AFRICAN AMERICAN HEALTH AND MENTAL HEALTH

As discussed, oppression can occur on several levels, and the intersection of multiple potential areas of oppression can further impact health and mental health outcomes. For example, the stereotype of the strong Black woman could potentially contribute to African American women failing to access treatment for mental health issues such as trauma. Help- and information-seeking behavior related to male gender identity is another factor that affects African American men's health.

In general, men are reluctant to seek care or talk about their health because they see such help-seeking as a sign of weakness or vulnerability and a threat to their masculinity. This is a reflection of the traditional construction of gender roles and identity, whereby boys are taught that self-reliance and stoicism are preferred. Men who embrace these gender ideals are less likely to engage in preventive medical treatment and mental health treatment. In the Black population, men have reported to avoid healthcare services because of fears and concerns about their negative health behaviors and history [19]. For example, Black men have reported avoiding screening for prostate and colorectal cancer because they see these procedures as "violating their manhood" [19; 20].

Among men who do have physician office visits, many are not forthcoming about symptoms or information they seek [21]. Because of their traditional discomfort with expressing feelings and emotions, they are less likely to seek help for psychosocial problems or emotional symptoms [22; 23]. Men tend to be more motivated to seek health care for male-oriented conditions, such as erectile dysfunction or sports-related injuries, or when their health or symptoms interfere with their routine activities [23].

Theoretically, there may be racial differences in culturally acceptable gender roles and masculine identity [4]. For African American men, slavery, a matriarchal family and community structure, and the civil rights movement are intertwined with gender identity. Franklin theorized that African American men repeatedly feel invisible due to cross-racial relations, which leads to issues associated with negative self-identification, adverse coping strategies, and elevated stress responses. Feelings of invisibility are strengthened by cultural and environmental factors, such as media stereotypes, microaggressions, and discrimination. Furthermore, invisibility syndrome impedes African American men's difficulties with identity formation and help seeking.

There also appear to be differences in the impact of perceived racial discrimination in African American women and men. In one study following 681 Black youths for 18 years, racial discrimination was associated with negative mental health consequences for both genders [24]. However, Black boys and men seem to be more susceptible than Black girls and women to the psychological effects (e.g., anxiety, depression) of an increase in racial discrimination over time.

RAPPORT BUILDING AND INTERVENTION PLANNING

ACKNOWLEDGING AND ADDRESSING RACE

Compared with Caucasian Americans, African Americans are less likely to follow through with or take advantage of health and mental health services [4]. Historical factors, such as the exploitation of African Americans in clinical trials, institutional racism, and biased healthcare services, have contributed to this disparity. The underutilization of healthcare services results in shorter lifespans, increased morbidity and mortality, and undiagnosed, misdiagnosed, and/or untreated health and mental health disorders. African American men are less likely than women to engage in therapy, preventive health services, and other healthcare services. Even today, African American men are one of the most underserved minority groups.

A myriad of factors, including genetics and cultural beliefs and practices, impact the symptoms and mental health disorders that occur in a particular population and a specific client. These same factors often impact a client's help-seeking behaviors. Work, Cropper, and Dalenberg state [25]:

> Despite evidence that ethnic minorities may experience higher rates of stressors and exposure to high-magnitude stressors and traumatic events, the non-Caucasian population of the United States is actually less likely to seek treatment than their Caucasian counterparts. Research has suggested that this may be the product of a social stigma against seeking services in many cultures, the fear of exposure of personal information to outsiders, the experience of misuse of information by authorities, and lower likelihood of access to culture-friendly explanations of available treatments.

Minorities who engage in mental health services are mainly connected with a practitioner of an ethnic/racial background in contrast to their own and therefore may feel uncomfortable discussing their experiences or may have cultural differences in help-seeking behaviors. Research on cross-racial therapeutic dyads has found client dissatisfaction and a lack of sensitivity in the way race was introduced by the therapist [25]. It is important to note that professionals have a responsibility to address any discomfort they may have discussing race and racism so it does not affect their clients. Work, Cropper, and Dalenberg recommend the following approaches to approach race-related issues [25]:

- Tackle the subject of race as theoretically important to therapeutic issues and talk therapy.
- Recognize any challenges with verbally communicating racial connections and disparities.
- Reflect upon acknowledging racial privilege.
- Discover opportunities to enhance racial sensitivity and awareness of cultural stereotypes.
- Advance clinical training.
- Expand community outreach endeavors.

For a variety of reasons, practitioners are often hesitant about introducing racial issues in counseling or therapy [25]. However, providers who openly communicate and display competency for race-related issues are more effective in their work with minority clients. Early conversations regarding the client's goals and expectations can influence the progression of therapy, offering opportunities to discuss any challenges or concerns and diminishing the power differential. These interactions should particularly refer to the advantages and disadvantages associated with a cross-racial pairing of therapist and client, if present. Acknowledgment of the limited expertise of the provider on cultural differences when establishing rapport offers a safe path for client correction of the provider or recommendations of alternative explanations of behaviors.

When discussing race and culture in therapy, it can be challenging for the client to verbalize cultural beliefs or practices that may be shared or diverged with the provider [25]. It is vital to discuss the indistinctness of culture to those dwelling within it. As discussed, cultural norms about symptoms or belief expressions impact the nature of therapy, and the likelihood that a communication challenge or different perspective may have a cultural bias should be explored. In addition to acknowledging the subject of race, providers should contemplate the therapeutically appropriate timing of addressing racial experiences. A colorblind approach is often ineffective and can impede therapy. This can also be true when the client and provider are both African American. It is vital not to assume a shared belief system or trauma history based only on shared race or ethnicity; however, appropriate sharing or supporting may be more effective in these dyads.

If a provider is Caucasian American, verbal recognition of his or her experienced privileges can offer a powerful therapeutic exchange [25]. Multicultural competency is essentially intended to enhance the provider's knowledge of cultural differences and potential stereotypes, but it is not possible to have an awareness of all stereotypes. Over the course of therapy, the provider should offer the client a safe environment to examine these stereotypes. In these discussions, the goal is for the client to understand the provider's awareness of the stereotypes and their potential negative impact on his or her life. By normalizing anxieties and fears in discussions of race and by using role-playing and experiential exercises, practical beneficial gains can be made.

In addition, providers may benefit from preparing acceptable language to initially raise the issue of race in the therapeutic relationship. This can be accomplished by seeking experts and/or mentors in the community and by researching appropriate terminology and approaches. Instead of focusing efforts solely on becoming an expert in a client's culture, providers should work toward fostering a safe environment to freely discuss disparities and acknowledge a shared discomfort on the subject of racial differences [25].

POST-TRAUMATIC GROWTH STRATEGIES

If untreated and unprocessed, the effects of race-based trauma can develop into depression, anger/rage, and a battered sense of self [4]. Mental and behavioral health professionals should strive to uncover, acknowledge, and treat these wounds. Strengths-based, activity driven, and preventive choices are approaches for enhancing African American clients' engagement in therapy.

While providing therapy services to African American clients that address race-based trauma, post-traumatic growth strategies are recommended [4]. Traumatic events challenge a person's previously held beliefs about the world and can affect how they define themselves and others. Discovering meaning or purpose in the trauma allows individuals to develop effective coping and self-care skills.

Although exposure to trauma has proven to have many adverse effects on physical and mental health, the possibility for positive change after hardships, torment, and suffering has long been established [4]. Modern researchers refer to this phenomenon as post-traumatic growth. An opposite extreme to PTSD in the spectrum of reactions to trauma, post-traumatic growth encompasses the resilience and growth that can ensue when a person develops meaning from a traumatic event. In one study, resilience was the most common outcome of potentially traumatic events [45]. The literature is mixed, however, on outcomes of trauma for those who live in contexts of ongoing war and chronic terrorism [46].

Some experts frame post-traumatic growth as a coping technique, while others posit that it is actually an effect of positive coping after a traumatic event [4]. Regardless, individuals who experience post-traumatic growth may display a heightened sense of kindness and empathy toward others, improved intimate relationships, and a genuine appreciation for life. Persons with these types of reactions to trauma report increased levels of independence/self-efficacy, better control over themselves and their environment, more positive interactions, a willingness to grow, improved self-acceptance, and the faith that they have uncovered their purpose in life [4].

It is important to note that race-based trauma does not need to meet a minimum level of severity in order to induce post-traumatic growth (or PTSD, for that matter). African American individuals are repeatedly subjected to implicit racial discrimination, resulting in verbal, behavioral, and environmental humiliations that nonetheless convey aggression or dehumanization due to their race. As these microaggressions accumulate, feelings of loneliness, loss of self-control, emotional detachment, intrusive rumination, and reduced self-care can follow. Interventions that promote post-traumatic growth emphasize the individual experience, recognize environmental conditions reinforced by trauma, and are exemplary tools when providing services to African American clients. Evidence-based interventions to promote post-traumatic growth include trauma-focused cognitive-behavioral therapy and written or verbal self-expression [47].

Intrusive or excessive rumination on traumatic events can be harmful to growth and healing. Certain models of cognitive processing encourage post-traumatic growth, while others are associated with negative outcomes [4]. Specifically, active coping styles have been positively linked to post-traumatic growth. Active coping strategies are characterized by directive problem-solving techniques, actively seeking social support, and employing reappraisal methods to reassess the situation. In contrast, passive coping strategies emphasize avoidance and techniques such as distancing, escaping, wishful thinking, and self-control. Mental health professionals should focus on positive cognitive processing practices. Promoting post-traumatic growth among African American clients involves a combination of cultural competence and the application of practices tailored for the care of trauma survivors. As discussed, enhancing one's cultural competence requires self-awareness and a working knowledge of cultural traditions and culturally appropriate interventions. Awareness of power, privilege, and racial oppression is also relevant.

CULTURALLY RELEVANT INTERVENTIONS TO PROMOTE POST-TRAUMATIC GROWTH

As discussed, acute traumatic responses result from a normal reaction to overwhelming stress and may be construed as a set of adaptive survival mechanisms that become pathologic if the traumatic experience remains unresolved or when the precipitating event(s) have passed. With repeated or chronic trauma exposure, such as that experienced by racial minorities, the effects of unresolved trauma are pervasive and become the central organizing structure around which profound neurobiologic adaptations occur [15; 16].

The symptom profile of complex trauma/PTSD recognizes deficits in emotional, social, cognitive, and psychologic competencies as the result of a failure to develop properly or deterioration from prolonged trauma exposure. Thus, treatment for complex trauma emphasizes reduction of psychiatric symptoms and, equally important, improvement in key functional capacities for self-regulation and strengthening of psychosocial and environmental resources. Loss of psychosocial resources, including deficits in self-efficacy, prosocial behaviors, or social support, is common and contributes to the severity and chronicity of PTSD symptoms. Therefore, strengths-based interventions to improve functioning, contribute to symptom management, and facilitate patient integration into family and community structures are integral to each phase of treatment [17; 18].

THE ROLE OF RUMINATION

After a traumatic event, an individual may engage in a process to restructure his or her view of the world and to encourage positive growth by developing meaning from the trauma [4]. The recommended process for developing meaning starts with substantial rumination, which can create a state of sustained heightened stress and hypervigilance for the individual and requires support and significant coping skills. With sustained hypervigilance, individuals escalate to deliberate rumination. This thoughtfulness can result in meaning-making approaches, decreased stress and related

symptomatology, and the development of post-traumatic growth. However, it is common for post-traumatic growth and event-associated distress to co-exist until the traumatic event has been resolved and/or fully processed. Instead of avoiding rumination, which would impede growth, providers should encourage safe rumination practices.

In order to diminish stress symptomatology during rumination, clinicians should incorporate post-traumatic growth approaches, integrating meaning-making and stress reduction techniques, when providing services to clients who have experienced race-based trauma [4]. Potentially useful interventions include:

- Refuting cognitive distortions
- Offering psychoeducational training on mindfulness and relaxation techniques
- Identifying healthy and effective coping skills
- Commemorating one's individuality (including race, gender, sexuality, age, etc.) through meaning-making activities

STRENGTHS-BASED APPROACHES

Personality, social, and psychosomatic factors all add to post-traumatic growth, and acknowledging individual strengths can help foster healthy cognitive processing [4]. Personality traits positively correlated with post-traumatic growth include extraversion, openness, agreeableness, conscientiousness, and optimism, and providers can promote these traits by fostering an environment that encourages self-efficacy and accentuates self-esteem. Collective memory exercises, narrative therapy, and an Integrity Model approach may all be helpful. The Integrity Model involves five distinct steps: safety, stability, strength, synthesis, and solidarity, and has been particularly recommended in work with men [26]. Strengths-based and solution-focused methods may be particularly valuable for African American male clients, as these offer problem-focused interventions consistent with typical male preferences for therapy [4].

It is vital that people individually evaluate the traumatic event and recognize and accept that their response to it is normal. Clients experiencing an increased awareness of harm or danger during the event may be better able to access post-traumatic growth. This association may be the result of increased self-awareness and sense of control. Some have suggested that in order for growth to occur, trauma has to be substantial enough to cause the individual to question earlier viewpoints, triggering rumination and reflection. If a viewpoint is not challenged or is reinforced by the traumatic event, post-traumatic growth may be less likely [4].

Mental health practitioners should consider providing strengths-based assessments and therapeutic interventions that focus on maladaptive thoughts (i.e., thought-stopping techniques and cognitive restructuring) to all individuals presenting with race-related trauma. By concentrating on strengths and positive cognitions, practitioners can help African American clients practicing resilience exercises evaluate individual experiences and potential coping techniques. Psychoeducational strategies, justification of the client's encounter, and collaboratively encouraging and supporting the individual can improve service delivery.

CREATING A SAFE ENVIRONMENT

Addressing race-based trauma and post-traumatic growth requires practitioners to have training in and comfort with discussions of racism, discrimination, and race-based trauma [4]. Caucasian practitioners in particular may consider incorporating techniques to aid in creating a safe environment for race-based conversations with minority clients.

Practitioners have a responsibility to recognize and identify trauma and should work to help process the trauma in the absence of rationalizing, correcting, or altering the viewpoint of the client. Clients assessing and exploring the importance of experiences of discrimination and racism benefit from talks centered on coping, resilience, and meaningful living without minimization of the experienced trauma. Practitioners may further help their clients with pinpointing useful coping strategies and promoting positive emotional functioning. Some individuals will relate feelings of invisibility, pressures of gender norms, and self-fulfilling prophecies. While it is important to recognize and validate this experience, practitioners should help clients identify skills that are gained through processing pain and distress. This can include exercising empathy for all victims of oppression and discrimination and becoming a change agent for future generations of African Americans.

SOCIAL SUPPORT

Social support is defined as access to individuals who offer compassion, solidarity, and coping support [4]. In the African American community, social support often involves sharing encounters and occurrences as a method of coping with racism. Social support systems may include family members, friends, neighbors, colleagues, ministers, or more formal social or activist groups. For clients with specific mental health needs, support groups, 12-step programs, and group therapy may be appropriate sources of support. These supports provide an adaptable shield against stress and are an opportunity to promote diversity and healthy coping. Individuals with good social support report a sense of connectedness and mutual understanding of racist encounters.

Contentment with social supports has been correlated with increased post-traumatic growth and reduction of PTSD symptoms in war veterans [27]. Furthermore, a strong, healthy support system may further contribute to the safety of self-disclosure. As such, social support has a clear role in promoting post-traumatic growth, with impact on a client's coping style, cognitive processing, and meaning-making expression [4]. Professionals should focus on identifying environmental supports as opposed to barriers. Meeting a client in a relaxing community-based setting, welcoming supportive individuals to therapy sessions, and encouraging discussions with social communities are all advantageous.

RELIGION AND SPIRITUALITY

Some have argued that religion and spirituality in African American culture are shaped by political and social contexts, particularly issues of race/racism, slavery, oppression, justice, and liberation [28; 29]. Notions of being freed from bondage, as espoused in Christian tenets, resonated with many slaves. It is important to remember this historical backdrop and how it continues to influence the views and coping mechanisms of African Americans today.

Spirituality for African Americans has been referenced in the following manner [30]:

> Faith in an omnipotent, transcendent force, experienced internally and/or externally as caring interconnectedness with others, God, or a higher power; manifested as empowering transformation of and liberating consolation for life's adversities; and thereby inspiring fortified belief in and reliance on the benevolent source of unlimited potential.

God, Allah, and figures of a higher being are viewed as conquerors for the oppressed. Consequently, religious and spiritual orientations are often used among African Americans both to deal with and construct meaning from oppression and promote social justice and activism [28].

In African American culture, a deep belief in spiritual and church-based practices can safeguard against trauma or it can be an obstacle for accessing treatment, as the church is a source of coping (sometimes to the detriment of other options). Devotion to religion, active engagement in spiritual activities, reflective prayer, willingness to transform, and a desire to explore perplexing questions connected to one's faith have all been positively associated with post-traumatic growth [4]. Membership in a religion or spiritual group offers a social support network, explanations for adverse experiences, and strategies for active coping following a traumatic event (or continued trauma). Acceptance, hope, life satisfaction, and stress-related growth have been reported results of positive religious coping strategies [31]. Conversely, negative religious coping (e.g., believing in a vengeful God, spiritual dissatisfaction) is predictive of PTSD symptoms. Survivors of racial trauma may be faced with reforming their views of the world and of God/a higher power as a result of a traumatic event. In these cases, clients are compelled to examine prior beliefs about religion and spirituality to develop a new belief system or to devote themselves more fully to an existing system.

Practitioners should integrate religion and spirituality into mental health care as appropriate [4]. In instances of race-based trauma, practitioners may aid clients with exploring their existing value system (e.g., beliefs, preconceptions, contradictions). At a minimum, three areas should be explored in a spiritual assessment: denomination or faith, spiritual beliefs, and spiritual practices [32]. If, in the initial assessment, it is clear that neither spirituality nor religiosity plays a dominant role in a client's life, it should not be a focus of interventions moving forward. If the practitioner finds that either spirituality or religiosity is a key dimension, a more comprehensive assessment is required. Practitioners may gain more understanding of their client's identity by inquiring about their viewpoints of life and their significance and purpose, with spirituality as a component of this overall assessment. This can be used to drive conversations of race and build rapport. In clients for whom it is important, emphasizing the significance of religion and spirituality may open opportunities for social support networks, active coping, and meaning-making.

In general, incorporating religion and spirituality into practice should not be spontaneous [33]. It should be thoughtful and systematic. In some cases, such as when a patient feels rejected by God/higher power or has been abused by a spiritual/religious leader, attempts to include spirituality/religion can trigger trauma reactions and anxiety [33].

The American Psychological Association recommends that clinicians aim to understand and encourage Indigenous/ethnocultural sources of healing within professional practice.

(https://www.apa.org/about/policy/guidelines-race-ethnicity.pdf. Last accessed May 6, 2021.)

Level of Evidence: Expert Opinion/Consensus Statement

TRAUMA-INFORMED CARE

It is important to use a trauma-informed approach when assessing and caring for potential victims, which requires that practitioners understand the impact of trauma on all areas of an individual's life [38]. Physical, emotional, and psychological safety is at the heart of trauma-informed care. This approach allows for trust-building and continued communication, both vital to ensuring that patients receive the care and support they require.

Being trauma-informed is a strengths-based approach that is responsive to the impact of trauma on a person's life. It requires recognizing symptoms of trauma and designing all interactions with victims of racial trauma in such a way that minimizes the potential for re-traumatization. This involves creating a safe physical space in which to interact with clients as well as assessing all levels of service and policy to create as many opportunities as possible for clients to rebuild a sense of control. Most importantly, it promotes empowerment and self-sufficiency.

EVIDENCE-BASED PRACTICE RECOMMENDATION

The American Psychiatric Association recommends using validation and empowerment in treatment of African American clients. For example, normalize—instead of pathologizing—the feelings of stress and anxiety that Africans Americans experience due to continuous reports of police brutality and racial discrimination. Identify coping skills that may help patients deal with these feelings.

(https://www.psychiatry.org/psychiatrists/cultural-competency/education/stress-and-trauma/african-americans. Last accessed May 6, 2021.)

Level of Evidence: Expert Opinion/Consensus Statement

When providing trauma-informed care, the practitioner should acknowledge that an individual's specific life experiences will affect his or her responses to traumatic events and opportunities for support and care. Because trauma is a societal problem, trauma-informed care should be practiced throughout health care and educational, legal, and governmental agency settings. In the clinical setting, trauma-informed care requires shaping every patient encounter in a way that empowers recovery and inspires resilience.

Trauma-informed care is based on the values of encouragement, options, cooperation, credibility, security, and client autonomy [3]. Frequently, traumatic events signify removal of power; affectively caring for trauma survivors therefore entails being cognizant of the power dynamic between client and practitioner. When individuals feel a sense of control over their lives and power over treatment and care, the process of healing and recovery accelerates. Encouragement involves recognizing and using patients' strengths in the beginning of treatment rather than focusing on diagnoses, vulnerabilities, or victim status. Truthfulness involves conveying clear-cut and reasonable expectations of the treatment process and fulfilling one's obligations. Likewise, promoting client autonomy through collaborative treatment planning is a crucial aspect of trauma-informed care. Providers and clients should be partners in care and mutually participate in care provided by the entire interprofessional team (including health and mental health practitioners, ancillary staff, community members, and family, as appropriate).

Security is a core principle of trauma-informed care, and this is manifested in many areas [3]. The basis is good clinician-client rapport. Shared respect is critical to a patient's feeling of psychological well-being. Security can also be fostered by a positive and safe physical setting. For clients who are acutely ill, both the illness experience and treatment process can produce trauma. This is particularly true if involuntary detainment or hospitalization is necessary, but exposure to other individuals' narratives of experienced trauma or observing atypical behaviors from individuals presenting as violent, disorganized, or harmful to themselves can also be traumatic. As such, care environments should be controlled in a way to minimize traumatic stress responses. Trauma-informed care providers will keep this in mind when structuring the environment (e.g., lighting, arrangement of space), creating processes (e.g., layout of appointments or care systems, forms), and providing staff guidance (e.g., nonverbal communication, intonation, communication patterns). During each encounter, the client's perception of safety is impacted by caretakers and ancillary staff.

Trauma-informed approaches are the standard of care whether or not a client has disclosed or experienced trauma [3]. Therefore, trauma-informed approaches can be initiated even before providers have knowledge of clients' traumatic experiences or have completed a full assessment.

The first step is to establish safety, security, and harmony with clients—the basics of client-centered care. The next consideration is individualized treatment. Trauma-informed care requires acknowledgement of the exclusivity of individual experiences, which are impacted by a collection of factors, including race, culture, ethnicity, nationality, sex/gender, age, and socioeconomic status.

CULTURAL AWARENESS AND HUMILITY

It is within and across a cultural framework that individuals create their truths, values, and personalities. The multifaceted relationship between experiences, individual biology, psychological resilience, cultural context, and social supports is both a source of trauma and of resilience building. Patients carry all of these factors into the clinical encounter.

Traumatic experiences do not occur outside of cultural perceptions, and cultural and societal structures impact and occasionally trigger trauma [3]. For example, racial trauma can result from work-related incidents or hate crimes, or it could possibly be the outcome of a buildup of microaggressions and cumulative minor occurrences relating to routine rejection. Ranjbar et al. states [3]:

> Although some patient populations may be more susceptible to trauma exposure on the basis of sociodemographic circumstances, culture is one of the mitigating factors that play a role in the variability of individual response to potentially traumatic events.

The cultural elements of African American culture and family cohesion may reinforce resilience, promote healing, and/or minimize the impact of trauma. In one study, high levels of resilience were noted in a sample of primarily trauma-exposed, inner-city African American adults [3].

In order to best meet the needs of clients who are culturally diverse, clinicians should explore their own self-identity, culture, individual history, and implicit biases [3]. Instead of working from the belief that patients from certain cultures or social environments require specific treatment, clinicians should reflect on culture being a vehicle for strength and a tool for healing. For clients whose histories include deeply distressing circumstances (e.g., warfare, sexual abuse, violence, racism), traumatic encounters will affect their cultural identity and worldview, potentially resulting in significant adverse mental and physical health effects. Healing focuses on the crossroads of trauma and culture.

While culture is an undeniably important aspect of mental health assessment and treatment, it is not possible for a clinician to know everything about a client's culture. Cultural humility is an open-ended approach to understanding, whereby the clinician approaches every encounter with an appreciation for the unknowability of culture [3]. The extent that culture is entrenched in personality, biology, individuality, and psychology is to some extent indescribable. Cultural humility involves acknowledging cultural experience as not fully analyzed or understood but appreciated and respected. Vital components of this approach are shared learning, crucial self-awareness, identification of power imbalances, and acknowledgment of the reality of implicit biases. Its practice can generate civil alliances and institutional liability.

In the clinical context, cultural humility can be the guiding notion for the practice of trauma-informed care in focusing and empowering patients to focus on healing and avoiding dominating the session. Clinicians should be open to being educated about ways a client's cultural background may play a part in the healing journey [3]. This may require connecting with family members or community organizers to incorporate cultural resources into the treatment plan or using cultural contacts to initiate constructive healing work. Because response to and affiliation with one's cultural upbringing, experiences of racism, and healthcare experiences are unique to each person, every client and every encounter should be approached humbly and with an open mind.

ETHICAL CONSIDERATIONS

Trauma-informed care, cultural humility, and addressing racial trauma are all in alliance with the ethical principles of autonomy, beneficence, nonmaleficence, and competency [3]. In general, all mental health providers should work to identify and eliminate discriminatory policies, demonstrate compassion, recognize patients' human rights and dignity, engage in lifelong learning, and contribute to the growth of society and community health. Culturally respectful encounters with patients from a variety of cultures contribute to the clinician's personal and professional development. In codes of ethics and ethical literature, there has been a move away from the term "cultural competence" and toward "cultural awareness," a change that acknowledges the fact that improving one's knowledge and appreciation of diverse cultures is an ongoing process. A vital aspect of this process is openness to new information and change. All clinicians should allocate time for self-reflection and analysis of their own cultural beliefs, experiences, and biases. After every encounter, reflect on whether the client's needs were paramount and remain the focus of ongoing treatment; ethical responsibility necessitates that the patient's interests be the utmost goal. Treatment approaches and diagnoses should evolve along with the client.

Trauma-informed care adapts to the principles of ethical practice established in the mental health fields [3]. Every decision and approach should be made with consideration of the professions' codes of ethics and ultimate purposes.

ADVOCACY AND SOCIAL JUSTICE

Racism occurs at interpersonal, environmental, institutional, and cultural levels, and eradicating racism and racial trauma necessitates interventions on every level (e.g., individuals, families, communities, and the entire nation). This should include advocacy and implementation of policy changes that eradicate structural racism in communities. As Congresswoman Shirley Chisholm said, "Racism is so universal in this country, so widespread and deep-seated, that it is invisible because it is so normal" [13]. National issues such as mass

incarceration, employment disparities, and the achievement gap should be addressed in order to reduce structural racism, alleviate some racial trauma experienced by African Americans, and improve socioeconomic position and related helplessness. One example of a macro-level intervention to address systemic racism is taking steps to improve the education system to better reflect African Americans' lives, culture, history, and experiences, with particular attention to the punitive approach to educating African American boys.

CONCLUSION

Acknowledgment of the historical context of racism and its current implications is a vital aspect of providing care to a diverse population. Mental health practitioners, medical providers, researchers, community leaders, advocates, activists, and laypersons should work to prevent and effectively treat the psychological and physical distress experienced as a result of the racism faced by African American clients.

Although continuously encountering racism and intersectional trauma, African Americans have often adopted positive adaptations, and it is important to recognize the inherent empowerment that can result with survival of chronic race-related trauma. Cultural awareness, responsiveness, and sensitivity improve relationships with clients and allow for provision of the best quality care. This includes the implementation of race-informed therapeutic practices and techniques that promote resilience and intraindividual and interpersonal healing and wholeness of minorities. A trauma-informed approach to treatment recognizes that healthcare systems and providers should have a comprehensive picture of a patient's previous and current life situation in order to offer successful and healing treatment. Implementing trauma-informed practices may increase patient commitment and treatment compliance, improve health outcomes, and enhance provider and staff well-being.

Customer Information/Answer Sheet/Evaluation insert located between pages 104–105.

TEST QUESTIONS
#76920 RACIAL TRAUMA: THE AFRICAN AMERICAN EXPERIENCE

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

This 5 Hour/1.5 NBCC Clock Hour activity must be completed by May 31, 2024.

1. Racial slurs, exclusion, and degradation are examples of individual and cultural racism.
- A) *True*
- B) *False*

2. All of the following are historical examples of institutional racism, EXCEPT:
- A) *slavery.*
- B) *disenfranchisement.*
- C) *low-quality customer service.*
- D) *unethical and damaging research practices.*

3. Resilience
- A) *is not variable.*
- B) *is expressed identically to identical stressors over time.*
- C) *is a process that evolves throughout a person's lifetime.*
- D) *does not require exposure to adversity, only positive adaptation.*

4. The modern civil rights movement was spurred largely by
- A) *Jim Crow laws in the South.*
- B) *legal challenges to segregation.*
- C) *reactions to institutional racism.*
- D) *All of the above*

5. Perhaps the most prominent display of racism today is housing discrimination.
- A) *True*
- B) *False*

6. Which of the following statements regarding racism and the judicial system is TRUE?
- A) *African Americans are less likely to be denied bail.*
- B) *African Americans are more likely to have their case taken to trial and to be more strictly sentenced.*
- C) *Black drivers are significantly less likely than White drivers to be searched and arrested during traffic stops.*
- D) *Although drug use rates are roughly the same across race/ethnicities, White persons are more likely to be arrested on drugs charges.*

7. African American or Black patients are
- A) *comfortable in health and mental health systems.*
- B) *less likely to obtain mental health treatment in emergency and hospital settings.*
- C) *misdiagnosed or diagnosed at disproportionately higher rates with schizophrenia and other psychotic disorders.*
- D) *more likely to be provided antidepressant therapy, even after controlling for insurance and financial conditions.*

8. All of the following are steps mental health providers should take to help alleviate racial and cultural prejudices, EXCEPT:
- A) *Avoid addressing personal biases in treatment.*
- B) *Seek out and learn about the experiences of the local African American community.*
- C) *Accurately screen and follow through with quality assessments that employ a biopsychosocial model.*
- D) *Re-evaluate professional practices to determine whether these practices relate to the fundamental values of African American culture.*

9. Implicit bias and racism are essentially the same concept.
- A) *True*
- B) *False*

10. Historical trauma is defined as
- A) *trauma that has been fully processed.*
- B) *adversity experienced only by ancestors.*
- C) *trauma experienced upon learning of historical events.*
- D) *collective trauma experienced over time and across generations.*

11. Adults who experienced adverse childhood experiences are at increased risk for
- A) *arrest.*
- B) *chronic illness.*
- C) *substance use disorder.*
- D) *All of the above*

Test questions continue on next page ➔

12. Narrative salience is defined as
- A) *an everyday, subtle, and nonverbal form of discrimination.*
- B) *ongoing reminders of past trauma in the form of publicly displayed photographs and symbols.*
- C) *stories of historical trauma, including oppression, injustices, or disasters, experienced by a population.*
- D) *the current relevance or impact of the historical trauma narrative on the individual and/or community.*

13. When providing services to oppressed minorities, the American Psychiatric Association recommends performing a Cultural Formulation Interview (CFI).
- A) *True*
- B) *False*

14. All of the following are categorized as a trauma- or stress-related disorder in the DSM-5, EXCEPT:
- A) *PTSD*
- B) *Acute stress disorder*
- C) *Reactive attachment disorder*
- D) *Obsessive-compulsive disorder*

15. Racism should only be considered a trauma if the person encounters an overt racist event (e.g., a violent hate crime).
- A) *True*
- B) *False*

16. Which of the following statements regarding help seeking and access to mental health care is FALSE?
- A) *African American men are less likely than women to engage in therapy.*
- B) *Historical factors have contributed to disparities in health and mental health care access.*
- C) *Compared with Caucasian Americans, African Americans are more likely to follow through with or take advantage of health and mental health services.*
- D) *The underutilization of healthcare services results in shorter lifespans, increased morbidity and mortality, and undiagnosed, misdiagnosed, and/or untreated health and mental health disorders.*

17. Research on cross-racial therapeutic dyads has found client dissatisfaction and a lack of sensitivity in the way race was introduced by the therapist.
- A) *True*
- B) *False*

18. Which of the following is NOT a recommended approach to approach race-related issues in mental health care?
- A) *Avoid discussion or racial privilege.*
- B) *Discover opportunities to enhance racial sensitivity and awareness of cultural stereotypes.*
- C) *Recognize any challenges with verbally communicating racial connections and disparities.*
- D) *Tackle the subject of race as theoretically important to therapeutic issues and talk therapy.*

19. Post-traumatic growth
- A) *should not be the focus of therapy.*
- B) *is the possibility for positive change after hardships.*
- C) *is similar to PTSD in the spectrum of reactions to trauma.*
- D) *is not a common outcome of potentially traumatic events.*

20. Active coping styles have been positively linked to post-traumatic growth.
- A) *True*
- B) *False*

21. Treatment for complex trauma, such as that experienced by racial minorities, emphasizes
- A) *elimination of any sources of trauma.*
- B) *identifying other persons at risk for trauma.*
- C) *avoidance of rumination on traumatic events.*
- D) *reduction of psychiatric symptoms and improvement in key functional capacities for self-regulation and strengthening of resources.*

22. The recommended process for developing meaning following trauma starts with
- A) *substantial rumination.*
- B) *creating a new worldview.*
- C) *support group engagement.*
- D) *construction of a personal narrative to the explain the trauma.*

23. Which of the following is a potentially useful intervention to diminish stress symptomatology during rumination?
- A) *Refuting cognitive distortions*
- B) *Commemorating one's individuality through meaning-making activities*
- C) *Offering psychoeducational training on mindfulness and relaxation techniques*
- D) *All of the above*

24. What are the steps of the Integrity Model?
- A) *Meditation, moderation, and maintenance*
- B) *Safety, stability, strength, synthesis, and solidarity*
- C) *Identification, integration, re-entry, and continuation*
- D) *Acceptance, amelioration, assimilation, and advocacy*

25. Practitioners have a responsibility to recognize and identify trauma and should work to help process the trauma in the absence of rationalizing, correcting, or altering the viewpoint of the client.
- A) *True*
- B) *False*

26. At a minimum, all of the following areas should be explored in a spiritual assessment, EXCEPT:
- A) *Spiritual family history*
- B) *Spiritual practices*
- C) *Denomination or faith*
- D) *Spiritual beliefs*

27. Providing trauma-informed care requires recognizing symptoms of trauma and designing all interactions with victims of racial trauma in such a way that minimizes the potential for re-traumatization.
- A) *True*
- B) *False*

28. Trauma-informed care is based on all of the following values, EXCEPT:
- A) *Cooperation*
- B) *Encouragement*
- C) *Client autonomy*
- D) *Practitioner expertise*

29. Which of the following statements regarding culture and trauma therapy is TRUE?
- A) *Clinicians should reflect on culture being a vehicle for retraumatizing events.*
- B) *Traumatic encounters generally do not affect an individual's cultural identity and worldview.*
- C) *Clinicians should explore their own self-identity, culture, individual history, and implicit biases.*
- D) *The cultural elements of African American culture and family cohesion may impede the development of resilience.*

30. All mental health providers should work to identify and eliminate discriminatory policies, demonstrate compassion, recognize patients' human rights and dignity, engage in lifelong learning, and contribute to the growth of society and community health.
- A) *True*
- B) *False*

Be sure to transfer your answers to the Answer Sheet located between pages 104–105.
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Ethics for Counselors

Approval(s): NBCC, NAADAC

This course is designed to meet the requirement for ethics education in most states.*
Please see page 152 of this booklet for state-specific information.

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

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

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

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

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

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

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

Texas LPCs and LPCSs may apply 2 hours to their ethics requirement.
Texas MFTs and MFTSs may apply 5 hours to their ethics requirement.

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Faculty Disclosure

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

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

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

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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 a new institution is young, the creation of a formal code of ethics is standard practice to inform prospective members, unify, advise, and protect existing members, help resolve ethics issues, protect those who the profession serves, and help establish and distinguish an organization, agency, and its members.

HISTORICAL CONTEXT OF COUNSELING ETHICS

HISTORY OF COUNSELING IN THE UNITED STATES

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

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

HISTORY OF ETHICS

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

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

codes of ethics must be developed to unify, guide, and protect individuals belonging to a group or institution and to protect the institution itself.

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

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

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

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

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

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

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

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

Recent History

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

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

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

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

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

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

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

Professional Ethics

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

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

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

Development of Ethical Codes in Counseling

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

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

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

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

Ethics and New Technologies

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

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

PHILOSOPHICAL HISTORY OF MODERN ETHICS

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

Modernism

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

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

Postmodernism

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

good and bad. Ultimately, a set of universal ethical principles cannot be easily applied [3].

Today, ethical codes and practices are also influenced by critical theory. Critical theorists focus on eliminating inequities and marginalization [112]. Ethics from this perspective explores the role of power and power inequalities, exploring who or what defines truth and whose voices are represented [112].

COMMON TERMS USED IN THE DISCUSSION OF ETHICS

VALUES

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

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

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

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

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

ETHICS

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

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

Counselor T is a high school counselor in Oregon who is against the termination of pregnancy due to her personal and religious values; she has had several miscarriages and is currently experiencing difficulty becoming pregnant. Student A, 15 years of age, enters Counselor T's office in tears; the student has not told anyone that she is 9 weeks pregnant. She is seeking help regarding obtaining an abortion. Counselor T learns that her client was the victim of sexual abuse by her first adoptive parents. Other foster children and individuals in support groups, which Student A has come to know, were also victims of physical and sexual abuse by their adoptive parents. She expresses fear of alienation from her friends, concern about falling behind in school, and anguish at not being able to remain active in sports, which are "her way of coping with life." The student has stated that she does not want to give birth to a child because she is too young to raise it properly and would not put her child up for adoption for fear that it too would become a victim. In fact, she states that she does not know if she "ever wants to bring a child into this world."

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

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

Ethical Dilemmas

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

Ethical Decision Making

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

Ethical Principles

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

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

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

VALUES AND ETHICAL PRINCIPLES IN ETHICAL CODES

ACA CODE OF ETHICS

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

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

Section A: The Counseling Relationship

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

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

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

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

Section B: Confidentiality and Privacy

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

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

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

Section C: Professional Responsibility

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

Section D: Relationships with Other Professionals

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

Section E: Evaluation, Assessment, and Interpretation

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

Section F: Supervision, Training, and Teaching

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

Section G: Research and Publication

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

Section H: Distance Counseling, Technology, and Social Media

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

Section I: Resolving Ethical Issues

Counselors should be familiar with their agency's or institution's rules and regulations; these should be accepted and upheld or employment should be sought elsewhere. When ethical dilemmas arise, they should be resolved using communication with all those involved. When a conflict cannot be resolved among the parties involved, consultation with peers may be necessary. Ethical codes should be followed, but in some cases, this may conflict with laws (e.g., subpoena). It is advised that laws prevail over ethics when all other means of resolution are exhausted. Counselors who become aware of colleagues' ethics violations that are not able to be resolved informally are obligated to report them provided it does not violate client-counselor confidentiality. The ethical resolution of dilemmas or issues requires the application of the ethical principles of ordering, respect, reparation, and veracity. Values of honesty, courage, independence, and intellect, among many others, determine positive outcomes in adverse situations.

NBCC CODE OF ETHICS

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

Prevent Harm

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

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

Provide Only Those Services for Which One Has Education and Qualified Experience

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

There are many assessment tools and techniques available to counselors, and counselors should be competent in the use and interpretation of each they intend to use. Consideration must be given to the fact that many tests/assessments are culturally biased; open-mindedness about test/assessment performance is valued.

Promote the Welfare of Clients, Students, or Supervisees

Counselors should explain the ramifications of tests and results to clients and use assessments only for the client's benefit. Only current, reliable, and valid tests and assessments should be used. The results of a single test/assessment should never be used as the sole basis for a decision.

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

Communicate Truthfully

Credentials and qualifications should be accurately represented, and it is the responsibility of the counselor to correct known misrepresentations. Supervisors must identify their qualifications and credentials to supervisees and provide information regarding the supervision process.

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

Act with Integrity to Preserve Trust

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

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

Encourage Active Participation of Clients, Students, or Supervisees

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

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

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

Adhere to Recognized Professional Standards and Practices

The underlying theme in this directive is that counselors have a responsibility to themselves, clients, and institutions to behave in an ethical manner consistent with the NBCC Code of Ethics. All applicable legal standards and professional regulations should be abided in all cases. Counselors speaking publicly should reflect their personal views and not those of an organization unless authorized to speak on its behalf. Tests and assessment administration and interpretation must comply with standard protocols. Identified security protocols for each must also be maintained.

Comply with Intellectual Property Laws

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

Counselors who are certified by the NBCC must follow the NBCC Code of Ethics. The Code may be reviewed online at https://www.nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf.

ETHICAL THEORIES

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

VIRTUE ETHICS

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

DEONTOLOGIC ETHICAL THEORIES

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

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

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

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

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

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

Theologic Ethical Theories

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

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

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

Categorical Imperative

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

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

TELEOLOGIC ETHICAL THEORIES

The teleologic ethical theories or consequential ethics are outcome-based theories. It is not the motive or intention that causes one to act ethically, but the consequences of the act [7]. If the action causes a positive effect, it is said to be ethical. So here, the end justifies the means.

Utilitarianism

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

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

Existentialism

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

Pragmatism

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

MOTIVIST ETHICAL THEORIES

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

NATURAL LAW ETHICAL THEORY

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

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

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

TRANSCULTURAL ETHICAL THEORY

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

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

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

Ethical Relativism/Multiculturalism

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

FEMINIST ETHICS

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

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

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

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

RELATIONAL ETHICS

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

ASSESSING ETHICAL THEORIES

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

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

There are other indicators to assess ethical theories. First, a sound ethical theory must be clear and easily understood. It should be simple, with no more rules and principles than professionals are able to remember and apply to real-life professional situations. Second, it should be internally consistent. This means that the different parts of a theory should

be in agreement and that different professionals applying the theory to similar circumstances should reach similar conclusions. Third, a good ethical theory should be as complete as possible, without major gaps or omissions. Finally, an ethical theory should be consistent with general daily experience and judgment. If an ethical theory is useful in helping to resolve moral dilemmas but is inconsistent with most or all our ordinary judgments, it will ultimately cause dissonance and will need to be modified.

PRACTICAL APPLICATIONS OF ETHICAL THEORIES

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

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

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

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

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

ETHICAL DECISION-MAKING FRAMEWORKS

The decision-making frameworks presented in this section are decision analyses. A decision analysis is a step-by-step procedure breaking down the decision into manageable components so one can trace the sequence of events that might be the consequence of selecting one course of action over another [23]. Decision analysis frameworks provide an objective analysis in order to help professionals make the best possible decision in a given situation, build logic and rationality into a decision-making process that is primarily intuitive, and lay the potential outcomes for various decision paths [23]. They are also attempts to shift the process of moral decision making from the arena of the personal and subjective to the arena of an intellectual process, characterized by rigor and systematization [24].

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

Osmo and Landau employ Toulmin's theory of argumentation [25; 26]. Toulmin defines an argument as an assertion followed by a justification. According to Toulmin, an argument consists of six components: (1) the claim, (2) data, evidence, or grounds for the claim, (3) a warrant, which

is the link between the claim and the data (may include empirical evidence, common knowledge, or practice theory), (4) qualification of the claim by expressing the degree of confidence or likelihood, (5) rebuttal of the claim by stating conditions that it does not hold, and (6) further justification using substantiation. In essence, decision-making frameworks are an attempt of explicit argumentation.

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

DECISION-MAKING MODELS FOR ETHICAL DILEMMAS

Kenyon's Ethical Decision-Making Model

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

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

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

KENYON'S ETHICAL DECISION-MAKING MODEL

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

Source: [10] *Table 2*

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

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

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

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

Solve the problem by creating several choices of action. This is vital to the decision-making process and to the client's sense of controlling his or her life. When faced with a difficult dilemma, individuals often see only two courses of action that can be explored. These may relate to choosing an intervention, dealing with family and friends, or exploring available resources. It is good to brainstorm about all

the possible actions that could be taken (even if some have been informally excluded). This process gives everyone a chance to think through the possibilities and to make clear arguments for and against the various alternatives. It also helps to discourage any possible polarization of the parties involved. Ethical decision making is not easy, but many problems can be solved with creativity and thought. This involves the following:

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

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

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

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

Ethical Principles Screen

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

Collaborative Model for Ethical Decision Making

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

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

LIMITATIONS OF ETHICAL DECISION-MAKING FRAMEWORKS

One of the criticisms of ethical decision-making frameworks is that they portray decision making in a linear progression, and in real life, such prescriptive models do not capture what professionals do [30]. In essence, these frameworks stem from a positivist approach. Positivism values objectivity and rationality. In subjectivity, one's values, feelings, and emotions are detached from scientific inquiry. Research has indicated that practitioners having these linear ethical decision frameworks in their knowledge base do not necessarily translate them into ethical practice. Consequently, Betan argues for a hermeneutic (i.e., interpretive) approach to ethical decision making. The person making the decision is not a detached observer; rather, the individual is inextricably part of the process. Betan maintains that this is vital because "ethics is rooted in regards to human life, and when confronting an ethical circumstance, one calls into service a personal sense of what it is to be human. Thus one cannot intervene in human affairs without being an active participant in defining dimensions of human conduct and human worth" [30]. This

does not necessarily mean that professionals should discard the linear approaches to ethical decision making. Rather, professionals should work toward understanding how the principles fit within the therapeutic context as well as the larger cultural context.

ETHICAL SELF-REFLECTION

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

PSYCHOLOGIC CONTEXT OF MORAL DECISION MAKING

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

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

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

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

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

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

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

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

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

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

It is important to understand that Kohlberg's stages do not help to find the right answers, as do ethical theories. Instead, recognizing these stages helps counselors to know how people get to their answers. As a result, if you asked the same question of someone at each of the six levels, the answer might be the same in all cases, but the rationale for the decision may be different. For example, let us suppose that a counselor is

becoming more involved in the life of his female client. He drives her home after Alcoholics Anonymous meetings and is talking with her on the weekends. Here are examples of the rationale for the counselor's decision and reply, in each stage, to the question of whether this relationship is appropriate.

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

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

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

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

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

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

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

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

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

MANAGED CARE AND ETHICS

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

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

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

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

Another ethical issue emerging within counseling practice in a managed care environment is that of the counselor's fiduciary relationship with their agency versus a fiduciary relationship with the client [37]. Each relationship has competing sets of loyalties and responsibilities. First, the counselor has a fiduciary relationship to the managed care company. The responsibility to the agency is to keep expenditures within

budget. Yet, there is also the counselor's obligation to the client's best interests and needs [37]. One way of managing this conflict is for counselors to be involved in the advocacy and development of policies that allow some leeway for clients who may require additional services.

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

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

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

DIVERSITY AND MULTICULTURALISM: ETHICAL ISSUES

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

DEMOGRAPHIC SHIFTS

Coupled with the ever-changing socioeconomic backdrop, demographic trends indicate increasing diversification and multiculturalism in U.S. society, including rapidly growing ethnic minority populations relative to the white population; a continual influx of documented and undocumented immigrants; a growing number of individuals with various gender and sexual identities (4% to 17% of the total population); an unprecedented increase in the older American population; and a vast number of Americans with disabilities (57 million individuals) [41; 42; 43; 44; 45; 46]. This has profound implications for counselors, as culture (in a general sense) influences every aspect of our lives, including our social and psychologic reality [47]. Consequently, it is inevitable that counselors will work with more clients and settings than they are familiar or comfortable with. It is therefore advisable that counselors take into account cultural context and their clients' sociocultural identity when entering into a counseling relationship. Richmond writes that "counselors and clients are both emotionally invested in 'right living' issues. Since no therapy is value free, clients face the dilemma of finding a therapist with values similar to their own or having their values challenged. Therapists face the ethical issue of clarifying their own values and determining how to make them known" [66].

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

MULTICULTURALISM IN RESEARCH

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

A positive example of a culturally appropriate study was one that was conducted within a Korean community in which research follow-ups took place at local ethnic grocery stores rather than in an institutional setting [68]. The businesses were identified as traditional gathering places whereas the institutions were identified as a source of fear or discomfort or were inconveniently located, which would have caused a reduction in willing participants. If the research had only

been conducted in institutional settings, instead of getting a true cross section, the study would likely end up with participants who were of a certain type (e.g., more affluent, no mobility issues).

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

DEBATES WITHIN MULTICULTURALISM/ DIVERSITY AND ETHICS

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

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

INFUSING DIVERSITY INTO THE ETHICAL DECISION-MAKING MODELS

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

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

Step 1: Interpreting the Situation through Awareness

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

Step 2: Formulating an Ethical Decision

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

Step 3: Weighing Competing, Nonmoral Values

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

Step 4: Implementing Action Plan

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

MULTICULTURALISM/DIVERSITY AND THE ACA CODE OF ETHICS

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

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

MULTICULTURALISM/DIVERSITY AND THE NBCC CODE OF ETHICS

Directive 26 of the NBCC Code of Ethics states that nationally certified counselors "shall demonstrate multicultural competence and shall not use techniques that discriminate against or show hostility towards individuals or groups based on gender, ethnicity, race, national origin, sexual orientation, disability, religion or any other legally prohibited basis" [58]. In addition to a working knowledge of a client's cultural norms, the counselor should have an understanding of the effect that discrimination and oversimplification have on various social groups.

Furthermore, Directive 48 states that counselors "shall accurately report test and assessment results and limit conclusions to those based on evidence, taking into consideration any influences that may affect results such as health, motivation and multicultural factors." It has been noted that many assessments, standardized tests, and techniques were normalized based on research with white, middle class populations. This includes psychologic test procedures and instruments in addition to educational or career assessment tools. Sociocultural norms and biases should be accounted for when interpreting results.

