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The Pennsylvania State Board of Social Workers, Marriage and Family Therapists and Professional Counselors accepts courses from any provider who is approved by ASWB and/or APA.

Child Abuse Identification and Reporting: The Pennsylvania Requirement

This course is approved by the Pennsylvania Department of Human Services to fulfill the requirement for 2 hours of Child Abuse Recognition and Reporting (Act 31) training for healthcare professionals renewing their license. Provider number CACE000020.

Audience
This course is designed for all Pennsylvania health professionals required to complete child abuse education.

Course Objective
The purpose of this course is to enable healthcare professionals in all practice settings to define child abuse and identify the children who are affected by violence. This course describes how a victim can be accurately diagnosed and identifies the community resources available in the state of Pennsylvania for child abuse victims.

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

1. Summarize the historical context of child abuse.
2. Discuss the emergence of the child welfare system in Pennsylvania.
3. Define child abuse and neglect and identify the different forms of child abuse and neglect.
4. Discuss the scope of child abuse and neglect in the United States and specifically in Pennsylvania.
5. Review the mandatory reporting process and mandated reporters in the state of Pennsylvania, including possible barriers to reporting suspected cases of child abuse.

Faculty
Alice Yick Flanagan, PhD, MSW. (A complete biography can be found at NetCE.com.)

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

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

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Designations of Credit

Social workers completing this intermediate-to-advanced course receive 3 Clinical continuing education credits.

NetCE designates this continuing education activity for 3 CE credits.

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

Special Approvals

This course is approved by the Pennsylvania Department of Human Services to fulfill the requirement for 3 hours of Child Abuse Recognition and Reporting (Act 31) training for healthcare professionals applying for licensure. Provider number CACE000020.

This course is approved by the Pennsylvania Department of Human Services to fulfill the requirement for 2 hours of Child Abuse Recognition and Reporting (Act 31) training for healthcare professionals renewing their license. Provider number CACE000020.

About the Sponsor

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

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

Disclosure Statement

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HISTORICAL CONTEXT

Today, there is an established system in the United States to respond to reports of child abuse and neglect; however, this has not always been the case. This is not because child abuse, neglect, and maltreatment are new social phenomena. Rather, the terms "child abuse," "child neglect," and "child maltreatment" are relatively new, despite the fact that this social problem has existed for thousands of years [1]. Cruelty to children by adults has been documented throughout history and across cultures. In China, infant girls were often neglected during times of famine or sold during times of extreme poverty. There is also historical evidence that cultures have taken steps to stop child abuse and cruelty. For example, 6,000 years ago in Mesopotamia, orphans had their own patron goddesses for help and protection [2].

In many cases, the physical abuse of children has been linked to punishment. Throughout history, physical child abuse was justified because it was believed that severe physical punishment was necessary to discipline, rid the child of evil, or educate [2; 13]. It was not until 1861 that there was a public outcry in the United States against extreme corporal punishment. This reform was instigated by Samuel Halliday, who reported the occurrence of many child beatings by parents in New York City [2].

Sexual abuse of children, particularly incest (defined as sex between family members), is very much a taboo. The first concerted efforts to protect children from sexual abuse occurred in England during the 16th century. During this period, boys were protected from forced sodomy and girls younger than 10 years of age from forcible rape [2]. However, in the 1920s, sexual abuse of children was described solely as an assault committed by "strangers," and the victim of such abuse was perceived as a "temptress" rather than an innocent child [2].

The first public case of child abuse in the United States that garnered widespread interest took place in 1866 in New York City. Mary Ellen Wilson was an illegitimate child, 10 years of age, who lived with her foster parents [3]. Neighbors were concerned that she was being mistreated; however, her foster

parents refused to change their behaviors and said that they could treat the child as they wished [2]. Because there were no agencies established to protect children specifically, Henry Berge, founder of the Society for the Prevention of Cruelty to Animals, intervened on Mary's behalf [3]. He argued that she was a member of the animal kingdom and deserved protection. The case received much publicity, and as a result, in 1874 the New York Society for the Prevention of Cruelty to Children was formed [3]. Because of this case, every state now has a system in place for reporting child abuse. The Pennsylvania Department of Public Welfare (now known as the Department for Human Services) was established in 1921 and part of its original intent was to care for "dependent, defective, and delinquent children" [7].

As a result of Berge's advocacy for children's safety, other nongovernmental agencies were formed throughout the United States, and the establishment of the juvenile court was a direct result of the Society for the Prevention of Cruelty to Children [13]. By 1919, all but three states had juvenile courts. However, many of these nongovernmental agencies could not sustain themselves during the Depression [13].

The topic of child abuse and neglect received renewed interest in the 1960s, when a famous study titled "The Battered-Child Syndrome" was published [1; 4]. In the study, researchers argued that the battered-child syndrome consisted of traumatic injuries to the head and long bones, most commonly to children younger than 3 years of age, inflicted by parents [1; 4]. The study was viewed as the seminal work on child abuse, alerting both the general public and the academic community to the problems of child abuse [1; 2]. Soon, all 50 states required physicians to report child abuse [14]. In the early 1970s, Senator Walter Mondale noted that there was no official agency that spent its energies on preventing and treating child maltreatment [13]. Congress passed the Child Abuse Prevention and Treatment Act (CAPTA) of 1974, which targeted federal funds to improve states' interventions for the identification and reporting of abuse [13]. In 2010, additional prevention and treatment programs were funded through CAPTA, and in 2012, the Administration on Children, Youth, and Families began to focus on protective factors to child abuse and neglect [61].

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

CHILD WELFARE IN PENNSYLVANIA

The Children's Aid Society of Pennsylvania, one of the first organizations to advocate for children and their welfare in the United States, was founded in 1882 [62]. In the following years, the Children's Aid Society was instrumental in educating the public about the unsanitary and unsafe conditions in almshouses, which were sometimes used for orphaned or abandoned children. Subsequently, legislation was passed in Pennsylvania to ensure that children were not permanently placed in almshouses [62].

In the state of Pennsylvania, Act 91 was passed in 1967 and gave child welfare agencies in all counties the responsibility to investigate child abuse reports made by physicians [18]. Three years later, Act 91 was modified to include school nurses and teachers as mandated reporters [18].

Pennsylvania was also the first state to take a noncriminal view of child abuse [22; 26]. In 1975, the Child Protective Services Law was enacted, which established a child abuse hotline and a statewide central registry in Pennsylvania in order to encourage the reporting of child abuse [18; 26].

The child welfare system in Pennsylvania is supervised by the state but administered by the different local counties [27]. This means that there are a total of 67 county agencies that administer the child welfare and juvenile justice services [27]. Aside from frank abuse, reports of other acts that might affect the well-being of a child are also accepted. The State of Pennsylvania delineates two functions for the local agencies: child protective services (CPS) and general protective services (GPS).

In 2016, SB1311 (Act 115) was signed and went into effect. This Act provides for additional grounds for involuntary termination of parental rights, provides for an additional grounds for aggravated circumstances, allows for the release of information in confidential reports to law enforcement when investigating cases of severe forms of trafficking in persons of sex trafficking, and adds a category of child abuse to include human trafficking. In 2017, Governor Tom Wolf approved Act 68 (also known as the Newborn Protection Act) to increase the number of locations for parents to give up their newborn without criminal liability [63]. In 2018, Act 29 was signed and expanded the definition of child abuse in Pennsylvania to include leaving a child unsupervised with a sexual predator [64]. That same year, Act 54 was signed and required mandatory notification when a medical provider has determined that a child (younger than 1 year of age) was born affected by substance use or withdrawal symptoms resulting from prenatal drug or alcohol exposure. This Act also mandates the development of "interagency protocols" to support local multidisciplinary teams to identify, assess, and develop a plan of safe care for infants born affected by substance use or withdrawal symptoms. In 2019, Act 88, relating to penalties for failure to report or refer, was enacted.

CHILD PROTECTIVE SERVICES

CPS is in place to address acts that are "non-accidental serious physical or mental injury, sexual abuse, or exploitation, or serious physical neglect caused by acts or omissions of the parent or caretaker" [32]. In other words, these are cases in which there is reasonable cause to suspect child abuse and conduct an investigation.

Case Scenario

A young boy comes into the community health clinic for a physical exam. The boy's mother hovers and does not seem to want to let her son answer any questions. During the exam, in the process of taking blood, the nurse notices some bruises and lacerations on the boy's arm. Later, bruises in the shape of a belt are observed on the boy's back as well. Upon questioning, the boy will only say that he was "bad."

In this case, the nurse should make a report to ChildLine. This would be classified as a CPS case, and an investigation would be conducted. More information will be presented about reporting in later sections of this course.

GENERAL PROTECTIVE SERVICES

GPS is involved in non-abuse cases or acts that involve "non-serious injury or neglect" [38]. This includes children who experience "inadequate shelter, food, clothing, health care, truancy, inappropriate discipline, lack of supervision, hygiene issues, abandonment, or other problems that threaten a child's opportunity for healthy growth and development" [38]. One of the following criteria must be met for GPS to be involved [55]:

- Lack of parental control
- Deprivation of the essentials of life
- Illegal placement for adoption or care
- Abandonment by parents or guardians
- Chronic truancy
- Habitual disobedience
- Formal adjudication
- Commitment of a delinquent act at an age younger than 10 years
- Defined as ungovernable
- Born to parents with terminated parental rights

Case Scenario

Ms. J, a neighbor, notices E (5 years of age) and S (6 years of age) running around their front yard at 8 p.m. The front door of the house is wide open, and Ms. J asks if their mother is home. S states that her mother went out with her girlfriend to a party. Ms. J asks if a baby-sitter is at the house, and S answers "no" again. This is not the first time neighbors have noticed that the kids are left at home alone. The neighbors report that the mother often comes home late, intoxicated.

In this case, a bystander (likely Ms. J or one of the neighbors) could call ChildLine, the local county agency, or even the police, and the case would be addressed by GPS. More information will be presented about reporting in later sections of this course.

DEFINITIONS OF CHILD ABUSE AND NEGLECT

The federal definition of child abuse is evident in CAPTA, published as a product of federal legislation. CAPTA defines a child to be any individual younger than 18 years of age, except in cases of sexual abuse. In cases of sexual abuse, the age specified by the child protection laws varies depending on the state in which the child resides [5]. CAPTA defines child abuse as, "any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act that presents an imminent risk of serious harm" [6].

In Pennsylvania, the child abuse law takes a very comprehensive approach to defining of child abuse [26]. According to Pennsylvania law, child abuse refers to intentionally, knowingly, or recklessly doing any of the following [43; 54]:

- Causing bodily injury to a child through any recent act or failure to act
- Fabricating, feigning, or intentionally exaggerating or inducing a medical symptom or disease that results in a potentially harmful medical evaluation or treatment to the child through any recent act
- Causing or substantially contributing to serious mental injury to a child through any act or failure to act or a series of such acts or failures to act
- Causing sexual abuse or exploitation of a child through any act or failure to act
- Creating a reasonable likelihood of bodily injury to a child through any recent act or failure to act
- Creating a likelihood of sexual abuse or exploitation of a child through any recent act or failure to act
- Causing serious physical neglect of a child
- Engaging in any of the following recent acts:
  - Kicking, biting, throwing, burning, stabbing, or cutting a child in a manner that endangers the child
  - Unreasonably restraining or confining a child, based on consideration of the method, location, or duration of the restraint or confinement
  - Forcefully shaking a child younger than 1 year of age
  - Forcefully slapping or otherwise striking a child younger than 1 year of age
  - Interfering with the breathing of a child
  - Causing a child to be present at a location while a violation relating to the operation of methamphetamine laboratory is occurring, provided that the violation is being investigated by law enforcement
  - Leaving a child unsupervised with an individual, other than the child's parent, who the actor knows or reasonably should have known a) is required to register as a Tier II or Tier III sexual offender, where the victim of the sexual offense was younger than 18 years of age when the crime was committed; b) has been determined to be a sexually violent predator; or c) has been determined to be a sexually violent delinquent child

- Causing the death of the child through any act or failure to act

- Engaging a child in a severe form of trafficking in persons or sex trafficking, as those terms are defined under section 103 of the Trafficking Victims Protection Act of 2000

In addition, the Code explicitly excludes specific acts and injuries from the definition of child abuse. Effective December 31, 2014, the following are considered exclusions to the definition of child abuse [44]:

- Environmental factors: No child shall be deemed to be physically or mentally abused based on injuries that result solely from environmental factors, such as inadequate housing, furnishings, income, clothing, and medical care, that are beyond the control of the parent or person responsible for the child's welfare with whom the child resides. This shall not apply to any child-care service, excluding an adoptive parent.

- Practice of religious beliefs: If, upon investigation, the county agency determines that a child has not been provided needed medical or surgical care because of sincerely held religious beliefs of the child's parents or relative within the third degree of consanguinity and with whom the child resides, which beliefs are consistent with those of a bona fide religion, the child shall not be deemed to be physically or mentally abused. In such cases the following shall apply:

  - The county agency shall closely monitor the child and the child's family and shall seek court-ordered medical intervention when the lack of medical or surgical care threatens the child's life or long-term health.

  - All correspondence with a subject of the report and the records of the department and the county agency shall not reference child abuse and shall acknowledge the religious basis for the child's condition.

  - The family shall be referred for general protective services, if appropriate.

  - This subsection shall not apply if the failure to provide needed medical or surgical care causes the death of the child.

  - This subsection shall not apply to any child-care service as defined in this chapter, excluding an adoptive parent.

- Use of force for supervision, control, and safety purposes: Subject to the rights of parents, the use of reasonable force on or against a child by the child's own parent or person responsible for the child's welfare shall not be considered child abuse if any of the following conditions apply:

  - The use of reasonable force constitutes incidental, minor, or reasonable physical contact with the child or other actions that are designed to maintain order and control.

  - The use of reasonable force is necessary to quell a disturbance or remove the child from the scene of a disturbance that threatens physical injury to persons or damage to property; to prevent the child from self-inflicted physical harm; for self-defense or the defense of another individual; or to obtain possession of weapons or other dangerous objects or controlled substances or paraphernalia that are on the child or within the control of the child.

- Rights of parents: Nothing in this chapter shall be construed to restrict the generally recognized existing rights of parents to use reasonable force on or against their children for the purposes of supervision, control, and discipline of their children. Such reasonable force shall not constitute child abuse.

- Participation in events that involve physical contact with child: An individual partici-pating in a practice or competition in an interscholastic sport, physical education, recreational activity, or extracurricular activity that involves physical contact with a child does not, in itself, constitute contact that is subject to the reporting requirements of this chapter.

- Defensive force: Reasonable force for self-defense or the defense of another individual shall not be considered child abuse.

  - Child-on-child contact: Harm or injury to a child that results from the act of another child shall not constitute child abuse unless the child who caused the harm or injury is a perpetrator. Notwithstanding this, the following shall apply: Acts constituting any of the following crimes against a child shall be subject to the reporting requirements: rape, involuntary deviate sexual intercourse, sexual assault, aggravated indecent assault, indecent assault, and indecent exposure.

  - No child shall be deemed to be a perpetrator of child abuse based solely on physical or mental injuries caused to another child in the course of a dispute, fight, or scuffle entered into by mutual consent.

  - A law enforcement official who receives a report of suspected child abuse is not required to make a report to the department if the person allegedly responsible for the child abuse is a nonperpetrator child.

It is important to note that exclusions are utilized by the CPS agency when investigating suspected abuse and should not be considered exclusions from reporting suspected abuse.

For the purposes of this course, a perpetrator is defined as a person who has committed child abuse. According to the Pennsylvania Code, the term includes only [42; 54]:

- A parent of the child
- A spouse or former spouse of the child's parent
- A paramour or former paramour of the child's parent
- A person 14 years of age or older and responsible for the child's welfare, including a person who provides temporary or permanent care, supervision, mental health diagnosis or treatment, or training or control of a child in lieu of parental care, supervision, and control
- An individual 14 years of age or older who resides in the same home as the child
- An individual 18 years of age or older who does not reside in the same home as the child but is related within the third degree of consanguinity or affinity by birth or adoption to the child
- An individual 18 years of age or older who engages a child in severe forms of trafficking in persons or sex trafficking, as those terms are defined under section 103 of the Trafficking Victims Protection Act of 2000

In a significant revision to the definition of perpetrator, school personnel and other childcare providers are considered "individuals responsible for the child's welfare" and may be perpetrators of child abuse; there is no longer a separate definition for student abuse [42]. As such, a perpetrator may be any such person who has direct or regular contact with a child through any program, activity, or services sponsored by a school, for-profit organization, or religious or other not-for-profit organization.

In addition, only the following may be considered a perpetrator for failing to act [42; 54]:

- A parent of the child
- A spouse or former spouse of the child's parent
- A paramour or former paramour of the child's parent
- A person 18 years of age or older and responsible for the child's welfare or who resides in the same home as the child

FORMS OF CHILD ABUSE AND NEGLECT

There are several acts that may be considered abusive, and knowledge of what constitutes abuse is vital for healthcare providers and other mandated reporters. In this section, specific behaviors that fall under the category of abuse and neglect will be reviewed.

Bodily Injury

Bodily injury, or physical abuse injuries, can range from minor bruises and lacerations to severe neurologic trauma and death. Physical abuse is one of the most easily identifiable forms of abuse and the type most commonly seen by healthcare professionals. Physical injuries that may be indicative of abuse include bruises/welts, burns, fractures, abdominal injuries, lacerations/abrasions, and central nervous system trauma [8; 34].

Bruises and welts are of particular concern, especially those that appear on:

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

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

Fractures that result from abuse might be found on the child's skull, ribs, nose, or any facial structure. These may be multiple or spiral fractures at various stages of healing. When examining patients, note bruises on the abdominal wall, any intestinal perforation, ruptured liver or spleen, and blood vessel, kidney, bladder, or pancreatic injury, especially if accounts for the cause do not make sense. Look for signs of abrasions on the child's wrists, ankles, neck, or torso. Lacerations might also appear on the child's lips, ears, eyes, mouth, or genitalia. If violent shaking or trauma occurred, the child might experience a subdural hematoma [8; 34].

Sexual Abuse/Exploitation

According to the Pennsylvania Code, sexual abuse or exploitation is defined as [45]:

- The employment, use, persuasion, inducement, enticement, or coercion of a child to engage in or assist another individual to engage in sexually explicit conduct, which includes, but is not limited to, the following:
  - Looking at the sexual or other intimate parts of a child or another individual for the purpose of arousing or gratifying sexual desire in any individual
  - Participating in sexually explicit conversation either in person, by telephone, by computer, or by a computer-aided device for the purpose of sexual stimulation or gratification of any individual
  - Actual or simulated sexual activity or nudity for the purpose of sexual stimulation or gratification of any individual
  - Actual or simulated sexual activity for the purpose of producing visual depiction, including photographing, videotaping, computer depicting, or filming
- Any of the following offenses committed against a child:
  - Rape
  - Statutory sexual assault
  - Involuntary deviate sexual intercourse

    – Sexual assault

    – Institutional sexual assault

    – Aggravated indecent assault

    – Indecent assault

    – Indecent exposure

    – Incest

    – Prostitution

    – Sexual abuse

    – Unlawful contact with a minor

    – Sexual exploitation

This does not include consensual activities between a child who is 14 years of age or older and another person who is 14 years of age or older and whose age is within four years of the child's age.

Child sexual abuse can be committed by a stranger or an individual known to the child. Sexual abuse may be manifested in many different ways, including [9; 10]:

- Verbal: Obscene phone calls or talking about sexual acts for the purpose of sexually arousing the adult perpetrator

- Voyeurism: Watching a child get dressed or encouraging the child to masturbate while the perpetrator watches

- Child prostitution: Involving the child in sexual acts for monetary profit

- Child pornography: Taking photos of a child in sexually explicit poses or acts

- Exhibitionism: Exposing his/her genitals to the child or forcing the child to observe the adult or other children in sexual acts

- Molestation: Touching, fondling, or kissing the child in a provocative manner; for example, fondling the child's genital area or long, lingering kisses

- Sexual penetration: The penetration of part of the perpetrator's body (e.g., finger, penis, tongue) into the child's body (e.g., mouth, vagina, anus)

- Rape: Usually involves sexual intercourse without the victim's consent and usually involves violence or the threat of violence

- Commercial sex act: Any sex act on account of which anything of value is given to or received by any person

Serious Physical Neglect

Pennsylvania law defines serious physical neglect of a child as repeated, prolonged, or egregious failure to supervise a child in a manner that is appropriate considering the child's developmental age and abilities, and/or the failure to provide a child with adequate essentials of life, including food, shelter, or medical care, when committed by a perpetrator that endangers a child's life or health, threatens a child's well-being, causes bodily injury, or impairs a child's health, development, or functioning. Due to the ambiguity of definitions of child abuse and neglect, CAPTA provides minimum standards that each state must incorporate in its definition of neglect. Examples of child neglect may include [6; 11; 12]:

- Failure to provide adequate food, clothing, shelter, hygiene, supervision, and protection

- Refusal and/or delay in medical attention and care (e.g., failure to provide needed medical attention as recommended by a healthcare professional or failure to seek timely and appropriate medical care for a health problem)

- Abandonment, characterized by desertion of a child without arranging adequate care and supervision. Children who are not claimed within two days or who are left alone with no supervision and without any information about their parents'/caretakers' whereabouts are examples of abandonment.

