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Maternal Health Disparities

4 Cultural Continuing Education Credits

Audience

This course is designed for all healthcare providers who may intervene to improve peripartum and postpartum health care and reduce health disparities.

Course Objective

The purpose of this course is to provide healthcare professionals with the knowledge and skills necessary to improve maternal outcomes in all races, ethnicities, and marginalized groups.

Learning Objectives

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

1. Outline the epidemiology of maternal morbidity and mortality.
2. Discuss how explicit and implicit bias may contribute to pregnancy-related deaths and maternal and infant health outcomes.
3. Identify cultural identity across racial, ethnic, and other marginalized groups, including historical and contemporary exclusion and oppression.
4. Identify environmental, personal, interpersonal, institutional, and cultural barriers to inclusion.
5. Describe effective approaches to communicate more effectively across racial, ethnic, religious, and gender identities.
6. Review information about racial and reproductive justice.
7. Identify measures to decrease explicit and implicit bias at the interpersonal and institutional levels.

Faculty

Mary Franks, MSN, APRN, FNP-C, is a board-certified Family Nurse Practitioner and NetCE Nurse Planner. She works as a Nurse Division Planner for NetCE and a per diem nurse practitioner in urgent care in Central Illinois. Mary graduated with her Associate's degree in nursing from Carl Sandburg College, her BSN from OSF Saint Francis Medical Center College of Nursing in 2013, and her MSN with a focus on nursing education from Chamberlain University in 2017. She received a second master's degree in nursing as a Family Nurse Practitioner from Chamberlain University in 2019. She is an adjunct faculty member for a local university in Central Illinois in the MSN FNP program. Her previous nursing experience includes emergency/trauma nursing, critical care nursing, surgery, pediatrics, and urgent care. As a nurse practitioner, she has practiced as a primary care provider for long-term care facilities and school-based health services. She enjoys caring for minor illnesses and injuries, prevention of disease processes, health, and wellness. In her spare time, she stays busy with her two children and husband, coaching baseball, staying active with her own personal fitness journey, and cooking. She is a member of the American Association of Nurse Practitioners and the Illinois Society of Advanced Practice Nursing, for which she is a member of the bylaws committee.

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INTRODUCTION

Substantial differences in maternal morbidity and mortality among racial and ethnic groups exist in the United States. Black women are more than twice as likely to die related to maternal complications compared with White women [1]. The Centers for Disease Control and Prevention (CDC) reports that nearly 20% of surveyed women reported experiences of mistreatment during their pregnancy and/or the delivery of their child/children [2]. However, the reported rates were higher among Black (30%), Hispanic (29%), and multiracial (27%) patients.

Increasingly, research has shown that the quality of health care is an important lever for expanding positive outcomes for racial and ethnic minority women [1]. This course will identify underlying drivers of maternal disparities, review potential contributing factors (with the intention of supporting amelioration), and outline approaches to improve maternal outcomes. This course will also explore supportive measures, particularly in minority populations to reduce explicit and implicit bias in perinatal care.

EPIDEMIOLOGY

WORLDWIDE

The United Nations International Children's Emergency Fund (UNICEF) reports an overall global 34% decline in the maternal mortality rate, from 342 maternal deaths per 100,000 live births in 2000 to 223 maternal deaths per 10,000 live births in 2020 [3]. This decrease is consistent with achieving the sustainable development goal of 70 maternal deaths per 100,000 live births by 2030. However, the maternal mortality rates plateaued in Western Europe and North America between 2016 and 2022, and Latin America and the Caribbean noted an increase over the same period. The goal annual reduction rate is 15% for every country [3].

The location with the largest number of maternal deaths is sub-Saharan Africa, where the rate is 545 maternal deaths per 100,000 live births. Countries with the lowest rates of maternal mortality include Australia and New Zealand (with 4 maternal deaths per 100,000 live births) [3]. Among regions, women in sub-Saharan Africa face the highest lifetime risk of maternal death (1 in 41), which is approximately 268 times higher than in Western Europe (1 in 11,000), the lowest-risk region [3].

UNITED STATES

In the United States, maternal deaths represent the largest disparity among all populations within perinatal health measures. The maternal mortality rate in the United States is unacceptably high and rising. In 2021, 1,205 women died of maternal causes in the United States, compared with 861 in 2020 and 754 in 2019 [4]. The maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births, compared with a rate of 23.8 in 2020 and 20.1 in 2019. More than 80% of all pregnancy-related deaths that occur in the United States are considered preventable [5].

Maternal mortality rates in the United States are higher among American Indian, Alaskan Native, Pacific Islander/Native Hawaiian, and Black women than among Asian, Hispanic, or White populations [6]. In 1933, the first time all states reported maternal deaths, the maternal mortality rate for Black women (1,000 deaths per 100,000 births) was 1.8 times greater than the rate for White women (564 deaths per 100,000 births). As of 2021, maternal death rates among Black women (69.9 per 100,000 births) had risen to 2.6 times higher than the rate noted for White women (26.6 per 100,000 births) [7].

Increases in maternal mortality rates are significantly greater among women 40 years of age and older. In this group, the mortality rate was 138.5 deaths per 100,000 live births in 2021 [7]. This represents an 83.4% increase compared with 2019. Data reported by the U.S. Government Accountability Office between 2020 and 2021 indicate the COVID-19 pandemic is a contributing factor to the increasing maternal mortality rate. This was believed to be linked to the chronic physiological stress present during pregnancy paired with severe illness from COVID-19 [8].

The CDC considers the following diagnoses/procedures as indicators of delivery hospitalizations with severe maternal mortality [9]:

- Acute myocardial infarction
- Aneurysm
- Acute renal failure
- Acute respiratory distress syndrome (ARDS)
- Amniotic fluid embolism
- Cardiac arrest/ventricular fibrillation
- Conversion of cardiac rhythm
- Disseminated intravascular coagulation
- Eclampsia
- Heart failure/arrest during surgery or procedure
- Puerperal cerebrovascular disorders
- Pulmonary edema/acute heart failure
- Severe anesthesia complications
- Sepsis
- Shock
- Sickle cell disease with crisis
- Air and thrombotic embolism
- Hysterectomy
- Temporary tracheostomy
- Ventilation

Blood transfusion is not included on this list but is considered separately as a potential indicator.

The American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine recommend using two criteria to screen for severe maternal morbidity: transfusion of 4 or more units of blood and admission of a pregnant or postpartum patient to an intensive care unit.

(https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2016/09/severe-maternal-morbidity-screening-and-review. Last accessed October 16, 2023.)

Strength of Recommendation: Expert Opinion/Consensus Statement

In addition to mortality, obstetric morbidity is also associated with increased risk in the minority populations, particularly for non-Hispanic Black women. For every reported maternal death, 100 women experience a severe obstetric disease or life-threatening diagnosis during their hospitalization for delivery. Analysis of 2012–2015 data indicates that the incidence of severe maternal morbidity was significantly higher among deliveries to women in every racial and ethnic minority category compared with deliveries among non-Hispanic White women [10]. Severe maternal morbidity occurred at a rate of 231.1 per 10,000 delivery hospitalizations for non-Hispanic Black patients; the rate was 139.2 per 10,000 delivery hospitalizations among non-Hispanic White women. Racial and ethnic minority women have higher rates on most major morbidity indicators than White patients [1; 9].

NEW JERSEY

In 2018, the New Jersey legislature enacted P.L. 2018, c.82, which requires the New Jersey Department of Health to issue a report on hospital maternity care. This report (often referred to as the maternal health report card for the state of New Jersey) gives insights into the evolution of the maternal population as well as trends in serious maternal morbidity and mortality [10]. Over time, the maternal population in New Jersey has become more diverse. In 2020, 54% of mothers identified as a race/ethnicity other than White, compared with 46% in 2000 [10]. There has also been a trend away from hospital births, with a 2% decrease in hospital deliveries between 2019 and 2020 [10].

The report assesses five measures to track maternal morbidities and delivery complications in the state: third- and fourth-degree perineal laceration, episiotomy, obstetric hemorrhage, post-admission infections, and severe maternal morbidity (a surrogate for other complications) [10]. In 2020, non-Hispanic Black mothers in New Jersey were noted to have the highest rate of obstetric hemorrhage, defined as cumulative blood loss greater than 1,000 mL regardless of the method of delivery (i.e., vaginal or cesarean birth) or blood loss accompanied by signs or symptoms of hypovolemia within 24 hours after the birth process. Risk factors for obstetric hemorrhage were Non-Hispanic Black or Hispanic race, cesarean delivery, placental or uterine disorders, nulliparity, premature gestational age, infection, pre-existing anemia, ICU admission, and pre-pregnancy overweight or obesity [10].

Non-Hispanic Black mothers in New Jersey also had the highest rate of severe maternal morbidity with need for blood transfusion, at a rate of 36.5 cases per 1,000 delivery hospitalizations. This represented a slight increase from the 2019 rate (35.6 cases per 1,000 delivery hospitalizations) [10]. Hispanic patients had the second highest rate (25.2 cases per 1,000 delivery hospitalizations). Non-Hispanic White mothers had the lowest documented transfusion rate (15.7 cases per 1,000 delivery hospitalizations)—a rate less than half that of Black mothers [10].

Asian mothers were identified to have the highest risk of third- and fourth-degree perineal tears without instrumentation (3.4 cases per 100 delivery hospitalizations). Hispanic and non-Hispanic Black mothers had the lowest rate of this complication (0.9 cases per 100 delivery hospitalizations) [10].

Asian mothers were also the most likely to experience episiotomies (11.6 cases per 100 delivery hospitalizations). The rate among this population is almost triple the next most likely group, Hispanic patients (4.3 cases per 100 delivery hospitalizations). Non-Hispanic Black mothers had the lowest episiotomy rate, at 2.8 cases per 100 delivery hospitalizations [10].

Postadmission infections were also most likely among Asian patients, who had a reported rate of 25.4 cases per 1,000 delivery hospitalizations. Hispanic mothers followed closely, with a rate of 21.8 per 1,000 delivery hospitalizations. The lowest rate occurred among non-Hispanic White mothers, who had a postadmission infection rate of 12.7 cases per 1,000 delivery hospitalizations (half the rate among Asian patients) [10].

Between 2016 and 2018, a total of 125 deaths with a temporal relationship to pregnancy (within 365 days) were reported in New Jersey [11]. Of these deaths, 44 (35%) were determined to be pregnancy-related, 74 (59%) were pregnancy-associated but not related, and 7 (6%) were unable to be determined. As in the rest of the country, the maternal mortality outcomes for non-Hispanic Black women continue to be largely disparate when compared to White women. The maternal mortality rate for Black women in New Jersey (39.2 deaths per 100,000 live births) is 6.6 times higher than the rate for White women (5.9 per 100,000 live births). The rate for Hispanic women (20.6 per 100,000 live births) is 3.5 times higher than the rate for White women [11].

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EXPLICIT AND IMPLICIT BIAS

Bias plays a pivotal role in health care, especially patient care. Therefore, it is important to define the term. In a sociocultural context, biases are generally defined as negative evaluations of a particular social group relative to another group. Explicit biases are conscious, whereby an individual is fully aware of his/her attitudes and there may be intentional behaviors related to these attitudes [13]. For example, an individual may openly endorse a belief that women are weak, and men are strong. This bias is fully conscious and is made explicitly known. Implicit bias refers to the unconscious attitudes and evaluations held by individuals. These individuals do not necessarily endorse the bias, but the embedded beliefs/attitudes can negatively affect their behaviors [14; 15; 16; 17]. Some have asserted that the cognitive processes that dictate implicit and explicit biases are separate and independent [17].

Implicit biases can start as early as 3 years of age. As children age, they may begin to become more egalitarian in what they explicitly endorse, but their implicit biases may not necessarily change in accordance with these outward expressions [18]. Because implicit biases occur on the subconscious or unconscious level, particular social attributes (e.g., skin color) can quietly and insidiously affect perceptions and behaviors [19]. According to Georgetown University's National Center on Cultural Competency, social characteristics that can trigger implicit biases include [20]:

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

An alternative way of conceptualizing implicit bias is that an unconscious evaluation is only negative if it has further adverse consequences on a group that is already disadvantaged or produces inequities [21; 22]. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages [21].

Implicit bias has been linked to a variety of health disparities [23]. Health disparities are differences in health status or disease that systematically and adversely affect less advantaged groups [24]. These inequities are often linked to historical and current unequal distribution of resources due to poverty, structural inequities, insufficient access to health care, and/or environmental barriers and threats [25]. As illustrated, health disparities have been clearly documented in maternal and perinatal care among racial/ethnic groups.

In an ideal situation, health professionals would be explicitly and implicitly objective, and clinical decisions would be completely free of bias. However, healthcare providers have implicit (and explicit) biases at a rate comparable to that of the general population [22; 26]. It is possible that these implicit biases shape healthcare professionals' behaviors, communications, and interactions, which may produce differences in help seeking, diagnoses, and ultimately treatments and interventions [26]. They may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up [15].

POWER DYNAMICS

Power dynamics are inevitable in many situations, including throughout the healthcare system, when two or more individuals are attempting to balance the power among themselves. These dynamics may look different in various situations. Seven types of power dynamics have been identified: coercive, expert, reward, informational, formal, referent, and connection [27]. When power is exerted differently between the parties, inequity can result. In practice, healthcare professionals may use power to protect their autonomy and exert their expertise. This can lead to problems in interprofessional collaboration and in a failure to focus on the patient's role in making healthcare decisions, advocating for their needs and preferences, and being an empowered member of the care team. Communication, competence, and role perceptions are common factors that influence power dynamics [28].

ORGANIZATIONAL FACTORS

Larger organizational, institutional, societal, and cultural forces contribute, perpetuate, and reinforce implicit and explicit biases, racism, and discrimination. Psychological and neuroscientific approaches ultimately decontextualize racism [17; 29]. Sources of bias in organizations include internal politics, culture, leadership, organizational history, and team-specific structures. Organizational bias reaches far beyond individuals themselves; the language used or tasks identified influence how the organization functions daily [30]. Bias within an organization can detour patients from visiting if they feel they are being viewed or cared for as a "lesser" patient. One of the primary roles and responsibilities of health professionals is to analyze how institutional and organizational factors promote racism and implicit bias and how these factors contribute to health disparities. This analysis should extend to include one's own position in this structure.

STRATEGIES TO PROMOTE AWARENESS

It is important to promote awareness of bias—both explicit and implicit biases and at personal, organizational, and professional levels. Education and training are powerful tools to identify and address issues related to bias. Reflection exercises and role play can be used, as hands-on skills are necessary in order to apply theories to practice. Creating safe environments and using skill-building exercises are key components of any program designed to reduce biases and related health disparities [31].

Harvard University sponsors Project Implicit, a research project which monitors implicit biases. Project Implicit houses the Implicit Association Test (IAT), which can be used as a metric to assess professionals' level of implicit bias on a variety of subjects, and this presupposes that implicit bias is a discrete phenomenon that can be measured quantitatively [32]. When providers are aware that implicit biases exist, discussion and education can be implemented to help reduce them and/or their impact. The IAT is available at https://implicit.harvard.edu/implicit, and anyone may complete an assessment.

Another way of facilitating awareness of providers' implicit bias is to ask self-reflective questions about each interaction with patients. Some have suggested using SOAP (or subjective, objective, assessment, and plan) notes to assist practitioners in identifying implicit biases in day-to-day interactions with patients [33]. Integrating the following questions into charts and notes can stimulate reflection about implicit bias globally and for each specific patient interaction:

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

When reviewing the SOAP notes, providers can look for recurring themes of stereotypical perceptions, biased communication patterns, and/or types of treatment/interventions proposed and assess whether these themes could be influenced by biases related to race, ethnicity, age, gender, sexuality, or other social characteristics. A review of empirical studies conducted on the effectiveness of interventions promoting implicit bias awareness found mixed results. At times, after a peer discussion of IAT scores, participants appeared less interested in learning and employing implicit bias reduction interventions. However, other studies have found that receiving feedback along with IAT scores resulted in a reduction in implicit bias. Any feedback, education, and discussions should be structured to minimize participant defensiveness [34].

IMPACT OF BIAS ON THE DELIVERY OF PERINATAL CARE

Worldwide, the maternal mortality has decreased 43% since 1993. However, the United States is the only developed country in which maternal mortality has increased [35]. As of 2023, the United States reports the highest maternal mortality of all developed countries. The rate in New Jersey (25.7 maternal deaths per 100,000 live births) is higher than the national average (23.5 deaths per 100,000 live births). The greatest rates tend to occur in the South [36].

What is further troubling is that most maternal deaths and cases of severe morbidity are preventable [35]. This then leads to the necessary question: Why are these deaths occurring? A review of maternal deaths across nine states found that the deaths were most commonly related to "clinician, facility, and system factors, such as inadequate training, missed or delayed diagnosis of complications, poor communication, and lack of coordination between clinicians" [37]. Improvements in clinician knowledge, skill, interprofessional collaboration, and bias could make inroads to improving maternal health care in the United States.

In a survey of 2,402 women regarding their maternal care, the following mistreatments were most commonly reported [2]:

- Receiving no response to requests for help
- Being shouted at or scolded
- Not having their physical privacy protected
- Being threatened with withholding treatment or made to accept unwanted treatment

About 30% of Black, Hispanic, and multiracial women reported mistreatment, with lower rates or reported mistreatment among White (19%), Native American/Alaska Native/Native Hawaiian/Pacific Islander (18%), and Asian (15%) patients. Mistreatment was most commonly reported by those with no insurance (28%) or public insurance (26%); only 16% of those with private insurance reported mistreatment. Patients most commonly reported discrimination and/or mistreatment during prenatal care related to age, weight, income, and race/ethnicity [2]. About 29% of women experienced discrimination, with the highest rates among Black (40%), multiracial (39%), and Hispanic (37%) women [2]. While satisfaction with maternity care overall was high (90%), satisfaction among those who reported mistreatment was considerably lower (75%). Mistreatment and discrimination impact experiences of care.

Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. For example, historical economic stresses and restrictions on housing, jobs, and education have resulted in health inequalities for racial and ethnic minority groups. Healthy People 2030 groups social determinants of health into five categories [38]:

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- Economic stability
- Education access and quality
- Health care access and quality
- Social and community context
- Neighborhood and built environment

These factors have a major impact on people's health, well-being, and quality of life. Social determinants contribute to maternal outcomes; however, they do not fully explain the large number of women of racial and ethnic backgrounds having higher than average maternal morbidity and mortality rates [37].

Implicit biases have been directly linked with lesser quality of care for certain patients, particularly those of minority groups. In some cases, this lower quality of care is triggered by stressful circumstances [35]. One explanation is that implicit biases are a heuristic, or a cognitive or mental shortcut. Heuristics offer individuals general rules to apply to situations in which there is limited, conflicting, or unclear information. Use of a heuristic results in a quick judgment based on fragments of memory and knowledge, and therefore, the decisions made may be erroneous. If the thinking patterns are flawed, negative attitudes can reinforce stereotypes [39].

Negative stereotyping can be a contributing factor to maternal health disparities. For example, healthcare providers may neglect to recognize the pain of non-Hispanic Black women or feel that this group's expressions of pain are more disproportionate than their actual experiences. One study found that a Black woman in New York City with a college education is nearly three times more likely to endure severe maternal morbidities compared with a White woman of similar age with less than a high school education [37]. In one study of patients following cesarean delivery, Black and Hispanic women were evaluated for pain less frequently, had higher pain scores, and received less pain medication than White women, even after controlling for other clinical factors, suggesting that these inequities are the result of different approaches to care delivery [40]. These implicit racial beliefs also have the potential to affect the way a patient is counseled about treatment options [35].

Serious maternal complications, including hemorrhage, embolism, eclampsia, and stroke, occur in all racial and age groups; however, there is a clearly documented increased risk for racial or ethnic minority women. Failure to recognize these complications could be related to the high-stress environments in which they occur, but they may also be related to stereotypical unconscious thoughts related to minority groups [38].

Preconception counseling and care is critical to optimizing maternal health. This includes management of chronic diseases, maternal and fetal screenings, and lifestyle changes. Racial and/or ethnic minority women tend to have less accessibility to preconception and antenatal care [37]. Closing these access and engagement gaps could help address some of the disparities in birth complications.

Postnatal care is less emphasized but is a significantly important aspect of maternal care. During the eight weeks following delivery, the physical and emotional needs of the mothers should be assessed, including chronic health issues or complications that developed during the gestational period (e.g., gestational diabetes, hypertension, anemia, peripartum anxiety, peripartum depression). Unfortunately, it is reported that 16% to 36% of women do not attend a six-week follow-up visit following birth [36]. Furthermore, those who do attend the six-week visit report insufficient care and postnatal guidance, indicating a need to improve both adherence and provision of care during this period.

Healthcare professionals have a responsibility to repair biased systems that perpetuate racial health disparities. The American College of Obstetricians and Gynecologists has released a statement on racism in obstetrics and gynecology that reads, in part, [41]:

> Racial and ethnic inequities in obstetrics and gynecology cannot be reversed without addressing all aspects of racism and racial bias, including sociopolitical forces that perpetuate racism. The actualization of an equitable health care system which serves all people can only occur through acknowledgment of the historical context from which modern health inequities grew, including reproductive injustices.

In order to reduce Black maternal mortality, the Centers for Disease Control and Prevention recommends that healthcare providers:

- Ask questions to better understand their patient and things that may be affecting their lives.
- Help patients, and those accompanying them, understand the urgent maternal warning signs and when to seek medical attention right away.
- Help patients manage chronic conditions or conditions that may arise during pregnancy, like hypertension, diabetes, or depression.
- Recognize and work to eliminate unconscious bias in themselves and in their office on an ongoing basis.
- Respond to any concerns patients may have.
- Provide all patients with respectful quality care.

(https://www.cdc.gov/healthequity/features/maternal-mortality. Last accessed October 16, 2023.)

Strength of Recommendation: Expert Opinion/Consensus Statement

INTERCULTURAL COMPETENCE AND CULTURAL IDENTITY

Cultural identity is defined as the "shared characteristics of a group of people, which encompasses place of birth, religion, language, cuisine, social behaviors, art, literature, and music" [42]. Cultural identity is important as it influences how we respond to different situations. In health care, cultural identity can influence the behaviors one exhibits, the barriers upheld, and professional decisions, interactions, and performance. Cultural identity can evolve, and even if one does not consider their culture consciously, it is exhibited subconsciously [43]. It is important to remember that one's cultural identity should not impede the care provided to patients. For example, religion can influence one's practice but it should not determine how one practices or the type or quality of care given.

Providing culturally responsive care can help to avoid practice that is influenced by explicit or implicit biases. The U.S. Department of Health and Human Services has outlined steps important to incorporate in evaluation and treatment planning processes to ensure culturally competent clinical and programmatic decisions and skills [44]. The first step is to engage patients. When engaging in any patient teaching, remember that individuals may be new to the specific language or jargon and expectations of the diagnosis and care process. Patients should be encouraged to collaborate in every step of their care. Practitioners should also work to identify screening and assessment tools that have been translated into or adapted for other languages and have been validated for their particular population group(s). Typically, culturally responsive care establishes holistic treatment goals that include objectives to improve physical health and spiritual strength; utilizes strengths-based strategies that fortify cultural heritage, identity, and resiliency; and recognizes that treatment planning is a dynamic process that evolves along with an understanding of patient history and treatment needs.

As part of the cultural competence process and as a reflection of cultural humility, practitioners should strive to learn as much as possible about the specific racial/ethnic populations they serve. However, considerable diversity exists within any specific culture, race, or ethnicity [45]. Cultural beliefs, traditions, and practices change over time, both through generations and within an individual's lifetime. It is also possible for the differences between two members of the same racial/ethnic group to be greater than the differences between two people from different racial/ethnic groups. Within-group variations in how people interact with their environments and specific social contexts are also often present.

In addition to these general approaches, specific considerations may be appropriate for specific populations. While discussion of every possible patient subgroup is outside of the scope of this course, some of the most common factors are outlined in the following sections.

BLACK PATIENTS

"Black" or "African American" is a classification that serves as a descriptor; it has sociopolitical and self-identification ramifications. The U.S. Census Bureau defines African Americans or Black Americans as persons "having origins in any of the Black racial groups of Africa" [46].

Historical adversity and institutional racism contribute to health disparities in this group. For the Black population, patient assessment and treatment planning should be framed in a context that recognizes the totality of life experiences faced by patients. In many cases, particularly in the provision of mental health care, equality is sought in the provider-patient relationship, with less distance and more disclosure. Practitioners should assess whether their practices connect with core values of Black culture, such as family, kinship, community, and spirituality. Generalized or Eurocentric treatment approaches may not easily align with these components of the Black community [47]. Providers should also consider the impact of racial discrimination on health and mental health among Black patients. Reports indicate that expressions of emotion by Black patients tend to be negatively misunderstood or dismissed; this reflects implicit or explicit biases.

ASIAN PATIENTS

"Asian" is a single term widely used to describe individuals who have kinship and identity ties to Asia, including the Far East, Southeast Asia, and the Indian subcontinent. This encompasses countries such as China, Japan, Korea, Vietnam, Cambodia, Thailand, India, Pakistan, and the Philippines. Pacific Islander is often combined with Asian American in census data. The Pacific Islands include Hawaii, Guam, Samoa, Fiji, and many others [48]. There are more than 25 Asian/Pacific Islander groups, each with a different migration history and widely varying sociopolitical environments in their homelands [49].

As of 2019, 22.9 million Americans identified as Asian [50]. Between 2000 and 2019, Asians experienced the greatest growth compared with any other racial group at 81% [51; 52]. The Chinese group represents the largest Asian subgroup in the United States, and it is projected that this population will grow to 35.7 million between 2015 and 2040 [53; 54].

Recommended best practices when caring for Asian American patients include:

- Create an advisory committee using representatives from the community.
- Incorporate cultural knowledge and maintain flexible attitudes.
- Provide services in the patients' primary language.
- Develop culturally specific questionnaires for intake to capture information that may be missed by standard questionnaires.

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- Emphasize traditional values and incorporate traditional practices (e.g., acupuncture) into treatment plans, when appropriate and desired.
- Explore patient coping mechanisms that draw upon cultural strengths.

While these approaches have been identified as useful for Asian patients, they may be broadly applicable across racial groups.

LATINO/A/X OR HISPANIC PATIENTS

In 2020, the Hispanic population in the United States numbered 60.6 million, comprising 18.7% of the U.S. population [55]. As such, they are the largest ethnic minority group in the United States. The majority of the Hispanic population in the United States (63.3%) identify themselves as being of Mexican descent [56]. Approximately 27% of the U.S. Hispanic population identify as Puerto Rican, Cuban, Salvadoran, Dominican, Guatemalan, Colombian, Honduran, Ecuadorian, or Peruvian [57].

When involved in the care of Latinx/Hispanic individuals, practitioners should strive to employ *personalismo* (warm, genuine communication) and recognize the importance of *familismo* (the centrality of the family). More flexible scheduling strategies may be more successful with this group, if possible, and some patients may benefit from culturally specific treatment and ethnic and gender matching with providers. Aspects of Latino culture can be assets in treatment: strength, perseverance, flexibility, and an ability to survive.

NATIVE AMERICAN PATIENTS

The Native American population is extremely diverse. According to the U.S. Census, the terms "Native American," "American Indian," or "Alaskan Native" refer to individuals who identify themselves with tribal attachment to indigenous groups of North and South America [58]. In the United States, there are 574 federally recognized tribal governments and 324 federally recognized reservations [59].

In 2020, it was reported that there were 7.1 million Native Americans in the United States, which is approximately 2% of the U.S. population. By 2060, this number is projected to increase to 10.1 million, or 2.5% of the total population [59].

Listening is an important aspect of rapport building with Native American patients, and practitioners should use active listening and reflective responses. Assessments and histories may include information regarding patients' stories, experiences, dreams, and rituals and their relevance. Interruptions and excessive questioning should be avoided if possible. Extended periods of silence may occur, and time should be allowed for patients to adjust and process information. Practitioners should avoid asking about family or personal matters unrelated to presenting issues without first asking permission to inquire about these areas. Native American patients often respond best when they are given suggestions and options rather than directions.

WHITE AMERICAN PATIENTS

In 2021, 76.3% of the U.S. population identified as White alone [60]. The U.S. Census Bureau defines White race as a person having origins in any of the original peoples of Europe, the Middle East, or North Africa [46]. While the proportion of the population identifying as White only decreased between 2010 and 2020, the numbers of persons identifying as White and another race/ethnicity increased significantly. The White population in the United States is diverse in its religious, cultural, and social composition. The greatest proportion of this group reports a German ancestry (17%), followed by Irish (13%), English (10%), and Italian (7%) [61].

Providers can assume that most well-accepted treatment approaches and interventions have been tested and evaluated with White American individuals, particularly men. However, approaches may need modification to suit class, ethnicity, religion, and other factors.

Providers should establish not only the patient's ethnic background but also how strongly the person identifies with that background. It is also important to be sensitive to a person's multiracial/multiethnic heritage, if present, and how this might affect their family relationships and social experiences. Assumption of White race should be avoided, as White-passing persons of color have their own unique needs.

BARRIERS TO INCLUSION

Culturally diverse patients experience a variety of barriers when seeking health and mental health care, including:

- Immigration status
- Lower socioeconomic status
- Language barriers
- Cultural differences
- Lack of or poor health insurance coverage
- Fear of or experiences with provider discrimination
- Mistrust of healthcare systems

Such obstacles can interfere with or prevent access to treatment and services, compromise appropriate referrals, affect compliance with recommendations, and result in poor outcomes. Culturally competent providers build and maintain rich referral resources to meet patients' assorted needs.

Encountering discrimination when seeking health or mental health services is a barrier to optimal care and contributor to poorer outcomes in under-represented groups. Some providers will not treat patients because of moral objections, which can affect all groups, but particularly those who are gender and/or sexual minorities, religious minorities, and/or immigrants. In fact, in 2016, Mississippi and Tennessee passed laws allowing health providers to refuse to provide services if doing so would violate their religious beliefs [62]. However, it is important to remember that providers are obligated to act within their profession's code of ethics and to ensure all patients receive the best possible care.

CULTURALLY RESPONSIVE COMMUNICATION

Styles of communication can be classified from high- to low-context [63]. High-context cultures are those cultures that disseminate information relying on shared experience, implicit messages, nonverbal cues, and the relationship between the two parties [64; 65]. Members of these cultural groups tend to listen with their eyes and focus on how something was said or conveyed [63; 66]. On the other hand, low-context cultures rely on verbal communication or what is explicitly stated in the conversation [64]. Consequently, low-context communicators listen with their ears and focus on what is being said [63; 65; 66]. Western culture, including the United States, can be classified as a low-context culture. On the other hand, groups from collectivistic cultures, such as Asian/Pacific Islanders, Hispanics, Native Americans, and Black Americans, are from high-context cultures [63].

Communicators from high-context cultures generally display the following characteristics [64; 65; 66; 67]:

- Use of indirect modes of communication
- Use of vague descriptions
- Less talk and less eye contact
- Interpersonal sensitivity
- Use of feelings to facilitate behavior
- Assumed recollection of shared experiences
- Reliance on nonverbal cues such as gestures, tone of voice, posture, voice level, rhythm of speaking, emotions, and pace and timing of speech
- Assimilation of the "whole" picture, including visual and auditory cues
- Emotional speech
- Use of silence
- Use of more formal language, emphasizing hierarchy between parties

On the other hand, low-context communicators can typically be described as [64; 65; 66]:

- Employing direct patterns of communication
- Using explicit descriptions and terms
- Assuming meanings are described explicitly
- Utilizing and relying minimally on nonverbal cues
- Speaking more and often raising their voices (more animated, dramatic)
- Often being impatient to get to the point of the discussion
- Using more informal language; less emphasis on hierarchy, more equality between parties (more friendly)
- Being more comfortable with fluidness and change
- Uncomfortable using long pauses and storytelling as a means of communicating

Understanding the distinctions between individuals who come from high- and low-context cultures can promote cultural sensitivity. However, it is vital that practitioners take heed of several words of caution. First, it is important not to assume that two individuals sharing the same culture (e.g., low-context culture) will automatically have a shared script for communicating. Second, it is important to not immediately classify an individual into a low- or high-context culture because of their ethnicity. Third, a major criticism of the discussion of low-/high-context cultures is that they reinforce dualism and ultimately oversimplify the complexities and nuances of communication [68].

In this multicultural landscape, interpreters are a valuable resource to help bridge the communication and cultural gap between clients/patients and practitioners. Interpreters are more than passive agents who translate and transmit information back and forth from party to party. When they are enlisted and treated as part of the interdisciplinary clinical team, they serve as cultural brokers, who ultimately enhance the clinical encounter. In any case in which information regarding diagnostic procedures, treatment options, and medication/treatment measures are being provided, the use of an interpreter should be considered. Whenever possible, professional interpreters are preferred. Family interpreters should be avoided if at all possible.

Preferred language and immigration/migration status should be considered. Stressing confidentiality and privacy is particularly important for undocumented workers or recent immigrants, who may be fearful of deportation.

RACIAL AND REPRODUCTIVE JUSTICE

Racial biases in healthcare access, treatment, and outcomes and institutional racism embedded in healthcare institutions contribute to poorer health outcomes in minority populations. Many healthcare organizations are committing to the improvement of racial inequalities by dedicating resources and infrastructure to negating this problem. Healthcare organizations and practitioners have a vital role in acknowledging and dismantling structural racism [69].

Race Forward defines racial justice as "a vision and transformation of society to eliminate racial hierarchies and advance collective liberation, where Black, Indigenous, Latinx, Asian Americans, Native Hawaiians, and Pacific Islanders, in particular, have the dignity, resources, power, and self-determination to fully thrive" [70]. In the context of health care, this concept is related to eliminating race-related health disparities, ensuring access and quality of care for minority groups, and improving quality of life for all persons, regardless of race, color, or ethnicity. This requires that practitioners take a perspective of cultural humility and proactively move to dismantle harmful stereotypes and practices.

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It is vital to actively listen and critically evaluate patient relationships. All practitioners should seek to educate themselves regarding the experiences of patients who are members of a community that differs from their own. Resources and opportunities to collaborate may be available from community organizations and leaders.

The term "reproductive justice" was coined by a group of Black women in 1994 [90]. This concept, linked to racial justice, is based on the core belief that sexual and reproductive justice exists when all people have the power and resources to make healthy decisions about their bodies, sexuality, and reproduction. Reproductive justice sheds light on the multiple combined forms of oppression that contribute to the reproductive oppression of women of color. This perspective asserts that intersecting systems of oppression (e.g., race, class, gender) result in the control and exploitation of women, girls, gender-expansive individuals, and others through their bodies, sexuality, labor, and/or reproduction [90]. Persons who experience multiple oppressions experience more severe maternal morbidity. Only addressing all of the systemic issues contributing to poorer maternal health outcomes in persons of color will resolve racial health disparities in the United States.