ONLINE COUNSELING

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

LIMITATIONS OF ONLINE COUNSELING

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

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

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

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

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

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

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

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

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

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

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

ONLINE COMMUNICATIONS AND DISTANCE COUNSELING: A SOCIOCULTURAL CONTEXT

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

Race, Culture, and Ethnicity

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

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

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

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

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

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

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

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

Gender

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

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

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

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

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

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

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

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

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

ETHICAL AND LEGAL ISSUES

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

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

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

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

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

ACA CODE OF ETHICS AND DISTANCE COUNSELING

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

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

Information Privacy and Confidentiality

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

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

Distance Counseling, Technology, and Social Media

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

- **Knowledge and legal considerations**: Counselors should have clear understanding of the technical, legal, and ethical aspects of distance counseling, technology, and social media. The laws and regulations of the counselor's practice location and the client's location must be known. Counselors should only practice within their area(s) of expertise.
- **Informed consent and security**: Intervention plans should reflect the client's individual needs, and the client should decide whether to use alternatives to face-to-face counseling. The counselor must disclose her or his distance counseling credentials, physical location, and contact information; risks and benefits of distance counseling, technology, or social media; response times; and possible failure of technology and alternatives in this eventuality. Counselors discuss and the client acknowledges the security risks and confidentiality limitations involved with distance counseling.
- **Client verification**: Counselors must ensure that the client is who he or she purports to be. Steps must be taken to verify clients' identity throughout the relationship.
- **Distance counseling relationship**: Counselors should be sure that clients are completely able use the technology and that the client is suited to distance counseling. Clients should understand that misunderstandings are possible due to lack of nonverbal cues between both individuals in the relationship. If it is assessed and determined that distance counseling is not appropriate, counselors should first consider providing face-to-face services; referrals should be made to alternative services if this is not feasible.
- **Records and web maintenance**: Laws and statutes regarding electronic record storage dictate how counselors maintain and secure client files and personal information. Clients should be informed about the security measures and encryption used in their database. If transaction records are archived, counselors should disclose how long these are kept. A distance counselor's licensure and professional certification board information should be linked on their website or personal page, and these links should be regularly updated.
- **Social media**: Counselors must maintain separate personal and professional social media profiles and/or web pages. Disclosure of confidential information on public social media or web pages must be avoided. Clients' Internet presence should remain private (even publicly shared information) unless a counselor receives consent.

NBCC STANDARDS FOR DISTANCE PROFESSIONAL SERVICES

The NBCC has issued a document, separate from their ethical code, containing guidelines for ethical behavior specific to e-mail, chat, and video based Internet counseling.

The following standards are from The NBCC Policy Regarding the Provision of Distance Professional Services, ©2016 National Board for Certified Counselors, Inc. and Affiliates. Reprinted with the permission of the National Board for Certified Counselors, Inc.™ and Affiliates; 3 Terrace Way, Greensboro, NC 27403-3660. In this section, "nationally certified counselor" is abbreviated as NCC.

1. NCCs shall adhere to all NBCC policies and procedures, including the Code of Ethics.
2. NCCs shall provide only those services for which they are qualified by education and experience. NCCs shall also consider their qualifications to offer such service via distance means.
3. NCCs shall carefully adhere to legal regulations before providing distance services. This review shall include legal regulations from the state in which the counselor is located as well as those from the recipient's location. Given that NCCs may be offering distance services to individuals in different states at any one time, the NCC shall document relevant state regulations in the respective record(s).
4. NCCs shall ensure that any electronic means used in distance service provision are in compliance with current regulatory standards.

5. NCCs shall use encryption security for all digital technology communications of a therapeutic type. Information regarding security should be communicated to individuals who receive distance services. Despite the use of precautions, distance service recipients shall be informed of the potential hazards of distance communications. Not the least of these considerations is the warning about entering private information when using a public access or computer that is on a shared network. NCCs shall caution recipients of distance services against using "auto-remember" user names and passwords. NCCs shall also inform recipients of distance services to consider employers' policies relating to the use of work computers for personal communications.

6. To prevent the loss of digital communications or records, NCCs who provide distance services shall maintain secure backup systems. If the backup system is also a digital mechanism, this too shall offer encryption-level security. This information shall be provided to the recipient of professional services.

7. NCCs shall screen potential distance service recipients for appropriateness to receive services via distance methods. These considerations shall be documented in the records.

8. During the screening or intake process, NCCs shall provide potential recipients with a detailed written description of the distance counseling process and service provision. This information shall be specific to the identified service delivery type and include considerations for that particular individual. These considerations shall include the appropriateness of distance counseling in relation to the specific goal, the format of service delivery, the associated needs (i.e., computer with certain capabilities, etc.), the limitations of confidentiality, the possibility of technological failure, anticipated response time to electronic communication, and any additional considerations necessary to assist the potential recipient in reaching a determination about the appropriateness of this service delivery format for their need(s). NCCs shall discuss this information at key times throughout the service delivery process to ensure that this method satisfies the anticipated goals, and if not, the NCC will document the discussion of alternative options and referrals in the client's record.

9. Because of the ease in which digital communications can inadvertently be sent to other individuals, NCCs shall adopt behaviors to prevent the distribution of confidential information to unauthorized individuals. NCCs shall discuss actions the recipient may take to reduce the possibility that they will send information to other individuals by mistake.

10. NCCs shall provide recipients of distance professional services with information concerning their professional credentials and links to the respective credentialing organization websites.

11. NCCs, either prior to or during the initial session, shall inform recipients of the purposes, goals, procedures, limitations, potential risks, and benefits of services and techniques. NCCs also shall provide information about rights and responsibilities as appropriate to the distance service. As a part of this type of service provision, NCCs shall discuss with recipients the associated challenges that may occur when communicating through distance means, including those associated with privacy and confidentiality.

12. In the event that the recipient of distance services is a minor or is unable to provide legal consent, the NCC shall obtain a legal guardian's consent prior to the provision of distance services. Furthermore, NCCs shall retain copies of documentation indicating the legal guardian's identity in the recipient's file.

13. NCCs shall avoid the use of public social media sources (e.g., tweets, blogs, etc.) to provide confidential information. To facilitate the secure provision of information, NCCs shall provide in writing the appropriate ways to contact them.

14. NCCs shall discuss with recipients the importance of identifying recipient-named contacts in the event of emergency situations. As a part of this discussion, NCCs will identify the circumstances in which these individuals will be contacted and what information will be shared with emergency contacts. NCCs will provide recipients of distance services with specific written procedures regarding emergency situations. This information shall include emergency responders near the recipient's location. Given the increased dangers intrinsic to providing certain distance professional services, NCCs shall take reasonable steps to secure reasonable referrals for recipients when needed.

15. NCCs shall develop written procedures for verifying the identity of the recipient, his or her current location, and readiness to proceed at the beginning of each contact. Examples of verification means include the use of code words, phrases, or inquiries. (For example, "Is this a good time to proceed?")

16. NCCs shall limit use of information obtained through social media sources (e.g., Facebook, LinkedIn, Twitter, etc.) in accordance with established practice procedures provided to the recipient at the initiation of services or adapted through ongoing informed consent process.

17. NCCs shall provide information concerning locations where members of the public may access the Internet free of charge or provide information regarding the location of complimentary Web communication services. In such cases, the informed consent process shall include the required discussion items, including how this affects confidentiality and privacy.

18. NCCs shall retain copies of all written communications with distance service recipients. Examples of written communications include e-mail/text messages, instant messages and histories of chat-based discussions even if they are related to housekeeping issues such as change of contact information or scheduling appointments.

19. At a minimum, NCCs shall retain distance service records for a minimum of five years unless state laws require additional time. NCCs shall limit the use of records to those permitted by law, professional standards, and as specified by the agreement with the respective recipient of distance services.

20. NCCs shall develop written procedures for the use of social media and other related digital technology with current and former recipients. These written procedures shall, at a minimum, provide appropriate protections against the disclosure of confidential information and the creation of multiple relationships. These procedures shall also identify that personal social media accounts are distinct from any used for professional purposes.

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

CONCLUSION

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

RESOURCES

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

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

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

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

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

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

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

National Board for Certified Counselors: Code of Ethics and Provision of Distance Professional Services
https://www.nbcc.org/Ethics

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

APPENDIX: THE ACA CODE OF ETHICS

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

SECTION A: THE COUNSELING RELATIONSHIP

Introduction

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

A.1. Client Welfare

A.1.a. Primary Responsibility

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

A.1.b. Records and Documentation

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

A.1.c. Counseling Plans

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

A.1.d. Support Network Involvement

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

A.2. Informed Consent in the Counseling Relationship

A.2.a. Informed Consent

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

A.2.b. Types of Information Needed

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

A.2.c. Developmental and Cultural Sensitivity

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

A.2.d. Inability to Give Consent

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

A.2.e. Mandated Clients

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

A.3. Clients Served by Others

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

A.4. Avoiding Harm and Imposing Values

A.4.a. Avoiding Harm

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

A.4.b. Personal Values

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

A.5. Prohibited Noncounseling Roles and Relationships

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

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

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

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

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

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

A.5.d. Friends or Family Members

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

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

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

A.6. Managing and Maintaining Boundaries and Professional Relationships

A.6.a. Previous Relationships

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

A.6.b. Extending Counseling Boundaries

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

A.6.c. Documenting Boundary Extensions

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

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

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

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

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

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

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

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

A.7.a. Advocacy

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

A.7.b. Confidentiality and Advocacy

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

A.8. Multiple Clients

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

A.9. Group Work

A.9.a. Screening

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

A.9.b. Protecting Clients

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

A.10. Fees and Business Practices

A.10.a. Self-Referral

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

A.10.b. Unacceptable Business Practices

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

A.10.c. Establishing Fees

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

A.10.d. Nonpayment of Fees

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

A.10.e. Bartering

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

A.10.f. Receiving Gifts

Counselors understand the challenges of accepting gifts from clients and recognize that in some cultures, small gifts are a token of respect and gratitude. When determining whether

to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift.

A.11. Termination and Referral

A.11.a. Competence within Termination and Referral

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

A.11.b. Values within Termination and Referral

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

A.11.c. Appropriate Termination

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

A.11.d. Appropriate Transfer of Services

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

A.12. Abandonment and Client Neglect

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

SECTION B: CONFIDENTIALITY AND PRIVACY

Introduction

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

B.1. Respecting Client Rights

B.1.a. Multicultural/Diversity Considerations

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

B.1.b. Respect for Privacy

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

B.1.c. Respect for Confidentiality

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

B.1.d. Explanation of Limitations

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

B.2. Exceptions

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

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

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

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

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

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

B.2.d. Court-Ordered Disclosure

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

B.2.e. Minimal Disclosure

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

B.3. Information Shared with Others

B.3.a. Subordinates

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

B.3.b. Interdisciplinary Teams

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

B.3.c. Confidential Settings

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

B.3.d. Third-Party Payers

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

B.3.e. Transmitting Confidential Information

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

B.3.f. Deceased Clients

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

B.4. Groups and Families

B.4.a. Group Work

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

B.4.b. Couples and Family Counseling

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

B.5. Clients Lacking Capacity to Give Informed Consent

B.5.a. Responsibility to Clients

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

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

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

B.5.c. Release of Confidential Information

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

B.6. Records and Documentation

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

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

B.6.b. Confidentiality of Records and Documentation

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

B.6.c. Permission to Record

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

B.6.d. Permission to Observe

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

B.6.e. Client Access

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

B.6.f. Assistance with Records

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

B.6.g. Disclosure or Transfer

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

B.6.h. Storage and Disposal After Termination

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

B.6.i. Reasonable Precautions

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

B.7. Case Consultation

B.7.a. Respect for Privacy

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

B.7.b. Disclosure of Confidential Information

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

SECTION C: PROFESSIONAL RESPONSIBILITY

Introduction

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

C.1. Knowledge of and Compliance with Standards

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

C.2. Professional Competence

C.2.a. Boundaries of Competence

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

C.2.b. New Specialty Areas of Practice

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

C.2.c. Qualified for Employment

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

C.2.d. Monitor Effectiveness

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

C.2.e. Consultations on Ethical Obligations

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

C.2.f. Continuing Education

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

C.2.g. Impairment

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

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

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

C.3. Advertising and Soliciting Clients

C.3.a. Accurate Advertising

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

C.3.b. Testimonials

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

C.3.c. Statements by Others

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

C.3.d. Recruiting Through Employment

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

C.3.e. Products and Training Advertisements

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

C.3.f. Promoting to Those Served

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

C.4. Professional Qualifications

C.4.a. Accurate Representation

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

C.4.b. Credentials

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

C.4.c. Educational Degrees

Counselors clearly differentiate between earned and honorary degrees.

C.4.d. Implying Doctoral-Level Competence

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

C.4.e. Accreditation Status

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

C.4.f. Professional Membership

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

C.5. Nondiscrimination

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

C.6. Public Responsibility

C.6.a. Sexual Harassment

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

C.6.b. Reports to Third Parties

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

C.6.c. Media Presentations

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

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

C.6.d. Exploitation of Others

Counselors do not exploit others in their professional relationships.

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

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

C.7. Treatment Modalities

C.7.a. Scientific Basis for Treatment

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

C.7.b. Development and Innovation

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

C.7.c. Harmful Practices

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

C.8. Responsibility to Other Professionals

C.8.a. Personal Public Statements

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

SECTION D: RELATIONSHIPS WITH OTHER PROFESSIONALS

Introduction

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

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

D.1.a. Different Approaches

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

D.1.b. Forming Relationships

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

D.1.c. Interdisciplinary Teamwork

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

D.1.d. Establishing Professional and Ethical Obligations

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

D.1.e. Confidentiality

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

D.1.f. Personnel Selection and Assignment

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

D.1.g. Employer Policies

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

D.1.h. Negative Conditions

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

D.1.i. Protection From Punitive Action

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

D.2. Provision of Consultation Services

D.2.a. Consultant Competency

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

D.2.b. Informed Consent in Formal Consultation

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

SECTION E: EVALUATION, ASSESSMENT, AND INTERPRETATION

Introduction

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

E.1. General

E.1.a. Assessment

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

E.1.b. Client Welfare

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

E.2. Competence to Use and Interpret Assessment Instruments

E.2.a. Limits of Competence

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

E.2.b. Appropriate Use

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

E.2.c. Decisions Based on Results

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

E.3. Informed Consent in Assessment

E.3.a. Explanation to Clients

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

E.3.b. Recipients of Results

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

E.4. Release of Data to Qualified Personnel

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

E.5. Diagnosis of Mental Disorders

E.5.a. Proper Diagnosis

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

E.5.b. Cultural Sensitivity

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

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

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

E.5.d. Refraining From Diagnosis

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

E.6. Instrument Selection

E.6.a. Appropriateness of Instruments

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

E.6.b. Referral Information

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

E.7. Conditions of Assessment Administration

E.7.a. Administration Conditions

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

E.7.b. Provision of Favorable Conditions

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

E.7.c. Technological Administration

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

E.7.d. Unsupervised Assessments

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

E.8. Multicultural Issues/Diversity in Assessment

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

E.9. Scoring and Interpretation of Assessments

E.9.a. Reporting

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

E.9.b. Instruments with Insufficient Empirical Data

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

E.9.c. Assessment Services

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

E.10. Assessment Security

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

E.11. Obsolete Assessment and Outdated Results

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

E.12. Assessment Construction

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

E.13. Forensic Evaluation: Evaluation for Legal Proceedings

E.13.a. Primary Obligations

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

E.13.b. Consent for Evaluation

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

E.13.c. Client Evaluation Prohibited

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

E.13.d. Avoid Potentially Harmful Relationships

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

SECTION F: SUPERVISION, TRAINING, AND TEACHING

Introduction

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

F.1. Counselor Supervision and Client Welfare

F.1.a. Client Welfare

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

F.1.b. Counselor Credentials

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

F.1.c. Informed Consent and Client Rights

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

F.2. Counselor Supervision Competence

F.2.a. Supervisor Preparation

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

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

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

F.2.c. Online Supervision

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

F.3. Supervisory Relationship

F.3.a. Extending Conventional Supervisory Relationships

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

F.3.b. Sexual Relationships

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

F.3.c. Sexual Harassment

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

F.3.d. Friends or Family Members

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

F.4. Supervisor Responsibilities

F.4.a. Informed Consent for Supervision

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

F.4.b. Emergencies and Absences

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

F.4.c. Standards for Supervisees

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

F.4.d. Termination of the Supervisory Relationship

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

F.5. Student and Supervisee Responsibilities

F.5.a. Ethical Responsibilities

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

F.5.b. Impairment

Students and supervisees monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They notify their faculty and/or supervisors and seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work.

F.5.c. Professional Disclosure

Before providing counseling services, students and supervisees disclose their status as supervisees and explain how this status affects the limits of confidentiality. Supervisors ensure that clients are aware of the services rendered and the qualifications of the students and supervisees rendering those services. Students and supervisees obtain client permission before they use any information concerning the counseling relationship in the training process.

F.6. Counseling Supervision Evaluation, Remediation, and Endorsement

F.6.a. Evaluation

Supervisors document and provide supervisees with ongoing feedback regarding their performance and schedule periodic formal evaluative sessions throughout the supervisory relationship.

F.6.b. Gatekeeping and Remediation

Through initial and ongoing evaluation, supervisors are aware of supervisee limitations that might impede performance. Supervisors assist supervisees in securing remedial assistance when needed. They recommend dismissal from training programs, applied counseling settings, and state or voluntary professional credentialing processes when those supervisees are unable to demonstrate that they can provide competent professional services to a range of diverse clients. Supervisors seek consultation and document their decisions to dismiss or refer supervisees for assistance. They ensure that supervisees are aware of options available to them to address such decisions.

F.6.c. Counseling for Supervisees

If supervisees request counseling, the supervisor assists the supervisee in identifying appropriate services. Supervisors do not provide counseling services to supervisees. Supervisors address interpersonal competencies in terms of the impact of these issues on clients, the supervisory relationship, and professional functioning.

F.6.d. Endorsements

Supervisors endorse supervisees for certification, licensure, employment, or completion of an academic or training program only when they believe that supervisees are qualified for the endorsement. Regardless of qualifications, supervisors do not endorse supervisees whom they believe to be impaired in any way that would interfere with the performance of the duties associated with the endorsement.

F.7. Responsibilities of Counselor Educators

F.7.a. Counselor Educators

Counselor educators who are responsible for developing, implementing, and supervising educational programs are skilled as teachers and practitioners. They are knowledgeable regarding the ethical, legal, and regulatory aspects of the profession; are skilled in applying that knowledge; and make students and supervisees aware of their responsibilities. Whether in traditional, hybrid, and/or online formats, counselor educators conduct counselor education and training programs in an ethical manner and serve as role models for professional behavior.

F.7.b. Counselor Educator Competence

Counselors who function as counselor educators or supervisors provide instruction within their areas of knowledge and competence and provide instruction based on current information and knowledge available in the profession. When using technology to deliver instruction, counselor educators develop competence in the use of the technology.

F.7.c. Infusing Multicultural Issues/Diversity

Counselor educators infuse material related to multiculturalism/diversity into all courses and workshops for the development of professional counselors.

F.7.d. Integration of Study and Practice

In traditional, hybrid, and/or online formats, counselor educators establish education and training programs that integrate academic study and supervised practice.

F.7.e. Teaching Ethics

Throughout the program, counselor educators ensure that students are aware of the ethical responsibilities and standards of the profession and the ethical responsibilities of students to the profession. Counselor educators infuse ethical considerations throughout the curriculum.

F.7.f. Use of Case Examples

The use of client, student, or supervisee information for the purposes of case examples in a lecture or classroom setting is permissible only when (a) the client, student, or supervisee has reviewed the material and agreed to its presentation or (b) the information has been sufficiently modified to obscure identity.

F.7.g. Student-to-Student Supervision and Instruction

When students function in the role of counselor educators or supervisors, they understand that they have the same ethical obligations as counselor educators, trainers, and supervisors. Counselor educators make every effort to ensure that the rights of students are not compromised when their peers lead experiential counseling activities in traditional, hybrid, and/or online formats (e.g., counseling groups, skills classes, clinical supervision).

F.7.h. Innovative Theories and Techniques

Counselor educators promote the use of techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation. When counselor educators discuss developing or innovative techniques/procedures/modalities, they explain the potential risks, benefits, and ethical considerations of using such techniques/procedures/modalities.

F.7.i. Field Placements

Counselor educators develop clear policies and provide direct assistance within their training programs regarding appropriate field placement and other clinical experiences. Counselor educators provide clearly stated roles and responsibilities for the student or supervisee, the site supervisor, and the program supervisor. They confirm that site supervisors are qualified to provide supervision in the formats in which services are provided and inform site supervisors of their professional and ethical responsibilities in this role.

F.8. Student Welfare

F.8.a. Program Information and Orientation

Counselor educators recognize that program orientation is a developmental process that begins upon students' initial contact with the counselor education program and continues throughout the educational and clinical training of students. Counselor education faculty provide prospective and current students with information about the counselor education program's expectations, including:

1. The values and ethical principles of the profession;
2. The type and level of skill and knowledge acquisition required for successful completion of the training;
3. Technology requirements;
4. Program training goals, objectives, and mission, and subject matter to be covered;
5. Bases for evaluation;
6. Training components that encourage self-growth or self-disclosure as part of the training process;
7. The type of supervision settings and requirements of the sites for required clinical field experiences;
8. Student and supervisor evaluation and dismissal policies and procedures; and
9. Up-to-date employment prospects for graduates.

F.8.b. Student Career Advising

Counselor educators provide career advisement for their students and make them aware of opportunities in the field.

F.8.c. Self-Growth Experiences

Self-growth is an expected component of counselor education. Counselor educators are mindful of ethical principles when they require students to engage in self-growth experiences. Counselor educators and supervisors inform students that they have a right to decide what information will be shared or withheld in class.

F.8.d. Addressing Personal Concerns

Counselor educators may require students to address any personal concerns that have the potential to affect professional competency.

F.9. Evaluation and Remediation

F.9.a. Evaluation of Students

Counselor educators clearly state to students, prior to and throughout the training program, the levels of competency expected, appraisal methods, and timing of evaluations for both didactic and clinical competencies. Counselor educators provide students with ongoing feedback regarding their performance throughout the training program.

F.9.b. Limitations

Counselor educators, through ongoing evaluation, are aware of and address the inability of some students to achieve counseling competencies. Counselor educators do the following:

1. Assist students in securing remedial assistance when needed,
2. Seek professional consultation and document their decision to dismiss or refer students for assistance, and
3. Ensure that students have recourse in a timely manner to address decisions requiring them to seek assistance or to dismiss them and provide students with due process according to institutional policies and procedures.

F.9.c. Counseling for Students

If students request counseling, or if counseling services are suggested as part of a remediation process, counselor educators assist students in identifying appropriate services.

F.10. Roles and Relationships Between Counselor Educators and Students

F.10.a. Sexual or Romantic Relationships

Counselor educators are prohibited from sexual or romantic interactions or relationships with students currently enrolled in a counseling or related program and over whom they have power and authority. This prohibition applies to both in-person and electronic interactions or relationships.

F.10.b. Sexual Harassment

Counselor educators do not condone or subject students to sexual harassment.

F.10.c. Relationships with Former Students

Counselor educators are aware of the power differential in the relationship between faculty and students. Faculty members discuss with former students potential risks when they consider engaging in social, sexual, or other intimate relationships.

F.10.d. Nonacademic Relationships

Counselor educators avoid nonacademic relationships with students in which there is a risk of potential harm to the student or which may compromise the training experience or grades assigned. In addition, counselor educators do not accept any form of professional services, fees, commissions, reimbursement, or remuneration from a site for student or supervisor placement.

F.10.e. Counseling Services

Counselor educators do not serve as counselors to students currently enrolled in a counseling or related program and over whom they have power and authority.

F.10.f. Extending Educator-Student Boundaries

Counselor educators are aware of the power differential in the relationship between faculty and students. If they believe that a nonprofessional relationship with a student may be potentially beneficial to the student, they take precautions similar to those taken by counselors when working with clients. Examples of potentially beneficial interactions or relationships include, but are not limited to, attending a formal ceremony; conducting hospital visits; providing support during a stressful event; or maintaining mutual membership in a professional association, organization, or community. Counselor educators discuss with students the rationale for such interactions, the potential benefits and drawbacks, and the anticipated consequences for the student. Educators clarify the specific nature and limitations of the additional role(s) they will have with the student prior to engaging in a nonprofessional relationship. Nonprofessional relationships with students should be time limited and/or context specific and initiated with student consent.

F.11. Multicultural/Diversity Competence in Counselor Education and Training Programs

F.11.a. Faculty Diversity

Counselor educators are committed to recruiting and retaining a diverse faculty.

F.11.b. Student Diversity

Counselor educators actively attempt to recruit and retain a diverse student body. Counselor educators demonstrate commitment to multicultural/diversity competence by recognizing and valuing the diverse cultures and types of abilities that students bring to the training experience. Counselor educators provide appropriate accommodations that enhance and support diverse student well-being and academic performance.

F.11.c. Multicultural/Diversity Competence

Counselor educators actively infuse multicultural/diversity competency in their training and supervision practices. They actively train students to gain awareness, knowledge, and skills in the competencies of multicultural practice.

SECTION G: RESEARCH AND PUBLICATION

Introduction

Counselors who conduct research are encouraged to contribute to the knowledge base of the profession and promote a clearer understanding of the conditions that lead to a healthy and more just society. Counselors support the efforts of researchers by participating fully and willingly whenever possible. Counselors minimize bias and respect diversity in designing and implementing research.

G.1. Research Responsibilities

G.1.a. Conducting Research

Counselors plan, design, conduct, and report research in a manner that is consistent with pertinent ethical principles, federal and state laws, host institutional regulations, and scientific standards governing research.

G.1.b. Confidentiality in Research

Counselors are responsible for understanding and adhering to state, federal, agency, or institutional policies or applicable guidelines regarding confidentiality in their research practices.

G.1.c. Independent Researchers

When counselors conduct independent research and do not have access to an institutional review board, they are bound to the same ethical principles and federal and state laws pertaining to the review of their plan, design, conduct, and reporting of research.

G.1.d. Deviation From Standard Practice

Counselors seek consultation and observe stringent safeguards to protect the rights of research participants when research indicates that a deviation from standard or acceptable practices may be necessary.

G.1.e. Precautions to Avoid Injury

Counselors who conduct research are responsible for their participants' welfare throughout the research process and should take reasonable precautions to avoid causing emotional, physical, or social harm to participants.

G.1.f. Principal Researcher Responsibility

The ultimate responsibility for ethical research practice lies with the principal researcher. All others involved in the research activities share ethical obligations and responsibility for their own actions.

G.2. Rights of Research Participants

G.2.a. Informed Consent in Research

Individuals have the right to decline requests to become research participants. In seeking consent, counselors use language that:

1. Accurately explains the purpose and procedures to be followed;
2. Identifies any procedures that are experimental or relatively untried;
3. Describes any attendant discomforts, risks, and potential power differentials between researchers and participants;
4. Describes any benefits or changes in individuals or organizations that might reasonably be expected;
5. Discloses appropriate alternative procedures that would be advantageous for participants;
6. Offers to answer any inquiries concerning the procedures;
7. Describes any limitations on confidentiality;
8. Describes the format and potential target audiences for the dissemination of research findings; and
9. Instructs participants that they are free to withdraw their consent and discontinue participation in the project at any time, without penalty.

G.2.b. Student/Supervisee Participation

Researchers who involve students or supervisees in research make clear to them that the decision regarding participation in research activities does not affect their academic standing or supervisory relationship. Students or supervisees who choose not to participate in research are provided with an appropriate alternative to fulfill their academic or clinical requirements.

G.2.c. Client Participation

Counselors conducting research involving clients make clear in the informed consent process that clients are free to choose whether to participate in research activities. Counselors take necessary precautions to protect clients from adverse consequences of declining or withdrawing from participation.

G.2.d. Confidentiality of Information

Information obtained about research participants during the course of research is confidential. Procedures are implemented to protect confidentiality.

G.2.e. Persons Not Capable of Giving Informed Consent

When a research participant is not capable of giving informed consent, counselors provide an appropriate explanation to, obtain agreement for participation from, and obtain the appropriate consent of a legally authorized person.

G.2.f. Commitments to Participants

Counselors take reasonable measures to honor all commitments to research participants.

G.2.g. Explanations After Data Collection

After data are collected, counselors provide participants with full clarification of the nature of the study to remove any misconceptions participants might have regarding the research. Where scientific or human values justify delaying or withholding information, counselors take reasonable measures to avoid causing harm.

G.2.h. Informing Sponsors

Counselors inform sponsors, institutions, and publication channels regarding research procedures and outcomes. Counselors ensure that appropriate bodies and authorities are given pertinent information and acknowledgment.

G.2.i. Research Records Custodian

As appropriate, researchers prepare and disseminate to an identified colleague or records custodian a plan for the transfer of research data in the case of their incapacitation, retirement, or death.

G.3. Managing and Maintaining Boundaries

G.3.a. Extending Researcher-Participant Boundaries

Researchers consider the risks and benefits of extending current research relationships beyond conventional parameters. When a nonresearch interaction between the researcher and the research participant may be potentially beneficial, the researcher must document, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the research participant. Such interactions should be initiated with appropriate consent of the research participant. Where unintentional harm occurs to the research participant, the researcher must show evidence of an attempt to remedy such harm.

G.3.b. Relationships with Research Participants

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

G.3.c. Sexual Harassment and Research Participants

Researchers do not condone or subject research participants to sexual harassment.

G.4. Reporting Results

G.4.a. Accurate Results

Counselors plan, conduct, and report research accurately. Counselors do not engage in misleading or fraudulent research, distort data, misrepresent data, or deliberately bias their results. They describe the extent to which results are applicable for diverse populations.

G.4.b. Obligation to Report Unfavorable Results

Counselors report the results of any research of professional value. Results that reflect unfavorably on institutions, programs, services, prevailing opinions, or vested interests are not withheld.

G.4.c. Reporting Errors

If counselors discover significant errors in their published research, they take reasonable steps to correct such errors in a correction erratum or through other appropriate publication means.

G.4.d. Identity of Participants

Counselors who supply data, aid in the research of another person, report research results, or make original data available take due care to disguise the identity of respective participants in the absence of specific authorization from the participants to do otherwise. In situations where participants self-identify their involvement in research studies, researchers take active steps to ensure that data are adapted/changed to protect the identity and welfare of all parties and that discussion of results does not cause harm to participants.

G.4.e. Replication Studies

Counselors are obligated to make available sufficient original research information to qualified professionals who may wish to replicate or extend the study.

G.5. Publications and Presentations

G.5.a. Use of Case Examples

The use of participants', clients', students', or supervisees' information for the purpose of case examples in a presentation or publication is permissible only when (a) participants, clients, students, or supervisees have reviewed the material and agreed to its presentation or publication or (b) the information has been sufficiently modified to obscure identity.

G.5.b. Plagiarism

Counselors do not plagiarize; that is, they do not present another person's work as their own.

G.5.c. Acknowledging Previous Work

In publications and presentations, counselors acknowledge and give recognition to previous work on the topic by others or self.

G.5.d. Contributors

Counselors give credit through joint authorship, acknowledgment, footnote statements, or other appropriate means to those who have contributed significantly to research or concept development in accordance with such contributions. The principal contributor is listed first, and minor technical or professional contributions are acknowledged in notes or introductory statements.

G.5.e. Agreement of Contributors

Counselors who conduct joint research with colleagues or students/supervisors establish agreements in advance regarding allocation of tasks, publication credit, and types of acknowledgment that will be received.

G.5.f. Student Research

Manuscripts or professional presentations in any medium that are substantially based on a student's course papers, projects, dissertations, or theses are used only with the student's permission and list the student as lead author.

G.5.g. Duplicate Submissions

Counselors submit manuscripts for consideration to only one journal at a time. Manuscripts that are published in whole or in substantial part in one journal or published work are not submitted for publication to another publisher without acknowledgment and permission from the original publisher.

G.5.h. Professional Review

Counselors who review material submitted for publication, research, or other scholarly purposes respect the confidentiality and proprietary rights of those who submitted it. Counselors make publication decisions based on valid and defensible standards. Counselors review article submissions in a timely manner and based on their scope and competency in research methodologies. Counselors who serve as reviewers at the request of editors or publishers make every effort to only review materials that are within their scope of competency and avoid personal biases.

SECTION H: DISTANCE COUNSELING, TECHNOLOGY, AND SOCIAL MEDIA

Introduction

Counselors understand that the profession of counseling may no longer be limited to in-person, face-to-face interactions. Counselors actively attempt to understand the evolving nature of the profession with regard to distance counseling, technology, and social media and how such resources may be used to better serve their clients. Counselors strive to become knowledgeable about these resources. Counselors understand the additional concerns related to the use of distance counseling, technology, and social media and make every attempt to protect confidentiality and meet any legal and ethical requirements for the use of such resources.

H.1. Knowledge and Legal Considerations

H.1.a. Knowledge and Competency

Counselors who engage in the use of distance counseling, technology, and/or social media develop knowledge and skills regarding related technical, ethical, and legal considerations (e.g., special certifications, additional course work).

H.1.b. Laws and Statutes

Counselors who engage in the use of distance counseling, technology, and social media within their counseling practice understand that they may be subject to laws and regulations of both the counselor's practicing location and the client's place of residence. Counselors ensure that their clients are aware of pertinent legal rights and limitations governing the practice of counseling across state lines or international boundaries.

H.2. Informed Consent and Security

H.2.a. Informed Consent and Disclosure

Clients have the freedom to choose whether to use distance counseling, social media, and/or technology within the counseling process. In addition to the usual and customary protocol of informed consent between counselor and client for face-to-face counseling, the following issues, unique to the use of distance counseling, technology, and/or social media, are addressed in the informed consent process:

- Distance counseling credentials, physical location of practice, and contact information;
- Risks and benefits of engaging in the use of distance counseling, technology, and/or social media;
- Possibility of technology failure and alternate methods of service delivery;
- Anticipated response time;
- Emergency procedures to follow when the counselor is not available;
- Time zone differences;
- Cultural and/or language differences that may affect delivery of services;
- Possible denial of insurance benefits; and
- Social media policy.

H.2.b. Confidentiality Maintained by the Counselor

Counselors acknowledge the limitations of maintaining the confidentiality of electronic records and transmissions. They inform clients that individuals might have authorized or unauthorized access to such records or transmissions (e.g., colleagues, supervisors, employees, information technologists).

H.2.c. Acknowledgment of Limitations

Counselors inform clients about the inherent limits of confidentiality when using technology. Counselors urge clients to be aware of authorized and/or unauthorized access to information disclosed using this medium in the counseling process.

H.2.d. Security

Counselors use current encryption standards within their websites and/or technology-based communications that meet applicable legal requirements. Counselors take reasonable precautions to ensure the confidentiality of information transmitted through any electronic means.

H.3. Client Verification

Counselors who engage in the use of distance counseling, technology, and/or social media to interact with clients take steps to verify the client's identity at the beginning and throughout the therapeutic process. Verification can include, but is not limited to, using code words, numbers, graphics, or other nondescript identifiers.

H.4. Distance Counseling Relationship

H.4.a. Benefits and Limitations

Counselors inform clients of the benefits and limitations of using technology applications in the provision of counseling services. Such technologies include, but are not limited to, computer hardware and/or software, telephones and applications, social media and Internet-based applications and other audio and/or video communication, or data storage devices or media.

H.4.b. Professional Boundaries in Distance Counseling

Counselors understand the necessity of maintaining a professional relationship with their clients. Counselors discuss and establish professional boundaries with clients regarding the appropriate use and/or application of technology and the limitations of its use within the counseling relationship (e.g., lack of confidentiality, times when not appropriate to use).

H.4.c. Technology-Assisted Services

When providing technology-assisted services, counselors make reasonable efforts to determine that clients are intellectually, emotionally, physically, linguistically, and functionally capable of using the application and that the application is appropriate for the needs of the client. Counselors verify that clients understand the purpose and operation of technology applications and follow up with clients to correct possible misconceptions, discover appropriate use, and assess subsequent steps.

H.4.d. Effectiveness of Services

When distance counseling services are deemed ineffective by the counselor or client, counselors consider delivering services face-to-face. If the counselor is not able to provide face-to-face services (e.g., lives in another state), the counselor assists the client in identifying appropriate services.

H.4.e. Access

Counselors provide information to clients regarding reasonable access to pertinent applications when providing technology-assisted services.

H.4.f. Communication Differences in Electronic Media

Counselors consider the differences between face-to-face and electronic communication (nonverbal and verbal cues) and how these may affect the counseling process. Counselors educate clients on how to prevent and address potential misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically.

H.5. Records and Web Maintenance

H.5.a. Records

Counselors maintain electronic records in accordance with relevant laws and statutes. Counselors inform clients on how records are maintained electronically. This includes, but is not limited to, the type of encryption and security assigned to the records, and if/for how long archival storage of transaction records is maintained.

H.5.b. Client Rights

Counselors who offer distance counseling services and/or maintain a professional website provide electronic links to relevant licensure and professional certification boards to protect consumer and client rights and address ethical concerns.

H.5.c. Electronic Links

Counselors regularly ensure that electronic links are working and are professionally appropriate.

H.5.d. Multicultural and Disability Considerations

Counselors who maintain websites provide accessibility to persons with disabilities. They provide translation capabilities for clients who have a different primary language, when feasible. Counselors acknowledge the imperfect nature of such translations and accessibilities.

H.6. Social Media

H.6.a. Virtual Professional Presence

In cases where counselors wish to maintain a professional and personal presence for social media use, separate professional and personal web pages and profiles are created to clearly distinguish between the two kinds of virtual presence.

H.6.b. Social Media as Part of Informed Consent

Counselors clearly explain to their clients, as part of the informed consent procedure, the benefits, limitations, and boundaries of the use of social media.

H.6.c. Client Virtual Presence

Counselors respect the privacy of their clients' presence on social media unless given consent to view such information.

H.6.d. Use of Public Social Media

Counselors take precautions to avoid disclosing confidential information through public social media.

SECTION I: RESOLVING ETHICAL ISSUES

Introduction

Professional counselors behave in an ethical and legal manner. They are aware that client welfare and trust in the profession depend on a high level of professional conduct. They hold other counselors to the same standards and are willing to take appropriate action to ensure that standards are upheld. Counselors strive to resolve ethical dilemmas with direct and open communication among all parties involved and seek consultation with colleagues and supervisors when necessary. Counselors incorporate ethical practice into their daily professional work and engage in ongoing professional development regarding current topics in ethical and legal issues in counseling. Counselors become familiar with the ACA Policy and Procedures for Processing Complaints of Ethical Violations and use it as a reference for assisting in the enforcement of the *ACA Code of Ethics*.

I.1. Standards and the Law

I.1.a. Knowledge

Counselors know and understand the *ACA Code of Ethics* and other applicable ethics codes from professional organizations or certification and licensure bodies of which they are members. Lack of knowledge or misunderstanding of an ethical responsibility is not a defense against a charge of unethical conduct.

I.1.b. Ethical Decision Making

When counselors are faced with an ethical dilemma, they use and document, as appropriate, an ethical decision-making model that may include, but is not limited to, consultation; consideration of relevant ethical standards, principles, and laws; generation of potential courses of action; deliberation of risks and benefits; and selection of an objective decision based on the circumstances and welfare of all involved.

I.1.c. Conflicts Between Ethics and Laws

If ethical responsibilities conflict with the law, regulations, and/or other governing legal authority, counselors make known their commitment to the *ACA Code of Ethics* and take steps to resolve the conflict. If the conflict cannot be resolved using this approach, counselors, acting in the best interest of the client, may adhere to the requirements of the law, regulations, and/or other governing legal authority.

I.2. Suspected Violations

I.2.a. Informal Resolution

When counselors have reason to believe that another counselor is violating or has violated an ethical standard and substantial harm has not occurred, they attempt to first resolve the issue informally with the other counselor if feasible, provided such action does not violate confidentiality rights that may be involved.

I.2.b. Reporting Ethical Violations

If an apparent violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution or is not resolved properly, counselors take further action depending on the situation. Such action may include referral to state or national committees on professional ethics, voluntary national certification bodies, state licensing boards, or appropriate institutional authorities. The confidentiality rights of clients should be considered in all actions. This standard does not apply when counselors have been retained to review the work of another counselor whose professional conduct is in question (e.g., consultation, expert testimony).

I.2.c. Consultation

When uncertain about whether a particular situation or course of action may be in violation of the *ACA Code of Ethics*, counselors consult with other counselors who are knowledgeable about ethics and the *ACA Code of Ethics*, with colleagues, or with appropriate authorities, such as the ACA Ethics and Professional Standards Department.

I.2.d. Organizational Conflicts

If the demands of an organization with which counselors are affiliated pose a conflict with the *ACA Code of Ethics*, counselors specify the nature of such conflicts and express to their supervisors or other responsible officials their commitment to the *ACA Code of Ethics* and, when possible, work through the appropriate channels to address the situation.

I.2.e. Unwarranted Complaints

Counselors do not initiate, participate in, or encourage the filing of ethics complaints that are retaliatory in nature or are made with reckless disregard or willful ignorance of facts that would disprove the allegation.

I.2.f. Unfair Discrimination Against Complainants and Respondents

Counselors do not deny individuals employment, advancement, admission to academic or other programs, tenure, or promotion based solely on their having made or their being the subject of an ethics complaint. This does not preclude taking action based on the outcome of such proceedings or considering other appropriate information.

I.3. Cooperation with Ethics Committees

Counselors assist in the process of enforcing the *ACA Code of Ethics*. Counselors cooperate with investigations, proceedings, and requirements of the ACA Ethics Committee or ethics committees of other duly constituted associations or boards having jurisdiction over those charged with a violation.

Customer Information/Answer Sheet/Evaluation insert located between pages 104–105.

TEST QUESTIONS
#77722 ETHICS FOR COUNSELORS

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

This 6 clock hour activity must be completed by April 30, 2022.

1. Virtue ethics is an ancient ethical system attributed to
- *A) Aristotle.*
- *B) Hippocrates.*
- *C) St. Augustine.*
- *D) St. Thomas Aquinas.*

2. Which of the following historical events reinforced the need for codified standards of ethics?
- *A) The Watergate trial*
- *B) The Belmont Report*
- *C) The guidance counseling movement*
- *D) Medical experiments conducted on Jews during the Nazi regime and on children at Willowbrook State School*

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

4. All of the following are reasons ethical codes are developed, EXCEPT:
- *A) To protect clients and professionals*
- *B) To provide guidance for ethical decision making*
- *C) To grant professional immunity from legal action when ethics violations occur*
- *D) To help to establish an organization by differentiating itself from similar institutions*

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

6. Courage, cleanliness, and cheerfulness are examples of
- *A) morals.*
- *B) terminal values.*
- *C) ethical principles.*
- *D) instrumental values.*

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

8. Morality is best defined as
- *A) ethics.*
- *B) views on sexual behavior.*
- *C) the attitude of counselors.*
- *D) the judgment or evaluation of ethical principles based on social, cultural, and religious norms.*

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

10. Ethical principles are best defined as
- *A) expressions of morality.*
- *B) statements that reflect values of society.*
- *C) ideas that provide direction for daily living.*
- *D) expressions that reflect people's obligations or duties.*

11. The ethical principle of competency is the duty to
- A) *tell the truth.*
- B) *only practice in areas of expertise.*
- C) *enter into challenging relationships.*
- D) *try to solve problems faster than other counselors.*

12. Which of the following is NOT one of the nine sections included in the ACA Code of Ethics?
- A) *Resolving Ethical Issues*
- B) *Institutional Assumptions*
- C) *Professional Responsibility*
- D) *Confidentiality and Privacy*

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

14. Which of the following is considered a teleologic ethical theory?
- A) *Utilitarianism*
- B) *Theologic ethics*
- C) *Mandatory ethics*
- D) *All of the above*

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

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

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

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

19. Which of the following ethical conflicts may be a concern in a managed care environment?
- A) *Distributive justice*
- B) *Client confidentiality*
- C) *Fiduciary relationships with clients vs. agencies*
- D) *All of the above*

20. According to Manhal-Baugus, the two main ethical issues in online counseling are privacy/confidentiality and
- A) *justice.*
- B) *beneficence.*
- C) *multiculturalism.*
- D) *principles of establishing online relationships.*

Be sure to transfer your answers to the Answer Sheet located between pages 104–105.
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.

Alcohol and Alcohol Use Disorders

Approval(s): APA, NBCC, NAADAC

Audience
This course is designed for mental and behavioral allied health professionals involved in the treatment or care of patients who consume alcohol.

Course Objective
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.

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

1. Review facts about the history, costs, and prevalence of alcohol use and abuse.
2. Define moderate drinking and take a history of alcohol use as defined by the standard drink equivalency.
3. Identify benefits reported in the literature for moderate alcohol consumption.
4. Distinguish between genetic and environmental risk and protective factors for developing alcohol problems.
5. Describe clinical characteristics of alcohol use disorder, intoxication, and withdrawal.
6. List complications associated with alcohol use disorders.
7. Recognize mental problems associated with alcohol use disorders.
8. Discuss screening instruments for detecting alcohol use disorders, including considerations for non-English-proficient patients.
9. Explain brief intervention efficacy and techniques.
10. Describe and evaluate treatment modalities.

Faculty
Mark S. Gold, MD, DFASAM, DLFAPA, is a teacher of the year, translational researcher, author, mentor, and inventor best known for his work on the brain systems underlying the effects of opiate drugs, cocaine, and food. Dr. Gold was a Professor, Eminent Scholar, Distinguished Professor, Distinguished Alumni Professor, Chairman, and Emeritus Eminent Scholar during his 25 years at the University of Florida. He was a Founding Director of the McKnight Brain Institute and a pioneering neuroscience-addiction researcher funded by the NIH-NIDA-Pharma, whose work helped to de-stigmatize addictions and mainstream addiction education and treatment. He also developed and taught courses and training programs at the University of Florida for undergraduates and medical students. (A complete biography appears at the end of this course.)

William S. Jacobs, MD, is a national clinical expert, triple board certified in Anesthesiology, Pain Medicine, and Addiction Medicine. A Phi Beta Kappa, magna cum laude University of Georgia undergraduate and graduate of the Medical College of Georgia, Dr. Jacobs did his anesthesiology residency at the University of Alabama-Birmingham, where he won the Dripps Award for the Best Anesthesiology Resident. He had a 13-year career as a private practitioner in anesthesiology and pain management before matriculating to the University of Florida for his addiction medicine fellowship. (A complete biography appears at the end of this course.)

Faculty Disclosure
Contributing faculty, Mark S. Gold, MD, DFASAM, DLFAPA, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Contributing faculty, William S. Jacobs, MD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planner
Alice Yick Flanagan, PhD, MSW

Division Planner Disclosure
The division planner has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Accreditations & Approvals
American Psychological Association
Continuing Education (CE) credits for psychologists are provided through the co-sponsorship of the American Psychological Association (APA) Office of Continuing Education in Psychology (CEP). The APA CEP Office maintains responsibility for the content of the programs.

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

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors. #MHC-0021.

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

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed marriage and family therapists. #MFT-0015.

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

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

NetCE is approved as a provider of continuing education by the California Consortium of Addiction Programs and Professionals (CCAPP). Provider Number 5-08-151-0622.

NetCE is approved as a provider of continuing education by the California Association for Alcohol/Drug Educators. Provider Number CP40 889 H 0623.

NetCE is approved as a provider of continuing education by the California Association of DUI Treatment Programs (CADTP). Provider Number 185.

Designations of Credit

NetCE designates this continuing education activity for 10 CE credits.

NetCE designates this continuing education activity for 4 NBCC clock hours.

Social Workers participating in this intermediate to advanced course will receive 10 Clinical continuing education clock hours.

NetCE designates this continuing education activity for 10 continuing education hours for addiction professionals.

Individual State Behavioral Health Approvals

In addition to states that accept ASWB, NetCE is approved as a provider of continuing education by the following state boards: Alabama State Board of Social Work Examiners, Provider #0515; Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health, Provider #50-2405; Illinois Division of Professional Regulation for Social Workers, License #159.001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197.000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168.000190; Texas State Board of Social Work Examiners, Approval #3011.

About the Sponsor

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

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

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- Read the following course.
- Complete the test questions at the end of the course.
- Return your Customer Information/Answer Sheet/Evaluation and payment to NetCE by mail or fax, or complete online at **www.NetCE.com/CTH21**.
- A full Works Cited list is available online at www.NetCE.com.

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

INTRODUCTION

No substance, legal or illegal, has a more paradoxical mythology than alcohol. It is undeniably one of the most widely and safely used intoxicants in the world; however, it is also potent and dangerous, both from a psychologic and a physiologic viewpoint. Alcohol is currently responsible for more deaths and personal destruction than any other known substance of abuse, with the exception of tobacco. All of this is known with scientific certainty. Alcohol is legal, easily obtained, and supported by a multi-billion-dollar worldwide industry. Alcohol consumption at reasonable doses reduces social inhibitions and produces pleasure and a sense of well-being. It also can have some rather impressive positive medical effects, such as a reduced risk of cardiovascular disease [1; 2].

SUBSTANCE ABUSE AND ADDICTION

Alcohol is defined as a substance of abuse by self-administration in lab animals and man. All drugs of abuse affect the brain's reward pathways. The effects of alcohol appear to be related to complex multiple interactions with the dopamine, gamma-aminobutyric acid (GABA), serotonin, opioid, and *N*-methyl-D aspartate (NMDA) neurotransmitter systems [3; 4]. Studies suggest that the reinforcing effect of alcohol is partially mediated through nicotinic receptors in the ventral tegmental area, which when combined with nicotine may be a factor in the high incidence of smoking among those with alcohol use disorder [5; 6; 7]. Alcohol, food, and other drugs of abuse have similar effects on dopamine receptors. The development of addiction, including to alcohol, is affected by genetic predisposition and influenced by alterations in the rewarding chemicals released per dose.

Substances of abuse are often put into categories based on their effects. Alcohol has effects similar to other depressants. Characteristics include:

- Decreased cognitive function while intoxicated
- Decreased inhibition and increased impulsivity
- Risk of overdose
- Development of depressive symptoms in heavy users
- Withdrawal symptoms similar to other depressants
- Symptoms of anxiety during withdrawal
- Substance-induced psychoses in some heavy users

The established criteria for the diagnosis of alcohol abuse and dependence will be discussed in detail later in this course.