- Expulsion or blatant refusals of custody on the part of parent/caretaker, such as ordering a child to leave the home without adequate arrangement of care by others

- Inadequate supervision (i.e., child is left unsupervised or inadequately supervised for extended periods of time)

Serious Mental Injury

Under Pennsylvania law, serious mental injury (or emotional or psychological abuse) involves an act or failure to act by a perpetrator that causes nonaccidental serious mental injury. Serious mental injury is "a psychological condition, as diagnosed by a physician or licensed psychologist, including the refusal of appropriate treatment, that renders a child chronically and severely anxious, agitated, depressed, socially withdrawn, psychotic, or in reasonable fear that his or her life or safety is threatened, or that seriously interferes with a child's ability to accomplish age-appropriate development and social tasks" [45].

The following behaviors could constitute emotional abuse [6; 11; 12]:

- Verbal abuse: Belittling or making pejorative statements in front of the child, which results in a loss or negative impact on the child's self-esteem or self-worth

- Inadequate nurturance/affection: Inattention to the child's needs for affection and emotional support

- Witnessing domestic violence: Chronic spousal abuse in homes where the child witnesses the violence

- Substance and/or alcohol abuse: The parent/caretaker is aware of the child's substance misuse problem but chooses not to intervene or allows the behavior to continue

- Refusal or delay of psychological care: Failure or delay in obtaining services for the child's emotional, mental, or behavioral impairments

- Permitted chronic truancy: The child averages at least five days per month of school absence and the parent/guardian does not intervene

- Failure to enroll: Failure to enroll or register a child of mandatory school age or causing the child to remain at home for nonlegitimate reasons

- Failure to access special education services: Refusal or failure to obtain recommended services or treatment for remedial or special education for a child's diagnosed learning disorder

Trafficking and Exploitation

It can be difficult to identify and intervene to stop human trafficking and exploitation, because it is hidden and even people who interact with victims may not recognize that it is happening. However, in many cases, women and children are considered the typical victims of human trafficking. Trafficking and exploitation are real risks to child safety and well-being and are reportable as forms of abuse.

There are several different types of child or minor human trafficking, but the term is generally defined as the recruitment, transportation, provision, or obtaining of a child for labor or services through the use of force, fraud, or coercion. Severe forms of human trafficking include sex and labor trafficking, including debt bondage and slavery.

Labor Trafficking

Labor trafficking is defined as labor obtained by the use of threat of serious harm, physical restraint, or abuse of the legal process. Severe labor trafficking includes the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion, for the purpose of subjection to involuntary servitude, peonage (i.e., paying off debt through work), debt bondage (i.e., debt slavery, bonded labor or services for a debt or other obligation), or slavery (i.e., a condition compared to that of a slave in respect of exhausting labor or restricted freedom).

Typically, children involved in forced labor are being given little or no pay. In the United States, forced labor is predominantly found in five sectors [57]:

- Prostitution and sex industry (46%)
- Domestic servitude (27%)
- Agriculture (10%)
- Sweatshops and factories (5%)
- Restaurant and hotel work (4%)

Among child victims, forced domestic servitude is a serious concern, particularly related to the provision of domestic services for 10 to 16 hours per day on activities such as child care, cooking, cleaning, and yard work/gardening.

Sex Trafficking

The Victims of Trafficking and Violence Protection Act defines sex trafficking as, "the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act" [58]. A commercial sex act is, "any sex act on account of which anything of value is given to or received by any person" [58]. In other words, it involves the illegal transport of humans to be exploited in a sexual manner for financial gains [59]. Victims of sex trafficking could be forced into prostitution, stripping, pornography, escort services, and other sexual services [60]. Under federal law, sex trafficking (such as prostitution, pornography, or exotic dancing) does not require there be force, fraud, or coercion if the victim is younger than 18 years of age.

The term "domestic minor sex trafficking" has become a popular term used to connote the buying, selling, and/or trading of children for sexual services within the country, not internationally [60]. In the United States, the children most vulnerable to domestic minor trafficking are [60]:

- Youth in the foster care system
- Youth who identify as LGBTQIA+
- Youth who are homeless or runaway
- Youth with disabilities
- Youth with mental health or substance abuse disorders
- Youth with a history of sexual abuse
- Youth with a history of being involved in the welfare system
- Youth who identify as native or aboriginal
- Youth with family dysfunction

EPIDEMIOLOGY OF CHILD ABUSE AND NEGLECT

NATIONAL PREVALENCE

In 2020, there were 3.9 million referrals to child protective agencies in the United States [15]. More than 2.1 million (or 54%) were assessed to be appropriate for a response, and 27.6% of reports were made by health, social service, and/or mental health professionals [15]. Girls tend to be victims at a slightly higher rate (8.9 per 1,000 population) compared with boys (7.9 per 1,000 population) [15]. The most common perpetrators were parents; 90.6% of victims are maltreated by one or both parents [15]. Specifically, mothers are more often perpetrators compared with fathers (58.3% of victims were abused by a mother vs. 44.3% of victims were abused by a father) [15].

As of 2020, 8.4 of every 1,000 children in the United States were victims of abuse and/or neglect [15]. This is the unique rate, meaning each child is counted only once regardless the

CHILD ABUSE VICTIMIZATION IN THE UNITED STATES ACCORDING TO RACE/ETHNICITY, 2020	
Race/Ethnicity	Child Abuse Rate per 1,000 Children
Native American/Alaska Native	15.5
African American	13.2
Multi-race	10.3
Pacific Islander	9.0
Hispanic	7.8
White	7.4
Asian American	1.6
Source: [15]	*Table 1*

number of times a report may have been filed for abuse/neglect. The fatality rate for 2020 was 2.38 deaths per 100,000 children [15].

Research has shown that racial and ethnic minority children (particularly African American, Native American/Alaska Native, and multi-racial children) tend to have higher rates of reported child maltreatment compared with their White counterparts (*Table 1*) [15]. However, the lowest reported rate is among Asian American children [15].

PENNSYLVANIA STATE PREVALENCE

According to the Annual Child Protective Services Report, a yearly statistical report that documents child abuse cases in Pennsylvania, the child abuse hotline registered a total of 39,093 reports of suspected abuse or neglect in 2022 [27]. Approximately 12.8% of these cases were substantiated, which translates to 4,992 cases of child abuse in 2022 [27]. This is an increase of 6,174 reports (18.7%) compared with 2020, a decline attributed to the end of COVID-19 precautions and the return to usual contact between children and mandated reporters [27]. Of the substantiated child abuse cases, there were 60 fatalities, 13 less than in 2020 [27]. More than half (50.1%) of perpetrators of child abuse in 2022 were the parent of the child victim [27].

RECOGNIZING WARNING SIGNS

It is crucial that practitioners become familiar with the indications of child abuse and neglect. These factors do not necessarily conclusively indicate the presence of abuse or neglect; rather, they are clues that require further interpretation and clinical investigation. Some parental risk indicators include [8; 10; 12; 16]:

- Recounting of events that do not conform either with the physical findings or the child's physical and/or developmental capabilities
- Inappropriate delay in bringing the child to a health facility

- Unwillingness to provide information or the information provided is vague
- History of family violence in the home
- Parental misuse of substances and/or alcohol
- Minimal knowledge or concern about the child's development and care
- Environmental stressors, such as poverty, single parenthood, unemployment, or chronic illness in the family
- Unwanted pregnancy
- Early adolescent parent
- Expression that the parent(s) wanted a baby in order to feel loved
- Unrealistic expectations of the child
- Use of excessive physical punishment
- Healthcare service "shopping"
- History of parent "losing control" or "hitting too hard"

Child risk indicators include [8; 10; 12; 16]:

- Multiple school absences
- Learning or developmental disabilities
- History of multiple, unexplained illnesses, hospitalizations, or accidents
- Poor general appearance (e.g., fearful, poor hygiene, malnourished appearance, inappropriate clothing for weather conditions)
- Stress-related symptoms, such as headaches or stomachaches
- Frozen watchfulness
- Mental illness or symptoms, such as psychosis, depression, anxiety, eating disorders, or panic attacks
- Regression to wetting and soiling
- Sexually explicit play
- Excessive or out-of-the-ordinary clinging behavior
- Difficulties with concentration
- Disruptions in sleep patterns and/or nightmares

In addition, warning signs specifically associated with victims of child trafficking and/or exploitation include (but are not limited to):

- A youth that has been verified to be younger than 18 years of age and is in any way involved in the commercial sex industry or has a record of prior arrest for prostitution or related charges

- An explicitly sexual online profile

- Excessive frequenting of Internet chat rooms or classified sites

- Depicting elements of sexual exploitation in drawing, poetry, or other modes of creative expression

- Frequent or multiple sexually transmitted infections or pregnancies

- Lying about or not being aware of their true age

- Having no knowledge of personal data (e.g., age, name, date of birth)

- Having no identification

- Wearing sexually provocative clothing

- Wearing new clothes of any style, getting hair and/or nails done with no financial means

- Being secretive about whereabouts

- Having late nights or unusual hours

- Having a tattoo that s/he is reluctant to explain

- Being in a controlling or dominating relationship

- Not having control of own finances

- Exhibiting hypervigilance or paranoid behaviors

- Expressing interest in or being in relationships with adults or much older men or women

Some of the types of behaviors and symptoms discussed in the definitions of physical, sexual, and emotional abuse/neglect are also warning signs. For example, any of the injuries that may result from physical abuse, such as a child presenting with bruises in the shape of electric cords or belt buckles, should be considered risk factors for abuse.

CONSEQUENCES OF CHILD ABUSE

The consequences of child abuse and neglect vary from child to child, and these differences continue as victims grow older. Several factors will mediate the outcomes, including the [17]:

- Severity, intensity, frequency, duration, and nature of the abuse and/or neglect

- Age or developmental stage of the child when the abuse occurred

- Relationship between the victim and the perpetrator

- Support from family members and friends

- Level of acknowledgment of the abuse by the perpetrator

- Quality of family functioning

In examining some of the effects of physical abuse, it is helpful to frame the consequences along a lifespan perspective [3]. During infancy, physical abuse can cause neurologic impairments. Most cases of infant head trauma are the result of child abuse [19]. Neurologic damage may also affect future cognitive, behavioral, and developmental outcomes. Some studies have noted that, in early childhood, physically abused children show less secure attachments to their caretakers compared to their non-abused counterparts [20].

By middle to late childhood, the consequences are more notable. Studies have shown significant intellectual and linguistic deficits in physically abused children [3]. Other environmental conditions, such as poverty, may also compound this effect. In addition, a number of affective and behavioral problems have been reported among child abuse victims, including anxiety, depression, low self-esteem, excessive aggressive behaviors, conduct disorders, delinquency, hyperactivity, and social detachment [3; 8; 10; 12].

Surprisingly, there has been little research on the effects of childhood physical abuse on adolescents [3]. However, differences have been noted in parents who abuse their children during adolescence rather than preadolescence. It appears that lower socioeconomic status plays a lesser role in adolescent abuse as compared with abuse during preadolescence [21]. In addition, parents who abuse their children during adolescence are less likely to have been abused as children themselves compared with those parents who abused their children during preadolescence [21]. It is believed that the psychosocial effects of physical abuse manifest similarly in late childhood and adolescence.

Research findings regarding the effects of childhood physical abuse on adult survivors indicate an increased risk for major psychiatric disorders, including depression, post-traumatic stress disorder, and substance abuse [36]. Some adult survivors function well socially and in terms of mental and physical health, even developing increased resilience as a result of their experiences, while others exhibit depression, anxiety, post-traumatic stress, substance abuse, criminal behavior, violent behavior, and poor interpersonal relationships [3; 17; 46]. A meta-analysis found that adult survivors of child abuse were more likely to experience depression than non-abused counterparts, with the rates varying according to the type of abuse sustained (1.5-fold increase for physical child abuse, 2.11-fold increase for neglect, and 3-fold increase for emotional abuse) [24]. Similar results were found in a longitudinal study that compared a child welfare cohort to a group with no child welfare involvement. The child welfare group was twice as likely to experience moderate-to-severe depression and generalized anxiety compared with the control group [25]. There is some evidence that vulnerability to long-term effects of maltreatment in childhood may be at least partially genetically mediated [50].

Although not all adult survivors of sexual abuse experience long-term psychological consequences, it is estimated that 20% to 50% of all adult survivors have identifiable adverse mental health outcomes [23]. Possible psychological outcomes include [10]:

- Affective symptoms: Numbing, post-traumatic stress disorder, anxiety, depression, obsessions and compulsions, somatization

- Interpersonal problems: Difficulties trusting others, social isolation, feelings of inadequacy, sexual difficulties (e.g., difficulties experiencing arousal and orgasm), avoidance of sex

- Distorted self-perceptions: Poor self-esteem, self-loathing, self-criticism, guilt, shame

- Behavioral problems: Risk of suicide, substance abuse, self-mutilation, violence

- Increased risk-taking behaviors: Abuse of substances, cigarette smoking, sexual risk-taking

Adult male survivors of child sexual abuse are three times as likely to perpetrate domestic violence as non-victims. In addition, female survivors of child sexual abuse are more vulnerable to bulimia, being a victim of domestic violence, and alcohol use disorder [28].

In more recent years, research has focused on the impact of adverse childhood experiences (ACEs) in general. ACEs are defined as potentially traumatic experiences that affect an individual during childhood (before 18 years of age) and increase the risk for future health and mental health problems (including increased engagement in risky behaviors) as adults [47]. Abuse and neglect during childhood are clear ACEs, but other examples include witnessing family or community violence; experiencing a family member attempting or completing suicide; parental divorce; parental or guardian substance abuse; and parental incarceration [47]. Adults who experienced ACEs are at increased risk for chronic illness, impaired health, violence, arrest, and substance use disorder [28; 52].

REPORTING SUSPECTED CHILD ABUSE

Pennsylvania has a delineated process in place to facilitate the reporting of suspected child abuse. In addition, in 2014, Governor Corbett signed four new bills intended to streamline and clarify the child abuse reporting process in Pennsylvania. These bills were spurred by the Sandusky child sexual abuse case.

PERMISSIVE REPORTERS

There are two general categories of child abuse reporters: mandated reporters and permissive reporters. Permissive reporters are individuals who report an incident of suspected child abuse. These persons are not required to act or intervene in cases of suspected abuse. Put plainly, permissive reporters can report abuse while mandated reporters must report. However, it is important to note that any person is encouraged to report

suspected child abuse or cause a report of suspected child abuse to be made to the department, county agency, or law enforcement, if that person has reasonable cause to suspect that a child is a victim of child abuse. Reasonable cause to suspect is a determination made based on training/experience and all known circumstances. Some indicators may be more apparent than others depending on the type of abuse and/or depending on the child's health, developmental level, and well-being. For example, some indicators may be visible on the child's body while other indicators may be present in the child's behaviors.

MANDATED REPORTERS

In Pennsylvania, a mandated reporter is required to make a report of suspected child abuse when he or she has reasonable cause to suspect that a child is a victim of child abuse if [48]:

- The mandated reporter comes into contact with the child in the course of employment, occupation, and practice of a profession or through a regularly scheduled program, activity, or service.

- The mandated reporter is directly responsible for the care, supervision, guidance, or training of the child, or is affiliated with an agency, institution, organization, school, regularly established church or religious organization, or other entity that is directly responsible for the care, supervision, guidance, or training of the child, regardless of the setting of the disclosure of abuse (within or outside of the reporter's professional role).

- A person makes a specific disclosure to the mandated reporter that an identifiable child is the victim of child abuse either within or outside of the reporter's professional role.

- An individual 14 years of age or older makes a specific disclosure to the mandated reporter (either within or outside of the reporter's professional role) that the individual has committed child abuse.

The mandated reporter is not required to interrogate the victim or identify the person responsible for the child abuse in order to make a report of suspected child abuse.

By law, individuals who come into contact with children on a frequent and consistent basis due to their work are legally required to report any suspected child abuse [39]. Mandated reporters in the state of Pennsylvania include, but are not limited to, [39]:

- Physicians (including osteopaths)
- Medical examiners
- Coroners
- Funeral directors
- Dentists
- Optometrists
- Chiropractors
- Podiatrists
- Interns

- Registered nurses
- Licensed practical nurses
- Hospital personnel engaged in the admission, examination, care, or treatment of persons
- Christian Science practitioners
- Members of the clergy
- School administrators
- School teachers
- School nurses
- Social services workers
- Day-care center workers or any other child-care or foster-care workers
- Mental health professionals
- Peace officers or law enforcement officials

Senate Bill 21 and House Bill 436 were two of the bills signed into law and enacted in 2014. These bills elucidate that mandated reporters are "to include anyone who comes in contact with a child, or is directly responsible for the care, supervision, guidance, or training of a child" [51]. Under this expanded definition, additional individuals who are also classified as mandatory reporters include [39]:

- A person licensed or certified to practice in any health-related field under the jurisdiction of the Department of State
- A school employee
- A foster parent
- An individual, paid or unpaid, who, on the basis of the individual's role as an integral part of a regularly scheduled program, activity, or service, accepts responsibility for a child
- An employee of a social services agency
- An employee of a public library
- Those who are supervised by mandated reporters
- An independent contractor with direct contact with children
- An attorney affiliated with an agency, institution, or organization that is responsible for the care, supervision, guidance, or control of children

It has long been debated whether attorneys should be included as mandated reporters. With this new definition, there is a seeming compromise, limiting the mandate to attorneys who are affiliated with an organization that is responsible for the care or supervision of children [37].

Privileged communication between any mandated reporter and his or her patient or client does not apply in cases of child abuse, and failure to report this information is considered a violation of the law [39]. There are exceptions: confidential communication made to an ordained member of the clergy (within the scope of 42 Pennsylvania CS §§ 5943), and confidential communications made to an attorney so long as they are within the scope of 42 Pennsylvania CS §§ 5916 (relating to confidential communications to attorney) and 5928 (relating to confidential communications to attorney), the attorney work product doctrine, or the rules of professional conduct for attorneys [39]. Notwithstanding any other provision of law, a mandated reporter who makes a report of suspected child abuse or who makes a report of a crime against a child to law enforcement officials shall not be in violation of the Mental Health Procedures Act by releasing information necessary to complete the report.

The Pennsylvania Code states that whenever a person is a mandated reporter in his or her capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, that person shall report immediately and immediately thereafter notify the person in charge of the institution, school, facility, or agency (or the designated agent) [48]. Upon notification, the person in charge or the designated agent is responsible for facilitating the cooperation of the institution, school, facility, or agency with the investigation of the report.

Not surprisingly, more than three-quarters (80%) of suspected child abuse reports are made by mandated reporters [27]. More specifically, the majority of child abuse reports come from mandated reporters in public/private social services agencies.

THE PROCESS OF REPORTING CHILD ABUSE IN PENNSYLVANIA

In Pennsylvania, mandated reports of potential child abuse (CPS or GPS cases) are made either in writing (through the online portal) or orally to ChildLine. The ChildLine is available seven days per week, 24 hours per day at 800-932-0313 or 412-473-2000. In 2020, ChildLine answered 163,215 calls, including suspected child abuse cases, referrals for GPS, and inquiries for general information to services [27]. Electronic submission of suspected child abuse reports may be made in lieu of calling ChildLine.

All mandated reporters who report via telephone shall also make a written report, which may be submitted electronically, within 48 hours [51]. The written reports are made through the Child Welfare Information Solution (CWIS) Portal, available online at https://www.compass.state.pa.us/cwis. The written report will include all of the following information, if known [55]:

- The names and addresses of the child, the child's parents, and any other person responsible for the child's welfare
- Where the suspected abuse occurred
- The age and sex of each subject of the report
- The nature and extent of the suspected child abuse, including any evidence of prior abuse to the child or any sibling of the child
- The name and relationship of each individual responsible for causing the suspected abuse and any evidence of prior abuse by each individual
- Family composition

- The source of the report
- The name, telephone number, and e-mail address of the person making the report
- The actions taken by the person making the report, including collection of evidence, protective custody, or admission to hospital
- Any other information required by federal law or regulation
- Any other information that the department requires by regulation

According to Pennsylvania law, a person or official required to report cases of suspected child abuse may take or request photographs of the child who is subject to a report and, if clinically indicated, request a radiologic examination and other medical tests on the child [56]. If completed, medical summaries or reports of the photographs, x-rays, and relevant medical tests should be sent along with the written report or within 48 hours after a report is made electronically. Persons who have reasonable cause to suspect a child is a victim of child abuse are NOT required to identify the person responsible for the abuse in order to make a report of suspected child abuse.