INTERVENTIONS TO REDUCE IMPLICIT BIAS AND RELATED MATERNAL HEALTH DISPARITIES

According to the CDC, interventions to address bias on multiple levels can reduce pregnancy-related deaths [2]. Healthcare systems should foster a respectful maternity culture by hiring and retaining a diverse labor force and training all healthcare staff to identify implicit bias and stigma. The CDC also recommends healthcare systems promote quality improvement measures, focusing on increasing the respectful maternity culture for all women, so all patients feel they are equal regardless of race, ethnicity, or socioeconomic status. It is also ideal for healthcare professionals to strive for all maternal patients to feel respected, understood, supported, and valued throughout their care [2].

The American College of Obstetricians and Gynecologists makes the following recommendations for obstetrician/gynecologists and other healthcare providers to improve patient-centered care and decrease inequities in reproductive health care by [71]:

- Inquiring about and documenting social and structural determinants of health that may influence a patient's health and use of health care
- Maximizing referrals to social services to help improve patients' abilities to fulfill these needs
- Providing access to interpreter services for all patient interactions when patient language is not the clinicians' language
- Recognizing that stereotyping patients using presumed cultural beliefs can negatively affect patient interactions, especially when patients' behaviors are attributed solely to individual choices without recognizing the role of social and structural factors

The CDC has also launched the Hear Her campaign to provide resources for practitioners and pregnant and postpartum women, with an emphasis on preventing pregnancy-related deaths by sharing potentially life-saving messages about urgent warning signs. The Hear Her campaign can be accessed online at https://www.cdc.gov/hearher.

Adherence to guideline-endorsed practice may also help to reduce health disparities. In a Ghanaian study, provider adherence to antenatal care guidelines beginning in the first visit improved delivery and neonatal outcomes [89]. In addition, racial and ethnic disparities in severe maternal morbidity and mortality may be at least partially explained by variation in hospital quality. The majority of Black women who deliver in the United States (75%) do so in only 25% of hospitals; only 18% of White women deliver in those same hospitals [1]. The hospitals more likely to serve Black communities have higher risk-adjusted severe maternal morbidity rates, regardless of the patient's race/ethnicity, than the national average. Improving access to high-quality maternal health care and adherence to antenatal and postpartum guidelines may thus effectively reduce racial disparities in maternal morbidity and mortality.

In addition to these strategies, practitioners should act to address their own implicit biases. Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors [72]. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

PERSPECTIVE TAKING

Perspective taking is a strategy of taking on a first-person perspective of a person in order to control one's automatic response toward individuals with certain social characteristics that might trigger implicit biases [73]. The goal is to increase psychological closeness, empathy, and connection with members of the group [39]. Engaging with media that presents a perspective (e.g., watching documentaries, reading an autobiography) can help promote better understanding of the specific group's lives, experiences, and viewpoints. In one study, participants who adopted the first-person perspectives of Black Americans had more positive automatic evaluations of the targeted group [74].

EMPATHY INTERVENTIONS

Promoting positive emotions such as empathy and compassion can help reduce implicit biases. This can involve strategies like perspective taking and role playing [75]. In a study examining analgesic prescription disparities, nurses were shown photos of White or African American patients exhibiting pain and were asked to recommend how much pain medication was needed; a control group was not shown photos. Those who were shown images of patients in pain displayed no differences in recommended dosage along racial lines; however, those who did not see the images averaged higher recommended dosages for White patients compared with Black patients [76]. This suggests that professionals' level of empathy (enhanced by seeing the patient in pain) affected prescription recommendations.

In a study of healthcare professionals randomly assigned to an empathy-inducing group or a control group, participants were given the IAT to measure implicit bias prior to and following the intervention. The level of implicit bias among participants in the empathy-inducing group decreased significantly compared with their control group counterparts [77].

INDIVIDUATION

Individuation is an implicit bias reduction intervention that involves obtaining specific information about the individual and relying on personal characteristics instead of stereotypes of the group to which he or she belongs [39; 73]. The key is to concentrate on the person's specific experiences, achievements, personality traits, qualifications, and other personal attributes rather than focusing on gender, race, ethnicity, age, ability, and other social attributes, all of which can activate implicit biases. When providers lack relevant information, they are more likely to fill in data with stereotypes, in some cases unconsciously. Time constraints and job stress increase the likelihood of this occurring [78].

MINDFULNESS

Mindfulness requires stopping oneself and deliberately emptying one's mind of distractions or allowing distractions to drift through one's mind unimpeded, focusing only on the moment; judgment and assumptions are set aside. This approach involves regulating one's emotions, responses, and attention to return to the present moment, which can reduce stress and anxiety [79]. There is evidence that mindfulness can help regulate biological and emotional responses and can have a positive effect on attention and habit formation [39]. A mindfulness activity assists individuals to be more aware of their thoughts and sensations. This focus on deliberation moves the practitioner away from a reliance on instincts, which is the foundation of implicit bias-affected practice [39; 80].

Mindfulness approaches include yoga, meditation, and guided imagery. One approach to mindfulness using the acronym STOPP has been developed as a practical exercise to engage in mindfulness in any moment. STOPP is an acronym for [81]:

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

Mindfulness practice has been explored as a technique to reduce activation or triggering of implicit bias, enhance awareness of and ability to control implicit biases that arise, and increase capacity for compassion and empathy toward patients by reducing stress, exhaustion, and compassion fatigue [82]. One study examined the effectiveness of a loving-kindness meditation practice training in improving implicit bias toward Black and unhoused persons. One hundred one non-Black adults were randomized to one of three groups: a six-week loving-kindness mindfulness practice, a six-week loving-kindness discussion, or the waitlist control. The IAT was used to measure implicit biases, and the results showed that the loving-kindness meditation practice decreased levels of implicit biases toward both groups [83].

COUNTER-STEREOTYPICAL IMAGING

Counter-stereotypical imaging approaches involve presenting an image, idea, or construct that is counter to the oversimplified stereotypes typically held regarding members of a specific group. In one study, participants were asked to imagine either a strong woman (the experimental condition) or a gender-neutral event (the control condition) [84]. Researchers found that participants in the experimental condition exhibited lower levels of implicit gender bias. Similarly, exposure to female leaders was found to reduce implicit gender bias [85]. Whether via increased contact with stigmatized groups to contradict prevailing stereotypes or simply exposure to counter-stereotypical imaging, it is possible to unlearn associations underlying various implicit biases. If the social environment is important in priming positive evaluations, having more positive visual images of members in stigmatized groups can help reduce implicit biases. Some have suggested that even just hanging photos and having computer screensavers reflecting positive images of various social groups could help to reduce negative associations [86].

CHIEF EQUITY OFFICERS

Equity teams are encouraged to help with implicit bias in healthcare institutions. A chief equity officer has strong relationships in the delivery system and works to ensure health equity is prioritized. Those in this role are leaders with practical oversight of healthcare delivery and implementation. Equity officers are distinct from chief diversity officers, who focus more on internal recruiting, retention, and inclusion opportunities. An equity officer drives an agenda that addresses internal performance in quality and access for all patients, particularly vulnerable patients [87].

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Chief equity officers often concentrate on staff preparation, responsibility, and biases, and work to assess and improve how staff regard and treat all patients, regardless of race, ethnicity, gender/sex, or socioeconomic status. Chief equity officers implement approaches to engage providers and the wider community to support and address medical and nonmedical (social determinants) risks to health outcomes [87].

RESOURCES

Maternal Mortality Review Committees
http://reviewtoaction.org/tools/networking-map

CDC Working Together to Reduce Black Maternal Mortality
https://www.cdc.gov/healthequity/features/maternal-mortality/index.html

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

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

New Jersey Maternal Care Quality Collaborative (NJMCQC)
https://www.nj.gov/health/maternal/mcqc

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

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

Partnership for Maternal and Child Health of Northern New Jersey
https://www.partnershipmch.org

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

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

Unconscious Bias Project
https://unconsciousbiasproject.org

CONCLUSION

There is no question that maternal health disparities are a significant problem in the United States. Inequalities have been associated with many factors, including education level, literacy, age, and socioeconomic status. However, the greatest disparities have been noted among racial/ethnic minority women and have been linked to explicit and implicit biases in healthcare providers and systems. It is of the utmost importance that those caring for patients in the peripartum and postpartum period are committed to lowering the morbidity and mortality rates of all mothers of color. Promoting equity and cultural competence, effectively addressing modifiable risk factors, improving communication and monitoring, and engaging in regular training are needed to improve the health and outcomes of this population.

GLOSSARY

Pregnancy-associated death: A death during or within one year of pregnancy, regardless of the cause [88].

Pregnancy-related death: A death during or within one year of pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy [88].

Preventability: A death is considered preventable if there was at least some chance of the death being prevented by one or more reasonable changes to patient, family, provider, facility, system, and/or community factors. This definition is used by maternal mortality review committees to determine if a death they review is preventable [88].

Maternal death: The death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental causes. This definition is used by the National Center for Health Statistics and the World Health Organization [88].

Maternal mortality ratio: The number of maternal deaths (as defined) per 100,000 live births. Also referred to as the maternal mortality rate [88].

Maternal mortality: Number of deaths during pregnancy, childbirth, and the postpartum period up to 365 days from the end of pregnancy [88].

Customer Information/Answer Sheet/Evaluation insert located between pages 48–49.

TEST QUESTIONS
#93010 MATERNAL HEALTH DISPARITIES

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 4 Hour activity must be completed by October 31, 2026.

1. Which of the following statements regarding the global maternal mortality rate is TRUE?
A) *The goal annual reduction rate is 15% for every country.*
B) *The location with the largest number of maternal deaths is southeast Asia.*
C) *There was an overall global 34% increase in the maternal mortality rate between 2000 and 2020.*
D) *The lowest rate of maternal mortality occurs in Sweden (with 4 maternal deaths per 100,000 live births).*

2. What percentage of all pregnancy-related deaths that occur in the United States are considered preventable?
A) *8%*
B) *20%*
C) *60%*
D) *80%*

3. As of 2021, maternal death rates among Black women in the United States is how much higher than the rate noted for White women?
A) *1*
B) *2.6*
C) *5.8*
D) *13*

4. Which of the following diagnoses/procedures is an indicator of delivery hospitalizations with severe maternal mortality?
A) *Sepsis*
B) *Eclampsia*
C) *Ventilation*
D) *All of the above*

5. Explicit bias refers to the unconscious attitudes and evaluations held by individuals.
A) *True*
B) *False*

6. Which of the following is a social characteristic that can trigger implicit bias?
A) *Age*
B) *Skin tone*
C) *English language proficiency and fluency*
D) *All of the above*

7. Healthcare providers have implicit (and explicit) biases at a rate comparable to that of the general population.
A) *True*
B) *False*

8. All of the following are sources of organizational bias, EXCEPT:
A) *Location*
B) *Leadership*
C) *Internal politics*
D) *Organizational history*

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

10. All of the following are categories of social determinants, EXCEPT:
A) *Race*
B) *Economic stability*
C) *Health care access and quality*
D) *Social and community context*

11. Racial and/or ethnic minority women tend to have less accessibility to preconception and antenatal care.
A) *True*
B) *False*

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12. **Cultural identity**
    A) *is static and does not evolve over one's life.*
    B) *does not significantly impact how we respond to different situations.*
    C) *can influence the behaviors, professional decisions, interactions, and performance in health care.*
    D) *is defined as an attitude of humbleness, acknowledging one's limitations in the cultural knowledge of groups.*

13. **Which of the following has been identified as a core value of Black culture?**
    A) *Spirituality*
    B) *Community*
    C) *Family/kinship*
    D) *All of the above*

14. **All of the following are aspects of Latino culture that can be assets in treatment, EXCEPT:**
    A) *Strength*
    B) *Flexibility*
    C) *Machismo*
    D) *Perseverance*

15. **Which of the following statements regarding providing care to Native American patients is TRUE?**
    A) *Listening is an important aspect of rapport building with Native American patients.*
    B) *Interruptions and in-depth questioning establish familiarity and are recommended, if possible.*
    C) *Practitioners should ask about family or personal matters unrelated to presenting issues as early as possible.*
    D) *Native American patients respond best when they are given directions rather than suggestions and options.*

16. **Which of the following statements regarding discrimination and refusal to treat is TRUE?**
    A) *It is illegal in all states to refuse to provide services even if doing so would violate one's religious beliefs.*
    B) *Failure to treat patients because of moral objections particularly affects those who are racial minorities and men.*
    C) *Providers are obligated to act within their profession's code of ethics and to ensure all patients receive the best possible care.*
    D) *Encountering discrimination when seeking health or mental health services is not a significant barrier to optimal care and generally does not contribute to poorer outcomes in under-represented groups.*

17. **Which of the following is a typical characteristic of communication in high-context cultures?**
    A) *Use of more informal language*
    B) *Speaking more and often raising one's voice*
    C) *Assumption that meanings are described explicitly*
    D) *Reliance on interpreting eye contact, gestures, and tone of voice*

18. **In the context of health care, the concept of racial justice involves**
    A) *participating in consciousness raising activities and committing funds to community programs.*
    B) *enacting policies guaranteeing a diverse workforce and the establishment of internal diversity committees.*
    C) *everyone getting the same opportunity and uniform approaches to care for all patients, regardless of race, color, or ethnicity.*
    D) *eliminating race-related health disparities, ensuring access and quality of care for minority groups, and improving quality of life for all persons, regardless of race, color, or ethnicity.*

19. **To improve patient-centered care and decrease inequities in reproductive health care, the American College of Obstetricians and Gynecologists (ACOG) recommends that providers**
    A) *provide access to interpreter services for all patient interactions when patient language is not the clinicians' language.*
    B) *refer patients to social services to help improve patients' abilities to fulfill their needs and overcome barriers to care.*
    C) *inquire about and document social and structural determinants of health that may influence a patient's health and use of health care.*
    D) *All of the above*

20. **Hospitals more likely to serve Black communities**
    A) *are also the largest source of maternal health care for White patients.*
    B) *generally have the best scores in terms of maternal mortality and morbidity.*
    C) *have higher rates of severe maternal morbidity rates for Black patients but not White patients.*
    D) *have higher risk-adjusted severe maternal morbidity rates, regardless of the patient's race/ethnicity, than the national average.*

Test questions continue on next page →

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

22. Mr. A, a social worker, attempts to record personal information about his patients and not simply social characteristics. For example, he writes, "Patient is an elderly Hispanic woman, age 79 years. She lives with her daughter and is an avid pianist." What is this an example of?
A) *STOPP*
B) *Priming*
C) *Power-sharing*
D) *Individuation*

23. The STOPP acronym for mindfulness stands for
A) *still, time, open, prayer, and pulse.*
B) *stand, tilt, observation, prudent, and philosophy.*
C) *stop, take a breath, observe, pull back, and practice.*
D) *sacred, top-down, one moment, push through, and priority.*

24. Counter-stereotypical imaging approaches involve
A) *promoting positive emotions such as empathy and compassion to help reduce implicit biases.*
B) *presenting an image, idea, or construct that is counter to the oversimplified stereotypes typically held regarding members of a specific group.*
C) *obtaining specific information about the individual and relying on personal characteristics instead of stereotypes of the group to which he or she belongs.*
D) *stopping oneself and deliberately emptying one's mind of distractions or allowing distractions to drift through one's mind unimpeded, focusing only on the moment.*

25. Equity officers are the same as chief diversity officers, as both focus on internal recruiting, retention, and inclusion opportunities.
A) *True*
B) *False*

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

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Ethics for Social Work

6 Social Work Ethics* Continuing Education Credits

Audience

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

Course Objective

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

Learning Objectives

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

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

Faculty

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

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

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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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Director Disclosure

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

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INTRODUCTION

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

HISTORICAL CONTEXT OF SOCIAL WORK ETHICS

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

These two events triggered the realization that an organized standard of ethics was needed. Values of self-determination, voluntary consent, and informed consent needed to be upheld. In 1966, the Public Health Services established ethical regulations for medical research. In 1974, the National Commission for the Protection of Human Subjects was created by public law. Finally, in 1979, the commission published *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. The commission recommended that all institu-

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

tions receiving federal research funding establish institutional review boards. Today, these boards, made up of researchers and lay people, review social science research proposals to ensure that they meet ethical standards for protecting the rights of the potential subjects. In 1991, the "Common Rule" or the federal policy about protecting human research participants was published [72]. In 2011, revisions to the Common Rule were introduced to provide additional protections for human research participants and lesson researcher burden [73].

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

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

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

PHILOSOPHICAL HISTORY OF ETHICS

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

Modernism

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

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

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

Postmodernism

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

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

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

HISTORICAL EVOLUTION OF ETHICS IN SOCIAL WORK

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

Morality Period

In the late 1800s, social work was concerned primarily with the morality of the poor [6]. Organized relief focused on pauperism and efforts to lift the poor out of their "shiftless" and "wayward" behaviors and habits. Poverty was attributed to internal personality traits. By the early 1900s, with the settlement house movement, social work ideology was moving away from attributing social problems to the individual and focused instead on causative environmental factors. However, an emphasis remained on the morality of social change and reform as focus shifted from the personal to the social [6; 97]. Consequently, a social worker's ethical obligation was to promote social justice and reform.

Values Period

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

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

Period of Ethical Theory and Decision Making

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

In the 1980s, social workers continued to further explore the profession's values. Drawing on ideas from philosophy

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and the newer field of applied ethics, social work literature focused on ethical theories, ethical decision making, and ethical challenges confronted in direct practice such as client self-determination, informed consent, and the relationships among practitioners [6].

Ethical Standards and Risk Management Period

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

Digital Period

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

Contemporary Issues

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

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

DEVELOPMENT OF THE CODES OF ETHICS IN SOCIAL WORK

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

It consisted of 14 general and idealistic statements that described social workers' responsibilities and obligations to the field [7]. In 1979, this Code of Ethics was revised, and the second iteration consisted of a ten-page document that described social workers' conduct and their responsibility to their clients, colleagues, professional field, and society. It was the first time that it was explicitly stated that social workers needed to abide by any disciplinary rulings based on the code. In 1990, another revision was made. This third iteration eliminated the prohibition against soliciting colleagues' clients and added a statement that prevented social work professionals from exploiting relationships with clients for personal advantage or accepting anything for making a referral. In 1993, the fourth iteration included two additional amendments—social workers' responsibility to impaired clients and the prohibition against dual relationships [7].

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

COMMON TERMS USED IN THE DISCUSSION OF ETHICS

VALUES

Frequently, the terms values and ethics are employed interchangeably; however, the terms are not synonymous. Values are beliefs, attitudes, or preferred conceptions about what is good or desirable that provide direction for daily living. They stem from our personal, societal, and agency values. Rokeach has argued that values may be organized into two categories: terminal values and instrumental values [9]. Terminal values describe the desired end-goal for a person's life; they are identified as: happiness, inner harmony, wisdom, salvation, equality,

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

freedom, pleasure, true friendship, mature love, self-respect, social recognition, family security, national security, a sense of accomplishment, a world of beauty, a world at peace, a comfortable life, and an exciting life. Instrumental values are those that help a person to achieve their desired terminal values, such as love, cheerfulness, politeness, responsibility, honesty, self-control, independence, intellect, broad-mindedness, obedience, capability, courage, imagination, logic, ambition, cleanliness, helpfulness, and forgiveness. Ultimately, all of these types of values influence how a person will behave. Not all individuals will identify with all of these values; most will have a few terminal values that are important to them. When there is conflict or tension between values, such as politeness and honesty, individuals will begin to prioritize [9; 69].

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

Values in the NASW Code of Ethics

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

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

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

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

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

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

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

ETHICS

Ethics are the beliefs an individual or group maintains about what constitutes correct or proper behavior [13]. To put it simply, ethics are the standards of conduct an individual uses to make decisions. The term morality is often confused with ethics; however, morality involves the judgment or evaluation of an ethical system, decision, or action based on social, cultural,

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or religious norms [13; 14]. The term morals is derived from the Latin word *mores*, which translates into customs or values.

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

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

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

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

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

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

NASW CODE OF ETHICS

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

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

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

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

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

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

1. Social workers' primary goal is to help people in need and to address social problems (drawn from core value of service).
2. Social workers challenge social injustice (drawn from core value of social justice).
3. Social workers respect the inherent dignity and worth of the person (drawn from the core value of dignity and worth of the person).

4. Social workers recognize the central importance of human relationships (drawn from the core value of importance of human relationships).
5. Social workers behave in a trustworthy manner (drawn from the core value of integrity).
6. Social workers practice within their areas of competence and develop and enhance their professional expertise (drawn from core value of competence).

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

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

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

ILLUSTRATIVE EXAMPLE

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

After testing is complete, the emergency room physician diagnoses Client A with aortic dissection. The client must make a decision of whether to proceed with surgery, which has significant risks. He is informed that he has only a slight chance of recovery given his age. He is also informed he must make a decision immediately. Client A and his wife say they cannot make a decision without consulting with their children, who are in transit to the hospital but still a few hours away. The treating physicians are pressuring the client to make a decision, as the window for success is short. A white social worker visits the couple. She knows that Asian culture is very family oriented and highly collectivistic. She indicates to the physicians that, in this case, decision-making will not necessarily revolve around self-autonomy.

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

ETHICAL THEORIES

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

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

DEONTOLOGIC ETHICAL THEORIES

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

The precepts in the deontologic system of ethical decision making stand on moral rules and unwavering principles. No matter what situation presents itself, the purest deontologic decision maker would stand fast by a hierarchy of maxims.

These are as follows [18; 103]:

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

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

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

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

Theologic Ethical Theory

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

Categorical Imperative

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

TELEOLOGIC ETHICAL THEORIES

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

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

Utilitarianism

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

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

One of the limitations of utilitarianism is its application to decision making in social work. In developing social policies for a nation of people based upon the principle of doing the greatest good for the greatest number, several questions arise. Who decides what is good or best for the greatest number: society,

government, or the individual? For the rest of the people, are they to receive some of the benefits, or is it an all or nothing concept? How does "good" become quantified in social work?

Existentialism

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

Pragmatism

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

VIRTUE ETHICS

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

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

RELATIONAL ETHICS

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

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

PRACTICAL APPLICATION OF ETHICAL THEORY

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

RELATIONSHIP BETWEEN ETHICAL THEORIES AND THE NASW CODE OF ETHICS

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

RELATIONSHIP BETWEEN ETHICAL THEORIES AND PROFESSIONAL PRACTICE

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

Ethics inform all aspects of practice, not just the resolution of dilemmas. It is important to remember that ethical obligations and repercussions differ somewhat between applications. Ethics used in research are abstract and do not necessarily take into account a unique client situation; however, when performing an assessment to guide a real-world intervention, values must be evaluated and prioritized to help clients achieve specific goals [43]. Most practitioners would agree that personal value systems must be flexible in order to accommodate the needs of the individual client-system (e.g., clients from differing cultures, elderly clients, clients with substance abuse disorders, groups). Of course, certain values, such as respect, should always be a high priority. It has been shown that respect is a fundamental value in social work and that demonstrating respect toward clients (in a variety of ways) can lead to better outcomes [44].

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

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

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

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

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

- Culture-, income-, education-, sexual orientation-, and gender-specific assessment are vital to predict how the client will perform their objectives, reduce the dropout rate, and increase cost-effectiveness.

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

Case Study

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

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

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

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

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

Discussion

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

ETHICAL DECISION-MAKING FRAMEWORKS

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

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

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

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

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

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

DECISION-MAKING MODELS FOR ETHICAL DILEMMAS

Congress ETHIC Model

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

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

CONGRESS'S ETHIC MODEL
Examine
Think
Hypothesize
Identify
Consult
Source: [7] *Table 3*

Kenyon's Ethical Decision-Making Model

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

KENYON'S ETHICAL DECISION-MAKING MODEL
1. Describe the issue.
2. Consider the ethical guidelines.
3. Examine the conflicts.
4. Resolve the conflicts.
5. Generate all possible courses of action.
6. Examine and evaluate the action alternatives.
7. Select and evaluate the preferred action.
8. Plan the action.
9. Evaluate the outcome.
10. Examine the implications.
Source: [10] *Table 4*

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

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

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

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

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

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

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

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

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

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

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

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

Ethical Principles Screen

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

Collaborative Model for Ethical Decision Making

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

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

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

I CARE Acronym

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

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

LIMITATIONS OF ETHICAL DECISION-MAKING FRAMEWORKS

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

ETHICAL SELF-REFLECTION

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

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

A qualitative study with social work students found they tended to place higher importance on the principle of self-determination over beneficence when confronted with an ethical dilemma, resulting in tension and conflict [57]. The researchers argue that students tend to be more familiar with the principle of self-determination, and as a result, they automatically resort to it. To combat this reflex, reflectivity to identify biases and values and how they influence ethical action is key. Social work agencies should ensure that reflec-

tion is incorporated into professional development on ethics to provide social workers an opportunity to apply ethical decision making to real-life case scenarios [57]. Supervision is also key in facilitating self-awareness and reflection when making ethical decisions [113].

PSYCHOLOGICAL CONTEXT OF MORAL DECISION MAKING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MANAGED CARE AND ETHICS

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

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

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

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

Another ethical issue emerging within social work practice in a managed care environment is that of the social worker's

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

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

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

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

DIVERSITY AND MULTICULTURALISM: ETHICAL ISSUES

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

DEBATES WITHIN MULTICULTURALISM/ DIVERSITY AND ETHICS

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

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

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

Consequently, the questions that arise in this debate are: Should ethical guidelines be based on the uniqueness of groups, taking into account distinct values, norms, and belief

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

INFUSING DIVERSITY INTO THE ETHICAL DECISION-MAKING MODELS

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

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

Step 1: Interpreting the Situation through Awareness

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

Step 2: Formulating an Ethical Decision

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

Step 3: Weighing Competing, Nonmoral Values

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

Step 4: Implementing Action Plan

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

SELF-CARE AND THE NASW CODE OF ETHICS

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

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

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

MULTICULTURALISM/DIVERSITY AND THE NASW CODE OF ETHICS

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

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

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

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

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

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

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

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

TECHNOLOGY AND THE NASW CODE OF ETHICS

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

1.03 Informed Consent

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

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

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

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

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

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

INTERPROFESSIONAL COLLABORATION AND ETHICS

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

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

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

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

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

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

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

CONCLUSION

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

RESOURCES

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

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

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

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

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

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

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

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

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

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

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

Customer Information/Answer Sheet/Evaluation insert located between pages 48–49.

TEST QUESTIONS
#77233 ETHICS FOR SOCIAL WORK

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

This 6 Hour activity must be completed by June 30, 2026.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Test questions continue on next page ➔

26. The first step in Kenyon's decision-making model is to resolve the conflicts.

A) *True*
B) *False*

27. Naming the dilemma involves identifying the values in conflict.

A) *True*
B) *False*

28. What is the main focus of the Ethical Principles Screen developed by Loewenberg and Dolgoff?

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

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

A) *True*
B) *False*

30. Lawrence Kohlberg identifies two important correlates of his six stages of moral development. One of these is that

A) *everyone goes through each stage in a different order.*
B) *every person can understand each stage of moral development.*
C) *a person at one stage can understand any stage below him, but cannot understand more than one stage above.*
D) *once a person progresses through a stage, they no longer understand the stage below, but can understand one stage above.*

31. Lawrence Kohlberg presumes there are six stages of moral development that people go through. A person making a stage 5 decision uses the following justification:

A) *"If I do not make that decision, I will be punished."*
B) *"If I make that decision, I will be rewarded and other people will help me."*
C) *"Others whom I care about will be pleased if I do this because they have taught me that this is what a good person does."*
D) *"This decision will contribute to social well-being, and, as members of a society, we have an obligation to every other member."*

32. Schema Theory consists of three domains: modernism, postmoderism, and multiculturalism.

A) *True*
B) *False*

33. The ethical concerns in managed care revolve around the issue of whether a social worker or practitioner should continue to provide services outside the parameter of the managed care contract.

A) *True*
B) *False*

34. How might the ethical principle of confidentiality be compromised in a managed care system?

A) *Distributive justice cannot be upheld.*
B) *A client's records are shared with the managed care operating organization without disclosure to the client.*
C) *The social worker has a fiduciary relationship with the managed care operating organization and values this more than the relationship with the client.*
D) *None of the above*

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

A) *True*
B) *False*

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Suicide Assessment and Prevention

6 Clinical Continuing Education Credits

Audience

This course is designed for social workers, therapists, counselors, and other healthcare professionals who may identify persons at risk for suicide and intervene to prevent or manage suicidality.

Course Objective

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.

Learning Objectives

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

1. Review the epidemiology of suicide.
2. Describe the impact of suicide in the treatment of special populations, including among military veterans.
3. Identify risk and protective factors for suicide.
4. Discuss warning signs of imminent suicide and the importance of lethal means.
5. Evaluate tools available for the assessment and evaluation of suicide risk.
6. Outline key components of an effective suicide prevention plan.

Faculty

Mark Rose, BS, MA, LP, is a licensed psychologist in the State of Minnesota with a private consulting practice and a medical research analyst with a biomedical communications firm. Earlier healthcare technology assessment work led to medical device and pharmaceutical sector experience in new product development involving cancer ablative devices and pain therapeutics. Along with substantial experience in addiction research, Mr. Rose has contributed to the authorship of numerous papers on CNS, oncology, and other medical disorders. He is the lead author of papers published in peer-reviewed addiction, psychiatry, and pain medicine journals and has written books on prescription opioids and alcoholism published by the Hazelden Foundation. He also serves as an Expert Advisor and Expert Witness to law firms that represent disability claimants or criminal defendants on cases related to chronic pain, psychiatric/substance use disorders, and acute pharmacologic/toxicologic effects. Mr. Rose is on the Board of Directors of the Minneapolis-based International Institute of Anti-Aging Medicine and is a member of several professional organizations.

Faculty Disclosure

Contributing faculty, Mark Rose, BS, MA, LP, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Division Planner/Director Disclosure

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

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Special Approvals

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.

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INTRODUCTION

In 2019, there were 47,511 reported suicide deaths in the United States, making it the 10th leading overall cause of mortality [1]. Every day, approximately 130 Americans take their own life, and one person dies by suicide every 11.2 minutes. An estimated 90% of persons who die by suicide have a diagnosable psychiatric disorder at the time of death, although only 46% have a documented diagnosis [2; 3].

For the approximately 48,000 suicide deaths each year, an estimated 200,000 additional individuals are affected by the loss of a loved one or acquaintance by suicide [5; 46]. This translate to about six survivors intimately affected per suicide. However, a 2019 study estimated that the rate is much higher, projecting a rate of 135 individuals exposed to a single suicide in addition to those intimately affected (equaling more than 6.9 million individuals) [13; 14]. Among these, 20% (or more than 1 million individuals) reported that the experience had a devastating impact or caused a major-life disruption [4]. These figures do not take into account the physical and emotional pain and trauma endured by persons who survive suicide attempts [5].

The total economic burden of suicide is estimated to be $69 billion annually, with the costs falling most heavily on adults of working age [2]. Depression causes an estimated 200 million lost workdays each year at a cost to employers of $17 to $44 billion [6]. However, the accuracy of attempts to quantify such costs on a national scale is hampered by incomplete data, such as the under-reporting of suicides and an absence of reliable data on suicide attempts [5].

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Among persons with a mood disorder, 12% to 20% will ultimately die by suicide. The first three months after diagnosis is the period of highest risk for a first attempt, with the three months following the first attempt being the highest risk period for a second attempt [7].

Case Scenario: Patient A

Two case studies will be referenced throughout the text to illustrate the challenges of assessing and treating patients with possible suicide attempt.

Patient A, 19 years of age, is brought to the local emergency department by ambulance after being found unconscious on the floor of her mother's living room, an empty pill bottle nearby. She exhibits quiet, shallow breathing but otherwise no spontaneous movement; she does react to deep, noxious stimuli by opening her eyes and moving her extremities but does not speak or respond to questioning. Her neck is supple, and a screening cranial nerve and motor exam shows no focal neurologic deficits. Her blood pressure is 110/70 mm Hg, pulse is 114 beats per minute, respiration 12 breaths per minute, and temperature 98.8°F; the lungs are clear. The empty bottle is a prescription for a tricyclic antidepressant made out to Patient A's mother. The friend who found her has followed and provides some context: she is not working at present, lives with a boyfriend who recently left her ("they fight a lot"), and has been living at her mother's home for several days. She is admitted to the intensive care unit and intubated, primarily to protect her airway from aspiration should she vomit.

EPIDEMIOLOGY OF SUICIDE

Every year, more than 700,000 people around the world die by suicide, with 77% occurring in low- and middle-income countries. The suicide rate has increased by more than 60% in the past 45 years, with suicide rates among young people increasing at alarming rates in both developed and developing countries [8]. Suicide is the 4th leading cause of death for people 15 to 29 years of age. However, since 2000, the overall rate appears to have decreased slightly.

Suicide rates vary according to race, ethnicity, sex, and many other factors, including age [8]. In almost every country, suicide is predominated by male victims, with the exception of China, which is the only country in which the female suicide rate (14.8 per 100,000) exceeds the male rate (13 per 100,000) [9]. In the United States, the number of deaths by suicide is nearly four times greater among men (37,256) than among women (10,255). Overall, suicide accounts for 1.7% of all deaths in the United States and a death rate of 13.9 per 100,000 [1].

From the mid-1950s to the late 1970s in the United States, the suicide rate tripled among men 15 to 24 years of age and doubled among women 15 to 24 years of age. The suicide rate reached a plateau during the 1980s and early 1990s and began decreasing during the mid-1990s [10]. However, the age-adjusted suicide rate increased 35% between 1999 and 2018, with increases in most groups younger than 75 years of age [11]. The suicide rate is consistently highest among men 75 years of age and older (40 deaths per 100,000). Among the elderly, the suicide rate peaked in 1987, at 21.8 per 100,000 people, and has since declined nearly 13% (to 19.2 per 100,000 in 2018) [11; 13]. Despite the growing recognition of suicide as a problem demanding public health attention, the overall rates of suicide in the United States have increased over the last half-century [13].

Although official national statistics are not compiled on attempted suicide (i.e., nonfatal actions), it is estimated that 1.2 million adults (18 years of age and older) attempt suicide each year [13]. Overall, there are roughly 25 attempts for every death by suicide; this ratio changes to 100 to 200:1 for the young and 4:1 for the elderly [13; 16]. The risk of attempted (nonfatal) suicide is greatest among women and the young, and the ratio of female-to-male nonfatal suicide attempts is 2 to 3:1 [2; 10; 13].

THE MISREPORTING OF DEATH BY SUICIDE

There is broad agreement that not all suicide deaths are accurately recorded and reported. Reasons for under-reporting include [5; 18; 19; 20; 21]:

- Families or family physicians may hide evidence due to the stigma of suicide.
- The determination of death is judged by local standards, which can vary widely.
- Ambiguous cases involving suicide may end up classified as "accidental" or "undetermined."
- Compared with the "accidental" or "undetermined" motive categories, a larger number of deaths are officially classified as "ill-defined and unknown causes of mortality," in which even the actual cause of death is uncertain and some of which are undoubtedly suicides.
- The frequency of physician-assisted suicide for the terminally ill is unknown but is probably both substantial and increasing.