HISTORY

From the earliest days of colonial settlement to the present, Americans have been drinking alcohol. The early American experience with alcohol provides a glimpse of patterns of use, as well as controversies involving alcohol. The argument could be made that alcohol, in one form or another, was used more in early revolutionary America than it is today. Drinking had almost religious support, with alcohol portrayed as a gift from God; a gift that could be abused by excessive drinking or drunkenness.

The story of alcohol in America begins with the Mayflower. The Mayflower dropped anchor in Plymouth, Massachusetts, in February 1621. The passengers were out of beer, and the crew was in no mood to share. Running out of beer or spirits was no laughing matter. So seriously did the crew take this lack of spirits that they quickly dropped the passengers off the Mayflower into very harsh conditions at Plymouth. This preference for beer was at least partly because it was a reliable source of nonpathogenic hydration, as bacteria and parasites are killed during the boiling stage of brewing.

In 1741, Benjamin Franklin, when listing the thirteen cardinal virtues, started with "Temperance: Drink not to elevation." Still, he noted that beer, applejack, and other alcohol-containing beverages of the day were safer to drink than the water in Boston or Philadelphia. Like Londoners, the colonists drank beer with breakfast after a sherry eye-opener, and drank beer at lunch and brandy if it was cold. They would have wine with dinner and punch or other liqueurs thereafter. Dr. Benjamin Rush, a signer of the Declaration of Independence who is also known as the father of American psychiatry, became alarmed by what he viewed as rampant health problems caused by alcohol and called for temperance. He described addiction and identified alcohol as an addictive substance. He argued that addiction was like a disease, and that the alcoholic victim was completely unable to control his consumption. Dr. Rush, a citizen of the Enlightenment Age, accurately described and anticipated the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) description of alcohol use disorder. However, he also suggested that alcoholism could be treated by whippings, bleeding, shame, emetics, oaths, and plunging the patient in cold water.

American attitudes about alcohol have flip-flopped from a free marketplace in the 18th and 19th centuries, to Prohibition in the 1920s, to the repeal of Prohibition in the 1930s, to lowering of the legal drinking age in most states during the late 1960s and early 1970s, and a return to the 21-years-of-age limit with the National Minimum Drinking Age Act of 1984. Alcohol consumption tends to be high during war years and was lowest during the Great Depression [8]. It was very high in the early 1980s, perhaps due to the low-

ered drinking age and poor economy. Like other consumer goods, alcohol consumption is generally inversely affected by changes in taxes and prices [9]. But interesting trends have been noted in the United States. While inflation-adjusted prices of alcohol declined between the late 1970s through the late 1990s, per capita alcohol consumption has also been declining since the mid-1980s [8; 10]. One study revealed that changing demographics, such as a shift to an older population that consumes less alcohol, could have more of an impact on consumption levels than falling prices. Other sources cite increased health awareness, national drunk-driving campaigns, and a less tolerant public attitude toward heavy drinking and youth intoxication [8].

This roller coaster of historical attitudes toward alcohol use results from conflicting sociologic and psychologic factors. For centuries, alcohol has been part of our social fabric and part of holidays and traditions. Simultaneously, our society has either shunned or punished those who succumbed to alcohol abuse, treating dependence as a legal issue or a moral failing rather than as a mental health problem. On one hand, alcohol is readily and cheaply accessible, safe for most people, moderately beneficial to health, and an important sector of our economy. However, we also understand that some individuals are at a high risk of losing control over alcohol.

CURRENT ESTIMATES OF ALCOHOL USE

As many as 90% of adults in the United States have had some experience with alcohol [11]. People drink alcohol for a variety of reasons:

- The pleasurable feeling that often accompanies drinking, including reduced tension and/or anxiety
- Enjoyment of the taste
- Social inclusion
- Self-medication
- Peer pressure
- Behavioral and physical addiction

Slightly more than half (50.8%) of all Americans older than 12 years of age reported being current consumers of alcohol in the 2019 National Survey on Drug Use and Health [12]. This translates to an estimated 139.7 million people, up from the 2016 estimate of 136.7 million people [12; 13]. Nearly one-half (47.1%) of Americans participated in binge drinking at least once in the 30 days prior to the survey. This represents approximately 65.8 million people. Heavy drinking was reported by 35.9% of the population 12 years of age and older (16.0 million people). The 2019 estimates for binge and heavy drinking are substantially higher than the 2016 estimates [12]. Past-month binge and heavy alcohol use for Americans 12 years of age and older are presented in ***Figure 1***.

Binge drinking among various races is 13.4% for Asians, 22.7% for blacks, 20.9% for American Indians or Alaska Natives, 25.8% for persons reporting two or more races, 25.0% for whites, and 24.2% for Hispanics [14].

Use of alcohol is higher for college graduates compared to those with only a high school diploma (90.3% and 82.2%, respectively) [14]. However, binge and heavy use is slightly higher for young adults 18 years of age and older who have not completed college [14]. The pattern of higher rates of current alcohol use, binge alcohol use, and heavy alcohol use among full-time college students, compared with rates for others 18 to 22 years of age, has remained consistent since 2002 [15]. In a 2002 study of alcohol use on college campuses, researchers at Harvard University reported that of the more than 14,000 students surveyed, 31% met the criteria for alcohol abuse and an additional 6% met the criteria for diagnosis of alcohol dependence [16]. In the study, alcohol abuse was defined as a positive response to any one of the four abuse criteria and the absence of dependence. Alcohol dependence was defined as a positive response to any three or more of seven dependence criteria. Percentages of students meeting specific alcohol abuse and dependence criteria are presented in ***Figure 2*** [16]. Male students are at greater risk than female students. Almost 10% of male students and 5% of female college students younger than 24 years of age met the criteria for a 12-month diagnosis of alcohol dependence [16].

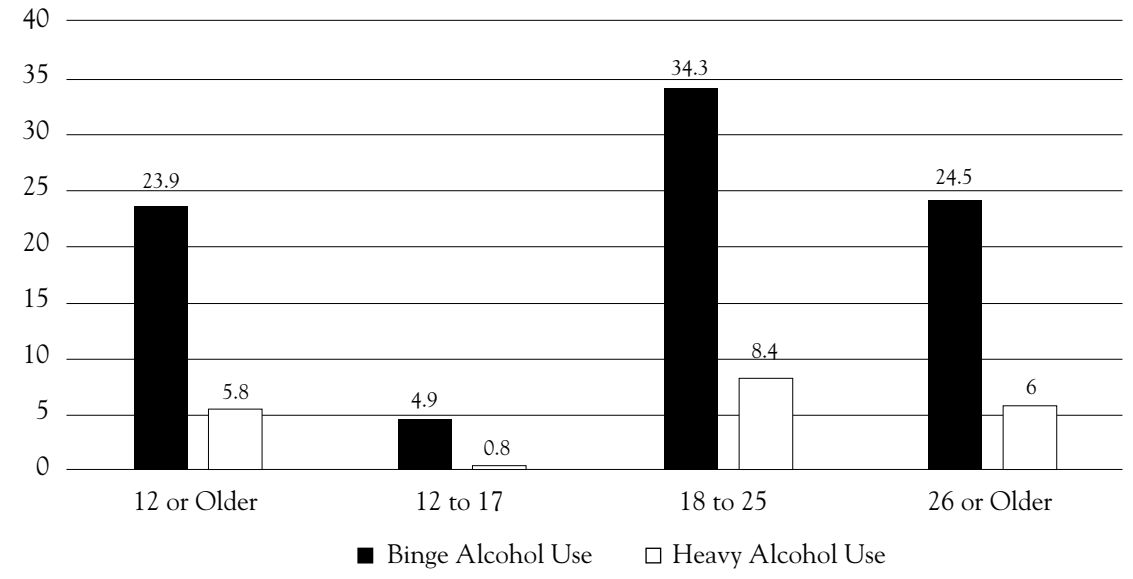
About 40% of people who drink have experienced an alcohol-related problem [11]. Between 3% and 8% of women and 10% to 15% of men will develop alcohol use disorder at some point in their lives. While alcohol use disorders can develop at any age, repeated intoxication at an early age increases the risk of developing an alcohol use disorder [11]. Usually, dependence develops in the mid-twenties through age forty.

COSTS OF ALCOHOL USE DISORDERS

The National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimated that the annual economic cost of alcohol and drug abuse was $365.4 billion in 1998 [9]. This estimate represents roughly $1,350 each year for every man, woman, and child living in the United States. Alcohol use disorders generated about half of the estimated costs ($184.6 billion). This figure rose to $249 billion in 2010, representing approximately $807 for every man, woman, and child living in the United States [17].

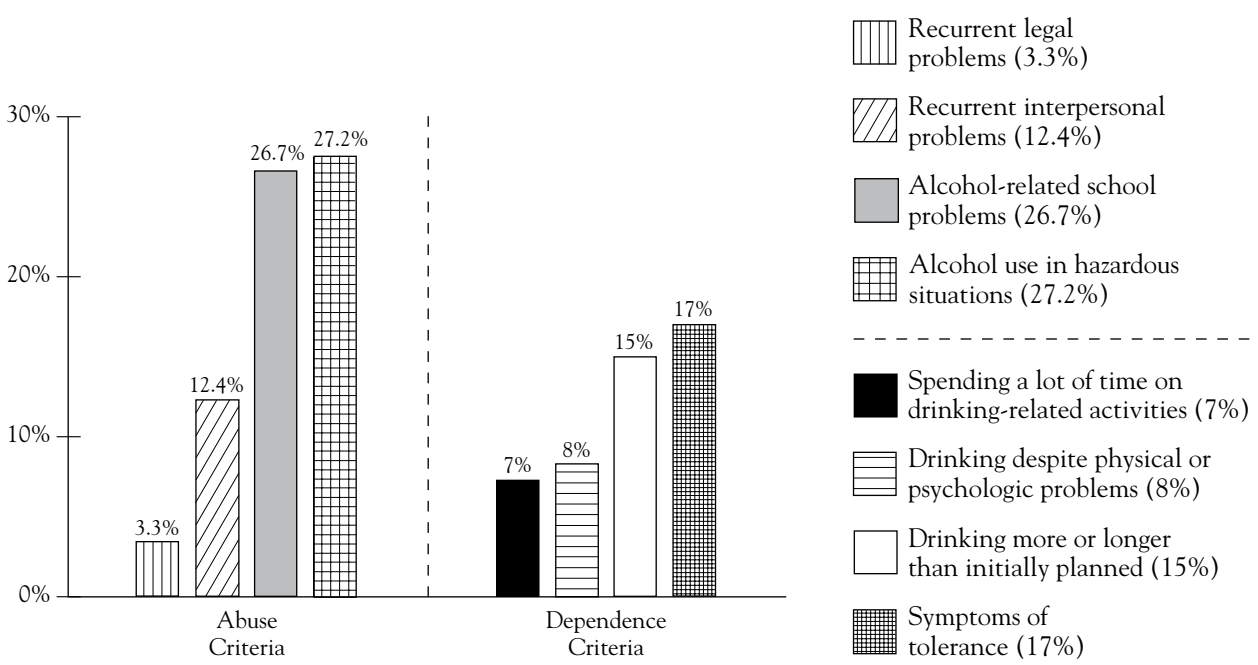
Nearly three-fourths (72%) of the costs of alcohol abuse are related to lost workplace productivity ($179 billion); 11% are related to healthcare expenses for treating problems caused by excessive drinking ($28 billion); 10% are law enforcement and other criminal justice expenses ($25 billion); and 5% are losses from motor vehicle crashes related to excessive alcohol use ($13 billion) [17]. Binge drinking is responsible for the majority of the cost at $191 billion [17]. Alcohol use disorder generally reduces the lifespan by 15 years [11]. Approximately

PAST MONTH BINGE AND HEAVY ALCOHOL USE, 2019



Source: [12] *Figure 1*

PERCENTAGE OF COLLEGE STUDENTS MEETING SPECIFIC ABUSE AND DEPENDENCE CRITERIA



Source: [16] *Figure 2*

$99.6 billion of the total costs of alcohol abuse is paid by federal, state, and local governments [17]. When both direct and indirect costs are included, the estimated annual cost of alcohol-related problems alone may be much greater [17].

DEFINITIONS

Tolerance: Either (1) a need for markedly increased amounts of the substance to achieve intoxication or desired effect; or (2) a markedly diminished effect with continued use of the same amount of the substance [18].

A Standard Drink: 1.5 ounces of 80-proof distilled spirits, 5 ounces of table wine, or 12 ounces of standard beer [19; 20].

Alcohol Intoxication: Clinically significant problematic behavioral or psychologic changes (e.g., inappropriate sexual or aggressive behavior, mood lability, impaired judgment) that developed during, or shortly after, alcohol ingestion [18]. Changes include slurred speech, loss of coordination, unsteady walking or running, impairment of attention or memory, nystagmus, stupor, or coma.

Alcohol Withdrawal: The presence of certain symptoms after stopping or reducing heavy and prolonged alcohol use [18]. The symptoms of alcohol withdrawal may develop within a few hours to a few days after stopping or reducing use and symptoms cause significant physical and emotional distress in social, occupational, or other important areas of functioning. Symptoms include increased hand tremor, sweating, increased pulse rate, nausea, vomiting, insomnia, temporary hallucinations or illusions, anxiety, psychomotor agitation, and generalized tonic-clonic seizures. Fewer than 5% of persons who develop alcohol withdrawal experience severe symptoms such as seizures and death [21].

Blood Alcohol Concentration (BAC): The percentage of alcohol present in the bloodstream. The BAC is usually what is measured by police officers to determine legal intoxication. It can be measured directly from a blood sample or a breath sample collected by a "Breathalyzer." The national legal limit for intoxication is a BAC of 0.08.

Moderate Drinking: No more than one drink per day for women and no more than two drinks per day for men [20].

Current Use: At least one drink in the past 30 days [17].

Binge Drinking: Consuming five or more drinks on the same occasion in the past 30 days [17].

Heavy Drinking: Five or more drinks on the same occasion on each of 5 or more days in the past 30 days [17].

Fetal Alcohol Syndrome (FAS): A severe fetal alcohol spectrum disease (FASD), FAS is a lifelong syndrome in children with confirmed prenatal exposure to alcohol. Signs include growth deficiencies, facial abnormalities, and neurocognitive deficits that may lead to problems with vision, hearing, attention, learning, memory, or any combination thereof [22]. There is no safe recommended level of alcohol use in pregnancy.

BENEFITS

Alcohol is consumed sensibly by the vast majority, but it can also be a cause of considerable damage and death when used excessively. Alcohol is part of many cultures, and most individuals learn from their bad experiences to moderate their drinking. Consequently, the majority of people do not have accidents or develop alcohol use disorder. Additionally, data suggests that moderate consumption of alcohol does have some health benefits.

The French consume large amounts of wine and high-cholesterol foods, yet they have a low incidence of heart disease. The Japanese drink large amounts of sake, but eat basically low-cholesterol foods and have a low incidence of heart disease. Other cultures traditionally drink whiskey and beer. Should we be drinking more, more regularly, or less on both counts?

Data for health benefits associated with low-to-moderate drinking appear to be common in many medical journals [23]. Light-to-moderate alcohol intake from beer, wine, or spirits is associated with a reduction in all-cause mortality, possibly due to its ability to decrease cardiovascular diseases, especially coronary heart disease (CHD). The relationship between alcohol intake and reduced risk of coronary disease is generally accepted as a U-shaped curve of low-dose protective effect and higher doses producing a loss of protective effects and increased all-cause deaths [25; 26; 27; 28; 29; 30; 31; 32]. The World Health Organization (WHO) reported that there is convincing evidence that low-to-moderate alcohol intake decreases risk for heart disease [24].

Many researchers have replicated the finding that moderate alcohol consumption is associated with a reduced risk of coronary artery disease, peripheral artery disease, sudden death, and stroke and suggest that this effect is to a large extent mediated by increases in high-density lipoproteins (HDLs) [1]. A 2011 meta-analysis inclusive of 84 out of 4,235 studies on the benefits of alcohol concluded that the lowest risk of CHD mortality was conferred by one to two drinks per day and that the lowest stroke mortality risk was conferred by consuming one or fewer drinks per day [2]. Research suggests that the protective effect may be a result of an interaction between diet and genetics, specifically related to a genetic variation in alcohol dehydrogenase (ADH) [33]. Moderate drinkers who are homozygous for the slow-oxidizing ADH3 allele have higher HDL levels and a substantially decreased risk of myocardial infarction [33]. An acute protective effect of alcohol consumption was also found for regular drinkers who consumed one or two drinks in the 24 hours preceding the onset of cardiac symptoms. Risk of a major coronary event is lowest among men who report daily drinking and among women who report one or two drinks daily. Alcohol does have effects on several markers for coronary risk factors, such as blood pressure, HDL cholesterol, low-density-lipoprotein (LDL) cholesterol, fibrinogen, clotting factors, and insulin sensitivity.

Prescribing alcohol to patients is not recommended, but research should continue in an attempt to identify the beneficial effects of alcohol alone. The psychiatric and other medical costs associated with drinking should be considered. Epidemiologists and other researchers are weighing the benefits of moderate alcohol consumption against the risks of addiction and accidents.

Alcohol clearly causes detrimental effects on a number of critical organs and systems in the human body when taken in large doses over time. Excessive alcohol consumption increases cardiovascular risk factors and mortality. Alcohol abuse is often considered the second most common cause of preventable death in the United States [34]. However, light-to-moderate drinking may protect against ischemic stroke and abstaining from alcohol may increase the risk of stroke [2]. A prospective study of moderate alcohol consumption and risk of peripheral arterial disease in U.S. male physicians found that any alcohol consumption decreases the risk of peripheral artery disease [1]. No evidence exists for a reduction in cardiovascular mortality in anyone younger than 40 years of age. Because almost no one dies of coronary artery disease before age 40, the studies to see if drinking in individuals younger than 40 years of age is particularly protective in later life have yet to be done.

Cardiovascular protection occurs primarily through blood lipids such as HDL, especially HDL subfraction 2 [1]. Moderate alcohol consumption inhibits platelets, especially after a fatty meal, suggesting an aspirin-like effect for moderate alcohol consumption [35]. Alcohol's effects on clotting appear to be related to the findings that drinking reduces acute heart attack risk. Certain alcoholic beverages, namely red wine, may also have an additional positive antioxidant effect as it contains flavonoids, which possibly slow oxidation of unsaturated fatty acids [36]. Additionally, low amounts of drinking can also enhance insulin sensitivity, reduce fasting insulin, and may also reduce stress.

Risk-to-benefit analysis should take into account a person's age, sex, family history, likelihood of an adverse effect on blood pressure, cancer risk, medication interaction, accidents, and dependency. Light-to-moderate alcohol consumption reduces overall risk of ischemic stroke; however, greater alcohol consumption has no additional benefit and can be harmful [2].

It has been questioned whether the cardiac protective effects can be easily generalized to women, in whom the risk of breast cancer complicates alcohol risks. For example, the consumption of seven or more drinks per week is associated with a twofold increase in postmenopausal hormone-sensitive breast cancers; however, several studies have shown that moderate alcohol consumption reduces the mortality of breast cancer [37; 38; 39]. It should also not be forgotten that alcohol increases the risk of certain other cancers (e.g., liver, mouth, esophageal, laryngeal, pharyngeal) that affect both men and women. After adjusting for the effects of age, smoking, and medical history, both men and women who consume one or two drinks of alcohol five or six days a week have a reduction in risk of a major coronary event compared with men and women who are nondrinkers [40].

Moderate drinking is heart-healthy for diabetics in the same way it is for other people, easing concerns that alcohol may disrupt diabetics' blood-sugar balance. In a 12-year study, diabetics who had one or two drinks daily were up to 80% less likely to die of heart disease than diabetics who did not drink [41].

WHAT TO ADVISE PATIENTS ABOUT DRINKING ALCOHOL

Although alcohol appears to have some moderate health benefits, physicians need not alter the drinking habits of those who consume low-to-moderate amounts of alcohol. It is problematic to advise a patient who is abstinent or who drinks infrequently to begin or increase alcohol consumption. In addition, social and religious factors may already dictate the patient's drinking habits.

Vulnerability to alcohol use disorders, depression, and alcohol-related pathologies varies greatly among individuals and cannot always be predicted before a patient begins or escalates drinking. Some individuals may be genetically predisposed to acquiring problems with alcohol use disorder. Similarly, excessive consumption often escapes detection before the onset of related health consequences. The balance of risk to benefit appears to favor encouraging some patients in midlife who are very infrequent drinkers to increase slightly the frequency of drinking. Again, this is debatable and will vary with the individual patient. Consuming alcohol is not the only means to reduce the risk of cardiovascular disease. Exercising, not smoking, lowering fat intake and lipids, and other health-related lifestyle issues should also be addressed.

For those who already have heart disease, it is clear that heavy drinkers should reduce their consumption or abstain and that everyone should avoid heavy and binge drinking. Data does not support advising abstainers with a history of myocardial infarction or decreased left ventricular function to start drinking for their health [42]. In general, moderate drinkers with these conditions should be able to continue to drink alcohol in moderation [42].

Alcohol is not without risks. Alcohol abuse worsens the course of psychiatric disorders. In countries with high alcohol consumption, the suicide rate is also high. One should ask whether the promotion of moderate alcohol consumption, justified on the basis of a biomedical effect (e.g., a reduction in all-cause mortality), might change a patient's quality of life or cause them to take offense. However, existing public educational efforts that target reductions in hazardous and harmful drinking and at the same time encourage drinkers to consume alcohol at responsible levels are appropriate and ethical.

RISK AND PROTECTIVE FACTORS

ALCOHOL AND GENETICS

Research has shown that genetic factors play a strong role in whether a person develops alcohol use disorder, accounting for 40% to 60% of the risk [43; 44]. In fact, family transmission of alcohol use disorder has been well established. Individuals who have relatives with alcohol use disorder are at three- to five-times greater risk of developing alcohol use disorder than the general population. The presence of alcohol use disorder in one or both biologic parents is more important than the presence of alcohol use disorder in one or both adoptive parents. The genetic risk of alcohol use disorder increases with the number of relatives with alcohol use disorder and the closeness of the genetic relationship [44]. However, most children of parents with alcohol use disorder do not become alcoholics themselves, and some children from families where alcohol is not a problem develop alcohol use disorders when they get older. Alcohol use disorder is seen in twins from alcoholic parents, even when they are raised in environments where there is little or no drinking. Identical twins adopted into households with an alcoholic stepfather do not show more alcohol use disorders than the general population. Children with close biologic relatives with alcohol use disorder, who are adopted into a never drinking, even religiously opposed family, can readily develop alcohol problems [45].

As mentioned previously, genetic factors are thought to account for 40% to 60% of the risk of developing alcohol use disorder [27; 44]. Animal studies have shown that genetic factors may be responsible for enhanced brain reward produced by alcohol, decreased initial impairment, or even altered metabolism of alcohol [46; 47; 48; 49; 50; 51; 52].

Genetic factors appear to influence the level of response (LR) to alcohol, as measured by the intensity with which one reacts to a given quantity [53]. The level of response to alcohol varies from individual to individual depending on the tolerance. Low LR at an early age contributes to the risk of alcohol use disorder later in life [53; 54].

Genetic differences in metabolic or other biologic processes may play a role in the development of alcohol use disorder in specific individuals. Studies using a self-rated scale have shown consistent results in sons of alcoholic fathers scoring themselves lower than sons of nonalcoholic fathers on feelings of drunkenness, dizziness, drug effect, and sleepiness following alcohol consumption [55]. This suggests that sons of alcoholic fathers have a less intense reaction to alcohol than sons of nonalcoholic fathers. Low reaction to alcohol suggests tolerance and impaired ability to recognize even modest levels of alcohol intoxication, indicators of tendency towards dependence [56; 57]. High alcohol sensitivity in men is associated with substantially decreased risk of alcohol use disorder. Understanding reactions to alcohol could establish a better understanding of future risk of developing alcohol use disorder in these men.

Studies have found similar results of higher tolerance for alcohol among daughters of parents with alcohol use disorder. One study examined the drinking patterns of 38 daughters of alcoholics compared with 75 family-history-positive men from the same families and 68 men with no family history of alcohol use disorder [58]. Family-history-positive men and women both displayed low reaction to alcohol. This indicates that the degree of genetic influence on alcohol-related behavior is similar for both men and women with family history of alcohol use disorder. In a study of adolescent and young adult offspring from families where alcohol use disorders are prevalent, researchers found both neurophysiologic and neuroanatomical differences, such as reduced right amygdala volume, when comparing these offspring to controls [59]. Another study assessed the relationship between amygdala and orbitofrontal cortex volumes obtained in adolescence and substance use disorder outcomes in young adulthood among high-risk offspring and low-risk controls [60]. A total of 78 participants 8 to 19 years of age (40 high-risk, 38 low-risk) from a longitudinal family study underwent magnetic resonance imaging. Volumes were obtained with manual tracing. Outcomes were assessed at approximately one-year intervals. The ratio of orbitofrontal cortex volume to amygdala volume significantly predicted substance use disorder survival time across the sample. A reduction in survival time was seen in participants with smaller ratios; this was true for both high-risk and low-risk participants [60].

Native Americans and Alaskan Natives have a lower level of response and an increased risk of alcohol use disorder [44]. The alcohol metabolizing enzymes are another important genetic influence, especially for persons of Asian descent. About 50% of Japanese, Chinese, and Korean persons flush and have a more intense response to alcohol because they have a form of alcohol dehydrogenase (ADH) that causes high levels of acetaldehyde. Forms of ADH and aldehyde dehydrogenase (ALDH) (e.g., homozygous or heterozygous) contribute to a higher rate of alcohol metabolism, intensify the response to alcohol, and lower the risk of alcohol use disorder. High levels of impulsivity/sensations seeking/disinhibition are also genetically influenced and may impact alcohol use disorder risk [44].

At least 95,000 people (approximately 68,000 men and 27,000 women) die from alcohol-related causes annually. According to NIAAA, alcohol is a significant cause of death, disease, and disability, currently ranked as the third leading preventable cause of death in the United States [355]. According to a 2020 SAMSHA survey reported by NSDUH, 14.5 million Americans 12 years of age and older (5.3% of this age group) have alcohol use disorder [355]. Almost 1 in 4 adults have had a heavy drinking event in the past year (defined as five or more drinks for men and four or more

drinks for women). The NIH and the CDC report increasing alcohol problems, deaths, and alcohol use disorders. The number of death certificates mentioning alcohol more than doubled between 1999 and 2017, and alcohol plays a role in approximately 3% of all deaths in the United States [356]. Increases in alcohol-related deaths are consistent with reports of increased alcohol sales, consumption, alcohol-involved emergency department visits, and hospitalizations. The most recent alcohol data provide more evidence of increasing heavy alcohol use and associated consequences during the COVID-19 pandemic [357]. Increased alcohol use may also worsen medical and mental health problems.

PSYCHOLOGIC AND SOCIOENVIRONMENTAL RISK FACTORS MODELS

Researchers who study risk factors have developed models of how known risk factors may interact to create pathways in children that lead to alcohol use disorders.

Children with Conduct Problems

One model focuses on children who have temperaments that make it difficult for them to regulate their emotions and control their impulses. Clearly, these children are difficult to parent, and if one or both of their parents have alcohol use disorder, it is likely that they will be poorly socialized and have trouble getting along in school [61; 62]. Poor academic performance and rejection by more mainstream peers at school may make it more likely for these children to join peer groups where drinking and other risky behaviors are encouraged. Parents with alcohol use disorders will likely not monitor their children closely and will lose control over them at an early age. These children will begin drinking early, often before 15 years of age [63]. If such a child is genetically predisposed to alcohol use disorders, these environmental factors may further increase the tendency [64].

Stress and Distress

Another model of risk factors leading to alcohol use disorder focuses on drinking to regulate inner distress [65]. Some children have temperaments that make them highly reactive to stress and disruption. This type of child may be born into a family with history of alcohol use disorder, where the stressors may be intense, or a nonalcoholic family, with everyday types of low-level stressors. Regardless of the child's family environment, he or she maintains higher levels of inner distress (anxious and depressed feelings) than other children. When they take their first drink, the inner distress dissipates for a while. This leads to more drinking and may lead to alcohol use disorder. However, for some individuals, at certain doses, alcohol may induce rather than reduce the stress response. Research demonstrates that alcohol actually induces the stress response by stimulating hormone release by the hypothalamus, pituitary, and adrenal glands [66]. Research also demonstrates a bidirectional relationship between alcohol and stress [67]. More research is required before the role of stress as a risk factor in alcohol use disorders is understood.

Sensitivity to Alcohol's Effects

A third risk factor model focuses on sensitivity to the effects of alcohol, both to its sedative properties and its stimulating qualities [68]. The stimulant-like (increased heart rate and blood pressure) and sedative properties (impaired vigilance and psychomotor performance) depend on the quantity of alcohol consumed, the time elapsed since consumption, and individual differences in response [69; 70]. Researchers believe that this subjective response to alcohol may be an important endophenotype in understanding genetic influences on drinking behavior and alcohol use disorders. While subjective response predicts alcohol use and problems, the exact pattern of association remains unclear [71; 72; 73]. Two prominent models of subjective response have been discussed in the literature. The low level of response model suggests that high-risk individuals experience decreased sensitivity to the full range of the effects of alcohol. The differentiator model suggests that high risk for alcohol problems is associated with increased sensitivity to alcohol's positive effects but decreased sensitivity to its negative effects [71; 72]. A literature review of studies that employed challenge paradigms to assess a range of the effects of alcohol (i.e., impairment, stimulation, sedation) found some support for both models [71]. Results of a quantitative review and meta-analysis suggest that the two models may describe two distinct sets of phenotypic risk with different etiologies and predictions for development of alcohol use disorder [72]. A total of 32 independent samples were combined to produce estimates of the effects of risk-group status (i.e., positive family history of alcohol use disorder or heavy alcohol consumption). Groups with positive family history for alcohol use disorder experienced reduced overall subjective response relative to groups with negative family history, as predicted by the low level of response model. In contrast, consistent with the differentiator model, heavy drinkers of both genders responded less on measures of sedation than did lighter drinkers, but more on measures of stimulation [72].

The effects of alcohol on the electroencephalogram (EEG) of subjects at risk for developing alcoholism are well known [74; 75; 76]. Researchers found that low EEG response to small amounts of alcohol may be associated with future development of alcohol use disorder. Additionally, differences in EEG response to alcohol may have ethnic variations [76]. Other studies have shown that heavy drinkers had less sedation and cortisol response after alcohol consumption than light drinkers. In addition, heavy drinkers were more sensitive to the positive stimulant-like properties as blood alcohol levels increased [68; 77].

KNOWN RISK FACTORS FOR ALCOHOL USE DISORDER

With these three models in mind, a review of some of the research findings on genetic and psychosocial risk factors may provide a better understanding of the factors leading to alcohol use disorders [11; 78]:

- Temperament: Moodiness, negativity, and provocative behavior may lead to a child being criticized by teachers and parents. These strained adult-child interactions may increase the chances that a child will drink.
- Hyperactivity: Hyperactivity in childhood is a risk factor for the development of adult alcohol use disorders. Children with attention deficit hyperactivity disorder (ADHD) and conduct disorders have increased risk of developing an alcohol use disorder. Childhood aggression also may predict adult alcohol abuse.
- Parents: The most compelling and largest body of research shows parents' use and attitudes toward use to be the most important factor in an adolescent's decision to drink.
- Gender: Among adults, heavy alcohol use is almost three times more common among men than women and also more common among boys in middle or high school than among girls. Men with ADHD and/or conduct disorders are more likely to use alcohol than men without these disorders, while women who experience more depression, anxiety, and social avoidance as children are more likely to begin using alcohol as teens than women who do not experience these negative states.
- Psychology: Bipolar disorder, schizophrenia, antisocial personality disorder, and panic disorder all also increase the risk of a future alcohol use disorder.

ABUSE AND ADVERSE CONDITIONS IN THE HOME

Childhood abuse is a significant risk factor for later alcohol and substance abuse [79]. Women who were physically abused are 1.5 to 2 times more likely to abuse alcohol than non-abused adults. Children from crowded, noisy, and disorderly homes without rules or religion are more likely to abuse alcohol as teens. Children who are quick to anger, who perceive themselves to be highly stressed, who are resentful of parents' absences, or who have repeated conflicts at home are more likely to abuse alcohol as teens.

PROTECTIVE FACTORS

An exciting area of research is focused on protective factors and poses the question, "What protects children from taking one of the risk pathways to alcohol use disorder?"

In 1997, some good news came from the National Longitudinal Study on Adolescent Health, a survey in which nearly 12,000 students in grades 7 through 12 were given lengthy interviews timed one year apart. The researchers were trying to determine what kept children, over the course of that year, from taking health risks in four areas: substance abuse (cigarettes, alcohol, and marijuana), sexuality, violence, and emotional health [80]. The researchers found two factors that protected these children in all four areas. They named the factors: parent-family connectedness and school connectedness. Children identified as having parent-family connectedness said they felt close to their mother or father, felt that their mother or father cared about them, felt satisfied with their relationship with their mother or father, and felt loved by family members [80]. School connectedness was experienced as a feeling of being part of one's school and a belief that students were treated fairly by the teachers.

There is broad evidence of the protective role of parenting on adolescent health risks. Another well-established protective factor is adolescents' perceived disapproval of alcohol use by their parents [81; 82; 83; 84; 85]. In 2019, the National Survey on Drug Use and Health asked children 12 to 17 years of age about their perceptions of the level of parental disapproval of substance use initiation, including alcohol [14]. Most adolescents (90.6%) reported that their parents would strongly disapprove of them having one or two alcoholic drinks nearly every day. This percentage was similar to percentages in most years since 2002, with rates ranging from 88.5% to 91.2% [14]. The number of past-year initiates 12 years of age or older for alcohol also remained stable between 2002 and 2019 [14].

ALCOHOL USE DISORDER

Alcohol use disorder, also referred to as alcohol abuse and/or alcohol dependence, is defined in the DSM-5 as a problematic pattern of use with two or more of the following criteria over a one-year period [18]:

- Alcohol often taken in larger amounts or over a longer period than was intended
- A persistent desire or unsuccessful efforts to cut down or control alcohol use
- A great deal of time spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects
- Craving, or a strong desire or urge to use alcohol
- Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home
- Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol
- Important social, occupational, or recreational activities given up or reduced because of alcohol use
- Recurrent alcohol use in situations in which it is physically hazardous
- Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychologic problem that is likely to have been caused or exacerbated by alcohol
- Tolerance
- Withdrawal

Alcohol use disorder is extremely amenable to brief intervention. Brief intervention usually includes giving patients information about problems associated with excessive drinking and advising them to cut down on their drinking or abstain. Without intervention, 10% will likely progress to dependence and 50% to 60% will continue to experience problems over the next five years [87; 88].

Alcohol use disorder is a primary and chronic disease that is progressive and often fatal; it is not a symptom of another physical or mental condition. It is a disease in itself, like cancer or heart disease, with a very recognizable set of symptoms that are shared by others with the same disorder. About 14.5 million people in the United States met DSM-5 criteria for alcohol use disorder in 2019, with an additional 5.9 million abusing or dependent on both alcohol and illicit drugs [89].

Like cancer and many other chronic diseases, alcohol use disorder progresses over time. People with alcohol use disorder experience physical, emotional, and other changes in their lives and relationships. These changes may worsen if drinking continues and if treatment specifically targeted to alcohol use disorder is not initiated. Left untreated, alcohol use disorders may lead to premature death through overdose or through damage to the brain, liver, heart, and many other organs. Excessive alcohol consumption is highly associated with suicide, motor vehicle accidents, violence, and other traumatic events [89]. People with untreated alcohol use disorders often lose their jobs, their families, their relationships, and other freedoms that were once important to them.

As noted, alcohol problems can often be prevented by early identification and brief intervention. A weak link in the early identification of problems is the lack of skill and competencies necessary to perform such an assessment and the experience to confidently move to more specific questions and suggestions for change.

EVIDENCE-BASED PRACTICE RECOMMENDATION

The U.S. Preventive Services Task Force (USPSTF) recommends screening for unhealthy alcohol use in primary care settings in adults 18 years of age or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.

(https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions. Last accessed May 10, 2021.)

Strength of Recommendation/Level of Evidence: B (The USPSTF recommends that clinicians provide this service to eligible patients based on at least fair evidence that the service improves important health outcomes and concludes that benefits outweigh harms.)

Alcohol dependence is included in the DSM-5 umbrella definition of alcohol use disorder [18]. The symptoms of withdrawal and tolerance have been the hallmarks of more severe disease, though alone they are neither necessary for nor sufficient to make the diagnosis.

Healthcare professionals should understand the criteria and warning signs of alcohol use disorder. This enables confrontation and intervention earlier in the course of the illness rather than relying on toxic liver markers. Verifying the facts that show a person is at risk for alcohol use disorder and confronting the impaired individual with those facts is the definition of an office or brief intervention. Brief intervention is most effective before dependence is reached. Once diagnosable, the patient needs more comprehensive intervention.

WITHDRAWAL

Individuals with alcohol use disorder often experience a severe, potentially fatal withdrawal syndrome when they either abruptly discontinue or sharply reduce their alcohol consumption. The symptoms may include sweating, rapid heartbeat, hypertension, tremors, anorexia, insomnia, agitation, anxiety, nausea, and vomiting. Tremors of the hands are usually the earliest symptom of alcohol withdrawal. Hallucinosis, seizures, and delirium tremens (DTs) are the most severe form of alcohol withdrawal. Hallucinosis, when it occurs, occurs one to two days after decreasing or abstaining from alcohol. While the effects of DTs can be life threatening, all other symptoms, with or without treatment, usually resolve several hours or days after appearance. Alcohol withdrawal in tolerant individuals can occur before the BAC has dropped below the established legal limit for intoxication. Some persons with alcohol use disorder have symptoms of irritability, emotional lability, insomnia, and anxiety that persist for weeks to months after alcohol withdrawal. The symptoms may be due to the residual effects of alcohol toxicity on the central nervous system and can be post-acute withdrawal symptoms; members of Alcoholics Anonymous (AA) refer to this as being a "dry drunk." AA considers alcoholics who are only abstaining from alcohol but who are not working a recovery program and remaining in essentially the same emotional state as they were when they were drinking to be "dry drunks."

INCREASED TOLERANCE

Long-term heavy drinking and genetic predisposition can result in the development of tolerance, which is the body's adaptation to the presence of alcohol. As tolerance develops, the drinker requires increasing amounts of alcohol to feel the same effect. For this reason, the usual reported effects for various BAC levels do not apply to individuals with tolerance. In our society, people are often admired for their ability to "hold their drinks." But the fact is, tolerance may be an early warning sign that a physical dependence on alcohol is developing. During the late stages of alcohol use disorder, reverse-tolerance occurs, meaning the individual becomes intoxicated more quickly and with less alcohol.

IMPAIRED CONTROL OF DRINKING

Impaired control over drinking means that a person is consistently unable to limit the number of occasions when alcohol is used or the amount of alcohol ingested on those occasions. Often, because of the damage alcohol causes in their lives, people with alcohol use disorder will express a strong and persistent desire to cut down or stop drinking. Often they may be able to do so, sometimes for a matter of weeks, a month, or even longer. One does not need to be a daily drinker to meet criteria for alcohol use disorder, as even those who go weeks or months without a drink may binge and meet diagnostic criteria. However, because alcohol use disorder is a chronic progressive disease, once patients with alcohol use disorder resume drinking, even after years of sobriety, they typically return to the previous quantities of consumption, with worsening adverse consequences.

PREOCCUPATION WITH ALCOHOL

Individuals with alcohol use disorder may have a preoccupation with alcohol, defined as a noticeable shift in priorities, with a focus on obtaining and consuming an adequate supply of alcohol. Drinking alcohol becomes a central focus in their lives. Over time, the energies of individuals with alcohol use disorder are diverted from people, places, and things that were once important to them.

Another highly noticeable feature of the preoccupation with alcohol may be the large amount of time that drinking consumes. Thinking about alcohol, obtaining alcohol, drinking alcohol, and recovering from the effects of alcohol take more and more of the individual's time. Hobbies and other activities once enjoyed are abandoned one by one, and the only pleasure seems to come from drinking.

USE OF ALCOHOL DESPITE ADVERSE CONSEQUENCES

Continued drinking despite adverse consequences is characterized by the inability of individuals with alcohol use disorder to stop drinking even when they recognize that their family, interpersonal, spiritual, occupational, legal, and financial problems are the result of their drinking. Furthermore, alcohol may be causing serious health and psychologic problems (e.g., anemia, gastritis, liver disease, neurologic disorders, depression) and still the dependent individual cannot stop.

DENIAL AS A DEFENSE MECHANISM

Denial is a common characteristic distortion in thinking that becomes profound in people with alcohol use disorder. For decades, those who have treated individuals with alcohol use disorder, and recovering alcoholics themselves, have puzzled over why these persons continue to drink when the link between alcohol and the losses they suffer is so clear. Denial is an integral part of the disease of alcohol use disorder and a major obstacle to recovery. Although the term denial is not specifically used in the wording of the diagnostic criteria, it underlies the primary criteria described as, "drinking despite adverse consequences."

RELAPSE

Because alcohol use disorder is a chronic disease, another symptom that is increasingly being recognized and treated is relapse. Although alcohol use disorder is a treatable, chronic disease, as yet, no cure has been found. This means that even if individuals with alcohol use disorder have been sober for a long time and have regained their health and reclaimed other important aspects of their lives, they may experience a relapse that will require further treatment in order to return to remission.

PHYSICAL CLUES THAT MAY SUGGEST ALCOHOL USE DISORDER

While a strong attachment to alcohol is the hallmark of early dependency, if the patient refuses to acknowledge a problem and no one from home or work helps to confirm the diagnosis, healthcare professionals are often left with nothing more than clinical intuition, resulting in a missed diagnosis. However, late in the course of alcohol use disorder, physical clues typically become increasingly apparent and suggestive of alcohol abuse and/or dependence. Alcohol abuse and dependence are often referred to as the "Great Masquerader" because many of the signs and symptoms are also commonly found in other conditions [90].

Elevated Laboratory Findings

- Serum glutamic oxaloacetic transaminase (SGOT)
- Lactic acid dehydrogenase (LDH)
- Cholesterol
- Gamma-glutamyltransferase (GGT)
- Mean corpuscular volume (MCV)
- Alkaline phosphatase
- Triglycerides
- Blood alcohol concentration (BAC)
- Urinary ethyl glucuronide (EtG) and ethyl sulfate (EtS)
- Whole blood phosphatidylethanol (PEth)
- Serum transferrin
- Uric acid

Gastrointestinal Signs/Symptoms

- Nausea
- Vomiting
- Reflux
- Diarrhea
- Gastritis
- Ulcers
- Esophagitis

Cardiopulmonary Signs/Symptoms

- Hypertension
- Palpitations
- Arrhythmias
- Recurrent respiratory infections

Central Nervous System (CNS) Signs/Symptoms

- Anxiety
- Insomnia
- Memory impairment
- Depression
- Irritability
- Panic
- Suicide attempt(s)
- Suicidal thinking

Behavioral Clues

- Loss of interest in previously favorite activities and people
- Marital and financial problems
- Positive family history
- Cigarette smoking
- Problems at home and work
- Anger when someone asks about drinking
- Legal difficulties
- Higher than normal scores on screening questionnaires, such as the Michigan Alcohol Screening Test (MAST) and CAGE

Miscellaneous Signs/Symptoms

- Gout
- Impotence
- Bloated face
- Parotid swelling
- Trauma injuries
- Aches and pains
- Unusual accidents
- Broken bones
- Driving accidents, multiple citations, and other problems

COMPLICATIONS

Alcohol use disorders are often associated with physical disorders and related problems.

LIVER DISEASE

The liver is a particularly vulnerable organ to alcohol consumption, in large part because it is where alcohol is metabolized prior to elimination from the body. As few as six drinks a day for men have been found to be associated with liver damage. The most common manifestation among persons with alcohol use disorder is called "fatty liver." Among heavy drinkers, the incidence of fatty liver is almost universal. For some, a fatty liver may precede the onset of alcoholic cirrhosis. Fatty deposits have been associated with men who have six or more drinks a day and women who have only one or two drinks daily.

Alcoholic hepatitis is a condition that, when severe, is characterized by jaundice, fever, anorexia, and right upper-quadrant pain. Between 10% and 35% of heavy drinkers (those drinking five or six standard drinks a day or more) develop alcoholic hepatitis and 10% to 20% develop cirrhosis [91; 92]. More than 60% of persons who develop both alcoholic hepatitis and cirrhosis will die within four years. Drinking 12 beers a day for 20 years has been associated with a 50% incidence of cirrhosis. It is not known which individuals will develop cirrhosis. Studies have shown that women develop liver disease faster and at lower levels of alcohol consumption than men [92; 93]. Women also have a higher incidence of alcoholic hepatitis and higher mortality rate from cirrhosis [94].

Alcohol use disorder is also a strong predictive factor for the development of hepatocellular cancer [95]. The presence of other hepatic risk factors, including hepatitis C, fatty liver disease, smoking, and obesity, further increases this risk.

Liver Transplantation

The leading indication for liver transplantation in the United States is chronic hepatitis C [96]. Cirrhosis due to alcoholic liver disease is the second most common cause for a person to require a liver transplantation [96]. Candidates for liver transplantation should be adequately screened for alcohol use disorders and receive appropriate treatment both perioperatively and as part of long-term follow-up. Patient survival after transplantation for both of these conditions is surprisingly good, with 72% of patients surviving after five years [96]. Short-term survival is similar; however, long-term survival for patients with hepatitis C now appears to be compromised by universal recurrence. When patients have both alcohol use disorder and chronic hepatitis C, they do worse than when both diseases occur independently. One study demonstrated that patients' short-term survival is the same for those who have alcohol use disorder, hepatitis C, or both diseases [97].

ALCOHOL/ACETAMINOPHEN INTERACTION

Chronic heavy drinking appears to activate the enzyme CYP2E1, which may be responsible for transforming the over-the-counter pain reliever acetaminophen into toxic metabolites that can cause liver damage [98]. Even when acetaminophen is taken in standard therapeutic doses, liver damage has been reported in this population [99; 100]. A review of studies of liver damage resulting from acetaminophen-alcohol interaction reported that, in individuals with alcohol use disorder, these effects may occur with as little as 2.6 grams of acetaminophen (four to five "extra-strength" pills) taken over the course of the day by persons consuming varying amounts of alcohol [101]. The damage caused by alcohol-acetaminophen interaction is more likely to occur when acetaminophen is taken after, rather than before, the alcohol has been metabolized [102]. Moderate drinkers should also be made aware of this potential for interaction. There is now a warning label on the bottle that states, "If you consume three or more alcoholic drinks every day, ask your doctor whether you should take acetaminophen or other pain relievers/fever reducers." Further, in 2014 the U.S. Food and Drug Administration (FDA) issued a statement that combination prescription pain relievers containing more than 325 mg acetaminophen per dosage unit should no longer be prescribed due to reported severe liver injury with acetaminophen in patients who took more than the prescribed dose in a 24-hour period; took more than one acetaminophen-containing product at the same time; or drank alcohol while taking acetaminophen products [103].

CARDIOVASCULAR DISORDERS

Alcohol can have a detrimental effect on the heart, including a decrease in myocardial contractility, hypertension, atrial and ventricular arrhythmias, and secondary nonischemic dilated cardiomyopathy [104]. A common complication in alcohol use disorder is elevated pulse and blood pressure, often in the hypertension range. Younger people with alcohol use disorder and those without existing hypertension are less likely to have an elevation than those who are older and predisposed to some hypertension. When drinking stops, the blood pressure often returns to normal over a period of a few days. One study found that people who had six or more drinks a day were twice as likely to suffer from hypertension than moderate drinkers (two or fewer drinks per day) or nondrinkers. Increased serum GGT levels may be an indicator of an individual's susceptibility to the hypertensive effect of alcohol [105].

Aside from hypertension, chronic heavy drinking can adversely affect the heart primarily through direct toxicity to striated muscle, leading to a form of cardiomyopathy [104; 106]. Alcoholic cardiomyopathy is probably more common than is currently thought because of underdiagnosis of alcohol use disorder in general. The reported prevalence of alcoholic cardiomyopathy has varied widely from 4% to 40% or more, depending on the characteristics of the study population and the threshold of alcohol consumption used to identify the disorder [107].

The association between heavy alcohol consumption and rhythm disturbances, particularly supraventricular tachyarrhythmias in apparently healthy people, is called "holiday heart syndrome" [106; 108]. The syndrome was first described in persons with heavy alcohol consumption, who typically presented on weekends or after holidays, but it may also occur in patients who usually drink little or no alcohol [106; 109]. The most common rhythm disorder is atrial fibrillation, which usually converts to normal sinus rhythm within 24 hours. The incidence of holiday heart syndrome depends on the drinking habits of the studied population. Holiday heart syndrome should be considered as a diagnosis particularly in patients without overt heart disease presenting with new onset atrial fibrillation. Though recurrences occur, the clinical course is benign and specific antiarrhythmic therapy is usually not warranted [106; 108; 109].

Vitamin Deficiency, Alcohol, and Cardiovascular Disease

Abnormally high plasma levels of the amino acid homocysteine have been shown in studies to increase the risk for cardiac and other vascular diseases [110]. Even small increases in homocysteine appear to increase the risk of heart disease. Vitamins like folate, B12, and B6 are required for homocysteine disposal within cells. The lower the concentration of these and other vitamins, the greater the concentration of homocysteine. A number of nutritional problems have been reported in people with alcohol use disorder. Malnourished persons with alcohol use disorder and liver diseases have been found to have B6 and folate deficiencies. In addition, average homocysteine levels are twice as high in patients with chronic alcohol use disorder when compared to nondrinking controls. Thus, homocysteine may contribute to the cardiovascular complications experienced by many with chronic alcohol use disorder. Lowering homocysteine with B vitamin supplementation may reduce cardiovascular risk [111; 112]. Further research is necessary to determine whether abstinence and recovery reverses the risk of cardiovascular disease, and whether folate and vitamins B12 and B6 should be considered as appropriate nutritional supplements for patients with alcohol use disorder [113].