Except as allowed by Pennsylvania law, reports made to CPS, including, but not limited to, report summaries of child abuse and any other information obtained, reports written, or photographs or X-rays taken concerning alleged instances of child abuse, shall be confidential. Mandated reporters must identify themselves when reporting [54]. However, their names are usually not released; only the Secretary of the Department of Human Services has this authority. If a mandated reporter so chooses, he/she can sign a consent form that gives consent to have his/her name released [54].

A specialist at ChildLine will interview the caller to determine what the next step should be. This includes assessing if the report will be forwarded to a county agency for investigation as CPS or GPS; if a report should be forward directly to law enforcement officials; or if the caller will be referred to local services [53].

For both GPS and CPS cases, the appropriate county agency is contacted immediately [35]. The county agency is then responsible for its investigation, completing both a "risk assessment" and a "safety assessment." In CPS cases, the agency sees and evaluates the child within 24 hours of receiving the report. The primary goal of the evaluations are to assess the nature and extent of the abuse reported; to evaluate the level of risk or harm if the child were to stay in the current living situation; and to determine action(s) needed to ensure the child's safety [53].

A GPS referral will be assessed for any further needs, and appropriate referrals for services may be made for the child and family. If it is a CPS case, further investigation will be conducted. During the investigation, the agency may take photographs of the child and his/her injuries for the files. All investigations must be completed within 30 days from the date the report is taken at ChildLine [27]. Mandated reporters have a right to know of the findings of the investigation and the services provided to the child and may follow the case [33].

SUBSTANCE USE EXPOSURE AND PLANS OF SAFE CARE

Healthcare professionals in Pennsylvania, including those involved in the delivery or care of an infant affected by substance use or withdrawal symptoms (including fetal alcohol spectrum disorder) or encountering infants younger than 1 year of age outside a hospital setting, are required to notify the Pennsylvania Department of Human Services so that a Plan of Safe Care can be developed. It is important to note that this notification is not considered a child abuse report. In this context, healthcare provider or professional is defined as a licensed hospital or healthcare facility or person who is licensed, certified, or otherwise regulated to provide healthcare services under the laws of Pennsylvania, including physicians, podiatrists, optometrists, psychologists, physical therapists, certified nurse practitioners, registered nurses, nurse midwives, physician assistants, chiropractors, dentists, pharmacists, or individuals accredited or certified to provide behavioral health services. This is a notable shift from the previous law, which limited notification to only cases including illegal substance use and included an exception to reporting if the pregnant woman was receiving active treatment for a substance use disorder.

In 2019, the Pennsylvania Department of Health, Pennsylvania Department of Drug and Alcohol Programs, and Pennsylvania Department of Human Services published the Pennsylvania Plan of Safe Care Guidance addressing a framework for responding to the health and substance use disorder treatment needs of infants born affected by substance use disorder and/or withdrawal symptoms and affected family or caregivers [65]. This publication includes definitions and evidence-based screening tools, based on standards of professional practice, to be utilized by healthcare providers to identify a child born affected by substance use or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder. The plan of safe care typically includes [65]:

- A release of information to allow for the collaboration among entities
- Referrals to treatment programs, mobile engagement and peer recovery specialists
- Education on neonatal abstinence syndrome, effects of substance use during pregnancy, and reporting requirements for substance exposed infants
- A relapse plan that includes child safety considerations and identified family supports
- Coordination between the obstetrician and the prescribing practitioner(s)
- Development of a birth plan, including pain management options
- Education and guidance on breastfeeding and substance use

- Stigma-reducing practices designed to engage the patient in consistent prenatal care

- Referrals to Family Strengthening, Early Head Start, Family Check Up for Children, Healthy Families America, Nurse-Family Partnership, Parents as Teachers, Family Group Decision Making (FGDM), Women Infant Children (WIC), public assistance, transportation assistance, counseling, housing assistance, domestic violence programs, and/or food banks

- Referral to ChildLine if there are concerns with mother's ability to be a caretaker for other children

After notification of a child born affected by substance use or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder, a multidisciplinary team meeting will be held prior to the child's discharge from the healthcare facility. For the purpose of informing the plan of safe care, this team may include public health agencies, maternal and child health agencies, home visitation programs, substance use disorder prevention and treatment providers, mental health providers, public and private children and youth agencies, early intervention and developmental services, courts, local education agencies, managed care organizations and private insurers, and hospitals and medical providers. The meeting will inform an assessment of the needs of the child and the child's parents and immediate caregivers to determine the most appropriate lead agency for developing, implementing, and monitoring a plan of safe care. The child's parents and immediate caregivers must be engaged to identify the need for access to treatment for any substance use disorder or other physical or behavioral health condition that may impact the safety, early childhood development, and well-being of the child.

Depending upon the needs of the child and parent(s)/caregiver(s), ongoing involvement of the county agency may not be required.

PROTECTIONS FOR REPORTERS

Reporters are afforded protections after reporting a suspected incidence of child abuse. Any person or institution who, in good faith, makes a report of child abuse, cooperates with a child abuse investigation, or testifies in a child abuse proceeding is considered immune from civil and criminal liability [44]. Mandated reporters who make a report in good faith and then later face discrimination in their workplace can take legal action [44]. (This protection from discrimination does not apply to an individual making a report who is found to be a perpetrator or to any individual who fails to make a required report.) For the most part, the reporter's identity is kept confidential. If a case is referred to law enforcement, then the name of the reporter must be given upon request; however, reporters are treated as confidential informants [49].

PENALTIES FOR FAILURE TO REPORT

According to Pennsylvania statutes, a person or official required to report a case of suspected child abuse or to make a referral to the appropriate authorities who willfully fails to do so commits a misdemeanor of the third degree for the first violation and a misdemeanor of the second degree for a second or subsequent violation [44; 54]. An offense is a felony of the third degree if all three of the following are true:

- The person or official willfully fails to report.

- The child abuse constitutes a felony of the first degree or higher.

- The person or official has direct knowledge of the nature of the abuse.

A person who commits a second or subsequent offense commits a felony of the third degree, except if the child abuse constitutes a felony of the first degree or higher, in which case the penalty for the second or subsequent offenses is a felony of the second degree. In addition, if a person's willful failure continues while the person knows or has reasonable cause to believe the child is actively being subjected to child abuse, the person commits a felony of the third degree; if the child abuse constitutes a felony of the first degree or higher, the person commits a felony of the second degree [44; 54]. The statute of limitations for an offense under this section shall be either the statute of limitations for the crime committed against the minor child or five years, whichever is greater.

BARRIERS TO REPORTING

Studies have shown that many professionals who are mandated to report child abuse and neglect are concerned and/or anxious about reporting. Identified barriers to reporting include [29; 30; 31; 40]:

- Professionals may not feel skilled in their knowledge base about child abuse and neglect. In addition, they lack the confidence to identify sexual and emotional abuse.

- Professionals may be frustrated with how little they can do about poverty, unemployment, drug use, and the intergenerational nature of abuse.

- Although professionals understand their legal obligation, they may still feel that they are violating patient confidentiality.

- Many professionals are skeptical about the effectiveness of reporting child abuse cases given the bureaucracy of the child welfare system.

- Practitioners may be concerned that they do not have adequate or sufficient evidence of child abuse.

- Practitioners may have a belief that government entities do not have the right to get involved in matters within the family.

- There may be some confusion and emotional distress in the reporting process.

- Practitioners may fear that reporting will negatively impact the therapeutic relationship.

- Some professionals have concerns that there might be negative repercussions against the child by the perpetrator.

- Some simply underestimate the seriousness and risk of the situation and may make excuses for the parents.

When interviewing children whose first language is not English, it is highly recommended that they be interviewed through the use of an interpreter. It can cause additional stress for children who struggle to find the right words in English, which can result in more feelings of fear, disempowerment, and voicelessness [41].

CASE SCENARIOS

In the following case scenarios, consider if the case should be reported as possible child abuse in accordance with Pennsylvania law.

A young girl, 2 years of age, is brought to the emergency department by her mother and stepfather for a scalp laceration. The girl is very quiet and appears listless and out of sorts. Her mother reports that she was injured when she fell onto a rock outside, but that the injury occurred when the girl was being watched by the stepfather. The girl undergoes assessment for traumatic brain injury, including assessment of function using the modified Glasgow Coma Score. The toddler is found to have mild impairment (a score of 13), and the follow-up test two hours later indicates normal functioning. The nurse notices that the toddler appears to be afraid of the stepfather, leaning away and crying when he is near her. The stepfather also appears to be easily frustrated with the child, saying that he does not know why she cries so much.

Aside from the physical injury, which could be consistent with the reported accident, this patient has some signs of bodily injury (e.g., flinches easily or avoids being touched) that may give a provider reasonable cause to suspect abuse. If the provider caring for this patient suspects that the stepfather may have neglected or physically abused her, they should make a report to ChildLine, which would initiate an investigation.

A boy, 13 years of age, is undergoing a routine physical exam with his family physician. The physician asks the boy if he is excited to start school in the next few weeks and how his baseball team is doing. The boy becomes quiet and states that he is nervous about an upcoming trip with his baseball team but does not give additional information. When asked directly, the boy says that he is uncomfortable with the new assistant coach, who watches pornography with them during out-of-town tournaments and supplies them with pornographic magazines. However, the boy states that he doesn't think it's a big deal and that "all of the other kids seem to really like it."

In this case, the physician should make a report to ChildLine. This would be classified as a CPS case, and an investigation would be conducted.

A girl, 6 years of age, visits the school nurse complaining of a stomach ache. She is disheveled in appearance, with torn, dirty clothing and unbrushed hair. She reports being hungry, as she did not have dinner the night before or breakfast this morning. She also reports that she has been sleeping in a car with her mother since they moved out of their apartment last month.

The signs in the case indicate poverty, not abuse. As such, a report should not be made to ChildLine. Instead, the patient and her family should be connected with available services and resources to assist in meeting their immediate needs.

CONCLUSION

Child abuse and neglect are considered significant social problems with deleterious consequences. As noted, a system has been implemented in all 50 states to ensure the safety of children, with laws defining what constitutes abuse and neglect and who is mandated to report. Healthcare professionals, regardless of their discipline or field, are in a unique position to assist in the identification, education, and prevention of child abuse and neglect. There are three key components of child abuse: a child victim and an act or failure to act (or series of acts or failures) engaged in intentionally, knowingly, or recklessly. The basis for reporting suspected child abuse is having reasonable cause to suspect a child is a victim of abuse. A person who has reasonable cause to suspect a child is a victim of child abuse is not required to identify the type of abuse they are reporting when making a report.

A mandated reporter must immediately make a report suspected child abuse to ChildLine if they have reasonable cause to suspect a child is a victim of child abuse under any of the following circumstances:

- The mandated reporter comes into contact with the child in the course of employment, occupation, and practice of a profession or through a regularly scheduled program, activity, or service.

- The mandated reporter is directly responsible for the care, supervision, guidance, or training of the child, or is affiliated with an agency, institution, organization, school, regularly established church or religious organization, or other entity that is directly responsible for the care, supervision, guidance, or training of the child.

- A person makes a specific disclosure to the mandated reporter that an identifiable child is the victim of child abuse.

- An individual 14 years of age or older makes a specific disclosure to the mandated reporter that the individual has committed child abuse.

It is not necessary for a child to come before the mandated reporter in order for the mandated reporter to make a report of suspected child abuse. In addition, the mandated reporter is not required to identify the person responsible for the child

abuse in order to make a report. A person who has reasonable cause to suspect a child is a victim of abuse does not have to consider the exclusions from child abuse in order to make a report of suspected abuse. A mandated reporter is presumed to have acted in good faith when making a report.

It is the duty of all mandated reporters in the state of Pennsylvania to know their responsibilities and the laws that govern the reporting process. All reporters should adhere to the established laws and rules that govern child abuse reporting, taking into account the expanded definition of perpetrator, the updated processes in place for reporting cases of suspected child abuse, and the delineated roles of mandated reporters. Doing so will help ensure the safety of millions of children in Pennsylvania.

RESOURCES

ChildLine: Pennsylvania Child Abuse Hotline
1-800-932-0313
https://www.dhs.pa.gov/keepkidssafe

Child Welfare Information Gateway
330 C Street SW
Washington, DC 20201
1-800-394-3366
To report abuse: 1-800-422-4453
https://www.childwelfare.gov

Child Welfare League of America
727 15th Street NW, 12th Floor
Washington, DC 20005
202-688-4200
https://www.cwla.org

National Council on Child Abuse and Family Violence
P.O. Box 5222
Arlington, VA 22205
202-429-6695
https://www.preventfamilyviolence.org

Pennsylvania Chapter of Children's Advocacy Centers and Multidisciplinary Teams
P.O. Box 3323
Erie, PA 16508
814-431-8151
https://penncac.org

Pennsylvania Child Welfare Information Solution
877-343-0494
https://www.compass.state.pa.us/cwis

Pennsylvania Department of Human Services
P.O. Box 2675
Harrisburg, PA 17105
1-800-692-7462
https://www.dhs.pa.gov

University of Pittsburgh, Pennsylvania Child Welfare Resource Center
403 East Winding Hill Road
Mechanicsburg, PA 17055
717-795-9048
http://www.pacwrc.pitt.edu

Customer Information, Answer Sheet, and Evaluation are located on pages 123–128.

TEST QUESTIONS

#97542 CHILD ABUSE IDENTIFICATION AND REPORTING: THE PENNSYLVANIA REQUIREMENT

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

This 3 hour activity must be completed by July 31, 2025.

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

2. **How is the child welfare system in Pennsylvania characterized?**
   A) *It is monitored by CAPTA.*
   B) *The child welfare system is founded on the criminal justice model.*
   C) *It is supervised by the state and administered by the various local county agencies.*
   D) *It is supervised by each respective local county agency and administered by the federal government.*

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

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

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

6. **How many substantiated cases of child abuse occurred in Pennsylvania in 2022?**
   A) *280*
   B) *1,967*
   C) *4,992*
   D) *26,944*

7. **Patient A, a child 10 years of age, arrives at the emergency department with a burn. Upon intake, a registered nurse notices that the burn on the child's thigh resembles the face of an iron. In addition, the child has bruising on her upper arm. The nurse suspects abuse and therefore calls the toll-free number for mandated reporters to report the case. Which of the following steps must the nurse take following the call?**
   A) *This nurse must report the suspected abuse in writing within 48 hours.*
   B) *The nurse must contact a physician for a complete evaluation of the child, including assessment for sexual abuse.*
   C) *The nurse should call a legal aid society to ask for a lawyer to represent her in the event he/she is held liable if the case is not substantiated.*
   D) *This nurse should inform the mother that he/she will be contacting the appropriate agencies regarding suspected child abuse and maltreatment.*

8. **When making a written report of suspected child abuse, the mandated reporter may be asked for**
   A) *family composition.*
   B) *photographs of the injuries, if available.*
   C) *the location where the suspected abuse occurred.*
   D) *All of the above*

9. **The identity of the individual who reported a child abuse incident is NOT kept confidential if**
   A) *the report is substantiated.*
   B) *the incident is reported to law enforcement officials.*
   C) *the intake specialist determines that the incident falls under general protective services.*
   D) *the individual who reported the incident is determined to not have made the call in good faith.*

10. **A failure to report suspected child abuse by a mandated reporter is considered a felony of the third degree if**
    A) *the person willfully fails to report.*
    B) *the child abuse constitutes a felony of the first degree or higher.*
    C) *the person has direct knowledge of the nature of the abuse.*
    D) *All of the above*

Be sure to transfer your answers to the Answer Sheet located on page 124.
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.*

Online Professionalism and Ethics

This course meets the Pennsylvania requirement for ethics education.

Audience

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

Course Objective

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

Learning Objectives

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

1. Define Internet usage patterns and common Internet technologies.

2. Analyze how various Internet technologies are utilized in clinical practice.

3. Define professionalism.

4. Evaluate how the use of specific Internet technologies can affect professionalism and ethics.

5. Discuss how the use of Internet technologies can impact issues of boundaries, self-disclosure, privacy/confidentiality, and professional relationships.

6. Identify best practices for using Internet technologies as a clinical practitioner.

Faculty

Alice Yick Flanagan, PhD, MSW. (A complete biography can be found at NetCE.com.)

Faculty Disclosure

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

Division Planners

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Margaret Donohue, PhD

Senior Director of Development and Academic Affairs

Sarah Campbell

Division Planners/Director Disclosure

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

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Social workers completing this intermediate-to-advanced course receive 3 Clinical continuing education credits.

NetCE designates this continuing education activity for 2 NBCC clock hours.

NetCE designates this continuing education activity for 3 continuing education hours for addiction professionals.

About the Sponsor

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

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INTRODUCTION

Professionals are increasingly entering the digital world to network both socially and professionally. Internet technology can be a powerful tool when job searching and developing and expanding professional networks; however, it is important for individuals to use discretion and judgment in the types of information they post, as the casual and informal nature of social networking sites can make it easy to inadvertently cross professional boundaries. The term "digital footprint" has been used to refer to the digital content and evidence left behind as a result of posting on discussion boards, social networking sites, blogs, and other Internet platforms [1]. These digital footprints can affect how the public, colleagues, supervisors, and employers will perceive an individual in the future. In fact, it is becoming increasingly commonplace for individuals to search online for information about another individual, particularly for professional reasons. For example, 19% of online adults in one study had searched the Internet for information about an individual with whom they had a professional relationship [1]. Some universities and colleges will look up their applicants on social media as part of the admission process [7]. What might a photo of an applicant partying, drinking, or using substances convey to the admissions panel [79]?

One of the hallmarks of curricula in graduate professional degree programs is to socialize novice professionals about the profession's identity, ethical practice within the field, and sense of professionalism. However, with the advent of technology and the era of online venues, the notion of professional identity and boundaries can become blurred. In 2000, there was little written on e-professionalism; since then, recommendations have been formulated to help professionals ensure their professional and personal identities are appropriately presented online [100]. The vestiges of digital footprints might be unintended, but they can have negative professional consequences in the future [13]. Today, 70% of future employers screen their applicants on social media [13]. A review found that 63% of employers decided to reject potential employees after finding inappropriate or unprofessional content in their profiles on social networking sites [2; 79]. A nurse in Sweden was dismissed after she posted a photo of herself holding a piece of flesh during a brain operation [3]. Agencies and organizations have to weigh the risks and benefits of these online behaviors, including perceived professionalism and potential legal risks of compromising confidentiality [100].

In professions such as medicine, psychology, social work, mental health counseling, family therapy, and nursing, unprofessional online identities can have negative repercussions for both the client and practitioner. This is because practitioners are viewed not merely as individuals but also as trusted representatives of their profession and their employers [65]. In addition, practitioners searching for information about clients on the Internet can result in damaged relationships and impact care. The Internet can be a powerful tool, but it is important to consider how appropriate it is to access information about a client who has not disclosed the information within the therapeutic setting. For example, what is the practitioner's ethical obligation if a client posts depressive thoughts that might be indicative of suicidal risk on a social networking site [5]? In one scenario, a clinician conducted an Internet search of a young client because the grandfather refused to elaborate about the trauma experienced as a result of the client's parents' plane crash [4]. When the clinician utilized the information during the search in the therapeutic process, the grandfather terminated the sessions. The grandfather perceived this as a violation of privacy, and ultimately the working alliance was adversely affected. Even something as seemingly innocuous as sending out an e-mail correspondence from an Internet hotspot or public terminal to a client or a clinical supervisor with the client's name could potentially violate issues of privacy [6].

The goal of this course is to raise awareness and build the knowledge base of psychologists, social workers, mental health counselors, family therapists, physicians, and nurses regarding the impact of Internet technology on professionalism and ethics [14]. Technology has become an integral part of the American lifestyle, and it is crucial for practitioners to determine how it impacts their professional lives. Of course, having an online presence is not necessarily negative. Instead of fear and abstinence from Internet and social media, practitioners should be thoughtful and fully evaluate the risks and benefits of developing and maintaining an online presence.