In contrast, some ambiguous cases are classified as suicides, often in institutions such as prisons, hospitals, religious orders, and the military, where the verdict of suicide is likely to be less embarrassing than homicide. Other motivations for declaring a death a suicide, despite much doubt surrounding a case, are that homicides must be investigated and a murderer sought and accidental death may be the basis of negligence lawsuits [5].

SUICIDE REPORTING IN THE MEDIA

Suicide rates may temporarily spike with intense media coverage of a suicide, especially among youth, and both news reports and fictional accounts of suicide in movies and television can produce this effect [22; 23; 24]. Imitation is often the key factor and is most powerful with the highly publicized suicides of entertainment celebrities [5; 25].

Media coverage of suicide can lead to misinformation, as when suicide is attributed to a single event, such as the loss of a job or a relationship, without mention of a broader context involv-

ing ongoing problems with depression, substance abuse, or lack of access to treatment for these conditions. On the other hand, responsible coverage of suicide can educate audiences about the causes, warning signs, and treatment advances and prevention of suicide [5].

Thirty-six hours after admission, Patient A has been extubated and is awake, sitting up, and talking to a young man (the boyfriend) at her bedside. As you approach, she smiles sheepishly and asks, "Can I go home now?" Before answering, which of the following management options would you consider appropriate at this juncture?

- *Have physical therapy assess strength and ambulation. If normal, discharge her home to the care of her family.*
- *Ask the young man to step out, then take a careful medical and social history, exploring in detail her mindset, actions, and intent in the period leading up to admission.*
- *Anticipate transfer out of the intensive care unit and the need for an around-the-clock "sitter" in her room as a suicide prevention precaution.*
- *Request social service consult to assess her resources and support system and a psychiatry consult to assess the need for further inpatient care and recommend a plan for outpatient follow-up.*

PATHOPHYSIOLOGY OF SUICIDAL BEHAVIOR

Although suicide is a potential complication of all psychiatric disorders, serious suicidal actions have a neurobiologic basis that is distinct from the psychiatric illnesses with which they are associated [26].

Alterations in several neurobiologic systems are associated with suicidal behavior, most prominently hyperactivity of the hypothalamic-pituitary-adrenal (HPA) axis, serotonergic system dysfunction, and excessive activity of the noradrenergic system. While the first and the last system appear to be involved in the response to stressful events, serotonergic dysfunction is thought to be trait-dependent and associated with disturbances in the regulation of anxiety, impulsivity, and aggression [27; 28]. Altered functioning of these systems may stem from both genetic and developmental causes. Exposure to extreme or chronic stress during childhood has developmental consequences on these systems that persist into adulthood. Genetic differences may also contribute to alterations in the functioning of these neurobiologic systems, and the interactive effect of adverse childhood experiences, such as physical abuse, sexual abuse, or caregiver abandonment, with genetic vulnerability is increasingly believed to play a role in suicidal behavior [27; 29].

Neurobiologic and psychologic perspectives have converged to identify the most prominent risk factors for suicidal behavior: dysregulated impulse control and a propensity to intense psychologic pain that includes hopelessness, often in the context of a mood disorder. These factors are believed to largely reflect serotonergic system dysregulation [30]. Investigation into the role played by serotonergic dysfunction in suicidal behavior has identified two prominent regions: the dorsal and median raphe nuclei in the midbrain, which host the main serotonergic cell bodies, and the prefrontal cortex, particularly the ventral prefrontal cortex, which is innervated by the serotonergic system. In vivo and postmortem examinations have revealed serotonergic hypofunction in these two brain systems in persons who have died by suicide or made serious suicide attempts. The deficient serotonergic input in the ventral prefrontal cortex stemming from this serotonin hypofunction can result in a breakdown in inhibitory function leading to a predisposition to impulsive and aggressive behavior. This vulnerability to deficient impulse control coupled with the development of psychiatric illness or other life stressors elevates the risk of acting on suicidal thoughts [31].

SUICIDE AND SPECIAL POPULATIONS

WOMEN

A woman takes her own life every 51.25 minutes in the United States [1]. Suicide is more common among women who are single, recently separated, divorced, or widowed, and the suicide rates for women peak between the ages of 45 to 64 years. Precipitating life events for women who attempt suicide often involve interpersonal losses or crises in significant social or family relationships. As noted, more women attempt suicide than men, and there is a 2 to 3:1 ratio of women versus men with a history of attempted suicide. The higher rates of attempted suicide among women are likely due to the higher rates of mood disorders such as major depression, persistent depressive disorder (dysthymia), and seasonal affective disorder. Factors that may contribute to the lower rates of suicide deaths in women relative to men include stronger social supports, feeling that their relationships are a deterrent to suicide, differences in preferred suicide method, and greater willingness to seek psychiatric and medical intervention [2; 13].

YOUTH

In 2020, suicide was the third leading cause of death for young people 10 to 24 years of age, exceeded only by unintentional injury and homicide [32]. As noted, an estimated 100 to 200 attempts are made for every suicide completion in this age group. Between 2008 and 2015, encounters for suicide ideation and/or attempt at children's hospitals nearly doubled [51]. Risk factors for suicide among the young include suicidal thoughts, psychiatric disorders (e.g., depression, impulsive aggressive behavior, bipolar disorder, panic disorder), drug and/or alcohol abuse, and previous suicide attempts. The risk is further elevated with situational stress or access to firearms [2; 13].

Children 10 to 14 Years of Age

In 2020, suicide was the second leading cause of death for children 10 to 14 years of age, with a rate of approximately 3 per 100,000 [11; 32]. The rate of suicide and percentage of total deaths varies considerably by race (***Table 1***) [122].

DEATHS BY SUICIDE AMONG U.S. CHILDREN 10 TO 14 YEARS OF AGE BY RACE IN 2020			
Race	Rate Per 100,000 Population	Total Suicide Deaths	Percentage of Total Deaths
Alaska Native/Native American	6.3	21	35%
Asian	1.3	15	14.5%
Black/African American	3.0	93	11.5%
Multiracial	2.1	24	19.7%
White	2.8	424	18.4%
Source: [122]			*Table 1*

College Students

More than 1,000 suicides occur each year on college campuses, and 1 in 10 college students have made a suicide plan [34]. A 2011 survey of 27,774 college students from 44 campuses found that 6.6% had seriously contemplated suicide and 1.1% had attempted suicide [16]. In the 12 months before the survey, 60.5% reported feeling very sad, 45.2% reported feeling hopeless, and 30.3% reported feeling so depressed they were unable to function [16]. More than 45% reported feelings of hopelessness; however, only 6.7% of men and 13.1% of women reported a diagnosis of depression, suggesting that many students are not receiving adequate diagnosis and/or treatment [16]. A 2015 follow-up survey including 93,034 college students from 108 campuses found a much higher rate of suicidality, with 24% of the survey population reporting seriously contemplating suicide, nearly 20% reporting self-injury, and 9% reporting a suicide attempt [33]. Rates of suicidality were highest among racial/ethnic, sexual, and gender minorities.

Students with a pre-existing mental health condition or who develop mental health conditions in college are at highest risk of suicide. In the 2015 study, 25% students were diagnosed with and/or received treatment for a mental health condition in the previous 12 months [33]. Risk factors for suicide among college students include depression, sadness, hopelessness, and stress [13].

Other Considerations in Youth Suicide

Most adolescent suicides occur at home after school hours. Adolescent nonfatal suicide attempters are typically girls who ingest pills, while those who die by suicide are typically boys who die from gunshot wounds. Intentional self-harm should be considered serious and in need of further evaluation because not all adolescent attempters admit their intent. Most adolescent suicide attempts are triggered by interpersonal conflicts and are motivated by the desire to change the behavior or attitude of others. Repeat attempters may use this behavior as a coping mechanism for stress and tend to exhibit more chronic symptomatology, worse coping histories, and higher rates of suicidal and substance abuse behaviors in their family histories [13]. The presence of multiple emotional, behavioral, and/or cognitive problems may be a more important predictor of suicide behavior risk than a specific type of problem (e.g., an addictive behavior or an emotional problem) [13; 33]. The presence of acne is associated with social and psychologic problems, and certain acne medications have been linked with an increased risk of suicidal ideation [36].

OLDER ADULTS (65 YEARS OF AGE AND OLDER)

The elderly account for roughly 19.3% of suicides but only 16% of the population [13]. Suicide rates rise with age for men, especially after 65 years of age, and the suicide rate in elderly men is 5 times that of same-aged women; more than 85% of elderly suicides are among men [13; 35]. The overall rate of elderly suicide is nearly 20 per 100,000. However, the rate is 40 per 100,000 among elderly White men and 51.8 per 100,000 among White men older than 85 years of age, a rate that is almost 2 times the rate for men of all ages. In contrast, the suicide rate of women declines after 60 years of age [13; 35].

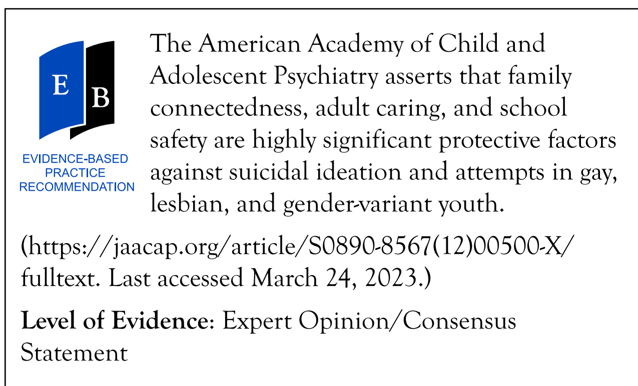
Although undiagnosed and/or untreated depression is the primary cause of suicide in the elderly, suicide completion is rarely preceded by only one factor. Risk factors for suicide in this population include a previous suicide attempt; mental illness; physical illness or uncontrollable pain; fear of a prolonged illness; major changes in social roles, such as retirement; loneliness and social isolation (especially in older men who have recently lost a loved one); and access to lethal means, such as firearms in the home [13].

LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT+) INDIVIDUALS

The true incidence of suicide among lesbian, gay, bisexual, transgender, and other gender and sexual minority (LGBT+) youth is unknown, but research indicates higher rates of suicidal behavior among LGBT+ youth (15 to 24 years of age) compared with heterosexual youth [33; 43]. Among adolescents and young adults, the lifetime prevalence of suicide attempts ranges from 20.5% to 52.4% among LGB individuals versus 4.2% to 24.8% among same-aged heterosexuals [39; 40; 42]. Among adolescents and young adults, past-year suicide attempts are more than 4.5 times higher among LGB youth than same-aged heterosexual youth [13; 37; 47].

LGBT+ youth generally have more risk factors, more severe risk factors, and fewer protective factors, such as family support and safe schools, than heterosexual youth. There are also risks unique to this population related to sexual orientation, such as

disclosure to family or friends [13]. The impact of stigma and discrimination against LGBT+ individuals is enormous and is directly tied to risk factors for suicide such as isolation, alienation and rejection from family, and lack of access to culturally competent care [43]. Family connectedness, perceived caring from other adults, and feeling safe at school were reported as significant protective factors in a survey of 6th-, 9th-, and 12th-grade LGBT+ students [37; 38]. It has also been noted that LGBT+ adults have a two-fold excess risk of suicide than their heterosexual counterparts [37].



The American Academy of Child and Adolescent Psychiatry asserts that family connectedness, adult caring, and school safety are highly significant protective factors against suicidal ideation and attempts in gay, lesbian, and gender-variant youth.

(https://jaacap.org/article/S0890-8567(12)00500-X/fulltext. Last accessed March 24, 2023.)

Level of Evidence: Expert Opinion/Consensus Statement

The effect of race/ethnicity and other demographic characteristics on suicidal behavior in the LGB population has also been studied little, but reports suggest high suicide attempt rates among African American gay/bisexual men, among gay/bisexual men of lower socioeconomic status, and among LGB Latinx [35].

Depression and suicide are also common among transgender individuals. One survey assessed transgender individuals' school experiences from kindergarten through grade 12. Of the individuals who were out as transgender during their school years, 77% reported at least one negative experience, including physical attacks, verbal abuse, and mistreatment by teachers and/or administrators. Among those with negative school experiences, 58% attempted suicide, compared with 37% of transgender individuals without negative school experiences. Among out transgender college students, 24% reported that they were physically, verbally, or sexually harassed. [38]. Across all age groups, 39% of transgender individuals reported experiencing serious psychologic distress in the past month, compared with 5% of the general U.S. population. Up to 82% of transgender persons have considered suicide in their lifetimes [124]. In addition, 40% of individuals reported attempting suicide, more than nine times the rate in the United States [38; 47; 124].

MILITARY SERVICE MEMBERS

Although the true incidence of suicide among military service members and veterans is difficult to estimate due to the lack of national suicide surveillance data, the U.S. Department of Veterans Affairs (VA) estimates that 18% of all deaths from suicide in the United States are in military war veterans [79]. Despite preventive measures taken by the military, the number of suicides in this population continues to increase [52; 54; 56; 79]. Although the majority of military suicides occur among young men shortly after their discharge from military service, military women 18 to 35 years of age commit suicide nearly three times more frequently than civilian women of the same age group [57; 58]. Servicewomen, in particular, experience high rates of interpersonal violence, including childhood abuse, intimate partner violence, and sexual trauma during adulthood (e.g., military sexual assault) [123].

Patient A is transferred to a regular floor and a sitter is assigned to her room. With the aid of additional clinical observation and consultations, a clearer picture emerges. In the presence of staff, Patient A appears open and optimistic and takes initiative; when her boyfriend or family are present, she becomes passive, more withdrawn, and demanding, expecting others to attend to her needs. Patient A's parents divorced when she was 11 years of age, and two years later, she came under psychiatric care, followed by counseling, because of depression and a brief period of suicide ideation. She had attended college but dropped out after two years. In recent months, her life had become more chaotic. She was unhappy in her job and subject to fits of anger and despondency. She was often at odds with her live-in boyfriend, who, on occasion, threatened to leave her and in fact did so four days prior to her admission. The decision to take an overdose of her mother's medication was judged to have been abrupt and impulsive, perhaps a "suicide gesture"—partly misdirected anger and partly designed to win back the attention of her boyfriend. Nevertheless, she almost succeeded in taking her life. The consultant's diagnosis is borderline personality disorder and likely major depression. She is transferred to the inpatient psychiatry service for further evaluation and care. Some days later, she is discharged to a mental health clinic for psychiatric and social service follow-up combined with ongoing counseling.

HEALTHCARE PROFESSIONALS

Some occupations are known to have higher rates of suicide than others. Job factors, including chronic stress, vicarious trauma, low job security, and low pay, can contribute to risk of suicide, as can easy access to lethal means (e.g., medications, firearms) among people at risk. Other factors that can influence the link between occupation and suicide include gender, socioeconomic status, economic environment, cultural factors, and stigma [115].

Healthcare workers have historically been at disproportionate risk of suicide, due to a variety of factors, including difficult working conditions, such as [115]:

- Long work hours
- Irregular shifts
- Emotionally difficult situations
- Risk for exposure to infectious diseases and other hazards on the job, including workplace violence
- Routine exposure to human suffering and death (vicarious or secondary trauma)
- Access to lethal means (e.g., medications) and knowledge about using them

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In 2019, a large review of more than 60 scientific studies was conducted to address conflicting data on the nature of suicide among healthcare workers. The researchers found that physicians were at a significant and increased risk for suicide, with female physicians at particularly high risk [116]. A cross-sectional survey involving 7,378 nurses found that nurses were at increased risk for past-year suicidal ideation (5.5%) [117]. In addition, nurses with suicidal ideation were less likely to be willing to seek help (72.6%) than nurses without suicidal ideation (85%). Burnout was strongly associated with suicidal ideation, even after controlling for other personal and professional characteristics [117].

RISK AND PROTECTIVE FACTORS FOR SUICIDE

Suicide is now understood to be a multidimensional disorder stemming from a complex interaction of biologic, genetic, psychologic, sociologic, and environmental factors [59; 60]. One of the first social scientists to empirically investigate contributing factors to suicide was Émile Durkheim. Instead of focusing only on shared traits among persons who had died by suicide, Durkheim compared one group with another and originated the scientific study of suicide risk factors [5; 61]. Protective factors reduce suicide risk by enhancing resilience and counterbalancing risk factors, while risk factors increase the potential for suicidal behavior. Protective and risk factors may be biopsychosocial, environmental, or sociocultural in nature [5].

PROTECTIVE FACTORS

Several protective factors against suicide behavior have been identified [5; 62]. These include:

- Access to effective clinical care for mental, physical, and substance use disorders, and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Emotionally supportive connections with medical and mental health providers
- Effective problem-solving and conflict-resolution skills
- Cultural and religious beliefs that discourage suicide and support self-preservation
- Reality testing ability
- Pregnancy, children in the home, or sense of family responsibility
- Life satisfaction

RISK FACTORS

In addition to risk factors specific to special populations, there are many general risk factors common among most populations. General biopsychosocial risk factors include [2; 5; 62]:

- Psychiatric disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of physical or sexual trauma or abuse, especially in childhood
- Medical illness involving the brain or central nervous system (CNS)
- Family history of suicide
- Suicidal ideas, plans, or attempts (current or previous)
- Lethality of suicidal plans or attempts

In addition, environmental factors can impact an individual's suicide risk. Attention to the presence of job or financial loss, relationship or social loss, easy access to lethal means, and local clusters of suicide (due to contagious influence) is necessary.

Lack of social support and sense of isolation are risk factors for suicide, along with cultural factors. Some cultural practices and/or beliefs can predispose an individual to suicide, such as stigma associated with help-seeking behavior; barriers to accessing mental health care and substance abuse treatment; certain cultural and religious beliefs (e.g., suicide as an honorable act); and media exposure to and the influence of others who have died by suicide [2; 5; 62].

According to the American Psychiatric Association, the assessment and treatment of major depressive disorder should consider the impact of language barriers, as well as cultural variables that may influence symptom presentation, treatment preferences, and the degree to which psychiatric illness is stigmatized.

(https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf. Last accessed March 24, 2023.)

Strength of Recommendation: I (Recommended with substantial clinical confidence)

Psychiatric Disorders

At least 90% of people who die by suicide have diagnosable psychiatric illness [2; 3]. The psychiatric conditions with the greatest association with suicidal behavior are depression, bipolar disorder, substance abuse, schizophrenia, and personality disorders.

Depression

Major depression is the psychiatric diagnosis most commonly associated with suicide. The risk of suicide in persons with major depression is roughly 20 times that of the general population [13]. About 30% of all patients with major depression

attempt suicide, half of whom ultimately take their own lives [63]. More than 60% of persons who die by suicide are clinically depressed at the time of their deaths, although this climbs to 75% when patients with comorbid depression and alcohol use disorder are added. Seven of every 100 men and 1 of every 100 women diagnosed with depression will die by suicide [13].

In one survey of adults who experienced depression in the previous year, 56.3% thought it would be better if they were dead during their worst or most recent episode, 40.3% contemplated suicide, 14.5% made a suicide plan, and 10.4% attempted suicide [65]. Among persons with depression, those with a history of multiple episodes of depression and those with an alcohol or other substance use disorder are at greatest risk [2]. Persons with depression who exhibit the following symptoms are at heightened risk for suicide [2; 13]:

- Extreme hopelessness or desperation
- A lack of interest in previously pleasurable activities
- Intense anxiety and/or panic attacks
- Insomnia
- Talk of suicide or history of attempts
- Irritability, agitation, or enraged behavior
- Isolation

Feelings of hopelessness (e.g., belief that there is no solution) are more predictive of suicide risk than a diagnosis of depression per se. It is also important to remember that patients who desire an early death during a serious or terminal illness are usually experiencing a treatable depressive illness [2].

Bipolar Disorder

Between 5 and 10 million Americans currently have bipolar disorder. Of these, as many as 1 in 5 will die by suicide [67]. Like depression, bipolar disorder is treatable, and effective treatment decreases the risk of suicide.

Alcohol and Substance Abuse

Alcohol and drug abuse are second only to depression and other mood disorders as conditions most associated with suicide. Substance use disorders and disordered mood are often comorbid. The suicide risk among patients with alcohol use disorder is 50% to 70% higher than the general population. Alcohol abuse is a factor in roughly 30% of suicides, and about 7% of persons with alcohol dependence die by suicide [2; 13; 68].

In 2011, an estimated 228,366 emergency department admissions were made for alcohol- or drug-related suicide attempts. Almost all (94.7%) involved either a prescription drug or an over-the-counter medication [69]. Approximately 64.4% involved multiple drugs, and 29% involved alcohol [69].

As mentioned, comorbid psychiatric and substance use disorders substantially increase the risk of suicide behavior. Combined data from 2004 and 2005 indicated that 16.4 million adults 18 years of age and older experienced a major depressive episode in the previous year. Of these persons, more than 10% attempted suicide. But when alcohol abuse or illicit drug use occurred with major depression, the proportion of suicide attempts rose to nearly 14% for alcohol abuse and close to 20% for illicit drug use [65]. A 2017 study conducted among more than 10,000 individuals in a prison population showed that those with a documented substance abuse disorder or other psychiatric disorder had a higher rate of attempted suicide (2.0 and 9.2 greater odds, respectively) than those without a diagnosis [41].

There are several possible explanations for the association between alcohol/drug use and suicide. Alcoholism can cause loss of friends, family, or job, leading to social isolation; however, the reverse is equally plausible. Alcohol abuse and suicide may also both represent attempts to deal with depression and misery. Alcohol increases the sedating effects of some drugs that are frequently used in suicide attempts and may increase impulsive actions, making suicide attempts and completions more common [18; 70]. To claim that alcoholism "causes" suicide is simplistic; while the association of alcohol and suicide is clear, a causal relationship is not. Both alcoholism and suicide may be responses to the same pain [18].

Schizophrenia

Suicide is the largest cause of premature death among individuals with schizophrenia, and young, unemployed men are at highest risk. Other risk factors include recurrent relapses; fear of deterioration, especially among persons with high intellectual ability; positive symptoms of suspiciousness and delusions; and depressive symptoms [59; 60]. The suicide risk is highest during early stages of the illness, early relapse, and early recovery. The risk decreases with prolonging illness duration [59; 60].

Personality Disorders

An estimated 20% to 50% of young people who die by suicide have a diagnosable personality disorder, with borderline personality and antisocial personality disorders being most frequently associated with suicide. Histrionic and narcissistic personality disorders and certain psychologic traits, such as impulsivity and aggression, are also associated with suicide [59; 60].

Medical Disorders

Illnesses affecting the brain and CNS have a greater effect on suicide risk compared with other medical conditions. These conditions include epilepsy, AIDS, Huntington disease, traumatic head injury, and cerebrovascular accidents. In contrast, cancer and other potentially fatal conditions carry a more modest suicide risk [71].

Sociodemographic Factors

Suicide is an individual act that also occurs in the context of a broader culture, and specific sociodemographic factors are associated with suicide risk, including marital status, occupation, and previous suicide attempt(s) [59; 60].

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Marital Status

Divorced, widowed, and single people have a higher suicide risk. Marriage appears to be protective for men, but not so for women. Marital separation also increases the risk of suicide [59; 60].

Occupation

Certain occupational groups, such as veterinary surgeons, pharmacists, dentists, farmers, and medical practitioners, have higher rates of suicide. Although obvious explanations are lacking, access to lethal means, work pressure, social isolation, and financial difficulties may account for the heightened risk [59; 60].

Unemployment and suicide are also correlated, although the nature of the association is complex. Poverty, social deprivation, domestic difficulties, and hopelessness likely mediate the effect of unemployment, but persons with psychiatric illness and personality disorders are also more likely to be unemployed. Recent job loss is a greater risk factor than long-term unemployment.

Previous Suicide Attempt

Approximately 20% of people who kill themselves had made a previous attempt, making previous serious suicide attempts a very high risk factor for future attempts [2].

Incarceration

Suicide is the single most common cause of death in correctional settings, and collectively, inmates have higher suicide rates than their community counterparts. One study found that the rate of suicide among male prisoners is 5 to 6 times higher than in the general population and as much as 20 times higher among women prisoners. Also, for every suicide death there are many more suicide attempts [44; 72].

Inmates at highest risk of suicide include young men, the mentally ill, the socially disenfranchised and socially isolated, substance abusers, previous suicide attempters, and juveniles placed in adult correctional facilities. Factors that increase the likelihood of suicidal behavior include the psychologic impact of arrest and incarceration; the stresses of prison life, including physical and sexual predation and assault from other inmates; and the absence of formal policies regarding managing suicidal patients, staff training, or access to mental health care [44; 72].

Vicarious Trauma and Burnout

Compassion fatigue is comprised of two components: burnout and vicarious traumatic stress [118]. The first component consists of characteristic negative feelings such as frustration, anger, exhaustion, and depression. The second component, vicarious traumatic stress, may result when the professional is negatively affected through vicarious or indirect exposure to trauma material through their work. Compassion fatigue is associated with a variety of negative mental health repercussions, including increased risk for depression and suicidal ideation.

Being aware of the factors that increase a professional's risk of burnout is very valuable in contributing to a prevention strategy. Contributing factors may be individual/personal, systemic, or frequently a combination of both. It is important to know what does not work (or what makes a toxic environment) first in order to prevent exposure and the associated fallout from such exposure.

Creative Personalities

Anecdotes of famous painters, writers, and musicians who were depressed and died by suicide have occurred for centuries, but only recently has science been able to identify the underlying basis of vulnerability to depression and suicide among creative people. Treatment of major depressive or bipolar illness in artists presents unique problems, one of which is the concern that creativity and the disorder are so intertwined that treatment might suppress the artist's unique talent [73; 74; 76].

Holiday Suicide Myth

The idea that suicide occurs more frequently during the holiday season is a myth perpetuated in part by the media and has been debunked [2]. The National Center for Health Statistics of the Centers for Disease Control and Prevention (CDC) reports that the suicide rate is actually lowest in December, with peak rates in the spring and the fall. This pattern has remained constant for many years [77]. The holiday suicide myth has been considered important to counter because it provides misinformation about suicide that might ultimately hamper prevention efforts [78].

ACTIVE-DUTY MILITARY AND VETERANS

Protective Factors

Several general protective factors may be more prevalent among military service members and veterans, including strong interpersonal bonds, responsibilities/duties to others, steady employment, sense of belonging/identity, and access to health care [79]. Historically, the selection bias for healthy recruits, employment, purposefulness, access to health care and a strong sense of belonging were believed to be protective against suicide, but increasing rates have challenged this assumption [79]. In one study, having a service-connected disability was associated with a lower risk of suicide in veterans, likely due to greater access to VA health care and regular compensation payments [52]. It is interesting to note that many of these protective factors do not apply to discharged or retired veterans. Other potentially protective factors include older age, African American/Black race, and admission to a nursing home [79].

Risk Factors

Veterans and military members often possess many risk factors for attempting or completing suicide. This includes combat exposure (particularly deployment to a combat theater and/or adverse deployment experiences), combat wounds, post-traumatic stress disorder (PTSD) and other mental health problems, comorbid major depression, traumatic brain injury, poor social support, feelings of not belonging or of being a

burden to others or society, acquired ability to inflict lethal self-injury, and access to lethal means [52; 58; 81; 82; 83]. There is conflicting evidence of the role of PTSD in suicide risk, with some studies finding PTSD diagnosis to be protective while others indicated it increased risk. Other possible risk factors include [79; 123]:

- Disciplinary actions
- Reduction in rank
- Career threatening change in fitness for duty
- Perceived sense of injustice or betrayal (unit/command)
- Command/leadership stress, isolation from unit
- Transferring duty station
- Administrative separation from service/unit
- Military sexual trauma

Case Scenario: Patient B

Patient B is 56 years of age, married with one grown daughter. She consults a primary care physician because of a gradual decline in health over the past 12 to 18 months. She has come at the insistence of her daughter, who accompanies her. Her given purpose is vague: a "check-up" and perhaps laboratory work. Her daughter tells the nurse, "My mother's not well. She's home alone, doesn't get enough sleep, and won't eat right. She complains about her stomach and thinks she has food allergies; she has tried special diets, supplements, and herbal remedies and claims she's getting better, but she's not." The patient is petite, well-groomed, and smiles readily. She tells the physician, "I'll be okay, but I do want to be sure I'm not anemic or have a thyroid problem." She gives a history of chronic, recurrent abdominal discomfort, bloating, periodic constipation, and intolerance to many foods. As a young woman, she was told she has irritable bowel syndrome and was given trials of medication, but she reports being unable to take these medications and being "very sensitive to any prescription medication." She thinks she has lost maybe 5 pounds in the past year. Her examination is unrevealing, except she is thin and there is a hint of generalized muscle atrophy. Over the course of the interview, she appears tired and to have a slightly blunt affect. The following laboratory tests are ordered: complete blood count, chemistry profile, vitamin D and B12 levels, and thyroid function tests. She is given an appointment to return in five days to discuss the results and plan a course of treatment.

IMMINENT SUICIDE

While risk factors for suicide represent broader, durable, and ongoing factors, a suicide crisis is a time-limited event that signals an immediate danger of suicide. A suicide crisis can be triggered by a particularly distressing event, such as loss of a loved one or career failure, and involve an intense emotional state in addition to depression, such as desperation (anguish plus urgent need for relief), rage, psychic pain or inner tension, anxiety, guilt, hopelessness, or acute sense of abandonment. Changes in behavior or speech can suggest that suicide is imminent; speech may be indirect, with statements such as, "My family would be better off without me." Persons contemplating suicide may also talk as if they are saying goodbye or going away, exhibit actions ranging from buying a gun to suddenly putting one's affairs in order, or deterioration in social or occupational functioning, increasing use of alcohol, other self-destructive behavior, loss of control, or rage explosions [2].

WARNING SIGNS

Most people who are suicidal exhibit warning signs, whether or not they are in an acute suicide crisis. These warning signs should be taken seriously and include observable signs of serious depression, such as unrelenting low mood, pessimism, hopelessness, desperation, anxiety, psychic pain, and inner tension; withdrawal from friends and/or social activities; sleep problems; and loss of interest in personal appearance, hobbies, work, and/or school [2; 13]. Other signs include:

- Increased alcohol and/or other drug use
- Recent impulsiveness and taking unnecessary risks
- Talk about suicide, death, and/or no reason to live
- Making a plan (e.g., giving away prized possessions, sudden or impulsive purchase of a firearm, or obtaining other means of killing oneself, such as poisons or medications)
- Unexpected rage, anger, or other drastic behavior change
- Recent humiliation, failure, or severe loss (especially a relationship)
- Unwillingness to "connect" with potential helpers.

The following expressions of thoughts, feelings, or behaviors may also be warning signs of suicidal behavior [13]:

- Can't stop the pain
- Can't think clearly
- Can't make decisions
- Can't see any way out
- Can't sleep, eat, or work
- Can't get out of the depression
- Can't make the sadness go away
- Can't see the possibility of change
- Can't see themselves as worthwhile
- Can't get someone's attention
- Can't seem to get control

A mnemonic device, IS PATH WARM, has been developed for use in identifying suicide risk [84]. This mnemonic device was derived from the consensus of internationally renowned clinical researchers held under the auspices of the American Association of Suicidology. It consists of the following [84]:

- **I**deation
- **S**ubstance abuse
- **P**urposelessness

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- **A**nxiety
- **T**rapped
- **H**opelessness
- **W**ithdrawal
- **A**nger
- **R**ecklessness
- **M**ood change

Intentional Self-Harm

Intentional self-harm is behavior related to, but distinct from, suicide behavior and includes suicide attempts and nonsuicidal self-injurious behaviors, such as burning, cutting, and hair pulling, that does not have fatal intent [85]. Self-injurious behavior falls into three categories [85]:

- Major self-injury: Infrequent, usually associated with psychosis or intoxication
- Stereotypic self-injury: Repetitive and reflects a biologic drive of self-harm
- Superficial-to-moderate self-injury: The most common form and is used by self-mutilators to relieve tension, release anger, regain self-control, escape from misery, or terminate a state of depersonalization

Patients with a history of intentional and repetitive self-harm are likely to be highly impulsive with a diagnosis of borderline personality disorder, and distress over their inability to curtail the behavior may heighten suicide risk [85; 86; 87]. It is essential to recognize that previous nonlethal self-harm does not preclude the development of suicidal ideation or plans with serious intent and lethality [62]. It is important to assess the intent of self-harm behaviors during the risk assessment.

Five days after the initial visit, in anticipation of follow-up later that day, the physician reviews Patient B's laboratory results, all of which are normal. That afternoon, the patient is a "no-show," and no further action is taken. Some time the following week, the office nurse asks her colleague about Patient B, stating "Something about her really bothered me." She recommends that the physician call the patient to follow-up, which he does. The daughter answers with a mix of concern and relief. She states, "I'm really worried about my mother. She's not making sense at times, seems really down, and says we'd all be better off if she just went to sleep and didn't wake up...I didn't mention it last week, but she and my dad are not doing well. He's busy, on the road a lot, and I get the feeling she thinks he's unfaithful to her." At this juncture what do you do?

- *Ask the daughter to bring her mother to the office today, along with all supplements and herbal medicines she may have been taking.*
- *Consider the key issue(s) and give some thought to your clinical approach (e.g., sequencing the encounter and useful tools that will help to identify major depression and assess suicide risk).*
- *Anticipate logistical barriers in relation to time of day and the possible need for immediate psychiatric consultation and/or hospitalization.*

SUICIDE ATTEMPTS

LETHAL MEANS

In the United States in 2019, use of a firearm was the cause of death in 50.4% of suicides and is the number one means among all individuals 15 years of age and older. Gun use accounts for 47% of all suicide deaths in individuals 15 to 24 years of age, reaching a low of 42.1% in those 35 to 44 years of age, and increasing to 51.8% in those 55 to 64 years of age. Firearm use for suicide completion is extremely high among the elderly, with individuals 75 to 84 and 85 years of age and older having the highest rates, at 75.4% and 76.6%, respectively. Gun use is also the most common suicide method among youth, accounting for 31.5% of all suicide deaths [1; 78].

Although most gun owners report keeping a firearm in their home for the purpose of protection or self-defense, 83% of gun-related deaths in these homes are the result of a suicide, usually by someone other than the gun owner. Guns are involved in more deaths by suicide than by homicide, and overall, death by firearm is the most common suicide method [12].

The suicide rates among youths 15 to 24 years of age by firearm increased from 5.3 per 100,000 in 2001 to 6.6 per 100,000 in 2019, while the suicide rates by suffocation (e.g., hanging) increased from 3.1 per 100,000 in 2001 to 5.0 per 100,000 in 2019. These trends among teens and young adults have been mirrored by children 5 to 14 years of age, in whom deaths by firearms and suffocation have been increasing since at least 2001 [1; 78].