CANCER

Heavy drinking increases the risk of cancer of the upper gastrointestinal and respiratory tracts [114]. Almost 50% of cancers of the mouth, pharynx, and larynx and approximately 75% of esophageal cancers in the United States are associated with chronic, excessive alcohol consumption [115; 116; 117]. When alcohol consumption is combined with tobacco use, the risk of esophageal cancer increases markedly, as much as 130-fold in one study [118; 119]. Alcohol increases production of estradiol, and increased levels of estradiol have been linked to an increased risk of breast cancer in women who drink [120].

GASTROINTESTINAL DISORDERS

Alcohol produces irritation and inflammation of the mucosal lining of the gastrointestinal tract and influences the motility in the esophagus, stomach, and small bowel [121]. Frank ulceration may occur with chronic excessive alcohol use. This well-known alcohol related "heartburn" is due to esophageal reflux with esophagitis that commonly occurs with irritation and inflammation of the gastroesophageal junction. Severe vomiting from alcohol gastritis may result in mucosal tears at the gastroesophageal junction, resulting in frank, usually transient pain in the upper gastrointestinal tract.

Short-term and long-term alcohol ingestion are associated with gastritis, erosive gastritis, gastric ulceration, atrophic gastritis, and gastric hemorrhage. Furthermore, duodenitis and duodenal ulcerations are a direct result of chronic excessive alcohol irritation and inflammation.

Patients who have undergone gastric bypass surgery for obesity have higher breath-alcohol levels after drinking the same amount as other people. Many bypass surgeries attach the jejunum directly to the stomach, allowing delivery of alcohol more rapidly to the jejunal site of primary absorption as well as minimizing the effect of the stomach's alcohol dehydrogenase. Findings from a small study suggest that it takes much longer for their levels to return to zero [122].

CHRONIC PANCREATITIS

Alcohol consumption is the leading cause of chronic pancreatitis, accounting for approximately 70% of cases in the United States; however, fewer than 10% of heavy alcohol drinkers develop the disease [123; 124; 125; 126; 127]. While there are many theories regarding the pathophysiology of chronic pancreatitis, the most prevalent for alcohol-induced chronic pancreatitis involves the effect of toxic metabolites on the pancreas. This theory suggests that inflammation and fibrotic changes in the pancreas are the direct result of premature activation of enzymes due to ethanol's effect on the Golgi complex [125; 127; 128]. Another theory suggests that pancreatic hypoxia results from decreased blood flow to the pancreas. Alcohol-induced acinar injury may reduce capillary flow and result in edema and capillary compression [125]. Individuals with alcohol use disorder may develop diabetes mellitus or hyperglycemia as a result of chronic pancreatitis, when the islet cells in the pancreas are eventually destroyed. Once alcohol-induced chronic pancreatitis has developed, ingestion of even small amounts can result in severe flare-up requiring hospitalization.

BODY WEIGHT

Although alcohol has a relatively high caloric value, 7.1 calories per gram (1 gram of fat contains 9 calories), alcohol consumption does not necessarily result in increased body weight. Moderate, regular doses of alcohol added to the diets of lean men and women do not seem to lead to weight gain. However, in some studies obese patients have gained weight when alcohol is added to their diets.

An analysis of data collected from the first National Health and Nutrition Examination Survey (NHANES I) found that although drinkers had significantly higher intakes of total calories than nondrinkers, drinkers were not more obese than nondrinkers. In fact, women drinkers had significantly lower body weight than nondrinkers. As alcohol intake among men increased, their body weight decreased. An analysis of data from the second National Health and Nutrition Examination Survey (NHANES II) and other large U.S. studies found similar results for women [129]. When chronic heavy drinkers substitute alcohol for food in their diets, they typically lose weight and weigh less than their nondrinking counterparts [130].

Many older studies, such as those discussed, have focused on total volume of alcohol based on intake over time (e.g., number of drinks per week), an average that reveals little about the actual drinking habits of individuals. This has led to a very inconsistent array of data on the relationship of drinking and body mass index (BMI). One study sought a better understanding of the relationship between BMI and regular/moderate versus infrequent binge drinking [131]. Researchers found that although individuals of similar height might consume the same weekly average of alcohol (e.g., 14 drinks per week), individuals who consume two drinks each day of the week typically have low BMIs and individuals who consume seven drinks on each of two days of the week typically have high BMIs. A 2018 study examined the associations of alcoholic beverage consumption with dietary intake, waist circumference, and BMI [132]. A total of 7,436 men and 6,939 women 20 to 79 years of age were included in the study. By average daily drinking volume, the differences in waist circumference and BMI between former and moderate drinkers were +1.78 cm and +0.65, respectively, in men and +4.67 cm and +2.49, respectively, in women. Compared with moderate drinking, heavier drinking volume (three drinks/day or more in men, two drinks/day or more in women) was not associated with higher waist circumference or BMI, whereas drinking five or more drinks/day was associated with higher waist circumference and BMI in men. There were no significant differences in women who consumed four or more drinks/day compared with women who consumed one drink/day [132].

It is also important to note those individuals who have undergone bariatric surgery. According to a research study conducted at a substance abuse treatment facility, bariatric surgery patients were more likely to be diagnosed with alcohol withdrawal than those who had not had the surgery [133]. In another study of patients in active weight management being considered for bariatric surgery, an inverse relationship was found between BMI and alcohol consumption—the more overweight the patient, the less alcohol was consumed [134]. Past-year alcohol consumption actually decreased as BMI increased. Surgeons felt it rare to have a patient excluded for bariatric surgery due to excessive alcohol consumption. The authors concluded that it is likely that food and alcohol compete at brain reward sites.

MALNUTRITION

Excessive drinking may interfere with the absorption, digestion, metabolism, and utilization of nutrients, particularly vitamins. Individuals with alcohol use disorder often use alcohol as a source of calories to the exclusion of other food sources, which may also lead to a nutrient deficiency and malnutrition. In the late stage of the disease, patients may develop anorexia or severe loss of appetite, and refuse to eat. Persons with alcohol use disorder account for a significant proportion of patients hospitalized for malnutrition [130].

Direct toxic effects of alcohol on the small bowel causes a decrease in the absorption of water-soluble vitamins (e.g., thiamine, folate, B6). Studies have suggested that alcoholism is the most common cause of vitamin and trace-element deficiency in adults in the United States. Alcohol's effects are dose dependent and the result of malnutrition, malabsorption, and ethanol toxicity [135]. Vitamins A, C, D, E, K, and the B vitamins are deficient in some individuals with alcohol use disorder. All of these vitamins are involved in wound healing and cell maintenance. Because vitamin K is necessary for blood clotting, deficiencies can cause delayed clotting and result in excess bleeding. Vitamin A deficiency can be associated with night blindness, and vitamin D deficiency is associated with softening of the bones. Deficiencies of other vitamins involved in brain function can cause severe neurologic damage (e.g., deficiencies of folic acid, pyridoxine, thiamine, iron, zinc).

Thiamine deficiency from chronic heavy alcohol consumption can lead to devastating neurologic complications, including Wernicke-Korsakoff syndrome, cerebellar degeneration, dementia, and peripheral neuropathy [136]. Thiamine deficiency in patients with alcohol use disorder who are suffering from Wernicke-Korsakoff syndrome leads to lesions and increased microhemorrhages in the mammillary bodies, thalamus, and brainstem. This syndrome can also be associated with diseases of the gastrointestinal tract when there is inadequate thiamine absorption. All patients with alcohol use disorders should receive supplemental thiamine whenever entered into hospitalization or treatment to reduce this possibility.

INFECTIOUS DISEASES

Alcohol abuse is a major risk factor for many infectious diseases, especially pulmonary infections [137]. Studies have shown that alcohol abuse increases the risk for acute respiratory distress syndrome and chronic obstructive pulmonary disease [138; 139; 140; 141]. Pneumonia, tuberculosis, and other pulmonary infections are frequent causes of illness and death among patients with alcohol use disorder [142]. Other infectious diseases that are over-represented among individuals with alcohol use disorder are bacterial meningitis, peritonitis, and ascending cholangitis. Less serious infections are chronic sinusitis, pharyngitis, and other minor infections.

Acute and chronic alcohol abuse also increase the risk for aspiration pneumonia. Alcohol use disorders are associated with increased risk of aspiration of gastric acid and/or oropharyngeal flora, decreased mucus-facilitated clearance of bacterial pathogens from the upper airway, and impaired pulmonary host defenses [143]. In addition, pathogenic colonization of the oropharynx is more common in patients with alcohol use disorder.

The consumption of alcohol alters T-lymphocyte functions, immunoglobulin production by B cells, NK cell function, and neutrophil and macrophage activities making patients with alcohol use disorder more susceptible to septic infection [144; 145; 146]. Studies have shown that animals given ethanol are unable to suppress infections that can ultimately result in progressive organ damage and death [147; 148; 149].

SLEEP DISORDERS

Although some people believe that alcohol helps them sleep, chronic excessive drinking can induce sleep disorders by disrupting the sequence and duration of sleep states and by altering total sleep time, as well as the time required to fall asleep [150; 151]. Specifically, drinking within an hour of bedtime appears to disrupt the second half of the sleep period [152]. The person may sleep poorly during the second half of sleep, awakening from dreams and returning to sleep with difficulty, resulting in daytime fatigue and sleepiness [150; 153].

Individuals with alcohol use disorder may be at increased risk for sleep apnea, a disorder in which the upper air passage narrows or closes during sleep [154; 155; 156; 157]. The combination of alcohol, obstructive sleep apnea, and snoring increases a person's risk for heart attack, arrhythmia, stroke, and sudden death [158]. Obstructive sleep apnea significantly increases the risk of stroke or death from any cause, independent of other risk factors, including hypertension [159; 160].

NERVOUS SYSTEM DYSFUNCTION

The most common neurologic abnormality among patients with alcohol use disorder is dementia syndrome, which manifests primarily as impairment in recent memory, and more subtle fluctuations in abstractions, calculations, and other aspects of cognitive functions. As previously stated, one specific neurologic complication resulting from thiamine deficiency is Wernicke-Korsakoff syndrome, which involves delirium, clouded sensorium, confusion, ophthalmoplegia, nystagmus, and ataxia [161]. Immediate administration of thiamine is usually successful in treating the symptoms, but in some cases permanent memory loss occurs [161]. Once delirium and confusion resolve, there is sometimes a profound loss in recent memory (out of proportion to the other cognitive deficits) and alcoholic peripheral neuropathy, which results in diminished sensitivity to touch, pinprick, and vibration (objectively, and paraesthesias subjectively).

The acute effects of alcohol on the nervous system are signs people commonly think of when they envision an intoxicated person, such as slurred speech, loss of coordination, unsteady gait, impairment of attention or memory, nystagmus, stupor, or coma. The degree to which the central nervous system is impaired is directly proportional to the BAC and degree of tolerance.

Alcohol and the Brain

Alcohol affects most neurochemical systems including NMDA, GABA, serotonin, dopamine (DA), and opioid systems.

Alcohol inhibits NMDA systems, which may contribute to feeling intoxicated. NMDA receptors change as tolerance develops. These receptor systems are overactive during withdrawal. Alcohol also enhances the action of the GABA system, producing some of the symptoms of acute intoxication. GABA receptors are especially sensitive to alcohol. The GABA system is underactive during withdrawal, and the genes that control these receptors may have an impact on the risk of alcohol use disorder [162; 163].

Alcohol causes the release of 5-HT, or serotonin. Lower 5-HT levels in the brain are associated with increased alcohol intake in animals and humans, while higher 5-HT levels are associated with slightly reduced alcohol intake. Several 5-HT genes may be related to the genetic risk of alcohol use disorder [11; 44].

Alcohol activates DA in the reward system in the ventral tegmental area of the brain. Alcohol also causes the release of DA. Several DA receptors may be related to the genetic risk of alcohol use disorder [11; 44].

Finally, alcohol causes the release of endogenous opioids. Opioid receptors change with tolerance and withdrawal. Some receptors may affect genetic predisposition for alcohol use disorder, and opioid antagonists can decrease voluntary alcohol consumption. Alcohol may also affect acetylcholine, norepinephrine, and steroids.

Most people who drink do not develop brain damage. However, studies do indicate that impaired cognition and motor abilities occur in some individuals who are heavy drinkers. Older persons with alcohol use disorder exhibit more brain tissue loss than both older and younger persons without alcohol use disorder. These results suggest that aging may render a person more susceptible to the effects of chronic excessive alcohol. Most studies suggest that, following long-term abstinence, most brain changes resolve.

Magnetic resonance imaging has been used to measure changes in the brain structure and volume in persons with alcohol use disorder at three weeks after abstinence from alcohol [164]. The results indicated that the brain volume in men and women with alcohol use disorder was significantly reduced as compared with healthy men and women. The differences, however, were much more significant in women than in men [165]. These results indicate that alcohol inflicts greater neurotoxic effects in women with alcohol use disorder than men, but again, these brain changes may resolve with long-term abstinence.

COMPLICATIONS SPECIFIC TO WOMEN

Although the literature on gender differences in addiction can appear at times to be inconsistent, as a whole men are more substance dependent than women for all substances except benzodiazepines and analgesics, on which women are equally or more frequently dependent [166]. However, on average, women show the effects of alcohol more immediately, more intensely, and for longer periods of time than men. They achieve higher concentrations of alcohol in the blood after drinking the same amounts of alcohol [167]. Women also produce a lower level of the enzymes required to break down alcohol. In addition, female hormones make women's bodies more susceptible to alcohol at certain times of the menstrual cycle. Women also tend to be shorter and weigh less than men. Because women generally have a higher percentage of body fat, they reserve alcohol in the body for longer periods of time. This is important because when a person drinks a large amount of alcohol, it is deposited in fatty tissues. Neurophysiology is more compromised in women with alcohol use disorder than men [168].

It may be because of these factors that women develop alcohol problems more quickly than men, and their progression to severe complications, such as liver disease, is more rapid. The death rate among women with alcohol use disorder is 50% to 100% greater than that of men because of their increased risk for suicide, alcohol-related accidents, cirrhosis, and hepatitis [169]. It is important to note, however, that women are more likely than men to obtain help, participate in treatment, and have long-term involvement in AA, and therefore are more likely to have better life outcomes [170].

International studies of gender differences indicate that the greater the societal gender equality in a country, the smaller the gender differences in drinking behavior. The gender gap in alcohol drinking is one of the few universal gender differences in human social behavior [171].

Fetal Alcohol Spectrum Disorders

The dangers of drinking while pregnant are well-documented. Pregnant women who drink risk the chance of their child developing FASD. Prenatal alcohol exposure is known to be toxic to the developing fetus and is one of the leading known preventable causes of mental retardation. Excess fetal mortality secondary to drinking is most prevalent during the first trimester of pregnancy. Even drinking as little as one beer a day has been associated with decreased birth weights and spontaneous abortions. Although FASD has received a great deal of publicity, the majority of people may not understand it correctly. For example, one large study of adults 18 to 44 years of age found that the majority of respondents incorrectly assumed that FAS referred to babies born with an addiction to alcohol.

EVIDENCE-BASED PRACTICE RECOMMENDATION

The World Health Organization recommends that healthcare providers should offer a brief intervention to all pregnant women using alcohol. (https://www.who.int/publications/i/item/9789241548731. Last accessed May 10, 2021.)

Strength of Recommendation/Level of Evidence: Strong/Low

FASDs refer to the whole range of conditions that can affect the offspring of mothers who drank alcohol during pregnancy. These conditions can affect each person in different ways and can range from mild to severe. A person with an FASD might have [172]:

- Abnormal facial features, such as a smooth ridge between the nose and upper lip (the philtrum)
- Small head size
- Shorter-than-average height
- Low body weight
- Poor coordination
- Hyperactive behavior
- Difficulty with attention
- Poor memory
- Difficulty in school (especially with math)
- Learning disabilities
- Speech and language delays
- Intellectual disability or low IQ
- Poor reasoning and judgment skills
- Sleep and sucking problems as an infant
- Vision or hearing problems
- Problems with the heart, kidneys, or bones

There are a variety of conditions that are considered FASDs. Alcohol-related neurodevelopmental disorder (ARND) is associated with intellectual difficulties and problems with behavior and learning. Patients with ARND may do poorly in school, with particular issues with math, memory, attention, judgment, and impulse control [172]. Offspring of mothers who consumed alcohol during pregnancy may also develop alcohol-related birth defects, including congenital malformations of the heart, kidneys, and/or bones or hearing problems.

The most commonly studied FASD is FAS. FAS is defined by the existence of certain physical characteristics of children whose mothers drank during pregnancy. These characteristics include [172]:

- Mental retardation
- Growth deficiencies
- Central nervous system dysfunction
- Decreased brain size
- Low birth weight
- Distorted facial features
- Behavioral maladjustments
- Abnormal joints and limbs

Other less visible symptoms of FAS include [173; 174; 175; 176; 177; 178; 179; 180; 181; 182]:

- Verbal learning and memory problems
- Visual-spatial learning problems
- Attention deficits and hyperactivity
- Increased reaction time/slow information processing
- Executive function problems
- Structural and functional changes in the brain

Alcohol apoptotic neurodegeneration has been shown to appear in the forebrain when rats are injected with alcohol. Seven-day-old rats were divided into a group receiving saline solution and another group receiving alcohol solution. The brains were examined after 24 hours of ingesting alcohol or saline. The alcohol group showed a very dense, widely distributed area of deterioration (cell death). When alcohol is administered, various neurons in the forebrain show sensitivity. Also, the brain weight of the alcohol-treated rats was much lower than the saline group. Exposure of the developing rat brain to alcohol for a certain period of time during a specific developmental stage induces destruction of brain cells that deletes large numbers of neurons from several areas of the brain. This period of time in humans is the last three months of gestation [183].

Alcohol is especially neurotoxic to the developing fetus. Vulnerability is highest at six months' gestation to several years after birth. During this period, alcohol exposure can kill millions of neurons in the developing brain. This helps to explain reduced brain size and behavior disturbances associated with FAS. The most disabling effects are hyperactivity and learning disabilities, depression, and psychosis. Depending on the time of exposure to alcohol, different neurons are depleted, which shows evidence of alcohol being an agent that can contribute to many mental disabilities.

The Centers for Disease Control and Prevention (CDC) reported in 2020 that 11.3% of pregnant women 18 to 44 years of age used alcohol and 4.0% were binge drinkers [184]. According to the CDC, drinking while pregnant costs the United States $5.5 billion annually. Additionally, an estimated 6 to 9 out of 1,000 U.S. school children may have FASDs [172]. Binge drinking among pregnant women during the first trimester increased from 10.8% in 2015–2016 to 12.6% in 2019 [14]. FASD is 100% preventable when pregnant women abstain from drinking alcohol [172; 185].

EFFECTS ON FAMILIES

Living with a non-recovering family member with alcohol use disorder can contribute to stress for all members of the family. Children raised in these families have different life experiences than children raised in nonalcoholic families. For example, children living with a non-recovering alcoholic score lower on measures of family cohesion, intellectual cultural orientation, active recreational orientation, and independence. They also experience higher levels of conflict within the family. Many children of alcoholics experience other family members as distant and noncommunicative and may be hampered by their inability to grow in developmentally healthy ways. The level of dysfunction or resiliency of the nonalcoholic spouse is a key factor in the effects of problems impacting the children. Support groups, such as Children of Alcoholics, are available to help people deal with these issues.

Alcohol use disorder usually has strong negative effects on marital relationships. Separated and divorced men and women were three times as likely as married men and women to say they had been married to a person with alcohol use disorder or problem drinker. Almost two-thirds of separated and divorced women and almost one-half of separated or divorced men younger than 45 years of age have been exposed to alcohol use disorder in the family at some time. As of 2019, approximately 14.5 million Americans met the diagnostic criteria for alcohol abuse and dependence; this number represents a decline from 18.1 million Americans in 2002 [14].

Child Abuse

The majority of studies suggest an increased prevalence of alcohol use disorder among parents who abuse children. Existing research suggests that alcoholism is more strongly related to child abuse than are other disorders, such as parental depression, but the most important factor is whether the abusive parent was abused themselves or witnessed a parent or sibling being abused. Although several studies report very high rates of alcoholism among the parents of incest victims, much additional research in this area is needed [186; 187].

VIOLENCE

Among some individuals and subgroups, excess alcohol consumption is associated with the risk of violent behavior. Alcohol may encourage aggression or violence by disrupting normal brain function, especially in levels of serotonin [188]. There is considerable overlap among nerve cell pathways in the brain that regulate aspects of aggression, sexual behavior, and alcohol consumption. Alcohol may weaken brain mechanisms that normally restrain impulsive behaviors, including inappropriate aggression.

Drinking and violence may occur together by chance. Also, violent criminals who drink heavily are more likely to be caught and consequently are over-represented in samples of people arrested for violent behavior. Antisocial personality disorder (ASPD) and early-onset alcoholism are common traits in many criminals. A person who intends to engage in a violent act may drink to bolster his or her courage or in hopes of evading punishment or censure. The motive of drinking to avoid censure is encouraged by the popular view of intoxication as a "time-out," during which a person is not subject to the same rules of conduct as when sober. Such alcohol-violence interactions are not readily treated. However, ongoing research has identified medications that have the potential to reduce violent behavior in both alcoholic and nonalcoholic subjects.

Young men who exhibit violent and antisocial behaviors often "burn out" with age [189]. By the time they reach 40 years of age, serotonin concentrations are increasing and testosterone concentrations are decreasing, both of which help to restrain violent behavior [190].

Research suggests that increasing the unit price of alcohol by raising alcohol taxes is an effective strategy for reducing excessive alcohol consumption and related harms, including violent behavior [191]. An examination of the impact of the price of alcoholic beverages on violence and other delinquent behavior among college students found that an increase in the price of beer could reduce the overall number of students involved in some sort of violent behavior by 4% [192]. In a study that used data from the National Household Survey on Drug Abuse, higher taxes on beer led to significant reductions in crime (e.g., property damage, use of force), with the largest impact among individuals younger than 21 years of age [193]. Another study that examined the impact of tax increases and advertising bans on reducing the prevalence of underage drinking and subsequent alcohol-related harms found both interventions to be effective [194]. A literature review of studies of underage populations found that increased taxes were significantly associated with reduced consumption and alcohol-related harms [195]. Public policies that affect the price of alcohol appear to have significant effects on alcohol-related disease and injury rates. The results of one systematic review suggest that doubling the tax on alcoholic beverages could reduce alcohol-related violence by 2% and crime by 1.4% [196].

According to the National Council on Alcoholism and Drug Dependence, on college campuses each year an estimated 696,000 students 18 to 24 years of age are assaulted by another student who has been drinking, and 97,000 students report experiencing alcohol-related sexual assault or date rape [197]. Four out of every five juvenile and teen arrestees are under the influence of alcohol or drugs while committing their crimes, test positive for drugs, are arrested for committing an alcohol- or drug-related offense, admit having substance abuse problems, or share some combination of these characteristics [198].

TRAFFIC ACCIDENTS

In 2019, 10,142 people died in alcohol-related traffic fatalities, accounting for 28% of all traffic-related deaths in the United States [199]. Of the 1,233 traffic fatalities that year among children 0 to 14 years of age, 214 (17%) involved an alcohol-impaired driver [200]. Of the 111 million self-reported episodes of alcohol-impaired driving among U.S. adults, nearly 1.1 million drivers were arrested for driving under the influence [200]. The CDC estimates that 29 people in the United States die in alcohol-related crashes every day [200]. In a study of persons who have been convicted of driving while impaired, 85% of women and 91% of men reported a lifetime alcohol use disorder [201]. Psychiatric comorbidity may be a key element distinguishing driving under the influence (DUI) offenders from others and in distinguishing repeat offenders from first-time offenders [202].

A study found that although marijuana's effects on driving performance were small or moderate when taken alone, the effects were severe when combined with even a low dose of alcohol. These findings are very serious considering the frequency with which these two substances are combined, especially in young inexperienced drivers [203; 204; 205; 206; 207].

OTHER PSYCHIATRIC DISORDERS ASSOCIATED WITH ALCOHOL USE DISORDERS

Persons with alcohol use disorder, like other addicts, generally have comorbid disorders, meaning they have alcohol problems as well as other illnesses or conditions [208]. These problems may include personality disorders (formerly Axis II disorders), other drug use (especially tobacco use disorders), or a number of psychiatric disorders, from major depression and bipolar illness to eating disorders and anxiety disorders. One study reported that 50% of women and 33% of males with a history of alcohol use disorders have at least one other psychiatric disorder [201]. Treatment of the comorbid disorder is absolutely essential in preventing relapses to drinking and in preventing other adverse consequences, such as suicide among patients with depression and alcohol use disorder.

DEPRESSIVE DISORDERS

Alcohol is both a stimulant and a depressant, depending on the levels and time after drinking. Patients with alcohol use disorder are often misdiagnosed with depression because of the many symptoms that mimic depression. Insomnia, reduced appetite, and decreased energy are just a few of the symptoms that can occur in both diseases. Alcohol can cause temporary depressive symptoms, even in persons who have no history of depression. In fact, as many as 80% of men and women with alcohol use disorder complain of depressive symptoms, and at least one-third meet the criteria for a major depressive disorder (excluding, of course, criterion D) [209]. Depression is often a comorbid disorder but can also be solely or partially due to alcohol. This carries important implications in the way depressive symptoms are evaluated and treated in patients with alcohol use disorders. Alcohol intoxication, especially binge drinking, can also cause mood swings that mimic the "highs" of people with manic depression/bipolar disorder. Thirty to fifty percent of persons with alcohol use disorder suffer from major depression at the same time [209; 210].

How alcohol use disorder is related to depression is not clear. Some studies have suggested that both conditions may share common risk factors. For example, both problems may run in families. Co-occurrence is very common, but likely has independent though inter-related etiology.

Treatment professionals have found that after two to three weeks of abstinence from alcohol and with good nutrition, the temporary depressive effects of alcohol dissipate. However, there are subgroups of individuals with alcohol use disorder who have a co-occurring depression or manic depression, and it is critically important to diagnose and treat these illnesses during alcohol treatment. If true co-occurring depression is left untreated, many patients will drop out of treatment and relapse to drinking. Alcohol use disorders and depression are important risk factors for suicidal thinking or actions. Because alcohol can increase impulsivity and make depression worse, even intolerable, alcohol is often a factor in suicides.

Suicide

Suicide is the 10th leading cause of death overall and the 2nd leading cause among persons 15 to 34 years of age [211; 212]. Most people who attempt suicide and 90% of suicide victims have a diagnosable psychiatric disorder [212]. Alcohol is the number one drug of abuse associated with suicide. In 2019, 47,511 people in the United States committed suicide and an estimated 1.2 million attempted suicide [211]. Among people who attempt suicide, alcohol use disorder is a common diagnosis. Major depression and alcohol use disorder, respectively, are the most commonly diagnosed psychiatric disorders in patients who commit suicide. Next to age, alcohol and drug addictions are the second most important risk factors in suicide. As many as 85% of individuals who commit suicide suffer from depression or alcohol use disorder, and 70% of patients with comorbid alcohol use disorder and depression report that they have made a suicide attempt at some point in their lives [213]. The reported likelihood of suicide in diagnosed alcoholism is between 60 and 120 times that of persons without mental illness [214].

Alcohol intoxication can exaggerate depression and increase the likelihood of an impulsive act like suicide or other forms of violence. Alcohol use is frequently detected in suicide methods involving firearms, driving a vehicle, or overdosing. Alcohol impairs judgment and lowers the threshold to commit suicide, explaining its association with suicide methods

that involve a high level of pain [215]. In a case-control study, researchers examined the relationship between near fatal suicide attempts and aspects of alcohol consumption, such as amount and frequency of drinking, alcoholism, binge drinking, and drinking within three hours of a suicide attempt, and found a J-shaped relationship between alcohol exposure and near lethal attempts for all measures [216].

In a comprehensive review of the subject, it is estimated that the lifetime suicide risk among individuals with alcohol use disorder is 10% to 15%, a figure 5 to 10 times greater than seen in the general population [215; 217]. Between 15% and 20% of persons with alcohol use disorder will attempt suicide, and of those who have attempted in the past, 15% to 20% will attempt suicide again in the next five years [217]. Approximately 40% of all patients seeking treatment for alcohol use disorder report at least one suicide attempt at some point in their lives [215].

One study conducted in Japan showed that, among drinkers, the risk of suicide increased with the amount of alcohol consumed. An unusual finding of this study was a U-shaped relationship between alcohol and suicide. Abstainers also have a significantly increased risk, similar to heavy drinkers. Among middle-aged males, moderate drinkers had the lowest risk for suicide [218].

In order to be most effective at the prevention of suicide, healthcare providers should be adept at eliciting both a substance use history and a psychiatric history. Risk factors associated with completed suicide with alcohol use disorder include comorbid major depression, active drinking, serious medical illness, living alone, and interpersonal loss and conflict.

Treatment of Patients with Comorbid Depression and Alcohol Use Disorder

Male, alcoholic, and depressed are the most common descriptors for suicide attempters. Always evaluate persons with alcohol use disorder for depression, suicide, and appropriate referral to a psychiatrist or psychologist. Depression and alcohol use disorder are common problems in the United States. Both are at the top of the list of problems that commonly require psychiatric treatment. Unfortunately, both problems are difficult to diagnose by physicians due to patient fears and stigma and the realities of a busy medical office. Treating one problem but not the other is also very common. In order to successfully treat alcohol use disorder and depression it is important that healthcare providers diagnose and treat both problems.

Treatment of alcohol use disorder begins with evaluation, stabilization, and detoxification and the appropriate level of treatment, which may include a 12-step program. Adding an antidepressant and treating the depression requires a number of subtle changes in thinking. First, the physician must be convinced that the depression is not transient and related to alcohol or detoxification or so severe that the patient is unable to do treatment work. Next, the patient must be willing to accept and adhere to simultaneous, coordinated treatment.

The next issue is determining which antidepressant to use. Lithium and tricyclics used to treat depression alone may not be effective or could have serious adverse effects when used in patients with comorbid depression and alcohol use disorder. Another class of antidepressants, selective serotonin reuptake inhibitors (SSRIs), has been studied to treat depression after failing to treat alcohol use disorder. SSRIs generally cause less serious adverse effects than tricyclics, but some, like fluoxetine, work slowly and cause sexual performance side effects. SSRIs, such as fluoxetine, sertraline, and paroxetine, and herbal remedies such as St. John's wort have been tried in a variety of studies and are generally able to help alleviate depression, but do not appear to help with drinking outcomes. Venlafaxine and bupropion appear to be especially effective in treating patients with depression and alcohol use disorder. Venlafaxine is well suited to treat alcohol use disorder with depression and even depression with anxiety [219]. Venlafaxine is effective in mild and severe depression with anhedonia. Bupropion is effective as well, but it has seizure risks in this population [220]. Men with depression who are using alcohol appear very sensitive to the sexual side effects of the SSRIs and may discontinue their use and drop out of treatment. Patients with major depression and alcohol use disorder are generally treated with venlafaxine and, when necessary, are augmented with bupropion or mirtazapine. Transcranial magnetic stimulation is now available for refractory depression, and studies are in progress for its use in treating substance use disorder [221].

BIPOLAR DISORDER

A 2000 study analyzed the substance/alcohol abuse patterns of 89 patients with a confirmed diagnosis of bipolar disorder (71 with bipolar I and 18 with bipolar II) [222]. The diagnosis was confirmed by a structured clinical interview for DSM-IV Axis I, an attending psychiatrist, a medical records review, and family members. The age of the patients ranged from 18 to 65 years. Among those with bipolar disorder I, 41 patients (57.8%) abused or were dependent on one or more substances (including alcohol), 28.2% abused or were dependent on two substances, and 11.3% abused or were dependent on three or more substances. Among those with bipolar disorder II, 39% of patients abused or were dependent on one or more substances, 17% were dependent on two or more substances, and 11% were dependent on three or more substances. The risk for substance or alcohol abuse was higher among patients with bipolar I disorder than with bipolar disorder II. Patients with both bipolar disorders I and II abused alcohol more often than any other substances [222].

ANXIETY

Alcohol withdrawal causes many of the signs and symptoms of anxiety and can even mimic panic attacks. Alcohol works much like a benzodiazepine; many people who abuse and are dependent on alcohol have learned to drink to temporarily relieve anxious feelings.

Special problems exist for people who drink to self-medicate the symptoms of a true generalized anxiety disorder, social phobia, or panic disorder. Alcohol may provide temporary relief, but it is not a good treatment for shyness or an anxiety disorder. The price a person may pay for self-medication are two diseases: anxiety and alcohol use disorder. Social anxiety can be a major impediment to active participation and even attendance to group therapy and 12-step meetings.

PAIN

Pain is a subjective experience, and the perception of being in pain is an important factor of the alcohol use disorder. It is hypothesized, as well as established in some research, that individuals in pain will drink as a means to decrease their perception of pain or as a reaction to painful stimuli [223]. According to the National Institute on Alcohol Abuse and Alcoholism, an estimated one in four adults in chronic pain reports self-medicating with alcohol and 43% to 73% of people with alcohol use disorder report experiencing chronic pain [224].

ABUSE/DEPENDENCE ON OTHER DRUGS

All drugs of abuse, including alcohol, cause dopamine release in the mesolimbic system in the brain. This dopamine system, sometimes referred to as the neuroanatomy of pleasure or reinforcement, starts in the ventral tegmental area and projects to the nucleus accumbens. Alcohol- or drug-taking results in a dopamine reward that stimulates its taking. Pavlovian conditioning to environmental cues (e.g., sights, smells, and sounds of a bar) that precede use become associated with use of the drug. Notably, this sense of "reward," which confers evolutionary fitness, is more likely to be perceived as crucial than even that produced by natural, survival-oriented stimuli (e.g., food, sex). This conditioning is reflective of synaptic strengthening mediated by the glutamatergic system, with neuroplasticity changes in brain areas thought to mediate drug-taking behavior, including the amygdala (stress and anxiety), hippocampus (memory), and dorsal striatum (routine motor movements). Natural stimuli (e.g., food, sex, other previously pleasurable activities) become less enjoyable, resulting in a profound state of anhedonia. With time, alcohol use disorders become ingrained. Ultimately, this preference for alcohol compared to natural rewards is mediated through a process of "bad learning," or neuroplasticity changes in the extended amygdala, also referred to as the antireward system. The anti-reward system involves stress-response hormones, including corticotrophin-releasing hormone and dynorphin. Long- or short-term abstinence activates the antireward system, and with more abstinence, it becomes even more difficult to ignore with the attendant anxiety, dysphoria, craving, and anhedonia. Over time, with repeated administration, nucleus accumbens dopamine receptors desensitize, leading to a functional decrease in available dopamine, anhedonia, and decreased sense of pleasure. Real-world examples include an individual with alcohol dependence developing a sudden craving for a drink when watching a beer commercial, walking by a bar, or seeing a place where s/he drinks. This stage reveals one of the remarkable properties of addiction; the act of drug-taking transitions from being impulsive (i.e., pleasure-seeking without afterthought) to compulsive (i.e., undertaken to relieve stress, tension, or physical signs such as pain).

Alcohol use disorders are often associated with dependence on or abuse of other substances, such as marijuana, cocaine, opioids, amphetamines, anxiolytics, designer or "club drugs," and tobacco. Alcohol may be used to alleviate the unwanted effects of these other substances or to augment their effects or substitute for them when they are not available.

Cocaine

According to the most recent National Survey on Drug Use and Health, about 5.5 million Americans 12 years of age and older were past year cocaine users in 2019 [14]. Many cocaine addicts also use alcohol to enhance euphoria, to reduce the mania associated with intoxication, or to calm or reduce the impact of dysphoria caused by cocaine withdrawal. Use of cocaine impairs both mental and physical functions, including learning and memory, hearing and seeing, motor coordination, speed of information processing, and problem-solving ability. Alcohol use has its own set of impairments, but many overlap with cocaine use. The negative impact exerted by alcohol and cocaine on either mental or physical activities has been found to be greater than when either is used alone. This is due to the production of a compound called cocaethylene. Cocaethylene is a novel compound that is produced in the bodies of individuals using cocaine and alcohol. Cocaethylene has been linked to cardiotoxicity, neurotoxicity, overdose deaths, and acute functional impairment [225; 226]. The combination of cocaine and alcohol may be associated with other neurologic changes, including poor memory and poorer judgment. Alcohol use can also be a trigger for cocaine relapse.

Nicotine Addiction

As many as 50% of persons with alcohol use disorder smoke, compared with about 18% of the general population [14; 227]. In a cohort study of 845 persons who had been treated for alcohol use disorder, more than 25% of the sample had died within 12 years [228]. Approximately one-half of the deaths were related to tobacco use and one-third were related to alcohol. Smoking and excessive alcohol use are risk factors for cardiovascular and lung diseases and some forms of cancer. Compared to nonsmoking nondrinkers, the risk for developing mouth and throat cancer is seven times greater

for those who use tobacco, six times greater for those who use alcohol, and 300 times greater for those who use both tobacco and alcohol [229].

Both nicotine and alcohol consumption cause the release of dopamine in the nucleus accumbens. Neurobiology may make the combination of the two substances more rewarding than if either substance was taken alone. Certain enzymes in the liver (i.e., microsomal enzymes) convert some of the ingredients found in tar from cigarette smoke into chemicals that can cause cancer [230]. Long-term excessive alcohol consumption may activate these enzymes as well as decrease the body's ability to respond to infections or abnormal states. Smoking and excessive alcohol use are significant risk factors for cancer of the mouth, throat, and esophagus [229].

A 2000 study has revealed that people who smoke, drink alcohol (one or more drinks per day) and develop non-small cell lung cancer had more mutations in the *p53* gene when compared to those who smoked only or did not smoke or drink [231]. Mutations in the *p53* gene have been seen in smoking-associated tumors and were present more often in alcohol drinkers who smoked cigarettes than in nondrinkers who smoked cigarettes or in nondrinkers who did not smoke. Seventy-six percent of patients who consumed one or more alcoholic drinks per day and smoked were found to have mutations in the *p53* gene. In contrast, 42% of smokers who did not drink (consuming less than one drink per day) had gene mutations [231].

A 2006 study sought to determine how nicotine delivered by tobacco smoke influences alcohol intake. Findings suggest that smoking increases alcohol consumption in at least a subset of smokers [232]. Animal studies have found that chronic nicotine use leads to escalation of alcohol self-administration through a dysregulation in opioid signaling [233; 234].

One of the major barriers to treating tobacco dependence in patients with a co-occurring alcohol use disorder is the notion that it is too difficult to quit both alcohol and tobacco and that attempts to quit tobacco might adversely affect the patient's recovery from alcoholism [235; 236]. Treatment facilities often concentrate on the "primary" addiction to alcohol and treat tobacco use as a more benign addiction. Fewer than 1 in 10 treatment facilities ban tobacco use on their grounds and many treatment facilities do not screen for or treat tobacco dependence [237]. Moreover, many treatment facilities enable patient smoking by adjourning meetings for "smoke breaks" and allowing staff to smoke openly with patients [238]. In fact, studies show that quitting smoking does not cause abstinent alcoholics to relapse and may actually decrease the likelihood of relapse [239]. Further, quitting smoking has been found to facilitate drinking cessation among tobacco and alcohol co-users [240].

EATING DISORDERS

Alcohol use disorder and eating disorders are commonly comorbid conditions, with patterns of comorbidity differing by eating disorder subtype [241]. A community-based sample of women found that those with lifetime alcohol use disorder or nicotine dependence were at higher risk for eating disorders [242]. The process of alcohol detoxification and treatment is often accompanied by overeating with weight gain, and in some cases food becomes a replacement for alcohol [134; 243].

PATHOLOGIC GAMBLING

As lotteries proliferate and states legalize casino gambling, pathologic or compulsive gambling is being recognized as a major public health problem. Alcohol use disorder is often a comorbid condition among compulsive gamblers. As with depression, each disorder can make the other more serious. Individuals with alcohol use disorder may bet more money and may be reluctant to quit chasing their losses. In one study, subjects received either three alcoholic drinks or an equal volume of a nonalcoholic beverage (placebo) [244]. The alcohol group persisted for twice as many gaming trials as the placebo group. One-half of the alcohol group lost their entire cash stake, compared with 15% of the placebo group [244].

Another study examined how alcohol affects judgment and decision-making during gambling, with a focus on sequential decision-making, including the gambler's fallacy (i.e., thinking that a certain event is more or less likely, given a previous series of events) [245]. Thirty-eight male participants completed a roulette-based gambling task 20 minutes after receiving either an alcoholic or placebo beverage. The task measured color choice decisions (red/black) and bet size, in response to varying lengths of color runs and winning/losing streaks. Color choice affected run length in line with the gambler's fallacy, which further varied by previous wins or losses. Bet size increased particularly for losing streaks. The alcohol group placed higher bets following losses than did the placebo group [245].

SEXUAL DYSFUNCTION

Alcohol metabolism alters the balance of reproductive hormones in men and women. In men, alcohol can impair the synthesis of testosterone and reduce sperm production. In women, chronic excessive alcohol use may cause a decreased interest in sex.

DETECTING ALCOHOL USE DISORDERS

Problem drinking described as severe is given the medical diagnosis of alcohol use disorder. An estimated 14.4 million adults 18 years of age and older in the United States have an AUD, including 9.2 million men and 5.3 million women. In addition, an estimated 401,000 adolescents 12 to 17 years of age had an alcohol use disorder [355].

AUD is a chronic relapsing addiction previously called alcoholism and characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences. To be diagnosed with alcohol use disorder, individuals must meet the specific DSM criteria. Using the DSM-5, anyone meeting any 2 of the 11 criteria during the same 12-month period receives a diagnosis of alcohol use disorder. The severity of the disorder—mild, moderate, or severe—is assigned based on the number of criteria met.

RECOMMENDED STANDARDIZED QUESTIONS OR TESTS

A variety of screening instruments are available to detect unhealthy alcohol use in adults. After conducting a systematic evidence review of trials published between 1985 and 2011 on screening and behavioral counseling interventions for unhealthy alcohol use in adults, the U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen all patients 18 years of age or older for alcohol abuse using one of the following tools [246; 247]:

- The abbreviated three-question AUDIT-Consumption (AUDIT-C)
- The NIAAA-recommended Single Alcohol Screening Question (SASQ)

The USPSTF concludes that there is insufficient evidence to determine the benefits and harms of screening for unhealthy alcohol use in adolescents 12 to 17 years of age [246].

For patients in general medical and mental healthcare settings, Veterans Affairs recommends screening for unhealthy alcohol use annually using the three-item Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) or Single-Item Alcohol Screening Questionnaire (SASQ).

(https://www.healthquality.va.gov/guidelines/mh/sud. Last accessed May 10, 2021.)

Strength of Recommendation: Strong for

The three questions on the Alcohol Use Disorders Identification Test-Concise (AUDIT-C) inquire about frequency of alcohol use, typical amount of alcohol use, and occasions of heavy use. The test takes one to two minutes to administer. Preliminary evidence suggests that the USAUDIT-C (based on U.S. standards) may be more valuable in identifying at-risk college drinkers [248]. In contrast, the SASQ inquires about past-year alcohol use and takes less than one minute to administer [246].

The CAGE questionnaire is the best known and most often studied screening tool used to detect alcohol problems. In an office setting, the four CAGE questions are often used to detect alcohol problems [249]. The first question, "Have you ever felt the need to cut down on your drinking?" is an easy question to ask. It is not threatening and at the same time suggests to the patient that you understand their pathologic attachment to alcohol [249]. A positive answer to the first and second questions strongly suggests further evaluation and brief intervention [246]. However, by itself, the CAGE questionnaire is not an adequate screening for alcohol use problems; it should trigger more intensive screening if positive [250].

CAGE Questionnaire

Ask current drinkers the CAGE questions:

1. Have you ever felt that you should **cut down** on your drinking?
2. Have people **annoyed** you by criticizing your drinking?
3. Have you ever felt bad or **guilty** about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover **(eye opener)**?

If there is a positive response to any of these questions:

- Ask if this occurred during the past year.

A patient may be at risk for alcohol-related problems if:

- Alcohol consumption is:

  Men:

  >14 drinks per week or

  >4 drinks per occasion

  Women:

  >7 drinks per week or

  >3 drinks per occasion

Or

- One or more positive responses to the CAGE that have occurred in the past year

When is screening for alcohol problems appropriate?

- As part of a routine health examination
- Before prescribing a medication that interacts with alcohol
- In response to presenting problems that may be alcohol related

One "yes" response to the CAGE questionnaire suggests an alcohol use problem. More than one "yes" is a strong indication that a problem exists [250; 251].

AUDIT Questionnaire

If a patient is CAGE positive, or if clinical suspicion remains high, the AUDIT questionnaire may be administered and can be extremely useful in detecting alcohol problems [252]. The AUDIT was developed by the WHO to identify persons whose alcohol consumption has become problematic to their health [253]. Research has shown that the AUDIT may be especially useful when screening women and minorities and has shown promise when tested in adolescents and young adults [254]. The AUDIT consists of 10 screening questions with three questions about the frequency and amount of drinking, three about dependence, and four questions about problems caused by alcohol [246; 249; 255].

1. How often do you have a drink containing alcohol?
   0 Never
   1 Monthly or less
   2 2 to 4 times a month
   3 2 to 3 times a week
   4 4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   0 1 or 2
   1 3 or 4
   2 5 or 6
   3 7 or 8
   4 10 or more
3. How often do you have 6 or more drinks on one occasion?
   0 Never
   1 Less than monthly
   2 Monthly
   3 Weekly
   4 Daily or almost daily
4. How often during the past year have you found that you were not able to stop drinking once you had started?
   0 Never
   1 Less than monthly
   2 Monthly
   3 Weekly
   4 Daily or almost daily
5. How often during the past year have you failed to do what was normally expected from you because of drinking?
   0 Never
   1 Less than monthly
   2 Monthly
   3 Weekly
   4 Daily or almost daily
6. How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   0 Never
   1 Less than monthly
   2 Monthly
   3 Weekly
   4 Daily or almost daily
7. How often during the past year have you had a feeling of guilt or remorse after drinking?
   0 Never
   1 Less than monthly
   2 Monthly
   3 Weekly
   4 Daily or almost daily
8. How often during the past year have you been unable to remember what happened the night before because you had been drinking?
   0 Never
   1 Less than monthly
   2 Monthly
   3 Weekly
   4 Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?
   0 No
   2 Yes, but not in the past year
   4 Yes, during the past year

10. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?

    0 No

    2 Yes, but not in the past year

    4 Yes, during the past year

The minimum score is 0 and the maximum possible score is 40. A score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption [195].

AUDIT-C Questionnaire

The AUDIT-C is a 3-question screening tool that can help identify persons who are at-risk drinkers (who may not be alcohol dependent) or who have active alcohol use disorders, including alcohol abuse or dependence [256].

1. How often do you have a drink containing alcohol?

   0 Never

   1 Monthly or less

   2 2 to 4 times a month

   3 2 to 3 times a week

   4 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

   0 1 or 2

   1 3 or 4

   2 5 or 6

   3 7 or 8

   4 10 or more

3. How often do you have six or more drinks on one occasion?

   0 Never

   1 Less than monthly

   2 Monthly

   3 Weekly

A score of 4 or more in men and 3 or more in women (when not all points are from question 1) is considered positive for hazardous drinking or alcohol use disorder [256].

Single Alcohol Screening Question (SASQ)

The SASQ consists of one question: "How many times in the past year have you had X or more drinks in a day?" [246]. The question is individualized based on sex, with X being five for men and four for women. A response of more than one is considered positive and requires additional assessment.

ADDITIONAL STANDARDIZED QUESTIONS OR TESTS

Michigan Alcohol Screening Test (MAST)

The Michigan Alcohol Screening Test (MAST) continues to be a good screening test for alcohol abuse and dependence, but for optimal results it should be used with a questionnaire that asks about the amount and frequency of alcohol consumption. The following questions are from the 13-item Short MAST (SMAST) regarding the respondent's involvement with alcohol during the past 12 months [249]:

1. Do you think you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)

   No = 1 Yes = 0

2. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?

   No = 0 Yes = 1

3. Do you feel guilty about your drinking?

   No = 0 Yes = 1

4. Do friends or relatives think you are a normal drinker?

   No = 1 Yes = 0

5. Are you able to stop drinking when you want to?

   No = 1 Yes = 0

6. Have you ever attended a meeting of Alcoholics Anonymous?

   No = 0 Yes = 1

7. Has drinking ever created problems between you and your wife, husband, a parent, or other near relative?

   No = 0 Yes = 1

8. Have you ever gotten into trouble at work because of your drinking?

   No = 0 Yes = 1

9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?

   No = 0 Yes = 1

10. Have you ever gone to anyone for help about your drinking?

    No = 0 Yes = 1

11. Have you ever been in a hospital because of drinking?

    No = 0 Yes = 1

12. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?

    No = 0 Yes = 1

13. Have you ever been arrested, even for a few hours, because of drunken behavior?

    No = 0 Yes = 1

Key: There are two definitions for this test.

1. Seltzer Definition:
   a. 0-1 points = Nonalcoholic
   b. 2 points = Possibly alcoholic
   c. 3 or "yes" to 6, 10, or 11 = Alcoholic
2. Ross Definition:
   5 points = Alcohol abuse

Comorbidity-Alcohol Risk Evaluation Tool (CARET)

There are certain risks and comorbidities (e.g., psychiatric and medical conditions requiring pharmacologic treatment) that may modify the criteria of at-risk drinking, especially within the geriatric population [257]. It is important for healthcare providers to assess each patient's threshold for alcohol use, taking into account their level of risk and comorbidities. The Comorbidity-Alcohol Risk Evaluation Tool (CARET) may be helpful in this task, with comorbidity-specific measures to place patients in "at-risk" or "not-at-risk" groups [258].