INTERNET AND DIGITAL TECHNOLOGY TRENDS

In order to understand the pervasive social, psychological, and cultural impact of the Internet on the lives of individuals, it is important to obtain a brief glimpse of Internet and digital technology usage and consumption. In 2018 in the United States, it was estimated that 85.3% of households had an Internet subscription [78]. In a 2018 study conducted by the

Pew Research Center with adults 18 years of age and older, 89% reported Internet use, compared with 52% in 2000 and 76% in 2010 [8]. However, as of 2021, an estimated 77% of households in the U.S. had broadband Internet [8]. Individuals 18 to 29 years of age are the most likely to utilize the Internet (98%), while adults 65 years of age and older are the least likely (75%) [8]. There is no doubt that Internet technology has become a ubiquitous part of the American landscape. Although data published in the last several years is among the most current, the Internet landscape changes so rapidly that obtaining accurate data is nearly impossible.

SOCIAL NETWORKING

A huge number of individuals are using online social networking sites like Facebook and Instagram. As of 2010, the average American spends 6 hours and 35 minutes on blogs and social networking sites every month [9]. As of 2021, an estimated 69% of Americans 18 years of age and older used Facebook, 81% used YouTube, 40% had an Instagram profile, 31% used Pinterest, 28% reported using LinkedIn, 25% used Snapchat, and 23% used X (formerly Twitter) [76]. TikTok, YouTube, and Reddit were the only two platforms measured that saw statistically significant growth since 2019. As of March 2022, TikTok videos with the hashtag #mentalhealth have been viewed more than 29 billion times [101].

Women and girls tend to use Facebook and Instagram at a slightly higher rate than men and boys, while men and boys are more like to report use of Reddit [76]. Instagram, Snapchat, and TikTok are more commonly used by younger individuals, while Facebook and WhatsApp appear to be more evenly used among all age groups [76].

The general belief is that social networking users are adolescents and young adults. While the percentage of adolescents and young adults using online social networking sites like Facebook and TikTok is higher compared to older adults, this is beginning to change. In 2021, 50% of adults 65 years of age and older used Facebook [76]. Older adults report using social networking technology to connect with people by sharing photos, personal news and updates, and links.

REVIEW OF INTERNET COMMUNICATION TOOLS

Before discussing how Internet technologies may impact professional ethics and conduct, it is important to have a clear understanding of the tools and terminology used. Each of the following applications presents unique benefits and challenges.

ELECTRONIC MAIL (E-MAIL)

E-mail is a form of electronic communication that involves sending messages over the Internet. It is one of the most commonly used Internet applications. It allows for the delivery of a message to another person or to a group of individuals rapidly, conveniently, and without incurring any per message charges (as with text messaging) [12].

CHATROOMS

A chatroom or chat group is a virtual community or venue in which a group of individuals can "dialogue" and share information about a common interest asynchronously (non-real time) or synchronously (real time). Chatrooms are often organized by specific topics or interests, such as a hobby, an illness, mental health disorders, or personal interests. For example, it is possible to find an online chatroom devoted to the discussion of depression.

BLOGS OR MICROBLOGS

Blogs are analogous to a website journal and generally consist of a log of entries displayed in chronologic order. Entries might include commentary, information about events, graphics, or videos posted by an individual or group. Globally, it is estimated that there are more than 600 million blogs, and in the United States, there are an estimated 32.7 million bloggers [102].

There are many free services to develop and search for blogs, including Blogger, Google, Tumblr, WordPress, Wix, Weebly, Blogspot, SquareSpace, and LiveJournal [77]. Microblogging is similar to blogging, but with a limit on the number of characters that may be used. Twitter, for example, is limited to 140 characters [5]. According to Nielsen, women are more likely than men to blog, and one in three bloggers is a mother [10]. The largest blogging platforms for 2024 were Wordpress, Wix, and Weebly [116].

INSTANT AND TEXT OR PHOTO MESSAGING

Instant messaging and text messaging are forms of synchronous communication whereby individuals communicate through text and/or photos using computers, cellular phones, or other devices. Text messaging has become one of the most popular forms of electronic communication, especially among adolescents and young adults. In 2020, 97% of Americans owned a cellphone of some kind, and 85% owned a smartphone [117]. For adults 65 years of age and older, 61% own a smartphone [117]. In a 2019 survey conducted by the Pew Research Center, 78% of cell phone owners in emerging countries use their phone for texting or messaging [58]. On average, more than two-thirds Americans check their texts at least 160 times per day [103]. Some estimate that they receive more than 2,000 texts monthly [104].

Applications that allow users to send photos or videos (usually modified with text and/or drawings) have also gained popularity since 2010. One popular example of this platform is Snapchat, which allows users to send images or videos and limit the amount of time they are available; after the set time, the file can no longer be accessed. Since 2019, the video-sharing platform TikTok has gained popularity. Teens are also likely to use apps such as Snapchat to send messages to friends (in lieu of or in addition to texting). Among cell phone owners 18 to 24 years of age, 65% were using this application as of 2021 [76].

SOCIAL NETWORKING WEBSITES

Social networking is a form of online communication that is comprised of "web-based services that allow individuals to construct a public or semi-public profile within a bounded system, articulate a list of other users with whom they share a connection, and view and traverse their list of connections and those made by others within the system" [15]. Examples of social networking sites include YouTube, Facebook, TikTok, LinkedIn, Pinterest, Twitter, Instagram, Snapchat, Tumblr, and Gab [76].

PHOTO OR VIDEO SHARING

Posting original photos and videos online is a common Internet activity, and there are a variety of ways that users may upload their images online. Most social media users include personal photos and videos on their online profiles; it is estimated that half of all persons using the Internet post original photos online [76]. A variety of photo- and video-based applications have been adopted by users, including Instagram, YouTube, TikTok, and Flickr.

WIKIS

Wikis, derived from the Hawaiian word for quick, are collaborative websites on which anyone with access can add, revise, or remove the content published [16]. The most popular wiki is Wikipedia, which is similar to a collaborative encyclopedia, but there are many specific wikis focusing on a single topic, such as suicide prevention or a video game. Often, access is not restricted, but in some cases, editing may be password restricted [16]. Wikis have grown tremendously popular, as they can be a vehicle to quickly access and share information [17]. Wikis have been developed in healthcare communities to promote continuing education and professional development [16].

USE OF INTERNET TOOLS IN CLINICAL PRACTICE

In addition to affecting personal life, recreation, and the dissemination of information, Internet technologies have also impacted the provision of health and mental health care. E-mail is one of the most commonly utilized web-based interventions in clinical practice [18]. E-mail-based counseling consists of asynchronous interactions between a counselor and client using text-based communications sent electronically. E-mail communications allow the client to provide brief narratives, and the counselor can structure the communication for exploration of the described symptoms with a problem-solving focus [19]. Some practitioners will use e-mail as a mechanism to provide support. The premise is that the opportunity to interact with another individual, even in writing, can help to mitigate maladaptive responses to stressors [20]. This may be the most useful for clients who cannot easily see a practitioner due to transportation issues or residing in remote areas. In addition, e-mail counseling or any type of counseling involving text-based communication may be cathartic for the client and allow him or her to control how much information to disclose and when to disclose it [80]. E-mail counseling has been likened to a journal, allowing clients to revisit conversations with counselors. E-mail counseling was also perceived as flexible and accessible [105]. Even with high risk and sensitive topics (e.g., suicide), e-mail counseling may be preferred to phone counseling if the client feels better able to express him/herself through writing [106].

In one study of abuse survivor care, nurse practitioners reported that e-mail technology allowed for immediate referrals, education, support, information, and guidance, improving their practice and level of care [20]. E-mails have also been used as a supplement for supervision, and they can serve as a journal of thoughts and questions between an intern and a supervisor to stimulate reflection [21]. Due to the convenience of e-mails and the ability to aggregate lists of e-mail addresses (e-mail distribution lists), forming groups in which participants interact through e-mail has proliferated [12]. A single individual can physically set-up distribution lists and send mass e-mails, or the distribution of the e-mails can be moderated through special software. E-mail software application systems are available to handle the task of subscribing or unsubscribing persons from the e-mail distribution list (LISTSERV) [12]. Such applications are often developed for the purpose of disseminating information or providing support for a specific issue [22]. They can be particularly helpful in keeping practitioners abreast of current information and connected with colleagues. These distribution lists may also be beneficial for training and continuing professional development [23]. In a study conducted by Cook and Doyle about the motivations of using e-mail-based counseling, many of the participants indicated that they preferred it to face-to-face counseling because it was less embarrassing and they had the ability to read and reread e-mails and reflect on the counseling sessions [59]. Furthermore, it offers flexibility for both the client and counselor, as they do not need to be communicating synchronously [118].

As of 2024, there are an estimated 10,000 to 20,000 mental health-oriented apps, focused on helping individuals with issues such as stress, anxiety, sleep, and depression [119]. While it is not clear how many mental health- and wellness-related type of apps are on smartphones, there are more than 80 apps on individuals' smartphones on average, and 92% of time spent on a smartphone is on an app [120]. It is estimated that only 3% to 5% of mental health apps have been empirically tested. Therefore, practitioners should be cautious about the apps they recommend or how they are used in conjunction with interventions [120].

Online chatting, texting, and instant messaging refers to the exchange of brief written messages in quasi-real time (i.e., quasi-synchronously) between two phones or computers [80]. Common platforms for online counseling may include MSN, WhatsApp, SMS, or IMessage [81]. While online chatting is slower than talking, clients appear to disclose the problem more quickly, which may be attributable to characteristics of chatting that promote disinhibition [82]. In a qualitative study examining counselor/client e-mails and online chats, clients tended to get to the point of the problem more quickly in

chats, while in e-mail counseling, clients wrote longer narratives with greater detail [82]. In e-mail counseling, there was more interactional space, while in online chat, there was more real-time interaction. Texting may also be used as an adjunct to traditional psychotherapy, particularly as a means of providing appointment reminders to increase treatment compliance [107]. Text messages can also increase rapport between the client and the counselor [107]. Others feel more open and disinhibited using text, and to some extent, they perceive there is more anonymity to texting. This promotes a greater sense of confidentiality [122]. Despite all the benefits of text-based counseling, the nuances of face-to-face interactions can get lost, and if the content is too long in the text, clients may be less likely to fully read and process the content [122]. Best practice is to use 160 characters of less in a single message [123].

Chatrooms or discussion groups may be established to address specific topics or interests (e.g., surviving cancer, coping with depression). Ideally, these websites will have experienced practitioners acting as facilitators who may observe and guide the "conversations" [24; 25]. Benefits of discussion groups include lasting documentation of discussions (in the form of archived transcripts), the creation of a supportive environment, and a minimization of isolation. Online discussion boards offer an opportunity for members to be heard and to relate to others, reducing feelings of isolation [108]. In a study of a real-time chatroom offering peer counseling on a variety of emotional issues, the online peer counseling was found to be person-centered [60]. The youths who participated were satisfied with their counselor's ability to provide support. However, the counselors had difficulty providing solutions and assisting participants to think critically and generate solutions.

Blogs have traditionally been used in clinical practice in one of two ways [26]. First, they may be used as an online journal of life events, feelings or emotions, and personal views or belief systems. A community of readers and fellow bloggers may comment and share their life experiences with each other. These responses can be empathic and sincere, giving the blogger a sense of community, understanding, and support [109]. In this way, the blog can act as a record of symptoms and triggers and also as a support group of sorts. Second, blogs may be used by professionals to discuss a particular topic, with readers or other bloggers providing recommendations and feedback [26; 109]. In a 2005 study, researchers found that half of all evaluated blog posts were written with the purpose of self-help or self-therapy [27]. Third, blogs may be used as a form of social justice activism, encouraging people into social action and change [83].

A 2010 study analyzing 951 blogs related to health during a two-year period found that women wrote more than half of blogs, and almost half of the blogs were written by those in the health professions [28]. Typically, the blogs included links, archives, and comments sections, and most of the topics revolved around mental health. For example, more than one-quarter focused on autism, while another quarter concentrated on bipolar disorders. The blogs were informational but also contained personal experiences. They obtain support and help patients and caregivers cope. However, it could also be a cathartic mechanism for health professionals dealing with workplace stress to share challenges experienced in the healthcare sector.

Social networking sites are being used in the health and mental health fields to build and connect members within a community. These sites often collect information about their members by having them create profiles. Members then connect with each other based on information from their profiles [29]. In a survey study of 658 nurses, 85% indicated that social media was beneficial for work-related activities. Many received work-related messages online, and more than 50% subscribed to a medical-related social media site [110]. Furthermore, the content on social media sites can be used for public education. TikTok, for example, has been widely adopted, and many videos have gone viral. Dr. Julie Smith, a psychologist who has successfully used TikTok for bite-sized public education on a range of mental health topics, has an estimated 2.9 million followers on the platform [124]. A content analysis of 100 TikTok therapy-related videos found that the videos were primarily used for psychoeducation, and it also offered a vehicle to validate and affirm viewers and their concerns [125]. Therapists also employed TikTok to normalize therapy and mental health support and to humanize the therapist.

Because social support is an essential factor in helping people cope with medical conditions, social networking may be an important tool. The U.S. Department of Health and Human Services and the National Suicide Prevention Lifeline partnered with Facebook in an initiative to prevent suicide. As part of this program, if a Facebook user notices that a "friend" posted a suicidal comment or a post that alluded to suicidal intent, the comment could be reported to the National Suicide Prevention Lifeline, with the "friend" then contacted via e-mail or an instant chat [61]. The Italian Service for Online Psychology (SIPO) also employs Facebook as a means to provide free online psychological consultations [84]. Between November 2011 and June 2014, 284 individuals used Facebook for 30-minute consultations with an SIPO clinician. Depression was the most common reported presenting problem. In this example, Facebook chat offers a convenient and non-stigmatizing way to access mental health assistance, thereby eliminating barriers to access to traditional mental health care [84].

The use of video-based counseling/therapy increased during the COVID-19 pandemic. Video technology may be used to facilitate long-distance therapeutic interventions as well as to share repetitive therapeutic information. Real-time video conferencing, using secure networks or online technology like Zoom, Skype, Google Hangouts, Microsoft Teams, or FaceTime, can allow practitioners to provide care in underserved areas or to persons who are unable to travel even small distances to receive therapy [81]. Counseling via video conferencing is generally less expensive than face-to-face therapy, and consequently, clients may have the opportunity to attend more frequently [126]. It also increases continuity of care due to increased access, flexibility, and reduced cost [126].

Using technology, people can more easily provide both emotional and informational support to each other regardless of geographic or other barriers. One example of a social networking site for patients focusing on health and medical conditions is PatientsLikeMe (https://www.patientslikeme.com). There are also social networking sites specifically developed to allow healthcare professionals to connect with each other and share information. Examples include AllNurses (https://allnurses.com), Sermo (https://app.sermo.com), and Doximity (https://www.doximity.com).

These are tools that can help facilitate communication, education, awareness, advocacy, and patient/client care. On the individual or micro level, professionals can more easily communicate with colleagues and other professionals from different disciplines, fostering interprofessional collaboration and communication [13]. Social networking tools can also be used to convey immediate health and mental health information to clients/patients and family members as well as to provide emotional and psychological support [127]. On the mezzo and community levels, Internet tools can help organize stakeholders, and on the macro level, it can influence legislators and policy makers [13].

OVERVIEW OF PROFESSIONALISM AND ETHICS

DEFINING PROFESSIONALISM

As noted, one of the hallmarks of curricula in graduate professional degree programs is to acquaint novice professionals about the profession's identity, ethical practice within the field, and sense of professionalism. Professional identity has been defined as a "frame of reference for carrying out work roles, making significant decisions, and developing as a professional" [30]. The developmental process of a practitioner's professional identity is a continual process involving attitudinal, behavioral, and structural changes that result in an understanding and acceptance of what is involved in being a professional. The development of a practitioner's professional identity begins in graduate school, and the process continues to affect future professional behaviors [30]. This dynamic process includes teaching knowledge, development of a professional identity, and socialization into the group or profession's norms and values [62].

To be even more exact, it is important to have a clear definition of what constitutes a profession. A profession is defined as involving, "the application of general principles to specific problems, and it is a feature of modern societies that such general principles are abundant and growing" [31]. Professions are characterized by two major dimensions: the substantive field of knowledge that the specialist professes to command, and the technique of production or application of knowledge over which the specialist claims mastery [31]. Therefore, professionals have or claim to have knowledge and apply this knowledge to specific problems.

Professionalism is defined as a set of norms endorsed by a collective community and is characterized by "a personal high standard of competence," including "the means by which a person promotes or maintains the image" of a profession [32]. Professionalism involves a set of qualities, including not only knowledge and clinical skills but commitment, integrity, altruism, individual responsibility, compassion, and accountability [33]. In health care, professionalism often involves employing and applying a unique set of clinical skills and scientific knowledge base [85]. In the helping professions, professionalism is designed to promote patient/client autonomy, protect the public, improve access to care, distribute constrained resources in a just and equitable manner, and ensure professional accountability to the public [34; 35]. Ultimately, the public has to trust the profession and its professionals [128].

In the past, and to some degree today, professional organizations defined specific behaviors and characteristics that conformed to the standards of a particular profession. Consequently, many graduate programs selected and screened students determined to be the "right kind" of person, one who met a set list of characteristics and behaviors that conformed to the standards of competence, ethics, and professionalism within the field [36]. In addition, there are codes of conduct to regulate behavior and supervisory processes to ensure appropriate use of autonomy [86]. Therefore, many argue that merely compiling a list of behaviors and characteristics does not allow for the fact that professionalism is field- and context-independent. The standards of professionalism, ethics, and competence are influenced by a range of external factors, such as the social, political, economic, and cultural goals of the professional institutions and organizations, social norms, and the experiences of clients/patients and their families [36]. There are also factors in the presentation of professionalism that can be more easily controlled. First impressions can be extremely influential in how a professional is perceived [37]. Professional appearance (e.g., clothing, hygiene, presentation) and behavior (e.g., language use, nonverbal cues, etiquette) are vital components of a positive first impression [37; 85]. Ultimately, professionalism forms the foundation of trust between the client/patient and practitioner [63].

E-professionalism is a set of online attitudinal and behavioral standards that conforms to the expectations and values of a profession (e.g., integrity, competence, confidentiality, beneficence) [111]. It is not simply etiquette in the Internet space, such as demonstrating respect in an email or in a social media post. Rather, it involves constructing and projecting an online persona and identity that embodies the traits of professionalism [129; 130]. Unfortunately, it is not clear if one can simply apply traditional professional principles directly in the online environment [111]. Breaches of privacy and confidentiality on social media, blurring of personal and professional relationships, online civility, and violations of agency/organizational policies are common issues that should be addressed in e-professionalism guidelines [112].

ETHICS AND CODES OF ETHICS

It is not possible to talk about professionalism without a discussion of ethics. The code of ethics in a profession has been said to be the "hallmark of professionalism" [64]. Codes of ethics provide guidance to the public and professionals regarding the responsibilities of professionals. They also serve as vehicles for accountability in the profession and as a means for practitioners to self-monitor and enhance practice [87].

Ethics are beliefs about what constitutes correct or proper behavior, the principles of right conduct and how to live as a good person [38]. Ethical principles are statements that reflect one's obligations or duties [39]. General ethical principles common to the helping profession include [39]:

- Autonomy: An individual's right to make his or 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. In an analysis of the codes of ethics of diverse professions, researchers were able to classify the codes into four domains [40]:

- The professional's qualities and characteristics

- Behaviors toward other professionals and colleagues

- Behaviors of professionals in a range of situations

- The responsibility of the profession and the professional to society and the common good

These same principles and values apply online. For example, if a practitioner posts unprofessional content on social media (e.g., a photo of him/herself surrounded by alcohol), how could this potentially affect his/her work with patients with alcohol use disorder? Could it harm the therapeutic goals? If so, this would violate the ethical principle of beneficence [79].

Although ethics and professionalism are different, there is considerable overlap. Acting professionally entails adhering to accepted codes of conduct and ethics within a given field, and acting in an ethical manner in online interactions is a good first step in ensuring online professionalism.

The International Society for Mental Health Online (ISMHO), established in 1997, formulated the Suggested Principles for the Online Provision of Mental Health Services in 2000 [88]. Many professional organizations have attempted to keep abreast advances in digital technology and its impact, and many have begun to revise their ethical standards to reflect the ubiquitous nature of technology in modern society. The American Counseling Association (ACA) added an addendum to their code of ethics in 1999 and, in 2005, finalized comprehensive guidelines for Internet counseling [88]. In the field of psychology, Guidelines for the Practice of Technology were developed by the American Psychological Association (APA), the Association of State and Provincial Psychology Boards, and the APA Insurance Trust [89]. In 2017, the National Association of Social Workers (NASW) Delegate Assembly approved updates to the NASW Code of Ethics, including new guidance regarding the role of technology in informed consent, privacy, confidentiality, competency, supervision, and client records [90]. 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 [91]. The American Nurses Association and the American Medical Association have developed opinion statements and toolkits for the appropriate use of technologies such as social media in their respective professions [92; 93].