The most common method of suicide death among women in all age groups from 2001 to 2019 was poisoning (35.5%); however, in 2018, firearms surpassed poisoning for the first time since 2000 among female victims [15; 78]. Although intentional overdose is the most common method for suicide attempts in women, it is much less likely to result in death. Many over-the-counter medications, prescription drugs, dietary supplements/herbal medications, or illicit drugs may be used to attempt suicide. Ibuprofen is a popular over-the-counter analgesic and a common drug of choice in intentional overdoses. There were more than 12,490 intentional overdose ingestions of ibuprofen reported by U.S. poison control centers in 2018, resulting in one death [89]. Opioid analgesics result in many deaths due to intentional overdose. In one study, researchers found that the percentage of individuals who died by suicide and had opioids in their system more than doubled, from 8.8% to 17.7%, between 2006 and 2017 [45].

Ingestion of other toxic substances (including bleach, poisons, and agricultural chemicals), jumps from tall heights, and exsanguination are also relatively common methods of suicide

attempt and completion. When assessing risk, it is important to consider the patient's level of impulsivity and the potential lethality of available means (particularly firearms).

MOTIVES BEHIND SUICIDAL BEHAVIOR

Although thousands of books have explored the question of why people kill themselves, in most cases the answer can be summed up in three words: to stop pain. The pain may be physical, as in chronic or terminal illness, but is usually emotional. However, Stone has delineated a more elaborate description of the motivations for suicide, including [18]:

- Altruistic/heroic suicide: Occurs when someone (more or less) voluntarily dies for the benefit of the group. Examples include the Japanese kamikaze pilots in WWII and the Buddhist monks who burned themselves to death protesting the Vietnam war.
- Philosophical suicide: Various philosophical schools, such as the stoics and existentialists, have advocated suicide under some circumstances.
- Religious suicide: Often as martyrdom, this type of suicide has a long history that spans from early Christianity to the Branch Davidians in Waco, Texas, and some members at Jonestown, Guyana.
- Escape: This type of suicide represents an escape from an unbearable situation, such as persecution, a terminal illness, or chronic misery.
- Excess alcohol and other drug use
- Romantic suicide: This includes suicide pacts (dual suicide), which constitute about 1% of suicides in Western Europe. Participants are usually older than 51 years of age, except in Japan, where 75% of dual suicides are "lovers' pacts."
- "Anniversary" suicide: Suicide involving the same method or date as a deceased loved one.
- "Contagion" suicide: Occurs when one suicide appears to trigger others (e.g., "cluster" and "copycat" suicides), most often among adolescents.
- Manipulation: Usually involving the theme "If you don't do what I want, I'll kill myself." The word "manipulative" does not imply a lack of seriousness, as fatal suicide attempts can be made by people hoping to influence or manipulate the feelings of others even though they will not be around to witness the outcome. However, the intent of manipulative attempts is to produce guilt in the other person, and a nonfatal result is usually intended.
- Call for help: An expression of unbearable pain and misery that is more frequent in the young.
- "Magical thinking" and vengeance: Associated with a feeling of power and complete control. This motivation to attempt suicide is driven by a "you'll be really sorry when I'm dead" fantasy. A fatal outcome is intended, and this is sometimes called "aggressive suicide."
- Cultural approval: In some cultures, such as Japanese culture, society has traditionally accepted or encouraged suicide when matters of honor were concerned.
- Lack of an outside source to blame for one's misery: Evidence exists that rage and homicide is the extreme response when an external cause of one's unhappiness can be identified, and depression and suicide is the extreme response in the absence of a perceived or identifiable external source.

SCREENING AND ASSESSMENT OF SUICIDE RISK

Many persons who die by suicide have contact with healthcare providers in the time preceding their deaths. Roughly 45% of all persons who die by suicide had contact with a mental health professional in the year before their deaths, and 75% of elderly persons who die by suicide had visited their physician in the month before their death [2; 5]. Although close to 90% of these cases had diagnosable psychiatric illness at the time of death, only 30% reported suicidal ideation or intent to a health professional before their suicide attempt [2]. These figures suggest a widespread inadequacy in identifying and assessing at-risk persons by healthcare professionals, and numerous studies have concluded that health professionals often lack sufficient training in the proper assessment, treatment, management, or referral of suicidal patients [2; 5]. Many health professionals also lack training in identifying grieving family members of loved ones who have died by suicide [5]. Primary care providers occupy a niche in the healthcare system and have perhaps the greatest opportunity to impact suicidal persons through educational means [5; 46; 59; 60; 91].

SCREENING IN THE PRIMARY CARE SETTING: EXPERT CONSENSUS

Many organizations have issued consensus statements regarding screening for suicide risk in the primary care setting. The U.S. Preventive Services Task Force (USPSTF) states that although suicide screening is of high national importance, it is very difficult to predict who will die from suicide and has found insufficient evidence for routine screening by primary care clinicians to detect suicide risk and limited evidence of the accuracy of screening tools to identify suicide risk in the primary care setting [92; 96]. The USPSTF recommends physicians screen all adolescents 12 to 18 years of age for major depressive disorder. The Canadian Task Force on Preventive Health Care found insufficient evidence for routine screening by primary care clinicians to detect depression and suicide risk [93].

However, the American Academy of Pediatrics (AAP) recommends universal screening for suicide risk throughout adolescence (12 years of age and older) and clinically indicated screening for children 8 to 11 years of age [94]. Screening should be performed in a developmentally and medically appropriate manner. The AAP notes that screening for depression is not

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the same as screening for suicide risk and that screening for depression alone misses 36% of patients at-risk for committing suicide [94]. Screening children younger than 8 years of age is not recommended, but warning signs or parental reports of self-harm or suicidal behaviors should be assessed further; these may include [94]:

- Talking about wanting to die or wanting to kill oneself
- Grabbing their throat in a "choking" motion, or placing their hand in the shape of a gun pointed toward their head
- Acting with impulsive aggression
- Giving away their treasured toys or possessions

The American Academy of Child and Adolescent Psychiatry recommends clinician awareness of patients at high risk for suicide (i.e., older male adolescents and all adolescents with current psychiatric illness or disordered mental state, particularly major depressive disorder), especially when complicated by comorbid substance abuse, irritability, agitation, psychosis, or previous suicide attempt [95; 125]. Suicide risk should be assessed at each visit in patients with long-term SSRI use.

ASSESSMENT OF SUICIDE RISK

Initial Inquiry

Healthcare providers may encounter a patient they suspect is suicidal. This suspicion may be prompted by the presence of one or more of the risk factors for suicide described previously, patient history, a statement expressed by the patient, or by their intuition. This scenario may present a dilemma of how to proceed. Although some healthcare professionals are uncomfortable with suicidal patients, it is essential not to ignore or deny the suspicion of suicide risk. The first and most immediate step is to allocate adequate time to the patient, even though many others may be scheduled. Showing a willingness to help begins the process of establishing a positive rapport with the patient. Closed-ended and direct questions at the beginning of the interview are not very helpful; instead, use open-ended questions such as, "You look very upset; tell me more about it." Listening with empathy is in itself a major step in reducing the level of suicidal despair and overall distress [59; 60]. It is helpful to lead into the topic gradually with a sequence of useful questions, such as [59; 60]:

- Do you feel unhappy and helpless?
- Do you feel desperate?
- Do you feel unable to face each day?
- Do you feel life is a burden?
- Do you feel life is not worth living?
- Have you had thoughts of ending your own life?

It is important to ask these questions after rapport has been established, when the patient feels comfortable expressing his or her feelings, and when the patient is in the process of expressing negative feelings [59; 60].

After the patient confirms an initial suspicion of suicidal ideation, the next step is to assess the frequency and severity of the ideation and the possibility of suicide. It is important to ask the patient about whether a method has been developed and planned, the accessibility to the means to attempt suicide, and the magnitude of lethal intent in a manner that is not demanding or coercive, but is asked in a warm and caring way that demonstrates empathy with the patient. Such general questions might include [59; 60]:

- Have you made any plans for ending your life?
- How are you planning to do it?
- Do you have in your possession [pills/guns/other means]?
- Have you considered when to do it?

In general, the more an individual has thought about suicide, made specific plans, and intends to act on those plans, the greater the suicide risk. Thus, as part of the assessment of suicide risk it is essential to inquire specifically about the patient's suicidal thoughts, plans, behaviors, and intent. Such questions may often flow naturally from discussion of the patient's current situation, but in other cases they should be explicitly asked [62].

Other questions may help further elucidate suicidal thoughts, plans, or behaviors, including [62]:

Patient's Feelings about Living

- Have you ever felt that life was not worth living?
- Did you ever wish you could go to sleep and just not wake up?

Thoughts of Death, Self-Harm, or Suicide

- Is death something you've thought about recently?
- Have things ever reached the point that you've thought of harming yourself?

Follow-Up Questions

- When did you first notice such thoughts?
- What led up to the thoughts (e.g., interpersonal and psychosocial precipitants, including real or imagined losses; specific symptoms such as mood changes, anhedonia, hopelessness, anxiety, agitation, psychosis)?
- How often have those thoughts occurred (including frequency, obsessional quality, controllability)?
- How close have you come to acting on those thoughts?
- How likely do you think it is that you will act on them in the future?
- Have you ever started to harm (or kill) yourself but stopped before doing something (e.g., holding knife or gun to your body but stopping before acting, going to edge of bridge but not jumping)?

- What do you envision happening if you actually killed yourself (e.g., escape, reunion with significant other, rebirth, reactions of others)?
- Have you made a specific plan to harm or kill yourself? If so, what does the plan include?
- Do you have guns or other weapons available to you?
- Have you made any particular preparations (e.g., purchasing specific items, writing a note or a will, making financial arrangements, taking steps to avoid discovery, rehearsing the plan)?
- Have you spoken to anyone about your plans?
- How does the future look to you?
- What things would lead you to feel more (or less) hopeful about the future (e.g., treatment, reconciliation of relationship, resolution of stressors)?
- What things would make it more (or less) likely that you would try to kill yourself?
- What things in your life would lead you to want to escape from life or be dead?
- What things in your life make you want to go on living?
- If you began to have thoughts of harming or killing yourself again, what would you do?

For persons with previous suicidal or self-harm behavior, the following questions address the antecedents, methods, and aftermath [62]:

- Can you describe what happened (e.g., circumstances, precipitants, view of future, use of alcohol or other substances, method, intent, seriousness of injury)?
- What thoughts were you having beforehand that led up to the attempt?
- What did you think would happen (e.g., going to sleep versus injury versus dying, getting a reaction out of a particular person)?
- Were other people present at the time?
- Did you seek help afterward yourself, or did someone get help for you?
- Had you planned to be discovered, or were you found accidentally?
- How did you feel afterward (e.g., relief versus regret at being alive)?
- Did you receive treatment afterward (e.g., medical versus psychiatric, emergency department, inpatient versus outpatient)?
- Has your view of things changed, or is anything different for you since the attempt?
- Are there other times in the past when you've tried to harm (or kill) yourself?

Repeated Suicidal Thoughts or Attempts

- About how often have you tried to harm (or kill) yourself?
- When was the most recent time?
- Can you describe your thoughts at the time that you were thinking most seriously about suicide?
- When was your most serious attempt at harming or killing yourself?
- What led up to it, and what happened afterward?

Persons with Psychosis, Hallucinations, and Delusions

- Can you describe the voices (e.g., single versus multiple, male versus female, internal versus external, recognizable versus unrecognizable)?
- What do the voices say (e.g., positive remarks, negative remarks, threats)? If the remarks are commands, determine if they are for harmless versus harmful acts; ask for examples.
- How do you cope with (or respond to) the voices?
- Have you ever done what the voices ask you to do? What led you to obey the voices? If you tried to resist them, what made it difficult?
- Have there been times when the voices told you to hurt or kill yourself? How often? What happened?
- Are you worried about having a serious illness or that your body is rotting?
- Are you concerned about your financial situation even when others tell you there is nothing to worry about?
- Are there things that you have been feeling guilty about or blaming yourself for?

Potential to Harm Others

- Are there others who you think may be responsible for what you are experiencing (e.g., persecutory ideas, passivity experiences)? Are you having any thoughts of harming them?
- Are there other people you would want to die with you?
- Are there others who you think would be unable to go on without you?

When assessing for suicide, it is important to be cautious of misleading information or false improvement [59; 60]. When an agitated patient suddenly appears calm, he or she may have made the decision to attempt suicide and feels calm after making the decision. Denial is another important consideration. Patients may deny harboring very serious intentions of killing themselves.

All patients at acute risk for suicide who are under the influence (intoxicated by drugs or alcohol) should be evaluated in an urgent care setting and be kept under observation until they are sober. If the patient is intoxicated when the initial assessment is completed, it should be repeated after he or she is sober [79].

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Lethal Means

All persons at risk for suicide should be assessed for availability or intent to acquire lethal means, including firearms and ammunition, drugs, poisons, and other means in the patient's home [79].

Clinicians should always inquire about access to firearms and ammunition and how they are stored. For military members and veterans, this includes assessing privately owned firearms. In addition, medication reconciliation should be performed for all patients. For any current and/or proposed medications, consider the risk/benefit of any medications that could be used as a lethal agent to facilitate suicide. Consider prescribing limited supplies for those at elevated risk for suicide or with histories of overdose or the availability of a caregiver to oversee the administration of the medications. In addition to medications, the availability of chemical poisons, especially agricultural and household chemicals, should be assessed, as many of these are highly toxic [79].

DETERMINING LEVEL OF RISK AND APPROPRIATE ACTIONS

The formulation of the level of risk for suicide guides the most appropriate care environment in which to address the risk and provide safety and care needs. The first priority is safety. Patients assessed as having a clear intention of taking their lives will require higher levels of safety protection than those with less inclination toward dying. Patients who are at high risk for suicide may require inpatient care to provide for increased level of supervision and higher intensity of care. Those at intermediate and low acute risk may be referred to an outpatient care setting and, with appropriate supports and safety plans, may be able to be followed-up in the community (***Table 2***) [79].

Risk Assessment Tools

Rating scales can be helpful in the assessment process. However, a clinical assessment by a trained professional is required to assess suicide risk. This professional should have the skills to engage patients in crisis and to elicit candid disclosures of suicide risk in a non-threatening environment. The assessment should comprise a physical and psychiatric examination, including a comprehensive history (with information from patient, parents, and significant others whenever possible) to obtain information about acute psychosocial stressors, psychiatric diagnoses, current mental status, and circumstances of prior suicide attempts. Assessment tools may be used to evaluate risk factors, in addition to the clinical interview, although there is insufficient evidence to recommend one tool over another.

High Acute Risk

Considering all the information gathered in the assessment, the clinician will formulate the level of risk in one of the following categories: high acute risk, intermediate acute risk, low acute risk, not at elevated risk [79].

High acute risk patients include those with warning signs, serious thoughts of suicide, a plan and/or intent to engage in lethal self-directed violence, a recent suicide attempt, and/or those with prominent agitation, impulsivity, and/or psychosis. In such cases, clinicians should ensure constant observation and monitoring before arranging for immediate transfer for psychiatric evaluation or hospitalization [79]. Patients at high acute risk should be immediately referred for a specialty evaluation with particular concern for ensuring the patient's safety and consideration for hospitalization.

Intermediate Acute Risk

Intermediate acute risk patients include those with suicidal ideation and a plan but with no intent or preparatory behavior. Combination of warning signs and risk factors to include history of self-directed violence (suicide attempt) increases a person's risk for suicide. Patients at intermediate risk should be evaluated by a behavioral health provider. The decision whether to urgently refer a patient to a mental health professional or emergency department depends on that patient's presentation. The patient who is referred may be hospitalized if further evaluation reveals that the level of illness or other clinical findings warrant it. The patient may be managed in outpatient care if patient and provider collectively determine that the individual is capable of maintaining safety by utilizing non-injurious coping methods and utilize a safety plan [79].

Low Acute Risk

Low acute risk patients include those with recent suicidal ideation who have no specific plans or intent to engage in lethal self-directed violence and have no history of active suicidal behavior. Consider consultation with behavioral health to determine need for referral to treatment addressing symptoms and safety issues. These patients should be followed up for reassessment. Patients at low acute risk should be considered for consultation with or referral to a behavioral health practitioner [79].

Not at Elevated Acute Risk or Risk Unknown

Persons with a mental disorder who are managed appropriately according to evidence-based guidelines and do not report suicidal thoughts are outside the scope of the classification of risk for suicide. Patients who at some point in the past have reported thoughts about death or suicide but currently do not have any of these symptoms are not considered to be at acute risk of suicide. There is no indication to consult with behavioral health specialty in these cases, and the patients should be followed in routine care, continue to receive treatment for their disorder, and be re-evaluated periodically for thoughts and ideation. Patients at no elevated acute risk should be followed in routine care with treatment of their underlying condition and evaluated periodically for ideation or suicidal thoughts. Patients for whom the risk remains undetermined (i.e., no collaboration of the patient or provider concerns about the patients despite denial of risk) should be evaluated by a behavioral health practitioner [79].

DETERMINE LEVEL OF RISK FOR SUICIDE AND APPROPRIATE ACTION			
Risk of Suicide Attempt	**Indicators of Suicide Risk**	**Contributing Factors[a]**	**Initial Action Based on Level of Risk**
High acute risk	Persistent suicidal ideation or thoughts Strong intention to act or plan Not able to control impulse Recent suicide attempt or preparatory behavior[b]	Acute state of mental disorder or acute psychiatric symptoms Acute precipitating event(s) Inadequate protective factors	Maintain direct observational control of the patient Limit access to lethal means Immediate transfer with escort to urgent/emergency care setting for hospitalization
Intermediate acute risk	Current suicidal ideation or thoughts No intention to act Able to control the impulse No recent attempt or preparatory behavior or rehearsal of act	Existence of warning signs or risk factors[b] and limited protective factors	Refer to behavioral health provider for complete evaluation and interventions Contact behavioral health provider to determine acuity of referral Limit access to lethal means
Low acute risk	Recent suicidal ideation or thoughts No intention to act or plan Able to control the impulse No planning or rehearsing a suicide act No previous attempt	Existence of protective factors and limited risk factors	Consider consultation with behavioral health to determine need for referral and treatment Treat presenting problems Address safety issues Document care and rationale for action

[a]Modifiers that increase the level of risk for suicide of any defined level include acute state of substance use, access to means (e.g., firearms, medications), and existence of multiple risk factors or warning signs or lack of protective factors.[b]Evidence of suicidal behavior warning signs in the context of denial of ideation should call for concern (e.g., contemplation of plan with denial of thoughts or ideation).

Source: U.S. Department of Veterans Affairs. VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide. Available at http://www.healthquality.va.gov/guidelines/MH/srb. *Table 2*

DOCUMENTATION

In order to ensure optimal patient care and to prevent miscommunication and litigation, the results of any suicide risk assessment should be fully documented. At a minimum, documentation should include the following points, noted by the mnemonic SUICIDE [17]:

- **S**uicide assessment: The results of suicide screening or assessment, including any relevant history (personal or family), access to lethal means, suicide plans, recent history of stressful events, and protective factors, should be noted.
- **U**npredictable: Family members and/or other supportive third parties should be alerted that suicide can be unpreventable, even given the best efforts and plans.
- **I**nterventions: All interventions planned and undertaken should be included in the patient's record.
- **C**lear and comprehensive: It is important to ensure that all documentation is clear and comprehensive, with specific notes regarding the patient's own words.
- **I**ntent: The intentions of any suicide attempt(s) or intentional self-harm should be noted.
- **D**iscussions with family members and/or other supportive third parties: Supportive third parties can be invaluable to the treatment process, and their inclusion in risk assessments and treatment planning should be documented.
- **E**ducate, engage, empathize: Documentation should include notes regarding the patient's involvement in treatment planning and the creation of a safety plan.

Patient B arrives at the office with her daughter. She appears withdrawn and preoccupied, having a look of resignation and despair. Seated together, you begin the interview in a positive, affirming manner: "I'm pleased that all your laboratory work, including your thyroid tests, is normal. You know you told me you would be okay, and I believe if we work together, so as to know and understand better what you are going through, we can relieve many of your symptoms and get you to a much better place." She is receptive, and after further discussions, the following picture emerges: Patient B has been unhappy for "a very long time." There is little to add to the somatic complaints related on the first visit. She sleeps poorly and is tired all the time; she has lost interest in what was previously an active social life and rarely "goes out." There is a good deal of psychic stress and pain attached to the relationship with her husband, and a sense of hopelessness has been

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building for months. In recent days, she has not slept and has periods of confusion. She wishes not to be a burden to those closest to her and has thought often of ending her life. Recently she has been thinking about just how to do this, the options available to her, and how it might be done so as to mask her intent. At the conclusion of the interview, you glance at the nurse with an expression of appreciation, and shudder to think how easily you might have missed all this.

- *Recall the mnemonic device IS PATH WARM. How many of the elements are positive for Patient B? Which ones?*
- *Would you rate Patient B's suicide risk as low? Intermediate? High?*
- *Which of the following management options is the LEAST appropriate at this juncture?*
  - *Send the patient home with a prescription for an antidepressant and a plan for regular return psychotherapy sessions in your office.*
  - *Refer her to a psychiatrist (appointment in 48 to 72 hours) and negotiate a "contract" with the patient that she is not to take matters into her own hands but will call you immediately if she has thoughts of doing so.*
  - *Arrange admission to the hospital medical service with a "sitter" and place an urgent psychiatry consultation.*
  - *Call your psychiatry consultant to summarize the case and request immediate consultation or admission to the inpatient psychiatry service.*

MANAGEMENT OF SUICIDAL PATIENTS

The opportunity for an emotionally disturbed patient with vague suicidal ideation to vent his or her thoughts and feelings to an understanding health or mental health provider may bring a degree of relief such that no further intervention is needed. However, in all cases the encouragement of further contact and follow-up should be conveyed to the patient, especially when inadequate social support is present. Independent of the actual catalyst, most suicidal persons possess feelings of helplessness, hopelessness, and despair and a triad of three cognitive/emotional conditions [59; 60]:

- Ambivalence: Most suicidal patients are ambivalent, with alternating wishes to die and to live. The healthcare provider can use patient ambivalence to increase the wish to live, thus reducing suicide risk.
- Impulsivity: Suicide is usually an impulsive act, and impulse, by its nature, is transient. A suicide crisis can be defused if support is provided at the moment of impulse.
- Rigidity: Suicidal people experience constricted thinking, mood, and action and dichotomized black-and-white reasoning to their problems. The provider can help the patient understand alternative options to death through gentle reasoning.

Healthcare professionals should assess the strength and availability of emotional support to the patient, help the patient identify a relative, friend, acquaintance, or other person who can provide emotional support, and solicit the person's help [59; 60]. The engagement of supportive third parties in the patient's life can be a useful tool in preventing suicide completion.

Adherence to established best practices general assures that assessment and care will be ethical and legal. It is important to consider and document informed consent. Underlying key ethical principles include respect for persons, autonomy, and beneficence [121].

PHARMACOTHERAPY TO REDUCE SUICIDE RISK

Abundant evidence has demonstrated that lithium reduces the rate of suicidal behavior in patients with bipolar disorder and recurrent major depression and that clozapine reduces suicidal behavior in schizophrenia [97; 98; 99; 100; 101; 102]. Both drugs reduce suicide risk independently of their effect on the primary psychiatric disorder. Although the exact anti-suicide mechanism of both drugs has yet to be identified, lithium enhances serotonergic activity and clozapine is a potent 5-HT2A antagonist. Serotonergic modulation is a likely explanation of the suicide-reducing effects of both medications, because aggression levels and suicide are correlated with prefrontal cortical 5-HT2A binding [71; 104; 105].

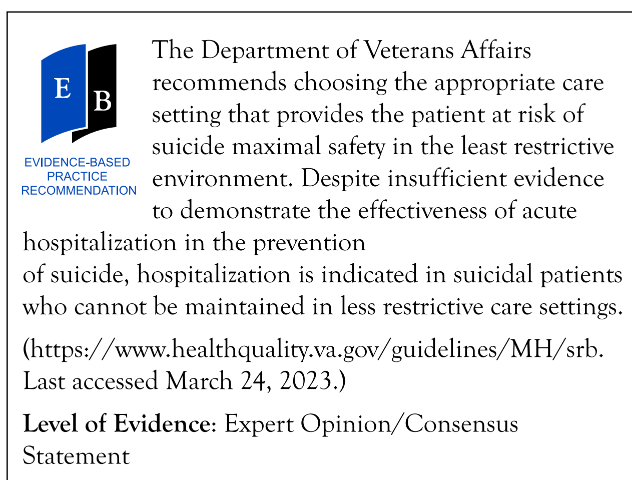
PSYCHOTHERAPY TO REDUCE SUICIDE RISK

In addition to pharmacotherapy, various psychotherapy approaches have been shown to decrease suicide risk in patients at low or intermediate risk for suicide [55]. Post-admission cognitive therapy is a cognitive-behavioral therapy approach designed to help patients who have suicide-related thoughts and/or behaviors. It consists of three phases of therapy for outpatients or inpatients [55]:

- The patient is asked to tell a story associated with her or his most recent episode of suicidal thoughts, behavior, or both.
- The patient is assisted with modifying underdeveloped or overdeveloped skills that are most closely associated with the risk of triggering a suicidal crisis.
- The patient is guided through a relapse-prevention task.

Another cognitive-behavioral approach is cognitive-behavioral psychotherapy for suicide prevention, which involves "acute and continuation phases, each lasting about 12 sessions, and includes a chain analysis of the suicidal event, safety plan development, skill building, psychoeducation, family intervention, and relapse prevention" [53].

Dialectical behavior therapy was originally designed to address the self-harm impulses of patients with borderline personality disorder, but it has good evidence for use in most suicidal individuals. Dialectical behavioral therapy is an adaptation of cognitive-behavioral therapy and is based on the theoretical principle that maladaptive behaviors, including self-injury, are attempts to manage intense overwhelming affect of biosocial origin. It consists of the two key elements of a behavioral, problem-solving approach blended with acceptance-based strategies and an emphasis on dialectical processes. Dialectical behavioral therapy emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapeutic targets are ranked in hierarchical order, with life-threatening behaviors addressed first, followed by therapy-interfering behaviors, and then behaviors that interfere with quality of life.



The Department of Veterans Affairs recommends choosing the appropriate care setting that provides the patient at risk of suicide maximal safety in the least restrictive environment. Despite insufficient evidence to demonstrate the effectiveness of acute hospitalization in the prevention of suicide, hospitalization is indicated in suicidal patients who cannot be maintained in less restrictive care settings.

(https://www.healthquality.va.gov/guidelines/MH/srb. Last accessed March 24, 2023.)

Level of Evidence: Expert Opinion/Consensus Statement

MENTAL HEALTH REFERRAL

Depending on the level of suicide risk, referral to a mental health professional (e.g., psychologist, counselor, therapist), psychiatrist, or hospitalization may be warranted. Long-term treatment and follow-up will be required for many patients, and appropriate referral to outpatient facilities is often necessary. If the person is currently in therapy, the therapist should be called and involved in the management decision. If the patient does not have a therapeutic relationship with a mental health professional, referral to one should be made. Suicidal patients should be referred to a psychiatrist when any of the following are present: psychiatric illness; previous suicide attempt; family history of suicide, alcoholism, and/or psychiatric disorder; physical illness; or absence of social support [59; 60]. After deciding to refer a patient to a mental health professional, the clinician should explain to the patient the reason for the referral and help alleviate patient anxiety over stigma and psychotropic medications. It is also important to help the patient understand that pharmacologic and psychologic therapies are both effective and to emphasize to the patient that referral does not mean "abandonment." The referring clinician should also arrange an appointment with the mental health professional, allocate time for the patient following the initial appointment with the therapist or psychiatrist, and ensure the ongoing relationship with the patient [59; 60].

REFERRAL TO BE HOSPITALIZED

Some indications for immediate hospitalization include recurrent suicidal thoughts, high levels of intent of dying in the immediate future (the next few hours or days), the presence of agitation or panic, or the existence of a plan to use a violent and immediate suicide method [59; 60]. When hospitalizing a patient, she or he should not be left alone; the hospitalization and transfer of the patient by ambulance or police should be arranged and the family, and any appropriate authorities should be informed [59; 60].

A patient may be discharged to a less restrictive level of care from an acute setting (emergency department/hospital/acute specialty care) after a behavioral health clinician evaluated the patient, or a behavioral health clinician was consulted, and all three of the following conditions have been met [79]:

- Clinician assessment indicates that the patient has no current suicidal intent.
- The patient's active psychiatric symptoms are assessed to be stable enough to allow for reduction of level of care.
- The patient has the capacity and willingness to follow the personalized safety plan (including having available support system resources).

ADDITIONAL OPTIONS FOR CONTINUITY OF CARE

It is important to ensure that the patient has follow-up contact even after discharge to another provider. At the point of discharge, information should be provided on crisis options (referred to as "crisis cards") and free, universally available help, such as hotlines. There is evidence that follow-up outreach in the form of letters or postcards expressing care and concern and continuing for up to three years may be helpful in suicide prevention [75]. These letters should generally be non-demanding, allowing the opportunity but not the requirement for patients to respond.

Alternatively, patients may be followed-up with phone calls from a mental health professional or suicide crisis volunteer [75]. If phone follow-up is preferred, calls should be made weekly or biweekly, in some cases supplemented with a home visit, and should continue for a period of three to six months.

In many cases, partnering with a community crisis center can be helpful [66]. Crisis call centers are a crucial resource in linking patients to services and providing emotional support. According to the Suicide Prevention Lifeline, crisis center follow-up before a service appointment is associated with improved motivation, a reduction in barriers to accessing services, improved adherence to medication, reduced symptoms of depression, and higher attendance rates [64].

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SAFETY PLANNING

The VA recommends establishing an individualized safety plan for all persons who are at high acute risk for suicide as part of discharge planning, regardless of inpatient or outpatient status [79]. The safety plan is designed to empower the patient, manage the suicidal crisis, and engage other resources. Safety should also be discussed with patients at intermediate and low risk, with appropriate patient education and a copy of a safety plan handout [79].

Stressful events, challenging life situations, mental/substance use disorders, and other factors can precipitate a crisis of suicidal thoughts and behaviors leading directly to self-injury. Advance anticipation of challenging situations and envisioning how one can identify and break a cycle of suicidal crises can reduce risk of self-injury and enhance a patient's sense of self-efficacy. Open dialogue between patients and clinicians to establish a therapeutic alliance and develop strategies and skills supporting the patient's ability to avoid acting on thoughts of suicide (including minimizing access to lethal means) is an essential component of suicide prevention in clinical settings. Putting this thinking-through process in writing for the anticipation of a suicidal crisis and how to manage it constitutes a patient's safety (action) plan [79].

Safety planning is a provider-patient collaborative process—not a "no harm" contract. The safety planning process results in a written plan that assists the patient with restricting access to means for completing suicide, problem-solving and coping strategies, enhancing social supports and identifying a network of emergency contacts including family members and friends, and ways to enhance motivation. These plans are tailored to the patient by assisting with identifying his or her specific warning signs and past effective coping strategies [79].

The safety plan should include the following elements, as appropriate:

- Early identification of warning signs or stressors
- Enhancing coping strategies (e.g., to distract and support)
- Utilizing social support contacts (discuss with whom to share the plan)
- Contact information about access to professional help
- Minimizing access to lethal means (e.g., weapons and ammunition or large quantities of medication)

The safety plan should be reviewed and updated by the healthcare team working with the patient as needed and shared with family and other supportive third parties if the patient consents. Safety plans should be updated to remain relevant during changes in clinical state and transitions of care [79].

Providers should document the safety plan or reasons for not completing such a plan in the medical record. In addition, patients should receive a copy of the plan [79].

Limiting Access to Lethal Means

Restricting at-risk patients from access to lethal means is considered an essential part of suicide prevention and safety planning. Methods of ensuring persons with suicidal intent do not have access to lethal means include restriction of access to firearms and ammunition, safer prescribing and dispensing of medications to prevent intentional overdoses, and modifying the environment of care in clinical settings to prevent fatal hangings [79]. For military service members, concerns about firearms should include privately owned guns and ammunition. It is also important to educate caregivers, family members, and/or other supportive third parties regarding the potential dangers of lethal means and how to keep these items or substances from the patient.

Storing firearms away from suicidal individuals can reduce gun deaths [79]. It must be stressed that the firearms are still the property of the individual, and they are not "giving them away." Options for safe storage of firearms include removing ammunition from an individual's possession, asking a friend or relative to take possession of firearms, disassembling firearms and storing various parts in different locations, storing firearms at a storage unit or gun locker at a shooting range, storing firearms at a gun shop or pawn shop, asking law enforcement to take possession of firearms, or storing personal firearms at military unit arms rooms [79]. The least restrictive and most acceptable means of removing easy accesses to lethal means should be employed in order to assure an individual welcomes the intervention. It is important to avoid implying that an individual is incapable of firearm possession or that they are unfit in a legal sense.

CONSIDERATIONS FOR VETERANS

With military service members, the command element should also be involved in education, safety planning, treatment planning, and implementation of duty limitations. Additional areas to address are the patient's medical and other specific needs. These may be psychosocial, socioeconomic, or spiritual in nature [79].

The VA/DoD has made the following recommendations when creating a treatment plan for veterans and active service members [79]:

- Providers should take reasonable steps to limit the disclosure of protected health information to the minimum necessary to accomplish the intended purpose.
- Providers should involve command in the treatment plan of service members at high acute risk for suicide to assist in the recovery and the reintegration of the patient to the unit. For service members at other risk levels, the provider should evaluate the risk and benefit of involving command and follow service department policies, procedures, and local regulations.

- When performing a medical profile, the provider should discuss with command the medical recommendation and the impact on the service member's limitations to duty and fitness for continued service.
- Providers should discuss with service members the benefit of having command involved in their plan and assure them their rights to protected health information, with some exceptions, regarding to the risk for suicide.
- As required by pertinent military regulations, communicate to the service member's chain of command regarding suicidal ideation along with any recommended restrictions to duty, health and welfare inspection, security clearance, deployment, and firearms access. Consider redeployment to home station any service member deployed to a hazardous or isolated area.
- Service members at high acute risk for suicide who meet criteria for hospitalization and require continuous (24-hour) direct supervision should be hospitalized in almost all instances. If not, the rationale should specifically state why this was not the preferred action, with appropriate documentation.
- During operational deployment conditions or other extreme situations during which hospitalization or evacuation is not possible, "unit watch" may be considered as appropriate in lieu of a high level care setting (hospitalization), and service department policies, procedures, and local regulations should be followed.
- Because of the high risk of suicide during the period of transition, providers should pay particular attention to ensure follow-up, referral, and continuity of care during the transition of service members at risk for suicide to a new duty station or after separation from a unit or from military service.