SCREENING FOR ALCOHOL ABUSE IN NON-ENGLISH-PROFICIENT PATIENTS

Communication with patients regarding history and current alcohol use patterns is a necessary step in determining if alcohol use has become a problem. When there is an obvious disconnect in the communication process between the practitioner and patient due to the patient's lack of proficiency in the English language, an interpreter is required. Frequently, this may be easier said than done, as there may be institutional and/or patient barriers.

If an interpreter is required, the practitioner should acknowledge that an interpreter is more than a body serving as a vehicle to transmit information verbatim from one party to another. Instead, the interpreter should be regarded as part of a collaborative team, bringing to the table a specific set of skills and expertise [259]. Several important guidelines should be adhered to in order to foster a beneficial working relationship and a positive atmosphere.

When interpreters are enlisted and treated as part of the interdisciplinary clinical team, they serve as cultural brokers, who ultimately enhance the clinical encounter. When providing care for patients for whom English is a second language, the consideration of the use of an interpreter and/or patient education materials in their native language may improve patient understanding and outcomes.

In addition, several organizations provide information and toolkits in languages other than English. The National Hispanic Medical Association offers an alcohol screening kit in Spanish, including patient education sheets [260]. The National Institute on Alcohol Abuse and Alcoholism also provides patient education brochures and pamphlets in English and Spanish [261].

LABORATORY TESTS

The FDA has approved a test to detect alcohol use disorder and alcohol-related diseases. The test detects the level of carbohydrate-deficient transferrin (CDT) in the body, which is elevated in persons with alcohol use disorder and remains elevated even several weeks after drinking is stopped [262]. The advantages of the CDT test are reliability and the availability of automated test results within four hours [263; 264]. The CDT is often used in combination with other screening tests, such as the gamma-glutamyl transferase (GGT) test. While both CDT and GGT are independently associated with alcohol abuse, combining tests may dramatically increase sensitivity [250; 265]. CDT is less sensitive/specific in women than in men [250].

Tests for Recent Alcohol Use (Hours)

The relationship between alcohol and the liver serves as the basis for many of the tests that identify possible alcohol abusers. Alcohol markers for recent alcohol ingestion include urine/breath/blood, AlcoPatch, methanol, urinary ethyl glucuronide (EtG) and ethyl sulfate(ES), whole blood phosphatidylethanol, and the ratio of 5-hydroxytryptophol (5-HTOL) to 5-hydroxyindole-3-acetic acid (5-HIAA) [250; 266].

Tests for Less Recent Alcohol Use (Weeks)

The CDT test is often used to assess prolonged ingestion of high amounts of alcohol (more than 50–80 g/day for two to three weeks) [250]. Another test examines hemoglobin or whole blood acetaldehyde adducts. In a study of almost 3,000 women and 4,000 men, the combination of CDT and GGT compared with either alone shows a higher diagnostic sensitivity and specificity and is correlated more strongly with alcohol consumption than either test alone (***Table 1***) [267; 268; 269].

Tests for Chronic Alcohol Use (Years)

Tests in this category look at the classic toxic markers that use of alcohol leaves on the body. They include [250]:

- Liver function tests
- GGT
- Aspartate aminotransferase (AST)
- Alanine aminotransferase (ALT)
- Red blood cell index
- Mean corpuscular volume (MCV)

LABORATORY MARKERS FOR ALCHOHOL USE		
Markers	**Sensitivity**	**Specificity**
Men		
CDT	73%	96%
GGT	65%	89%
CDT with GGT	90%	84%
Women		
CDT	52%	94%
GGT	54%	97%
CDT with GGT	76%	91%

Source: [267] *Table 1*

BRIEF INTERVENTION

Despite the fact that alcohol abuse complications have caused grave illness and many deaths, physicians are not always good at detecting alcohol and other drug abuse in their patients. Even when physicians and other health professionals identify an individual with alcohol use disorder, they are sometimes unsure of how to proceed. At times, the physician will offer help but the patient refuses. Nevertheless, the addiction specialist or the primary care physician with a continuous, comprehensive, patient-centered approach to the medical, psychosocial, and family issues is the ideal person to offer intervention, treatment, and recovery support.

Almost 20% of patients treated in a primary care setting drink at levels that may place them at risk for developing alcohol-related problems [250; 270]. Brief intervention, as part of primary healthcare, can help reduce this risk. Brief intervention is generally conducted over one to a few visits with each session lasting from just a few minutes up to one hour. The type of brief intervention varies depending on how severe the problem. Brief intervention is often used with patients who have not yet developed alcohol use disorder and the goal may be to reduce drinking rather than abstinence. For persons with alcohol use disorder, the goal of brief intervention is abstinence, and for these individuals, referral to a more comprehensive treatment may be necessary. The USPSTF recommends that clinicians provide patients who are engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse [246].

EVIDENCE-BASED PRACTICE RECOMMENDATION

For patients without documented alcohol use disorder who screen positive for unhealthy alcohol use, Veterans Affairs recommends providing a single initial brief intervention regarding alcohol-related risks and advice to abstain or drink within nationally established age and gender-specific limits for daily and weekly consumption.

(https://www.healthquality.va.gov/guidelines/mh/sud. Last accessed May 10, 2021.)

Strength of Recommendation: Strong for

COMMON ELEMENTS OF BRIEF INTERVENTION

Miller and Sanchez proposed six elements, summarized by the acronym FRAMES, to describe the key elements of brief intervention: feedback, responsibility, advice, menu of strategies, empathy, and self-efficacy [271]. How these elements enhance effectiveness has been supported in other reviews [272; 273]. Goal setting, follow-up, and timing are also important in brief intervention [274; 275].

- **F**eedback of Personal Risk: Health professionals use current drinking behaviors, lab test results, and actual or potential consequences of drinking to provide patients with feedback on the risk of developing a problem.
- **R**esponsibility of the Patient: Brief intervention often includes encouraging the patient to recognize that it is his or her responsibility and choice to change the behavior. This gives patients a sense of personal control in the process of change.
- **A**dvice to Change: Brief intervention may also include recommendations about moderate- or low-risk drinking and advice on cutting down or eliminating alcohol consumption.

- **M**enu of Ways to Reduce Drinking: Patients are advised about how to cut back or avoid alcohol consumption. Health professionals can help patients set limits, recognize reasons for drinking, and acquire skills to avoid high-risk drinking. Often, self-help materials such as drinking diaries are given to patients to help monitor their progress.
- **E**mpathetic Counseling Style: Confrontational methods of brief intervention are not as effective as when health professionals use a more empathetic counseling approach.
- **S**elf-Efficacy or Optimism of the Patient: Patients should be encouraged during brief intervention to help themselves by creating a plan to change their behavior and to think positively about their ability to reduce or stop drinking. Health professionals often use motivation-enhancing techniques.

In addition to FRAMES, the following items are important:

- Establishing a drinking goal: Patients should be encouraged to set a drinking goal with help from their physician. In some cases it is helpful to put the goal in writing. The drinking goal may be abstinence.
- Follow-up: It is important that the healthcare provider follows the patient's progress by telephone calls, or repeat tests or visits.

Patients are more likely to change their behavior when they recognize they have a problem and when they are optimistic about prospects for change; therefore, evaluating readiness to change is an important part of brief intervention. Some patients are not ready to change at the start of brief intervention, but may be ready when they experience adverse consequences of alcohol use. One study found that 77% of patients who were very confident and motivated were able to reduce their alcohol consumption by using self-help instructions and drinking diaries [276]. Motivation techniques are more useful to the resistant patient than self-help instructions.

Motivational interviewing is a method of brief intervention that is used to help move individuals from the precontemplation, contemplation, or determination/preparation stage into the action stage of change related to their drinking. In addition to focusing on the patient's view of the problem and consequences of the behavior, the interview often includes a comprehensive assessment of drinking behaviors with personalized feedback. Motivational interviewing therapists emphasize personal responsibility and support their patients' feelings of self-efficacy for making a change in their drinking. This method has demonstrated empirical efficacy with problem drinkers [277].

EFFECTIVENESS OF BRIEF INTERVENTION

Many studies have documented that brief intervention can assist patients without clinical alcohol use disorder to reduce alcohol consumption [278; 279; 280; 281; 282]. Brief intervention can also help motivate the patient with alcohol use disorder to enter treatment. One study in an emergency care setting found that 65% of individuals with alcohol use disorder who received brief counseling kept a follow-up appointment for treatment, compared with only 5% percent of those who did not have counseling [278]. Some studies have found that brief intervention may be as effective as more specialized treatment for some patients with alcohol use disorder [279; 283; 284].

Researchers conducted a comprehensive meta-analysis of controlled studies of brief intervention in treatment and nontreatment settings [285]. In this meta-analysis, effect sizes were calculated for several outcome variables, including amount and timing of alcohol consumed, abstinence rates and duration, proportion and duration of non-problem drinking, frequency of intoxication, laboratory markers, ratings of drinking severity, ratings of improvements, dependence symptoms, and problems resulting from drinking [285]. Two types of investigations were examined. The first group of studies (N=34) compared brief intervention to control conditions in non-treatment-seeking patients and generally did not include persons with severe alcohol problems. The second group of investigations (N=20) included persons who had more severe alcohol problems in a treatment setting. The effect size for brief intervention on alcohol consumption was noted at between three to six months in studies that excluded more severe alcohol problems [285]. This meta-analysis provides further documentation of the effectiveness of brief intervention provided by healthcare professionals to patients with alcohol problems, especially during the first three to six months after intervention. Effectiveness may decrease over time, so progress should be monitored and referrals made if necessary. For those with more severe alcohol problems in a treatment setting, brief intervention may be appropriate as an initial treatment with nonresponders receiving more extensive/intensive treatment [285].

In summary, brief intervention can help patients without disordered alcohol consumption reduce or stop drinking, can help motivate patients with alcohol use disorder to enter treatment, and can be used to treat some patients with alcohol use disorder. One study reported that brief intervention is associated with decreased alcohol consumption and decreased healthcare utilization, motor vehicle events, and other related costs [286]. The study also reported that the cost-benefit analysis suggests that for every $10,000 invested in early intervention, there will be a $43,000 decrease in future healthcare costs [286]. A meta-analysis of brief alcohol interventions for adolescents and young adults found that the interventions yielded modest, but clinically significant positive effects on problematic alcohol use trajectories among youth [287].

MOTIVATIONS FOR CHANGE

Patients are more likely to seek treatment if:

- There are few actual or perceived barriers to treatment.
- The expectation is that treatment will work and that it is a positive change.
- They think they need help.
- They "hit bottom."
- They no longer feel in control.
- They cannot change on their own.
- They want to change their behavior.
- They perceive that treatment will suit their needs.
- There is social pressure to stop drinking or get treatment.
- They experience notable or multiple problems (e.g., black-outs, DUI arrest, etc.).

Patients are less likely to seek treatment if:

- There are numerous real or perceived barriers to treatment.
- They fear being unable to cope without alcohol.
- There are negative perceptions of treatment or changing behavior.
- They think that treatment will not work.
- There is fear of withdrawal.
- They think they will be stigmatized.
- They believe that they will be unable to stop.
- They fear failure.
- They perceive continued use as positive.

Source: [289] *Table 2*

READINESS TO CHANGE

Readiness to Change is Dimension 4 of the American Society of Addiction Medicine's (ASAM's) Six Dimensions of Multidimensional Assessment (also known as the ASAM Criteria) that is the standard for placement, continued stay, transfer, or discharge of patients with substance use disorder and co-occurring conditions [288]. Several factors influence a person's readiness and ability to change behaviors. It is useful to help patients to weigh the risks of continued alcohol consumption and benefits of decreasing or eliminating alcohol consumption. Physicians can help motivate the patient to become ready for treatment if the patient appears ready to change.

Is the patient ready to change? The role of motivation is an important part of changing behavior. ***Table 2*** summarizes the "pros" and "cons" of changing [289].

The Stages of Change Model is also useful in determining where a patient is in the process of change [290]. The stages of change include:

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse

TREATMENT

Treatment works. People who make the decision to stop drinking will be able to find the treatment and support they need to quit, remain sober, and regain their lives. However, as with treatment for any other disease, it is important to have a good idea of the options available in order to make informed choices.

PHASES OF TREATMENT

To understand treatment and make the right treatment choices, it helps to have an overview. Treatment should be seen as having three phases.

- Phase 1: Assessment and evaluation of disease symptoms and accompanying life problems including co-occurring medical and psychiatric conditions utilizing ASAM Criteria, detoxification (withdrawal management), acute stabilization of comorbid conditions, making treatment choices, and developing a plan

- Phase 2: Residential treatment or therapeutic communities, intensive and regular outpatient treatment, medications to help with alcohol craving and to discourage alcohol use, medications to treat concurrent psychiatric illnesses, treatment of concurrent medical conditions, trauma and family therapy, 12-step programs, other self-help and mutual-help groups
- Phase 3: Maintaining sobriety and relapse prevention with ongoing outpatient treatment as needed, facilitated group meetings, contingency management, 12-step programs, other self-help and mutual-help groups

Drug testing frequently, randomly, and for-cause should be a mandatory component of all phases. Transition from one phase to the next should not be based on time but on individual symptoms and progress.

Getting Started

First, the individual with alcohol use disorder must overcome denial and distorted thinking and develop the willingness to begin treatment—what AA calls the desire to stop drinking. At this stage, it is important to obtain the help of someone knowledgeable about treatment and the options available.

When getting started, some people have lost control over alcohol to such an extent that they will only be able to make immediate decisions and set the most basic goal of quitting drinking. Development of a detailed treatment plan with goals and choices may have to wait until after detoxification. On the other hand, getting started is exactly the place where some people with alcohol problems get stuck. In being stuck, denial is always a problem, but complete denial is not universal: people have various levels of awareness of their alcohol use problems, which means they are in different stages of readiness to change their drinking behavior. Professionals have taken advantage of this insight about alcohol use disorder to develop treatment approaches that are matched to a person's readiness to change. Addiction specialists can best decide which treatment is best and which is less restrictive at specific times during recovery.

Detoxification

Individuals with alcohol use disorder must stop using in order to be able to progress in treatment, which can be done on either an inpatient or outpatient basis. Medical evaluation and treatment are particularly important at this stage. A large proportion of persons with alcohol use disorder develop dangerous withdrawal symptoms that must be medically managed either in a hospital or on an outpatient basis.

Although detoxification is a critical step for many with alcohol use disorder, most treatment professionals are reluctant to call it treatment, and for good reason. Treatment is what helps a person develop a commitment to change, keep the motivation to change, create a realistic plan to change, and put the plan in action. Successful treatment means a person begins to experience the rewards of seeing the plan work. Just taking away the alcohol does not automatically produce any of these outcomes.

Withdrawal Symptoms and Medical Management

Abrupt discontinuation or even cutting down on the amount of drinking by persons who are physiologically dependent on alcohol produces a characteristic withdrawal syndrome with sweating, rapid heartbeat, hypertension, tremors, anorexia, insomnia, agitation, anxiety, nausea, and vomiting [291]. In some ways, alcohol withdrawal resembles withdrawal from opioids, but unlike opioid withdrawal, which is rarely life-threatening in and of itself, alcohol withdrawal can be fatal. As many as 15% of persons with alcoholism progress from the autonomic hyperactivity and agitation common to withdrawal from other drugs to seizures and, for some, even death. In some cases, DT may occur within the first 48 to 72 hours and can include disorientation, confusion, auditory or visual hallucinations, and psychomotor hyperactivity [291].

The Revised Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar) is a symptom-triggered, 10-item scale that quantifies the risk and severity of alcohol withdrawal [291]. However, in order to be most useful, it requires patient input, which may not be feasible in patients undergoing severe DTs. If the patient is able, the assessment takes only minutes and aids in identification of patients who may need immediate pharmacologic treatment to prevent further complications. Very mild withdrawal usually corresponds with a score of 9 or less, mild withdrawal with a score between 10 and 15, modest withdrawal with a score between 16 and 20, and scores greater than 20 indicate severe withdrawal [292]. Patients scoring less than 9 may not require pharmacologic intervention. However, reassessment of symptoms should be performed every one to two hours until withdrawal is resolved.

Pharmacologic management of acute alcohol withdrawal generally involves the use of benzodiazepines, which reduce related anxiety, restlessness, insomnia, tremors, DT, and withdrawal seizures [291]. Benzodiazepines are the most widely used, and while they may have abuse liability in some patients, they have been safely used for years [293; 294; 295]. These medications may be administered either on a fixed interval or symptom-triggered schedule. However, both short-acting and long-acting benzodiazepines have their problems. The long-acting benzodiazepines can decrease rebound symptoms and work for long periods of time, but intramuscular absorption can be very erratic. Short-acting benzodiazepines have less risk of oversedation, no active metabolites, and considerable utility in patients with liver problems or disease. Yet, breakthrough symptoms can and do occur, and risk of seizure is imminent.

Patients with withdrawal symptoms are generally treated with diazepam or chlordiazepoxide until withdrawal subsides [291; 293; 294]. These medications are preferred due to their long action, which decreases the risk of rebound symptoms. If intramuscular administration is necessary, lorazepam is the drug of choice. More severe withdrawal is generally treated in a hospital setting. In patients with severe hepatic dysfunction, benzodiazepines that are metabolized outside the liver (lorazepam and oxazepam) are preferred. Treatment-resistant withdrawal warrants the use of phenobarbital or propofol, both with demonstrated efficacy in management [295].

Other medications may be used in conjunction with benzodiazepines for the treatment of withdrawal. Anticonvulsants, especially carbamazepine, are used safely to treat withdrawal [293]. They do not have abuse liability and have anticonvulsant and antikindling effects. Nevertheless, they also have problems. They do not reduce delirium and can have liver toxicity. The anticonvulsant gabapentin has demonstrated efficacy for mild alcohol withdrawal and early abstinence, but there is concern about its potential for abuse [296]. Alpha-adrenergic agonists like clonidine can reverse many of the behavioral symptoms of withdrawal but do not prevent seizure and can cause hypotension. However, for those patients with coronary artery disease, use of an alpha-adrenergic agonist or beta blocker may be indicated; however, these agents do not prevent seizures and can mask some signs of worsening withdrawal. They should be used only in conjunction with benzodiazepines [297]. More research is necessary regarding the efficacy of calcium channel antagonists in the treatment of alcohol withdrawal [298]. Studies have shown that those who have withdrawal seizures may have a worse prognosis than those who do not [87; 88].

In the earliest views of alcohol use disorder, relapse to alcohol use was primarily seen as the patient's failure to respond to withdrawal treatment. After all, if the addicted person's primary problem was the trap of withdrawal, it would be reasonable to expect that the newly freed prisoner would gratefully and persistently grasp onto alcohol-free status, never to return voluntarily to the prison of addiction. But many people returned repeatedly for detoxification.

The medical profession was remarkably slow to recognize the ineffectiveness of repeated detoxification. Rather than question the underlying assumption that medical diagnosis and treatment of withdrawal was the solution to the problem of dependence, physicians seemed content to recycle people through one emergency room or detoxification experience after another for what often proved to be an addiction-shortened lifetime. Detoxification is only the first step in the treatment process, and the beginning of a lifelong process.

As the detoxification process occurs, careful evaluation should be done to identify co-occurring medical and psychiatric conditions that require acute stabilization. This should be done before facilitating a smooth transition to phase 2.

It is crucial to decide if the patient requires acute hospitalization or inpatient detoxification. It has been established that hospitalization can be cost-effective, but this is not always a possibility. However, if a patient appears to have acute intoxication, exhibits or will exhibit withdrawal symptoms that will require medical management, has failed outpatient detoxification, appears to be depressed or suicidal, relapses shortly after previous detoxification, has an extremely unstable home situation, or has the possibility of family disruption or job loss, then inpatient hospitalization is likely indicated. If you are in doubt, call a physician who is a member of the ASAM or the American Academy of Addiction Psychiatry who specializes in these problems.

Active Treatment

The next step is what has been commonly known as "active treatment." Relapse to alcohol use disorder is most likely to occur in the first three to six months after a person stops drinking; a period characterized by physiologic abnormalities, mood changes, and complaints of anxiety, depression, insomnia, and hormone and sleep problems. Getting active help and support during the early months of sobriety is critical for treatment to succeed.

This is the stage in which a person gains the motivation necessary to maintain a commitment to sobriety, the knowledge and skills necessary to stay sober, and the support systems necessary to cope with all the problems of daily life (the problems that everyone has to face) without resorting to the old "solution" of drinking. This is when the assistance of a treatment professional is important. A professional can help patients better understand how alcohol has affected their lives, so they can set goals and develop a plan to stay sober. In addition, the treatment professional can assist the patient in choosing the treatment options that are right for them.

Some proven medications are available to help with alcohol craving and to discourage alcohol use and will be discussed in detail later in this course. The treatment professional will also need to choose medications and treatments for concurrent psychiatric illnesses, like depression or anxiety, if appropriate, or for a variety of health problems that often accompany alcohol use disorder.

Research has shown that the longer people stay in treatment, remain sober, and are actively committed to sobriety, the more likely it is that they will maintain sobriety. Some treatment professionals think of the phase of active treatment as lasting from 6 to 12 months. During the first critical months of treatment, people often need a variety of supports, especially drug testing and AA or other self-help groups, to achieve and maintain lasting sobriety.

Maintaining Sobriety and Relapse Prevention

It is often difficult to pinpoint when the active treatment phase ends and a person enters the maintenance phase of recovery. In phase 2, people learn what they need to do to stay sober and they develop the many skills they will use to avoid relapse. A person could be said to enter this maintenance and growth stage when he or she is comfortable with these skills and has had a chance to rely on them to stay sober when life throws them the inevitable curveballs, either as a crisis or an everyday problem. Many people in recovery attribute their ongoing sobriety to participation in a support group such as AA or Women for Sobriety.

A promising approach to maintain gains made in active treatment is a low-intensity, telephone-based approach. In a 2005 study, this program of follow-up care was compared with two more intensive face-to-face continuing care interventions. Patients with alcohol use disorder who had completed 4-week intensive outpatient programs were provided three 12-week continuing care treatments. Telephone-based continuing care was found to be an effective form of step-down treatment for most patients with alcohol use disorder who complete an initial stabilization treatment, compared with more intensive face-to-face interventions [299].

ALCOHOLICS ANONYMOUS AND OTHER 12-STEP PROGRAMS

The grandfather of successful alcohol treatment is Alcoholics Anonymous, a self-help organization founded in 1935 that changed the way professionals thought about alcohol use disorder and treatment. AA developed a very successful 12-step program that combines self-help with a spiritual foundation and is based on the fellowship of recovering alcoholics. Although there is a spiritual foundation in AA, one is not required to be religious. The organization is run entirely by recovering alcoholics and reaches into virtually every community with a specific program as well as around-the-clock assistance. Membership is available to anyone wishing to join, and there are no financial dues. AA has probably done more to promote the self-help concept than any other organization.

For many people with alcohol use disorder, attending an AA meeting is like brushing their teeth. Prevention of relapse is an active daily process. AA provides fellowship that can be exceptionally positive and counterbalance the feelings of loss, grief, and shame often associated with alcohol use disorder.

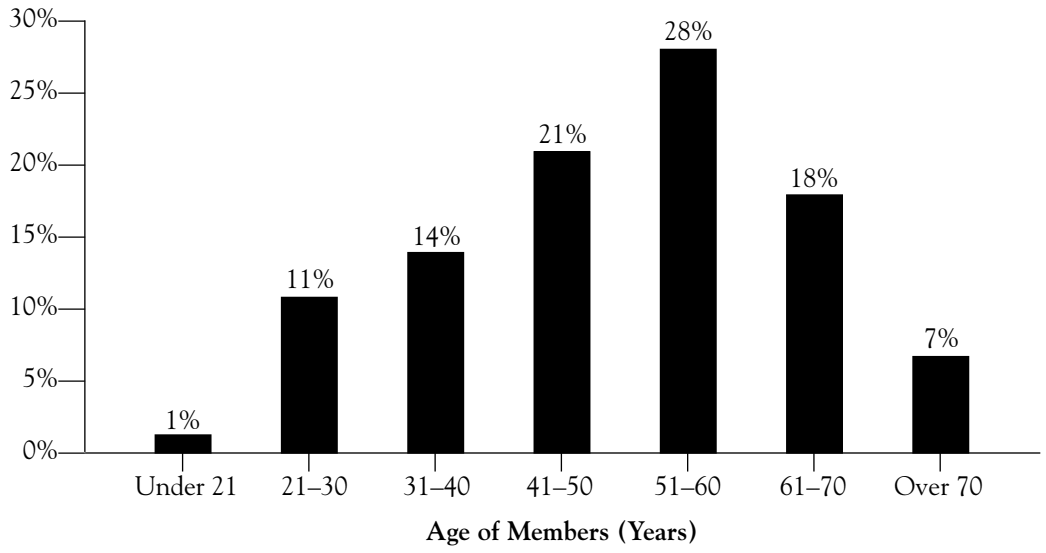
AA and other 12-step programs are effective treatment programs that facilitate long-term abstinence after treatment, especially for patients with low psychiatric severity [300]. AA provides important group process therapy for individuals with alcohol use disorder. AA also helps individuals with relapse and relapse prevention by prescribing that people keep it simple, take it one day at a time, and avoid the people, places, and things associated with their use. They also help recovering alcoholics to develop positive lifestyles and find new ways to solve old problems. The feeling of fellowship, the support, and guidance to sobriety makes recovery more likely. Reduction of shame and guilt and acceptance of powerlessness over drinking may be reported by individuals with alcohol use disorder after attending meetings every day. An AA meeting may take one of several forms, but at any meeting you will find alcoholics talking about what drinking did to their lives and personalities, what actions they took to help themselves, and how they are living their lives today. The age distribution of AA members is illustrated in ***Figure 3***.

Patients can find the listing for a nearby AA group in the telephone book or online. Typically, a person in recovery will answer the telephone. Websites provide printable lists of all local meetings with time, location, types of meeting, and often directions. One of AA's principles is the value of performing services that will help other alcoholics. Answering the telephone at the local AA office is one of these services, reserved for those who have been in recovery long enough to answer questions in a knowledgeable manner and provide a nonjudgmental ear.

A Cochrane review found that AA, the premier mutual aid peer-recovery program definitely helps people get sober [358]. In addition, AA has significantly higher rates of continuous sobriety compared with evidence-based professional mental health therapy, such as cognitive-behavioral therapy, alone. AA was often was found to be markedly better than other interventions or quitting cold turkey. One study found the program 60% more effective than alternatives [358].

The study by Harvard and Stanford addiction researchers of 10,565 subjects determined that AA was nearly always found to be more effective than psychotherapy in achieving abstinence [358].This review concluded that AA participation improved the duration of abstinence and the amount they reduced their drinking (if they continued drinking). AA had harm reduction features as well, reducing the medical consequences of drinking and related healthcare costs. While not a random assignment treatment comparison study, in this analysis, AA was never found less effective than other treatments. As such, AA could be a helpful addition to any treatment for alcohol use disorder. For example, adding AA to naltrexone would be expected to be better than pharmacotherapy alone. Recent studies and the preponderance of evidence supports the effectiveness of 12-step program involvement in sustaining abstinence [10]. Stable and long-term abstinence was associated with living longer, better mental health, better marriages, being more responsible parents, and being successful employees.

ALCOHOLICS ANONYMOUS 2014 MEMBERSHIP SURVEY[a]



[a]Represents the most recent AA Membership Surveys as of 2021.

Source: [301] *Figure 3*

A brain imaging study by Yale researchers showed that those diagnosed with alcohol use disorder showed disruptions of activity between the ventromedial prefrontal cortex and striatum, a brain network linked to decision making [360]. Time is necessary for re-learning how to be sober but also for brain recovery. The more recent the last drink, the more severe the disruption, and the more likely the individual will relapse to drinking. The Yale researchers also found that the severity of disruption between these brain regions recovers very slowly, day after day, gradually over time. They conclude the longer subjects with alcohol use disorder abstain from alcohol, the better. The number of days of alcohol abstinence at treatment initiation significantly affected functional disruption of the prefrontal-striatal responses to alcohol cues in patients with alcohol use disorder and brain imaging abnormalities [360].

COUNSELING

Cognitive-behavioral therapies (CBTs) are among the most frequently evaluated approaches used to treat substance use disorders [302; 303]. CBTs have been shown to be effective in several clinical trials of substance users [304]. Characteristics of CBTs include:

- Social learning and behavioral theories of drug abuse
- An approach summarized as "recognize, avoid, and cope"
- Organization built around a functional analysis of substance use (i.e., understanding substance use with respect to its antecedents and consequences)
- Skill training focused on strategies for coping with craving, fostering motivation to change, managing thoughts about drugs, developing problem-solving skills, planning for and managing high-risk situations, and cultivating drug refusal skills

Basic principles of CBTs are that [305; 306]:

- Basic skills should be mastered before more complex ones are given.
- Material presented by the therapist should be matched to patient needs.
- Repetition fosters the development of skills.
- Practice is needed for mastery of skills.
- The patient is an active participant in treatment.
- Skills taught are general enough to be applied to a variety of problem areas.

Structured behavior therapy techniques can be effective components of alcohol use disorder treatment. Contingent incentive procedures are designed to enhance a patient's motivation to meet treatment goals by offering concrete rewards for specific performance outcomes.

Behavioral therapy techniques are often part of CBT. In this approach, substance use is believed to develop from changes in behavior and a reduction in opportunities for reinforcement of positive experience. The goal is to increase the person's engagement in positive or socially reinforcing activities. Techniques such as having patients complete a schedule of weekly activities, engaging in homework to learn new skills, role-playing, and behavior modification are used. Activity, exercise, and scheduling are major components of this approach based on the following:

- Drug abuse patients need motivation and skills to succeed in stopping drug use.
- Research has shown that drug abuse behavior can be reduced by offering contingent incentives for abstinence.
- The most striking successes have come from positive reinforcement programs that provide contingent incentives for abstinence using money-based vouchers as rewards.
- Research provides examples, but treatment providers may need to be creative in discovering reinforcers that can be used for contingency management in their own clinical settings.

Family therapy is a highly effective treatment for alcohol use disorder, especially in adolescents. While most treatments emphasize the individual as the target of intervention, the defining characteristic of family therapy is the transformation of family interactions. Repetitive patterns of family interactions are the focus of treatment. Changing these patterns results in diminished antisocial behavior including alcohol abuse. Family therapy can work with a broad range of family and social network populations. Family therapy approaches have developed specific interventions for engaging and keeping reluctant, unmotivated adolescents and family members in treatment.

MEDICATIONS USED TO TREAT ALCOHOL USE DISORDER

Alcohol drinking is an immensely complex human behavior, but it has been modeled in laboratory animals. Two similar strains of alcoholic rats, the alcohol-preferring (P) rats and the high-alcohol-drinking (HAD) rats, have been successfully used to study alcohol use disorders. Like patients with DSM-5 qualifying alcohol use disorders, these rats self-administer alcohol, show tolerance, lose control over alcohol, and spend a lot of time. They also have cravings and physical stigmata of withdrawal, providing psychopharmacologic researchers with excellent face validity with animal models. Models have helped us develop anti-withdrawal, anti-craving, and harm-reducing treatments.

Several medications are available to help treat alcohol use disorder [307; 308]. Some are used for detoxification and others are used to prevent relapse. Research has shown that medications are most effective when used in conjunction with other therapies.

Disulfiram

Disulfiram, commonly known as Antabuse, was the first drug to be made available for the treatment of alcohol use disorder. It was approved for treatment of alcohol use disorder by the FDA in 1951 and has been used safely and effectively for more than half a century. It works by blocking an enzyme, aldehyde dehydrogenase, that helps metabolize alcohol. Taking even one drink while on disulfiram causes the alcohol at the acetaldehyde stage to accumulate in the blood. This produces nausea, vomiting, sweating, and even difficulty breathing. More alcohol in the patient's system produces more severe reactions (e.g., respiratory depression, cardiovascular collapse, unconsciousness, convulsions, death) [308; 309]. Patients must also be mindful of consuming even minute amounts of alcohol in foods, over-the-counter medications, mouthwash, and even topical lotions. Disulfiram can be effective for people who have completed alcohol withdrawal, are committed to staying sober, and are willing to take the medication under the supervision of a family member or treatment program [308]. Due to more modern and improved medication modalities, many clinicians prescribe disulfiram as a last resort intervention. Although widely used, it is less clearly supported by clinical trial evidence [310; 311; 312].

The recommended dose for disulfiram is 250 mg/day, which can be increased to 500 mg based upon whether a patient experiences the disulfiram-ethanol reaction [313]. Doses may need to be reduced in patients older than 60 years of age [308]. Labeling for disulfiram includes several precautions regarding drug-drug interactions; therefore, caution should be used when prescribing it to older adults at risk for polypharmacy [308]. Due to the physiologic changes that occur with use, use of disulfiram is not recommended in patients with diabetes, cardiovascular or cerebrovascular disease, or kidney or liver failure. It also is contraindicated in the presence of psychoses and pregnancy and in those with high levels of impulsivity and suicidality [308].

Naltrexone

Naltrexone (ReVia) is an opioid antagonist that interferes with the rewarding or pleasurable effects of alcohol and reduces alcohol craving [314; 315; 316]. The exact mechanisms by which naltrexone induces the reduction in alcohol consumption observed in patients with alcohol use disorder is not entirely understood, but preclinical data suggest involvement of the endogenous opioid system [308]. Naltrexone has been shown to reduce alcohol relapses, decrease the likelihood that a slip becomes a relapse, and decrease the total amount of drinking [308]. The FDA approved the use of oral naltrexone in alcohol use disorder in December 1994

[308; 316]. In 2006, the FDA approved an extended-release injectable formulation, which is indicated for use only in patients who can refrain from drinking for several days prior to beginning treatment [308]. In 2010, the FDA approved the injectable naltrexone for the prevention of relapse to opioid dependence following opioid detoxification [308]. Naltrexone, which has long been used to treat heroin addicts, was not known as a treatment that could reduce alcohol relapse until the 1980s. In 1980, researchers reported reductions in monkey ethanol self-administration when they were pretreated with naltrexone [317].

By 1992, researchers reported a six-week, double-blind placebo-controlled outpatient naltrexone trial with 70 individuals with alcohol use disorder. They found that the naltrexone-treated patients had a lower relapse rate, fewer drinking episodes, longer time to relapse, and reduced tendency for a slip to become a relapse [318]. These and other data suggested that endogenous opioids were important in alcohol reinforcement.

Also in 1992, researchers compared naltrexone with placebo and found that naltrexone-treated patients had lower rates of relapse to heavy drinking, consumed fewer drinks per drinking-day, and had lower dropout rates than placebo-treated patients with alcohol use disorder [319]. These results have since been supported by other studies [320]. Research suggests that naltrexone may be most effective for individuals with alcohol use disorder and a family history of alcohol use disorder [321]. However, one study found no significant effects for naltrexone in individuals with a family history of alcoholism on percentage of days abstinent, drinks per drinking day, and percentage of heavy drinking days [322].

Another study investigated pretreatment social network variables as potential moderators of naltrexone's treatment effects [323]. The study sample included 1,197 participants from the COMBINE study, the largest pharmacotherapy trial conducted for alcoholism in the United States. In treatment conditions involving combined CBT and medical management, the effects of naltrexone on heavy drinking were significantly greater for individuals with frequent drinkers in their social network and greater frequency of contact with those drinkers, indicating patterns of environmental exposure to alcohol [323; 324].

After a complete history, physical exam, and laboratory testing, most patients are started on 50 mg orally per day [220]. For most patients, this is the safe and effective dose of naltrexone. However, in a four-month study period, the COMBINE study demonstrated efficacy of naltrexone at a dose of 100 mg daily [325]. Some treatment providers give patients a naltrexone identification card or ask them to order a MedicAlert bracelet that clearly indicates that they are maintained on an opioid antagonist, so if they need an opiate drug or medication for pain relief, the dose of the pain medication can be adjusted higher. Meta-analyses have revealed that approximately 70% of previous clinical trials that measured reductions in "heavy or excessive drinking" demonstrated an advantage for prescribing naltrexone over placebo [326]. In another trial, naltrexone was determined to have the greatest impact on reducing daily drinking when craving for alcohol was highest [327]. The approved dose of the extended-release formulation is 380 mg IM once per month. Pretreatment with oral naltrexone is not required before induction onto extended-release injectable naltrexone [308].

The most common side effects of naltrexone are light-headedness, diarrhea, dizziness, and nausea. Pain or tenderness at the injection site is a side effect unique to the extended-release injectable formulation [308]. Most side effects tend to disappear quickly in most patients. Naltrexone is not recommended for patients with acute hepatitis or liver failure, for adolescents, or for pregnant or breastfeeding women [308; 325]. Weight loss and increased interest in sex have been reported by some patients. In general, patients maintained on opioid antagonists should be treated with nonopioid cough, antidiarrheal, headache, and pain medications. The patient's family or physician should call the treating physician if questions arise about opioid blockade or analgesia. It is important to realize that naltrexone is not disulfiram; drinking while maintained on naltrexone does not produce side effects or symptoms.

Naltrexone works best when it is used in the context of a full spectrum of treatment services, possibly including traditional 12-step fellowship-based treatments. Studies show also that naltrexone is effective when coupled with CBT. Patients receiving medical management with naltrexone, CBT, or both fared better on drinking outcomes [325].

Acamprosate

Acamprosate (Campral) is a synthetic compound that has a chemical structure similar to that of the naturally occurring amino acid neurotransmitters taurine and GABA [220]. Because chronic alcohol use is associated with decreased GABA and glutamate activity, a hyperexcitable glutamate system is one possible alcohol withdrawal mechanism. Glutamate systems may become unstable for 12 months after a person stops drinking. In a review of published, double-blind, placebo-controlled clinical trials evaluating the safety and efficacy of acamprosate in the treatment of alcohol use disorder, Mason reported that acamprosate appeared to improve treatment completion rate, abstinence rate and/or cumulative abstinence during treatment, and time to first drink, than placebo [328]. The effect on abstinence, combined with an excellent safety profile, lend support to the use of acamprosate across a broad range of patients with alcohol use disorder. A dose of 2,000 mg/day is associated with the greatest efficacy regardless of body weight [329]. It is important to note that medication in combination with therapies can improve outcomes.

In July 2004, after many years of safe use in Europe and around the world, the FDA approved the use of acamprosate for the maintenance of alcohol abstinence [316]. As in the case of naltrexone, acamprosate reduces the reinforcing (pleasurable) effects of alcohol to reduce craving. Oral dosing is two 33-mg delayed-release tablets three times daily [220; 308]. Common side effects include diarrhea, anxiety, insomnia, nausea, dizziness, and weakness. Some research indicates that acamprosate may worsen depression and/or suicidal ideation; so, patients with a history of major depression should be monitored closely or prescribed a different medication [220]. Acamprosate is contraindicated in patients with severe renal impairment [220; 308]. Due to risk of diminished renal function in patients 65 years of age and older, baseline and frequent renal function tests should be performed in this population. Dose reductions also may be necessary [308].

The effectiveness of acamprosate in promoting abstinence has not been demonstrated in individuals who have not completed detoxification or who have not achieved alcohol abstinence before beginning treatment [308]. An analysis of many studies of acamprosate showed a benefit in maintaining abstinence when coupled with CBT [325]. A systematic review found similar benefit [330]. Results of other research into the effectiveness of acamprosate have been mixed. One study showed no improvement in measures of psychologic well-being or health status when compared to treatment with placebo. Another study demonstrated both safety and effectiveness of acamprosate for treating alcohol use disorder [331].

Baclofen

Baclofen is a GABA agonist that may prove to be a unique therapeutic alternative to reduce alcohol craving and consumption. In a small, 12-week trial, patients with alcohol use disorder were given 10 mg of baclofen three times daily paired with motivational enhancement therapy. Patients experienced a reduction in number of drinks, drinking days, anxiety, and craving [332]. In a study of patients with alcohol use disorder and liver cirrhosis, baclofen was also found to work favorably in maintenance of alcohol abstinence. Seventy-one percent of baclofen-treated patients maintained abstinence as compared with 29% of the placebo group [333]. A 2018 meta-analysis of 12 randomized controlled trials that compared the efficacy of baclofen to placebo found that baclofen was associated with higher rates of abstinence than placebo but that its effects were not superior to placebo in increasing the number of abstinent days or in decreasing heavy drinking, craving, depression, or anxiety [334].

Anticonvulsants

Research has demonstrated that topiramate is efficacious in decreasing heavy drinking among individuals with alcohol use disorder [335]. In a controlled study, topiramate produced significant and meaningful improvement in a wide variety of drinking outcomes [336]. Topiramate may suppress the craving and rewarding effects of alcohol [337]. In a double-blind, controlled trial, 150 patients with alcohol use disorder were randomized to escalating doses of topiramate (25–300 mg/day) or placebo. Those on topiramate had a reduction in self-reported drinking (number of drinks and drinking days), alcohol craving, and plasma y-glutamyl transferase (an indicator of alcohol consumption) [338]. Side effects of topiramate include numbness in the extremities, fatigue, confusion, paresthesia, depression, change in taste, and weight loss. Use of topiramate for alcohol use disorder is off-label [220].

Carbamazepine has proven effective for treating acute alcohol withdrawal [339]. Its side effects include nausea, vomiting, drowsiness, dizziness, chest pain, headache, trouble urinating, numbness in extremities, liver damage, and allergic reaction [220]. In a 12-month, double-blind, placebo-controlled trial, 29 patients were assigned to carbamazepine three times daily (to reach an average blood level of 6 mg/liter) or placebo. Those treated with carbamazepine showed a delay in time to first drink and a decrease in number of drinks and drinking days [340].

Oxcarbazepine is a carbamazepine derivative, with fewer side effects and contraindications, used to prevent relapse in patients with alcohol use disorder by blocking alcohol withdrawal [339]. A group of 84 patients with alcohol use disorder following detoxification were randomized to 50 mg naltrexone, 1,500–1,800 mg oxcarbazepine, or 600–900 mg oxcarbazepine for 90 days. Approximately 58.6% of the high-dose oxcarbazepine patients remained alcohol-free, a significantly larger number as compared to the low-dose (42.8%) and naltrexone groups (40.7%) [341].

Treatment in Special Populations

Ondansetron is a serotonin antagonist and antiemetic that may block the rewarding effects of alcohol, specifically in the early-onset alcoholic subgroup. Early-onset alcoholism differs from late-onset in its association with abnormal serotonin and antisocial behavior. In a double-blind, controlled trial of ondansetron as an adjunct to cognitive-behavioral therapy, ondansetron was shown to reduce self-reported drinking and increase abstinence as compared to placebo. These results were confirmed by measure of plasma carbohydrate deficient transferring, a biomarker of alcohol consumption [342]. One hypothesis suggests that ondansetron may reduce drinking in individuals with alcohol use disorder with the LL genotype [343].

Buspirone hydrochloride is a dopamine antagonist and partial agonist for serotonin, exhibiting anxiolytic properties. In a 12-week randomized, placebo-controlled trial among 61 patients with alcohol use disorder and anxiety, buspirone was associated with slower return to heavy alcohol consumption and fewer drinking days [344]. One study found buspirone to be effective in treatment of comorbid anxiety disorder and alcohol use disorder [345].

Clozapine is an atypical antipsychotic approved to treat schizophrenia and its resultant symptoms (e.g., hallucinations, suicidal behavior). In case studies, it has shown promise in the treatment of comorbid substance use. In a study of 151 individuals with schizophrenia with comorbid substance use, 36 were given clozapine [346]. Those who abused alcohol experienced a reduction in drinks and drinking days.

Other drugs under trial for use in the treatment of alcohol use disorder include varenicline and lithium. Varenicline does appear to help reduce drinking in some individuals with alcohol use disorder; however, concerns exist regarding reports of an association between the drug and an increased risk for suicidal thoughts and cardiovascular events [347]. Studies have demonstrated that varenicline helps reduce alcohol craving and consumption in patients with alcohol use disorder and in individuals with alcohol use disorder who also smoke [348; 349; 350]. None of the medications mentioned for alcohol use disorder are recommended for women who are pregnant or breastfeeding.

TREATMENT OF ALCOHOL WITHDRAWAL

Benzodiazepines have been used for 30 years in the United States as the primary medical treatment for alcohol withdrawal syndrome. All benzodiazepines appear similarly effective in the treatment of alcohol withdrawal syndrome [351]. Although benzodiazepines are the drugs of choice, there are concerns about the side effects and, as stated, problems of abuse, especially for outpatient detoxification. Benzodiazepines are sedatives and cause deficiencies in psychomotor abilities that, when combined with alcohol, can cause accidents and affect the ability to think clearly. However, benzodiazepines are, and have been, effective in treating alcohol withdrawal symptoms and preventing most seizures. Other regimens for alcohol withdrawal syndrome include barbiturates, propofol, and ethanol [352; 353; 354].

A desirable alternative to benzodiazepines would be a nonsedative anticonvulsant that has less potential for abuse and dependence. Valproic acid has been used in Europe safely and successfully for many years for alcohol withdrawal syndrome, but is only approved by the FDA for the treatment of mania, seizures, and migraines. Valproic acid should be used as an adjunctive therapy, not as monotherapy [351]. According to clinical reports, valproic acid is an anticonvulsant with no potential for abuse and is better tolerated by patients. Valproic acid also has less cognitive impairment and causes fewer deficiencies of psychomotor abilities than benzodiazepines; however, benzodiazepines have allowed for safe detoxification for patients with alcohol use disorder since they were approved. While detoxification is not treatment, and detoxification problems have not been the most important problem area in successful treatment of the patient with alcohol use disorder, these are important findings.

Recognizing that relapse prevention and harm-reducing medications are safe and effective in alcohol use disorders, fewer than 10% of these patients are given medication-assisted treatment. In a 2018 meeting of the American Psychiatric Association, experts suggested [359]:

- Naltrexone or acamprosate should be offered to those patients with moderate-to-severe alcohol use disorder that have a goal of reducing consumption or achieving abstinence, prefer pharmacotherapy, or have not responded to nonpharmacologic therapies, and have no contraindications.
- Disulfiram should be offered to patients with severe alcohol use disorder that seek to achieve abstinence, prefer the therapy, or have not responded (or are intolerant) to naltrexone or acamprosate, and have no contraindications. Additionally, patients must understand the risks associated with consuming alcohol while on disulfiram.
- Topiramate or gabapentin should be offered to patients with moderate-to-severe alcohol use disorder when they aim to reduce or achieve abstinence, prefer them to other medications, or have not responded to naltrexone or acamprosate and have no contraindications.
- Benzodiazepine use is discouraged except in patients with alcohol use disorder who require treatment for acute alcohol withdrawal.

MANDATORY TREATMENT

Even coerced or court-mandated treatment for alcohol use disorder can work. In a follow-up study (six months to one year) of Florida physicians with alcohol use disorder, 84% had positive outcomes, defined as positive counselor and physician assessment, negative alcohol testing, group attendance, and full return to work [86].

CONCLUSION

In a society where alcohol use is ubiquitous, it is important for healthcare professionals to recognize the signs and symptoms of alcohol abuse and intervene before a state of dependence is reached. It is critical to stress upon patients the negative health effects of excessive alcohol consumption, especially the synergistic effects of alcohol and tobacco use, beginning at an early age. Owing to the several benefits provided by low to moderate drinking as discussed in this course, certain patients can be advised to drink more regularly, provided alcohol use is not contraindicated due to drug or herb interactions.

RESOURCES

Al-Anon Family Groups
The mission of Al-Anon is to provide support for friends and families of problem drinkers.
https://al-anon.org
1600 Corporate Landing Parkway
Virginia Beach, VA 23454-5617
757-563-1600

Alcoholics Anonymous
https://www.aa.org

American Society of Addiction Medicine (ASAM)
The nation's medical specialty society dedicated to educating physicians and improving the treatment of individuals suffering from alcoholism and other addictions. The mission of the ASAM is to:

- Increase access to and improve the quality of addiction treatment
- Educate physicians, medical and osteopathic students, other healthcare providers, and the public
- Promote research and prevention
- Promote the appropriate role of the physician in the care of patients with addiction
- Establish addiction medicine as a specialty recognized by the American Board of Medical Specialties

https://www.asam.org
11400 Rockville Pike
Suite 200
Rockville, MD 20852
301-656-3920

MedicAlert Foundation
https://www.medicalert.org
101 Lander Avenue
Turlock, CA 95380
1-800-432-5378

FACULTY BIOGRAPHIES

Mark S. Gold, MD, DFASAM, DLFAPA, is a teacher of the year, translational researcher, author, mentor, and inventor best known for his work on the brain systems underlying the effects of opiate drugs, cocaine, and food. Dr. Gold was a Professor, Eminent Scholar, Distinguished Professor, Distinguished Alumni Professor, Chairman, and Emeritus Eminent Scholar during his 25 years at the University of Florida. He was a Founding Director of the McKnight Brain Institute and a pioneering neuroscience-addiction researcher funded by the NIH-NIDA-Pharma, whose work helped to de-stigmatize addictions and mainstream addiction education and treatment. He also developed and taught courses and training programs at the University of Florida for undergraduates and medical students.

He is an author and inventor who has published more than 1,000 peer-reviewed scientific articles, 20 text books, popular-general audience books, and physician practice guidelines. Dr. Gold was co-inventor of the use of clonidine in opioid withdrawal and the dopamine hypothesis for cocaine addiction and anhedonia. Both revolutionized how neuroscientists and physicians thought about drugs of abuse, addiction, and the brain. He pioneered the use of clonidine and lofexidine, which became the first non-opioid medication-assisted therapies. His first academic appointment was at Yale University School of Medicine in 1978. Working with Dr. Herb Kleber, he advanced his noradrenergic hyperactivity theory of opioid withdrawal and the use of clonidine and lofexidine to ameliorate these signs and symptoms. During this time, Dr. Gold and Dr. Kleber also worked on rapid detoxification with naloxone and induction on to naltrexone.