A content analysis of nine different Codes of Ethics in social work found that among three codes that were published between 20025 and 2014 there was no mention of the development and inclusion of Internet technologies in social work [131]. Although Codes of Ethics are living documents, it is time-consuming to revise them to keep up with the changing environment. Codes of Ethics should be viewed as not necessarily prescriptive; instead, they offer general guidelines or principles and cannot account for every possible scenario and outcome [131].

INTERNET TECHNOLOGIES AND PROFESSIONALISM AND ETHICS

Internet technologies can be powerful tools when job-searching, developing and growing professional networks, promoting health and mental health, and providing support to clients. As a result, e-professionalism, or professionalism in the Internet world, should be instilled in practitioners [3; 94].

Some maintain that e-professionalism, the application of ethics online, and digital literacy should be essential components of the knowledge and skill of practitioners [83]. In terms of the applications of ethical principles to the online world, some are concerned with the anonymity associated with the Internet and how it might affect the principle of beneficence and the duty of care. How does a practitioner deal with an individual who has disappeared virtually after having disclosed that they may be a danger to themselves? How can appropriate referrals be made [131]? Beneficence may be more easily maintained in the physical world and more easily compromised in the virtual world [127]. For example, details of client's history might be inadvertently posted, thereby infringing on principles of confidentiality. It is also important, for example, to use discretion and judgment in the types of information made public online. The casual and informal nature of social networking sites, for example, can cause practitioners to inadvertently cross professional boundaries, which can negatively affect their professional identity and may breach ethical standards. This is referred to as digital boundary crossing [132]. If practitioners discuss work-related problems (e.g., difficult clients, conflicts with colleagues) on social media, it could disclose confidential information or qualify as abuse [95]. Not everyone considers how the image or persona portrayed online may be perceived in the future. Because the Internet can be a public forum, viewers do not necessarily avoid viewing personal, intimate, and/or embarrassing behaviors [41]. The issue may not be the ever-growing presence of Internet communications, but rather the seeming mindlessness or carelessness with which information is shared; this has been referred to as the diminishing of intentionality of online communication [42]. Misinformation can be highly detrimental and potentially dangerous, again compromising the duty of care [127]. Practitioners may adhere to strict guidelines for self-disclosure in "real" life, but the Internet may defy practitioners' best intentions. Some have likened the Internet to a clinical practice in a rural area, where practitioners inevitably have unplanned encounters with their clients/patients due to the size of the community [42]. In some cases, individuals may inaccurately believe that the privacy settings will ensure confidentiality [95; 110]. With the Internet, practitioners have minimal control over when and how clients encounter information about them online [42]. The Internet has no expiration date, and anything posted online should be assumed to be permanent [66]. Unfortunately, many codes of ethics in fields such as medicine, psychology, social work, nursing, and counseling have struggled to keep up with these technologic changes [41]. In some cases, standards have been established for the provision of technology-assisted services (such as online counseling), but not for online professional conduct [43].

SOCIAL NETWORKING SITES

The use of social networking platforms can affect professional relationships and boundaries. In a 2013 survey of psychologists, social workers, and physicians, 59% of the practitioners indicated they maintained a Facebook account and 75% of users reported using a privacy setting [67]. Similarly, in a survey study with 695 psychology students and psychologists, 77% indicated they had an account on a social networking site, and of these users, 85% used privacy settings [42]. In a 2018 study with nursing students, 96.6% reported having a Facebook account [96]. However, practitioners were ambivalent about what to do when clients contacted them through a social networking site. It may appear to be an innocuous request, but it can bring up many ethical issues. If the practitioner accepts the client as a friend, the client may have access to personal information, blurring professional boundaries. If the practitioner does not accept the request, the client might misconstrue this as rejection, potentially harming the therapeutic relationship. This is made more complicated with platforms like TikTok, because practitioners may not have any control over who "follows" them [101]. Similar issues may arise if information about a client is gleaned from a social networking site. In a study of 302 graduate psychology students, 27% had reported actively seeking out client information on the Internet; most stated they wanted to verify the clients' claims [41]. In a study with 346 undergraduates, participants were asked to evaluate their likelihood of posting different types of "problematic" information in their Facebook profiles and their perceptions of how others would view their image after seeing their profiles [44]. Gender differences were found; specifically, undergraduate men were more likely to report that their Facebook profile contained an image that was sexually appealing, wild, or offensive. Men were also more likely to post "problematic" content in their profiles compared to their female counterparts. In a survey of nurses and midwives, 18.4% of the participants reported having accepted a request from a patient and/or family member to be a social media contact [65]. Younger participants were more likely to receive a request from a patient or family member of a patient to add them and were more likely to accept a request. In a qualitative study of 813 medical students and residents, 44% were found to have an account and only 33% of these profiles were made private [45]. Of the profiles that were not private, the researchers found that more than half included overt mentions of personal and/or ideologic views, such as political affiliation (50%), sexual orientation (52%), and relationship status (58%). In some cases, the medical students and residents had uploaded photos that could be interpreted negatively (e.g., photos with alcohol, excess drinking, drug use). In the study of graduate psychology students, 81% confirmed having some sort of online profile, with 37% reporting having a social networking page [46]. Of the students who used social networking, more than 65% used their real names and 13% stated they posted photos they would not want their faculty members to see. Nearly 30% stated they posted photos they would not want their clients to see, and 37% posted information they would not want to their clients to read. A study of first-year nursing students, participants reported ambivalence regarding patients seeing their posts in Facebook, perhaps because they lack clinical experiences [96]. In a content analysis of Facebook profiles of nurses in the United Kingdom and Italy, the researcher looked at photos posted and classified them according to the content [68]. Approximately 18.5% of the profiles included photos of the

nurse engaged in unhealthy behavior, including smoking and drinking alcohol [68]. The representations of professionals' behaviors on social networking sites could inadvertently have a negative effect on the integrity of the profession [69].

Therapeutic boundaries are established to promote client beneficence and define the client/practitioner relationship. Informed consent, single-role relationship, and confidentiality support these boundaries [70]. The boundaries of the client-practitioner relationship will get blurred as online friendship interactions can lead to sharing of private information on the part of both parties, which may negatively impact the professional relationship [47; 79; 125]. If practitioners find sensitive or embarrassing information about clients, they may be conflicted regarding the appropriate way to use this information. For example, a practitioner may be working with a client on abstaining alcohol, and in the session, the client denies having used alcohol in the past 24 hours. However, if the client and practitioner are linked on a social networking site, the practitioner may stumble onto a photo of the client at a party holding a beer bottle. There is no clear correct course of action. Should the practitioner utilize this information in the next clinical session? If the practitioner does bring it up, does it violate privacy issues? Will it affect the clinical rapport and relationship?

In some cases, social media profiles have been used by law enforcement or social service providers to guide their interactions with clients. For example, there have been reports of social workers "friending" a youth in foster care in order to keep track of them, using a client's social media post to demonstrate his/her lack of progress or faulty character, or using an online profile picture to search for someone [94].

A good first step is to consider the ethical ramifications of each action utilizing the ethical principles identified in many of the professional codes of ethics [41]:

- Beneficence (the duty to do good): How would the information obtained from a social networking site promote the well-being and welfare of the client?

- Fidelity (the duty to keep one's promises): How would the information gleaned about a client on a social networking site help promote trust?

- Nonmaleficence (the duty to do no harm): What harm might emerge from using social networking sites to find information about the client? How might this unintentionally harm the client?

- Autonomy (the individual's right to make his or her own decisions): How does the information found on a social networking site help to promote the client's ability to make his or her own choices about what to share or not in the clinical sessions? Will seeking information on the Internet without the client's consent violate autonomy and respect for the client?

- Justice (the duty to treat everyone fairly): How will the practitioner's being able to find information (or not) on a social networking site provide clues to the client's gender, race, sexual orientation, socioeconomic status, religion, ability, etc.? How might this information affect how the practitioner treats the client?

The same questions can be asked when practitioners use social networking sites to create profiles and post information. How might this information harm the client or jeopardize trust, credibility, and the working the relationship? If a practitioner is a supervisor, what issues of subtle coercion may arise [5]? Of course, each practitioner's behavior on social networking sites must be in accordance with the profession's ethical codes. Befriending a client or patient on a social networking site could potentially violate standards regarding multiple relationships or dual relationships [48].

Practitioners should use their self-reflective skills to ask themselves the following questions in order to guide the information they post on social networking sites [71; 95]:

- What information do you want to share? Is this information important, harmful, protected?

- Why do you want to share this information? What are the benefits and consequences of sharing the information?

- Who needs to see this information? Why?

- Where do I want to share this information?

- What professional boundary issues might "friending" someone pose?

- How might any "off-duty" conduct be perceived?

- How might a photo or post be taken out of context?

- How does my professional code of ethics or other organizational policies guide sharing this information?

E-MAIL DISTRIBUTION LISTS

The main ethical issues associated with e-mail distribution lists concern risks to confidentiality and privacy. Mass e-mail communications can be intercepted at four different points: prior to being e-mailed from the originating computer, during transmission, upon receipt, and when subpoenaed [24]. In one study, 10% of social workers reported having e-mailed something to the wrong person [97]. Some practitioners may utilize this technology to solicit professional consultation from their colleagues. If this is the case, they may describe a case in detail. Even if the client's name and specific identifying information are excluded, the details provided could increase the risk to violating confidentiality. This risk is further increased with the advent of data mining software, which can analyze and search e-mails for certain content or key words [23].

In addition, there is no insurance that the sender or receiver is the person whom they claim to be. A best practice to reduce these risks is to encrypt the e-mail, to alert the client that an e-mail will be sent, or to ask for a phone confirmation that the e-mail has been received [97].

One of the main applications of the ethical principle of respect for persons is informed consent. When seeking consultation from another colleague on the phone or face-to-face, practi-

tioners obtain informed consent from their clients; the same is true when using e-mail distribution lists for this purpose. Practitioners should inform clients they plan to use e-mail for the purpose of consultation and that certain details of the case will be provided. The potential for violations of privacy and confidentiality using this technology should be outlined [23].

CELL PHONES/SMARTPHONES

Cell phones and smartphones are commonplace, and it is important to carefully consider the possible benefits and consequences before providing a personal cell phone number to a patient or client. First, conversations on cell phones cannot be guaranteed confidentiality, as it possible that the conversation will be intercepted by another device (e.g., baby monitor) [70]. Perhaps more importantly, cell phones can imply some level of personal familiarity that goes beyond the client/practitioner relationship [70]. Finally, giving a cell phone number may imply that the practitioner will be available at any time, including after professional hours. To create boundaries, practitioners may inform the client that messages will only be checked during work hours [97].

It is important to be upfront with clients regarding the use of a cell phone in order to clarify the policies and to obtain informed consent form [70]. Practitioners should explicitly discuss the circumstances under which a client may call the practitioner on his/her cell phone, when he/she would not be available, any additional fees involved, and the amount of time he/she will spend on the cell phone with the client.

If practitioners recommend or use mental health apps as part of their interventions, they should keep in mind that many of these apps have not been empirically tested. Therefore, client safety should be considered. Disclaimers should be provided about calling 911 or seeking help from mental health professionals in emergency situations [120]. Clients should also be informed or reminded that any personal information that is collected by the installation of the app can be given/sold to third parties. Clients should read any privacy disclaimers (if provided) [120].

BLOGS AND ONLINE DISCUSSION GROUPS

Concerns about privacy and confidentiality also apply to blogs and online discussions. Practitioners who write or comment on blogs must be sensitive to revealing personal identifiers of clients, which could violate practitioner/client confidentiality and privacy. Practitioners in the health fields should keep the Health Insurance Portability and Accountability Act (HIPAA) in the forefront of their minds when blogging or posting in online discussion groups. HIPAA privacy rules protect any identifiable health data, including any past, present, or future health information that can be used to identify an individual [49]. For example, a practitioner might blog about a difficult client who was treated at his or her workplace at a particular time and date [50]. Even if the client's name is not provided in the blog, if the blog author is not anonymous, it is possible that the workplace could be traced and the identity of the client linked back to the appointment book. Or a practitioner

could post a message to his or her friends on a discussion board describing clinical experiences, but in doing so, express enough information about a client to be identifiable [49; 72]. It is also important to be careful of how clients or patients are depicted, including the tone and content of postings, so as not to threaten or damage the integrity of the professional field or discipline [51].

Conflict of interest is another ethical issue that may arise when using blogs or discussion boards. A practitioner should be cautious of openly endorsing any products or services. Some blogging software platforms, particularly free ones, automatically display advertisements along with the platform. It is vital to avoid dual relationships or have the appearance of having a conflict of interest with service providers. Some experts recommend limiting blog content to announcements about conferences, events, and professional organizations that represent the practitioner's field [26].

In a 2008 study involving 271 medical blogs, individual patients were described in 42% of the blogs, and 16.6% of these had sufficient identifiers, revealing the identity of physicians or patients [51]. The researchers found that 17.7% of the blogs depicted patients in a negative manner (by tone or content), and 11.4% contained product promotions, either by images or direct content. There is a definite need for practitioners to practice self-regulation and self-monitoring, carefully considering ethics and professionalism while blogging, so the ethical principles of respect for persons and beneficence are not compromised.

ONLINE SELF-DISCLOSURES

Much of science and medicine in Western culture is premised on the tenets of logical positivism, advocating for quantification and objectivity [52]. The psychology, counseling, mental health, and social work fields have followed suit, and as a result, paternalism has become the backbone of the patient/client and practitioner relationship. For example, the physician/patient relationship is typically characterized as hierarchical, with the physician viewed as the "expert." Many counseling and social work models, with the exception of feminist and humanistic orientations, similarly espouse this hierarchical relationship. Traditionally, practitioners are positioned as the "objective" experts, disclosing very little about themselves. In the Freudian tradition, therapists are supposed to present as a blank slate to reflect the client's image [79]. However, the extent to which practitioners self-disclose has changed with the growth of the Internet. With the prevalent use of Internet technologies, the client/patient is now an active consumer of health and mental health services, and they are more likely to use the Internet to research or share information about practitioners, services, and facilities [53]. Therefore, the question is not to what extent practitioners should disclose private information to their clients, but rather how to manage the Internet-driven self-disclosure that has become almost inevitable [54; 125]. It is ultimately the practitioner's responsibility to develop the tone

of the professional relationship [66]. Therefore, when disclosing information on social networking sites, the practitioner should take time to reflect on how it may affect the client and the therapeutic relationship.

There are three main types of self-disclosures, and the Internet can affect each of these types [53]:

- Deliberate self-disclosure: The practitioner intentionally discloses certain information, verbally or nonverbally. Internet examples include uploading a photo on LinkedIn, a professional social networking site, or posting information on a commercial website about one's professional background, training, and experiences.

- Accidental self-disclosure: Personal information about the practitioner is inadvertently revealed to the client. For example, a client sees his or her therapist at a boutique, which may reveal information that the practitioner had no plan of sharing. On the Internet, accidental self-disclosures can occur when clients inadvertently come across photographs of their practitioner in a non-professional setting or personal blog posts on a social networking site.

- Unavoidable self-disclosure: These types of revelations are not deliberate but are related to information conveyed by conducting the normal affairs of life. For example, wearing a wedding ring indicates one's marital status. Of course, one can argue whether this is deliberate or unavoidable. Again, photos uploaded on a website or a professional social networking account can reveal information that the practitioner has no control over.

There are two types of anonymity: visual anonymity and discursive anonymity [113]. Visual anonymity refers to a lack of physical or visual cues (e.g., a photo in an online profile) to provide the other party a sense of who is being represented online. Discursive anonymity refers to a lack of textual cues (e.g., use of an online pseudonym) to give a sense of who is being represented. It does not appear that type of anonymity affects the extent of online disclosure.

The most typical disclosures via Facebook profiles are of one's age, gender, education, and relationship status [98]. In the past, if a client asked about a practitioner's background, this could be used as an opportunity to understand the underlying dynamics of the client's interest. Ultimately, practitioners must be diligent in managing their images in both the face-to-face and Internet worlds. Issues of self-disclosure and transparency have moved outside the therapeutic encounter and onto the Internet, and online posts, blogs, threads in discussion forums, and mass e-mails will for the most part stay "alive" in the virtual world [54; 125]. The psychotherapy environment is relational and intimate, and the Internet has reduced the physical dimensions between the client and professional, all of which makes it easier for therapists to accidentally reveal their non-therapist self to their clients [125].

ONLINE SEARCHES FOR INFORMATION ON PATIENTS OR CLIENTS

Conducting online searches, commonly referred to as "Googling," is a common part of modern Internet use. Some practitioners engage in patient-targeted Googling, searching for a specific patient or client on the Internet [73]. In a 2014 study involving counseling graduate students, 75% reported using the Internet to search for information about a client, with 29.2% using Google and 19.5% using a social networking site. Of those who searched, more than 80% stated that they did not obtain informed consent from the client, did not document the search in the client's file, and did not consider this to be a confidentiality issue [73]. In a study with mental health professionals, almost half indicated they had purposively searched for information on the Internet regarding their clients or prospective clients, and in another 2016 survey study, 39.4% of psychotherapists reported having looked online for additional information about their clients; 75% had not obtained client consent to do an online search [99; 133]. In a survey of psychotherapists, 10% of the participants were uncertain about the ethicalness of Googling a client [132]. Almost one-third stated that Googling a client was "unquestionably unethical," and almost a half (48%) believed it was "ethical under rare circumstances." There are cases in which patient-targeted Googling may have yielded fruitful clinical outcomes, such as locating family members of a patient with dementia after all other venues have been exhausted [73].

There is empirical evidence that practitioners are ambivalent about garnering online information about their clients to use for assessment and interventions. It appears that their decisions to do so are dictated by pragmatism, with the risks and the benefits weighed [134]. A 15-month ethnographic study used observations and interviews to explore how social workers in child protection services used Facebook to obtain information about service users [134]. Some of the participants were adamantly against using Facebook to obtain information about their clients. However, there were some who did use Facebook information, especially if supervisors or colleagues were open about using Facebook for the monitoring and surveillance of clients' and families' activities and behaviors. Some argued that if the information was employed in the best interest of the child, they did not view it as unethical. There were some who were drawn into it regardless of how they felt when managers or supervisors gave them the information from Facebook to act on it. Due to the lack of guidance in many organizations and agencies, there continues to be confusion about social media usage to inform practice.

Searching online to obtain information about an individual's home has become a common Internet activity, but there are some who argue it may not be a place for such activity in the clinical encounter. It is vital for practitioners to draw a line between voyeurism and a clinical constructive goal [11; 73]. Although the Internet is considered public, for practitioners to make an active decision to search for additional information

not given by the client may be a violation of his or her rights [74]. This continues to be an issue when considering what to do with information obtained online. If search results are documented in the client's record, it may impact their future care or insurance coverage [73]. In addition, it can undermine the therapeutic relationship and the client's trust in the practitioner and cause boundary issues [114]. Some experts assert that it may be inappropriate to search for online information about a client unless there is a clinical emergency [114].

The following questions may be useful when considering searching for client information on the Internet [94; 114]:

- Why do I want to conduct this search?
- How will the information obtained from the search affect engagement and treatment?
- Is an informed consent needed from the client before searching?

BEST PRACTICE GUIDELINES

In today's environment of technology and information proliferation, it is important to balance the amount of information available to clients and to carefully consider one's online persona as an extension of one's professional identity [55]. Practitioners must now actively manage their virtual identities and reputations. In order to do so, the following best practice guidelines have been established for practitioners when using Internet technologies for both personal and professional reasons.

USE PRIVACY FILTERS

When using social networking sites and/or blogs, practitioners should use a pseudonym, check their privacy filters, block certain personal information (e.g., birthdates, marital status, hometown), and research the restrictions in place for their online profiles in order to exercise control over who can access the information [79; 135]. Most social networking sites and blog platforms have some kind of privacy filter available, but even when in use, clients may be able to view limited information (e.g., a profile picture). Practitioners should remember that privacy controls are subject to change at the discretion of the social media company [66]. Some experts recommend checking privacy settings every three to six months or with every software update [112].

POST CAUTIOUSLY

Practitioners should be cautious regarding posting client/patient information. The Internet has made the world smaller, and it is not difficult to trace the identity of the author of online postings. Furthermore, it is easy to inadvertently post information online that may violate a client's/patient's confidentiality and privacy [5]. Along these same lines, think twice about sharing personal information or photos online. The concept of digital footprints should be at the forefront of practitioners' minds. If any uploaded photos can be professionally compromising, they should not be posted. Consider the

underlying message any information might convey [56; 112]. Certainly, photos that could endanger the privacy of clients or violate HIPAA rules should not be uploaded. Carefully weigh the costs and benefits of posting various information [46]. It is wise to assume that online forums are public, even if it says it is closed and private [100].