CONSIDERATIONS FOR HEALTHCARE PROFESSIONALS

Although confidentiality is crucial when caring for any patient, this is heightened for healthcare providers who would potentially be seeking assessment and treatment in their workplace. All healthcare providers should be offered the opportunity for anonymous screening for depression and suicide. The healer education assessment and referral (HEAR) screening program is a sustainable suicide prevention program that uses an anonymous method to provide screening for untreated depression or suicide [119; 121]. The American Foundation for Suicide Prevention also provides services specifically for healthcare providers, accessible at https://afsp.org/suicide-prevention-for-healthcare-professionals.

SUICIDE PREVENTION

Understanding the interactive relationship between risk and protective factors in suicidal behavior and how this interaction can be modified forms the basis of suicide prevention [5; 106]. The characteristics shared by effective suicide prevention programs include clear identification of the intended population, definition of desired outcomes, use of interventions known to effect a particular outcome, and use of community coordination and organization to achieve an objective. Prevention efforts are based on a clear plan with goals, objectives, and implementation steps [5; 45].

HISTORY OF SUICIDE PREVENTION IN THE UNITED STATES

In the United States, large-scale suicide prevention efforts began in 1958. Funding from the U.S. Public Health Service established the first suicide prevention center in Los Angeles, and other crisis intervention centers replicating this model were opened across the country [5]. The risk factor approach to suicide prevention was first implemented in 1966, and the American Association of Suicidology and the American Foundation for Suicide Prevention were established over the next two decades. Their activities included increasing the scientific understanding of suicide as the basis for effective prevention activities [5]. In 1983, the CDC established a violence prevention division that alerted the public to the disturbing increase in youth suicide rates.

In 1996, survivors of suicide loss mobilized to form the Suicide Prevention Advocacy Network USA (SPAN USA) and launched a campaign to advocate for the development of a national suicide prevention strategy [107]. In 2009, SPAN USA merged with the American Foundation for Suicide Prevention to raise awareness, fund research, and provide resources and aid to those affected by suicide [48].

The National Strategy for Suicide Prevention (NSSP) was released by the Surgeon General of the United States in 2001 and updated in 2012. The NSSP describes a series of goals and objectives designed to reduce the incidence of suicide behaviors in the United States [46]. Although activity in the field of suicide prevention has increased exponentially since publication of the NSSP, the overall rate of suicide since 2000 continues to increase [1].

SUICIDE PREVENTION THAT TARGETS AT-RISK POPULATIONS

College Students

Colleges and universities are increasingly challenged to identify and manage mental health and substance use problems in students. Because the risk and protective factors for suicide among young adults include substance abuse and interpersonal violence, suicide prevention may best be integrated within broader prevention efforts [5; 108; 109].

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Inmates in Jails and Correctional Settings

As discussed, jails and juvenile justice facilities have exceptionally high suicide rates. The highest rates of jail suicide occur within the first 24 to 48 hours of arrest, suggesting an important role of medical assessment of substance abuse and suicide proneness at intake. Comprehensive prevention programs targeting inmate suicide include training, screening, effective communication methods, intervention, use of reporting protocols, and mortality review [5; 110].

Elderly Persons

Almost 70% of elderly patients who take their own lives see their primary care physician within a few months of their death [111; 112]. This represents an absolutely vital, yet narrow, window for accurate screening and assessment of suicide risk [2]. Unfortunately, healthcare and mental health professionals are not immune from harboring the stereotypes of the elderly often found among society in general. These can include attitudes that a depressive response to interpersonal loss, physical limitation, or changing societal role is an inevitable and even normal aspect of aging [111; 113; 114]. Suicidal thoughts may even be considered age-appropriate in the elderly [112]. When held by patients and family members, these erroneous beliefs can lead to under-reporting of symptoms and lack of effort on the part of family members to seek care for patients [114]. When held by clinicians, these beliefs can result in delayed or missed diagnoses, less effective treatment, or suicide in the elderly patient.

Because the elderly have the highest overall suicide rate of all age groups, organizations with special access to older persons have an important role in suicide prevention. State aging networks exist in every state, and these networks develop and fund a variety of in-home and community-based services. States organize the provision of such services through area agencies on aging, which coordinate a broad range of services for older people [5].

Patients with Bipolar Disorder

Although 20% of patients with bipolar disorder have their first episode during adolescence, diagnosis is often delayed for years, which can result in problems such as substance abuse and suicidal behaviors. Thus, early recognition and aggressive treatment may prevent years of needless suffering and death by suicide. In particular, lithium is effective in preventing suicidal behavior in patients with bipolar disorder. Maintaining treatment is essential in preventing suicide, and the suicide rate in the first year of discontinuation of lithium treatment is 20 times higher than during lithium treatment [103].

Patients with Schizophrenia

Approximately 0.9% of people in the United States are living with schizophrenia or a related disorder [49]. One study of patients with schizophrenia showed a lifetime prevalence of suicide attempt of 39.2%, versus 2.8% of nonafflicted individuals; furthermore, about 5% of patients with schizophrenia will eventually die by suicide [50; 90]. Depression is the most important risk factor for suicide in patients with schizophrenia; only 4% of patients with schizophrenia who exhibit suicidal behavior do so in response to instructions from "command" voices. Clozapine is effective in reducing suicide and attempted suicide in patients with schizophrenia, and effective suicide prevention involves the early recognition and prompt treatment of schizophrenia and all comorbid conditions [2].

Military Veterans

Assessment of suicide risk and protective factors in military personnel is vital, particularly at times of transition (e.g., deployment, separation from service/unit). It is important to include life planning, referral information, and resources for patients who experience suicidal ideation, and there are military-specific resources available for current or former members of the military. The Veterans Crisis Line, https://www.veteranscrisisline.net or 988, is free to all active service members, including members of the National Guard and Reserve, and veterans, even if they are not registered with the VA or enrolled in VA health care [81].

STIGMA AND SUICIDE

The stigma of mental illness and substance abuse, both of which are closely linked to suicide, prevents many persons from seeking help out of a fear of prejudice and discrimination [88]. People who have a substance use disorder face additional stigma because many people believe that abuse and addiction are moral failings and that individuals are fully capable of controlling these behaviors if they want to [5; 80]. The stigma of suicide, while deterring some from attempting suicide, is also a barrier to treatment for many persons who have suicidal thoughts or have attempted suicide. Family members of suicide attempters often hide the behavior from friends and relatives, because they may believe that it reflects badly on their own relationship with the suicide attempter or that suicidal behavior itself is shameful or sinful. Persons who attempt suicide may have many of these same feelings [5].

On a systems level, the stigma surrounding mental illness, substance use disorders, and suicide has contributed to inadequate funding for preventive services and inadequate insurance reimbursement for treatments. Substance use and mental health conditions, including those associated with suicide, will remain undertreated and services tailored to persons in crisis will remain limited as long as stigma persists, resulting in an unnecessarily high rate of suicidal behavior and suicide [5]. Additionally, the stigma associated with mental illness and substance abuse has led to separate systems for physical health and mental health care, a consequence being that preventive and treatment services for mental illness and substance abuse are much less available than for other health problems. This separation has also led to bureaucratic and institutional barriers between the two systems that impede and complicate access to care and service implementation [5].

SUICIDE SURVIVORS: TREATMENT AND RESOURCES

Family members and friends affected by the death of a loved one through suicide are referred to as "suicide survivors." Conservative estimates suggesting a ratio of six survivors for every suicide deaths indicate that an estimated 6 million Americans became suicide survivors in the past 25 years; however, as noted, many more individuals are affected by a single suicide [4; 13; 14].

The death of a loved one by suicide can be shocking, painful, and unexpected for survivors. The ensuing grief can be intense, complex, chronic, and nonlinear. Working through grief is a highly individual and unique process that survivors experience in their own way and at their own pace. Grief does not always move in a forward direction, and there is no timeframe for grief. Survivors should not expect their lives to return to their previous state and should strive to adjust to life without their loved one. The initial emotional response may be overwhelming, and crying is a natural reaction and an expression of sadness following the loss of a loved one [13].

Survivors often struggle with trying to comprehend why the suicide occurred and how they could have intervened. Feelings of guilt are likely when the survivor believes he or she could have prevented the suicide. The survivor may even experience relief at times, especially if the loved one had a psychiatric illness. The stigma and shame that surround suicide may cause difficulty among the family members and friends of survivors in knowing what to say and how to support the survivor and might prevent the survivor from reaching out for help. Ongoing support remains important to maintain family and other relationships during the grieving process [13].

Many survivors find that the best help comes from attending a support group for survivors of suicide in which they can openly share their own story and their feelings with fellow survivors without pressure or fear of judgment and shame. Support groups can be a helpful source of guidance, understanding, and support through the healing process [13]. The American Foundation for Suicide Prevention maintains an international directory of suicide bereavement support groups on their website, https://afsp.org.

CONCLUSION

Suicide is a major preventable public health problem and a significant cause of mortality. This course has reviewed the major aspects of suicide assessment, management, and prevention, with a special focus on military veterans. Primary care contact may represent the last opportunity for intervention in the severely depressed suicidal patient, making the thorough comprehension of identification and treatment of depression and suicide risk imperative.

Customer Information/Answer Sheet/Evaluation insert located between pages 48–49.

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TEST QUESTIONS

#76442 SUICIDE ASSESSMENT AND PREVENTION

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

This 6 Hour activity must be completed by March 31, 2026.

1. In 2019, how many suicide deaths were reported in the United States?
A) 4,277
B) 27,489
C) 47,511
D) 173,422

2. The only country in which the female suicide rate exceeds the male rate is
A) Cuba.
B) China.
C) Russia.
D) the United States.

3. Overall, there are roughly 25 attempts for every death by suicide.
A) True
B) False

4. Genetic vulnerability is increasingly believed to play a role in suicidal behavior.
A) True
B) False

5. Which of the following relationship statuses is NOT a high-risk demographic for suicide among women?
A) Single
B) Married
C) Widowed
D) Recently separated

6. Most adolescent suicides occur at
A) school after hours.
B) the residence of a friend.
C) home after school hours.
D) the residence of a relative.

7. Which of the following is TRUE regarding suicide among older adults?
A) Untreated depression is a primary cause.
B) Suicide is rarely preceded by only one factor.
C) The suicide rate in elderly men is 5 times that of same-aged women.
D) All of the above

8. Which of the following contributes to the high rate of suicide attempts among lesbian, gay, bisexual, and transgender youth?
A) Higher income
B) Greater family support
C) Stigma and discrimination
D) Higher perceived safety at school

9. The majority of military suicides occur among young men shortly after their discharge from military service.
A) True
B) False

10. Which of the following is NOT a protective factor against suicide?
A) Shame and stigma
B) Access to effective clinical care
C) Restricted access to highly lethal means of suicide
D) Strong connections to family and community support

11. Which of the following is an example of a general biopsychosocial risk factor for suicide?
A) Local clusters of suicide
B) Media exposure to suicide
C) History of childhood physical or sexual abuse
D) Barriers to accessing mental health care or support

12. What proportion of persons who die of suicide have diagnosable psychiatric illness at the time of death?
A) Less than 10%
B) 25%
C) 50%
D) 90%

13. The psychiatric condition most associated with suicide is
A) schizophrenia.
B) panic disorder.
C) anxiety disorder.
D) major depression.

Test questions continue on next page →

14. Which of the following is TRUE regarding alcohol/drug use and suicide?

A) *A substantial proportion of suicide victims test positive for alcohol and/or other drugs.*
B) *Comorbid substance use and psychiatric disorders substantially increase the risk of suicidal behavior.*
C) *Alcohol and drug abuse are second only to mood disorders as conditions most associated with suicide.*
D) *All of the above*

15. Patients with medical illnesses affecting the brain and central nervous system have a lower suicide risk compared with those with other medical conditions.

A) *True*
B) *False*

16. Which of the following sociodemographic factors is NOT associated with increased suicide risk?

A) *Unemployment*
B) *Marriage among men*
C) *Previous suicide attempt*
D) *Occupations such as veterinary surgeons, pharmacists, dentists, and farmers*

17. Inmates at highest risk of suicide include older men and those with no history of mental illness.

A) *True*
B) *False*

18. Which of the following is considered a risk factor for suicide in military veterans?

A) *Traumatic brain injury*
B) *Administrative separation from service/unit*
C) *Combat exposure (particularly deployment to a combat theater and/or adverse deployment experiences)*
D) *All of the above*

19. Which of the following is a warning sign of imminent suicide?

A) *Decreased alcohol and/or other drug use*
B) *Distant history of humiliation, failure, or severe loss*
C) *Making a plan (e.g., giving away prized possessions)*
D) *Recent inhibition and unwillingness to take necessary risks*

20. Superficial-to-moderate intentional self-harm is characterized by

A) *dementia.*
B) *fatal intent.*
C) *suicidal behaviors.*
D) *a desire to relieve tension, release anger, and regain self-control.*

21. What is the most commonly used lethal means in suicide completions?

A) *Firearms*
B) *Prescription drugs*
C) *Rope (i.e., suffocation)*
D) *Household toxins (e.g., bleach)*

22. The most common method of suicide among women in all age groups is suffocation.

A) *True*
B) *False*

23. All of the following are recommended in the assessment of suicide risk, EXCEPT:

A) *Show a willingness to help.*
B) *Establish a positive rapport with the patient.*
C) *Ask closed-ended and direct questions at the beginning of the meeting.*
D) *Gradually ask a series of open-ended questions probing for feelings, thoughts, and behaviors consistent with suicide risk.*

24. In general, the more an individual has thought about suicide, made specific plans, and intends to act on those plans, the greater the suicide risk.

A) *True*
B) *False*

25. Intermediate acute risk patients include those patients with

A) *recent suicidal ideation who have no specific plans or intent to engage in lethal self-directed violence and have no history of active suicidal behavior.*
B) *an appropriately managed mental disorder who do not report suicidal thoughts.*
C) *current suicidal ideation but with no intent or preparatory behavior.*
D) *warning signs, serious thoughts of suicide, a plan and/or intent to engage in lethal self-directed violence, a recent suicide attempt, and/or those with prominent agitation, impulsivity, psychosis.*

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26. **Which of the following is an appropriate initial action for a person who is at low acute risk for suicide?**
    A) *Treat presenting problems*
    B) *Refer to behavioral health provider for complete evaluation and interventions*
    C) *Immediate transfer with escort to urgent/ emergency care setting for hospitalization*
    D) *Maintain direct observational control of the patient*

27. **Patients for whom suicide risk remains undetermined (i.e., no collaboration of the patient or provider concerns about the patient despite denial of risk) should be evaluated by a behavioral health practitioner.**
    A) *True*
    B) *False*

28. **Independent of the actual catalyst, most suicidal persons possess feelings of helplessness, hopelessness, and despair and a triad of three cognitive/emotional conditions: ambivalence, impulsivity, and rigidity.**
    A) *True*
    B) *False*

29. **Abundant evidence has demonstrated that lithium increases the rate of suicidal behavior in patients with bipolar disorder and recurrent major depression.**
    A) *True*
    B) *False*

30. **Dialectical behavior therapy consists of the key elements of a behavioral, problem-solving approach blended with acceptance-based strategies and an emphasis on dialectical processes.**
    A) *True*
    B) *False*

31. **Suicidal patients with a family history of suicide, alcoholism, and/or psychiatric disorder should be referred to a psychiatrist.**
    A) *True*
    B) *False*

32. **More than one month of follow-up outreach in the form of letters or postcards expressing care and concern is considered generally unhelpful in suicide prevention.**
    A) *True*
    B) *False*

33. **During operational deployment conditions or other extreme situations during which hospitalization or evacuation is not possible, "unit watch" is an inappropriate approach to managing military personnel at risk for suicide.**
    A) *True*
    B) *False*

34. **Which of the following is NOT a characteristic shared by effective suicide prevention programs?**
    A) *Definition of the desired outcomes*
    B) *Clear identification of the intended population*
    C) *Use of interventions known to effect a particular outcome*
    D) *Acting independently to eliminate the need for coordination*

35. **The stigma surrounding mental illness, substance use disorders, and suicide has contributed to inadequate funding for preventive services and inadequate insurance reimbursement for treatments.**
    A) *True*
    B) *False*

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COURSE #78250 — 10 HOURS Release Date: 04/01/24 Expiration Date: 03/31/27

Movement and Dance in Psychotherapy

10 Clinical Continuing Education Credits

Audience

This course is designed for professional clinicians who work with clients on a regular basis or who teach/supervise those working with clients who might benefit from the inclusion of movement in their therapy.

Course Objective

The purpose of this course is to introduce movement therapy as a treatment option that practitioners can incorporate into their work with clients, with the goal of improvement outcomes.

Learning Objectives

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

1. Describe movement and dance in the context of psychotherapy.
2. Describe how various world cultures have used movement, dance, and ritual for emotional healing as a separate entity from modern psychology.
3. Outline the work of earlier pioneers in the psychotherapeutic and dance professions who used movement in healing.
4. Describe how the field of dance and movement therapy emerged as its own discipline.
5. Define conscious dance and explain its differences to dance therapy.
6. Discuss the importance of movement to healing the limbic area of the brain affected by trauma.
7. Summarize the psychotherapeutic profession's research findings and applications for working with mindfulness, movement, and yoga.
8. Describe how to assess clients for the appropriateness of movement-based adjuncts in clinical therapy.
9. Discuss how adding simple movement techniques can enhance traditional, talk-based therapy, and apply basic movement-related exercises to existing clinical work.
10. Decide whether or not further training in movement-related modalities is a good fit for one's own clinical repertoire.
11. Outline special considerations for movement- and dance-related modalities, including cultural competence and group therapy.

Faculty

Jamie Marich, PhD, LPCC-S, REAT, RYT-500, RMT, (she/they) travels internationally speaking on topics related to EMDR therapy, trauma, addiction, expressive arts, and mindfulness while maintaining a private practice and online education operation, the Institute for Creative Mindfulness, in her home base of northeast Ohio. She is the developer of the Dancing Mindfulness approach to expressive arts therapy and the developer of Yoga for Clinicians. Dr. Marich is the author of numerous books, including *EMDR Made Simple*, *Trauma Made Simple*, and *EMDR Therapy and Mindfulness for Trauma Focused Care* (written in collaboration with Dr. Stephen Dansiger). She is also the author of Process Not Perfection: Expressive Arts Solutions for Trauma Recovery. In 2020, a revised and expanded edition of *Trauma and the 12 Steps* was released. In 2022 and 2023, Dr. Marich published two additional books: *The Healing Power of Jiu-Jitsu: A Guide to Transforming Trauma and Facilitating Recovery* and *Dissociation Made Simple*. Dr. Marich is a woman living with a dissociative disorder, and this forms the basis of her award-winning passion for advocacy in the mental health field.

Faculty Disclosure

Contributing faculty, Jamie Marich, PhD, LPCC-S, REAT, RYT-500, RMT, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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

Designations of Credit

Social workers completing this intermediate-to-advanced course receive 10 Clinical continuing education credits.

Individual State Behavioral Health Approvals

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

INTRODUCTION

The various disciplines composing the psychotherapeutic profession look to Bessel van der Kolk as a prominent thought leader on issues connected to trauma. Originally from the Netherlands and based in the Boston area, Dr. van der Kolk is an outspoken advocate for the use of creative, innovative, and dynamically body-based interventions in the healing of traumatic stress. In a documentary entitled *Trauma Treatment for the 21st Century*, van der Kolk speaks on a plethora of issues related to trauma treatment in the modern era [1; 46]. One statement in his interview jumps out as a summary position: "The purpose of trauma treatment is to help people feel safe in their own bodies" [1]. He goes on to explain in the interview that some people arrive at this safety through yoga or exercise, while for other people it comes through receiving bodywork, like massage or Reiki. For others, this safety is achieved through a combination of channels, particularly innovative approaches to psychotherapy that honor the mind-body connection.

van der Kolk and his contemporaries have raised awareness about the importance of using the body in the treatment of unhealed trauma and its manifestations, which may or may not include post-traumatic stress disorder, or PTSD. As will be explored in this course, unhealed traumatic memories and experiences generally get stored in the limbic brain, the part of the human brain that cannot be easily accessed using words. Thus, the challenge is to work with the parts of the human brain (i.e., the limbic brain and brain stem) that are deeper than the cerebral cortex, or our talking, thinking, and reasoning brain. If not words, what then?

Remember the adage you likely learned sometime in your youth: Actions speak louder than words. As described in the section of this course on trauma and the brain, there is a great deal of neurobiological wisdom in this statement. Many helping professionals in the modern era trained primarily in cognitive or talk therapy interventions are being asked to engage in a paradigm shift, informed by modern neuroscience. How can we more dynamically engage our clients in their healing, especially when we know that many of their problems are happening in a part of their brain that cannot be easily accessed by talking? The simple answer is to work more fully with action-oriented interventions, and these can include a wide range of movement strategies. Present-day discussions in the psychotherapeutic professions tend to label movement or dance therapy as an "innovative" approach. However, many world cultures have made use of dance, ritual ceremony, aerobic activity, and other forms of movement as part of their healing traditions. Thus, engaging in this paradigm shift of "actions speak louder than words" when it comes to fully healing the brain may involve, more than anything, a back-to-basics approach. As will be highlighted in this course, movement as a healing art is not a new idea—in fact, it is quite ancient. Even after the birth of modern psychology in the 19th century, early thinkers in the field made connections between movement and emotional wellness.

This course will present a brief overview of this history and to consider its relevance to modern-day helping and healing. This course assumes that treating emotional distress is more than a cognitive or medical pursuit. Rather, the optimal pursuit of emotional wellness is more than just treating disease or distress—it requires a holistic approach that looks at the whole person. After examining the history, the impact that movement can have on healing will be explored, especially when healing is framed through a holistic lens. Material on trauma and the brain will be presented, including research from the modern era on the use of movement approaches, specifically yoga. Step-by-step instructions on how clinicians of all backgrounds can implement simple movement strategies to their existing practice without formal or specialized training will also be provided. The course will conclude with information on the specialized training that is available, and learners will have a chance to evaluate if this specialized training is right for them and their practice.

This course offers an overview of many practices and principles that cultures around the globe have used for millennia. Although special attention is paid to highlighting what is most relevant for the modern clinician working in mainstream settings, please understand that if your interest is piqued by any one area of the course, there is more material that you can seek out to expand your knowledge. Throughout the course, recommendations are given for further reading and pursuit of these resources.

FOUNDATIONS: MOVEMENT AND HEALING

A MULTICULTURAL VIEW OF MOVEMENT AS A HEALING ART FORM

Eye movement desensitization and reprocessing (EMDR) is one of the most popular and researched therapies in the treatment of PTSD. In brief review, the therapy makes use of back-and-forth eye movements, audio tones, or tapping (of the feet, legs, or arms) to induce emotional and somatic processing more expeditiously. For dancers or drummers, as well as EMDR practitioners, the idea of EMDR and its bilateral mechanism of action makes a great deal of sense. In many Native American traditions, drumming and dancing, typically done in communal ceremony, have been the two most used approaches to treat warriors returning from battle. Many similarities exist in cultures on the Asian continent, from which the tribal nations of North America share a common origin. Traditions of dance as emotional empowerment or communal gathering occur globally: the Haka, a dance of the Maori of New Zealand, the Umoya of South Africa, and even the bouncy circle dances or *kolos* of Slavic traditions are known to many, even in the modern era.

Rabbi Miriam Maron, a dancer and psychotherapist, summarizes the role of dance and movement as healing art within Judaism [2]. She writes, "The word for dance and the word for illness, taught Rebbe Nachman of Breslav, are related: *ma'cho'l* for dance, *machah'lah* for illness or affliction. Not by accident do they both share the same root. After all, dancing brings one to a state of joy, and when the body is in a state of joy, the negative energies contributing to illness begin to dissipate" [2]. If one examines texts and traditions from a variety of world cultures, similar themes are evident, making a strong case for dance as a cultural healing universal. Summarizing global research on dance in her book *Dance: The Sacred Art*, Rev. Cynthia Winton-Henry states [3]:

> At the beginning of nearly every culture, dance arose at the foundation of collective spiritual life. Just as inconceivable as separating out deities and goddesses from everyday activities, dancing was intrinsic to the religiosity of indigenous groups. It could not be extricated. It was manna, daily bread. More than mere expression, dancing served as a primary means of knowing and creating the world. It carried technologies of healing, entertainment, and most definitely praying.

Perhaps the most famous story of a Western-trained psychiatrist being affected by the power of indigenous healing traditions is that of Dr. Carl Hammerschlag. In his memoir *The Dancing Healers: A Doctor's Journey of Healing with Native Americans*, Hammerschlag, trained as a psychiatrist at Yale, relates that when he first traveled to Arizona to work with the Indian Health

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Services, he believed he was bringing a wealth of knowledge about the human brain to an "uncivilized" people [4]. He soon learned that they had more to teach him about healing than he could ever teach them. He relays a particularly touching story of a tribal elder who, after listening to Dr. Hammerschlag's credentials, asked him if he could dance. To appease him, the doctor did a little shuffle by his bedside. The elder chuckled, replying, "You must be able to dance if you are to heal people." Hammerschlag's memoir offers a glimpse into his own paradigm shift of being trained as a physician, in the traditional Western sense, to being a more holistically rounded healer. He calls for the adoption of the dances and ceremonial customs of indigenous and other cultures generally described as "non-Western" as a way to get clients and patients comfortable with cultivating their own insights. He observes, "Artists and other of creative mind know that the unconscious must be uninhibited to make the associations that produce new understanding" [4].

Gabrielle Roth (founder of the 5Rhythms practice and considered by many to be the mother of the modern conscious dance movement) summarized her work with Native American healers in this anthem of empowerment amongst holistic practitioners [5]:

> In many shamanic societies, if you came to a medicine person complaining of being disheartened, dispirited, or depressed, they would ask one of four questions. When did you stop dancing? When did you stop singing? When did you stop being enchanted by stories? When did you stop finding comfort in the sweet territory of silence?

The National Institutes of Health recognize Native American healing approaches as a whole medical system [6]. This system encompasses a range of holistic treatments used by indigenous healers for a multitude of acute and chronic conditions and to promote total health and well-being. Many psychotherapists trained in Western traditions are honoring the holistic missions of their practices by incorporating approaches from the Native American and other healing traditions.

Incorporation of traditional forms of healing into clinical practice can be helpful, but it can be difficult to know where to start. One resource for this integration is Susan Pease Bannit's *The Trauma Toolkit: Healing Trauma from the Inside Out* [7]. A traditionally trained social worker who completed her internship in the Harvard medical system, Bannit proposes a taxonomy for healing using the five subtle bodies of yoga philosophy. She integrates movement and ceremonial techniques from yoga and Ayurveda (Indian systems of healing), in addition to Native American practices. Bannit's text is an excellent resource for the traditional practitioner working in a North American system wanting to incorporate these multicultural healing traditions in a safe and user-friendly way.

If exploring the cultural roots of dance as a healing art appeals, consider further reading the work of Bannit, Roth, Hammerschlag, Winton-Henry, and Maron. For many clients who have Native American roots, there can be great power in claiming the connection to their lineage, so encouraging them to explore dance and other Native American healing arts may serve as an important adjunct to treatment. This connection does not just apply for Native American clients—truly, encouraging a client to explore their cultural heritage's views on healing can be powerful, whatever that culture may be.

Here are some websites in the area of dance/movement, ceremony, culture, and healing that you and your clients may find useful:

- African healing dance: http://www.wyomadance.com/african-healing-dance.html
- Classical Indian dance: https://www.shaktibhakti.com
- National Center for Complementary and Integrative Health: https://www.nccih.nih.gov
- Various Indigenous cultures: http://www.healing-arts.org

EARLY IDEAS ON MOVEMENT IN THE HELPING AND DANCE PROFESSIONS

Professionals and scholars have been making the links between movement and emotional healing almost since the beginning of modern psychology. These links are not just attributed to psychologists and related psychological professionals—professional dancers and other artists also made connections that we can find valuable as helpers to this day. In this section, we will review some of these modern pioneers. In addition to Lowen, Fritz Perls, Frederick Alexander, Moishe Feldenkrais, Florence Noyes, and Martha Graham will be explored. Some of these leaders and their ideas overlapped, although most of their work represented independent thought that essentially worked with the same ideas: There is great capacity for emotional healing when the body moves itself. These overviews will dovetail into the next section on Marian Chase and the formal discovery of dance therapy, compared with the similar (yet related) conscious dance movement. Then, we will take a look at how the formal literature and practice standards view the use of dance and movement work, both formal and informal.

Alexander Lowen

Alexander Lowen was an American-born physician who originally studied under Wilhelm Reich, a second-generation Freudian psychoanalyst. Like another of Reich's students, Fritz Perls, Lowen added his own ideas to the work of Reich, resulting in the development of Bioenergetic analysis (BA) (founding date credited as 1956). According to the International Institute for Bioenergetic Analysis, BA is a body-based psychotherapy rooted in the principles of mind-body connection taught to Lowen by Reich [8]. Some of the core tenants of this therapeutic approach include:

- BA basically combines a bodily, analytic, and relational therapeutic work, based upon an energetic understanding.

- BA helps to release chronic muscular tensions, manage affects, expand the capacity for intimacy, heal sexual trauma or dysfunction, and learn new, more fulfilling ways of relating to others. Tenderness, aggression, and assertion—and their confluence in sexuality—are seen as core life-saving forces. The therapeutic relationship provides a place of safety in which healing begins.
- The therapist reads the body, resonates with its energy, feels the emotions, listens, hears, and answers the words. The language of the body (i.e., posture/gesture, breathing, motility, expression) is the focus, as it indicates the status on the way to personhood, from the past to the present and future.
- Techniques are used to address the energetic aspect of the individual, including their self-perception, self-expression, and self-possession. These also include work with body contact, boundaries, grounding, and the understanding of muscular tensions as indications of somatic and psychological defenses against past trauma. The goal of therapy is more than the absence of symptoms. It is having aliveness, getting a taste of pleasure, joy, love—vibrant health.
- According to Lowen, wellness starts with the reality of the body and its basic functions of motility and expression.

BA is still being practiced throughout the world today, stemming from Lowen's work. During his lifetime, he wrote or co-wrote 14 books on various topics related to health and wellness, explained through the lens of BA. Because it has origins in Freudian psychoanalysis, many view BA as the most classical of the movement and body basic approaches to therapy. The International Institute for Bioenergetic Analysis keeps a catalogue of the latest research and conference presentations on the use of BA as a treatment and wellness approach. For more, visit http://www.bioenergetic-therapy.com.

Fritz Perls

Fritz Perls, regarded as the father of Gestalt Therapy, is typically a more recognizable name than Alexander Lowen, although they studied in the same tradition. Perls developed the Gestalt approach in collaboration with his wife Laura in the 1940s and 1950s, and he also lived in residence at the Esalen Institute in California during the 1960s, where Lowen also completed much of his work. Gestalt is generally considered one of the more classical psychotherapy approaches, with most graduate students in North America receiving some basic training in its principles. Toward the end of his life when an interviewer asked Perls to define the Gestalt approach, he struggled with putting words to it, preferring instead to demonstrate [9]. Perls set out to revise the classic psychoanalysis of his training, and one might observe the Gestalt approach as a more dynamic practice of psychoanalytic principles.

The Gestalt therapist is actively involved with the client, often engaging in their own disclosure, unlike the distance established in psychoanalysis [10]. The Gestalt therapist uses an active array of methods to engage the client, including promoting body awareness and making use of behavioral tools, like movement. Experimentation is encouraged to ultimately allow the client to work through unfinished trauma or issues. Yontef and Jacobs identify Gestalt psychotherapy as the first truly holistic approach to Western psychotherapy, making use of affective, sensory, interpersonal, and behavioral components [10]. The Gestalt approach draws from existential, humanistic, and Zen philosophy, and it can be common for a Gestalt session to work with body alignment, awareness, and movement. It is also common for Gestalt psychotherapists to also work with dance or movement modalities. For an example of a therapist who is integrating the two because of their obvious overlap, visit https://gestaltdance.com.

Although Gestalt psychotherapy is not typically discussed in the new wave of psychotherapies generating attention in the treatment of trauma, many modern approaches (e.g., EMDR therapy, dialectical behavior therapy, sensorimotor psychotherapy, somatic experiencing) draw on many time-honored Gestalt principles. Linda Curran, a psychotherapist, teacher, and director of several educational documentaries on trauma, refers to Gestalt psychotherapy as the "original trauma therapy" [11]. Indeed, many of the newer approaches to trauma and other mental health treatment that appear in the Substance Abuse and Mental Health Services Administration (SAMHSA) Evidence-Based Practices Resource Center make use of coping skills that simply represent a repurposing of many time-honored Gestalt approaches.

Moshé Feldenkrais

Moshé Feldenkrais, a Russian-Israeli engineer and practitioner of the Eastern martial arts, is another name associated with the movement practitioners who taught at the Esalen Institute in the 1960s and 1970s. Feldenkrais was inspired to develop his now trademarked method, described as a type of somatic education, after he was injured playing soccer in his young adulthood. He published his first book in 1949 describing his method. The method is something that anyone interested in learning more about their body and the information it gives them can study. Feldenkrais himself is well-known for giving lessons in his method to the prime minister of Israel. The training program to become a recognized Feldenkrais Method practitioner is extensive, and it is a training program that professionals from many disciplines (e.g., massotherapists, psychotherapists, dance teachers) pursue. Many of the popular conscious dance movements, most notably the Nia movement practice, draw on influences from Feldenkrias. To read more about the method and to pursue a catalogue of current research about the Feldenkrais method, please visit https://feldenkrais.com.

F.M. Alexander

Feldenkrais studied with F.M. Alexander, an Australian actor who explored the somatic connections between body, emotion, and performance decades before doing such became popular within psychotherapy. Despite his early work, Alexander is

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much less recognized among psychotherapists and counselors. However, many musicians and performing artists are familiar with Alexander's work. According to the public story published about his life, Alexander found himself struggling from chronic laryngitis, which clearly got in the way of his performance as an actor. His healthcare providers were unable to detect an organic cause, so he began engaging in his own inquiry. Alexander discovered that excess tension in his neck and back was causing the problems with his vocalization. Through trial and error, he began making modifications in his movement, which ultimately eradicated his laryngitis. So impressed were the doctors who were unable to help him, they encouraged him to begin teaching his method.

Research conducted on the Alexander technique spans a wide range of academic disciplines. Alexander was also known for promoting the idea of self-discovery with movement, which has led to many individuals engaging in the Alexander technique as a self-study method. Many of the available resources in this area are billed as "Alexander Self-Help." There are many resources available that can assist interested parties in this process. A good first resource to read more about the Alexander technique, its practice, and related research is https://alexandertechnique.com.

Florence Noyes

Like Alexander, Florence Noyes was a performer—a classically trained dancer who regularly performed at New York venues like Carnegie Hall. In her own work as a dance teacher, she began making links between movement and life. She created a system of study now called Noyes Rhythm, described as working with physical technique, improvisational exercises, and building internal awareness. From the days of Noyes, the approach was billed as a something that from which both dancers and non-dancers could derive benefit, if their goal was to open up to greater creativity and ease in life. The work of Noyes can be described as one of the forerunners of modern-day dance therapy. There is an active community of teachers working and sharing the original work of Noyes throughout the world. To read more about Noyes Rhythm and the work being done, please visit https://www.noyesrhythm.org.