Dr. Gold has been awarded many state and national awards for research and service over his long career. He has been awarded major national awards for his neuroscience research including the annual Foundations Fund Prize for the most important research in Psychiatry, the DEA 30 Years of Service Pin (2014), the American Foundation for Addiction Research's Lifetime Achievement Award (2014), the McGovern Award for Lifetime Achievement (2015) for the most important contributions to the understanding and treatment of addiction, the National Leadership Award (NAATP) from addiction treatment providers for helping understand that addiction is a disease of the brain, the DARE Lifetime Achievement Award for volunteer and prevention efforts, the Silver Anvil from the PR Society of America for anti-drug prevention ads, the PRIDE and DARE awards for

his career in research and prevention (2015), and the PATH Foundation's Lifetime Achievement Award (2016) as one of the "fathers" of addiction medicine and MAT presented to him by President Obama's White House Drug Czar Michael Botticelli. He was awarded Distinguished Alumni Awards at Yale University, the University of Florida, and Washington University and the Wall of Fame at the University of Florida College of Medicine. Gold was appointed by the University President to two terms as the University's overall Distinguished Professor, allowing him to mentor students and faculty from every college and institute. The University of Florida College of Medicine's White Coat Ceremony for new medical students is named in his honor.

Since his retirement as a full-time academic in 2014, Dr. Gold has continued his teaching, mentoring, research, and writing as an Adjunct Professor in the Department of Psychiatry at Washington University and an active member of the Clinical Council at the Washington University School of Medicine's Public Health Institute. He regularly lectures at medical schools and grand rounds around the country and at international and national scientific meetings on his career and on bench-to-bedside science in eating disorders, psychiatry, obesity, and addictions. He continues on the Faculty at the University of Florida College of Medicine, Department of Psychiatry as an Emeritus Distinguished Professor. He has traveled extensively to help many states develop prevention, education, and treatment approaches to the opioid crisis.

William S. Jacobs, MD, is a national clinical expert, triple board certified in Anesthesiology, Pain Medicine, and Addiction Medicine. A Phi Beta Kappa, magna cum laude University of Georgia undergraduate and graduate of the Medical College of Georgia, Dr. Jacobs did his anesthesiology residency at the University of Alabama-Birmingham, where he won the Dripps Award for the Best Anesthesiology Resident. He had a 13-year career as a private practitioner in anesthesiology and pain management before matriculating to the University of Florida for his addiction medicine fellowship. Dr. Jacobs has been a national expert, testifying on Capitol Hill on MDMA and prescription misuse and abuse. He has also served the State of Florida and its Drug Czars. He was a medical and scientific consultant to the U.S. Senate Crime and Drugs Subcommittee as well as the Department of Labor. Dr. Jacobs has testified and consulted for the DEA on safe prescribing of narcotic drugs and the model of ideal treatment programs. A gifted clinician and addiction medical director, Dr. Jacobs has been the medical director of nonprofit, profit, and academic chemical dependency and dual-diagnosis detoxification and stabilization, residential, partial hospitalization, intensive outpatient, and hospital programs. Over his career, he has served as attending physician, Chief Medical Officer, or Medical Director at a variety of facilities. He has been a monitoring physician for the Florida Board of Medicine and an evaluator and treatment provider for Florida Professionals Resource Network, Intervention Project for Nurses, and Lawyers Assistance programs. He has worked with the Duval County Adult and Adolescent Drug Courts and is a member of the Drug Free America Foundation Board of Directors. After his promotion to Associate Professor, he left academia and started NexStep Integrated Pain Care, Inc., a model outpatient program for the treatment of patients with both chronic pain and addiction disorders in Jacksonville. He returned to the University of Florida full time as Associate Professor in Psychiatry and Addiction Medicine and was co-chief of Pain Medicine in 2012. Dr. Jacobs was a principal or co-principal investigator for the Florida site of the pivotal trials for bupropion vs. placebo in smoking cessation as well as in pharmacological studies of naltrexone, depression, OCD, and anxiety. He is the author of peer-reviewed scientific papers, abstracts, textbook chapters (including the ASAM and APA definitive substance use volumes), and practice guidelines including highly cited studies on mitigating opioid abuse in chronic pain treatment, physician recovery, naltrexone, urine drug testing, and body mass index and alcohol use. Dr. Jacobs has returned to Georgia to become the first Chief of Addiction Medicine at The Medical College of Georgia/Georgia Regents University. He is also Medical Director of The Bluff Plantation as well as Chief Medical Officer for Georgia Detox & Recovery. He was recently invited to serve on the American Academy of Pain Medicine's Acute Pain Initiative and made keynote presentation at the 2014 Addiction Research & Therapy Conference on Pain and Addiction.

Customer Information/Answer Sheet/Evaluation insert located between pages 104–105.

TEST QUESTIONS
#76563 ALCOHOL AND ALCOHOL USE DISORDERS

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/4 NBCC Clock Hour activity must be completed by May 31, 2024.

1. Approximately what percentage of all Americans older than 12 years of age report being current consumers of alcohol?
- *A) 30%*
- *B) 51%*
- *C) 75%*
- *D) 90%*

2. Binge drinking rates are highest for which of the following racial groups in America?
- *A) Asian*
- *B) Hispanic*
- *C) African/Black*
- *D) White/European*

3. What percentage of people who drink have experienced an alcohol-related problem?
- *A) 10%*
- *B) 20%*
- *C) 30%*
- *D) 40%*

4. The estimated annual cost of alcohol abuse in the United States in 2010 was approximately
- *A) $96 million.*
- *B) $1.85 billion.*
- *C) $90 billion.*
- *D) $249 billion.*

5. A standard drink is generally defined as
- *A) 1 ounce of 80-proof distilled spirits, 4 ounces of wine, or 8 ounces of beer.*
- *B) 1.5 ounces of 80-proof distilled spirits, 4 ounces of wine, or 8 ounces of beer.*
- *C) 1.5 ounces of 80-proof distilled spirits, 5 ounces of wine, or 12 ounces of beer.*
- *D) 1 ounce of 80-proof distilled spirits, 4 ounces of wine, or 12 ounces of beer.*

6. After recent alcohol consumption, all of the following are symptoms of intoxication, EXCEPT:
- *A) Bruxism*
- *B) Loss of coordination*
- *C) Unsteady walking or running*
- *D) Impairment of attention or memory*

7. Moderate drinking is defined as no more than
- *A) three drinks per day for men.*
- *B) two drinks per day for women.*
- *C) one drink per day for men and women.*
- *D) one drink per day for women and two drinks per day for men.*

8. Heavy drinking is defined as five or more drinks on the same occasion on each of 5 or more days in the past 30 days.
- *A) True*
- *B) False*

9. All of the following statements regarding the benefits of alcohol are TRUE, EXCEPT:
- *A) Light-to-moderate alcohol intake from beer, wine, or spirits is associated with a reduction in all-cause mortality.*
- *B) Those who abstain from alcohol have a decreased incidence of cardiovascular disease when compared to moderate consumers.*
- *C) Moderate alcohol intake reduces all-cause mortality primarily due to its ability to decrease cardiovascular diseases, especially coronary heart disease.*
- *D) The relationship between alcohol intake and reduced risk of coronary disease is generally accepted as a U-shaped curve of low-dose protective effect and higher doses producing a loss of protective effects and increased all-cause deaths.*

10. Cardiovascular protection associated with moderate drinking occurs primarily through
- A) *vasodilation.*
- B) *accident prevention.*
- C) *blood lipids, such as HDL.*
- D) *Improvements in blood pressure.*

11. Which of the following is most likely to increase the risk of alcohol use disorder?
- A) *A history of alcohol use disorder in the person's spouse*
- B) *A history of alcohol use disorder in the person's brother*
- C) *A history of alcohol use disorder in the person's stepfather*
- D) *A history of alcohol use disorder in the person's biologic father*

12. Genetic factors appear to influence the level of response to alcohol, as measured by the intensity with which one reacts to a given quantity.
- A) *True*
- B) *False*

13. Which of the following is NOT a genetically influenced risk/protective factor for alcohol use disorder?
- A) *Low level of response to alcohol*
- B) *Increased right amygdala volume*
- C) *High levels of impulsivity/sensations seeking/ disinhibition*
- D) *The alcohol metabolizing enzyme aldehyde dehydrogenase*

14. Researchers found that high EEG response to small amounts of alcohol may be associated with future development of alcohol use disorder.
- A) *True*
- B) *False*

15. All of the following conditions increase the risk of developing an alcohol use disorder, EXCEPT:
- A) *Lethargy*
- B) *Schizophrenia*
- C) *Bipolar disorder*
- D) *Antisocial personality disorder*

16. Among adults, heavy alcohol use is almost three times more common among women than men.
- A) *True*
- B) *False*

17. Which of the following is NOT one of the diagnostic criteria for alcohol use disorder in the DSM-5?
- A) *Little time is spent obtaining alcohol*
- B) *Craving, or a strong desire or urge to use alcohol*
- C) *Alcohol often taken in larger amounts or over a longer period than was intended*
- D) *Continued use despite having persistent problems caused or exacerbated by alcohol use*

18. Which symptom(s) have traditionally been the hallmarks of more severe alcohol use?
- A) *Intoxication*
- B) *Hallucinations*
- C) *Legal problems*
- D) *Withdrawal and tolerance*

19. Individuals with alcohol use disorder often experience a severe, potentially fatal withdrawal syndrome when they either abruptly discontinue or sharply reduce their alcohol consumption.
- A) *True*
- B) *False*

20. One does not need to be a daily drinker to meet criteria for alcohol use disorder.
- A) *True*
- B) *False*

21. All of the following are clues to alcohol use disorder, EXCEPT:
- A) *Broken bones*
- B) *Anxiety or panic*
- C) *Elevated LDH values*
- D) *Elevated mood and increased energy*

22. Among chronic heavy drinkers, the most common pre-existing condition in the liver prior to cirrhosis is
- A) *fatty liver.*
- B) *cholelithiasis.*
- C) *viral hepatitis.*
- D) *thrombosis of the portal vein.*

23. Alcoholic hepatitis is a condition that, when severe, is characterized by jaundice, fever, anorexia, and right upper-quadrant pain.
- A) *True*
- B) *False*

Test questions continue on next page ➔

24. Increases in plasma levels of the amino acid homocysteine are
- A) *associated with a risk of cardiac and other vascular diseases.*
- B) *correlated with decreases in the levels of vitamins like folate, B12, and B6.*
- C) *twice as high in patients with chronic alcohol use disorder when compared with non-drinking controls.*
- D) *All of the above*

25. Excessive chronic alcohol use is associated with all of the following, EXCEPT:
- A) *Weight gain*
- B) *Sleep disorders*
- C) *Impaired body utilization of vitamins*
- D) *Low resistance to bacterial infections*

26. Alcohol affects numerous neurotransmitters in the brain. The systems affected that may have a genetic influence on alcohol use disorder include the
- A) *GABA system.*
- B) *serotonin system.*
- C) *dopamine system.*
- D) *All of the above*

27. Which of the following statements regarding women and alcohol consumption is TRUE?
- A) *Women produce a higher level of the enzymes required to break down alcohol.*
- B) *Women show the effects of alcohol less intensely and for shorter periods of time than men.*
- C) *Female hormones make women's bodies more susceptible to alcohol at certain times of the menstrual cycle.*
- D) *Women achieve lower concentrations of alcohol in the blood after drinking the same amounts of alcohol as men.*

28. The death rate among women with alcohol use disorder is 50% to 100% greater than that of men due to their increased risk of all of the following conditions, EXCEPT:
- A) *Suicide*
- B) *Cirrhosis*
- C) *HIV infection*
- D) *Alcohol-related accidents*

29. Excess fetal mortality secondary to drinking is most prevalent
- A) *during the first trimester of pregnancy.*
- B) *during the second trimester of pregnancy.*
- C) *during the third trimester of pregnancy.*
- D) *throughout pregnancy.*

30. The most commonly studied FASD is alcohol-related neurodevelopmental disorder (ARND).
- A) *True*
- B) *False*

31. Many children of alcoholics experience other family members as distant and noncommunicative and may be hampered by their inability to grow in developmentally healthy ways.
- A) *True*
- B) *False*

32. Alcohol may weaken brain mechanisms that normally restrain impulsive behaviors, including inappropriate aggression.
- A) *True*
- B) *False*

33. All of the following are TRUE about alcohol use disorder and depression, EXCEPT:
- A) *Both have the same etiology.*
- B) *If true co-occurring depression is left untreated in recovering alcoholics, relapse is common.*
- C) *As many as 80% of men and women with alcohol use disorder complain of depressive symptoms, and at least one-third meet the criteria for major depressive disorder.*
- D) *Treatment professionals have found that after two or three weeks of abstinence from alcohol, and with good nutrition, the temporary depressive effects of alcohol dissipate.*

34. The medication of choice for the treatment of patients with major depression and alcohol use disorder is usually
- A) *lithium.*
- B) *sertraline.*
- C) *venlafaxine.*
- D) *St. John's wort.*

35. Alcohol consumption causes many of the signs and symptoms of anxiety and can even mimic panic attacks.
A) *True*
B) *False*

36. Neurobiology may make co-ingestion of alcohol and nicotine more rewarding than if either substance is taken alone.
A) *True*
B) *False*

37. The three questions on the Alcohol Use Disorders Identification Test-Concise (AUDIT-C) inquire about frequency of alcohol use, typical amount of alcohol use, and occasions of heavy use.
A) *True*
B) *False*

38. Certain questions are useful in screening to determine presence of alcohol use disorder. One such set of questions is known as the CAGE questionnaire. The CAGE acronym stands for
A) *Confusion, Agitation, S3 Gallop, Edema.*
B) *Cut down, Annoyed, Guilty, Eye-opener.*
C) *Chloral hydrate, Alcohol, Glutethimide, Ethchlorvynol.*
D) *un-Controllable urge to drink, un-Able to limit intake, un-Grateful for help to stop drinking, un-Excited about treatment.*

39. Laboratory tests that can be used to identify chronic alcohol intake include
A) *red blood cell index.*
B) *alanine aminotransferase (ALT).*
C) *aspartate aminotransferase (AST).*
D) *All of the above*

40. All of the following are common elements of brief intervention, EXCEPT:
A) *Advice to change*
B) *Feedback of personal risk*
C) *Responsibility of the patient*
D) *Confrontational counseling style*

41. Motivational interviewing therapists emphasize personal responsibility and support their patients' feelings of self-efficacy for making a change in their drinking.
A) *True*
B) *False*

42. Twelve-step programs are useful in which of the following phases of alcohol abuse treatment?
A) *Pretreatment*
B) *Phase 1*
C) *Phase 2*
D) *None of the above*

43. Which of the following is NOT true about alcohol withdrawal symptoms?
A) *Once these symptoms are treated, relapse is unlikely.*
B) *Pharmacologic management of acute alcohol withdrawal generally involves the use of benzodiazepines.*
C) *Symptoms include sweating, rapid heartbeat, hypertension, tremors, anorexia, insomnia, agitation, anxiety, nausea, and vomiting.*
D) *As many as 15% of individuals with alcohol use disorder progress from the autonomic hyperactivity and agitation common to withdrawal from other drugs to seizures and, for some, even death.*

44. Research has shown that the longer people stay in treatment, remain sober, and are actively committed to sobriety, the more likely it is that they will maintain sobriety.
A) *True*
B) *False*

45. A person could be said to enter the maintenance and growth stage of alcohol use disorder treatment when he or she is comfortable with relapse-prevention skills and has had a chance to rely on them to stay sober.
A) *True*
B) *False*

Test questions continue on next page ➔

46. All of the following statements about Alcoholics Anonymous are generally true, EXCEPT:
A) *There are no dues.*
B) *Anyone can become a member.*
C) *Belief in God is a prerequisite to join.*
D) *Research has shown this approach to be effective.*

47. Cognitive-behavioral therapies (CBTs)
A) *can be summarized as "recognize, avoid, and cope."*
B) *are organized around a functional analysis of substance use.*
C) *are based on social learning and behavioral theories of drug abuse.*
D) *All of the above*

48. Which of the following is a basic principle of cognitive-behavioral therapy?
A) *Practice is needed for mastery of skills.*
B) *Basic skills should be mastered before more complex ones are given.*
C) *Material presented by the therapist should be matched to patient needs.*
D) *All of the above*

49. In behavioral therapy, substance use is believed to develop from changes in behavior and a reduction in opportunities for reinforcement of positive experience.
A) *True*
B) *False*

50. Research provides examples, but treatment providers may need to be creative in discovering reinforcers for patients with alcohol use disorder that can be used for contingency management in their own clinical settings.
A) *True*
B) *False*

51. Family therapy is not an effective treatment for alcohol use disorder, especially in adolescents.
A) *True*
B) *False*

52. Research has shown that medications for alcohol use disorder are most effective when used in as monotherapy.
A) *True*
B) *False*

53. Naltrexone has been shown to reduce alcohol relapses, decrease the likelihood that a slip becomes a relapse, and decrease the total amount of drinking.
A) *True*
B) *False*

54. Which of the following is a common side effect associated with naltrexone?
A) *Dizziness*
B) *Weight gain*
C) *Difficulty breathing*
D) *Decreased interest in sex*

55. Coerced or court-mandated treatment for alcohol use disorder is never effective.
A) *True*
B) *False*

Be sure to transfer your answers to the Answer Sheet located between pages 104–105.
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.

Demystifying Dissociation: Principles, Best Practices, and Clinical Approaches

Approval(s): APA, NBCC, NAADAC

Audience
This course is designed for psychotherapists, counselors, social workers, and other helping professionals practicing in a variety of modalities and from a variety of traditions.

Course Objective
The purpose of this course is to equip clinicians with the knowledge and skills that they need to better understand dissociation and its connection to trauma.

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

1. Define dissociation in a trauma-focused manner.
2. Describe the impact and manifestations of trauma and dissociation on the brain.
3. Identify common myths about working with dissociative clients in psychotherapy, including historical roots.
4. Outline diagnostic criteria for dissociative disorders.
5. Describe the Dissociative Profile exercise.
6. Describe the screening tools and inventories available for use in clinical settings regarding dissociation.
7. Apply personal metaphor and parts work in the care of clients with dissociation.
8. Outline the similarities between addiction and dissociation and how they can be framed.
9. Discuss key components of successful treatment planning for clients with dissociation.
10. Implement approaches for early and later phases of dissociative disorder treatment.

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

Faculty Disclosure
Contributing faculty, Jamie Marich, PhD, LPCC-S, LICDC-CS, REAT, RYT-200, RMT, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planner
Alice Yick Flanagan, PhD, MSW

Division Planner Disclosure
The division planner has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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American Psychological Association
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NetCE has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6361. Programs that do not qualify for NBCC credit are clearly identified. NetCE is solely responsible for all aspects of the programs.

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

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

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Designations of Credit

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NetCE designates this continuing education activity for 3 NBCC clock hours.

Social Workers participating in this intermediate to advanced course will receive 10 Clinical continuing education clock hours.

NetCE designates this continuing education activity for 10 continuing education hours for addiction professionals.

Individual State Behavioral Health Approvals

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INTRODUCTION

Dissociation is great puzzlement to many clinical professionals, and often it is through no fault of their own. Many graduate training programs skim over the dissociation part of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and teach that dissociative identify disorder (DID) is extremely rare. Likewise, very little may be included on trauma as well, so the potential association with dissociation is often left unexplored.

Since 2000, there has been more interest and a greater respect for trauma and what is called trauma-informed and trauma-focused care in the clinical professions. The term trauma comes from the Greek word meaning wound, and in its most general sense, it can be defined as any unhealed wound of a physical, emotional, psychological, sexual, or spiritual nature. Like physical wounds, other types of trauma can be experienced in various degrees and levels of intensity. If left unhealed or unprocessed, problems can result that impair an individual's lifestyle or way of being in the world. The most common trauma-related diagnosis is post-traumatic stress disorder (PTSD), although other clinical diagnoses (e.g., adjustment disorders, reactive attachment disorder, personality disorders) can also have their root in unhealed trauma. As trauma awareness and understanding increases, the field is also realizing that many other diagnoses can have a root in unhealed trauma or their severity can be exacerbated by unhealed trauma.

Some have hypothesized that wherever there is trauma, some aspect of dissociation exists, reflected in the idiom: "If trauma is walking in the door, dissociation is at least waiting in the parking lot." If systems of care are truly going to be trauma-informed (i.e., understanding how unhealed trauma affects the brain and manifests in human distress and behavior), they should also work toward being more dissociation-informed. The hope is that all systems of human services can at least be trauma-informed, yet many clinicians are also in a position to be trauma-focused in their care. Trauma-focused care recognizes the role that unhealed trauma plays in human pathology, and trauma-focused clinicians develop treatment plans using the modalities in which they are trained to actively target sources of trauma and work to bring about resolution [1]. To deliver trauma-focused care, competency in working with dissociation is imperative.

The aim of this course is to equip clinicians with the knowledge and skills that they need to better understand dissociation and its connection to trauma. These knowledge and skills will allow clinicians to be more trauma-informed and trauma-focused in their approach to clinical work. There can be frustration that comes with addressing dissociation, which often originates from myths and misinformation in the field—and teachings on dissociation from some sources that can be too technical.

This phenomenological approach will hopefully empower clinicians to more effectively address dissociation and its various manifestations in clinical practice. Having a sense of dissociation's inherent normalcy in the human experience is a critical aspect of demystifying dissociation. The more one is willing to be introspective throughout this course, as opposed to just reading through the content, the more that can be gained from the course. A series of guided exercises are designed to assist in this process.

***Author's Note**: The voice with which I am guiding you in this course is one of a trauma and dissociation specialist, trainer, and author. I am also a woman in long-term recovery from a dissociative disorder. I was diagnosed in graduate school when I struggled with internship due to my own unhealed trauma. I endeavor to use my lived experience in concert with modern scholarship about dissociation. Personal stories and experiences will be included throughout the text in italics.*

FUNDAMENTALS OF DISSOCIATION

DEFINITIONS AND ORIGINS

The word dissociation is derived from a Latin root word meaning to sever or to separate. In clinical understanding, dissociation is the inherent human tendency to separate oneself from the present moment when it becomes unpleasant or overwhelming. Dissociation can also refer to severed or separated aspects of self. In common clinical parlance, these separations may be referred to as "parts." Older terminology (e.g., "alters," "introjects") may still be used, although parts is generally seen as more normalizing and less shaming as a clinical conceptualization strategy. Just like all humans dissociate, all humans have different parts or aspects of themselves. In cases of clinically significant dissociation, the separation of parts is typically more pronounced.

The fact that dissociation encapsulates two meanings—the separation from the present moment that can manifest in a variety of ways and the separation from aspects of self—can make learning about and understanding it rather confusing. Consider, however, that the general purposes of dissociation are the same in both constructs: to protect oneself and to get one's needs met. Even the most innocuous example of a person "zoning out" or daydreaming can be seen through this lens. Individuals can go away in their minds to protect themselves from the distress of the present moment, whether that distress shows up as boredom, pain, or overwhelm. Parts, or aspects of self, will either develop over time or fail to integrate with the total self (depending on defining theory) to protect the self or to get needs met, typically needs that primary caregivers are not providing. Underlying theories of dissociation will be discussed in detail later in this course.

One of the leading psychiatric scholars in the treatment of dissociation is Dr. Elizabeth Howell. In her book *The Dissociative Mind*, she contends [2]:

> Chronic trauma...that occurs early in life has profound effects on personality development and can lead to the development of dissociative identity disorder (DID), other dissociative disorders, personality disorders, psychotic thinking, and a host of symptoms such as anxiety, depression, eating disorders, and substance abuse. In my view, DID is simply an extreme version of the dissociative structure of the psyche that characterizes us all. Dissociation, in a general sense, refers to the rigid separation of parts of experience, including somatic experience, consciousness, affects, perception, identity, and memory.

This contention has inspired scores of clinicians. The key to better understanding dissociation truly rests in normalizing it [2; 3].

When contemplating dissociation in a general sense, common expressions that come to mind include daydreaming, "zoning out," inability to make appropriate eye contact, escaping to imaginal or fantastical landscapes in the mind, or losing emotional connection to a story being told. Some people will start to yawn, fall asleep, or lose appropriate volume in their voice when distressed. It is very likely that most (if not all) people have done one or more of these things in their lives and may even do them on a regular basis, with or without a clinically significant dissociative diagnosis. Modern-day examples of dissociation include watching too much television, playing on the smartphone, or mind numbingly scrolling through social media. These activities are not dissociative in and of themselves but can be used in a dissociative manner. Even activities used in therapy for emotion regulation, including guided visualizations, can be dissociative because they remove the practitioner from their present surroundings and experiences. While the intention may be solid and indeed very helpful to many people, consider how a person could continue to use such an exercise as an escape instead of as a healthy coping strategy.

In normalizing dissociation, it is useful to look at the construct of adaptive and maladaptive in describing dissociative phenomenon. These distinctions of adaptive and maladaptive are essential to eye movement desensitization and reprocessing (EMDR) therapy [4]. As constructs, they are similar to the descriptors healthy and unhealthy but with much less of a value judgment. Furthermore, what is adaptive to one person may not be adaptive to another person. What was adaptive at one point in one's life may not be adaptive at other points in his or her life. Consider this example as it relates to dissociation: For a young child growing up in a dysfunctional home, daydreaming was adaptive because it helped him/her survive the perils of this upbringing. However, as an adult, chronic daydreaming can impede one's ability to work and support oneself, keeping one removed from certain realities that need to be faced.

Another example of commonplace dissociation is binge watching television. This practice could be dissociative in a maladaptive sense, but it could also be a needed avenue for self-care that helps a person disconnect from the rigors of work life and day-to-day responsibilities, depending on the relationship and intention with the activity. Clinicians can assist clients in making this distinction only after considering how these patterns show up in their own lives. For example, a clinician may regularly binge watch television and feel like it is a healthy outlet for rest. When the clinician is dealing with intensity in their feelings and life, it is important that they take a break. One could argue that it would be more dissociative, as an avenue to escape feelings, if the clinician dove into doing more work to keep from being present. Work can be tricky for individuals to evaluate, because while it is often an inherently positive activity, it can be taken to a maladaptively dissociative place. A later section of this course will more fully examine the intricate relationship between dissociation and addiction, but briefly, addictive behaviors generally begin as dissociative coping, usually in response to trauma or to distress.

In normalizing dissociation, it is also imperative to examine the notion of parts or aspects of self. Again, this will be more fully explored later in this course, but before starting this activity, take a moment to examine whether or not you relate to having different parts, sides, or aspects of yourself. Many use the common terminology of "inner child," vis-à-vis the more rational, presenting adult. If you have ever used this language, you are already recognizing the construct of parts. Some people, especially those who struggle with addiction, may reference having a "Dr. Jekyll and Mr. Hyde" phenomenon happening within them. Some people will even say that their sadness, anger, or other emotional experience can take on a life of their own, which can also speak to the separation of parts, or that they feel "cut off" from their bodies due to an injury, illness, or other distress. As illustrated in the passage from Dr. Howell, diagnoses like DID or other dissociative disorders refer to a more rigid separation of this very natural part of the human condition [2].

TRAUMA, DISSOCIATION, AND THE BRAIN

There have been many advances in better understanding trauma and dissociation through a neurobiologic lens. While this section will conclude with some of that research, it is important to obtain a basic understanding of the human brain and how unhealed trauma can impact its functioning. The simplest explanatory model that seems to work the best for clinicians to gain this understanding is the triune model of the human brain, originally developed by psychiatrist Paul MacLean [5]. Many modern scholars (e.g., Bessel van der Kolk, Daniel Siegel) continue to use it as a base of explanation.

The triune brain model espouses that the human brain operates as three separate brains, each with its own special roles—which include respective senses of time, space, and memory [5]:

- The R-complex or reptilian brain: Includes the brainstem and cerebellum. Controls instinctual survival behaviors, muscle control, balance, breathing, and heartbeat. Most associated with the freeze response and dissociative experiences. The reptilian brain is very reactive to direct stimuli.
- The limbic brain (mammalian brain or heart brain): Includes the amygdala, hypothalamus, hippocampus, and nucleus accumbens (responsible for dopamine release). The limbic system is the source of emotions and instincts within the brain and responsible for fight-or-flight responses. According to MacLean, everything in the limbic system is either agreeable (pleasure) or disagreeable (pain). Survival is based on the avoidance of pain and the recurrence of pleasure.
- The neocortex (or cerebral cortex): Contains the frontal lobe. Unique to primates and some other highly evolved species like dolphins and orcas. This region of the brain regulates our executive functioning, which can include higher-order thinking skills, reason, speech, and sapience (e.g., wisdom, calling upon experience). The limbic system must interact with the neocortex in order to process emotions.

Many strategies in the psychotherapeutic professions work primarily with the neocortex. For a person with unprocessed or unhealed trauma symptoms, the three brains are not optimally communicating with each other when the limbic system gets triggered or activated [6]. During periods of intense emotional disturbance, distress, or crisis, a person cannot optimally access the functions of the neocortex because the limbic, or emotional brain, is in control. In essence, a dissociative phenomenon occurs. Blood flow slows to the left prefrontal cortex when the limbic system is triggered to some degree. Thus, a person may be aware of what is happening around them, and yet that disruption or dissociation from the brain's innate totality impedes a person's capacity to process or make sense of it.

Consider these examples that may be familiar to your clinical practice: Have you ever tried to reason with someone in crisis? Have you ever asked someone who has relapsed on a drug or problematic behavior, "What were you thinking?" Have you ever tried to be logical with someone who is newly in love or lust? Attempting any of this is like trying to send an e-mail without an Internet signal. You may have awesome wisdom and cognitive strategies to impart and you can keep clicking send, but the message is not ever going to get through. Moreover, because the activated person has awareness, they may grow increasingly annoyed by persistence, which can activate the limbic responses even further.

Triggers are limbic-level activities that cannot be easily addressed using neocortical interventions alone. If a stimulus triggers a person into reaction at the limbic level, one of the quickest ways to alleviate that pain/negative reaction is to feed the pleasure potential in the limbic system. As many traumatized individuals discover, alcohol use, drug use, food, sex, or other reinforcing activities are particularly effective at killing/numbing the pain. For children growing up in the high distress of a traumatic home, dissociation can become the brain's natural and preferred way to escape the pain. Cultural commentators and scholars have referred to dissociation as a "gift" to the traumatized child for this reason [7].

Dissociation, trauma-related disorders, and addiction are inter-related because dissociation is a defense that the human brain can call upon to handle intense disturbance. People dissociate in order to escape—to sever ties with a present moment that is subjectively unpleasant or overwhelming, stemming from unhealed trauma and its impact. In referencing the triune brain model, dissociative responses—often conceptualized as similar to freeze responses—are even deeper than the limbic brain, taking place in the R-complex or brainstem [8]. This is a testament to their primary, protective quality.

Precise neurobiologic explanations of dissociative phenomenon are still being investigated, and understanding remains incomplete. In their comprehensive review, Krause-Utz, Frost, Winter, and Elzinga summarize that there is a suggested link between dissociative symptoms and alterations in brain activity associated with "emotion processing and memory (amygdala, hippocampus, parahippocampal gyrus, and middle/superior temporal gyrus), attention and interoceptive awareness (insula), filtering of sensory input (thalamus), self-referential processes (posterior cingulate cortex, precuneus, and medial prefrontal cortex), cognitive control, and arousal modulation (inferior frontal gyrus, anterior cingulate cortex, and lateral prefrontal cortices)" [9]. Electrical neuroimaging studies show a correlation between the temporoparietal junction—an area involved in sense of self, agency, perspective taking, and multimodal integration of somatosensory information—and dissociative symptoms, and specific forms of dissociation are connected with brain areas in question [10].

While the neurobiologic implications of dissociation are discussed in detail later in the course, this section has endeavored to give enough base knowledge to understand that trauma and dissociation are inter-related. Basically, dissociation can be described as an inherent mechanism of the human brain that can be called upon to manage distress. The higher the degree and the more intense the trauma, the greater the likelihood that some aspects of dissociation, whether clinically significant or not, can manifest.

DEBUNKING MYTHS ABOUT DISSOCIATION

Dissociative identity disorder or DID, formerly referred to as multiple personality disorder, can make for fascinating plot points and opportunities for characterization in the media. Unfortunately, these media portrayals have fed perpetuated myths and misconceptions about dissociative disorders that persist in the general public and in mental health professions. In many cases, the media only showcases the most extreme or sensationalized cases of DID [11]. Many clinicians do not realize that their clients are experiencing distress that can be described through the lens of a dissociative disorder because their clients are not presenting with symptoms that look as extreme or severe as the largely fictionalized *Sybil* or the highly sensationalized portrayal in the 2016 film *Split*. If clinicians are only using these media portrayals as their point of reference, they may be unnecessarily frightened to treat their dissociative clients, fearing violence, self-injury, or other expressions they may not feel prepared to handle.

Many individuals who dissociate express trepidation about making their condition known to the general public; this can even include fear about coming out to one's partner or one's therapist in fear of judgment.

For example, I, a mental health professional active in addiction and trauma care, found "coming out" fully as a person with a dissociative disorder was much scarier than being out as someone in recovery from addiction or being out as a bisexual woman. There was a great fear that I would no longer be taken seriously, especially among professional colleagues, if I was public and open about my experiences.

In 2010, Jaime Pollack started the Healing Together Conference with the goal of providing survivors of complex trauma who identify as having a dissociative disorder a place where they could feel safe enough to share freely. Pollack and others did not feel welcome to share from personal experience as non-clinicians at professional conferences that address trauma and dissociation. Even professional clinicians have experienced a similar sense of disregard for the lived experience. Spaces like Healing Together give people with dissociative disorders from a variety of professional backgrounds a chance to be open and share freely, something that can be a rarity in this world.

There are a variety of myths and misconceptions regularly encountered from clinical professionals and from colleagues who also work as trauma trainers. The most common are the usual fears about people with dissociation acting out and causing harm to self or to others, although clinical experience and evidence suggests that there is no more risk of these behaviors than with other diagnoses [12]. The next set of myths revolves around treatment. There can be a sense that people with clinically significant dissociation, especially DID, do not respond well to treatment and cannot live full and functional lives. In many cases, professionals who hold such myths generally do not have enough grounding in trauma-informed or trauma-focused care to realize the connection between unhealed trauma and the successful treatment of maladaptive dissociation. The other major treatment myth is that for successful treatment of DID or another dissociative disorder to occur, there must be an integration of the various alters or parts into one presenting person. While this is discussed further in the section on treatment, for the time being, please know that many exist functionally and adaptively with the help of their system, and integration in the simplistic sense is never achieved—nor does it need to be.

Many individuals with DID or other dissociative disorders do not shun the word integration, but instead view integration as a healthy sense of cohesion or communication between the system. The term working wholeness may be preferred. However, when working with a client with dissociation, integration can be quite a triggering word, because previous providers may have used the term incorrectly or abusively, making them believe that they must integrate if they want to live a normal life. This can cause upheaval in the system, especially if more vulnerable parts believe they are going to be forced out. Consider this metaphorical comparison: For many years the United States was referred to a "melting pot" of sorts, suggesting the people from various backgrounds came together and blended. This metaphor has garnered criticism because a melting pot suggests that various peoples come together, melt down, and then a single, ideal alloy of an "American" emerges. While some people would like this to be so, it is neither culturally inclusive nor sensitive. An alternate metaphor refers to the United States as a salad or a bowl of stew, indicating that each ingredient brings their own unique flavor while contributing to the whole. This metaphor is also workable when referencing dissociative systems.

Many individuals with clinically significant dissociative disorders do not reach the "integration" debate stage of treatment with their providers because many mental health providers are not willing to take on their cases. Screening out for dissociation and making referrals is very common, leaving many with a message that they are "too much to handle." Often, individuals with dissociative disorders can be prematurely admitted into psychiatric facilities at the mention of self-harm or blanking out time. While clinical professionals should not go against their ethical training if there is a viable intent or a plan articulated for injury to self or others, bear in mind that suicidal ideation and self-harm can be a very normal complex trauma response and part of one's dissociative profile. In some cases, having these feelings normalized and a viable plan for addressing them developed is insufficient. Yet, many individuals who struggle with dissociative issues will not articulate struggles to their providers out of fear of being committed to an institution, which can be an unsafe place for someone with a dissociative disorder. Perhaps the biggest misconception in the mental health field is that dissociation is not real, does not exist, or, if it does, is extremely rare. Not only is this an invalidating experience for individuals, they can end up receiving a host of other diagnoses that result in excessive or improper pharmacotherapy. To understand more

about the invalidation factor, please read on to the next section, which discusses historical perspectives on dissociation, how to treat it, and how to diagnose it.

HISTORICAL PERSPECTIVES ON DISSOCIATION

The issue of dissociation and how to diagnose it has been historically shrouded in controversy in the psychological and helping professions, largely because trauma can make people uneasy. Giving people, especially children, trauma-related diagnoses can be an uncomfortable matter. When a child gets a diagnosis like attention deficit and hyperactivity disorder (ADHD) or bipolar disorder, the implication and suggestion of the medical model is that something is impaired with their brain. Medications, although often prescribed in concert with some kind of behavioral therapy, are typically emphasized as the solution. However, when a child receives a trauma-related diagnosis, generally someone is responsible—a parent or guardian who exposed them to harm, the school system, or even society at large. This meanders into uncomfortable territory for many people. Further, most medications used in the treatment of dissociative disorders focus on comorbid symptoms (e.g., depression, anxiety); psychotherapy remains the cornerstone of treatment.

Although clinically significant dissociation can develop in adulthood as a response to trauma or other distress, its etiology is usually traced to significant, complex trauma in early childhood. Often, this trauma is of a developmental nature, meaning that it happened when a child was still vulnerable and often involved betrayal by someone they loved or trusted. Useful distinctions between trauma as an incident or event (typically associated with the PTSD diagnosis as presented by the DSM) and complex or development trauma is that complex trauma experiences [13]:

- Are repetitive or prolonged
- Involve direct harm and/or neglect or abandonment by caregivers or ostensibly responsible adults
- Occur at developmentally vulnerable times in the victim's life, such as early childhood
- Have great potential to severely compromise a child's development

Initially, even Freud seemed to be convinced of trauma's impact in his early investigation of dissociative phenomenon. As is well-established in the history of psychology, widespread pressure from his influential colleagues resulted in Freud backing down from this hypothesis and instead focusing more on repression and subconscious desires as etiology for mental and emotional disorders. The gendered label of hysteria was put into wide use, a construct that modern trauma scholars now view as a manifestation of complex trauma and dissociation [14]. Much of the early thinking in the field, especially from Pierre Janet, suggested that there is an element of dissociative phenomenon in all mental and emotional disorders, even conceptualizing what would come to be known as schizophrenia through this lens [12]. Other French colleagues of his era proposed similarly.

The dissociative disorders formally debuted in the DSM-III in 1980. The PTSD diagnosis also appeared in that edition as an anxiety disorder, but dissociative disorders were presented as a separate category. Although new to DSM-III, their discussion and inclusion were not new to the field [15]. With every iteration of the DSM since then, up to the current DSM-5, there has been intense debate and scrutiny over the dissociative disorders as being worthy of inclusion. In reality, many leaders of the field, especially those on DSM work groups, openly doubt their existence [16]. The purpose of this course is not to engage in this debate—clearly the position of this course is that dissociative disorders do exist and are potentially more widely prevalent than once thought and reported. However, major medical and psychological groups continue to report that dissociative disorders are extremely rare. This approach to dissociative disorders and resistance to their existence is borne from the same discomfort about trauma and responsibility that Freud encountered in the early days of his work. Although the general phenomenon of dissociation can show up in a wide array of clinical diagnoses, it has been established that unhealed trauma is a major etiologic factor in the development of clinically significant dissociative disorders [17].

Clinicians interested in reading more about the history and debate around dissociation, trauma, and memory are directed to Anna Holtzman's article exploring the "memory wars" in the field of psychology, written in the wake of the Harvey Weinstein trials (***Resources***). The memory wars refer to decades of debate in the field about the trustworthiness of memory, particularly as it relates to accusations of abuse by survivors of trauma. She discusses the history of the False Memory Syndrome Foundation, founded by the parents of Dr. Jennifer Freyd (a former president of the International Society for the Study of Trauma and Dissociation [ISSTD]). Dr. Freyd accused her parents of abuse and their response was to establish an organization to discredit survivors of abuse.

As long as unhealed trauma continues and people are threatened by its impact or made to feel responsible for it, there is a likelihood that such debate, even in scholarly settings, will continue. The general state of the evidence suggests that not only are dissociative disorders real, the prevalence is higher than previously thought [18].

While the ISSTD and mainstream advocates in the field of dissociation have promoted research and scholarship to prove that dissociation exists, there is a concern by advocates that such a focus may measure the experiences of survivors without adequately including their voices into the advocacy. In the spirit of both/and, this course acknowledges that while scholarship and research are always critical to validate constructs in the mainstream, clinicians can get overwhelmed

by trying to study dissociation in this manner. Normalizing dissociation as a human phenomenon and describing how trauma and distress can impact its manifestations should also be a part of the discussion moving forward.

DIAGNOSTIC PERSPECTIVES ON DISSOCIATION

Because dissociation can be explained as a coping device that crosses the line to being a maladaptive symptom for some individuals, it can be contended that trauma-associated dissociation manifests in a variety of clinical diagnoses. In this section, the primary diagnoses categorized in the Dissociative Disorders chapter of the DSM-5 are presented [19]. However, remember that these are not the only places where dissociation may show up diagnostically. Substance use and other disorders, for instance, have a strong dissociative component, and these will be handled separately in another section. There is also a great deal of confusion about where the line exists between distraction (that might be more commonly associated with diagnoses like ADHD, but can also appear in clients with PTSD) and dissociation. Moreover, in the most recent updates to the DSM, there is a new subtype of PTSD that specifically addresses dissociation, which will be included in this section.

For an individual to meet any of the diagnostic criteria that follow, dissociation must not be better explained by a phenomenon like intoxication. Thus, it becomes imperative for clinicians to understand the intricacies of how trauma and dissociation manifest, because many different diagnoses may be on the proverbial table for consideration.

The following sections have been reprinted with permission from The Infinite Mind [20]. These summaries are clinically sound (reflecting what appears in the DSM-5) while also being written in a language that the general public will likely find friendly.

DISSOCIATIVE IDENTITY DISORDER (DID)

DID, formerly called multiple personality disorder, develops as a childhood coping mechanism. To escape pain and trauma in childhood, the mind splits off feelings, personality traits, characteristics, and memories into separate compartments which then develop into unique personality states. Each identity can have its own name and personal history. These personality states recurrently take control of the individual's behavior, accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness. DID is a spectrum disorder with varying degrees of severity. In some cases, certain parts of a person's personalities are aware of important personal information, whereas other personalities are unaware. Some personalities appear to know and interact with one another in an elaborate inner world. In other cases, a person with DID may be completely aware of all the parts of their internal system. Because the personalities often interact with each other, people with DID report hearing inner dialogue. The voices may comment on their behavior or talk directly to them. It is important to note the voices are heard on the inside versus the outside, as this is one of the main distinguishers from schizophrenia. People with DID will often lose track of time and have amnesia to life events. They may not be able to recall things they have done or account for changes in their behavior. Some may lose track of hours, while some lose track of days. They have feelings of detachment from one's self and feelings that one's surroundings are unreal. While most people cannot recall much about the first 3 to 5 years of life, people with dissociative identity disorder may have considerable amnesia for the period between 6 and 11 years of age as well. Often, people with DID will refer to themselves in the plural [20].

DISSOCIATIVE AMNESIA

The most common of all dissociative disorders and usually seen in conjunction with other mental disorders, dissociative amnesia occurs when a person blocks out information, usually associated with a stressful or traumatic event, leaving him or her unable to remember important personal information. The degree of memory loss goes beyond normal forgetfulness and includes gaps in memory for long periods of time or of memories involving the traumatic event [20].

DEPERSONALIZATION DISORDER

Having depersonalization has been described as being numb or in a dream or feeling as if you are watching yourself from outside your body. There is a sense of being disconnected or detached from one's body. This often occurs after a person experiences life-threatening danger, such as an accident, assault, or serious illness or injury. Symptoms may be temporary or persist or recur for many years. People with the disorder often have a great deal of difficulty describing their symptoms and may fear or believe that they are going crazy [20].

UNSPECIFIED DISSOCIATIVE DISORDER

Symptoms of unspecified dissociative disorder do not meet the full criteria for any other dissociative disorder. The diagnosing clinician chooses not to specify the reason that the criteria are not met [20].

OTHER SPECIFIED DISSOCIATIVE DISORDER (OSDD)

The other specified dissociative disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific dissociative disorder [20].

TRAUMA- AND STRESSOR-RELATED DISORDERS

Many experts have expressed confusion that dissociative disorders were separately categorized instead of being included in the DSM-5 chapter grouping trauma- and stressor-related disorders. This may reflect some of the controversy and misunderstanding about dissociative disorders, or a lack of cohesion among the work groups that determine the categories in the DSM.

The chapter of trauma- and stressor-related disorders (which includes PTSD, acute stress disorder, adjustment disorders, reactive attachment disorder, and disinhibited social engagement) does make mention of dissociative symptomology as a potential feature of PTSD. In the DSM-5 version of the PTSD diagnosis, there is a qualifier option of PTSD with predominant dissociative symptoms. Dissociation can play out in all five symptom areas of the PTSD diagnosis, with flashbacks (under Criterion B, intrusion) specifically being described as a dissociative phenomenon. In DSM-5, depersonalization is defined as "persistent or recurrent experiences of feeling detached from, as if one were an outside observer of, one's mental process or body" (potentially an avoidance or negative mood/cognition manifestation) [19]. Derealization is defined as "persistent or recurrent experiences of unreality of surroundings" (potentially a part of the PTSD symptoms of intrusion, avoidance, or negative mood/cognitions) [19]. Although depersonalization and derealization still appear as their own diagnoses in the dissociative disorders category, those diagnoses should be ruled out if PTSD is the better explanation.

This is a gray area to navigate diagnostically, particularly because people struggling with clinically significant dissociative disorders likely meet the criteria for PTSD. With PTSD long being conceptualized as a more event-centric diagnosis that does not accurately encapsulate the depth of complex trauma, this qualifier may be more appropriate for adults who experience a traumatic event not connected to childhood or developmental trauma and develop these dissociative tendencies as a result.

THE DISSOCIATIVE PROFILE EXERCISE

The Dissociative Profile is a process used to evaluate and become aware of one's own tendencies to dissociate, both adaptively and maladaptively, and identify best strategies for directing one's knowing awareness back to the here and now. Therapists and helping professionals should first know their own dissociative profile and by doing this, will help clients to investigate their own [21]. This exercise is not only valuable as an exploratory device—the knowledge gleaned from it can become a valuable part of treatment planning, especially in managing distress that may rise between sessions. This approach is presented prior to discussion of formal psychometric measures with the intent that a general understanding and ability to identify association will help you truly understand these psychometrics and how to use them.

Before engaging in this exercise, please remember that every human dissociates; it is natural and normal. This is not intended to be an exercise in shaming; rather, it should focus on self-inquiry. To engage in the Dissociative Profile exercise, take the following steps, using the sample Dissociative Profile (***Table 1***) as a guide as needed.

Take out paper or open up a word processing program on your computer. Make two columns. Title the left-hand column "My Dissociative Tendencies," and title the right-hand column, "Strategies for Returning to the Present Moment."

Take as much time as you need to make a list of the ways in which you tend to dissociate—this can be general patterns like "zoning out or daydreaming when I'm bored," or "spending time on Facebook wondering what everyone else is doing." You can take this inventory a step farther by noting if these strategies or behaviors are adaptive, maladaptive, or both (depending on context). Also note, perhaps, how often you engage in these dissociative strategies and if you have knowing awareness about what triggers them (e.g., boredom, emotional pain, overwhelm, conversations with certain people).

After the left column feels complete, go to the right column and beside each item on the left, make some notes about what helps you return to the present moment when you need to. This can be more intrinsic skills (e.g., my mindfulness practice, especially grounding with solid objects), or more externally motivating factors (e.g., hearing my child call out that they need me). Remember that this is not an interrogation; it is simply a true assessment of where you stand. You are also free to be honest and note that you are not sure yet how to draw yourself back to present moment awareness when you get stuck in certain patters.

After finishing your own dissociative profile, take a moment to notice whatever you notice. Is there anything that surprises you? Is there anything you ought to consider sharing with your own therapist, friend, partner, or members of your support system? How can you use what you discover here to assist you in your own personal development and goals or intentions for healing, whatever those may be?

If you are guiding a client through this exercise, be open to debriefing their discoveries with them and developing a plan of action. This can form a solid base for engaging in treatment planning. Moreover, many trauma-focused approaches to therapy stress the importance of having a skills-and-strategies plan for between sessions so the client stays as safe as possible, especially if distress arises in between sessions. Engaging in the Dissociative Profile exercise gives you and your client a general sense of where they stand in terms of existing adaptive skills, and what they need to build for more adaptive engagement with the present moment.

SAMPLE DISSOCIATIVE PROFILE EXERCISE	
My Dissociative Tendencies	**What Helps Me Return to Present Moment**
Daydreaming when I'm bored. This was adaptive when I was a kid; it's how I survived my parents' fighting. Somewhat of a problem/maladaptive now, as it can keep me from paying attention at work or with the kids.	Telling myself to "snap out of it" helps sometimes. This is something I'd like to work on though, because it can be hard to get out of the dream world.
Playing too much Candy Crush on the phone. Boredom also seems to trigger this. Doesn't seem to be a problem at the level of addiction or anything; I just know I do it.	Sometimes my eyes get too strained or tired, and that helps me put it down. When I know I have something more exciting/stimulating to work on, I stop. This can include having a conversation with people I enjoy.
Saying "it's no big deal" to my own therapist whenever I get too emotional. It's clear that this protected me at home growing up (adaptive), but I know it gets in the way of me doing deeper work	Having my therapist, who I fundamentally trust, gently call me out on it seems to help. When she can guide me through one of her mindfulness exercises encouraging me to notice my body and sit with whatever is coming up, I make steps in the right direction.
Problems paying attention when I drive (only sometimes). I'm not sure if this is dissociation or just general distraction. Either way, it does seem to happen when I'm overwhelmed.	Playing music I like in the car helps. I haven't yet taken my therapist's suggestion of taking a few deep breaths before I start driving regardless of how I'm feeling; perhaps I should try that.
Source: Author	*Table 1*

FOUNDATIONS OF WORKING WITH CLINICALLY SIGNIFICANT DISSOCIATION

The introduction and first section of this course are designed to provide a foundation to understand the phenomenon of dissociation and how it manifests in the human experience. With this foundation in place, this section seeks to take you deeper into some of the tools, models, and strategies that may be useful in clinical settings to optimally work with dissociation. These may also help to inform treatment planning, which is covered in a later section of the course.