Clinicians should also refrain from posting clinical advice or comments regarding people's mental health situation or personal problems social media [101]. It is also important for practitioners not to use online platforms as mechanisms to vent about professional issues. Venting feelings of frustrations with clients, employers, supervisors, salaries, or an agency/organization are likely to be perceived negatively by colleagues and conveys a message of unprofessionalism [50; 115]. Reflect on how information posted on the Internet could undermine one's professional credibility as well as the legitimacy of the professional field [46].

Practitioners might consider having a separate professional email, social media account, and any other digital accounts [135]. This helps mitigate the blurring of boundaries, although practitioners will still need to exercise caution about how their professional online persona and identities are conveyed.

THE "FRIEND" DILEMMA

As discussed, the issue of dual relationships is at the heart of deciding whether or not to accept patients/clients as "friends" on social networking sites [66]. The risks and the benefits should be weighed. If a patient or client invites a practitioner to be an online "friend," the practitioner can discuss dual relationships and the reasons why this is unprofessional and unethical; this request could become part of the clinical work [46; 47; 125]. If the client becomes angry that the practitioner has "rejected" him or her or ignored the invitation, this could be discussed within the context of the client's previous experiences with loss, rejection, and self-esteem [97].

Consider crafting a professional statement about why accepting patients/clients as online friends is inappropriate. If this is an issue affecting your practice, spend time writing a standard statement to send to clients/patients regarding the professional policy not to accept clients as online friends [50]. This statement can be friendly but firm and should indicate the reasons it is not wise to establish this online relationship due to privacy and confidentiality issues. However, clients should be encouraged to discuss any issues with the practitioner during a scheduled session within the context of the therapeutic setting.

SEARCH WISELY

Practitioners should reflect on the underlying motivations for searching for client information on the Internet and how this information could be used positively. Therefore, searching for information about a client or patient is not necessarily unethical. Rather, consider how clients or the therapeutic relationship could ultimately be negatively affected by any information found and how the information can help the client [11; 46; 114; 132]. In general, it is best to avoid searching for client information online.

However, practitioners should search for themselves on the Internet. Many professionals believe that everyone experiences some level of privacy through online obscurity, and in general, individuals take the path of least resistance in monitoring their online presence [57; 79]. This can be detrimental and may limit the practitioner's ability to control disclosures. Practitioners should conduct Internet searches regularly to monitor the information available about themselves and to have better control of the content [42]. Furthermore, if clients raise information they found on the Internet in a clinical session, this will prevent practitioners from being caught unaware.

SOCIAL MEDIA AND TECHNOLOGY IN INFORMED CONSENT

The content of informed consent forms should reflect the changing technologic times. The following points should be incorporated into informed consent forms [70; 72; 75; 79; 107]:

- How cell phones, e-mails, and social media will be used with the patient/client

- Whether the practitioner will search for information about the patient/client on the Internet

- How the practitioner will respond if contact is made by the patient/client on a social media site

- If the practitioner will follow, respond, or block clients, and how clients will be advised that they have permission to block practitioners

- If the practitioner will take cell phone calls and, if so, parameters for use

- Whether there will be additional fees if the client makes contact with the practitioner via phone, e-mail, and/or social networking site

- Whether therapeutic issues will be discussed via e-mail

- If the practitioner does respond via e-mail, expected response turnaround time

- Risks and benefits of clients using social media within the therapeutic context

Some practitioners recommend openly discussing social media with their clients. For example, if a practitioner is active on social media, it may be good practice to ask clients if they have viewed their online postings and how they feel about the content [101; 124]. If practitioners are active on social media for professional reasons, a disclaimer is recommended. A weblink for referral to mental health resources can be provided in the profile area and/or other areas in the social media profile [101]. Any content developed for psychoeducation should have a disclaimer that the information is not directed to any specific individual and that the individual should always seek formal mental health services [124].

CONCLUSION

The landscape of professional practice has changed with the increasing use of Internet technology by both practitioners and clients/patients. The opportunities that the Internet affords are endless, and practitioners should reflect on how information posted online can have implications on their professional practice and their relationships with clients/patients. The codes of ethics and professional standards may not have necessarily kept up with the technologic changes, and therefore, there may not be clear guidelines on how to behave online. Ultimately, more education is needed for professionals entering the fields to prepare to make the complex ethical decisions they will face using new technologies. Clinical supervisors should initiate conversations with their supervisees regarding how online personas and identities can affect professional identities, credibility, and roles. Finally, psychologists, social workers, counselors, therapists, physicians, and nurses must take an active role in shaping the development of professional standards for the provision of services in the new online environment, conforming to the ethical and professional best practices in their respective fields.

Customer Information, Answer Sheet, and Evaluation are located on pages 123–128.

TEST QUESTIONS

#97664 ONLINE PROFESSIONALISM AND ETHICS

This is an open book test. Please record your responses on the Answer Sheet.

A passing grade of at least 80% must be achieved in order to receive credit for this course.

This 3 hour activity must be completed by April 30, 2027.

1. **Which of the following statements regarding older adults' use of social networking sites is TRUE?**
   A) *They have social networking accounts for professional reasons only.*
   B) *They tend not to use social networking sites at all due to their fear of technology.*
   C) *They are using Facebook more and more, with 50% using this platform in 2021.*
   D) *They comprise the largest proportion of users among the adult population in the United States.*

2. **A chatroom or chat group is a virtual community or venue in which a group of individuals can "dialogue" and share information about a common interest.**
   A) *True*
   B) *False*

3. **Which web tool is analogous to an online journal, generally consisting of a log of chronologic entries?**
   A) *Blog*
   B) *E-mail*
   C) *Chatroom*
   D) *Social networking site*

4. **All of the following are social networking sites, EXCEPT:**
   A) *TikTok*
   B) *YouTube*
   C) *Facebook*
   D) *Wikipedia*

5. **Which of the following is a way Internet technologies can be used for clinical practice?**
   A) *Provide patient support*
   B) *Self-help or self-therapy*
   C) *Dissemination of information*
   D) *All of the above*

6. **Because social support is an essential factor in helping people cope with medical conditions, social networking may be an important tool.**
   A) *True*
   B) *False*

7. **PatientsLikeMe is an example of a**
   A) *blog.*
   B) *mass e-mail list.*
   C) *social networking site.*
   D) *None of the above*

8. **The development of a practitioner's professional identity begins and ends with his or her first job.**
   A) *True*
   B) *False*

9. **Professionalism is characterized by**
   A) *a personal high standard of competence.*
   B) *a frame of reference for carrying out work roles.*
   C) *the application of general principles to specific problems.*
   D) *the developmental process of a practitioner's professional identity.*

10. **E-professionalism is a set of online attitudinal and behavioral standards that conforms to the expectations and values of a profession.**
    A) *True*
    B) *False*

11. **An analysis of the codes of ethics of diverse professions classified professional codes of ethics into four domains, including**
    A) *the professional's qualities and characteristics*
    B) *behaviors toward other professionals and colleagues*
    C) *behaviors of professionals in a range of situations*
    D) *All of the above*

12. The boundaries of the client-practitioner relationship will get blurred as online friendship interactions can lead to sharing of private information on the part of both parties.
    A) True
    B) False

13. Accepting a client's request to befriend him/her on a social networking site could potentially violate standards regarding
    A) online addiction.
    B) dual relationships.
    C) transference issues.
    D) diminishing intentionality.

14. What is the main ethical concern associated with using e-mail distribution lists for consultations?
    A) Risks to veracity
    B) Risks to intentionality
    C) Risks to the principle of justice
    D) Risks to privacy and confidentiality

15. Cell phones can imply some level of personal familiarity that goes beyond the client/practitioner relationship.
    A) True
    B) False

16. Which of the following is NOT a type of self-disclosure?
    A) Deliberate
    B) Accidental
    C) Accounted
    D) Unavoidable

17. If a healthcare professional has a website on which his or her educational background, licensures, and professional experience is described, what type of disclosure does this represent?
    A) Personal
    B) Deliberate
    C) Accidental
    D) Unavoidable

18. The most typical disclosures via Facebook profiles are of religious and political affiliations.
    A) True
    B) False

19. Which of the following is NOT considered a best practice guideline when managing one's virtual identity?
    A) Search for one's self on the Internet.
    B) Use a privacy filter on online profiles.
    C) Use online platforms as mechanisms to vent about professional issues.
    D) Create a professional statement explaining why accepting patients/clients as online friends is inappropriate.

20. Professionals should consider crafting a professional statement about why accepting patients/clients as online friends is inappropriate.
    A) True
    B) False

Be sure to transfer your answers to the Answer Sheet located on page 124.

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.*

Maternal Health Disparities

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

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Faculty Disclosure

Contributing faculty, Mary Franks, MSN, APRN, FNP-C, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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

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

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INTRODUCTION

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.

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].

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]:

- 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.

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.

- 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 fluidity 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.

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].

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].

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

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.

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 page 124.

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.*

Counseling Patients at the End of Life

Audience

This course is designed for all members of the interprofessional team responsible for supporting patients at the end of life.

Course Objective

The purpose of this course is to provide health and mental health professionals with the knowledge and strategies necessary to best assist patients to seek and receive optimal end-of-life care.

Learning Objectives

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

1. Define palliative and end-of-life care.
2. Outline the role of health and mental health professionals in end-of-life counseling.
3. Identify psychological concerns present at the end of life.
4. Discuss key components of end-of-life conversations.
5. Analyze mental health interventions that can be incorporated into end-of-life care and bereavement.
6. Describe practical, ethical, and legal issues that can arise in the provision of end-of-life care.
7. Examine the impact of culture and culturally competent care on end-of-life decisions and support.

Faculty

Lisa Hutchison, LMHC. (A complete biography can be found at NetCE.com.)

Faculty Disclosure

Contributing faculty, Lisa Hutchison, LMHC, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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INTRODUCTION

End-of-life decisions can be complex and challenging. Health and mental health professionals can help with their expertise, whether it is for the person facing death, their family, surrogate decision makers, or caregiver. It is vital for health and mental health professionals to learn when and how to include end-of-life discussions into their sessions, assist with decision making and planning, and learn the differences between palliative and end-of-life care.

DEFINING END-OF-LIFE CARE

The terms palliative care and end-of-life care often are used interchangeably, but there are some differences. The goal of palliative care is to improve the quality of life of patients and their families when faced with life-threatening illness. This is achieved through the prevention and relief of suffering and treatment of pain and other physical, psychosocial, and spiritual problems [1]. Palliative care includes measures used to achieve comfort for the patient. Palliative care can be provided at any stage of a serious illness, including as early as the time of diagnosis. Unlike patients receiving end-of-life care, those receiving palliative care may still be pursuing curative treatment [2].

End-of-life care (which may include palliative care) is generally defined as care that is provided to seriously ill patients who have a prognosis of six months or less. It is care intended for the last few weeks or months of a patient's life. End-of-life care can be provided in a variety of settings, including the patient's home, nursing homes or assisted living facilities, or inpatient hospice facilities [2]. End-of-life care is a multidisciplinary team approach toward "whole person care." It is intended for people with advanced, progressive, incurable, or life-limiting illness

to enable them to live as well as possible before they die [3]. This course will focus on end-of-life care.

THE ROLE OF HEALTH AND MENTAL HEALTH PROFESSIONALS IN END-OF-LIFE COUNSELING

The transition of care from eliminating or mitigating illness to preparing for death can be difficult for patients, families, and caregivers, and it can be equally difficult for healthcare professionals, who are expected to meet the physical and emotional needs of dying patients and their families [4]. By understanding the experiences of the dying patient, health and mental health professionals can best support the unique needs of each patient and the patient's loved ones as well as self and other members of the patient's healthcare team [4; 5; 6; 7]. Mental health professionals are uniquely positioned to address the cognitive, mental, and emotional needs that arise during this period of life-limiting illness [8; 9]. They work to normalize emotions during a difficult time; provide spiritual support; educate about normal physical, emotional, and social changes; and assist in managing practical problems. They also may develop relationships with survivors to provide a continuity of care following the patient's death. Health and mental health professionals work in a variety of settings that address end-of-life care, including health agencies, hospitals, hospice and home care settings, nursing homes, and courts [10].

Both end-of-life and palliative counseling are services provided by clinicians who work with the terminally ill. End-of-life counseling helps patients struggling with death or families struggling with the death of a loved one and may be provided by counselors, therapists, social workers, psychologists, critical care nurses, physicians, hospice workers, and others trained in working with emotions related to death, dying, grief, and bereavement [8].

Health and mental health providers provide services to diverse individuals in a variety of settings, including end-of-life settings, as part of an interprofessional team. In the end-of-life setting, clinicians help dying patients prepare for death with education and supportive therapeutic interventions that address the patient's physical, emotional, social, spiritual, and practical needs [10]. They also help patients and their families navigate the many challenges associated with dying, including end-of-life planning; managing stresses associated with life-limiting illness; assessing patients to develop interventions and treatment planning; advocating for patients' treatment plans; overcoming crisis situations; and connecting them with other support services [11; 12]. Life-limiting illness is mentally taxing and can exacerbate or incite symptoms of anxiety, depression, and trauma and make manifest complex presentations of cognitive decline. Providers can help differentiate between trauma symptoms, mental illness, or medical decline. Reducing mental health symptoms can help patients engage more meaningfully, including in the participation of

end-of-life decisions [9]. A cohesive, standardized approach to end-of-life care addresses issues related to the patient, family, caregivers, and the team of healthcare professionals involved in providing care [12].

PSYCHOLOGICAL CONCERNS FOR PATIENTS AT THE END OF LIFE

Psychological suffering is a universal experience for patients at the end of life. It exists on a continuum and has many sources, including grief over anticipated loss or worry about unresolved issues. It is important to assess and differentiate the major types of distress in the dying patient and among their families to effectively treat these sources of suffering.

LIFE-CYCLE ISSUES/RELATIONSHIPS

Psychological responses to the news of a life-limiting illness will vary according to the patient's developmental stage. The young adult, about to become independent, might struggle with being thrust back into dependence upon parents or other adult figures. Parents of young children with life-limiting illness often are consumed with what and how much to tell their ill child, the impact of the child's illness on other siblings, and how to cope with the loss of the child's future. Worries about a spouse or partner are a common concern for older adults. They may feel cheated out of the expected rewards of a life of hard work. Worries about family members are a major issue for most patients at the end of life [13]. One study found that 92% to 97% of patients rated as extremely or very important "feeling appreciated by my family," "saying goodbye to people closest to me," "expressing my feelings to family," and "knowing that my family will be all right without me" [14]. Caregivers of patients with terminal illness also experience significant strains (e.g., adverse impact on work and finances) [15]. Awareness of these life-cycle and relationship issues can help the clinician listen for and inquire about concerns and emotions, normalize patient responses, and explore areas of distress [13].

MEANING AND IDENTITY

Illness comes with practical and emotional challenges that are unique to each patient. The clinician who understands what the illness means to the patient can identify specific concerns, address fears, provide reassurance, and help the patient make plans. Providing patients with the opportunity to share what their illness means can be therapeutic in and of itself [13]. Some patients state that finding meaning in illness is derived from the belief that their life has a purpose that extends beyond self. Others find that meaning enhances their ability to cope with their illness. Still others experience a loss of meaning when faced with life-limiting illness. The patient's ability to find and maintain a sense that life has purpose and meaning is associated with the ability to tolerate physical symptoms of the illness and protect against depression and a desire for hastened death [13]. Meaning and hope are closely allied in patients at the end of life, and hopes for the future reflect the patient's priorities.

Maintaining a sense of self is a high priority among patients with life-limiting illness, yet serious illness has a profound impact on patient self-identity. The physical and psychological losses (e.g., loss of feeling whole, loss of independence, loss of control) present major challenges to the patient's emotional health. Control and independence often are combined in the literature to mean the patient's dignity, or the "quality or state of being worthy, honored, or esteemed" [13]. Preservation of this dignity should be a primary concern of end-of-life care practitioners.

COPING AND STRESS

Confronting a life-limiting illness causes patients to make psychological adjustments to preserve equilibrium. Coping responses can include seeking information about the illness, staying busy to avoid thinking about the illness, resigning one's self to the illness, examining alternatives, and talking about feelings. Effective coping occurs when the patient is able to use active problem-solving strategies. Yet, as illnesses progress, patients' ability to perform cognitive tasks can decline. Some patients cope by defending against or denying the reality of their illness to fend off acute emotional distress. The dynamic tension between coping and defending/denying causes most patients to use a combination of these responses [13]. While denial is a powerful mechanism that helps preserve psychological equilibrium, it can have many negative effects, including refusal to accept death; lost trust in the healthcare team; focus on unrealistic treatment goals; and failure to make legal, financial, and healthcare arrangements [13]. Life-limiting illness represents a major adaptational challenge to patients' learned coping mechanisms. Psychosocial stressors enhance the likelihood that a patient will become depressed. Practical stressors (e.g., relationships, work, finances, legal matters) also can impact patients' ability to cope with their illness. Economic circumstances have been found to be a major stressor for patients and their families, often resulting in a decline in family economic well-being [13]. In one study, 20% of family members of seriously ill adult patients had to make a major life change (including quitting work) to care for their loved one; up to 31% of families lost all or most of their savings while caring for their ill loved one [14].

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) may first emerge, re-emerge, or worsen as individuals approach the end of life and may complicate the dying process. Unfortunately, lack of awareness of the occurrence and/or manifestation of PTSD at the end of life can result in it being unaddressed in these patients. Even if PTSD is properly diagnosed, traditional evidence-based, trauma-focused treatments may not be feasible or advisable for patients at the end of life, as they often lack the physical and mental stamina to participate in traditional psychotherapy [16]. Many therapies for PTSD require a longer window of treatment than a typical hospice period. Providers can tailor treatment for short-term interventions or use approaches such as the Stepwise Psychosocial Palliative Care (SPPC) model.

The SPPC model is a multidimensional approach, integrating environmental, problem-solving, and other psychosocial interventions with patient advocacy in a patient-centered, time-sensitive manner. It incorporates techniques drawn from evidence-based approaches to PTSD, deploying them in a stage-wise manner appropriate for patients at the end of life [17]. Debriefing interventions have been widely used to treat PTSD and the psychological sequelae of traumatic events, and these approaches can be appropriate in the end of life. Further, antidepressant, antianxiety, and antipsychotic agents may be used to manage intense symptoms. Support groups and psychoeducational approaches are also common approaches, but evidence of their effectiveness in this setting is lacking [13].

ANTICIPATORY GRIEF

Anticipatory grief is the experience of grieving the loss of a patient or loved one in advance of their death [18]. It is a response to impending loss of life, identity, function, hopes, and future plans and is associated with anxiety, depression, hopelessness, and strained communication [19]. Other intense emotions, such as fear and panic, can appear as a result of unexplained symptoms and uncertainties regarding treatment [20]. One study evaluated anticipatory grief in 57 family members of patients with terminal illness receiving palliative care services [18]. Elevated anticipatory grief was found in families characterized by relational dependency, lower education, and poor grief-specific support. These families also experienced discomfort with closeness and intimacy, neuroticism, spiritual crisis, and an inability to make sense of the loss [18]. Patients, families, caregivers, and clinicians all can experience anticipatory grief. Several factors (e.g., spiritual beliefs, quality of relationships, attitudes of close others or colleagues/peers) can influence the anticipatory grief toward either positive or negative outcomes [21].

As a core component of psychological flexibility, acceptance is beneficial in situations in which individuals have little or no control over circumstances, such as when faced with a life-limiting illness. Acceptance becomes an active process wherein the patient acknowledges and opens up to their situation in order to make the most of their remaining time. Although acceptance shares a strong relationship with anticipatory grief, depression, and anxiety, it is independent of anxious and depressive symptomatology and more likely to predict the level of anticipatory grief than anxiety or depression. A higher degree of acceptance is associated with lower anticipatory grief in patients in palliative care [19]. When anticipatory grief is an expression of past or current trauma, it may develop into complicated grief if left untreated. A thorough assessment is warranted to determine if the grief is current or connected to unresolved trauma. Consider treating the initial trauma before the anticipatory grief. At the end of life, if time does not allow for intensive treatment, look to reduce individual trauma symptoms or grief.