Martha Graham

Many present-day teachers of conscious dance and dance therapists look to Martha Graham as a role model. Her inspirational sayings (e.g., "Dance is the hidden language of the soul") regularly make their way around social media pages and other promotional materials. Recognized as the mother of what is now referred to as modern or contemporary dance, Graham clearly extrapolated a great deal of psychological learning about mind-body connection from her own training and work with others. An alumnus of her dance company, Albert Pesso, is well-known in the mind-body circles of psychotherapy for his method, psychomotor psychotherapy, which will be briefly discussed later in this course.

Graham's 1991 autobiography *Blood Memory* largely reads like a study in mind-body-spirit connection, with tremendous insights provided about the role of breath in movement. One such insight about the role of breath can be beneficial to anyone working with the psychological process [12]:

> Every time you breathe life in or expel it, it is a release or a contraction. It is that basic to the body. You are born with these two movements, and you keep both until you die. But you begin to use them consciously so that they are beneficial to the dance dramatically. You must animate that energy within yourself. Energy is that thing that sustains the world and the universe. It animates the world and everything in it. I recognized early in my life that there was this kind of energy, some animating spark, or whatever you choose to call it. It can be Buddha, it can be anything, it can be everything. It begins with the breath.

The role of linking breath with movement will be explored further later in this course. Many psychotherapeutic professionals do not realize the powerful connection between the two, yet teaching deep, full breath is a practice that is within our scope as clinical professionals.

MARIAN CHACE AND THE DISCOVERY OF DANCE AND MOVEMENT THERAPY

Although the use of dance as a therapeutic method for healing and wholeness was certainly not new to the 1960s, the founding of dance therapy as a distinct and separate discipline traces here. Marian Chace, like Martha Graham, was a student of Ruth St. Denis and the Denishawn School of Dance during the same era. Chace launched her own career as a dance teacher and was inspired by ideas from Carl Jung about the connection between mind and body. Chace discovered that many of her dance students became more interested in the psychology of movement rather than the technique of dance. Thus, she began further developing her ideas with the support of many in the local medical community of Washington, DC, her home teaching base. She launched into offering her own training programs in what she coined dance/movement therapy, and in 1966, she founded and became the first president of what is now called the American Dance Therapy Association (ADTA).

Although one does not have to be a fully credentialed dance/movement therapist to incorporate movement into the practice of psychotherapy, billing oneself as a dance/movement therapist, at least with the blessing of the ADTA and often credentialing boards, requires specialized training and accredited credentialing. There are now graduate degree programs specifically offered in dance and movement therapy that can count toward ADTA accreditation and toward professional licensure in the mainstream psychotherapy professions (e.g., social work, counseling, marriage and family therapy) in many states. Professionals with a standard Master's degree that is not specific to dance and movement therapy can still become an ADTA-accredited dance/movement therapist through extra

training and supervision. Full details about this process can be obtained at https://www.adta.org.

The ADTA's official definition of dance/movement therapy, as stated in their promotional literature and on their website, is as follows [13]:

- Focused on movement behavior as it emerges in the therapeutic relationship. Expressive, communicative, and adaptive behaviors are all considered for group and individual treatment. Body movement, as the core component of dance, simultaneously provides the means of assessment and the mode of intervention for dance/movement therapy.
- Is practiced in mental health, rehabilitation, medical, educational, and forensic settings, and in nursing homes, day care centers, disease prevention, health promotion programs and in private practice.
- Is effective for individuals with developmental, medical, social, physical, and psychological impairments.
- Is used with people of all ages, races and ethnic backgrounds in individual, couples, family and group therapy formats.

The ADTA publishes its own peer-reviewed research journal in dance/movement therapy. Although there is a wide array of research documenting the use of dance and movement therapy approaches in a wide array of physical and medical conditions, the use of such approaches as stand-alone treatments for mental and emotional disturbances has not been fully established [14].

THE CONSCIOUS DANCE MOVEMENT

Those who practice conscious dance (sometimes referred to as ecstatic dance) are well-acquainted with the healing and therapeutic properties of dance, even if they are not practicing healing dance under the formal umbrella of credentialed dance therapy. Mark Metz, founder of the DanceFirst Association and editor of Conscious Dancer Magazine, jokingly states that when you try to define it, it is no longer "conscious dance." Yet for the sake of furthering the academic discussion, Metz offered this definition: movement with an intention toward higher awareness [15].

As noted, Gabrielle Roth is generally credited as the mother of the conscious dance movement. Like Lowen, Perls, and Feldenkrais, much of her work is traced to the Esalen Institute in Big Sur, California. She developed her own practice, which is now called 5Rhythms, because she was asked to put together a movement program for residents and retreatants at the institute while she resided there. In one of her books, *Sweat Your Prayers: Movement as Spiritual Practice*, Roth wrote (in describing her early years of developing the practice): "Sometimes two hours of moving are as powerful as two years on the couch. I discovered that the body can't lie; put it in motion and the truth kicks in" [5].

Conscious dance practices like 5Rhythms are often associated with places like the Esalen Institute and other retreat centers like the Kripalu School of Yoga and Health and The Omega Institute, as well as music and consciousness festivals like Burning Man. However, mainstream psychological and helping professions have been taking more and more notice of these practices. There are a plethora of dance practices, some developed independently of Roth's 5Rhythms, with most developing in the wake of her legacy, that can be described as conscious dance practices. Many conscious dance practitioners within the helping professions are integrating conscious dance practices as an adjunct to clinical work in clinical settings. Moreover, many professionals are also noticing the value of sending their clients to conscious dance classes as wellness and skills-building technique to help them better manage affect. Even the dance classes that are more fitness-based as opposed to conscious-based, like Zumba fitness, can serve this purpose.

In linking clients with dance resources in the community for their own health and wellness, conscious dance and fitness dance practices are generally more accessible and available than dance/movement therapy. Metz, recognizing this phenomenon, started the DanceFirst organization as a fellowship for those working in movement and dance, designed to be more inclusive than exclusive. This organization publishes a calendar including more than 100 modalities within the scope of conscious dance being taught around the world today and provides a search tool for finding local classes and programs on their website at https://consciousdancer.com.

THE IMPACT OF MOVEMENT ON HEALING

REFLECTION

F.M. Alexander is quoted as saying, "You translate everything, whether physical, mental or spiritual, into muscular tension." Does this resonate with you and your practice? How might this manifest in your clients?

Recall the previous discussion in this course regarding the age-old adage that actions speak louder than words. When it comes to emotional healing, especially regarding those issues that are deeply entrenched in our more primitive brains, the saying carries a great deal of neurobiological wisdom. Many therapists reach a frustration point in working with traumatized clients because, even if these clients can talk about the trauma, they may not experience much forward movement with their healing. In fact, these clients may end up subjectively worse from talking so much about their trauma. A basic understanding of how unhealed trauma or other adverse life experiences can become stuck in the limbic brain suggests that when it comes to complete healing, talking is not enough.

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A BRIEF PRIMER ON UNHEALED TRAUMA AND THE LIMBIC BRAIN

For survivors of trauma and other adverse life experiences, the effects in the neuronetworks of the brain tend to occur at the lower levels of the brain called the limbic brain and the brain stem. These two lower areas in the human brain structure are related to emotion, movement, and the basic functions of human life, but not with concepts like speech, higher-order thinking, or rational judgment. As complicated as the study of trauma neurobiology can get, the most basic concept to grasp in making sense of this material is the human brain is composed of three separate brains, also referred to as the triune brain model.

According to this model, each of the three areas (i.e., the R-complex brain or brainstem, the limbic brain, and the cerebral brain or neocortex) has their own separate functions and senses of time. This model was introduced by MacLean in 1990 and has been used by trauma specialists in the ensuing years to help describe the impact of trauma and trauma processing [16].

The base of the brain contains the cerebellum, and it directly connects to the spinal cord (the brainstem). MacLean terms this as the R-complex (his original name for the basal ganglia), sometimes referred to as the reptilian complex or the "lizard brain." This area is equated with animal instincts. Those basic functions of animal life originate in this lowest part of the brain: reflex behaviors, muscle control, balance, breathing, heartbeat, feeding/digestion, and reproduction. The brainstem is very reactive to direct stimulation.

The paleomammalian complex (limbic system), sometimes called the midbrain, is unique to mammals. According to MacLean, this center of emotion and learning developed very early in mammalian evolution to regulate the motivations and emotions now associated with feeding, reproduction, and attachment behaviors [16]. In MacLean's explanation, everything in the limbic system is either agreeable (pleasure) or disagreeable (pain/distress), and survival is based on the avoidance of pain and the recurrence of pleasure. The limbic brain contains the amygdala and hypothalamus and does not operate on the same rational sense of time we know as humans. The amygdala is a filter and determines if incoming input is dangerous or not [17]. If the amygdala classifies the information as not a threat, it can process through to the neocortex and is integrated with other useful or useless data that have been acquired over the years. In essence, the information integrates into one's existing experience without fallout. As will be discussed later in this course, for many people who go through experiences from which threat or danger is signaled, receiving help, support, or validation sooner rather than later can assist a person with this process of integration, thus decreasing the chances of long-term consequences.

If the amygdala signals threat/danger, other parts of the limbic brain are activated, specifically the survival part of the brain, or the thalamus. These activities can incite one of three reactions, fueled by the lower reptilian brain: the fight response, the flight response, or the freeze response. When these responses are activated and re-activated, the body will respond, regardless of what rational thought might be saying. Even after the danger has passed, the thalamus remains on high alert, activating the same responses if anything reminiscent of the original danger passes through again. Together, the thalamus and the reptilian brain may work extra hard to prevent a similar response the next time. Obviously, these problematic symptoms can keep occurring in a vicious cycle until the limbic-reptilian levels of the brain can return to balance.

The limbic brain has no sense of time. When traumatized people feel "stuck," it is as if their proverbial panic button is not fully functional. When crossed wires get stuck in the limbic brain, they take on a high level of significance, because material was not meant to be stored here long term. When the regulatory capacities of this brain are impaired, it works longer and harder than it was intended to, causing the symptoms associated with traumatic stress.

The goal of successful trauma processing is to move or to connect the charged material out of the limbic brain into a part of the brain that is more efficient in its long-term storage capacities. In the triune brain model, this is referred to as the neomammalian complex (or cerebral neocortex). This is unique to primates, and a more highly evolved version is unique to humans. The neocortex contains the prefrontal lobes of the brain frequently discussed in explaining human behavior. This brain regulates so much of what makes us human: executive functioning, higher-order thinking skills, reason, speech, meaning making, willpower, and wisdom.

Most working in the psychological and behavioral health professions are familiar with attempting to talk reason to people in crisis or to encourage people to leave the past in the past and focus on the present. These types of interventions are common in much of the cognitively focused modern-day training in human services; it is natural to confront a person's negative thinking or to encourage a client to see the "silver lining" or reason. However, talking reason to a person in crisis is often futile. Cognitive (or any reason-based) interventions primarily target the prefrontal regions of the brain. However, the limbic region of the brain was activated during the original trauma to help the person survive (through flight, fight, or freeze responses). Because the frontal lobes were not activated or involved, the individual was never able to link up that limbic activation with frontal lobe functions during the experience. For a person in crisis or intense emotional distress, this process is playing out in real time and/or triggers from earlier, unprocessed experiences fuel the distress.

To summarize, when the limbic brain is activated, the prefrontal lobes are not. For optimal healing to occur, all three brains must be able to work together. Neurologically, unprocessed trauma creates disconnection in the brain. However, it is important to keep in mind that complex interventions are not necessary to encourage whole-brain interaction. Consider that deep breathing is a whole-brain intervention. Breath originates

in the primal, reptilian region of the brain. Any movement-based or body-based intervention automatically works with the limbic and reptilian brains. The action parts of one's experience (and conversely the inaction or freeze responses that can result from unhealed trauma) are regulated by the limbic brain and brain stem. Thus, some of the most basic interventions for healing involve taking action.

HOW MOVEMENT AND RITUAL ENHANCE HEALING

Many in Western cultures tend to assume that talking is the best way to process trauma. You may have heard or even used phrases like, "We have to get her talking about it so she doesn't hold it all in," or "Well, he's talking about it, so that's a good sign." In many mental health and addiction treatment cultures, talking is synonymous with processing, and talking can play a role in helping a person to process. However, talking is primarily a function of the frontal lobe. A person can talk about the trauma all he or she wants, but until the person can address it at the limbic level, traumas will likely stay stuck. Being psychologically stuck means that a memory fragment is too large for the brain to process. Thus, something additional is required to help dissolve the fragment. Other healthy modalities of processing that can help with this dissolution include exercise, breath work, imagery, journaling, drawing, prayer, dreaming, and of course, dancing and movement. These experiential modalities are more likely to address limbic-level activity when compared with the classic "talking it out" strategies.

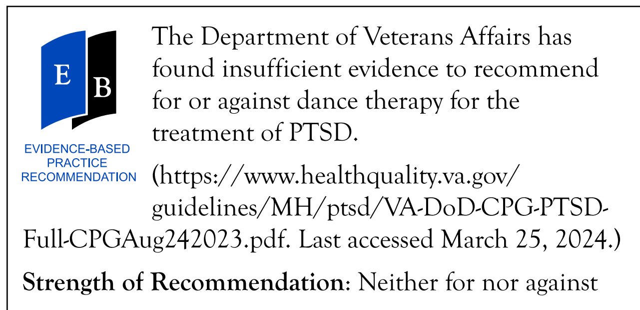
van der Kolk offers a solid summary of how to engage a person in a multi-tiered approach to healing in *The Body Keeps the Score* [14]. He writes that there are three primary ways for helping survivors feel alive in the present and move on with their lives:

- Top-down methods: Talking, connecting with others, self-knowledge
- Medication and technology: Medications to shut down inappropriate alarm reactions, other therapies/technologies that change the way the brain organizes information
- Bottom-up methods: Allowing the body to have experiences that deeply and viscerally contradict the helplessness, rage, and collapse that result from trauma

Usually, a combination of the three approaches is needed. The movement-based strategies addressed throughout this course are designed to help a person work from the bottom up.

THE ROLE OF MINDFULNESS, MOVEMENT, AND YOGA

Evidence supporting the role of holistic strategies like mindfulness and movement strategies, especially yoga, continues to mount. Research indicates that these modalities provide powerful adjuncts to traditional psychotherapy. Although the field of dance/movement therapy and yoga therapy has existed for quite some time—each with their own journals—van der Kolk made history in 2014 when a psychiatric journal published a study that he and his team completed on yoga and PTSD. Using empirical methodology to study 64 women with described "chronic, treatment-resistant PTSD," the study concluded that yoga significantly reduced PTSD symptomatology, with effect sizes comparable to well-researched psychotherapeutic and psychopharmacologic approaches. Yoga may improve the functioning of traumatized individuals by helping them to tolerate physical and sensory experiences associated with fear and helplessness and to increase emotional awareness and affect tolerance [14].



The Department of Veterans Affairs has found insufficient evidence to recommend for or against dance therapy for the treatment of PTSD.

(https://www.healthquality.va.gov/guidelines/MH/ptsd/VA-DoD-CPG-PTSD-Full-CPGAug242023.pdf. Last accessed March 25, 2024.)

Strength of Recommendation: Neither for nor against

Many innovators have worked to bring yoga and movement strategies into their work with trauma survivors, recovering addicts, and others who are struggling with problems of living. One such innovator is Nikki Myers, founder of a growing program called Y12SR, the Yoga of 12-Step Recovery. Nikki, a recovering addict and survivor of multiple layers of trauma, launched the program in early 2000. Y12SR meetings are not affiliated with any specific 12-step fellowship; rather, they are independent gatherings that combine the essence of a 12-step discussion meeting with a yoga class. The guiding principle of Y12SR is that "the issues live in our tissues" [18]. As Nikki explains, when one is in the physical posture of a yoga pose or even a simple stretch outside of the context of yoga and they feel muscles quiver, the body is working something out. Myers remembers being a 9-year-old girl watching the news and seeing people of color, people who looked just like her, being hosed and gassed and beaten. She absorbed these images during the social upheaval of the Civil Rights movement, and although she was raised in the northern United States, seeing those images completely shook her sense of authority and self. As Nikki explains, [18]:

> Something had to be wrong with me if these people who looked like me were being treated this way. Everything I'd learned in school taught me that government and authority was to be respected, so if government and authority was doing this to children like me, I must be flawed.

She discloses that, to this day, reflecting on that memory brings up a strong visceral reaction in her [18]. These visceral reactions that people experience can rarely be addressed by talking alone, which is why integrating holistic strategies, including movement, are important competencies to weave into clinical skill sets.

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In addition to yoga, work with mindfulness meditation and mindful movement programs (some being within the scope of dance therapy) continues to expand in the helping professions. Barton's research on a program she designed called *Movement and Mindfulness* offers some interesting results and implications [19]. *Movement and Mindfulness* was a body-based curriculum introduced into a group rehabilitation setting for severely mentally ill clients, using a combination of dance/movement therapy techniques, yoga skills, and traditional group therapy with a focus on mindfulness/Eastern meditation. Using qualitative methods of evaluation, results indicated numerous examples of physical and psychological shifts and experiences of pro-social behavior [19].

Crane-Okada, Kiger, Sugerman, et al. investigated the use of dance/movement therapy paradigms and mindfulness with female cancer survivors [20]. In this randomized design of 49 female participants between 50 and 90 years of age, the program's major benefits included reducing fear and improving attitudes of mindfulness. Another study examined Vipassana meditation and dance as vehicles for promoting somatic and emotional coherence, concluding through empirical measures that the coherence between somatic and cardiac aspects of emotion was greater in those that had specialized training in meditation or dance, as compared with the control group [21].

Since the early 2000s, the field of traumatic stress studies has taken special notice of mindfulness and other Eastern practices like yoga and the martial arts as healing channels. A major reason for this interest relates to neurobiology. Mindfulness practices play a key role in activating the prefrontal cortex and promoting a greater sense of concentration; concentration problems are common among trauma survivors, with the DSM-5-TR identifying them as a heightened arousal symptom [22; 23]. Mindfulness can calm a client's inner experience and promote greater introspection, an important feature considering that disorganized memory structure may be one process that impedes access to, and modification of, trauma-related cognitive schema [24; 25]. Structured mindfulness practice can cause positive structural changes in the brain related to learning and memory (hippocampus) and can cause a thinning in the amygdala, lessening the charge of fear-based responses [26; 27]. There is also evidence that mindfulness meditation practices lead to decreases in ruminative thinking, alter the neural expression of sadness, positively influence change in neural activity, and positively impact working memory capacity and affective experience [28; 29; 30; 31].

In 2012, a task force assembled by the International Society for Traumatic Stress Studies (ISTSS) published a paper on best practices in the treatment of trauma-related disorders. One of the team's conclusions, supported by literature reviews, was that "optimization of outcomes also includes exploration of novel treatment approaches such as complementary medicine strategies that focus on somatosensory experience and the mind-body relationship, for which there is emerging evidence regarding efficacy" [32].

Considerations for Clients Who Fear the Body/Movement

While some clients will be very open to incorporating movement into their therapy, many clients get fearful, skeptical, or otherwise uncomfortable when interventions like yoga, meditation, dance, or other movement strategies are suggested. In trainings, learners often ask, "How do you pitch these interventions to clients? Won't they think they're weird?"

In general, when working with new clients, one can ask general questions about the role of exercise and/or spirituality in their life. If a client is already using exercise, begin discussing some of those benefits and how they can continue working with those as part of their recovery and goals for wellness. In talking about the importance of building coping skills to a treatment plan, also ask if they are open to using simple breathing and movement strategies in the work in the office. If they are amenable, then proceed, and if this results in positive feedback, one can become more proactive about working in yoga, movement, or dance strategies. Sometimes it may be within one's scope to do this in sessions, and other times, it may be appropriate to work to match the client with community resources where they can take classes in these areas.

When clients begin asking the "why" questions about strategies like the ones covered in this course, it can be helpful to respond in one of two ways. The first is to provide a description of the triune model of the human brain, as described earlier in this course, to explain why talking alone may not meet all of their needs. Another approach is to share the following demonstration. A common symptom of PTSD and other trauma-related issues is hypervigilience, or always being on guard for something bad to happen. When one is hypervigiliant, their shoulders tend to creep up a bit toward their ears. Try this now—let your shoulders move up toward your ears and hold them there for a few moments. What are you noticing about your breath when you do this?

If you've held your shoulders up by your ears for even a moment, you probably began to notice a shallowing of your breath. Indeed, when muscles are tense or we are otherwise on guard, we do not breathe as fully as we should. Thus, working on breath and muscle-release strategies can prove to be a radically new, life-changing intervention for people. Most clients are not aware that their muscles are tense or that their breathing is so affected until they do this exercise. This can be a good way to offer a physical/movement-based demonstration instead of just lecturing about the potential benefits.

Of course, clients in therapy have various degrees of receptivity about working with the spectrum of action-based and movement-based strategies, which is why it is important to gauge their readiness and meet them where they are at with interventions. In the next section, a wide range of options that clinicians have at their disposal for integrating breath, movement, and even yoga or dance-related strategies into their clinical work will be presented.

Perhaps the highest degree of resistance from clients will be related to dance. Of course, it is important not to force dance-based interventions on clients or to tell them that they have to seek out a dance class, although it may be worth exploring why a person may be open to other movement strategies like yoga (which is generally more structured) or simple stretching, but closed off when it comes to dance or other more creative movement modalities. Cynthia Winton-Henry, developer of the InterPlay technique and author of *Dance the Sacred Art: The Joy of Movement as Spiritual Practice*, identifies these primary reasons people tend to be blocked from giving dance a try [3]:

- It is too embarrassing to dance.
- There is no connection between dance and spirituality (a myth).
- The body is a Pandora's box and not to be trusted.
- Dancing is not important.

In some cases, a combination of these factors may be at play. Hence, even while respecting a person's right to say no to dance or creative movement interventions, it may be worth exploring the source of their "no" and using that as grist for the clinical mill.

For those who are scared of or unsure about creative or expressive movement, structured movement exercises can provide for comfort, at least when someone is new to the process of embodiment. Even in approaches in which the goal may be for the group to open up and to explore freely, some clearly show discomfort in this area so they may need more direct physical instruction that feels like stretching. For example, "Open up your arm to the right side, stretch it out away from you, then let the arm float back and across your body to the left side." For this reason, dance or fitness classes that are highly structured may be a better fit for newcomers to dance and movement than classes or techniques that encourage free creative movement.

For the hesitant client, whether in a dance class or group or in an office-based setting, relying on more structure and direction is a solid best practice. Even with the simple breath and movement strategies covered in the next section, letting a person go too long in silence is what causes many to become uncomfortable beyond their window of tolerance. Also, getting continuous feedback from a client is helpful. Let them know that in trying some of these movement and other holistic coping practices, you want to get a sense about what will work for them and what they are not able to handle. Thus, trying six to eight breaths at a time to start with may be too much, so scale it back to two to three. Using the arms for stretching may seem uncomfortable but working with gentle twists from the waist may be a better fit. An axiom that can be helpful in work with movement, either one-on-one or with groups, is that there is always a variation, an adaptation, and alternative movement that can be tried. Additionally, there are ways that movement can be subtly added into favorite, time-honored talk therapy, cognitive therapy, or traditional recovery therapy (e.g., 12-step programs) strategies.

SIMPLE MOVEMENT TECHNIQUES IN CLINICAL WORK

REFLECTION

Consider the following quote from Fritz Perls: "Fear is excitement without the breath." Does this concept resonate with you? How might it present in your clients?

One of the classical techniques in the broad practice of cognitive-behavioral therapy is thought stopping. Typically practiced as a combination of visualization (e.g., a literal red octagon of a stop sign or any other symbol for stopping) and intentional thwarting of a negative belief (e.g., "I cannot succeed"), the thought stopping approach helps many. However, for some clients, it only goes so far. Many individuals are well aware of what their self-defeating negative cognitions are and even using intention, confrontation, or visualization cannot stop the flow of the negative thought into permeating their emotions and/or behavior.

In these cases, a simple variation on the thought stopping technique using movement can be attempted. Instead of or in addition to visualizing a stop sign, this time bring your hands into a motion that signals stop. For most people, this means raising one or both hands in front of their core body, making some style of barrier motion. By adding this simple movement into the classic technique, the client is automatically working with more functions of the human brain. Clients can continue to make this barrier motion with their hands over and over again, even if it is 50 repetitions, until the negative belief passes. This simple activity in and of itself may not resolve the core negative belief (more intensive processing or cathartic interventions may be needed for that), but as a body-responsive coping skill, it can work wonders for distress tolerance.

Many clinicians (and clients) do not realize that incorporating dance and movement strategies into their work with clients can be done in such a simple fashion. When many clinicians hear "dance and movement work," they fear that this means actually getting clients to dance and engage in other movement activities in the office. Although dance and movement work can involve such strategies, assuming that the clinician feels comfortable and qualified to lead them, they do not have to incorporate that level of intensity. Clinicians who are new to movement work can begin by adding a gesture to the thought stopping technique, see how that works, and then proceed from there.

This section will explore other simple movement activities that correspond well with time-honored counseling and recovery techniques. Specific instructions are given to guide. Clinicians are encouraged to weave them into work with clients in whatever order may make sense. It can also be helpful to try these strategies yourself first, as you read this course. The key to

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being able to effectively pass these techniques along to clients, whether in an individual context or in a group setting, is to make sure that you have tried and understand the motions.

CLENCH-AND-RELEASE TECHNIQUE/ PROGRESSIVE MUSCLE RELAXATION

The time-honored hypnotherapy technique of progressive muscle relaxation dates back to the 1920s. In this technique, recipients are guided to clench and release one muscle group at a time. So, for instance, one may begin by first clenching the left fist, holding it for about 20 to 30 seconds, and then with a nice deep exhale, releasing the contraction. This isometric motion is continued throughout the entire body. There are variations. Some will start with the left fist, and then continue into contracting and releasing the left forearm, then the left upper arm. Some people may prefer, after contracting and releasing the left fist, to move over to the right fist, beginning a pattern of left-right alternation through the body. Some progressive muscle relaxation guided meditation can be very detailed (e.g., challenging you to work with even the smallest of muscular contractions), whereas others are very general.

A full progressive muscle relaxation exercise that covers the whole body, if done slowly and mindfully, can take upwards of 20 minutes to complete. Such an exercise can be an excellent technique for clients who struggle with sleep. However, in most arenas of life, going into a full 20-minute exercise, especially one that may result in complete relaxation and sleepiness, is not optimally realistic. Thus, clients can be encouraged to use the same spirit of isometric muscle contraction used in progressive muscle relaxation in a simplified, "express" format. The following is an example of how one might teach such a skill to a client and work with variations [33].

Have you ever been so angry or stressed you just want to make fists and hit something? In this exercise, you'll be able to make that first…and then practice mindfully, intentionally letting go. Here are the steps:

- Make fists.
- As you focus on your clenched fists, bring to mind something that stresses you out.
- As you reflect on the stressor, really notice the contraction of your muscles. Feel your fingernails dig into your skin, if possible.
- Whenever it feels too uncomfortable for you to keep holding on, know that you can slowly, mindfully let go at any time.
- Notice your fingers uncurling, and feel the trickle of letting go all through your arms, up to your shoulders.
- Notice how it feels to let go.

Clinicians can repeat this basic, core exercise with a client for as many repetitions as necessary and helpful. There is no right or wrong experience that said client should be feeling after the letting-go motion. Rather, this can be a way to help clients cultivate the practice of noticing how certain experiences feel in their body. Alternatively, the client's observations may be used as a channel for dialogue within a standard clinical skill set. For instance, one time I did this exercise with a client who struggled with letting go of things that no longer served her—old memories, old relationships, old beliefs about herself. I guided her through this exercise, using the standard line, "Whenever it feels too uncomfortable for you to keep holding on, know that you can slowly and mindfully let go." My client held on tightly for 15 minutes—the longest I have seen a client hold it. We rode out the experience for a few minutes in silence. She finally broke the ice declaring, "I guess I can really hold on to things for a long time." We ended up having one of the most productive dialogues in our clinical relationship about how holding on to things was a barrier to her health and wellness.

Prior to us doing this exercise, this client was very hesitant about doing anything too deep, explorative, or cathartic with her therapy. Within a few sessions using this simple clench-and-release technique, the client knew that she could no longer stall with her therapy if she wanted to reach her goals.

Clinicians very often talk with clients about the importance on letting go: letting go of the past, letting go of fear, letting go of anger or resentment. The 12-step recovery model places a great deal of emphasis of letting go of resentments. This extensive talk about the virtues of letting go can continue with no results, or clinicians can dynamically, experientially urge clients to work with the concept of letting go, hopefully allowing them to experience how good it can feel to do it.

There are extensive modifications and creative variations that can be made if the basic clench-and-release exercise does not seem to optimally resonate with a client. Some examples include:

- Any muscle group can be clenched and released, especially if clenching the fists is too painful or not possible due to context or physical limitations. Clenching and releasing the stomach and feet are other popular choices.
- A bilateral component can be added to the exercise. For instance, consider clenching the left fist first for a period of time, then move over to the right fist and repeat the motion. Continue alternating left-and-right, giving it a minimum of three sets. Notice if it gets more difficult to "clench" after each sequence of "release."
- Add a relaxing sound (e.g., nature sound, music) in the background or use an aromatherapy diffuser, particularly if using this exercise for sleep.
- The client can be instructed to write down a stressor, resentment, or thing that they wish to let go of on a slip of paper. For some, hearing the drop of the paper to the floor, or releasing it into a recipient (e.g., a trash can, the wind, a flowing river) makes the release experience even more powerful.

In a later section of this course, we will explore how this clench-and-release principle can be used as an actual dance exercise with a client or other recipient.

BILATERAL MOVEMENTS FOR STRETCHING AND CLEANSING

In the clench-and-release variations, adding a bilateral element is noted as a possible option that can be powerful for many. Most clients report a greater sense of relaxation doing the clench-and-release technique bilaterally as opposed to using both fists together. There is something special about the power of bilateral movement on the brain (i.e., back-and-forth/left-to-right), as evidenced by ancient spiritual/healing practices (e.g., drum circles) and modern approaches (e.g., EMDR). Modern research in neuroscience is beginning to support one of the core healing principles in Native American healing arts: moving back and forth has a transformative effect on the brain and the body [34].

Contrary to some misinformation, simply invoking bilateral eye movements or other forms of bilateral stimulation will not cause a person to go into a full-on trauma abreaction. As discussed in the book *Trauma Competency,* [1]:

> Bilateral stimulation is not dangerous, nor is EMDR as a modality. If it were, wouldn't it follow that we should all abreact when walking, snapping our fingers, or playing Miss Mary Mac? However, when administered by clinicians without prerequisite knowledge to effectively address and treat trauma's sequelae, the EMDR protocol proves challenging, fear-inducing and, oftentimes, traumatizing for clinicians and re-traumatizing for clients.

Consider this: If you are pairing bilateral movements together with questions for digging deep into a person's past without training in trauma and its effects, you may be treading into dangerous territory. However, as a basic coping strategy, bilateral interventions themselves are not inherently harmful. It truly comes down to the intention of the movement. If paired with the intention to self-soothe or bring the brain back into balance, as opposed to the intention of inducing deep exploration or catharsis, most clinicians are well within their scope to bring them into the therapeutic context. Within the cannon of EMDR literature, master clinician Dr. Laurel Parnell first introduced the idea of using bilateral tapping, paired with positive imagery, as a self-help strategy [35]. Even the founder of EMDR therapy, Dr. Francine Shapiro, followed suit with a book on using basic EMDR techniques as self-help strategies [36]. Both works serve as excellent supplementary resources to the material provided in this course.

Many clinicians may note that clients who have never heard of EMDR therapy intuitively engage in bilateral "techniques" to help alleviate stress. For example:

Whenever a client feels stressed at work, he goes outside and takes a cigarette lighter and tosses it back and forth from one hand to another. Interestingly, he does not smoke cigarettes anymore; he just uses this self-created technique with the lighter.

Another client was intrigued when EMDR was first suggested to her because she said it seemed like a process she has used to help her calm down over the years. She wears a ring on which a bejeweled bumblebee is set on a spring hinge. When you touch the bee, it rapidly moves back and forth horizontally. This client would stare at the back-and-forth motion of the bee to calm herself whenever she felt agitated or triggered.

Think back to your own experiences in elementary school or preschool. Did your teachers ever use techniques like having the class get up and run in place for a minute or so to work out the stale energy and get the blood pumping? Maybe you have even used such an approach with your own children, telling them to go outside and burn off some of that energy. Conversely, when some are too lethargic or sluggish, engaging in a similar pursuit can generate more productive energy. Such activities bring a greater sense of equilibrium to the brain, opening them up for a greater sense of calm and enhanced learning.

Some of this same logic may resonate with clients. Consider the following cases:

- A client comes into the office. They are so high strung and anxious, they can barely sit down to even give voice to what is happening with them on that given day.
- The session "goes stale"—there is either nothing to talk about, or the client has "hit a wall" from talking too much about a specifically heavy emotion.

In either scenario, consider how bringing some simple movement into standard interventions can make a difference. The following approach may work in either scenario: Instruct the client to stand up tall and encourage them to rotate from the hips, letting their arms fall against the body on each side. The client can keep the motion gentle, especially if their mobility is restricted, simply moving the arms at waist-level from side to side. If the client wants to get more movement into the motion, they can make the hip rotation more vigorous, even moving on to the balls of the feet with each back-and-forth motion.

If you have the option in your setting to do "walking therapy" outside, especially in decent weather, you may take advantage of that experience. In his book *The Wounds Within: A Veteran, a PTSD Therapist, and a Nation Unprepared*, Mark Nickerson (with Goldstein) shared his experience using this approach with a returning veteran who had a serious case of PTSD [37]. The young man was not only unable to sit still to talk, he had a very difficult time making eye contact because of his intense shame. When the veteran client asked if they could take a walk, my colleague was willing to make some modifications to facilitate and found that the client opened up in a way he was not able to in the office. For many who work in the adventure or wilderness therapy model, similar experiences are regularly observed. Indeed, one of the guiding premises of adventure therapy is that there is healing potential in getting out there and doing instead of just sitting around and talking.

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If stepping outside of the office is not a feasible option in addressing either of these two scenarios, or if the client is not open to overt physical movement, clinicians have the option of using only the hands. Some refer to this technique "energetic massage," although the title can be modified to best reach the client. The following is an example of how to teach the exercise [33].

Do you ever feel, quite literally like your brain hurts? Wouldn't it be great if you could give your brain a massage? With a simple exercise that harnesses the power of your own tactile (e.g., touch), you can.