WORKING WITH PSYCHOMETRICS

There are a variety of psychometrics and clinical interview guides available for clinicians to help in their identification of dissociation. It is important to keep in mind, as a trauma-focused clinician, many of these devices may be too interrogatory, Use good clinical judgment about whether some of these scales or measures are a good fit for your practice and your clients. They have all played a role in research and helping to validate the existence of dissociative disorders. However, taking a test for a psychometric evaluation can be triggering in its own right and can lead to a sense of confusion in a person's system if they are not properly guided.

According to the International Society for the Study of Trauma and Dissociation, some measures commonly used in psychological testing can provide understanding of the patient's personality structure and may yield information useful in making the differential diagnosis between disorders often confused with DID, such as borderline personality disorder and psychotic disorders.

(https://www.isst-d.org/wp-content/uploads/2019/02/GUIDELINES_REVISED2011.pdf. Last accessed May 21, 2021.)

Level of Evidence: Consensus Statement/Expert Opinion

Dissociative Experiences Scale (DES)

At a minimum, clinicians should be familiar with the Dissociative Experiences Scale (DES), developed by Eva Bernstein Carlson and Frank Putnam [22]. This is a screening device, not a pure diagnostic evaluation, so a clinical interview will be necessary in order verify a diagnosis. Even as a screening device, the DES can be a conversation starter and vehicle for investigation, regardless of a person's specific diagnosis. The DES is a 28-item screen in which people are asked to give a general impression of how often they engage in a certain behavior or activity that can be potentially dissociative. Sample items include [22]:

- Some people have the experience of driving a car and suddenly realizing that they don't remember what has happened during all or part of the trip.
- Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something as if they were looking at another person.
- Some people sometimes find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them.

In the DES-II, people taking the evaluation rate these items by percentage (e.g., this happens to me about 20% of the time). In the DES-III, a basic 0–10 scale is adapted that corresponds with percentages; both versions are approved for clinical use.

To get an average score on the DES-II, you add up the total number of percentages and then divide by 28 (the number of items on the evaluation). Anything above 30% is generally considered to be cautionary for a clinically significant dissociative disorder. Anything greater than 40% is generally considered to be in the range of a clinically significant dissociative disorder. The DES is a starting point for clinicians and clients alike who are not familiar with addressing dissociation. Of course, nothing significant occurs at 30% or 40%; these are simply meant to be a guide for further diagnostic evaluation. One concern is that training programs in specialty therapies that use the DES to screen for dissociation can promote fear. For example, in the EMDR therapy community, some programs can promote the idea that people with a DES score greater than 30% are not appropriate candidates for EMDR or other types of deep trauma work. This is another of the myths and misconceptions. If the DES is greater than 30%, precautions should be taken and therapists can use the information gleaned from the DES to obtain a better sense of a person's relationships to dissociative responses based on their trauma.

After a client takes the inventory (preferably in office, so a therapist is available if they have any questions or concerns or get triggered), review the high item responses with them (greater than 30% to 40%) and ask them to talk more about when they started noticing that response over the course of their life and how it plays out for them presently. You may also ask if they notice how the specific behavior helps them to cope in any way. This information is more valuable, both in diagnosis and treatment planning (which also includes between-session safety planning) than any specific number.

In the spirit of getting to know one's own dissociative profile and relationship with dissociation, clinicians should take the DES for themselves first. It can be scored, but it may be more valuable to investigate how some of the higher scoring items fit into the Dissociative Profile exercise completed in the previous section. Other psychometrics in use clinically include:

- Structured Clinical Interview for Dissociative Disorders (SCID-D)
- Dissociative Disorders Interview Schedule (DDIS)
- Multidimensional Interview of Dissociation (MID)

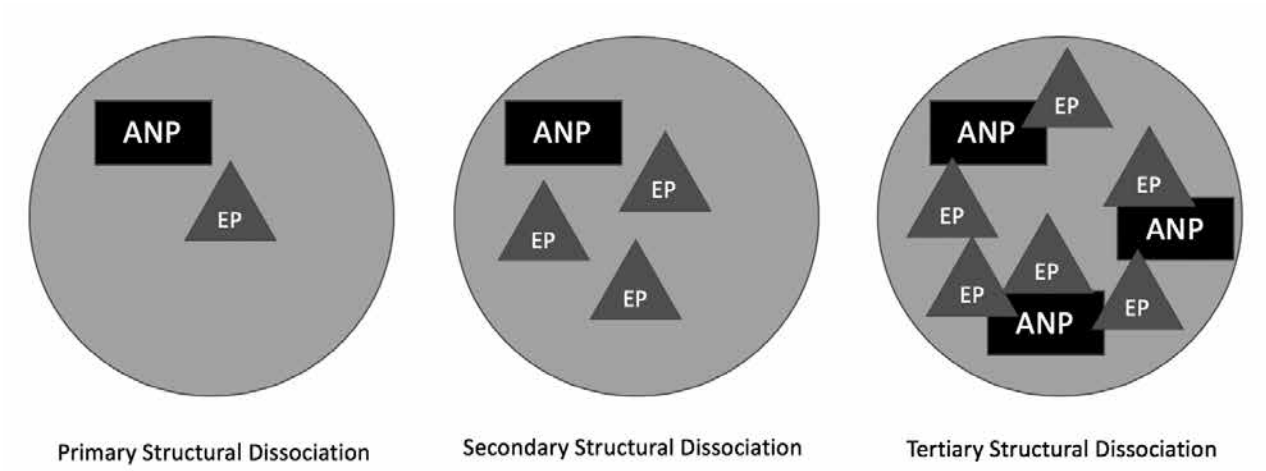
Many of these tools are available online (***Resources***).

Fraser's Dissociative Table Technique

One of the classic concepts and articles in the field of dissociation studies is Fraser's Technique. This concept was key to introducing the idea that a person with dissociative parts could get to know their system and how the various parts inter-relate with each other. Publication of Fraser's seminal article led to the popularization of the "conference table" metaphor for individuals with dissociation mapping out their parts and how they inter-relate. Fraser introduces a variety of other metaphorical possibilities as well for this mapping, with an emphasis that the table metaphor is only one part of his larger technique [23; 24]. In his core article, he discusses the use of the following approaches that make up the Dissociative Table [23]:

- Relaxation imagery: Using guided imagery as preparation and resourcing.
- Dissociative table imagery: Presented as the most important component of the exercise, this involves using the principle of imagery for a client to begin seeing their internal system take seats around a table (with modifications if tables feel unsafe). He credits this as a Gestalt-based technique.
- Spotlight technique: Sets up the idea of the spotlight being shined on the alter (or part) that is directly speaking to the therapist (with modifications if the light feels unsafe).
- The middleman technique: Establishes a system of communication between the alters or parts whereby one can speak on behalf of several others. This technique addresses the concept of co-consciousness, referring to two or more parts/alters sharing consciousness at the same time (not blacking out, "going away," etc.).
- Screen technique: A distancing technique whereby distressing memories can be viewed as if they are on a screen in the same room as the table.
- Search for the center ego state (inner self-helper): Establishing or revealing what may be referred to as the "core self" of the presenting self that has the strongest overview/sense of the entire system. This may be referred to as the presenting adult or the core self. Some controversy exists over whether or not it is necessary for some dissociative systems to have a center ego state.

VISUAL PRESENTATION OF THE THEORY OF STRUCTURAL DISSOCIATION



ANP = apparently normal personality, EP = emotional part.

Source: Created by Author *Figure 1*

- Memory projection technique: Another technique for furthering communication between the various alters/parts and their memories, using the various parts to bring in resources as other states may work to process or heal other memories on the screen.
- Transformation stage technique: A technique that can be used to transform a person's relationship to the memory and how they see themselves in the memory in terms of time, space, and age.
- Fusion/integration techniques: Although there is some controversy and trigger potential around integration in these techniques (as discussed previously), Fraser ultimately seems to be an advocate of integration using some of these fusion points as stepping stones.

The original article is a vital source of information for those interested in working more deeply with dissociation (***Resources***). Although it has its flaws, Fraser's Table can be a good starting point for clinicians who want direction on how to work with a system. The piece is also important because Fraser advocates for the reality of dissociation and how to work with it. He also addresses one of the controversies around dissociation—the idea that the therapist inserts parts or alters and their memories. While clinicians can guide people into identifying their own system and understanding how it works, it is vital that they do not force agendas and ideas on a person about what is happening. In EMDR therapy, there is a concept of therapists staying out of the way as much as possible and viewing themselves as facilitators or guides. Such an attitude is very helping, regardless of orientation, in helping people work with and identify their parts.

Theory of Structural Dissociation

While Fraser's Table is arguably one of the most popular approaches in the first wave of dissociation studies following the formal introduction of dissociative disorders into the DSM-III, the Theory of Structural Dissociation, developed by Onno van der Hart, Ellert Nijenhuis, and Kathy Steele, has become the focus of dissociation studies in the 21st century. Many trauma-focused professionals are advocates of this theory because, at its heart, it is non-pathologizing, positing that everyone is born with a fragmented or dissociative mind [25]. This is normal for infants, who get their various needs met in the absence of speech, language, or a more developed neocortex. Healthy development is defined by needs being consistently met engendering a natural integration of the personality structure. Yet, in the presence of unhealed trauma, disorganized attachment or developmental distress, a natural separation can remain.

The two main terms used in the Theory of Structural Dissociation are apparently normal personality (ANP), which is similar to Fraser's idea of the center ego state, and emotional part or personality. Emotional parts remain to protect or to meet a need, and some systems contain a more complicated interconnection of emotional parts and ANPs than others. While this is a bit of an oversimplification of how structural dissociation plays out systemically, it gives people new to this theory a good frame of reference. The model also makes use of the terms primary structural dissociation (which is more likely to be used in relation to PTSD and other trauma-related disorders), secondary dissociation (mainly related to personality disorders, dissociative disorders other than DID, and complex PTSD or developmental trauma), and tertiary dissociation (classically presented as DID). ***Figure 1*** provides a visual presentation of how this may play out.

The Theory of Structural Dissociation is certainly not without criticism. For example, psychiatric leader in the field of dissociation Dr. Colin Ross proposed an extensive modification to the theory. In his modification, Ross proposes that an emotional part does not have to be separate entities in and of themselves; instead, they can hold a fragment or experience like a thought, feeling, memory, or sensation. In this modification to the model, he expands on the Janetian idea that many disorders can be viewed through the lens of dissociation and that the idea of parts can be used as treatment conceptualization for conditions like substance use disorders and compulsive behaviors.

The theory of structural dissociation is a step in the right direction, and Ross' modifications expand the scope of what is possible and gives more permission to modify, which is essential in any facet of trauma-focused care. If rigidly interpreted, the original model is too inflexible, which is dangerous when applied to the phenomenon of systems that is fundamentally fluid and unique to the individual. Another consideration is the potentially offensive use of the adjective "normal" to describe the core self or presenting adult (ANP). This speaks to a reality of care in helping people to identify and to get to know their system; part of this is helping them to identify the terminology that best works for them and their understanding.

PERSONAL METAPHOR AND PARTS WORK

In working with clients with dissociation and identifying your own dissociative tendencies, clinicians can lean into the metaphorical possibilities that people can develop as they endeavor to understand their systems and how they work. Fraser's metaphors are a solid start, and the circles and shapes often used to represent structural dissociation are a good jumping off point. However, because creativity and expression are part of what defines the dissociative mind, using more creative metaphors may be better serving to you and to your clients [21].

Consider Ms. M, a client with an unspecified dissociative disorder. Ms. M is aware of a very defined inner world before coming into therapy, an inner world that she describes as a series of eight parts, all with their own name and purposes. Ms. M is delighted and surprised when her new therapist allows her to reference her parts and talk this way about them, as previous therapists discouraged her from using this language and conceptualization to refer to herself. "Show up as the adult," is something she heard more times than she ever cared to count.

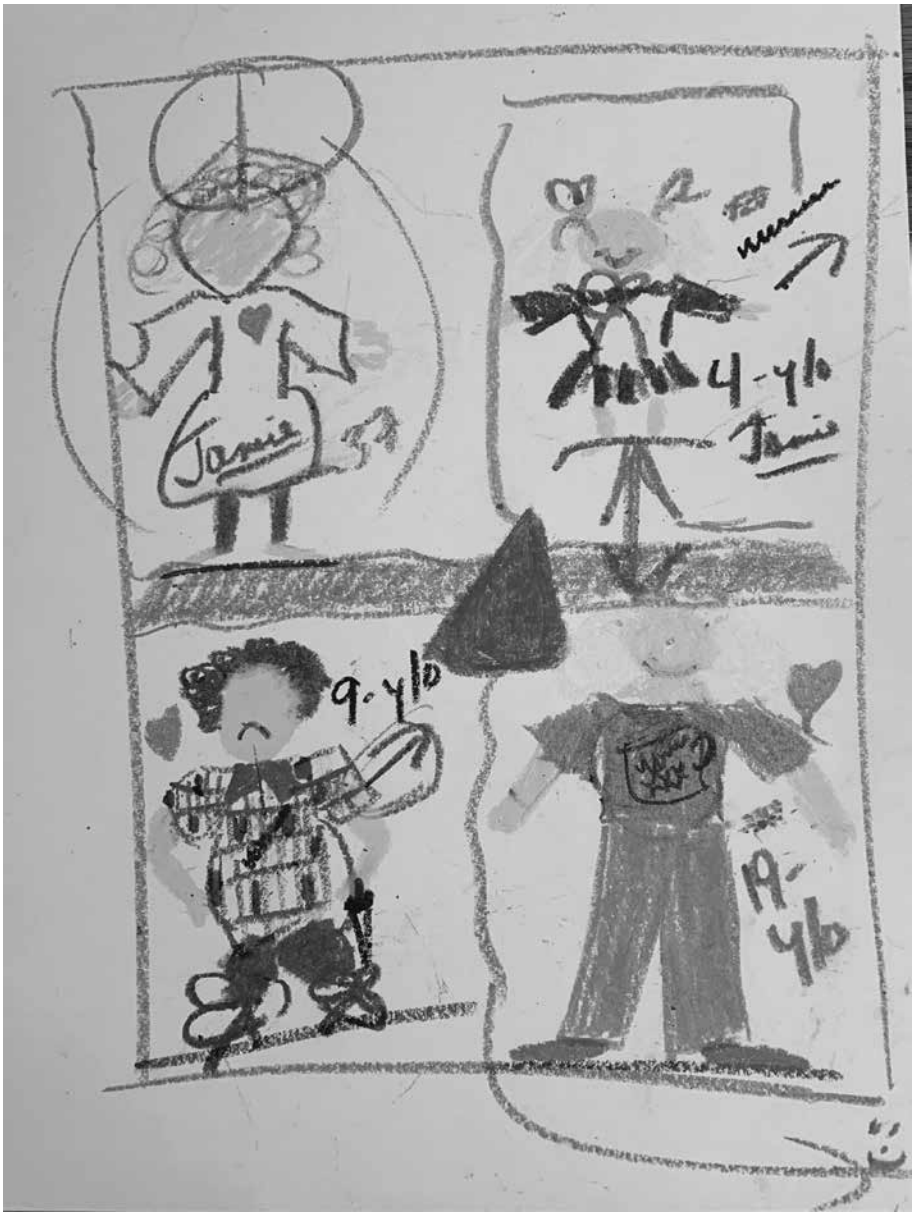
The therapist asks Ms. M if she sees her parts in any specific way, and she answers immediately—"Yes, I see them as a dollhouse!" She goes on to describe that each part has their own room, and that when she wants them to come together and have a discussion, she senses that they all meet in the living room for a gathering of sorts. They use this mapping of her system as vital information in developing her treatment plan and approach. Interestingly, Ms. M did not require assistance in developing this metaphor—it was already innate within her, and she just needed permission and space to speak it. Other clients may require more of a guide or some examples to help them map out their parts and how they interplay within a system. This can be a creative exploration to understanding the self whether or not a person has a clinically significant dissociative disorder. Other metaphorical possibilities include:

- A car or van
- A circle of people, like you see in group therapy or a 12-step meeting
- Balloons
- Bouquet of flowers
- An orchestra or band
- Salad or stew
- Mosaics
- Hindu gods
- Gathering of saints
- The elements (i.e., earth, air, water, and fire)
- Keys on a ring
- Movie references (e.g., the houses used in *Harry Potter*, ensemble pieces like *Star Wars*, *Guardians of the Galaxy*, *Black Panther*, or *The Wizard of Oz*)
- Other pop culture references (e.g., television shows, songs on a playlist, characters from literature)

Figure 2 is an example of how visual representation or other art work can be used to help a person identify the parts of their system and how the inter-relate.

*The example in **Figure 2** is from my own healing journey. I find the car or the van to be a particularly useful metaphorical construct for helping me (and others) to understand my system and how the parts inter-relate. The way I know myself, my presenting adult or core self is always driving the car. However, if the various parts that ride along with me—who I call 4, 9, and 19 (representing their ages)—are not getting their needs met or are not being listened to, they can start to act out or withdrawal in the car. For me, they usually do things like tap on my shoulder, pull my hair, or scream until I pay attention to them and what they are trying to tell me. During an earlier period of my own healing, when the 4-year-old state had some serious healing work to do, it literally felt like she was sneaking behind me and covering my eyes with her hands just so I would pay attention to her. Clearly that caused some distress in my life, and I was not able to return to a place of equilibrium and optimal functioning until I engaged in therapeutic work that helped to heal the four-year-old, the actual age when my own traumatic experiences intensified.*

EXAMPLE OF METAPHORICAL EXPRESSIVE ARTS: THE CAR OR VAN



Source: Created by Author *Figure 2*

If you have ever been on a road trip with children, you know that keeping the peace can be a delicate balance. That is what my mind feels like when I am not listening to the consensus of my system. My 9-year-old part, for instance, is now good about telling us when we need to pull over and take a break. Although she originally developed as the part that held destructive behaviors like self-injury and suicidal thoughts, she has become the voice, in our healing, that tells us when we need to take care of ourselves. I have also used my 19-year-old part as a middlewoman of sorts (using the Fraser term) to broker peace between the 4 and 9 year old, who can annoy each other. Although 19, who has a baby-sitter quality, can be good at this, she has recently become very good at telling me when this tires her out too much and she needs her own space. Interestingly, I experienced a series of traumatic losses and also crossed the threshold into active addiction at 19 years of age, which is why she emerged or stayed around as a separate emotional part in my system. In healing, I have come to appreciate 19 as a strong, rebellious spirit who started to question the norms in which she was raised. Though this naturally brought about some distress for her, healing from this distress has helped to heal our whole system.

I hope this personal look at a few metaphorical possibilities has been helpful to you as you begin to conceptualize systems and parts work.

EXERCISE: MAPPING YOUR PERSONAL SYSTEM

Some clients will develop names for their parts, some will refer to them just as numbers or ages (as in the related experience), and others will refer to them just by descriptive qualities (e.g., my angry side, my soft side, the shame part, the inner child). Before beginning work with people using Fraser's Table, mapping in the spirit of structural dissociation theory, or one of these more creative metaphors, clinicians are encouraged to first do some mapping of their own internal system. In essence, this is an important continuation of the Dissociative Profile exercise.

To do this, first spend some time brainstorming, preferably writing down, how you see the parts of yourself. Remember that if you are stuck and nothing you are reading here resonates, you can use the basic presenting adult/inner child construct. If that is the case, how do you see them inter-relating? Staying with the idea of the table, perhaps you simply imagine them sitting down to interact over a cup of tea (or maybe your adult drinks the tea and you pour lemonade for the inner child).

Using paper and whatever basic art supplies you might have on hand (or even just a pen or pencil), begin to map how you see your internal system inter-relating. Doing this exercise does not diagnose you with a dissociative disorder. We all have parts, and seeing ourselves in this way can be a useful strategy for conceptualizing.

This exercise is not about being an outstanding artist—you are not being graded or judged. Simply think of this as drawing out a rudimentary map (and for that matter—the "map" itself could be another useful, metaphorical example). Some people like to use the idea of a circle (e.g., in some cases using plain white paper plates) as the backdrop for how they map out their system.

Take as much time as you require to complete the exercise. When you are though, consider journaling/writing some impressions or sharing them with a friend or colleague. What have you learned about how the various parts of your system inter-relate? Where is there room for a greater sense of communication or understanding in your system? Are there any blocks that are apparent to communication, cohesion, or wholeness?

An exercise like this offers creative, client-centered insight into working with parts or mapping a system, and it may certainly be used with clients, especially in the early stages of working together. What you learn here can phenomenally inform your strategies for treatment planning, which is covered in a later section. Perhaps you are already beginning to understand that what works for one part of the system for resourcing and healing may be different than what other parts in the system require. This will be valuable information for moving forward with treatment.

ADDICTION AS DISSOCIATION

EXPLORING THE SIMILARITIES BETWEEN DISSOCIATION AND ADDICTION

The addiction treatment field is making steady steps toward becoming more trauma-informed, but a deficit in professionals' ability to identify signs and symptoms of dissociation persists [26]. This is a problem, especially because of the strong interplay between dissociation and addiction. Many clients will be unaware of dissociative symptoms experienced in childhood because drinking and using drugs can become their dissociative outlet in adulthood. Specific dissociative symptoms (e.g., "zoning out" at work or when emotionally overloaded) can develop in sobriety, and will require trauma-focused treatment. This phenomenon is relatively common in recovery circles, but it is often written off as "the pink cloud of recovery is passing," or "things are getting tough." When a person has a difficult time staying sober after getting sober, unhealed trauma is usually the culprit, and dissociation is a possible manifestation [6; 26].

In an article on the importance of dissociation-informed treatment, several other dissociative behaviors that manifest clinically but that professionals often fail to identify were identified [26]. They included clients struggling to pay attention in group, at 12-step meetings, or during lectures; a client changing tone (e.g., "It's like I'm suddenly speaking to a 5 year old") when something distressing comes up in sessions or in group; and other manifestations of blocking or resistant client behaviors. When a client gets belligerent or angry, this may be a sign of dissociation. In some clients, these types of behaviors could be a part speaking out to protect the system or to get a need met.

THE ADDICTION AS DISSOCIATION MODEL

The Addiction as Dissociation Model posits that addiction is a manifestation of dissociation. When children grow up in traumatizing, invalidating, or high-stress environments, the natural tendency is to dissociate in order to get needs met and protect themselves. If this happens frequently, the systems bond to this dissociative experience. At a later point in life, when chemicals or other reinforcing behaviors are introduced as possibilities, the chemical impact enhances the potency of an already familiar experience [27].

The term addiction is controversial in the modern era, because many critics feel that term is stigmatizing and not adequately trauma-informed [28]. To address this, the Addiction as Dissociation Model defines addiction as "the relationship created between unresolved trauma and the continued and unchecked progression of dissociative responses" [27]. In

ADDICTION AS DISSOCIATION MODEL
Foundation: The Human Brain
Integration, a process by which separate elements are linked together into a working whole, is optimal for healthy brain functioning.
Adverse life experiences can cause traumatic and dissociative responses.
Temporal perceptions are distorted by overwhelming experiences.
Bottom up/survival-oriented processes over-ride the neocortex.
Dissociation, a bottom-up process, is the survival-driven act of disconnecting.
Addiction is on the dissociative spectrum and can be viewed as the act of connecting to dissociation.
Similar to traumatic memory, addiction memory creates intrusive symptoms and produces dissociation.
Endogenous opioid and cannabinoid neurotransmitters play a key role in dissociation and underlie addictive processes.
The Impact of Trauma-Dissociation-Addiction
Addictions are an extreme way to meet one's basic survival needs of safety, belonging, and nurturing. These are based on the hardwired emotions of fear, panic, anger, play, care, seeking, and lust.
Addiction is the relationship created between unresolved trauma and the continued and unchecked progression of dissociative responses.
Addictive behaviors can be considered self-abuse and produce dissociative symptomology through intrusive means.
Dissociative states can switch subtly and produce re-enactments/feedback loops.
Active addiction can be seen as a dissociative state whereby one is trying to meet their basic survival needs.
Addictive behaviors are survival-oriented, a substitute for attachment, seeking connection, stress management, and/or acts of self-soothing.
Due to the role of the endogenous opioid system, traumas that produce dissociative states can become addicting.
Treatment and Healing Implications
There are a variety of solutions that providers can consider for healing trauma-dissociation through the lens of Janet's three-stage model (i.e., symptom management, memory reprocessing, and maintenance), with respect to appropriate interventions for ego state/parts work.
Naltrexone helps prevent dissociative states from overpowering conscious awareness and helps manage symptoms of alcohol use disorder.
Time-honored strategies for treating addiction can still be useful for initial healing, although therapies that provide symptom management alone (e.g., top-down processes) undermine unconscious healing processes, which can lead to treatment resistance.
Healing traumatic-dissociative-addiction memory through memory reconsolidation is paramount. The reconsolidation generally involves body-centered therapies that address bottom-up processes and allows for holistic integration of lived experience.
Integration of experience and neurobiological disharmony is imperative for individuals to live a more adaptive life.
Source: [27] *Table 2*

presentations where primary addiction treatment has failed to address trauma, dissociative experiences may produce a dissociative disorder or clinically significant symptoms of dissociation. Similarly, if dissociation in trauma has not been treated accordingly, addiction can often manifest [29]. The model contends that addiction develops in relation to trauma and dissociation, because trauma (cause) produces dissociation (effect).

According to the dissociation in trauma concept, there is a "division of an individual's personality, that is, of the dynamic, biopsychosocial system as a whole that determines his or her characteristic mental and behavioral actions" [29]. This distinction can also be seen in Waller, Putnam, and Carlson's taxometric analysis regarding nonpathologic and pathologic (e.g., adaptive and maladaptive) dissociative traits, of which "dissociation in trauma" would be represented by the latter [30]. Dissociation is what creates safety and ultimately pain relief in the moment of need. Trauma deeply impacts a person's psyche—extreme limits are pushed, and extreme reactions become necessary.

Mergler, Driessen, Ludecke, et al. examined the relationship between the PTSD dissociation subtype (PTSD-D) and other clinical presentations [31]. In a sample of 459 participants, the PTSD-D group demonstrated a statistically significantly higher need for treatment due to substance use problems, in addition to higher current use of opioids/analgesics and a higher number of lifetime drug overdoses. They ultimately concluded that PTSD-D is related to "a more severe course

of substance-related problems in patients with substance use disorder, indicating that this group also has additional treatment needs" [31]. Such a connection seems like clinical common sense, but it has not been fully explored in the treatment literature.

Table 2 illustrates the tenets of the Addiction as Dissociation Model, a cohesive presentation of what exists in the literature on the inter-relation and interplay of trauma, addiction, and dissociation. While the literature clearly exists to support such a model, the model represents the first cohesive discussion of their interplay. The implications for treatment, which are summarized here and continued into the next section, are various.

IMPLICATIONS FOR TREATMENT

Case conceptualization that respects addiction as dissociation and the related interplays between trauma, dissociation, and addiction acknowledges that addictive behavior is a dissociative response that can elicit its own continued trauma. Moreover, case conceptualization in this model defines and validates the symptoms of addiction accurately and sees the survival behavior as adaptive. This model presents how trauma and dissociation become addictive (i.e., highlights the endogenous neurochemical processes that create the dependent bond in dissociation/addictive processes), how unconscious re-enactments and feedback looping are foundational to recidivism, and provides the justification for comprehensive treatments to directly incorporate a memory reconsolidation phase.

This contention does not suggest that time-honored interventions for treating addiction should be abandoned. However, these interventions should be fortified based on the light of evolving knowledge about trauma and dissociation [6]. Solutions worth highlighting include developing the power of nonjudgmental support communities and the importance of cultivating daily practices that lead to lifestyle change. As such, the community of mutual help fellowships also benefits from an understanding of trauma and dissociation. Peer support services and fellowships like Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, and Adult Children of Alcoholics can provide a safe place to discuss solutions, as long as there is a reasonable degree of trauma-informed ethics in the culture of the meeting.

Cognitive-behavioral therapy (CBT), dialectical behavioral therapy (DBT), and Seeking Safety (SS) are often used in the treatment of addiction. There is an evidence base for their use in successfully treating addiction and other substance use disorders [32]. Yet with the public health crisis of addiction continuing, it is clear that more should be done to address the root of the problem—trauma. Each of these approaches lacks a comprehensive definition of addiction, a conceptualization of where addiction fits into the psychopathology of mental health disorders, and an appreciation for how addiction is experienced as traumatic and how addiction relates to trauma and dissociation. Furthermore, they do not directly incorporate memory resolution or memory reconsolidation as an aspect of treatment.

Treatments like DBT and SS specifically offer PTSD symptom management, and they can be helpful to clients in early stages of treatment for addiction and for individuals with clinically significant dissociative disorders. However, they are not comprehensive therapies if one appreciates addiction as a manifestation of dissociation, as the memory resolution phase of the three-stage consensus model of trauma treatment is absent [33]. Clinicians who mainly practice CBT are advised to incorporate trauma-focused CBT (TF-CBT) to work with both trauma and addiction memory. While processing the narrative or explicit memories is important, having ways to process the physical aspects of trauma is necessary for adaptive resolution and to produce personal transformation [34; 35; 36; 37].

Ultimately, incorporating trauma resolution and memory reconsolidation therapies is essential to bring about healing of the root of the problem, not just the symptoms. Memory reconsolidation is based on the belief that the brain, through a process of memory retrieval and activation, can delete unwanted emotional learning [35]. Progressive counting, emotional coherence, brainspotting, deep brain reorienting, and EMDR therapy provide more direct ways of resolving traumatic/addiction memories [4; 35; 37; 38; 39].

SUCCESSFUL TREATMENT PLANNING

No instant cure or approach to psychotherapy exists for healing trauma, dissociative disorders, or any mental health conditions. In fact, if a professional claims that they have the curative answer for working with trauma and dissociation, proceed with caution. Particularly when working with dissociative systems, the answer to successful treatment rests in finding the approach or series of approaches that works best for that client to achieve their treatment goals. With the intricacies of parts and dissociative systems, it is very likely that a variety of tools and approaches will be necessary, as what works for one part may not resonate with another. This is where being an eclectic or integrated therapist, albeit with a solid understanding of trauma, will serve best.

This section does not endorse any one specific approach for working with or treating dissociation. Some people approach coming to treatment to address clinically significant dissociation as a process of healing maladaptive dissociation while fundamentally working to embrace the aspects of having a dissociative mind that serve them. As with treating any mental health condition using any approach (or approaches) to psychotherapy, it is important to get a sense of what the client's goals and intentions are for engaging in treatment. Never assume that integration is the client's goal or promote any biases that integration is what is required for a person

to heal and to live an adaptive life, especially when a client presents with DID or any other dissociative condition that involves parts. Plausible goals that may appear in a treatment plan include:

- To manage problematic dissociative symptoms that get in the way of day-to-day life by more regularly using coping skills focused on grounding and mindfulness.
- To eliminate acting out behaviors (e.g., drinking, dangerous sex) that are more likely to happen when intense feeling is trying to be avoided.
- To promote a greater sense of communication in the internal system that will lead to a reduction of acting out behaviors and dissociating in situations that may be harmful (e.g., driving, at work).
- To decrease incidents of acting out inappropriately at work (e.g., shouting at superiors, ignoring colleagues) when feeling triggered. This will require working on two of the protector parts and the origin of their traumatic experience.
- To complete a creative project (writing a book) that is currently in progress, learning how to harness the potential of the mind and its dissociative qualities to help in reaching this goal.

EVIDENCE-BASED PRACTICE RECOMMENDATION

The International Society for the Study of Trauma and Dissociation asserts that a fundamental tenet of the psychotherapy of patients with dissociative disorder is to bring about an increased degree of communication and coordination among the identities.

(https://www.isst-d.org/wp-content/uploads/2019/02/GUIDELINES_REVISED2011.pdf. Last accessed May 21, 2021.)

Level of Evidence: Consensus Statement/Expert Opinion

REFLECTION

Are there any other goals, knowing the clients you are treating right now, that may feel appropriate in developing a treatment plan with a dissociative client?

THE THREE-STAGE CONSENSUS MODEL OF TRAUMA TREATMENT

After treatment goals have been established in the early stages of rapport building and setting the foundation for treatment, paths for intervention can be more clearly established. Please bear in mind that treatment goals can change and evolve throughout the course of treatment, and this is especially true when working with complex trauma and dissociation. Regardless of the specific interventions a clinician is trained to use, the general recommendation in working with complex trauma and dissociation is that the three stages of treatment established by Janet in 1889 be used as a general guide for treatment planning [33]. The field of trauma study generally refers to this model as the three-stage consensus model of trauma treatment because a consensus does exist on their use as a general structure in treatment planning for anything connected to trauma or dissociation.

The stages and their tasks, as presented in modern language are [40]:

- **Stage 1**: Stabilization, symptom-oriented treatment, and preparation for liquidation of traumatic memories
- **Stage 2**: Identification, exploration, and modification of traumatic memories
- **Stage 3**: Relapse prevention, relief of residual symptomatology, personality reintegration, and rehabilitation

Put simply, clients work to become prepared to handle the symptoms that show up in day-today life while also preparing for a deeper level of work, if they have the intention to go there and heal trauma at its root. Treatment should also include preparing clients to adjust to the changes in their life that happen as a result of unhealed trauma being addressed and transformed. Trauma resolution is only part of treatment—it is not the entire process. Preparation and adjustment to life are also major components of treatment.

These three stages are accepted by the current academic literature reviews that guide formal treatment for dissociation in adults by the ISSTD [41]. Clinicians can access the academic papers cited by ISSTD as best practice treatment guidelines free of charge on the ISSTD website (***Resources***).

The three-stage consensus model is not without controversy or challenge. In a 2016 review, de Jongh, Resick, Zoellner, et al. contend that the three-stage consensus model has no clear evidence base in treatment of more complex manifestations of trauma [42]. They generally contend that survivors of trauma may not be able to achieve any semblance of stabilization until they first engage in some type of complex trauma work. This debate speaks to one of the greatest clinical puzzles that exists in working with complex trauma—when is a client ready to do the work of trauma resolution? Is taking them to the core of their traumatic memories for healing dangerous and thus focus ought to be on symptom resolution?

Unfortunately, the answer is that there is no easy answer; it must be evaluated on a case-by-case basis. When a dissociative system is involved, clinical judgment should take into account how the entire system works. In EMDR therapy, the term preparation is used instead of stabilization [4]. Perfect stabilization likely will not exist for a survivor of trauma unless they have engaged in some degree of trauma work. Stabilization, like dissociation, really can be seen as a continuum. So, the better question may be: Is the client

stable enough or sufficiently prepared to take their healing to a deeper place? Preparation suggests that certain skills will need to be in place to manage life on a day-to-day basis, and widening a person's (or a system's) affective window of tolerance will be required for experiencing emotions and body sensations that are imperative in true trauma resolution work. Evaluating what a client has and what they may need to prepare themselves for meeting their treatment goals is a natural by-product of the Dissociative Profile exercise discussed previously.

TRAUMA-FOCUSED PREPARATION AND GROUNDING SKILLS

Many of the approaches to treatment that exist in the mental health field make wide use of guided imagery or visualization in preparation; these techniques are exclusively cognitive. In working with trauma, especially complex trauma and dissociation, it is vitally important that clinicians have a wide variety of skills that they can offer clients for use during and between sessions. These skills should work with all of the senses and many avenues of human experience [6; 43]. Grounding is the very practice of using all available senses and all available channels of human experience to remain in or return to the here and now.

Although clients will not respond favorably to all of these skills and strategies, it is important to offer choice. This choice becomes even more imperative when working with a dissociative system, because one skill may work well for one part when they are active and not another. Certain skills may work better to prevent maladaptive dissociative responses, while others are superior for helping a person (or certain parts) return to the present moment when they experience problematic dissociation.

Skills that may be used for preparation and widening affect windows of tolerance generally fall into the following categories:

- Basic awareness/mindfulness and grounding strategies
- Breathing strategies
- Muscle tensing/releasing exercises
- Visualization and multisensory soothing
- Containment (i.e., having a visual strategy or actual physical container to "hold" material until the timing is better to address; different than avoiding or pushing something away)
- Movement strategies
- Identification of other recovery capital (e.g., hobbies, support systems, mutual/self-help/church groups, advocacy activities, community support resources, pets)

Video teachings on skills in each of these categories are available online via the Trauma Made Simple website (***Resources***).

Some may be further ahead than others in use of such skills in clinical practice, so some clinicians may require a deeper investigation on how to use these skills personally and teach them to others. Regardless of the skills a clinician uses, it is important to trauma-inform the language and leave people plenty of options for modifying. Reading an exercise out of a book, showing a client a video, or even reading one of the skills word-for-word from this course will generally not be sufficient. If a client expresses that something is not working, it could be that they are overwhelmed; a general best practice is to modify the skill either in length or style.

In modern clinical work, many of the skills advocated for helping people to ground or widen their affective window of tolerance can be described as mindfulness practices. Mindfulness is fundamentally about remaining in or returning to the here and now. Consider that dissociation, by its nature, is the antithesis of mindfulness. Forner posits that mindfulness is fundamentally about connection (e.g., to the self, to the present moment, to others), whereas dissociation is ultimately about surviving disconnection [44]. If a person dissociates long enough or becomes bonded to this state (as proposed in the Addiction as Dissociation Model), they can become phobic of mindfulness. As with any other phobia, the answer is not to avoid teaching mindfulness strategies. Rather, clinicians should be cognizant of the idea that when mindfulness strategies are presented to people who dissociate, they are being asked to try something that can feel radical and new. Small steps are required to help people become more comfortable with being present.

Trauma- and Dissociation-Informing Practices

Strategies for trauma (and dissociation)-informing existing practices are diverse [1]. First, remember that eyes can stay open. Many clinicians and approaches to therapy or meditation automatically will tell people to "close the eyes," either because they have been trained to do this or because closed eyes help them to focus more effectively. Consider, however, that many people feel claustrophobic or closed in/trapped when their eyes are locked shut. This can promote anxiety. Moreover, closed eyes can be a dissociative response that can create a greater sense of drift or separation from the task at hand. Any exercise can work just as well with the eyes open, and for many clients with dissociation, keeping the eyes open can create a very necessary dual awareness between the room they are in (the present moment) and the memories or experiences that they are visiting in their work.

Second, time in the exercise is variable. Different approaches to clinical work and meditation will often write up skills with suggested lengths of time spent in each strategy, ranging from 3 to 5 minutes up to 25 minutes. Skills on the high end are generally too long for people who dissociate or who are just getting used to working with mindful skills and strategies. Clinicians are always empowered to alter the length of time that they guide a person through an exercise. Even 15 to 30 seconds at first can be an accomplishment for a client, and they can always build on this progress.

Next, let people know how long the exercise, particularly the silence, will last. Many people are triggered or further activated to dissociate when they are not sure how long something will last, especially periods of silence. While a goal may be to help people sit with silence for longer periods of time, be advised that a clinician's voice can be an anchor in many of these exercises. If there will be a period of silence in a meditation or skill, preface the exercise with, "We will now sit silently for the next 30 seconds."

It is also important to clarify any misconceptions or misinformation about what mindfulness, meditation, or yoga means. Many people think that these strategies are automatic relaxation devices, but in reality, their intent is to help people be with what is, even if that present moment experience is something distressing or upsetting. A solid working definition of mindfulness is the practice of returning to the present moment or noticing whatever is in the present moment without judgment.

Be open to variations in practice. Some people associate mindfulness as purely a sitting meditation practice. While this is a popular and potentially very beneficial way to work with mindfulness, any activity can be a vehicle for practicing mindfulness. Many find that walking, engaging in expressive arts practices, using grounding objects (e.g., rocks, crystals, soft blankets), or even activities of daily living (e.g., cleaning, cooking) are better avenues, especially at first. It is all about the intention and where the client is keeping their focus.

Clinicians are encouraged to have their own mindfulness practice. Clinicians who have their own practices realize the importance of modifications and can draw on this experience in teaching clients.

"Starter Pack" of Grounding Skills

The following grounding skills are written in language that clinicians might use with clients, with the intent to model the principles of trauma-informing exercises. The modifications and variations presented are not exhaustive. Consider what else might be coming up as variations that can be used in presenting these skills.

Basic Grounding and Sensory Scan

Take a look around the space that you are in right now. Start naming the different things you see. Be as specific as possible. For instance, you might say "I see the carpet below my feet. The carpet is blue with some bits of brown in the thread. I see the lamp on the desk. The base of the lamp is brown glass, and the shade is beige." Keep going for as long as you need, until you feel fully present in the space.

If you need, move on to the other senses. What are you hearing (or not hearing) in this moment, in this space? Observe and describe. What are you smelling? What are you tasting? Use your hands and either touch your clothes or make contact with the chair or the table. Observe and describe the touch sensation.

If you are working with an entire system, feel free to ask if all of the parts in a system feel sufficiently grounded and "here." If the answer is no from the presenting adult or the person/parts you work with primarily, invite those part(s) to engage in the same exercise. In using strategies like this, it is recommended you continue to speak to the present adult, using only a middleman (Fraser's term) or speaking directly to the parts in question if needed. In the case of DID in which there are multiple ANPs/presenting adults, the general advice is to work with whoever is present with you.

Mindful Breathing

In working with complex trauma and dissociation, it is important to recognize that breath work may be both a trigger and a resource. So, while deeper breathing strategies may be appropriate eventually, know that starting with basic breath tracking is sufficient.

Pay attention to your normal breathing for 30 seconds to 1 minute. If your mind starts to drift, that is okay, just bring the focus back to your breath.

A whole minute can be a challenge to start. Do not worry; start slowly and be gentle with yourself. If you can eventually work your breath practice up to three minutes, you will find that your breath will be there for you to help you calm yourself when you need it most. It takes practice. If you need the extra help, consider using this classic mantra as a guide, saying it to yourself as you breathe: "As I breathe in, I know I'm breathing in—as I breathe out, I know I'm breathing out." A simple "in-out" also works.

Clench and Release

Start with your hands, if they are available to you. Clench your fists together and notice your edge. Do not hurt yourself. Once you feel you are squeezing as tightly as possible, begin to notice your nails make contact with your skin. Notice the tension. As you do this, bring to mind a person, place, or thing that is causing you distress. Hold the clench as long as you can, at least 10 to 20 seconds.

When you feel like you no longer want to hold on, slowly release the grip of the fists. Feel each finger unlock and spread out. Notice the sensation of letting go and how you experience that in your body. Take a few breaths of your choice as you notice the sensations of release. Repeat as many times as necessary until you are at your desired level of relaxation about the stressor.

Optional: You can also choose to take a deep breath in with the fist clench and hold it as you clench your fists. Release the breath as you release the fists. Only do this if you feel comfortable enough holding the breath.

Variation: Some people are not able to make fists due to body differences or medical conditions (e.g., rheumatoid arthritis), or it may not be considered culturally appropriate. Any muscle group can be tensed and released for this exercise, including the shoulder, the stomach, the forearms, the thighs, or the feet.

Mountain Pose/Standing Meditation

In this practice, we will be working with one of the core poses of Hatha yoga—mountain pose—to explore the idea of standing tall and holding your ground, no matter what distress may exists around you. You do not need a yoga mat for this practice; just use the ground on which you stand.

Come to the front of your mat or to a place on the floor where you feel strong in your stance. Keep your feet together. If this puts too much pressure on your knees or hips, modify by stepping the feet apart slightly (no wider than hip width) while maintaining your balance. Press down into your feet and extend up through the crown of your head. Keep your eyes open and look straight ahead. Bring your hands into prayer position in front of your chest. To engage the energetic potential of the pose even more, become firm through your buttocks and inner thighs and drop the tailbone.

As you inhale, extend your arms straight overhead, interlacing your fingers if possible. If this is not available in your body, keep the arms straight overhead, palms facing each other, shoulder distance apart. Do your best to keep the arms alongside your ears and slightly back.

Use your breath to help you support the holding of the pose. This is not a contest to see how long you can hold the pose. Rather, when you first notice that you want to come out of it, challenge yourself to use your breath and other tools you now have to help you sustain the pose. Remember that the purpose of an edge is never to strive or push through pain. Always honor your body and back off when you need to.

Reset and try again if possible. The lesson we can learn in doing this type of work is of one's ability to practice adaptability by taking a break, resetting the breath, and then trying again.

Variations: You are free to use the wall or a chair for support. You can stand up and come up against the wall for that extra support. If using a chair, you can stand behind the chair and hold on with one hand, and do your best to use the other hand and arm for the overhead component of the pose. If you are not able to stand, feel free to modify the spirit of this pose as needed from a sitting position. Press down wherever you can in your lower body, and bring the upper body into position as you are able.

After engaging in this practice with a system, you can also inquire to see if all of the parts in the system responded well to this pose or if any struggled. If so, explore the source of that struggle and ask, perhaps, if there is a resource you can align for working with that part when they are standing up. For instance, some parts may not like the prayer hands, especially if they experienced spiritual or religious trauma. It may feel better to keep them at the side. Another part may like to envision a bright and healing light while they are standing tall. The options are limitless if you are willing to get feedback from clients as you go and explore options and variations.

THE THERAPEUTIC ALLIANCE

While the therapeutic alliance is an important feature of any therapy and in working with any population, issues around therapeutic alliance should be attended to in a special way when working with the spectrum of dissociation. A clinician's willingness to admit that dissociation is real and that a system is not manifestation of one's imagination is a great start in building rapport. As always, clinicians should be mindful not put their own agendas or projections on to a client, even in taking a more normalizing approach to dissociation.

Navigating the particulars of the therapeutic relationship can be sensitive. For instance, some parts in the system may not like a therapist or not be a fan of therapy in general. Clinicians are encouraged to roll with this resistance and take great care not to take any insults personally. Rather, consider what that particular part may find distressing and work to explore a solution. In doing clinical work, "hearing out" a part is generally more beneficial than trying to fight it.

Another potential problem area is a tendency for therapists to over-attach to younger or more vulnerable parts. There can be a desire for younger parts to turn the therapist into a parent figure, and this can cause some enmeshment and blurring of boundaries. While it is certainly possible to validate a client's or system's desire to see one as a parent, it is important to be clear that you are not their parent. This can feel cruel, but many of clients suffer because good boundaries were not modeled for them in early childhood. So, clinicians are in a position to validate their feelings and also challenge them into action, all while modeling and offering instruction about healthy boundaries. If this type of relationship is developing, ask the client/parts what qualities are being exhibited that they may have needed in a parent. These qualities can be used when evaluating what resources need to be built or worked on for younger parts in the system.

The following meditation and resourcing strategy may prove helpful for you and your clients in this process. As always, feel free to adjust and modify if needed.

Protector Figures

Protector figure resources may include people (real or imagined), spiritual entities, or even fictional characters to whom the client has a special attachment can be used. Another adjective may feel better than protector, including guardian, nurturer, advocate, or healer. Precautions should be taken, especially if using people who are still alive or may qualify as

a mixed resource (i.e., they possess adaptive and maladaptive qualities). The exercise is written to go slowly and be adapted to the specific person and their system. Guided visualization may be used for this, as can expressive arts strategies or any strategy that works in the system of therapy in which you are trained.

Single Figure

Start by working with just a single figure. Try to stay away from real people at first. Think of the spiritual realm, fictional characters, or an entity that you create using the power of your imagination. You can choose if you want to use an adjective to describe this figure, like protector figure or sacred figure. Maybe a word like cheerleader or nurturer works better for the intention that you are setting today.

Breathe and notice. Does this figure you chose have a name? What do they look like? What are they wearing? If they have a face, what do you observe on their face? Notice what this figure is doing, or where they are in relation to you in this meditation. Maybe they are literally sitting beside you. Maybe you imagine them putting their hands on your shoulders in support. Maybe you are engaging in an activity with them. Notice whatever you notice.

Then notice the qualities that the figure you have selected brings to you. How do they make you feel about yourself? What are you noticing in your thoughts, your feelings, and your experiences when you are in their presence? Is there a certain bodily sensation that you may be noticing, the deeper you engage or notice this figure of yours? Keep breathing.

To go further, recall a challenging situation that may be coming up in your life the next few days or weeks. What would it look like, or what would it feel like, if you imagined bringing this protector figure with you?

Circle of Figures

After establishing this practice with a single figure, you can go further by imagining a circle of support—people who are spiritual entities or fictional entities from whom we have drawn great strength. Historical figures and inspirational persons who have passed away can also be part of your circle. You can also bring people who are in your life right now into your circle, as long as they feel like a primarily positive resource. Imagine who is surrounding you. Who constitutes your circle of support?

Maybe there are only two figures, or maybe there are several. Maybe each figure takes on a different quality. Perhaps you have a protector figure, a sacred figure, a cheerleading figure, and a nurturing figure.

Notice what you most need in your life today, or in your life in general. Who are some figures that you can ally with to present you with those qualities? Take a moment here to see what comes into focus.

Think of a situation coming up in your life in the next few days or the next week that may present a particular challenge. When that has come into your awareness, notice it. Notice what that would feel like, and what that would look like. Next, notice your response as you imagine your circle of support taking you into this challenge. Keep breathing.

OPTIONS FOR REPROCESSING AND HEALING TRAUMATIC ETIOLOGY OF DISSOCIATION

When a client (and their system) experiences an adequate sense of preparation to move forward, the system can begin heal using any number of therapeutic strategies. Before continuing, it can be helpful for clinicians to contemplate what they consider to be their primary therapeutic orientation or orientations. In many cases, professionals can use what they have already learned to help people reach their established goals by assisting them to process or modify how traumatic memories are stored in the brain.