ANXIETY AND FEAR

Death is an ever-present reality despite increasingly technologically advanced health systems, longer survivals, and novel curative treatments for life-threatening conditions [22]. Fear of the unknown has been described as the propensity to experience fear caused by the perceived absence of information at any level of consciousness or point of processing [23]. Fear of death and dying is common. In one study, a majority (70%) of participants reported some, a little, or no fear of death and dying; 30% reported more severe fears [24]. A common fear in Western society is that the process of dying will be painful and prolonged and will reduce the quality of life. Other fears associated with death include [25]:

- Fear of separation from loved ones, home, and job
- Fear of becoming a burden to others
- Fear of losing control
- Fear for dependents
- Fear of pain or other worsening symptoms
- Fear of being unable to complete life tasks or responsibilities
- Fear for the fears of others (reflected fear)
- Fear of being dead

It is important that clinicians allow patients a full expression of these fears, without judgment. Patients with anxiety often cannot take in information and may ask the same questions over and over again. They may seek detailed information or not ask reasonable questions. They may be suspicious of the physician's recommendations or not ask questions because of regression or high levels of fear. They may over-react to symptoms or treatments or behave inexpressively and stoically. Their behavior may seem inconsistent and impulsive [13]. An ongoing assessment of anxiety symptoms and anxiety's various presentations is critical to maintaining the patient's mental health. Equally important is that the clinician recognize that anxiety in end-of-life care also may be the result of a pre-existing anxiety disorder or other undertreated symptoms, especially pain. A multidrug treatment regimen in the palliative care setting also can contribute to anxiety [13].

Thanatophobia

Thanatophobia is an extreme fear of death or of the dying process [26]. Fear of death as a disease entity behaves much like initial anxiety due to trauma that leads to PTSD [27]. Evidence suggests that thanatophobia is highest in patients who do not have high self-esteem, religious beliefs, good health, a sense of fulfillment in life, intimacy, or "a fighting spirit" [27]. While anxiety, depressive symptoms, and beliefs about what will happen after death can contribute to a patient's fear, death anxiety does not always follow after a diagnosis of life-limiting illness [27]. It appears to be a basic fear at the core of a range of mental disorders, including hypochondriasis, panic disorder,

and anxiety and depressive disorders [28]. Antecedents of death anxiety include stressful environments and the experience of unpredictable circumstances, diagnosis of a life-threatening illness or the experience of a life-threatening event, and experiences with death and dying. Consequences of death anxiety include both adaptive and maladaptive presentations. When encountering death anxiety in a patient, assess for PTSD and the various anxiety disorders to determine whether it is anxiety-based or associated with an underlying trauma [22].

Death anxiety is a central feature of health anxiety and may play a significant role in other anxiety disorders [29]. Exposure to death-related themes has been found useful for the treatment of death anxiety [29]. A 2015 study that assessed death anxiety among patients with life-limiting cancer found that life stage, particularly having dependent children, and individual factors, such as lower self-esteem, increased patients' vulnerability to death anxiety [30]. Depressive symptoms also have been reported in health professionals who work with dying patients [31]. A 2011 study sought to assess the impact of death and dying on the personal lives of clinicians involved in end-of-life care [32]. Early life experiences and clinical exposure to death and dying helped the clinicians to live in the present, cultivate spirituality, and reflect on their own mortality and the continuity of life. Despite reporting accounts of death's ugliness, participants consistently described the end of life as a meaningful life stage [32]. Yet, not all clinicians find that working with patients at the end of life decreases their death-related anxiety, and many will require support and guidance. Burnout and death anxiety can be emotionally devastating, resulting in impaired performance that makes the goal of quality patient care almost impossible to accomplish [33]. All providers of end-of-life care should be reminded that they are not alone and that they can rely on other members of the healthcare team [34].

Education about death also may be helpful. In a 2015 study of 86 human services professionals, participation in a course on death, dying, and bereavement was shown to significantly reduce clinicians' fear of death and death anxiety [35]. In a study that included 42 nurses enrolled in death education programs, some affirmative impacts on the death distress of participants was observed [31]. Younger nurses consistently reported a stronger fear of death and more negative attitudes towards end-of-life patient care, indicating that workplace education might be beneficial [36]. One study investigated whether a brief induction of gratitude could reduce death anxiety [37]. Participants (mean age: 62.7 years) were randomly assigned into one of three conditions (gratitude, hassle, and neutral) and asked to write about a variety of life events before responding to measures of death anxiety. Participants in the gratitude condition reported lower death anxiety than those in the hassle and neutral conditions; no difference was observed between hassle and neutral conditions [37]. Even a temporary relief of death anxiety may help facilitate the making of important end-of-life decisions [37].

PAIN

Pain management is an integral part of palliative care. Pain management in end-of-life care presents unique opportunities in the patient-physician relationship [38]. In some instances, pain can be reduced when the patient has a sense of control and knows what to expect. Patients report feeling empowered by participating in treatment decisions with their physicians [39]. Pain management in children presents special challenges. A multidisciplinary team with an open attitude to differences, listening skills, availability, flexibility, creativity, resourcefulness, and empathy can help the child and his or her family live with the least pain possible [40]. For both adult and pediatric patients at the end life, planning for what could happen is often key. Honest, dynamic discussions about treatment goals and possible options and their respective side effects allows patients and their families to make choices that best fit their wishes [40]. Treating pain at the end of life means caring for all possible manifestations, including physical symptoms as well as psychological symptoms and reduced well-being. This can be achieved by integrating pharmacotherapy with psycho-socio-spiritual interventions [41].

DEPRESSION

Evidence of hopelessness, helplessness, worthlessness, guilt, and suicidal ideation are better indicators of depression in the context of life-limiting illness than neurovegetative symptoms [42]. Yet, diagnosing and treating depression in patients with life-limiting illness remains challenging for several reasons. Typical symptoms of depression (e.g., impaired concentration, anergia, sleep disturbances) also are common symptoms of advanced mental illness, and side effects from medications commonly used at the end of life can mimic depressive symptoms. Delirium occurs in up to 90% of patients at the end of life. A mistaken diagnosis of depression in a patient with hypoactive delirium can lead to a prescription for an antidepressant or psychostimulant, which can exacerbate the delirium. To further complicate assessment, patients frequently do not report or may disguise symptoms of depression at the end of life [43]. It can also be difficult to determine if pharmacotherapy or reflective listening would be the appropriate intervention for the specific patient.

An assessment of available screening tools and rating scales for depressive symptoms in palliative care found that the tool with the highest sensitivity, specificity, and positive predictive value was the question: "Are you feeling down, depressed, or hopeless most of the time over the last two weeks?" [43]. One structured approach was found to help clinicians differentiate major depressive disorder from common physical symptoms of the patient's illness. With this approach, physical criteria for a diagnosis of major depressive disorder are replaced by psychological symptoms (*Table 1*) [43].

PHYSICAL DEPRESSIVE SYMPTOMS VERSUS REPLACEMENT PSYCHOLOGICAL SYMPTOMS	
Physical Symptoms	**Replacement Psychological Symptoms**
Change in appetite	Tearfulness, depressed appearance
Sleep disturbance	Social withdrawal, decreased talkativeness
Fatigue	Brooding, self-pity, pessimism
Diminished ability to think or concentrate	Lack of reactivity, blunting
Source: [43]	*Table 1*

Some patients fear that being diagnosed with depression will cause their medical providers to stigmatize them or treat their physical symptoms less aggressively. It may then be necessary to address these issues before the patient will be willing to accept treatment for depression [42]. Left untreated, depression in seriously ill patients can be associated with increased physical symptoms, suicidal thoughts, worsened quality of life, and emotional distress. It also can impair the patient's interaction with family and erode patient autonomy [43]. Although patients with terminal illness often have suicidal thoughts, they are usually fleeting. Sustained suicidal ideation should prompt a comprehensive evaluation [42].

SUICIDALITY

Suicide is a response to two stimuli (i.e., pain and despair) that often overlap. The pain can be physical or psychological, but in either aspect, it consumes the person to the point of seeking release. Despair is the result of believing that there is no longer any hope of having a good life [44]. Uncertainty about how death will unfold and whether they will be able to cope can be intensely stressful for patients. For some, suicide may seem preferable to a protracted period of anxiety, uncertainty about the process of dying, and fear of substantial physical suffering [29]. Diagnosis of severe physical illness (e.g., chronic obstructive pulmonary disease, low-survival cancer, degenerative neurological conditions) is associated with higher suicide risk [162].

A Wish to Die

Despite research efforts to deepen understanding of why some patients with terminal illness express a wish to die, there is consensus that there is more to learn about the factors that influence such a wish [45]. A case study review of patients with terminal cancer diagnoses in palliative care sought to understand possible motivations and explanations of patients who express or experience a wish to die [45]. Intentions, motivations, and social interactions were key to understanding and analyzing a patient's wish-to-die statements. The study focused on motivations, which address the question (from the patient's perspective) of why a wish to die is present. Motivations appear to consist of three layers: reasons (the causal factors), meanings (explanatory factors), and functions (effects of the wish) [45]. Patients' motivations were not able to be explained by a single reason, and, for most, their wish to die had broader significance

that reflected their personal values and moral understandings—that is, the "meaning" of their wish to die [45]. Patients reported nine types of meanings, with some appearing more frequently than others. The meanings were shaped by patients' personal experiences, cultural background, and relationships. Patients expressed that a wish to die can be a wish to [45]:

- Allow a life-ending process to take its course
- Let death put an end to severe suffering
- End a situation that is seen as an unreasonable demand
- Spare others from the burden of oneself
- Preserve self-determination in the last moments of life
- End a life that is now without value
- Move on to another reality
- Be an example to others
- Not have to wait until death arrives

Health and mental health professionals cannot properly address a patient's wish to die if the meanings of the wish remain unexplored. Meanings are loaded with moral beliefs that need to be understood and respected in communication, disease management, and care of patients and their families [45].

END-OF-LIFE CONVERSATIONS

Dr. Elisabeth Kübler-Ross is credited as one of the first clinicians to formalize recommendations for working with patients with life-limiting illness. Her book, *On Death and Dying*, identified a gap in our understanding of how both patients and clinicians cope with death [46]. She wrote that it could be helpful if people could talk about death and dying as an intrinsic part of life [47]. In writing specifically about psychotherapy with the terminally ill, Dr. Kübler-Ross stated: "It is evident that the terminally ill patient has very special needs which can be fulfilled if we take time to sit and listen and find out what they are" [47].

Patients who receive the news that they do not have long to live will experience strong emotions accompanied by questions, which can be viewed as opportunities for clinicians to provide answers and open a broader discussion about the end of life. Such questions (and answers) may include [48]:

- *How long have I got?*

  Giving patients a sense of how much time is left allows them to focus on what is important to them. Answers to this question should be clear and as accurate as possible, while acknowledging that exact timeframes are impossible to know.

- *Will palliative care help?*

  When palliative care is appropriate, it supports patients and their families/caregivers by helping them to manage their physical, mental/emotional, spiritual, and practical needs. For patients at the end of life, palliative care is almost always appropriate.

- *What is a "good death?"*

  The answer to this question varies depending on each patient's attitudes, cultural background, spiritual beliefs, and medical treatments. Patients' wishes regarding where they prefer to die (e.g., at home, in hospital) also should be discussed.

- *How will I know that the end is near?*

  The answer depends on the patient and the patient's illness, but events that commonly occur during the dying process include reduced appetite, gradual withdrawal from the outside world, and sleeping more.

Data derived from a national survey of physicians, nurses, social workers, chaplains, hospice volunteers, seriously ill patients, and recently bereaved family members indicate an overwhelming preference for an opportunity to discuss and prepare for the end of life [39]. And while a majority (92%) of Americans say it is important to discuss their wishes for end-of-life care, only 32% have had such a conversation [49]. A majority of patients also prefer that a healthcare provider initiate end-of-life discussions [50]. It is important to note that these discussions do not have to wait for the end of the patient's life. The American Psychological Association has identified four time periods when health and mental health professionals can contribute to end-of-life care [51]:

- Before illness strikes
- After illness is diagnosed and treatments begin
- During advanced illness and the dying process
- After the death of the patient, with bereaved survivors

The end-of-life conversation can be divided into four simple steps [50]:

- Initiate the discussion:
  - Establish a supportive relationship with the patient and the patient's family.
  - Help the patient to appoint a surrogate decision maker.
  - Elicit general thoughts about end-of-life preferences through the use of probing questions.

- Clarify the prognosis:
  - Be direct yet caring.
  - Be truthful but sustain spirit.
  - Use simple, everyday language.

- Identify end-of-life goals:
  - Facilitate open discussion about desired medical care and remaining life goals.
  - Recognize that, as death nears, most patients share similar goals (e.g., maximizing time with family and friends, avoiding hospitalization and unnecessary procedures, maintaining functionality, minimizing pain).

- Develop a treatment plan:
  - Provide guidance in understanding medical options.
  - Make recommendations regarding appropriate treatment.
  - Clarify resuscitation orders.
  - Initiate timely palliative care, when appropriate.

Optimal end-of-life care begins with an honest discussion between clinicians and patients about disease progression and prognosis [52]. Patients and families are sensitive to verbal and nonverbal cues during these discussions. It is therefore incumbent on the healthcare team to train themselves in active listening skills, correct body language, and appropriate empathic responses in order to convey information in a clear, concise, and empathic manner [3]. Physicians also must balance their desire to honor patient wishes and autonomy against the concern of inflicting psychological harm. A 2008 study sought to determine whether end-of-life discussions were associated with fewer aggressive interventions and earlier hospice referrals [53]. The study enrolled advanced cancer patients and their informal caregivers (332 dyads) and followed them up to the time of death, a median of 4.4 months later. Quality of life and psychiatric illness was assessed in bereaved caregivers a median of 6.5 months later. Thirty-seven percent of patients reported having end-of-life discussions at baseline. These discussions were associated with lower rates of ventilation, resuscitation, intensive care unit (ICU) admission, and earlier hospice enrollment. Overall, end-of-life discussions were associated with less aggressive medical care near death, better patient quality of life, and earlier hospice referrals [53].

PATIENT WISHES

What do patients consider important in the process of preparing for the end of their lives? How do their perspectives differ from the values of family members or healthcare providers [39]? A 2015 study was conducted to define what matters most about end-of-life care [54]. Providers and administrators from 14 specialized palliative care teams were interviewed and their responses were analyzed to derive themes depicting the universal essence of end-of-life care. The most predominate theme,

GUIDELINES FOR BREAKING BAD NEWS
Formulate a plan. Mentally rehearse the steps of the conversation.
Schedule a time for the discussion to allow all important family members and medical staff to be present.
Meet in a quiet and private setting.
Make arrangements for a professional translator if English is not the first language of the patient/family. Meet with the professional translator before the discussion to discuss expectations.
Preface bad news with a phrase to prepare the patient or family, such as "I wish the results were different, but…"
Communicate clearly and minimize use of technical language.
Let the patient's and family's reactions guide the flow of the conversation. Allow silence.
Be empathetic and acknowledge the patient's/family's emotions.
Determine the family's level of understanding of the illness/situation to assess misconceptions, aspects of news that will be surprising, and their unique information needs.
Determine if the patient or any family members are "numbers people" so they can be provided the type of information with which they feel most comfortable.
Schedule a future meeting to discuss the bad news and options (e.g., in an hour, the next day, the next week).

Source: [159; 160; 161]   *Table 2*

mentioned by almost one-half of the respondents, was that the "patient's wishes are fulfilled" [54]. Honoring patient wishes involves identifying what a patient wants through open communication and end-of-life care planning, providing education about options, providing realistic expectations, and allowing patients to have control over decision making [54]. Clinicians can regularly promote communication and education about end-of-life care issues by taking the initiative and discussing each patient's goals for end-of-life care. These goals may change over time and with illness and should be regularly re-evaluated and restated [55]. The patient's cultural and/or religious background can influence end-of-life decisions regarding comfort care and patient management, who can be present at the time of death, who will make healthcare decisions, and where the patient wants to die [56]. Encourage patients to elaborate on their wishes with prompts such as [56]:

- "In my religion, we . . ." This will help patients describe religious traditions to be observed at death.
- "Where we come from . . ." This will help patients share important customs to be observed at death.
- "In our family, when someone is dying, we prefer . . ." This will help patients describe what they hope will happen at death.

BARRIERS TO END-OF-LIFE CONVERSATIONS

Barriers to end-of-life discussions can seriously interfere with the quality of remaining life for patients with terminal illness. Barriers have been identified as originating with patients/families, with healthcare professionals, and within the structure of the healthcare system [57].

Patient-Related Barriers

Patients often avoid discussing end-of-life care with their clinicians and may conceal the full extent of what and how they are feeling, given the scope of end-of-life decisions. Family members and significant others also can complicate end-of-life conversations when they either cannot or will not discuss and accept the advanced nature of the patient's disease or the patient's preferences concerning end-of-life care, or when they overestimate the chance of cure, placing unreasonable demands upon the clinician [57].

Clinician-Related Barriers

Clinicians might avoid end-of-life discussions with their patients because they are reluctant to cause pain or be the bearers of bad news. They may lack the necessary communication training and skills, particularly in the delivery of bad news. They may focus solely on clinical parameters or have medical-legal concerns. Clinicians may fear confrontation and/or disagreement with the patient's family, particularly if they feel ill-prepared for such discussions. They may have a lack of confidence in their own judgment of their patient's true condition [57; 58]. Structured and content-based interventions are needed to ensure that critical aspects of the patient's physical, psychological, and spiritual experience are not excluded from care. For healthcare professionals who are delivering bad news, guidelines for the conversation can help give structure and enhance the confidence of the clinician (**Table 2**).

Organizational Barriers

Barriers to end-of-life conversations also originate within the healthcare system. First, end-of-life discussions are not always considered part of routine care; clinicians are not always given the time and structure for discussing end-of-life issues.

Next, coordination of these conversations, which becomes more necessary as the patient's illness progresses, may not be included as part of routine care. When patient care is provided by multiple clinicians across multiple sites, there is no clear directive about which clinician should be responsible for initiating and documenting end-of-life conversations. Last, decreased contact time and fewer long-term patient/clinician relationships inhibit end-of-life discussions [57].

No single clinician can successfully undertake all aspects of this challenge. End-of-life planning should be one component of a series of ongoing conversations that together can assist patients with advanced illness to approach death in accord with their own values and wishes. These necessary discussions can draw on the expertise of several disciplines, and the creation of a new professional role specializing in this area might be considered [57].

MENTAL HEALTH INTERVENTIONS FOR END-OF-LIFE CARE

Shortly after Kübler-Ross began to publish her work, group psychotherapists began developing systematic interventions for patients who were dying. This included Irvin Yalom in the 1980s, who was heavily influenced by existential philosophy. Yalom's work formed the basis for what became supportive expressive group psychotherapy (SEGT). SEGT was originally developed to help patients with metastatic breast cancer face and adjust to their existential concerns (e.g., death, meaninglessness), express and manage disease-related emotions, and enhance relationships with family and healthcare providers. SEGT challenged the thinking that group therapy for patients with terminal illness would be demoralizing [47; 59]. Over the next several decades, research in end-of-life care, patients' end-of-life needs, and the role of mental health professionals in these settings increased [47].

In the late 20th century, physician-assisted death (also referred to as medical aid in dying, physician aid in dying, physician-assisted suicide, or euthanasia) became a topic of interest as researchers sought to understand why some patients with life-limiting illness might want to hasten death [47]. Pain, depression, and physical symptoms were at first thought to be the primary motives behind the desire to hasten death, but literature in the 1990s and 2000s emphasized the psychological and existential correlates (i.e., depression, hopelessness, spiritual well-being) of physician-assisted death. This shift in emphasis led to the development of a number of psychotherapeutic interventions that focused on the psychological and spiritual needs of patients [47].

DIGNITY MODEL/DIGNITY THERAPY

Dignity therapy was one of the first interventions developed for use in end-of-life care [60]. This modality aims to relieve psycho-emotional and existential distress to improve the experiences of patients with life-limiting illness. It offers patients the opportunity to reflect on what is important to them and on what they might want to communicate to loved ones [61]. In dignity therapy, patients are invited to reflect on and later discuss what aspects of their life they most want recorded and remembered—often referred to as their "legacy" [62]. The sessions are audiotaped and guided by a framework of questions (provided in advance) that facilitate disclosure of the patient's thoughts, feelings, and memories. The interview is then transcribed and printed for the patient's review and editing, as desired. Once finalized, the document is given to the patient, who may (or may not) share with friends and family, as desired. In addition to providing a tangible legacy for the patient, dignity therapy helps enhance the patient's sense of meaning and purpose, thus contributing to a preservation of the patient's dignity [47].