- Rub your hands together for at least 30 seconds (or longer if you want). Really work up some heat!
- Pull your hands apart and bring them to your forehead. You can close your eyes, and place the base of your palms over your eyes; let the rest of your hands curl over your forehead to the top of the forehead. Or you can rest the base of your palms on your cheeks and go around your eyes. Choose a variation that is comfortable and helps facilitate relaxation.
- Settle in and feel the energy you generated in your hands move into your brain. Just allow the head to exist without judgement. Hold as long as you like.

This simple strategy, which you may already do inherently when you have a headache, can be used in many ways during therapy sessions. First, when the client comes into session and they seem to be talking rapidly and/or are unfocused, this exercise can be done as a simple ceremony to settling in before beginning talking. This can set a much calmer, more even pace for the session. A second option is as a session closer. If the client has been working on difficult material throughout the session, they may be feeling a little exhausted or too overwhelmed to leave. This option can be presented as a "brain massage" to return the client back to balance before leaving the session. As with many of the exercises discussed in this section, a third option is when/if the session "goes stale." If you've hit a wall with the session content or the client seems too exhausted to continue, this energetic massage movement technique can provide the much needed shift.

Other options and variations on this core exercise include:

- Bringing the energy from your hands to any part of your body that is feeling tense or anxious. Think about bringing the heat energy from your hands to your heart/chest or stomach if you are noticing any tension or pain.
- The "cranial hold" position is an option after generating the energy. To achieve this, horizontally bring one hand to your forehead and the other hand to the back of your head.
- Consider adding another sense into the process for optimal relaxation, like meditative music or an aromatherapy oil of your choice.

USING HAND GESTURES AND POSTURING FOR TEACHING NEW BEHAVIORS

So far in this section, we have covered how to bring the "stop" hand gesture into the classic thought stopping coping skills, how to use clenching and releasing to work with the concept of letting go, and how to use bilateral motion achieved via rubbing the hands together for a simple energetic massage. It should be becoming clear that incorporating movement in the context of traditional psychotherapy can be as simple as working with the hands. The next sections will present a few more ideas for how to bring gestures into therapeutic work to highlight certain principles and begin to explore how advocating certain changes in posture can achieve similar effects.

Regardless of one's primary approach to psychotherapy, clinicians are likely to have worked with clients on setting boundaries. Many clients struggle with boundaries, often as a result of trauma and abuse, with possible connection to codependency or co-addiction patterns. A simple exercise based on a yoga gesture (e.g., a mudra) may be included in this work. The following example is of the mudra of self-confidence, also known as the *vajrapradama* (or *vajra*) *mudra*:

- Interlace your two hands together, allowing your thumbs to point up and away from your body.
- Now bring these interlaced hands over your heart. If touching your body feels too invasive or uncomfortable for you, as a variation, you can bring the gesture over your heart without touching your hand to your skin.
- Hold this gesture over your heart for as long as you are able. Think about this gesture as a fence or a guard for your heart. Consider that you are in control of what comes into your heart, and you are in control of what flows from your heart.
- If you ever need to be reminded of this boundary and that you are powerful, come into this hand gesture and hold it, together with your breath, for as long as you need to.

If a client develops another hand gesture or posture that works better for them based on this original suggestion, this can be a great way of incorporating their feedback and creating a useful variation.

Coming into postures of confidence and power can have similarly positive results. Practitioners of yoga, yoga therapy, and many of the newer somatic therapy approaches that will be briefly discussed in the final section of this course are well-acquainted with this principle. How one sits, stands, and postures oneself overall, in relation to others, can tell a great deal about how one feels and/or perceives oneself in that relationship. For many individuals, having an awareness of this relationship dynamic is the first step of awareness that helps them to renegotiate their own perceptions of the relationship through making an adjustment in the posture. Such adjustments are well-known interventions within the Alexander technique.

Case Example

Client A presents to therapy with several goals, one of which is improved, positive assertiveness in her work setting. The client reports a high degree of stress about an abusive boss. Even after many years in his employ, she continually struggles with feeling heard by him, and she knows that the power dynamic he casts is reminiscent of how she related to a previous spouse with alcohol use disorder. Although she identifies that these older wound issues will need to be addressed and healed later in therapy, her therapist begins, during stabilization, to help her develop some skills to better cope in her work setting. The therapist asks Client A if she is sitting or standing during these difficult conversations with her boss. She replies that he always summons her into his office and that the available chair is lower than the boss's own. When the therapist asks her to visualize herself in this scenario and recall how it makes her feel, she reports that she feels small in his presence, and because of that, she has a natural tendency to curl or cower inward. Inspired by work with trauma-informed chair yoga, the therapist/client dyad spends some time in the session working on how to sit with confidence: sitting forward in the chair so that her feet can remain firmly planted and grounded on the floor, spine upright and straight, shoulders relaxed away from her ears. In the first part of the exercise, Client A simply practices this posture, specifically practicing coming into it from her natural position, which is to sit back in the big chair and cower inward while her shoulders are spiking up toward her ears. After the client feels confident with the posture, she then visualizes sitting in this more confident posture while in her boss's presence. As a homework assignment, the therapist advises her to practice coming into this seated posture every day, pairing it with some of the breath exercises, other safeguard visualizations, and other positive affirmations she is learning in her therapy/healing. When it comes time to actually speak to her boss again, Client A is able to use this simple shift in her posture, which she reports allows her to speak more confidently and feel less affected by the boss's natural critical countenance.

SITTING AND STANDING WITH INTENTION

If Client A had typically interacted with her boss while standing, the exercise could have been easily adjusted to target the standing posture and to practice standing with confidence. A common question in counseling and community settings is what skill can be used when talking to a difficult person. For these situations, it can be most effective to teach one of the foundational poses of yoga: mountain pose (*tadasana*). To a casual observer, mountain pose may not look very dynamic: it may appear that the practitioner is standing and looking out at the horizon. But there is power in standing with purpose and intention—embodying the power and grace of a mountain. Notice the full surface area of the foot connected to the earth below. Keeping one's gaze to the horizon can help support standing with purpose and confidence. Let the shoulders relax away from the ears, and feel the crown of the head extend to the sky. Allow the hands to rest gently at one's side if practicing this inconspicuously, or if practicing alone or with more intention, consider facing the palms out.

The simple motion of moving from sitting to standing may also be used as a technique for working with clients with movement. Rising from a seated position, assuming physical capacity, is something that most take for granted. Yet even this simple activity of life can be practiced mindfully, allowing one to build an even greater sense of body awareness and empowerment. One example of how this technique (referred to as full body rising) can be taught follows [33].

Whenever one does an activity that is normally automatic in a slow, mindful way, it is a perfect chance to cultivate the attitude of patience. Consider the following exercise:

- While in a sitting position, allow your upper body to fold over your seated, lower body. Your hands do not need to touch the ground, but aim there. Take a few moments and notice how it feels when the blood moves to your head as you fold over.
- Very slowly and carefully, allow your buttocks to lift off of the chair while remaining in the bent-over position. If your hands can touch your feet or the ground, do that; if not, just allow your hands to fall wherever they may on your legs.
- Stay in this folded over, "rag doll" position as long as you are able.
- Slowly, mindfully begin to unfold your spine and rise. Think one vertebra at a time; avoid just rushing up.
- When you have totally unfolded, let your shoulders roll back and keep your gaze straight ahead, with confidence. Notice how you feel.

As with all of the activities presented in this chapter, there are no "rights" or "wrongs" about what a person should (or should not) be feeling. Rather, use the feedback that clients give about the experience to elicit further dialogue within the existing therapeutic context, or use the feedback to make modifications. For instance, if a client is unable to stand, they can still achieve the benefits of this exercise by doing the first part of bending over and then unfolding the spine. The client can be encouraged to take the confidence stance with their upper body, even in a seated position. One can also incorporate music that creates a vibe of rising or emergence to enhance the mood of growing into confidence. This variation can be especially effective in engaging children.

A yogic breathing technique that can be coupled with a confident posture is an approach called lion breathing. Although many adult clients may be initially too self-conscious to try it, they often find benefit if they are eventually able to overcome their reticence, and it can be a useful coping approach for assertiveness training. The following script can be used to teach lion breathing [33].

Although taking on the full character of a lion is optional with this exercise, allowing yourself to make the face of a lion with this breath can help you with letting go of negativity:

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- Begin with a healthy inhale with your nose that allows the belly to expand as fully as possible.
- Exhale vigorously, allowing the tongue to hang out. Feel the jaw and cheeks loosen. Open the eyes widely and let them roll back slightly to help with the sensation of letting go.
- Try at least three to five sets, taking time to adjust to the level of your physical comfort. With each set, see if you can allow your tongue to hang out further. Bring your hands up like lion paws to fully get into the character of the breath.

Following attempt of this exercise, individuals should experience a loosening in the jaw on both sides. We often discuss how important it is to stretch the joints, but the jaw, one of the most powerful joints in the human body, tends to be overlooked. It is often said that when a trauma or other stressor has silenced someone, it is felt somatically through jaw pain or throat tension. Doing an exercise like lion breathing, and practicing it with consistently, is a way to promote movement in the somatic and energetic body and resultantly serve as an aid in building confidence. After teaching lion breathing in the office setting, clients can be advised to craft a few minutes each day where they can practice the exercise on their own. As a variation option, adding a musical track that one finds empowering can take the exercise to a new dimension. Although going into a difficult conversation with a boss or other person while doing lion breathing is generally not advised, taking a few minutes to do some lion breaths before going into these types of interactions can make a significant difference.

With lion breathing or any of the strategies, you never want to engage in them to the point of physical pain. Hence, starting with a simple one or two sets of the breath is generally advised until you see how well a person will tolerate the technique. The same spirit of encouraging clients to listen to their body's own limits must also be taken into the next series of exercises.

RITUAL MOVEMENTS FOR LETTING GO AND RELEASE

There can be healing power for many in both ritual and ceremony. For many indigenous cultures, the idea of helping a person to heal without involving ceremony would not be possible. Although one could argue that there is a certain ceremony to the process of coming to an office and sitting down in the therapist's chair, it is a ceremony that has become more of a mindless ritual in modern society. For clinicians committed to bringing in more creativity and movement into their practice of psychotherapy, the essential question is: How can I make the process more dynamic and engaging for my clients?

REFLECTION

Scan your memory of your practice. What are some of the memories that stick out to you about when you've worked with the client to come up with a creative solution to a problem at hand? What role did creativity, specifically invoking some type of ritual or ceremony, play in that solution? Take time to make notes of how these approaches might inform work with your current clients.

A time-honored psychotherapy technique from the Gestalt tradition is the unsent letter technique. In this process, a person writes, in letter form, everything that s/he would like to say to a person who was a source of trauma or offense. When making use of this technique, clients are encouraged to get it all out—avoid censoring language or judging emotional content. Assuming that the client is stable and ready enough to handle this process, they should be supported in really letting it all out. Together, after they've released the emotions through the physical process of writing, devise a method for best releasing the unsent letter. This is where movement, ceremony, and ritual can be introduced to enhance the process. Some people choose to rip their letters up and leave them in the trash bin in the office (again, symbolizing letting go and leaving it behind), whereas others may choose to burn the letter, noticing the rising smoke as a symbolic releasing of the pain in the letter to God/Higher Power/nature. Others may choose to leave unsent letters at a cemetery, if the letter is to someone who has passed away. The options here are endless; the common denominator is that the physical processes involved with these activities powerfully activate the brain to help with the overall sense of release.

Such a ceremonial process may be particularly helpful if a person is struggling with complicated mourning issues, especially if there were words left unsaid or the client/mourner was unable to say goodbye in the way that they would have wished. Taking an unsent letter to a gravesite may be sufficient, but others may want to invite others in to witness the process. Perhaps bringing in the element of fire to burn the letter and setting the intention of it rising to the heavens with the smoke can add to the richness of the ceremony. Bringing in loved ones' favorite songs may also add a dimension to the ceremony.

Experts have also identified a variety of ideas for incorporation of elements of traditional ceremony and ritual into the Western counseling process [4; 7]. This can include Native American customs and ceremonies, traditional Chinese medicine practices, and yogic traditions. For example, the text *Yoga Skills for Therapists* provides examples of how psychotherapists can weave elements of yoga into their own practices without formal training [38].

Although this course will cover direct dance strategies for letting go and release in the next section, a simple movement technique can also be useful as a ritual/ceremony for "shaking off" negativity or stress. Inspired by Cornelius Hubbard, this exercise is referred to as noodling. Like running in place, it can have a similar effect to getting a person whose attention has drifted or who has become overwhelmed to refocus. The following is a sample script for teaching noodling [33].

Haven't you ever envied a cooked noodle? The way it just moves free and easy, without stress, is an admirable quality that can teach us how to practice the attitude of letting go. Think of how fun, and potentially beneficial, it could be to take on the role of a noodle.

- For optimal benefit, rise to your feet (although you can also do this sitting or lying down).
- With your next breath, think of taking on the qualities of a noodle...it is suggested that you begin in your shoulders and then let the "noodling" move through the rest of your body.
- Keep noodling, in an intentional way, practicing beginner's mind, nonjudgment, and non-striving for at least three minutes.
- When you have completed this exercise, allow yourself to be still for a few moments longer (either standing, sitting, or lying down), and notice how it feels.
- Although you can do this in silence, one potential creative modification is to put on some music that can bring out your inner noodle. You can also bring scarves, ribbons, or others props into the action—this is an especially fun exercise to engage children.

As with many of the exercises covered thus far, the dialogue with clients following their attempts of these exercise can be powerful. Comments from clients following an attempt at noodling can lead to an amazing discussion about how hypervigilence plays a role in mental health and body sensations. Clients may begin to get a sense of the extent to which somatic hypervigilence is engrained and how it keeps them from fully "relaxing into" and ultimately enjoying life.

DANCING MINDFULNESS

In 2010, I worked to develop "dance-based" interventions that can be woven into traditional psychotherapy through the lens of a practice called Dancing Mindfulness. Dancing Mindfulness is an approach that uses the human activity of spontaneous dance as a mechanism for teaching and practicing mindfulness meditation. The practice adapts the classic practices of mindfulness in Eastern philosophy for a more Westernized audience using an expressive art form [39]. While various articles and writings within the field of dance therapy reference mindful movement, Dancing Mindfulness exists outside of the structured precepts of dance therapy. Whereas dance therapy approaches may draw upon mindfulness, Dancing Mindfulness is a modern approach to mindfulness meditation that draws on dance as the vehicle for practicing the present-focused meditation. Meditation is any activity that helps one systematically regulate attention and energy, thereby influencing and possibly transforming the quality of experience in service of realizing the full range of humanity and of relationships to others in the world [27]. There are numerous ways to meditate, with different approaches having nuanced effects for individual practitioners [40]. A study consisting of interviews with both nuns and laywomen led Buddhist teacher Batchelor to conclude that the specific techniques of meditation used do not seem to matter as much as one's sincerity in practicing the Dharma, or "the body of principles and practices that sustain human beings in their quest for happiness and spiritual freedom" [41].

Although the phrase Dancing Mindfulness has been coined to describe an approach to mindfulness meditation, cultures around the globe have collectively drawn on the power of dance and present-moment meditation since the dawn of time. Dancing Mindfulness is a wellness practice that grew from my clinical experiences working with trauma and addiction. It can be learned in a group class and practiced in community as well as individually; experience in yoga, meditation, or dance is not required to practice. Participants are simply asked to come as they are with attitudes of open-mindedness. Structured classes begin with a facilitator gently leading participants through a series of breathing and body awareness exercises. Following a mindful stretch series, the facilitator leads participants up to their feet for letting go and dancing with the freedom one might tap into by simply turning on some music and dancing around their houses. Many participants find this practice, especially when supported by the energy of other practitioners who are also taking risks, a cathartic experience. Although some find themselves overwhelmed and intimidated, they are encouraged to just acknowledge their experience, without judgment, and can choose to opt out of a certain dance or use their breath and movement as vehicles for moving through the discomfort. Safety is imperative to Dancing Mindfulness practice—facilitators emphasize that no one ought ever feel forced to participate in any component of the practice.

The primary attitudes cultivated by mindful practice, as identified by Kabat-Zinn in his synthesis of mindfulness research, are used as thematic guidelines in structuring classes: acceptance, beginner's mind, letting go, non-judging, non-striving, patience, and trust [27]. Any of these attitudes may be used as a thematic guide in choosing music for the class, or the facilitator may call upon a series of these attitudes in dancing with an element. The elements of Dancing Mindfulness are networks through which mindfulness can be practiced: breath, body, mind, spirit, sound, story, and fusion of all the elements. A facilitator may elect to start the class working with breath in silence, advising participants that when they use their bodies to come up to their feet and dance, their breaths are with them as a guiding force. Using breath to guide movement is a way, for example, to cultivate the attitude of trust.

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Although Dancing Mindfulness was developed within a group context, the attitudes and elements of dancing mindfulness can be used as part of a daily wellness practice and in individual work with clients. Many Dancing Mindfulness facilitators use the practice as an adjunctive activity in clinical settings, bringing moving meditations inspired by Dancing Mindfulness into individual sessions with clients. The following sections will outline versions of some of these mindfulness-informed approaches. Learners are encouraged to try the interventions out first and then determine if they can or should be weaved into work within clients in their existing therapy setting and therapeutic approach. When it comes to physical safety, be sure to advise clients to listen to the feedback that their bodies give them about how far or how fast they are going. In terms of your own clinical scope of practice, if any of these exercises are going to be used for more of a cathartic experience, be sure that you feel comfortable addressing, within your existing therapeutic orientation, what may come up during the movement process.

Clench-and-Release Variation

One Dancing Mindfulness-inspired approach is to take the clench-and-release exercise (discussed previously) to a more dynamic, "dancey" place. The purpose of this dance is to consider whatever it is you are holding onto: anger, resentment, hatred. It is up to the individual to decide what they want to work with. After this selection is made, the dancer is instructed to take two stress balls and grip their hands tightly around them. As the music inspires, they should move through the space and notice the experience of holding on. It is important to allow time for this process. In addition, the choice of music is very important here; "angstier" music can generate more tension in dancers, which is useful here. When the song ends, the client should be instructed to release the stress balls, notice them leave their hands, and drop to the floor. Ask the client to take a moment to notice how good it can feel to let go and to let the earth absorb any of the negativity that arose in the room.

It is generally a good idea to choose the next song as a counterpoint, one that continues to work with the power of release. As a caution: Not everyone likes this dance; some may feel that it is "too much." For those attempting this facilitation in a group or within an individual counseling setting, remind your group or individual client that opting out is always an option. As a variation, the individual could do the same dance without stress balls—simply have people clench their fists and when you invite the release, have them notice how good it feels to release the grip on the hands. Encourage the opening of the hands to trickle into the rest of the body and then dance with that sense of release.

Mindful Music Listening

If an exercise like this seems too advanced or risky for your clients, consider working with the client in the context of a mindful listening exercise and then adding in some movement if it seems organic. Too often, music is in the background. In this exercise, the client can explore how really paying attention to the music in a nonjudgmental manner can usher in a new experience. Clinicians are encouraged to try all four parts of this exercise, in order, before attempting it with clients. It can be an excellent exercise for personal practice in addition to working on it with clients or students.

To start, ask clients to get into a comfortable yet alert position, as if about to do a seated or lying down meditation. Then, cue up a piece of music that the client has never heard before. For the length of the song, their only task is to pay attention to the song, listening mindfully. Just be with the experience.

After a few minutes of silence, cue up the song again and let the music connect with breath. Be open to movement should it happen, and just go with it. Some clients will only be inspired to sway and swivel a little bit; others may break out into a full-on dance routine. Whatever happens, just honor the experience.

Now, find a piece of music that the client knows very well, preferably something that they connect with emotionally. Instruct the listener to return to a sitting or lying meditative position and listen to this piece of music with total awareness, as if it is the first time they are hearing it. Once again, just be with the experience and notice what happens within when listening with mindful ears.

Finally, replay the song, only this time being open to movement. Just go with it, and notice what happens.

FURTHER TRAINING AND COLLABORATION

REFLECTION

"Almost all creativity involves purposeful play."

–Abraham Maslow

Consider for a moment how purposeful play in the form of dancing and movement might inspire your clinical practice. How do your own experiences with movement inform your understanding of other individuals and cultures?

IS FURTHER TRAINING RIGHT FOR MY CLINICAL PRACTICE?

If the interventions outlined in this article excite you, there is a chance that you may want to pursue further training in dance and/or movement modalities as part of your continuing education. There are several avenues that you can explore—the conscious dance routes (e.g., 5Rhythms, Dancing Mindfulness); the more structured dance, movement, and expressive arts therapies routes; and finally, approaches to psychotherapy that typically are not viewed as dance/movement therapy, but certainly incorporate movement and somatic work (e.g., EMDR therapy, somatic experiencing). This section will provide a very brief overview of available avenues and resources for further information.

If you are interested in the conscious dance route, consider visiting https://consciousdancer.com, the official website of Conscious Dancer Magazine and the DanceFirst Association. Of particular interest may be the Upshift Guide, which lists summaries and training requirements for more than 100 conscious dance modalities operating around the world. The training lengths for each modality vary, although it is not unrealistic to complete full training in some modalities within several weekend modules. Conscious dance training is generally ideal for those who seek to bring movement practices into the larger community (e.g., yoga studios, churches, schools, wellness fairs, festivals) and not just in a clinical setting. In addition, those who work in a clinical setting that is open-minded to practices like this, having some training in a conscious dance form will generally suffice to support the incorporation of dancing approaches into clinical practice.

For those who are looking for a more structured experience in dance/movement or expressive arts therapy, there are options available through the ADTA (https://www.adta.org) and the International Expressive Arts Therapy Association (https://www.ieata.org). Both entities offer formal training programs, many of which come with continuing professional education. For the ADTA route, to become a registered dance and movement therapist, a period of working with an approved supervisor is required. The ADTA also lists Master's degree programs that they recognize in dance and movement therapy for fulfilling much of these requirements, although a post-Master's training route is available for those wishing to register as a dance/movement therapist after having completed a general clinical Master's degree. The IEATA model allows for individuals to become certified through both traditional and non-traditional models of demonstrating their training and education. These paths are recommended for clinicians who truly want to deepen their educational experience and those who are likely to work in settings where formal accreditations are expected and/or required.

A final, and perhaps the most career-advantageous, path could be to explore the newer wave modalities of psychotherapy that utilize somatic interventions and creative affect tolerance modalities. Many of these, like dialectical behavioral therapy and EMDR therapy, are recognized in the SAMHSA Evidence-Based Practices Resource Center. Others, such as sensorimotor psychotherapy, are increasingly gaining credibility based on their grounding in the latest findings in trauma-informed care and neurobiology. In addition to the traditional modalities in movement discussed in the first section of this course, clinicians should also consider checking out the regulatory websites of these modalities for information about training and formation:

- EMDR therapy:
  https://www.emdria.org
- Dialectical behavior therapy:
  https://dbt-lbc.org
- Somatic experiencing:
  https://traumahealing.org/professional-training
- Sensorimotor psychotherapy:
  https://sensorimotorpsychotherapy.org
- Psychomotor psychotherapy:
  https://pbsp.com
- Hakomi mindful somatic psychotherapy:
  https://hakomiinstitute.com
- Body psychotherapy:
  https://www.usabp.org

The imperative here is not that all persons interested in incorporating movement into their clinical practice must seek training in every one of these modalities. Rather, they offer a potential avenue for blending somatically informed movement work into a psychotherapy practice. Learners are encouraged to visit the sites, read about each, watch demonstration videos, and if possible, arrange to have some work in each modality done. This process of inquiry will provide a good idea of which approach best resonates and will likely prove to be the best fit for your practice.

COLLABORATING WITH OTHER PROVIDERS

After participating in this course, clinicians should be empowered to, at least, try out some of these movement practices themselves. Even those who do not foresee incorporating movement or dance approaches into work with clients are encouraged to experiment with making them a part of their own self-care. In between stressful meetings or client appointments, consider if you might incorporate a little movement to improve posture or to shake the stress away.

In addition, clinicians should consider the option of collaboration with other professionals. Even if pursuing formal training is not appealing, consider exploring some of the websites and organizations provided. They might be able to direct you to providers in your area who are willing to work with you collaboratively. Especially if it seems like you have exhausted the extent of your clinical repertoire with a certain client, sending them for some supplemental sessions in one of the modalities described here may be a good fit. Many conscious dance or yoga classes offered in communities have a healing spin that is appropriate for clients. Bringing these to clients' attention as resources they can seek out for coping can be helpful, as long as you check back in with them after they sought out the suggestion to make sure that it was not unproductively triggering in any way. This follow-up feedback can be used to continue working with them on wellness measures.

CONCLUSION

The intent of this course was to inspire creative thought processes related to how to work movement and dance modalities into an existing psychotherapy practice. There are many options available using various traditions and levels of movement engagement. The creative descriptions are intended to be resources to support work on some of these skills. Before

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passing them along to clients, it is important to have first tried them. If you have been able to incorporate movement or dance exercises into your daily life and wellness practice, you are in an even better position to be an ambassador for movement.

APPENDIX 1: MULTICULTURAL AWARENESS AND COMPETENCE

As discussed throughout this course, dance and movement have long cultural traditions around the world, and the healing properties of movement have been a staple in ancient and modern communities. With this in mind, all clinicians should be mindful of the role of clients' cultural identity, beliefs, and traditions as well as of the cultural roots of modalities.

In its Code of Ethics and Standards, the American Dance Therapy Association has established criteria for providing culturally competent dance/movement therapy [42]. Although this code applies to certified dance therapists, it provides a good guideline for all clinicians incorporating movement, dance, and/or somatic techniques into their practice. The Code includes the following requirements for clinicians [42]:

- Dance/movement therapists should consider the role of cultural context in the practice of therapy and continuously attend to developing the awareness, knowledge, and skills needed to competently work with diverse client groups.
- Dance/movement therapists examine the meaning of their ethnic and cultural backgrounds and how they may affect cross-cultural therapy dynamics.
- Dance/movement therapists develop awareness of their own worldviews, values, and beliefs and seek to understand the worldviews, values, and beliefs of their clients.
- Dance/movement therapists actively engage in broadening their knowledge of all cultures and in particular acquire information about the cultural group(s) with whom they are working, with attention to the inherent strengths of the cultural group. Dance/movement therapists seek this knowledge from multiple sources.
- Dance/movement therapists are sensitive to individual differences that exist within a cultural group and understand that individuals may have varying responses to cultural norms.
- Dance/movement therapists consider the impact of societal dynamics of power, privilege, and oppression on individual client experience and behavior.
- Dance/movement therapists inquire about client concerns, including perceptions of racism, language barriers, or cultural differences, which the client may experience as compromising trust and communication in the therapy relationship or treatment setting.

While these ethical standards do not vary significantly from the codes of ethics governing the various behavioral and mental health professions, there are unique considerations when considering the inclusion of culturally bound traditions. For example, tribal dance has been a vital component of many Native American communities, and clients from these backgrounds (and potentially beyond) may express interest in incorporating indigenous dance into mindfulness practices and/or therapeutic work. Behavioral health service providers should recognize that Native American tribes represent a wide variety of cultural groups that differ from one another in many ways [6]. Each Native American culture has its own specific healing practices, and not all of those practices are necessarily appropriate to adapt to behavioral health treatment settings. However, many traditional healing activities and ceremonies have been made accessible during treatment or effectively integrated into treatment settings. These practices include sacred dances (such as the Plains Indians' sun dance and the Kiowa's gourd dance) [6]. Clinicians from outside of these communities should seek consultation with a Native expert and/or refer clients to a culturally appropriate community or professional resource.

BEST PRACTICES FOR CULTURALLY RESPONSIVE CARE

The U.S. Department of Health and Human Services has outlined steps important to incorporate in evaluation and treatment planning processes to ensure culturally competent clinical and programmatic decisions and skills [6].

The first step is to engage clients. In nonemergent situations, it is important to establish rapport before asking a series of assessment questions or delving deeply into history taking. Providers should use simple gestures as culturally appropriate (e.g., handshakes, facial expressions, greetings) to help establish a first impression. The intent is that all clients feel understood and seen following each interaction. Culturally responsive interview behaviors and paperwork should be used at all times [6].

When engaging in any client teaching, remember that individuals may be new to the specific language or jargon and expectations of the diagnosis and care process. Clients should be encouraged to collaborate in every step of their care. This consists of seeking the client's input and interpretation and establishing ways they can seek clarification. Client feedback can then be used to help identify cultural issues and specific needs. If appropriate, collaboration should extend to include family and community members.

Assessment should incorporate culturally relevant themes in order to more fully understand clients and identify their cultural strengths and challenges. Themes include [6]:

- Immigration history
- Cultural identity and acculturation
- Membership in a subculture

- Beliefs about health, healing, and help-seeking
- Trauma and loss

In some cases, it may be appropriate and beneficial to obtain culturally relevant collateral information, with the client's permission, from sources other than the client (e.g., family or community members) to better understand beliefs and practices that shape the client's cultural identity and understanding of the world.

Practitioners should work to identify screening and assessment tools that have been translated into or adapted for other languages and have been validated for their particular population group(s). An instrument's cultural applicability to the population being served should be assessed, keeping in mind that research is limited on the cross-cultural applicability of specific test items or questions, diagnostic criteria, and concepts in evaluative and diagnostic processes [6].

Typically, culturally responsive care establishes holistic treatment goals that include objectives to improve physical health and spiritual strength; utilizes strengths-based strategies that fortify cultural heritage, identity, and resiliency; and recognizes that treatment planning is a dynamic process that evolves along with an understanding of client history and treatment needs. In addition to these general approaches, specific considerations may be appropriate for specific populations.

CREATING A WELCOMING AND SAFE ENVIRONMENT

Ensuring clients feel comfortable enough to participate in therapy, including movement and/or dance approaches, begins with client comfort. This can be facilitated, in part, by providing a welcoming environment. The basis of establishing a safe and welcoming environment for all clients is security, which begins with inclusive practice and good clinician-client rapport. Shared respect is critical to a client's feeling of psychological well-being. Security can also be fostered by a positive and safe physical setting. As such, therapy environments should be controlled in a way to minimize traumatic stress responses. Providers should 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.

Experts recommend the adoption and posting of a nondiscrimination policy that signals to both clinicians and clients that all persons will be treated with dignity and respect [43]. Also, checklists and records should include options for the client defining their race/ethnicity, preferred language, gender expression, and pronouns; this can help to better capture information about clients and be a sign of acceptance to that person. If appropriate, providers should admit their lack of experience with client subgroups and seek guidance from clients regarding their expectations of the visit.

Front office staff should avoid discriminatory language and behaviors. For example, staff should avoid using gender-based pronouns, both on the phone and in person. Instead of asking, "How may I help you, sir?" the staff person could simply ask, "How may I help you?" Offices that utilize electronic health records should have a system to track and record the gender, name, and pronoun of all clients. This can be accomplished by standardizing the notes field to document a preferred name and pronoun for all clients [44]. Persons who identify as nonbinary (i.e., neither or both genders) or with dissociative identity disorder may prefer that plural pronouns (e.g., they) be used.

Questions should be framed in ways that do not make assumptions about a client's culture, gender identity, sexual orientation, or behavior. Language should be inclusive, allowing the client to decide when and what to disclose. Assurance of confidentiality should be stressed to the client to allow for a more open discussion, and confidentiality should be ensured if a client is being referred to a different healthcare provider. Asking open-ended questions can be helpful during a history and physical.

APPENDIX 2: DANCE IN THE CONTEXT OF EXPRESSIVE GROUP THERAPY

When practiced as a formal group modality, dance and movement therapy is included in the larger umbrella of expressive groups, which includes a range of therapeutic activities that allow clients to express feelings and thoughts—conscious or unconscious—that they might have difficulty communicating with spoken words alone. The purpose of expressive therapy groups is generally to foster social interaction among group members as they engage either together or independently in a creative activity. These groups therefore can improve socialization and the development of creative interests. Further, by enabling clients to express themselves in ways they might not be able to in traditional talking therapies, expressive therapies can help clients explore their substance abuse, its origins, the effect it has had on their lives, and new options for coping. These groups can also help clients resolve trauma that may have been a progenitor of their current presenting problem. For example, clinical observation has suggested benefits for female clients with substance use disorder involved in dance therapy [45]. Expressive therapy groups often can be "a source of valuable insight into clients' deficits and assets, both of which may go undetected by treatment staff members concerned with more narrowly focused treatment interventions" [45].

The actual characteristics of an expressive therapy group will depend on the form of expression clients are asked to use. Expressive therapy may use music, dance, or free movement. Expressive group leaders generally will have a highly interactive style in group. They will need to focus the group's attention on creative activities while remaining mindful of group process issues. The leader of an expressive group will typically need to be trained in the particular modality to be used (e.g., dance

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therapy). In some cases, expressive therapies can require highly skilled staff, and, if a program does not have a trained staff person, it may need to hire an outside consultant to provide these services. Any consultant working with the group should be in regular communication with other staff, because expressive activities need to be integrated into the overall program, and group leaders need to know about each client if they are to understand their work in the group. Expressive therapies can stir up very powerful feelings and memories. The group leader should be able to recognize the signs of reactions to trauma and be able to contain clients' emotional responses when necessary. Group leaders need to know as well how to help clients obtain the resources they need to work though their powerful emotions [45].

Finally, it is important to be sensitive to a client's ability and willingness to participate in an activity. To protect participants who may be in a vulnerable emotional state, the leader should be able to set boundaries for group members' behavior. For example, in a movement therapy group, participants need to be aware of each other's personal space and understand what types of touching are not permissible.

After clients have spent some time working on their creative activity (e.g., dance), the group comes together to discuss the experience and receive feedback from the group leader and each other. In all expressive therapy groups, client participation is a paramount goal. All clients should be involved in the group activity if the therapy is to exert its full effect [45].

Another point to consider is the role of touch. Touch in a group is never neutral. People have different personal histories and cultural backgrounds that lead to different interpretations of what touch means. Consequently, the leader should evaluate carefully any circumstance in which physical contact occurs, even when it is intended to be positive. In most groups, touch (handholding or hugs) as part of group rituals is not recommended, though in an expressive therapy or dance group, touch may be acceptable and normative. Naturally, group agreements always should include a clause prohibiting physical violence. Whenever the therapist invites the group to participate in any form of physical contact, individuals should be allowed to opt out without any negative perceptions within the group. All members uncomfortable with physical contact should be assured of permission to refrain from touching or having anyone touch them [45].

Leaders also should make sure that suggestions to touch are intended to serve the clients' best interests and not the needs of the therapist. Under no circumstances should a counselor ask for or initiate physical contact. Like their clients, counselors need to learn that such impulses affect them as well. It is wrong for those providing psychotherapy to allow feelings of attraction to dictate or influence their behavior [45].

Customer Information/Answer Sheet/Evaluation insert located between pages 48–49.

TEST QUESTIONS
#78250 MOVEMENT AND DANCE IN PSYCHOTHERAPY

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

This 10 Hour activity must be completed by March 31, 2027.