For instance, EMDR therapy is appropriate for working with dissociation if the clinician offering the therapy is well-informed in how dissociation can play out in an individual or their system and plans their targets and strategies with respect to how the system may work. Regardless of the approach used, if a block or a resistance shows up in the work, this is likely another part trying to have their voice heard, either to meet a need or to protect the system. Clinicians should be prepared with protocols in place to address these blocks. Seeking consultation from someone who practices the specific therapeutic approach and is well-skilled in working with dissociation and dissociative parts may be warranted to help build skills and confidence.

Expressive arts therapy, which refers to using any and all available creative forms (e.g. dance/movement, writing, art, drama, music) in combination, or any of the creative arts therapies as singular strategies can be a solid adjunct to any strategy available for processing or transforming trauma's impact in the brain. In many cases, parts in a system are young in terms of chronological age or exist in a state that cannot easily be accessed by words or language. Drawing or dancing may be a way to access the material that needs to be processed. Expressive arts strategies can be used in concert other approaches to trauma-focused therapy if the clinician has a sense of adventure and a willingness to personally try these strategies [45].

Table 3 provides a list of therapeutic approaches and online resources to access additional information. All of these approaches have some form of evidence base for working with the processing of traumatic memories and a protocol for how to best handle dissociation. Some of the modalities require more training than others, and clinicians who feel unprepared to work with processing traumatic memories in a holistic way may consider pursuing additional training in one of these modalities.

RESOURCES FOR THERAPEUTIC APPROACHES TO PROCESSING TRAUMA AND RELATED DISSOCIATION[a]	
Approach	**Recommended Resource**
Accelerated experiential dynamic psychotherapy (AEDP)	https://aedpinstitute.org
Acceptance and commitment therapy (ACT)	https://contextualscience.org/act
Art therapy	https://arttherapy.org
Body-centered psychotherapy and somatic psychology	https://usabp.org
Brainspotting	https://brainspotting.com
Cognitive processing therapy	https://cptforptsd.com
Coherence therapy	http://www.coherencetherapy.org
Dance/movement therapy	https://www.adta.org
Developmental needs meeting strategy	https://www.dnmsinstitute.com
Dialectical behavior therapy (DBT)	https://linehaninstitute.org
Drama therapy	https://www.nadta.org
Emotional freedom techniques (EFT)	https://www.emofree.com
Energy psychology	https://www.energypsych.org
Equine-assisted therapy	https://www.eagala.org
Exposure therapy	https://www.apa.org/ptsd-guideline/patients-and-families/exposure-therapy
Expressive arts therapy	https://www.ieata.org
Eye movement desensitization and reprocessing (EMDR)	https://www.emdria.org
Focusing	https://focusing.org
Gestalt therapy	https://aagt.org
Hakomi mindful somatic psychotherapy	https://hakomiinstitute.com
Hypnosis and hypnotherapy	https://www.asch.net
Internal family systems therapy (IFS)	https://ifs-institute.com
Music therapy	https://www.musictherapy.org
Narrative therapy	https://narrativetherapycentre.com
Neuro emotional technique (NET)	https://www.netmindbody.com
Neurofeedback	https://isnr.org
Neuro-linguistic programming (NLP)	https://www.neurolinguisticprogramming.com
Play therapy	https://www.a4pt.org
Progressive counting (PC)	https://www.childtrauma.com/treatment/pc
Psychoanalysis	https://apsa.org
Psychomotor therapeutic system	https://pbsp.com
The Sanctuary Model	https://www.nctsn.org/interventions/sanctuary-model
Sensorimotor psychotherapy	https://sensorimotorpsychotherapy.org
Somatic experiencing	https://www.somaticexperiencing.com
Trauma-focused cognitive-behavioral therapy (TF-CBT)	https://tfcbt.org
Trauma incident reduction (TIR)	https://www.tira.org
Trauma Resiliency and Community Resiliency Models	https://www.traumaresourceinstitute.com
Yoga therapy	https://www.iayt.org
[a]This list is not intended to be exhaustive, and other modalities and resources may be appropriate.	
Source: Compiled by Author	*Table 3*

In the treatment recommendations provided by the ISSTD, no one specific treatment modality is endorsed for doing stage 2 work. What is important is that clinician and client has a solid therapeutic alliance established with good boundaries, and that they understand how to work with abreaction (when material shifts from the sub-conscious into consciousness, with some type of affective release typically accompanying it). Working integration will help a client and their system be able to put the past in its proper place and allow all facets of experience to be attended to. With a system involved, this may not be an easy task; it should be handled with care and attention to the system. The client-driven An Infinite Mind organization also does not endorse any one modality in the treatment of DID. Instead, they emphasize the importance of finding a therapist who believes in dissociation and who is willing to work with it, while also giving a client/survivor of trauma options for care.

HELPING PEOPLE TO LIVE A MORE ADAPTIVE LIFE

An estimated 10% of the adult population is estimated to have a dissociative disorder; the majority are living typical lives and making valuable contributions to society [46]. Prevalence rates are higher in certain populations (e.g., psychiatric inpatients). For the sake of these patients, biases or preconceived notions about the impossibility of healing and optimal functioning in people who clinically dissociate should be put aside. These clients deserve the best available care to address their traumatic memories and improve their quality of life. The third stage of the three-stage consensus model of trauma treatment is generally called reintegration, and its primary objective is to assist people to make adjustments based on healing gains in therapy, ultimately living more adaptive, fulfilling lives.

How a clinician approaches stage three work with individuals who have DID or otherwise dissociate is not unlike how one might approach this stage with any other client impacted by trauma. One should be mindful that this work should be geared toward helping the system function as optimally and as peacefully as possible. Much of the work that took place in the preparation stages has a natural carry over to the reintegration phase. A helpful strategy can be to have the client and their system do the Dissociative Profile exercise at several intervals to see if any adjustments may need made. Completing one after an initial round of some work in stage two and also re-evaluating as termination nears is recommended.

Another question that arises is whether or not people with DID especially will require continued treatment or care for the rest of their lives or if termination is possible. In many ways, DID and other dissociative disorders are no different than any other major mental health disorders when contemplating termination. Some people will need long-term care as they adjust to living a more adaptive life aligned with their goals and intentions; others will reach a place where regular therapeutic care is no longer necessary. Like many issues in mental health, a case-by-case approach should be taken. Pharmacotherapy is outside of the scope of this course, but clients with dissociative symptoms or DID might be prescribed medications under the care of a psychiatrist or addiction medicine specialist. If this is the case, as a therapist, it is important to have regular contact with these providers to assure continuity in care and interprofessional collaboration.

According to the International Society for the Study of Trauma and Dissociation, psychotropic medication is not a primary treatment for dissociative processes, and specific recommendations for pharmacotherapy for most dissociative symptoms await systematic research.

(https://www.isst-d.org/wp-content/uploads/2019/02/GUIDELINES_REVISED2011.pdf. Last accessed May 21, 2021.)

Level of Evidence: Consensus Statement/Expert Opinion

REFLECTION

Now that you are nearing the end of this course, it may be a good idea for you to go back to your original Dissociative Profile exercise and re-evaluate. Knowing what you know now, after reading and working through this course, are there any adjustments that you would make? Even if this course has inspired you to take on healthier, proactive skills in the area of grounding, do there still seem to be some places where you feel stuck? Remember that there is no shame, especially as a therapist or helping professional, to seek out your own care, especially where issues around trauma or dissociation are concerned. Not only might this care help you to live a more adaptive life, it will likely have a positive impact on your efficacy as a therapist, especially in navigating complex situations.

Introduction to Parts Journaling

Parts journaling is an exercise based on Gestalt principles and other time-honored strategies in the field of psychotherapy, with an expressive arts twist. Like any exercise in this course, clinicians are encouraged to personally complete it first, and then consider sharing it with clients.

For this exercise, refer to any artwork or mapping that you created for your personal parts exploration. The purpose of that exercise was to provide a sense of how your system works. In this exercise, the objective is to further explore how the system interacts. Where might some areas of communication need to take place? As you examine the artwork you created, is there one part, segment, or facet that is most jumping out or resonating for you right now? If so, notice it and consider this question: If that part had a message for me right now, what would it be? It is permissible to use the presenting adult/core ego state/ANP, if that is what you are noticing the most. Take about three to five minutes to free write.

After this initial writing, look at the art work once more and notice if there is a second part, segment, or facet that is also calling your attention. Follow the same steps—notice and ask if that part had a message for me right now, what would it be? Again, take about three to five minutes to free write.

Now you are encouraged to write a dialogue between the two parts, segments, or facets. Take at least three to five minutes to let this unfold, although you can take longer if you wish. Consider the following example:

Adult Jamie (AJ): I'm working on my presentation for the EMDR conference.

9: Oh, boy. You still go to that?

AJ: Of course. It's gotten better for me. For all of us, I think.

9: What are you teaching on this year?

AJ: Dissociation—about how our mind works.

9: Oh, brother. Do you think we can handle it without chewing their heads off?

AJ: I'm hoping we can. Can I get your input first?

9: You really sure you want to hear from me on this one?

AJ: Yes, I do.

You can name your parts, segments, or facets whatever you wish. (What appears in the example reflects how I specifically engage in parts journaling.) As with every exercise outlined in this course, it is important not to censor yourself—let whatever unfolds happen, being open to any surprises or insights. If at any point you feel too overwhelmed, you have permission to stop and go back to one of your grounding or other coping skills. You can choose to resume the exercise later or leave it. What did you notice about yourself, the process, and your own internal world as a result of this exercise?

Parts journaling can be particularly useful for clients working with material in the system between sessions. There are also many implications for this sense of dialogue and communication can be used to help one's systems and internal world live more adaptively. When using this exercise with a client, it is strongly advised that it is personally completed first and that the client do the exercise in the presence of the clinician the first time it is attempted, so they have assistance working through any distress or overwhelm they might experience. As always, it is vital to use good clinical judgment about assigning this as therapeutic homework between sessions. Clients may do very well with this on their own after they understand its intention—to give voice to parts of the system that may need to speak and to engender a higher degree of communication. Although one should begin writing between only two parts to start, the voices of other parts can be brought in, especially if they have a mediating influence or hold an important part of the solution.

Other expressive arts possibilities (e.g., art, movement) can be integrated into parts journaling work. For some people, after they engage in the parts journaling, it can feel nourishing and transformative to make art (even if it is scribbles or doodles) on top of the words. With any kind of journaling, it is important to let clients know that they do not need to keep the writing or leave their words exposed; ripping pages or burning them safely are always options. Making art on top of the words is another option that speaks to this idea of making something beautiful out of something potential painful. If working with movement, consider this variation: If Part A's message could be expressed in a movement or a gesture, what would that be? If Part B's message could be expressive in a movement or a gesture, what would that be? Then spend a few minutes going back-and-forth between the movements/gestures and see what naturally unfolds.

CONCLUSION

Dissociation is a natural and normal part of the human experience. An inherent mechanism of the primitive brain, dissociation allows for needs to be met and for protection when one feels especially vulnerable. Understanding the intricacies of dissociation is imperative if a therapist or other helping professional wishes to be as trauma-focused as possible. Trauma and dissociation go hand-in-hand, and this interplay can manifest in ways that are clinically puzzling. However, a main theme of this course is that understanding one's own relationship with dissociation and internal world of parts is an important educational step to working with dissociation effectively. There is a time-honored piece of wisdom—we cannot take our clients farther than we have personally gone ourselves. A clinician's willingness to do this work, even if it starts with the three experiential exercises that appeared in this course, will go a long way. Moreover, clinical consultation, or consultation with a trauma survivor who has DID or another dissociative disorder, can be valuable. As with any pursuit in the helping professions, it is important not to let the science over-ride the art.

RESOURCES

An Infinite Mind
https://www.aninfinitemind.com

DID Research
https://www.did-research.org

Discovering DID
https://blog.discoveringdid.com

Dissociative Disorders Interview Schedule
https://www.rossinst.com/ddis

Dissociative Experiences Scale-II
http://traumadissociation.com/des

How to Use Fraser's Dissociative Table Technique to Access and Work with Emotional Parts of the Personality by Kathleen Martin
https://connect.springerpub.com/content/sgremdr/6/4/179

Harvey Weinstein's "False Memory" Defense and Its Shocking Origin Story by Anna Holtzman
https://medium.com/fourth-wave/harvey-weinsteins-false-memory-defense-and-its-shocking-origin-story-2b0e4b98d526

Institute for Creative Mindfulness Dissociation and Addiction Resources
https://www.instituteforcreativemindfulness.com/dissociation--addiction-resources

International Society for the Study of Trauma and Dissociation
https://www.isst-d.org

Multidimensional Interview of Dissociation (MID)
http://www.mid-assessment.com

Deconstructing the Stigma of Dissociative Identity Disorder by Olga Trujillo, JD
https://olgatrujillo.com

Ritual Abuse, Ritual Crime, and Healing
http://ra-info.org

Dissociative Disorders Interview Schedule (DSM-5 Version)
https://www.rossinst.com/Downloads/DDIS-DSM-5.pdf

Trauma and Dissociative Disorders Explained
http://traumadissociation.com

Trauma Made Simple
https://www.traumamadesimple.com

Guidelines for Treating Dissociative Identity Disorder in Adults
https://www.isst-d.org/resources/adult-treatment-guidelines

Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents
https://www.isst-d.org/resources/child-adolescent-treatment-guidelines

Customer Information/Answer Sheet/Evaluation insert located between pages 104–105.

TEST QUESTIONS

#76080 DEMYSTIFYING DISSOCIATION: PRINCIPLES, BEST PRACTICES, AND CLINICAL APPROACHES

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

This 10 Hour/3 NBCC Clock Hour activity must be completed by May 31, 2024.

1. The word dissociation is derived from a Latin root word meaning
- A) *wound.*
- B) *to integrate.*
- C) *to fight against.*
- D) *to sever or to separate.*

2. In clinical practice, the preferred term for separated aspects of self, seen as more normalizing, is
- A) *parts.*
- B) *alters.*
- C) *introjects.*
- D) *personalities.*

3. According to the triune brain model, the brainstem and cerebellum are parts of the
- A) *neocortex.*
- B) *limbic brain.*
- C) *mammalian brain.*
- D) *R-complex or reptilian brain.*

4. If a stimulus triggers a person into reaction at the limbic level, one of the quickest ways to alleviate that pain/negative reaction is to
- A) *go catatonic.*
- B) *engage in adaptive coping work.*
- C) *trigger pain at a different brain level.*
- D) *feed the pleasure potential in the limbic system.*

5. Electrical neuroimaging studies show a correlation between what brain area and dissociative symptoms?
- A) *Brainstem*
- B) *Sylvian fissure*
- C) *Occipital lobe*
- D) *Temporoparietal junction*

6. People with dissociation are more likely to act out and cause harm to self or to others than clients with other diagnoses.
- A) *True*
- B) *False*

7. Which of the following statements regarding integration for clients with dissociative disorder is TRUE?
- A) *Integration is only used to refer to the complete absence of parts.*
- B) *Integration in the simplistic sense is never achieved—nor does it need to be.*
- C) *The goal for all individuals with DID or other dissociative disorders should be integration and complete resolution of inter-part communication.*
- D) *For successful treatment of DID or another dissociative disorder to occur, there must be an integration of the various parts into one presenting person.*

8. All of the following are components of complex trauma experiences, EXCEPT:
- A) *Are repetitive or prolonged*
- B) *Generally involve a single majorly traumatic incident or event*
- C) *Occur at developmentally vulnerable times in the victim's life, such as early childhood*
- D) *Involve direct harm and/or neglect or abandonment by caregivers or ostensibly responsible adults*

9. It has been established that unhealed trauma is a major etiologic factor in the development of clinically significant
- A) *psychosis.*
- B) *personality disorders.*
- C) *dissociative disorders.*
- D) *post-traumatic stress disorder.*

Test questions continue on next page ➔

10. The memory wars refer to
- A) *the hypothesis that dissociative disorders are the result of deficits in memory processing.*
- B) *the conflict that occurs cognitively when two different perspectives of an event are presented.*
- C) *decades of debate about the trustworthiness of memory, particularly as it relates to accusations of abuse by survivors of trauma.*
- D) *conflict in the psychiatric and psychological communities regarding the role of memory in the development of trauma- and stressor-related disorders.*

11. Which of the following statements regarding dissociative identity disorder (DID) is FALSE?
- A) *It develops as a childhood coping mechanism.*
- B) *It is a spectrum disorder with varying degrees of severity.*
- C) *Parts of a person's personalities are always unaware of the other parts.*
- D) *It is important to note voices heard in DID are on the inside versus the outside.*

12. What is the most common of all dissociative disorders?
- A) *Dissociative amnesia*
- B) *Depersonalization disorder*
- C) *Unspecified dissociation disorder*
- D) *Dissociative identity disorder (DID)*

13. Depersonalization
- A) *symptoms always persist or recur for many years.*
- B) *only occurs after a person long-term complex trauma.*
- C) *is associated with considerable amnesia for the period between 6 and 11 years of age.*
- D) *has been described as being numb or in a dream or feeling as if you are watching yourself from outside your body.*

14. In the DSM-5 criteria for PTSD diagnosis, there is a qualifier option of PTSD with predominant dissociative symptoms. Dissociation can play out in
- A) *Criterion B (intrusion symptoms).*
- B) *Criterion D (negative cognitions/mood).*
- C) *Criterion E (alterations in arousal and reactivity).*
- D) *all five symptom areas.*

15. The Dissociative Profile is
- A) *a clinical tool used to diagnose dissociative disorders.*
- B) *used for personal development but is not useful for treatment planning.*
- C) *a process used to evaluate and become aware of one's own tendencies to dissociate.*
- D) *an exercise used to assign a descriptive metaphor to one's experiences with dissociation.*

16. The Dissociative Experiences Scale (DES)
- A) *consists of five items.*
- B) *is a purely diagnostic evaluation.*
- C) *is a useful conversation starter and vehicle for investigations.*
- D) *should only be used for persons with a specific dissociative diagnosis.*

17. What score on the DES-II is generally considered to be in the range of a clinically significant dissociative disorder?
- A) *10%*
- B) *25%*
- C) *40%*
- D) *80%*

18. All of the following are psychometrics in use clinically to assess dissociation, EXCEPT:
- A) *Dissociative Disorders Interview Schedule (DDIS)*
- B) *Multidimensional Interview of Dissociation (MID)*
- C) *Structured Clinical Interview for Dissociative Disorders (SCID-D)*
- D) *Comprehensive Assessment for At-Risk Mental States (CAARMS)*

19. Which of the following is an approach used in Fraser's Dissociative Table Technique?
- A) *Relaxation imagery*
- B) *Spotlight technique*
- C) *Middleman technique*
- D) *All of the above*

20. The transformation stage technique can be used to transform a person's relationship to the memory and how they see themselves in the memory in terms of time, space, and age.
- A) *True*
- B) *False*

21. As used in the Theory of Structural Dissociation, apparently normal personality (ANP) is
- *A) always singular.*
- *B) essential to final integration.*
- *C) similar to Fraser's idea of the center ego state.*
- *D) the part that remains to protect or to meet a need.*

22. In the Theory of Structural Dissociation, tertiary structural dissociation
- *A) classically presents as DID.*
- *B) involves a maximum of three emotional parts.*
- *C) is more likely to be used in relation to PTSD and other trauma-related disorders.*
- *D) is mainly related to personality disorders, dissociative disorders other than DID, and complex PTSD or developmental trauma.*

23. In working with clients with dissociation and identifying your own dissociative tendencies, clinicians can lean into the metaphorical possibilities.
- *A) True*
- *B) False*

24. Which of the following is a metaphorical possibility when exploring a client's emotional parts?
- *A) A car or van*
- *B) Keys on a ring*
- *C) A bouquet of flowers*
- *D) All of the above*

25. All clients with dissociative disorders will develop names for their parts.
- *A) True*
- *B) False*

26. Which of the following statements regarding dissociation and addiction is TRUE?
- *A) Specific dissociative symptoms usually resolve in sobriety.*
- *B) There is a weak relationship between dissociation and addiction.*
- *C) Many clients become aware of dissociative symptoms experienced in childhood because drinking and using drugs feels familiar.*
- *D) When a person has a difficult time staying sober, unhealed trauma is usually the culprit, and dissociation is a possible manifestation.*

27. All of the following are commonly overlooked dissociative behaviors that manifest clinically during recovery, EXCEPT:
- *A) Relapse*
- *B) Blocking or resistant client behaviors*
- *C) Clients struggling to pay attention in group, at 12-step meetings, or during lectures*
- *D) Clients changing tone when something distressing comes up in sessions or in group*

28. The Addiction as Dissociation Model contends that dissociation develops in relation to trauma and addiction, because trauma (cause) produces dissociation (effect).
- *A) True*
- *B) False*

29. In one study, participants with PTSD dissociation subtype (PTSD-D) demonstrated
- *A) fewer lifetime drug overdoses.*
- *B) less risk of current use of opioids/analgesics.*
- *C) a more severe course of substance-related problems.*
- *D) a decreased need for treatment due to substance use problems.*

30. Which of the following is NOT a tenet of the Addiction as Dissociation Model?
- *A) Addiction is separate from the dissociative spectrum.*
- *B) Dissociative states can switch subtly and produce re-enactments/feedback loops.*
- *C) Integration of experience and neurobiological disharmony is imperative for individuals to live a more adaptive life.*
- *D) Naltrexone helps prevent dissociative states from overpowering conscious awareness and helps manage symptoms of alcohol use disorder.*

31. Time-honored interventions for treating addiction should be fortified with approaches that
- *A) seek to exclude problematic family members.*
- *B) cultivate daily practices that lead to lifestyle change.*
- *C) develop the power of nonjudgmental support communities.*
- *D) Both B and C*

Test questions continue on next page ➔

32. Which of the following interventions provides a more direct way of resolving traumatic/addiction memories?
- A) *Seeking safety*
- B) *Progressive counting*
- C) *Cognitive-behavioral therapy*
- D) *Dialectical behavioral therapy*

33. With the intricacies of parts and dissociative systems, it is very likely that a variety of tools and approaches will be necessary, as what works for one part may not resonate with another.
- A) *True*
- B) *False*

34. Never assume that integration is the client's goal or promote any biases that integration is what is required for a person to heal and to live an adaptive life, especially when a client presents with DID or any other dissociative condition that involves parts.
- A) *True*
- B) *False*

35. In the three-stage consensus model of trauma treatment, stage 1 consists of
- A) *identifying and agreeing on goals of treatment.*
- B) *identification, exploration, and modification of traumatic memories.*
- C) *stabilization, symptom-oriented treatment, and preparation for liquidation of traumatic memories.*
- D) *relapse prevention, relief of residual symptomatology, personality reintegration, and rehabilitation.*

36. Which of the following statements regarding trauma treatment is TRUE?
- A) *Trauma resolution encompasses the entire treatment process.*
- B) *Preparation and adjustment to life are major components of treatment.*
- C) *It is important to focus on a single treatment modality in order to ensure success.*
- D) *Preparing clients to adjust to the changes in their life that happen as a result of unhealed trauma being addressed takes place after treatment is complete.*

37. Grounding is defined as
- A) *the active pursuit of relapse prevention.*
- B) *a phase of treatment focusing on affect regulation and coping skills.*
- C) *a maladaptive form of dissociation that limits a client's ability to work through traumatic memories.*
- D) *the practice of using all senses and all available channels of human experience to remain in or return to the here and now.*

38. In terms of a skill used for preparation and widening of the affect windows, containment is
- A) *avoiding or pushing away traumatic material so it does not affect the client.*
- B) *a type of breathing exercise characterized by extended holding of the breath and a slow release.*
- C) *having a visual strategy or actual physical container to "hold" material until the timing is better to address.*
- D) *the community surrounding a client that may be accessed as a support system and often referred to as recovery capital.*

39. If a client expresses that a preparation exercise/skill is not working, it could be that they are overwhelmed; a general best practice is to modify the skill either in length or style.
- A) *True*
- B) *False*

40. Which of the following statements regarding mindfulness practices for clients who dissociate is FALSE?
- A) *Dissociation, by its nature, is the antithesis of mindfulness.*
- B) *It is important to avoid teaching mindfulness strategies to clients who dissociate.*
- C) *Small steps are required to help people who dissociate to become more comfortable with being present.*
- D) *If a person dissociates long enough or becomes bonded to this state, they can become phobic of mindfulness.*

41. Which of the following is a strategy for trauma- and dissociation-informing existing practices?
- A) *Eyes remain open*
- B) *Shorten time spent in an exercise*
- C) *Alert the client to the time that will be spent in an exercise*
- D) *All of the above*

42. Walking, engaging in expressive arts practices, using grounding objects, and activities of daily living can be avenues to practice mindfulness.
- A) *True*
- B) *False*

43. All of the following are grounding exercises, EXCEPT:
- A) *Sensory scan*
- B) *Mindful breathing*
- C) *Clench and release*
- D) *Dialectical behavioral therapy*

44. Clinicians should be mindful not put their own agendas or projections on to a client, even in taking a more normalizing approach to dissociation.
- A) *True*
- B) *False*

45. Which of the following is a potential issue in the therapeutic alliance when working with clients on the dissociation spectrum?
- A) *One part's rejection or dislike for the therapist*
- B) *Needing to act as a parent to the client or to a part*
- C) *Under-attachment to younger or more vulnerable parts*
- D) *Less time is necessary to establish rapport, which can be jarring*

46. When conducting a protector figure exercise,
- A) *the protector adjective should always be used, as it best describes the intended use.*
- B) *expressive arts strategies may be incorporated, but guided visualization should be avoided.*
- C) *Precautions should be taken, especially if using people who may qualify as a mixed resource.*
- D) *protector resources may include fictional people or spiritual entities, but real people should be avoided.*

47. Clinicians should only use specifically designed interventions for reprocessing and healing of traumatic memories, even if they are outside what they consider to be their primary therapeutic orientation or orientations.
- A) *True*
- B) *False*

48. What role does expressive arts therapy play in stage 2 reprocessing work to address trauma and dissociation?
- A) *Only visual arts are an appropriate avenue for treatment.*
- B) *These approaches may be effectively used as monotherapy to address dissociation.*
- C) *Expressive arts strategies can be used in concert other approaches to trauma-focused therapy.*
- D) *Expressive arts should not be used with parts in a system that are young, as they may not understand the goals.*

49. In the treatment recommendations provided by the International Society for the Study of Trauma and Dissociation, no one specific treatment modality is endorsed for doing stage 2 work.
- A) *True*
- B) *False*

50. All of the following are essential aspects of the care of clients with dissociation, EXCEPT:
- A) *Involvement of family members*
- B) *A clinician prepared to work with abreaction*
- C) *A solid therapeutic alliance established with good boundaries*
- D) *The client and their system putting the past in its proper place and allowing all facets of the experience to be attended to*

51. What proportion of the population is estimated to have a dissociative disorder?
- A) *0.1%*
- B) *1.5%*
- C) *10%*
- D) *25%*

52. The primary objective of the third stage of the three-stage consensus model of trauma treatment is to
- A) *reprocess and ultimately heal traumatic memories.*
- B) *fully integrate all emotional parts into one presenting adult.*
- C) *provide clients with resources for continued lifelong treatment.*
- D) *assist people to make adjustments based on healing gains in therapy, ultimately living more adaptive, fulfilling lives.*

Test questions continue on next page ➔

53. When considering continued care of clients with dissociation or DID,

A) a case-by-case approach should be taken.
B) all clients should work toward an ultimate goal of treatment termination.
C) clients will require continued treatment or care for the rest of their lives.
D) treatment should be discontinued if pharmacotherapy has been successful.

54. Parts journaling is an exercise based on Freudian principles.

A) True
B) False

55. Which of the following statements regarding parts journaling is FALSE?

A) The client should journal in the presence of their clinician the first time it is attempted.
B) Parts journaling can be particularly useful for clients working with material in the system between sessions.
C) The initial journaling session should include all of a client's parts, as excluding a part can lead to resentments.
D) When using this exercise with a client, it is strongly advised that it is personally completed by the clinician first.

Be sure to transfer your answers to the Answer Sheet located between pages 104–105.
DO NOT send these test pages to NetCE. Retain them for your records.
PLEASE NOTE: Your postmark or facsimile date will be used as your test completion date.

Course Availability List

These courses may be ordered by mail on the Customer Information form located between pages 104–105.
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BEYOND THERAPY: THE BASICS OF CLINICAL DOCUMENTATION

#71072 • 4 APA Hours, 1.5 NBCC Hour

Book By Mail – $24 • **ONLINE – $16**

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

MANAGING AND PREVENTING BURNOUT

#71463 • 4 APA/NAADAC Hours, 1 NBCC Hour

Book By Mail – $24 • **ONLINE – $16**

Purpose: Although work stress and burnout are present in every occupation, human service professionals, who spend their work lives attending to the needs of others, are at the highest risk. The purpose of this course is to orient the participants to the ramifications of not taking care of themselves and to promote strategies for enhancing health and well-being as individuals while working as professionals.
Faculty: Jamie Marich, PhD, LPCC-S, LICDC-CS, REAT, RYT-500, RMT
Audience: This course is designed for helping professionals of any kind, including counselors, social workers, therapists, and chemical dependency counselors, who require the tools necessary to address issues of work-life balance.

INTEGRATING RELIGION AND SPIRITUALITY INTO COUNSELING

#71610 • 5 APA Hours, 2.5 NBCC Hours

Book By Mail – $28 • **ONLINE – $20**

Purpose: The purpose of this course is to assist social workers, counselors, and mental health professionals in raising their level of expertise when working with clients who present with spiritual and religious issues.
Faculty: Katherine Greig, MSW, PhD
Audience: This course is designed for social workers, mental health counselors, therapists, and other allied health professionals who work in clinical practice settings.

ANXIETY DISORDERS

#76181 • 15 APA/NAADAC Hours, 6.5 NBCC Hours

Book By Mail – $68 • **ONLINE – $60**

Purpose: The purpose of this course is to provide mental health professionals with the knowledge and skills necessary to appropriately identify and treat patients with anxiety disorders.
Faculty: Mark Rose, BS, MA
Audience: This course is designed for mental health providers involved in the identification, treatment, and care of patients with anxiety disorder.

BORDERLINE PERSONALITY DISORDER

#76221 • 15 APA Hours, 6 NBCC Hours

Book By Mail – $68 • **ONLINE – $60**

Purpose: The purpose of this course is to provide behavioral and mental health professionals with the information necessary to assess and treat patients with borderline personality disorder effectively and safely, while minimizing their own stress level and clinic disruption these patients are capable of producing.
Faculty: Mark Rose, BS, MA
Audience: This course is designed for counselors, therapists, social workers, and other mental health professionals who are involved in the care of patients with borderline personality disorder.

SHYNESS: CAUSES AND IMPACT

#76383 • 3 APA Hours, 1.5 NBCC Hours

Book By Mail – $23 • **ONLINE – $15**

Purpose: To understand shyness from a biologic, psychologic, social, and attributional perspective can help expand treatment options. The purpose of this course is to bring about awareness of the intricacy of shyness, which can assist clinicians in providing thorough treatment.
Faculty: Michael E. Considine, PsyD, LPC
Audience: This course is designed for licensed mental health professionals, including social workers, counselors, and therapists, who may assist persons with their shyness.

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

Course Availability List *(Cont'd)*

BEHAVIORAL ADDICTIONS

#76411 • 15 APA/NAADAC Hours, 6 NBCC Hours

Book By Mail – $68 • **ONLINE – $60**

Purpose: The purpose of this course is to provide social workers, counselors, therapists, and other mental health professionals with the knowledge and skills to appropriately identify, diagnose, and treat behavioral addictions.

Faculty: Mark Rose, BS, MA

Audience: This course is designed for mental health practitioners who may intervene in diagnosing and treating behavioral addictions in their patients.

SUICIDE ASSESSMENT AND PREVENTION

#76441 • 6 APA/NAADAC Hours, 2 NBCC Hours

WA Mandate

Book By Mail – $32 • **ONLINE – $24**

Purpose: The purpose of this course is to provide behavioral and mental health professionals with an appreciation of the impact of depression and suicide on patient health as well as the skills necessary to identify and intervene for patients at risk for suicide.

Faculty: Mark Rose, BS, MA

Audience: This course is designed for social workers, therapists, counselors, and other professionals who may identify persons at risk for suicide and intervene to prevent or manage suicidality.

Special Approval: This course is 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

CLINICAL SUPERVISION: A PERSON-CENTERED APPROACH

Supervision

#76862 • 10 ASWB Hours, 3 NBCC Hours

Book By Mail – $48 • **ONLINE – $40**

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.

DOMESTIC AND SEXUAL VIOLENCE

#77790 • 5 APA Hours, 2 NBCC Hours

Book By Mail – $28 • **ONLINE – $20**

Purpose: The purpose of this course is to provide professionals with the skills and confidence necessary to identify victims of sexual or domestic violence and to intervene appropriately and effectively.

Faculty: Alice Yick Flanagan, PhD, MSW; John M. Leonard, MD

Audience: This course is designed for a wide range of behavioral and mental health professionals, including social workers, mental health counselors, and marriage and family therapists.

AUTISM SPECTRUM DISORDER

#92203 • 5 ASWB Hours, 2 NBCC Hours

Book By Mail – $28 • **ONLINE – $20**

Purpose: The purpose of this course is to provide healthcare professionals with a basic understanding of the very complex, misunderstood, often puzzling, and sometimes disabling condition, enabling them to provide more thorough patient care, recognize symptomatology, and educate patients, families, teachers and communities about autism spectrum disorder.

Faculty: Sharon M. Griffin, RN, PhD

Audience: This course is designed for healthcare professionals in all practice settings who may be involved in the care of patients with an autism spectrum disorder.

ALZHEIMER DISEASE

#96153 • 15 APA Hours, 7.5 NBCC Hours

Book By Mail – $68 • **ONLINE – $60**

Purpose: In order to increase and maintain a reasonable quality of life for patients with Alzheimer disease throughout the course of the disease, caregivers must have a thorough knowledge and understanding of the disease. The purpose of this course is to provide clinicians with the skills to care for patients with Alzheimer disease in any setting as part of the interdisciplinary team.

Faculty: Joan Needham, MSEd, RNC

Audience: This course is designed for clinicians who come in contact with patients with Alzheimer disease in hospitals, long-term care facilities, home health care, and the office.

SEXUAL ADDICTION

#96273 • 5 ASWB/NAADAC Hours, 2.5 NBCC Hours

Book By Mail – $28 • **ONLINE – $20**

Purpose: The purpose of this course is to provide healthcare professionals the information necessary to conduct a thorough sexual history and allow a clear and nonjudgmental approach to issues surrounding sexuality and sex addiction.

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

Audience: This course is designed for professional clinicians such as counselors, social workers, psychologists, pastoral counselors, and nurses who would benefit from additional competence on how to assess for sexual addiction and how to make the best referral for care.

VICARIOUS TRAUMA AND RESILIENCE

#96623 • 15 APA Hours, 6 NBCC Hours

Book By Mail – $68 • **ONLINE – $60**

Purpose: The purpose of this course is to expand health and mental health professionals' abilities to identify and understand countertransference reactions common in work with trauma survivors, the causes and signs of burnout and compassion fatigue, and factors contributing to vicarious trauma and resilience.

Faculty: S. Megan Berthold, PhD, LCSW

Audience: This course is designed for social workers, marriage and family therapists, nurses, mental health counselors, and allied health professionals who work with trauma survivors.

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

Course Availability List *(Cont'd)*

METHAMPHETAMINE USE DISORDER

#96953 • 5 APA Hours, 2 NBCC Hours

Substance Abuse

Book By Mail – $28 • **ONLINE – $20**

Purpose: Methamphetamine use has risen alarmingly, reaching epidemic proportions in some regions. The purpose of this course is to provide a current, evidence-based overview of methamphetamine abuse and dependence and its treatment in order to allow healthcare professionals to more effectively identify, treat, or refer patients who use methamphetamine.

Faculty: Mark Rose, BS, MA

Audience: This course is designed for health and mental health professionals who are involved in the evaluation or treatment of persons who use methamphetamine.

SEXUAL HARASSMENT PREVENTION: THE ILLINOIS REQUIREMENT

#97080 • 1 APA/ASWB, 0.5 NBCC Hours

IL Mandate

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.

HUMAN TRAFFICKING AND EXPLOITATION: THE TEXAS REQUIREMENT

#97470 • 5 APA Hours, 2 NBCC Hours

TX Mandate

Book By Mail – $28 • **ONLINE – $20**

Purpose: As human trafficking becomes an increasingly more common problem in the United States, healthcare and mental health professionals will require knowledge of human trafficking patterns, the health and mental health needs of human trafficking victims, and successful interventions for victims. The purpose of this course is to increase the level of awareness and knowledge about human trafficking and exploitation so health and mental health professionals can identify and intervene in cases of exploitation.

Faculty: Alice Yick Flanagan, PhD, MSW

Audience: This course is designed for Texas physicians, nurses, social workers, pharmacy professionals, therapists, mental health counselors, and other members of the interdisciplinary team who may intervene in suspected cases of human trafficking and/or exploitation.

Special Approvals: This course has been approved by the Texas Health and Human Services Commission (HHSC) to meet the requirements for human trafficking training..

ONLINE PROFESSIONALISM AND ETHICS

#97663 • 3 APA Hours, 2 NBCC Hours

Ethics

Book By Mail – $23 • **ONLINE – $15**

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

Faculty: Alice Yick Flanagan, PhD, MSW

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

ELDER ABUSE: CULTURAL CONTEXTS AND IMPLICATIONS

#97823 • 5 APA Hours, 4 NBCC Hours

Book By Mail – $28 • **ONLINE – $20**

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

Faculty: Alice Yick Flanagan, PhD, MSW

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

SLEEP DISORDERS

#98882 • 10 APA Hours, 4 NBCC Hours

Book By Mail – $48 • **Online – $40**

Purpose: The purpose of this course is to provide healthcare professionals with the information necessary to identify and effectively treat sleep disorders, thereby improving patients' quality of life and preventing possible complications.

Faculty: Teisha Phillips, RN, BSN

Audience: This course is designed for all healthcare professionals, including physicians, nurses, and mental health practitioners, who are involved in the care of patients experiencing a sleep-related disorder.

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

Counselor and Therapist Continuing Education Requirements by State

State	COUNSELOR	THERAPIST
	Approval Accepted/Hours by Home Study	Approval Accepted/Hours by Home Study
Alabama	APA, NBCC/10✶	NBCC/20✶, ♦
Alaska	APA, NBCC, ASWB, NAADAC/20✶	Accepted by Board/22✶, ❖, ♦
Arizona	APA, NBCC, ASWB, NAADAC/30✶, ❖, ♦	APA, NBCC, ASWB, NAADAC/30✶, ❖, ♦
Arkansas	APA, NBCC/24✶	APA, NBCC/24✶
California	APA, NBCC, ASWB/36✶, ♦	APA, NBCC, ASWB/36✶, ♦
Colorado	Accepted by Board/20 Coursework, 20 Independent learning♦	Accepted by Board/20 Coursework, 20 Independent learning♦
Connecticut	APA, NBCC, ASWB/15❖, ♦	APA, NBCC, ASWB/15❖, ♦
Delaware	APA, NBCC, ASWB, NAADAC/20	APA, NBCC, ASWB, NAADAC/20
District of Columbia	APA, NBCC, ASWB, NAADAC/40✶, ♦	APA, NBCC/15✶, ♦
Florida	#50-2405/30✶, ♦	#50-2405/30✶, ♦
Georgia	APA, NBCC, ASWB/10✿	APA, NBCC, ASWB/10✿
Hawaii	No CE Required	APA, NBCC/45✶
Idaho	APA, NBCC, ASWB/20✿	APA, NBCC, ASWB/20✿
Illinois	#197.000185/30♦	#168.000190/30♦
Indiana	APA, NBCC, ASWB, NAADAC/40✶	APA, NBCC, ASWB, NAADAC/40✶
Iowa	NBCC/20✶	NBCC/20✶
Kansas	Accepted by Board/30✶, ♦	Accepted by Board/40✶, ♦
Kentucky	NBCC/10✶, ♦	Not Approved/15
Louisiana	NBCC/10 in print & 20 online✶, ♦	Not Approved/20
Maine	APA, NBCC/55✶, ♦	APA, NBCC/55✶, ♦
Maryland	NBCC, NAADAC/10	NBCC, NAADAC/10
Massachusetts	NBCC/LMHC 15♦; LRC May Seek Board Pre-approval	May Seek Board Pre-approval/15
Michigan	No CE Required♦	No CE Required♦
Minnesota	APA, NBCC, ASWB/LPC 10; NBCC/LADC 40✶, ❖	Not Approved/7.5
Mississippi	NBCC/24✶	May Seek Board Pre-approval/6✶
Missouri	APA, NBCC, ASWB/40♦	APA, NBCC, ASWB/40♦
Montana	Accepted by Board. Must be scope of practice/20	Accepted by Board. Must be scope of practice/20
Nebraska	Accepted by Board/20✶	Accepted by Board/20✶
Nevada	Accepted by Board/10✶, ♦	Accepted by Board/10✶, ♦
New Hampshire	APA, ASWB, NBCC/20✶, ♦	APA, ASWB, NBCC/20✶, ♦
New Jersey	APA, NBCC, NAADAC, ANA/LPC, LRC 40✶, ❖; LCADC 20❖, ♦; CADC 30❖, ♦	APA, NBCC, NAADAC, ANA/20✶, ❖
New Mexico	APA, NBCC, ASWB, NAADAC/12 in print & 12 online✶, ♦	APA, NBCC, ASWB, NAADAC/12 in print & 12 online✶, ♦
New York	#MHC-0021/36 May complete all hours through 1/1/22 due to COVID-19	#MFT-0015/36 May complete all hours through 1/1/22 due to COVID-19
North Carolina	NBCC/40; APA, NAADAC/15✶	Accepted by Board/20✶
North Dakota	APA, NBCC/LAPC, LPC, LPCC 15✶	Not Approved/7.5✶
Ohio	NBCC/LPC, LPCC 30✶, ♦	May Seek Board Post-approval/30♦
Oklahoma	May Seek Board Pre-approval/10♦, ✿	May Seek Board Pre-approval/10♦
Oregon	APA, NBCC/40✶, ❖, ♦	APA, NBCC/40✶, ❖, ♦
Pennsylvania	APA, NBCC, ASWB/30✶, ♦	APA, NBCC, ASWB/30✶, ♦
Rhode Island	APA, NBCC, ASWB, NAADAC/MHC 40; NAADAC/SAC, CADC, CAADC, CCDP, CPS 40✶; NAADAC/CPRS 20✶	APA, NBCC/MFT 40
South Carolina	NBCC, NAADAC/15✶	NBCC, NAADAC/15✶
South Dakota	APA, NBCC/40✶	APA, NBCC/40✶
Tennessee	APA, NBCC/5 per year✶	APA, NBCC/5 per year✶
Texas	Accepted by Board LPC 24✶,♦; Accepted by Board, NAADAC/LCDC 40✶, ♦	Accepted by Board/30✶
Utah	Accepted by Board/10✶, ♦	Accepted by Board/15✶, ♦
Vermont	APA, NBCC/28✶	APA, NBCC/10✶
Virginia	APA, NBCC, ASWB, NAADAC/20✶	APA, NBCC, ASWB, NAADAC/20✶
Washington	APA, NBCC, ASWB, NAADAC/MHC 26✶, ♦; CC, CA 12✶, ♦; CDP 40✶, ♦	APA, NBCC, ASWB, NAADAC/26✶, ♦
West Virginia	NBCC/20✶, ♦	Not Approved/15✶, ♦
Wisconsin	APA, NBCC, ASWB, NAADAC/30✶	APA, NBCC, ASWB, NAADAC/30✶
Wyoming	Accepted by Board/45✶, ♦	Accepted by Board/45✶, ♦

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	77722	Ethics for Counselors / 6 Clock Hours (6 NBCC Clock Hours)	$24
	76563	Alcohol and Alcohol Use Disorders / 10 Clock Hours (4 NBCC Clock Hours)	$40
	76080	Demystifying Dissociation: Principles, Best Practices, & Clinical Approaches / 10 Clock Hours (3 NBCC Clock Hours)	$40

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✓	Course #	Course Title / Clock Hours (NBCC Clock Hours)	Price
☐	71072	Beyond Therapy: The Basics of Clinical Documentation / 4	$24
☐	71463	Managing and Preventing Burnout / 4	$24
☐	71610	Integrating Religion & Spirituality into Counseling / 5	$28
☐	76181	Anxiety Disorders / 15	$68
☐	76221	Borderline Personality Disorder / 15	$68
☐	76383	Shyness: Causes and Impact / 3	$23
☐	76411	Behavioral Addictions / 15	$68
☐	76441	Suicide Assessment and Prevention / 6	$32
☐	76862	Clinical Supervision: A Person-Centered Approach / 10	$48
☐	77790	Domestic and Sexual Violence / 5	$28
☐	92203	Autism Spectrum Disorder / 5	$28
☐	96153	Alzheimer Disease / 15	$68
☐	96273	Sexual Addiction / 5	$28
☐	96623	Vicarious Trauma and Resilience / 15	$68
☐	96953	Methamphetamine Use Disorder / 5	$28
☐	97080	Sexual Harassment Prevention: The Illinois Req. / 1	$23
☐	97470	Human Trafficking and Exploitation: The Texas Req. / 5	$28
☐	97663	Online Professionalism and Ethics / 3	$23
☐	97823	Elder Abuse: Cultural Context and Implications / 5	$28
☐	98882	Sleep Disorders / 10	$48

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CTH21

Answer Sheet

(Completion of this form is mandatory)

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Please note the following:

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

#76920 RACIAL TRAUMA: THE AFRICAN AMERICAN EXPERIENCE—5 HOURS

Please refer to pages 17–19.

Expiration Date: 05/31/24 — *May be taken individually for $20*

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

#77722 ETHICS FOR COUNSELORS—6 HOURS

Please refer to pages 70–71.

Expiration Date: 04/30/22 — *May be taken individually for $24*

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

#76563 ALCOHOL AND ALCOHOL USE DISORDERS—10 HOURS

Please refer to pages 112–116.

Expiration Date: 05/31/24 — *May be taken individually for $40*

	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.	❍	❍	❍	❍					

#76080 DEMYSTIFYING DISSOCIATION—10 HOURS

Please refer to pages 143–148.

Expiration Date: 05/31/24 — *May be taken individually for $40*

	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)

CTH21

Last Name _____ First Name _____ MI _____

State _____ License # _____ Expiration Date _____

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

Compliance with APA, NBCC, and ASWB requires that providers collect a course evaluation from the participant that includes assessment of the content, delivery method, and achievement of the individual learning objectives.

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

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

#76920
Racial Trauma
5 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

#77722
Ethics for Counselors
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

#76563
Alcohol Use Disorders
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

#76080
Demystifying Dissociation
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

#76920 Racial Trauma: The African American Experience — Do you have any additional comments or suggestions? _____

#77722 Ethics for Counselors — Do you have any additional comments or suggestions? _____

#76563 Alcohol and Alcohol Use Disorders — Do you have any additional comments or suggestions? _____

#76080 Demystifying Dissociation: Principles, Best Practices, and Clinical Approaches — Do you have any additional comments or suggestions? _____

Signature _____

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Evaluation *(Continued)*

CTH21

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):

#76920 RACIAL TRAUMA: THE AFRICAN AMERICAN EXPERIENCE—5 HOURS (Course expires 05/31/24)

• Define racism and its historical and current manifestations in the United States.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe the impact of structural racism and related racial trauma on African American individuals.	☐ A	☐ B	☐ C	☐ D	☐ F
• Evaluate the adverse health and mental health impacts of racial trauma on African Americans.	☐ A	☐ B	☐ C	☐ D	☐ F
• Outline approaches to rapport building and mental health interventions best suited for African American clients who have experienced racial trauma.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss culturally relevant approaches to promote post-traumatic growth and provide trauma-informed care.	☐ A	☐ B	☐ C	☐ D	☐ F

#77722 ETHICS FOR COUNSELORS—6 HOURS (Course expires 04/30/22)

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

#76563 ALCOHOL AND ALCOHOL USE DISORDERS—10 HOURS (Course expires 05/31/24)

• Review facts about the history, costs, and prevalence of alcohol use and abuse.	☐ A	☐ B	☐ C	☐ D	☐ F
• Define moderate drinking and take a history of alcohol use as defined by the standard drink equivalency.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify benefits reported in the literature for moderate alcohol consumption.	☐ A	☐ B	☐ C	☐ D	☐ F
• Distinguish between genetic and environmental risk and protective factors for developing alcohol problems.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe clinical characteristics of alcohol use disorder, intoxication, and withdrawal.	☐ A	☐ B	☐ C	☐ D	☐ F
• List complications associated with alcohol use disorders.	☐ A	☐ B	☐ C	☐ D	☐ F
• Recognize mental problems associated with alcohol use disorders.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss screening instruments for detecting alcohol use disorders, including considerations for non-English-proficient patients.	☐ A	☐ B	☐ C	☐ D	☐ F
• Explain brief intervention efficacy and techniques.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe and evaluate treatment modalities.	☐ A	☐ B	☐ C	☐ D	☐ F

#76080 DEMYSTIFYING DISSOCIATON: PRINCIPLES, BEST PRACTICES, & CLINICAL APPROACHES—10 HOURS (Course expires 05/31/24)

• Define dissociation in a trauma-focused manner.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe the impact and manifestations of trauma and dissociation on the brain.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify common myths about working with dissociative clients in psychotherapy, including historical roots.	☐ A	☐ B	☐ C	☐ D	☐ F
• Outline diagnostic criteria for dissociative disorders.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe the Dissociative Profile exercise.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe the screening tools and inventories available for use in clinical settings regarding dissociation.	☐ A	☐ B	☐ C	☐ D	☐ F
• Apply personal metaphor and parts work in the care of clients with dissociation.	☐ A	☐ B	☐ C	☐ D	☐ F
• Outline the similarities between addiction and dissociation and how they can be found.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss key components of successful treatment planning for clients with dissociation.	☐ A	☐ B	☐ C	☐ D	☐ F
• Implement approaches for early and later phases of dissociative disorder treatment.	☐ A	☐ B	☐ C	☐ D	☐ F

Signature _____

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