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1. According to trauma scholar and innovator, Bessel van der Kolk the purpose of trauma treatment is
- *A) catharsis.*
- *B) stabilization.*
- *C) to get engaged in the most innovation treatment possible for resolution.*
- *D) to help people fundamentally experience greater safety in their own body.*

2. What common adage fundamentally offers solid direction for holistic trauma resolution?
- *A) Let go and let God.*
- *B) Actions speak louder than words.*
- *C) God helps those who help themselves.*
- *D) What doesn't kill you makes you stronger.*

3. Which of the following best represents the multicultural value of using dance/movement work in therapy?
- *A) Indigenous cultures around the globe have been making use of dance/movement techniques long before modern psychology was invented.*
- *B) Many techniques in dance and movement are true cultural universals.*
- *C) Learning the movement and dance traditions of a client's culture can be an excellent way to open up conversation and promote understanding.*
- *D) All of the above*

4. What is a traditional folk dance of the Maori people of New Zealand?
- *A) Kolo*
- *B) Haka*
- *C) Umoya*
- *D) Shapiro*

5. Who is best known for the memoir he wrote detailing his service with Native American tribes and the lessons that they taught him on healing?
- *A) Fritz Perls*
- *B) Alexander Lowen*
- *C) Moishe Feldenkrais*
- *D) Carl Hammerschlag*

6. Who is the founder of the 5Rhythms conscious dance practice?
- *A) Marian Chace*
- *B) Gabrielle Roth*
- *C) Francine Shapiro*
- *D) Florence Noyes*

7. The National Institutes of Health recognize Native American healing approaches as
- *A) unfounded.*
- *B) homeopathic.*
- *C) a whole medical system.*
- *D) a complementary medical system only.*

8. The healing systems/practices of yoga and Ayurveda originated in
- *A) India.*
- *B) Pakistan.*
- *C) South Africa.*
- *D) New Zealand.*

9. Bioenergetic analysis (BA) is a body-based psychotherapy rooted in the principles of mind-body connection.
- *A) True*
- *B) False*

10. Alexander Lowen, the founder of Bioenergetics, studied originally in
- *A) Gestalt psychotherapy.*
- *B) Jungian psychoanalysis.*
- *C) Freudian psychoanalysis.*
- *D) Native American psychology.*

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11. **Lowen, Perls, and Feldenkrais primarily worked on bringing their innovative work and approaches to prominence at**
    A) *Harvard University.*
    B) *the Esalen Institute.*
    C) *the Omega Institute.*
    D) *the University of Vienna.*

12. **Which approach to Western psychotherapy was the first truly holistic system of psychotherapy because of its use of affective, sensory, interpersonal, and behavioral components?**
    A) *Psychoanalysis*
    B) *EMDR therapy*
    C) *Gestalt psychotherapy*
    D) *Body-centered psychotherapy*

13. **Perls incorporated which Eastern philosophical approach into the Gestalt approach to psychotherapy?**
    A) *Tao*
    B) *Christianity*
    C) *Zen Buddhism*
    D) *Tibetan Buddhism*

14. **Who developed a system of somatic education that is now practiced by dancers, bodyworkers, and psychotherapists?**
    A) *Fritz Perls*
    B) *Francine Shapiro*
    C) *Alexander Lowen*
    D) *Moshé Feldenkrais*

15. **F.M. Alexander originally honed his ideas when he was working as a(n)**
    A) *actor*
    B) *musician*
    C) *physician*
    D) *psychoanalyist*

16. **Which contemporary dancers are considered to be forerunners of modern-day dance therapy?**
    A) *Ruth St. Denis*
    B) *Martha Graham*
    C) *Florence Noyes*
    D) *All of the above*

17. **Pesso, the developer of psychomotor psychotherapy, was a dancer in whose performance company?**
    A) *Florence Noyes*
    B) *F.M. Alexander*
    C) *Martha Graham*
    D) *Ruth St. Denis*

18. **Who is considered to be the founder of the formal practice of dance therapy and the American Dance Therapy Association?**
    A) *Florence Noyes*
    B) *Martha Graham*
    C) *Marian Chace*
    D) *Gabrielle Roth*

19. **Dance and movement therapy, as defined by the American Dance Therapy Association, may be practiced in**
    A) *nursing homes.*
    B) *day care centers.*
    C) *mental health hospitals.*
    D) *All of the above*

20. **Movement with an intention towards higher awareness is typically a definition given for**
    A) *5 Rhythms.*
    B) *Zumba fitness.*
    C) *conscious dance.*
    D) *Dance and movement therapy.*

21. **In linking clients with dance resources in the community for their own health and wellness, dance/movement therapy is generally more accessible and available than conscious dance and fitness dance practices.**
    A) *True*
    B) *False*

22. **What are the three "brains" in MacLean's triune brain model?**
    A) *Animal, vegetable, mineral*
    B) *Neocortex, limbic, R-complex*
    C) *Prefrotal lobe, midbrain, R-complex*
    D) *Amygdala, hippocampus, hypothalamus*

23. **According to the triune brain model, what part of the brain is generally described as having no rational time clock?**
    A) *the limbic brain*
    B) *the neocortex*
    C) *the prefrontal cortex*
    D) *the R-complex*

24. **Cognitive or any reason-based interventions primarily target the**
    A) *limbic brain.*
    B) *amygdala.*
    C) *neocortex.*
    D) *R-complex.*

Test questions continue on next page →

25. What is the major reason cognitive therapies alone are generally ineffective for processing trauma?

A) *Cognitive therapies are outdated for trauma.*
B) *People cannot process information cognitively.*
C) *Research shows that cognitive therapies are not as effective for trauma as EMDR, dance, and other, newer therapies.*
D) *Cognitive therapies primarily target the frontal lobe of the brain, an area that shuts down when a person is viscerally triggered by traumatic memories.*

26. Talking, connecting with others, and self-knowledge are all examples of what types of interventions for healing?

A) *Technology*
B) *Top-down methods*
C) *Bottom-up methods*
D) *All of the above*

27. Allowing the body to have experiences that deeply and viscerally contradict the helplessness, rage, and collapse that result from the trauma are examples of what types of interventions for healing?

A) *Technology*
B) *Top-down methods*
C) *Bottom-up methods*
D) *All of the above*

28. Yoga has been found to help traumatized individuals

A) *to promote a greater sense of creativity.*
B) *to promote an outlet for exercise that helps you work through physical fear.*
C) *to tolerate physical and sensory experiences associated with fear and helplessness and to increase emotional awareness and affect tolerance.*
D) *None of the above*

29. Nikki Myers is associated with combining which two healing practices?

A) *Dance and yoga*
B) *Yoga and 12-step recovery*
C) *Psychoanalysis and yoga*
D) *12-step recovery and dance*

30. What slogan is used by Nikki Myers in her movement work?

A) *Easy does it.*
B) *The body never lies.*
C) *The issues live in our tissues.*
D) *Actions speak louder than words.*

31. Mindfulness practices create which benefit(s) in the human brain?

A) *Calm a client's inner experience and promote greater introspection*
B) *Play a key role in activating the pre-frontal cortex and promoting a greater sense of concentration*
C) *Practice can cause positive structural changes in the brain related to learning and memory (hippocampus) and can cause a thinning in the amygdala, lessening the charge of fear-based responses*
D) *All of the above*

32. Which group concluded that, in the treatment of trauma, "optimization of outcomes also includes exploration of novel treatment approaches such as complementary medicine strategies that focus on somatosensory experience and the mind-body relationship, for which there is emerging evidence regarding efficacy"?

A) *The National Institute of Mental Health (NIMH)*
B) *The American Psychological Association (APA)*
C) *The American Dance Therapy Association (ADTA)*
D) *The International Society of Traumatic Stress Studies (ISTSS)*

33. In general, when working with new clients and assessing the appropriateness of movement and dance modalities, one can ask general questions about the role of exercise and/or spirituality in their life.

A) *True*
B) *False*

34. Which term is generally defined as always being on guard for something bad to happen?

A) *Hypoarosal*
B) *Hypervigilience*
C) *Heightened startle response*
D) *None of the above*

35. It is important not to force dance-based interventions on clients or to tell them that they have to seek out a dance class, although it may be worth exploring why a person may be open to other movement strategies but closed off when it comes to dance or other more creative movement modalities.

A) *True*
B) *False*

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36. According to Winton-Henry, which of the following is NOT a reason clients may resist dance and movement interventions?
- A) *Dancing is not important.*
- B) *It is too embarrassing to dance.*
- C) *Dancing is unfounded in science.*
- D) *The body is a Pandora's box and not to be trusted.*

37. What is a primary reason that a structured movement practice may be a better fit for a client who is a newcomer to movement work, especially when compared with the conscious dance practices?
- A) *It is time-tested.*
- B) *The communal setting is healing.*
- C) *The Latin music makes it more fun*
- D) *There is a greater degree of structure which newcomer's may need to feel safe moving.*

38. In working with clients who might be more resistant to movement activities, one should
- A) *be open to client feedback.*
- B) *respect the art of variations and adjustments.*
- C) *provide more opportunities for instruction/structure.*
- D) *All of the above*

39. Which of the following is a cognitive-behavioral coping technique that pairs a visualization of a traditional stop sign and an intention to not engage a distressing negative cognition?
- A) *Guided imagery*
- B) *Thought stopping*
- C) *Diaphragmatic breathing*
- D) *None of the above*

40. Clinicians who are new to movement work can begin by adding a gesture to the thought stopping technique.
- A) *True*
- B) *False*

41. Progressive muscle relaxation, as a technique, originated in which therapeutic tradition/technique in the 1920s?
- A) *Psychoanalysis*
- B) *Bioenergetics*
- C) *Hypnotherapy*
- D) *The Alexander technique*

42. The technical phrase for back-and-forth motion used in EMDR therapy is
- A) *bilateral stimulation.*
- B) *left-to-right attention.*
- C) *dual attention stimulus.*
- D) *None of the above*

43. Which of the following activities includes bilateral motion and may be useful in therapy?
- A) *Taking a walk*
- B) *Doing jumping jacks*
- C) *Sitting and meditating quietly*
- D) *None of the above*

44. Besides movement, what may be one of the other primary psychotherapeutic benefits of taking a walk with a client during a session?
- A) *Physical exercise*
- B) *Not having to look the therapist in the eye*
- C) *Self-induced EMDR therapy benefits*
- D) *None of the above*

45. Which approach to psychotherapy is built upon the value of experiential education for improving self-esteem, positive self-concept, and other pro-social behavioral like cooperation, often in wilderness-based settings?
- A) *Gestalt psychotherapy*
- B) *Bioenergetics*
- C) *Adventure therapy*
- D) *Dance and movement therapy*

46. One technique that can be helpful for promoting boundary setting comes from the yoga mudra named
- A) *self-confidence.*
- B) *mountain pose.*
- C) *seal of knowledge.*
- D) *None of the above*

47. Which yoga pose consists of standing with a sense of embodied purpose?
- A) *Warrior pose*
- B) *Child's pose*
- C) *Mountain pose*
- D) *Pidgeon pose*

Test questions continue on next page ➔

48. What yoga breath technique can be helpful for releasing jaw tension?
- A) *Diaphragmatic breathing*
- B) *Lion breathing*
- C) *Ujjayi breathing*
- D) *Tension release breathing*

49. The unsent letter technique comes from which primary psychotherapeutic tradition?
- A) *Bioenergetics*
- B) *Dance and movement therapy*
- C) *Psychoanalysis*
- D) *Gestalt therapy*

50. Dancing Mindfulness, an approach to movement meditation, draws on the attitudes of mindfulness identified by
- A) *Martine Bachelor.*
- B) *Thich Nhat Hanh.*
- C) *Jon Kabat-Zinn.*
- D) *Ram Dass.*

51. Clinicians who are interested in furthering their education in dance/movement modalities can explore
- A) *the conscious dance routes.*
- B) *the more structured dance, movement, and expressive arts therapies routes.*
- C) *approaches to psychotherapy that typically are not viewed as dance/movement therapy but that incorporate movement and somatic work.*
- D) *Any of the above*

52. Which area of dance/movement would be the most optimal area of training for those interested in taking dance into the community beyond clinical settings?
- A) *Conscious dance*
- B) *An ADTA-approved Master's degree program*
- C) *Somatic experience or related training*
- D) *No training is discussed for this kind of work*

53. Which of the following is part of the American Dance Therapy Association's Code of Ethics and Standards?
- A) *Dance/movement therapists should consider the role of cultural context in the practice of therapy.*
- B) *Dance/movement therapists examine the meaning of their ethnic and cultural backgrounds and how they may affect cross-cultural therapy dynamics.*
- C) *Dance/movement therapists consider the impact of societal dynamics of power, privilege, and oppression on individual client experience and behavior.*
- D) *All of the above*

54. Which of the following statements regarding incorporation of Native American approaches into clinical therapy is TRUE?
- A) *Native American cultures have similar universal healing practices.*
- B) *All Native American practices are appropriate to adapt to behavioral health treatment settings.*
- C) *Clinicians from outside of Native communities can effectively adopt these practices without consultation and/or referral.*
- D) *Many traditional healing activities and ceremonies have been made accessible during treatment or effectively integrated into treatment settings.*

55. The purpose of expressive therapy groups is generally to
- A) *foster social interaction among group members as they engage either together or independently in a creative activity.*
- B) *to resolve the conflicts and ambiguities that result from the failure to integrate features of the personality.*
- C) *to produce rapid and effective change while the client maintains equilibrium during and between sessions.*
- D) *help you deal with overwhelming problems in a more positive way by breaking them down into smaller parts.*

Be sure to transfer your answers to the Answer Sheet located on the envelope insert.
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MANAGING AND PREVENTING BURNOUT
#71464 • 4 Hours
Book By Mail – $32 • ONLINE – $24
Purpose: Although work stress and burnout are present in every occupation, human service professionals, who spend their work lives attending to the needs of others, are at the highest risk. The purpose of this course is to orient the participants to the ramifications of not taking care of themselves and to promote strategies for enhancing health and well-being as individuals while working as professionals.
Faculty: Jamie Marich, PhD, LPCC-S, REAT, RYT-500, RMT
Audience: This course is designed for helping professionals of any kind, including counselors, social workers, therapists, and chemical dependency counselors, who require the tools necessary to address issues of work-life balance.

CHILDHOOD OBESITY: THE ROLE OF THE MENTAL HEALTH PROFESSIONAL
#72254 • 4 Hours
Book By Mail – $32 • ONLINE – $24
Purpose: The purpose of this course is to provide mental health professionals with the skills and motivation necessary to contribute to resolving the obesity epidemic.
Faculty: Barry Panzer, PhD, ACSW
Audience: This course is designed for mental health professionals, including social workers, counselors, and therapists, who are currently treating overweight or obese children and adolescents and their parents.

FRONTOTEMPORAL DEMENTIA
#76102 • 2 Hours
Book By Mail – $23 • ONLINE – $15
Purpose: Understanding the epidemiology, pathology, clinical features, diagnostic process, genetics, symptom treatment/management, role of brain autopsy, and current research provides a foundation for the care of patients with FTD and support for their families. The purpose of this course is to provide mental health professionals with current information on frontotemporal dementia (FTD).
Faculty: Ellen Steinbart, RN, MA; Lauren E. Evans, MSW
Audience: This course is designed for mental and behavioral health professionals who may intervene to support patients with frontotemporal dementia and their families.

FUNDAMENTALS OF TRAUMA PROCESSING
#76233 • 8 Hours
Book By Mail – $56 • ONLINE – $48
Purpose: The purpose of this course is to provide mental health professionals with the information necessary to assist clients to identify and process traumas that may be affecting their lives.
Faculty: Jamie Marich, PhD, LPCC-S, REAT, RYT-500, RMT
Audience: This course is designed for counselors, social workers, therapists, chemical dependency counselors, and psychologists who may encounter trauma-related disorders and their manifestations in professional settings.

BEHAVIORAL ADDICTIONS
#76412 • 15 Hours
Book By Mail – $98 • ONLINE – $90
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, LP
Audience: This course is designed for mental health practitioners who may intervene in diagnosing and treating behavioral addictions in their patients.

ALCOHOL AND ALCOHOL USE DISORDERS
#76564 • 10 Hours
Book By Mail – $68 • ONLINE – $60
Purpose: The purpose of this course is to address the ongoing alcohol competency educational needs of practicing mental and behavioral health providers. The material will include core competencies as well as knowledge, assessment, and treatment-based competencies.
Faculty: Mark S. Gold, MD, DFASAM, DLFAPA; William S. Jacobs, MD
Audience: This course is designed for mental and behavioral allied health professionals involved in the treatment or care of patients who consume alcohol.

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Course Availability List *(Cont'd)*

CLINICAL SUPERVISION: A PERSON-CENTERED APPROACH

Supervision

#76863 • 10 Hours

Book By Mail – $68 • ONLINE – $60

Purpose: The purpose of this course is to help supervisors or potential supervisors in the human services or helping professions to more effectively work with those they are entrusted to supervise.
Faculty: Jamie Marich, PhD, LPCC-S, LICDC-CS, REAT, RYT-200, RMT
Audience: This course is designed for professional clinicians, including counselors, social workers, therapists, psychologists, and pastoral counselors, who supervise others, clinically and/or administratively.
Special Approval: This course is designed to meet requirements for supervision education.

RACIAL TRAUMA: THE AFRICAN AMERICAN EXPERIENCE

MA Mandate

#76921 • 5 Hours

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to provide mental and behavioral health professionals with the knowledge and skills necessary to provide trauma-informed care to African American clients.
Faculty: Tanika Johnson, EdD, MA, LPC-MHSP, LMHC, NCC, BC-TMH, CCTP
Audience: This course is designed for mental and behavioral health professionals who provide services to African American clients who have experienced racial trauma.
Special Approval: This course meets the Massachusetts requirement for 2 hours of anti-racism and 1 hour of anti-discrimination education.

PROVIDING CARE TO ALASKA NATIVES

AK Mandate

#77091 • 3 Hours

Book By Mail – $26 • ONLINE – $18

Purpose: The purpose of this course is to provide mental and behavioral health professionals with the information necessary to provide the best possible care to Alaska Natives.
Faculty: Lauren E. Evans, MSW
Audience: This course is designed for social workers, therapists, and counselors who may provide care to Alaska Natives.
Special Approval: This course meets the Alaska requirement for 3 hours of cross-cultural education activity relating to Alaskan Natives.

ASSESSMENT AND MANAGEMENT OF PAIN AT THE END OF LIFE

Pain Mgmt

#77143 • 2 Hours

Book By Mail – $23 • ONLINE – $15

Purpose: Because pain is frequently encountered in the palliative and hospice care environments, a knowledge of appropriate diagnosis and alleviation is vital to all members of the interdisciplinary team. The purpose of this course is to provide an overview of the assessment and management of pain in the end of life, focusing on the components integral to providing optimum care.
Faculty: Lori L. Alexander, MTPW, ELS, MWC
Audience: This course is designed for social workers, counselors, and other members of the healthcare team seeking to enhance their knowledge of pain management.
Special Approval: This course meets the District of Columbia and Michigan requirements for pain management education.

AUTISM SPECTRUM DISORDER

#92204 • 5 Hours

Book By Mail – $38 • ONLINE – $30

Purpose: Autism spectrum disorder (ASD) has a significant impact on daily functioning and quality of life and has significant morbidity and disability associated with severe cases. However, it often goes unrecognized and is commonly underdiagnosed. The purpose of this course is to educate healthcare professionals about the epidemiology, diagnosis, and management of ASD. Additionally, this course will provide the information necessary to screen children seen in primary care for ASD in order to appropriately refer patients and their families for more expansive assessment and treatment referral as rapidly as possible in order to avoid unnecessary morbidity and mortality.
Faculty: Sharon M. Griffin, RN, PhD; Mary Franks, MSN, APRN, FNP-C
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.

HUMAN TRAFFICKING AND EXPLOITATION

MI Mandate

#96313 • 5 Hours

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to increase the level of awareness and knowledge about human trafficking and exploitation so health and mental health professionals can identify and intervene in cases of exploitation.
Faculty: Alice Yick Flanagan, PhD, MSW
Audience: This course is designed for physicians, nurses, social workers, pharmacy professionals, therapists, mental health counselors, and other members of the interdisciplinary team who may intervene in suspected cases of human trafficking and/or exploitation.
Special Approval: This course fulfills the Michigan requirement for training in identifying victims of human trafficking.

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

Course Availability List *(Cont'd)*

MENTAL HEALTH ISSUES COMMON TO VETERANS AND THEIR FAMILIES
#96342 • 2 Hours

Book By Mail – $23 • ONLINE – $15

Purpose: The purpose of this course is to provide health and mental health professionals with an appreciation of the impact of military service on patient health as well as the skills necessary to effectively identify and intervene for these patients.
Faculty: Alice Yick Flanagan, PhD, MSW; Mark Rose, BS, MA, LP
Audience: This course is designed for physicians, nurses, psychologists, social workers, therapists, counselors, and other healthcare professionals who may treat veterans or their family members.
Special Approvals: This course is designed to meet the Connecticut requirement for 2 hours of education on mental health conditions common to veterans and family members of veterans.

This course is designed to meet the West Virginia requirement for 2 hours of education on mental health conditions common to veterans and family members of veterans.

IMPLICIT BIAS: THE MICHIGAN REQUIREMENT
#97440 • 2 Hours

ONLINE ONLY – $30

Purpose: The purpose of this course is to provide healthcare professionals with an overview of the impact of implicit biases on clinical interactions and decision making.
Faculty: Alice Yick Flanagan, PhD, MSW
Audience: This course is designed for the interprofessional healthcare team and professions working in all practice settings in Michigan.
Special Approval: This course meets the Michigan requirement for 2 hours of implicit bias training.

HUMAN TRAFFICKING AND EXPLOITATION: THE TEXAS REQUIREMENT
#97471 • 1 Hour

Book By Mail – $23 • ONLINE – $15

Purpose: As human trafficking becomes an increasingly more common problem in the United States, healthcare and mental health professionals will require knowledge of human trafficking patterns, the health and mental health needs of human trafficking victims, and successful interventions for victims. The purpose of this course is to increase the level of awareness and knowledge about human trafficking and exploitation so health and mental health professionals can identify and intervene in cases of exploitation.
Faculty: Alice Yick Flanagan, PhD, MSW
Audience: This course is designed for Texas physicians, nurses, social workers, pharmacy professionals, therapists, mental health counselors, and other members of the interdisciplinary team who may intervene in suspected cases of human trafficking and/or exploitation.
Special Approval: This course has been approved by the Texas Health and Human Services Commission (HHSC) to meet the requirements for human trafficking training.

INTERCULTURAL COMPETENCE AND PATIENT-CENTERED CARE
#97510 • 4 Hours

Book By Mail – $32 • ONLINE – $24

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

CANNABINOID OVERVIEW
#98010 • 3 Hours

Book By Mail – $26 • ONLINE – $18

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

GERIATRIC FAILURE TO THRIVE: A MULTIDIMENSIONAL PROBLEM
#99204 • 5 Hours

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to educate nurses, social workers, and other healthcare providers regarding geriatric failure to thrive and to promote evidence-based clinical practice when caring for patients with this condition.
Faculty: Susan Waterbury, MSN, FNP-BC, ACHPN
Audience: This course is designed for nurses, nurse practitioners, and behavioral health professionals who work in or are interested in learning more about geriatrics. Other disciplines that may benefit from this training include dieticians, therapists, and psychologists.

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

Social Worker Continuing Education Requirements by State

State	Approval Accepted by Board	Hours Allowed by Home Study
Alabama	#0515	20✶, ⧫
Alaska	ASWB	45✶, ❖, ⧫
Arizona	ASWB	30✶, ❖
Arkansas	Approved	15✶
California	ASWB	36✶, ⧫
Colorado	Approved	40 (Coursework)
Connecticut	ASWB	6❖, ⧫
Delaware	ASWB	LCSW 40✶, ⧫; LMSW 30✶, ⧫; LBSW 20✶, ⧫
District of Columbia	ASWB	12✶, ⧫
Florida	#50-2405	30✶, ⧫
Georgia	ASWB	10✪
Hawaii	ASWB	45✶
Idaho	ASWB	20✶
Illinois	#159.001094	30✶, ❖, ⧫
Indiana	ASWB	40✶
Iowa	ASWB	27✶, ⧫
Kansas	Accepted by Board	40✶, ⧫
Kentucky	ASWB	LCSW, CSW 27♠, ⧫; LSW 12♠, ⧫
Louisiana	Accepted by Board	10✶, ⧫
Maine	Accepted by Board	10✶, ⧫
Maryland	ASWB	LCSW, LCSW-C 20✶, ⧫; LBSW 15✶, ⧫
Massachusetts	ASWB	LICSW 30⧫; LCSW 20⧫; LSW 15⧫; LSWA 10⧫
Michigan	ASWB	22.5✶, ⧫
Minnesota	ASWB	20✶, ⧫
Mississippi	ASWB	20✶, ⧫, ❖
Missouri	ASWB	30✶, ⧫, ❖
Montana	Accepted by Board of Scope of Practice	20⧫
Nebraska	ASWB	20✶
Nevada	ASWB	LASW, LSW 30✶, ❖, ⧫; LISW, LCSW 36✶, ❖, ⧫
New Hampshire	ASWB	20✶, ⧫
New Jersey	NASW-NJ	LCSW 40✶, ❖, ⧫; LSW 30✶, ❖, ⧫; CSW 20✶, ❖, ⧫
New Mexico	ASWB	30⧫, ❖
New York	SW-0033	12⧫
North Carolina	ASWB	20✶
North Dakota	ASWB	10✶
Ohio	ASWB	LISW 30⧫, ✶; LSW 30✶; SWA 15✶
Oklahoma	ASWB	8✶
Oregon	ASWB	LCSW 40⧫, ✶, ❖; LMSW 30⧫, ✶, ❖; RBSW 20⧫, ✶, ❖
Pennsylvania	ASWB	30✶, ⧫
Rhode Island	ASWB	8✶, ❖
South Carolina	ASWB	40
South Dakota	ASWB	30
Tennessee	Accepted by Board	LCSW, LAPSW 15✶, ⧫; LMSW 12✶, ⧫; LBSW 9✶, ⧫
Texas	Accepted by Board	30✶, ❖, ⧫
Utah	ASWB	LCSW 15✶, ⧫; CSW, SSW 8✶, ⧫
Vermont	ASWB	LICSW 5✶; LMSW 10✶
Virginia	ASWB	LCSW 30✶; LBSW, LMSW 15✶
Washington	ASWB	SWIs, SWAs 26✶, ⧫; SWIA, SWAAs 18✶, ⧫
West Virginia	ASWB	20✶, ⧫
Wisconsin	ASWB	26✪
Wyoming	ASWB	45✶, ⧫

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#93010 MATERNAL HEALTH DISPARITIES—4 HOURS

Please refer to pages 14–16.

Expiration Date: 10/31/26 *May be taken individually for $24*

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

#77233 ETHICS FOR SOCIAL WORK—6 HOURS

Please refer to pages 38–40.

Expiration Date: 06/30/26 *May be taken individually for $36*

	A	B	C	D		A	B	C	D		A	B	C	D		A	B	C	D
1.	❍	❍	❍	❍	11.	❍	❍	❍	❍	21.	❍	❍	❍	❍	31.	❍	❍	❍	❍
2.	❍	❍	❍	❍	12.	❍	❍	❍	❍	22.	❍	❍	❍	❍	32.	❍	❍	❍	❍
3.	❍	❍	❍	❍	13.	❍	❍	❍	❍	23.	❍	❍	❍	❍	33.	❍	❍	❍	❍
4.	❍	❍	❍	❍	14.	❍	❍	❍	❍	24.	❍	❍	❍	❍	34.	❍	❍	❍	❍
5.	❍	❍	❍	❍	15.	❍	❍	❍	❍	25.	❍	❍	❍	❍	35.	❍	❍	❍	❍
6.	❍	❍	❍	❍	16.	❍	❍	❍	❍	26.	❍	❍	❍	❍					
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#76442 SUICIDE ASSESSMENT AND PREVENTION—6 HOURS

Please refer to pages 63–65.

Expiration Date: 03/31/26 *May be taken individually for $36*

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

#78250 MOVEMENT AND DANCE IN PSYCHOTHERAPY—10 HOURS

Please refer to pages 88–92.

Expiration Date: 03/31/27 *May be taken individually for $60*

	A	B	C	D		A	B	C	D		A	B	C	D		A	B	C	D
1.	❍	❍	❍	❍	16.	❍	❍	❍	❍	31.	❍	❍	❍	❍	46.	❍	❍	❍	❍
2.	❍	❍	❍	❍	17.	❍	❍	❍	❍	32.	❍	❍	❍	❍	47.	❍	❍	❍	❍
3.	❍	❍	❍	❍	18.	❍	❍	❍	❍	33.	❍	❍	❍	❍	48.	❍	❍	❍	❍
4.	❍	❍	❍	❍	19.	❍	❍	❍	❍	34.	❍	❍	❍	❍	49.	❍	❍	❍	❍
5.	❍	❍	❍	❍	20.	❍	❍	❍	❍	35.	❍	❍	❍	❍	50.	❍	❍	❍	❍
6.	❍	❍	❍	❍	21.	❍	❍	❍	❍	36.	❍	❍	❍	❍	51.	❍	❍	❍	❍
7.	❍	❍	❍	❍	22.	❍	❍	❍	❍	37.	❍	❍	❍	❍	52.	❍	❍	❍	❍
8.	❍	❍	❍	❍	23.	❍	❍	❍	❍	38.	❍	❍	❍	❍	53.	❍	❍	❍	❍
9.	❍	❍	❍	❍	24.	❍	❍	❍	❍	39.	❍	❍	❍	❍	54.	❍	❍	❍	❍
10.	❍	❍	❍	❍	25.	❍	❍	❍	❍	40.	❍	❍	❍	❍	55.	❍	❍	❍	❍
11.	❍	❍	❍	❍	26.	❍	❍	❍	❍	41.	❍	❍	❍	❍					
12.	❍	❍	❍	❍	27.	❍	❍	❍	❍	42.	❍	❍	❍	❍					
13.	❍	❍	❍	❍	28.	❍	❍	❍	❍	43.	❍	❍	❍	❍					
14.	❍	❍	❍	❍	29.	❍	❍	❍	❍	44.	❍	❍	❍	❍					
15.	❍	❍	❍	❍	30.	❍	❍	❍	❍	45.	❍	❍	❍	❍					

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Evaluation

(Completion of this form is mandatory)

SW24

Last Name ____ First Name ________________________________ MI _____

State _________________________ License # ___________________________________ Expiration Date _____________

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

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

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

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

	#93010 4 Hours	**#77233** 6 Hours	**#76442** 6 Hours	**#78250** 10 Hours
1.	☐ New ☐ Review	☐ New ☐ Review	☐ New ☐ Review	☐ New ☐ Review
2.	____ Hours	____ Hours	____ Hours	____ Hours
3.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
11.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
12.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
13.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
14.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
15.	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A

#93010 Maternal Health Disparities — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? ____

____

#77233 Ethics for Social Work — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? ____

____

#76442 Suicide Assessment and Prevention — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? ____

____

#78250 Movement and Dance in Psychotherapy — If you answered YES to question #14, how specifically will this activity enhance your role as a member of the interprofessional team? ____

____

Signature ____

Signature required to receive continuing education credit.

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Evaluation *(Continued)*

SW24

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):					
#93010 MATERNAL HEALTH DISPARITIES—4 HOURS (Course expires 10/31/26)					
• Outline the epidemiology of maternal morbidity and mortality.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss how explicit and implicit bias may contribute to pregnancy-related deaths and maternal and infant health outcomes.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify cultural identity across racial, ethnic, and other marginalized groups, including historical and contemporary exclusion and oppression.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify environmental, personal, interpersonal, institutional, and cultural barriers to inclusion.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe effective approaches to communicate more effectively across racial, ethnic, religious, and gender identities.	☐ A	☐ B	☐ C	☐ D	☐ F
• Review information about racial and reproductive justice.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify measures to decrease explicit and implicit bias at the interpersonal and institutional levels.	☐ A	☐ B	☐ C	☐ D	☐ F
#77233 ETHICS FOR SOCIAL WORK—6 HOURS (Course expires 06/30/26)					
• Discuss the historical context of ethics in social work and the emergence of the National Association of Social Workers (NASW) Code of Ethics.	☐ A	☐ B	☐ C	☐ D	☐ F
• Define common terms such as ethics, morality, ethical dilemmas, and ethical principles.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify the purpose and functions of the NASW Code of Ethics.	☐ A	☐ B	☐ C	☐ D	☐ F
• Differentiate between deontologic, teleologic, motivist, natural law, transcultural ethical, and ethical relativism theories.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss the relationship between ethical theories and the NASW Code of Ethics.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify the different ethical decision-making models.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss the psychologic context of ethical decision making by applying the Lawrence Kohlberg's theory of moral development.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss ethical issues that emerge with social work practice under managed care systems.	☐ A	☐ B	☐ C	☐ D	☐ F
#76442 SUICIDE ASSESSMENT AND PREVENTION—6 HOURS (Course expires 03/31/26)					
• Review the epidemiology of suicide.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe the impact of suicide in the treatment of special populations, including among military veterans.	☐ A	☐ B	☐ C	☐ D	☐ F
• Identify risk and protective factors for suicide.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss warning signs of imminent suicide and the importance of lethal means.	☐ A	☐ B	☐ C	☐ D	☐ F
• Evaluate tools available for the assessment and evaluation of suicide risk.	☐ A	☐ B	☐ C	☐ D	☐ F
• Outline key components of an effective suicide prevention plan.	☐ A	☐ B	☐ C	☐ D	☐ F
#78250 MOVEMENT AND DANCE IN PSYCHOTHERAPY—10 HOURS (Course expires 03/31/27)					
• Describe movement and dance in the context of psychotherapy.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe how various world cultures have used movement, dance, and ritual for emotional healing as a separate entity from modern psychology.	☐ A	☐ B	☐ C	☐ D	☐ F
• Outline the work of earlier pioneers in the psychotherapeutic and dance professions who used movement in healing.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe how the field of dance and movement therapy emerged as its own discipline.	☐ A	☐ B	☐ C	☐ D	☐ F
• Define conscious dance and explain its differences to dance therapy.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss the importance of movement to healing the limbic area of the brain affected by trauma.	☐ A	☐ B	☐ C	☐ D	☐ F
• Summarize the psychotherapeutic profession's research findings and applications for working with mindfulness, movement, and yoga.	☐ A	☐ B	☐ C	☐ D	☐ F
• Describe how to assess clients for the appropriateness of movement-based adjuncts in clinical therapy.	☐ A	☐ B	☐ C	☐ D	☐ F
• Discuss how adding simple movement techniques can enhance traditional, talk-based therapy, and apply basic movement-related exercises to existing clinical work.	☐ A	☐ B	☐ C	☐ D	☐ F
• Decide whether or not further training in movement-related modalities is a good fit for one's own clinical repertoire.	☐ A	☐ B	☐ C	☐ D	☐ F

Signature ______________________________________

Signature required to receive continuing education credit.

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