A 2011 study revealed that the items most commonly included in legacy documents were autobiographical information, lessons learned in life, defining roles (e.g., vocations, hobbies), accomplishments, character traits, unfinished business, overcoming challenges, and guidance for others [63]. Dignity therapy has been shown to positively affect patients' sense of generativity, meaning, and acceptance near the end of life. Positive impacts on families and caregivers of dignity therapy participants provide additional support for the clinical utility of this intervention [64]. However, dignity therapy is not for every patient with terminal illness. Despite the demonstrated beneficial effects, its ability to mitigate outright distress (e.g., depression, desire for death or suicidality) has yet to be proven [65]. Acknowledged limitations of dignity therapy include having adequate time, space, and means to engage in this intervention. Dignity therapy also cannot be used with patients who are nonverbal or unconscious or with those who have severe cognitive limitations [66]. Further studies are needed to determine whether patients with specific types of terminal illnesses (e.g., oncologic, cardiac, renal, pulmonary, neurologic) or in specific age cohorts (e.g., pediatric, adult, geriatric) benefit more or less significantly in certain domains (e.g., measures of spiritual distress, autonomy, death anxiety) [66].

Life Review

Dignity therapy incorporates the concept of life review, which is the systematic and structured process of recalling past events and memories in an effort to find meaning and achieve resolution of one's life. It is conducted over four sessions in which patients chronologically review their childhood, adolescence, adulthood, and present situation. A health or mental health professional takes notes, but no other end product is produced [67]. Life review can be useful for patients of any age at the end of life [68]. Life review is typically structured around life themes (e.g., being a parent/grandparent, first job, life's work, important turning points) [69]. The process can be either reminiscent or evaluative. It also can teach or inform others and pass on knowledge and experience to a new generation. Life review conducted for therapeutic purposes can help patients cope with loss, guilt, conflict, or defeat and find meaning in their accomplishments [69]. In Western culture, life review may

subsequently be shared with family or friends. For patients of other cultures, life review may be more communal and may involve rituals that are an important part of the dying process [34]. Few studies have evaluated therapeutic life review interventions, but preliminary results are promising [67].

Narrative Approach

Narrative practice is built on the assumption that people live multistoried lives. This perspective allows patients to shift from one life story to another to give meaning to their lives and shape their identities. A narrative approach frees the care team from the role of "expert" to the role of "helper" who facilitates patients' creation of personal stories of agency at times of life-limiting illness [70]. Narrative therapy is a practical psychotherapeutic process in which the professional and patient collaborate to deconstruct cultural and personal narratives that negatively affect the patient's sense of resources, efficacy, and identity. Together, clinician and patient discover and enrich positive, empowering, and helpful stories that originate in the patient's previous experiences [71]. Narrative therapy is patient-centered and goal-directed. Goals are to help patients improve their sense of self, separate problematic experiences away from their identity, and see themselves outside problems they may be facing. Narrative interventions can help patients and their families create new meaning of the patient's illness and end-of-life experiences [72].

TERROR MANAGEMENT THEORY

The concept of terror management theory was developed in 1986 and was based upon the work of Ernest Becker, a cultural anthropologist who had written about death and anxiety [73; 74]. Terror management theory is the concept that people feel threatened by a deep and terrifying fear of living an insignificant life that is destined to be erased by death. People cope with the awareness of their mortality in different ways. Some will adopt a worldview that allows them to find meaning, purpose, and enduring significance; others simply avoid thinking about death altogether and instead devote themselves to leaving behind a legacy that will make them "immortal" [74; 75]. While the fear of death can promote insecurity and bias or prejudice (based upon one's worldview), terror management theory helps people use their awareness of death to consciously choose to take positive steps to find meaning in their lives [74]. The awareness of mortality can motivate people to prioritize growth-oriented goals, live according to positive standards and beliefs, and foster the development of peaceful, charitable communities [76].

COGNITIVE-BEHAVIORAL THERAPY

The focus of traditional cognitive-behavioral therapy (CBT) is changing maladaptive thought patterns or perceptions that lead to mood disorders, such as anxiety and depression. But changing maladaptive thoughts to more realistic or positive ones does not always meet the needs of patients with life-limiting illness. These patients have very real fears about suffering and uncontrolled pain and other noxious symptoms, and their fears and thoughts are neither maladaptive nor unreasonable [77]. CBT adapted to end-of-life care can help patients identify "all-or-nothing" thinking and help them recognize that core parts of themselves remain unchanged [78].

Studies demonstrate that palliative care professionals have effectively applied CBT techniques to reduce mild-to-moderate anxiety or depression at the end of life and increase the patient's focus on the quality of remaining life [77; 79; 80]. For example, researchers incorporated elements of acceptance and commitment therapy (ACT) and dialectical behavior therapy (DBT). With ACT, patients learn to stop avoiding, denying, and struggling with their emotions. They instead learn to accept their emotions (and the source), accept their private circumstances, and not allow the circumstances to prevent them from moving forward in ways that serve their chosen values [81; 82]. DBT includes a strong educational component designed to provide patients with the skills to manage intense emotions [83].

MEANING-CENTERED PSYCHOTHERAPY

Meaning-centered group psychotherapy, based on the works of Viktor Frankl, was originally conceived as a group-based intervention for individuals with advanced cancer. Frankl's theory is existential in nature and postulates that the creation of meaning is a primary force of human motivation, even during times of great suffering [69]. The group therapy helps patients identify sources of meaning as a resource to sustain meaning, spiritual well-being, and purpose in the midst of suffering [47; 69]. Meaning-centered psychotherapy was later adapted for use with individual patients [84]. The goals of meaning-centered psychotherapy are to provide support for patients to explore personal issues and feelings related to their illness; to help patients identify sources of meaning; and to help patients discover and maintain a sense of meaning in life, even as their illness progresses [47]. Randomized controlled trials conducted to date, totaling nearly 800 patients, have demonstrated support for meaning-centered psychotherapy in improving spiritual well-being and reducing psychological stress in patients at the end of life [85; 86; 87]. The extent to which the observed results can be attributed to the patient's changes in sense of meaning require further study [47]. Like dignity therapy, meaning-centered psychotherapy has fueled multiple adaptations to target unique clinical populations and settings (e.g., bereaved family members, caregivers) [88; 89; 90].

COMPASSION-BASED THERAPY

Compassion-based therapy is rooted in an evolutionary analysis of basic social and emotional systems that motivate humans to live in groups, form hierarchies, help and share through alliances, care for kin, respond to threats, and seek states of contentment/safeness [91]. Compassion-based therapy can be supportive to those facing end-of-life decision making. It is inextricably linked to the inherent values, needs, and expectations of patients, families, and healthcare providers. Compassion coupled with a collaborative framework sustains patient- and family-centered care in end-of-life practice settings [92].

Compassion-based therapy offers a novel, transdiagnostic approach for reducing psychopathology and increasing well-being. It changes the focus of therapy from individual thoughts or unconscious conflicts toward the development of affiliative and prosocial functioning [93]. One overview of compassion-based therapies found at least eight different interventions (e.g., compassion-focused therapy, mindful self-compassion, cognitively based compassion training), six of which have been evaluated in randomized controlled trials. Compassion-based interventions demonstrated reduced suffering and improved life satisfaction for patients [93]. A systematic review conducted to assess the effectiveness of compassion-based therapy analyzed 14 studies, including three randomized controlled studies [94]. Compassion-focused therapy was effective with depressive disorders and for people who are highly self-critical. Compassion-based therapy is most effective when used in conjunction with other types of treatment and therapy [94].

Being Present

One of the most important therapeutic and compassionate aspects a health professional can offer is their presence. Listening to and allowing patients to express their end-of-life experience is healing and can be more comforting than guidance. One study investigated how palliative care chaplains work with patients at the point when it has been decided to cease active treatment, the point at which patients risk losing hope and falling into despair [95]. The author identified four types of presence in the chaplain-patient relationship that were a result of the chaplain's "being with the patient." Each type of presence (i.e., evocative, accompanying, comforting, hopeful) represented a discernable development in the chaplain/patient relationship—a theory of chaplain as hopeful presence [95].

The effects of educating patients and families about the importance of being present was the goal of a descriptive study that included 19 critical care nurses [96]. The nurses were interviewed to understand their experiences and perceptions about caring for patients and families transitioning from aggressive life-saving care to palliative and end-of-life care [96]. The nurses prioritized educating the family, advocating for the patient, encouraging and supporting the family's presence, protecting families, and helping them create positive memories. The family's presence at the end of life also helped them to process the reality of their loved one's death and make peace with it [96].

OTHER INTERVENTIONS

Researchers and clinicians have developed a variety of other interventions for end-of-life care. One proposed treatment is called short-term life review (STLR). Like dignity therapy, STLR interviews the patient for the purpose of creating a legacy album, but STLR differs from dignity therapy in the substance of the interview. A single published randomized controlled trial has examined the utility of STLR, and little research has been conducted to support the STLR approach. The research that has been published has suggested increases in spiritual well-being, sense of hope, and death preparedness among patients with terminal cancer [47; 97; 98].

Managing cancer and living meaningfully (CALM) is a brief, structured intervention developed for patients with advanced and/or terminal cancer [47; 99; 100]. The focus of CALM is similar to meaning-centered psychotherapy, but it provides less emphasis on spiritual well-being and existential issues due to its longer timeframe [47]. The first large-scale randomized controlled trial of CALM reports that individuals demonstrated significantly greater improvements in depressive symptoms and overall quality of life compared to those who received usual care [101].

Mindfulness

Mindfulness is the practice of paying deliberate attention to experiences of the present moment with openness, curiosity, and a willingness to allow things to be as they are [102]. End-of-life care is, by its nature, rooted in mindfulness through [103]:

- The healthcare team providing steady presence and compassion to the dying patient
- Bringing one's full attention to clinical assessments and supportive interactions and acknowledging what arises during these interactions for patients, families, and clinicians
- Being attuned to the dying and their needs, remaining present with their suffering
- Being genuinely interested in the patient's/family's experiences
- Allowing the full expression of personal experiences, with no attempt to change or fix them
- Cultivating compassion and acknowledging our shared humanity

Spiritual Care

Spiritual care is considered a basic tenet of palliative care and a responsibility of the entire end-of-life care team. Patients who receive good spiritual care report greater quality of life, better coping, and greater well-being, hope, optimism, and reduction of despair at the end of life. Despite these benefits, patients and caregivers often refuse spiritual care when offered. One study that sought to understand this reluctance focused on the effect of education. The authors reported that an educational intervention, which included explaining the services of hospice chaplains and the evidence-based benefits of spiritual support, led to greater patient/caregiver acceptance of spiritual care [104]. End-of-life counselors, therapists, and social workers are uniquely positioned to work with patients to explore the variables that they and their families use as guiding principles when making difficult decisions [105]. This requires assessing the patient's spiritual, religious, and existential needs (i.e., spiritual needs) to provide appropriate interventions [106].

The specifics of how to conduct assessment are determined by individual healthcare organizations but usually consist first of obtaining a spiritual history of the patient and the patient's family. A variety of tools are available. The FICA acronym asks four questions about faith, importance/influence of beliefs,

community involvement, and addressing issues of care [107]. The HOPE questions inquire about patients' sources of hope and meaning, whether they belong to an organized religion, their personal spirituality and practices, and what effect their spirituality may have on end-of-life care [108]. Reported barriers to spiritual assessment include clinician lack of time/experience, difficulty identifying patients who wish to discuss spiritual beliefs, and addressing concerns not regarded as the clinician's responsibility. Assessing and integrating patient spirituality into end-of-life care can build trust and rapport and strengthen the patient's relationship with the end-of-life care team [108]. Unaddressed spiritual issues may frustrate attempts to treat other symptoms and adversely impact the patient's quality of life [105].

Art and Music Therapy

Art and music therapists are becoming increasingly available to palliative care teams and are advancing the diverse and unique clinical services available to effectively meet the holistic needs of patients with serious illness [109]. Art can connect with deep psychological and physical pain, allowing the patient to find expression and relief. Studies have found that expressive arts (e.g., paint, clay, textiles, drawing) help patients more effectively deal with ambivalent emotions regarding life-death issues and communicate with their families about their feelings. It helps patients articulate their end-of-life journey beyond language [110; 111].

Art therapy also may be helpful in reducing burnout among end-of-life care providers by enhancing their emotional awareness, fostering meaning-making, and promoting reflection on death. One study found significant reductions in exhaustion and death anxiety in end-of-life care providers who participated in an art therapy program [38].

Music therapy incorporates music chosen by the patient in consultation with a qualified music therapist. The music is often chosen to arouse specific emotions that allow the patient to more easily access, recall, and interrogate memories, with the goal of understanding the role those memories play in the patient's current circumstances [38]. Music therapy also may be an effective adjuvant to pain management therapy [38].

BEREAVEMENT

As stated, Kübler-Ross wrote that it could be helpful if people could talk about death and dying as an intrinsic part of life and emphasized the importance of listening as a way for practitioners to support terminally ill patients and their families when confronting the realities of impending death [46; 47]. She subsequently applied her model to the experience of loss in many contexts, including grief and other significant life changes [112]. This model identified five stages of bereavement—denial, anger, bargaining, depression, and acceptance. Though the stages are frequently interpreted strictly and hierarchically, this was not Kübler-Ross's intention. She expressed that individual patients could manifest each stage differently, if at all, and might move between stages in a nonlinear manner [112]. Her model has received criticism in recent years and many alternative models (some based on Kübler-Ross's model) have been developed [112; 113; 114; 115].

PROLONGED GRIEF DISORDER

The death of a loved one is followed by an intensely emotional and disruptive period that gradually attenuates as the death is comprehended and accepted and its consequences understood (integration). It is a highly stressful period accompanied by the need to attend to a range of things not usually on one's agenda. Most people meet the coping demands and are able to find a pathway through the sorrow, numbness, and even guilt and anger that are part of the normal grieving process. A small minority, however, do not cope effectively. For them, the feelings of loss become debilitating. They do not improve with the passing of time and can become so long-lasting and severe that recovering from the loss and resuming a normal life is impossible without assistance [116]. These people are suffering from prolonged grief disorder, a syndrome in which healing is impeded and acute grief is intense and prolonged.

Prolonged grief disorder is the newest disorder to be added to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The disorder was added to the DSM-5-TR in 2022 after several decades of studies that suggested "many people were experiencing persistent difficulties associated with bereavement that exceeded expected social, cultural, or religious expectations" [117]. Prolonged grief disorder often co-occurs with other mental disorders (e.g., PTSD, anxiety, depression). Sleep problems, such as poor long-term sleep, occur in an estimated 80% of people with this disorder [118].

Prolonged grief disorder is defined as "intense yearning or longing for the deceased (often with intense sorrow and emotional pain) and preoccupation with thoughts or memories of the deceased. In children and adolescents, this preoccupation may focus on the circumstances of the death" [117]. In adults, this intense grief must still be present one year after a loss to be considered prolonged grief disorder; in children, the timeframe is six months. Additionally, the individual with prolonged grief disorder may experience significant distress or problems performing daily activities at home, work, or other important areas [117]. It is important for clinicians to differentiate prolonged grief disorder from usual acute grief, as well as depression and anxiety disorders [116]. Risk factors for prolonged grief disorder include past losses, separations that can impact current losses, and a history of depressive illness [115]. Symptoms include [117]:

- Identity disruption (e.g., feeling as though part of oneself has died)
- A marked sense of disbelief about the death
- Avoidance of reminders that the person is dead
- Intense emotional pain (e.g., anger, bitterness, sorrow)

- Difficulty reintegrating (e.g., unable to engage with friends, pursue interests, plan for the future)
- Emotional numbness
- Feeling that life is meaningless
- Intense loneliness and feeling of being detached from others

An estimated 7% to 10% of bereaved adults will experience the persistent symptoms of prolonged grief disorder, and 5% to 10% of bereaved children and adolescents will experience depression, PTSD, and/or prolonged grief disorder [118; 119]. Treatments using elements of CBT have been found to be effective in reducing symptoms [117]. Complicated grief treatment incorporates components of CBT and other approaches to help patients adapt to the loss. It focuses on accepting the reality of the loss and on working toward goals and a sense of satisfaction in a world without the loved one [118]. Research has shown that CBT is effective in addressing sleep problems associated with prolonged grief disorder. CBT also has been shown to be superior in long-term effects to supportive counseling in children and adolescents experiencing symptoms of prolonged grief disorder [119; 120].

Bereavement support groups can provide a useful source of social connection and support. They can help people feel less alone, thus helping to avoid the isolation that could increase the risk for prolonged grief disorder. Despite the existence of effective treatments, people experiencing prolonged grief disorder may not seek help. One study of 86 bereaved caregivers with symptoms of prolonged grief disorder found that only 43% accessed mental health services [121].

PRACTICAL, ETHICAL, AND LEGAL CONSIDERATIONS

Planning ahead provides patients with the most control over their end-of-life care, but not all patients have the opportunity to do so. End-of-life planning for the patient will include knowing the type of care they need and want, knowing where they want to receive this care, knowing what documents (e.g., advance directives) and associated costs to include in planning, and determining who will help carry out their wishes [122].

CAREGIVING AND SURROGACY

The vast majority (80%) of care given to hospice patients is provided by informal and unpaid caregivers who are often family members. They can be responsible for everything from the management of household and finances to medical and personal care. Providing this level of care can contribute to increased stress and health problems [123]. Caregivers often report significant levels of anxiety, depression, and perceived stress as well as poorer physical health and decreased quality of life compared with non-caregivers [124]. In one study, nearly one-third (31%) of caregivers reported moderate-to-high levels of anxiety [125]. Even family members who are not caregivers experience distress and require support. Supporting the growing number of family and other unpaid caregivers is an urgent public health issue. The need for adequate support is especially pressing when older patients and the loved ones who assist them are most vulnerable, as at the end of life [126]. Health and mental health professionals can help the caregiver and/or family by preparing them for their loved one's death, treating symptoms of burnout and stress, and offering grief counseling when desired [127].

Family members may be called upon to make decisions on their loved one's behalf if incapacitation becomes an issue. Ideally, the decision-making process will reflect the patient's physiologic realities, preferences, and recognition of what, clinically, may or may not be accomplished [128; 129]. Being a surrogate decision maker is stressful for many and can have negative emotional effects that last months or years [130]. Frequent tension can occur between the desire to respect the patient's values and the fear of responsibility for a loved one's death, a desire to pursue any chance of recovery, and a need to ensure family well-being [131]. Counseling for the surrogate both during and after the decision-making process can be beneficial.

Shared decision making also has been found to be beneficial. Healthcare providers can encourage decision makers to involve other family members. They can repeat relevant information in simple language, prompt them to think about what the patient would or would not want, and frequently remind them that everything that can be done is being done [132]. Support for the surrogate should foster respect for patient preferences and values and help reduce guilt about decisions made following the patient's death [132]. An ideal surrogate will participate in collaborative decision-making with care providers. If a surrogate avoids communication or requests interventions that are clearly not considered in the patient's best interest, counseling should be provided. If counseling is unsuccessful, replacement of the surrogate should be considered [133]. Family members who reside far away and who are not designated as decision maker also can create difficulties by trying to undo, contest, undermine, or alter decisions made by local family members who have long been involved in the patient's care. These disagreements can compromise the ability of the patient's healthcare team to provide quality care. These limits of formal advance care planning have led some practitioners to assert that informal conversations with patients' significant others are most critical to end-of-life planning [134].

Current practice frequently fails to promote patient goals. This is an area for future research and improvement. In the meantime, clinicians should encourage patients to document their own goals, including treatment preferences and preferences regarding how they want decisions to be made for them during periods of decisional incapacity. This is achieved through advance care planning [135; 136].

ADVANCE CARE PLANNING

Advance care planning is widely considered an essential step toward achieving end-of-life care that is consistent with the preferences of dying patients and their families. Advance care planning typically includes a living will and a durable power of attorney for health care, which enable patients to articulate and convey their treatment preferences while they are cognitively intact [136]. Advance care planning documents also can include do not resuscitate (DNR) orders, medical/physician order for life-sustaining treatment (MOLST/POLST), and informal documents of preference or other healthcare proxies. Ideally, these documents reflect discussions among the patient's family, surrogate, and healthcare provider about the patient's preferences for health care in the context of serious illness [129]. Advance care planning is considered an essential step for achieving a "good death" in which physical pain and emotional distress are minimized and the patient's and family members' treatment preferences are respected [134]. Advance care planning is associated with greater use of palliative care among dying patients, lower medical expenditures at the end of life, and less distress among patients and patients' families.

Race and socioeconomic disparities in rates of advance care planning have been documented. Policy advances (e.g., Medicare reimbursement for doctor-patient consultations) may increase rates of planning among populations who may not have access to professionals who encourage such preparations [136]. Health and mental health professionals can assist families in the process of preparing advanced care planning documents. Being a mediator in advance care planning conversations can provide clarity for patients and family members about the patient's wishes regarding death [137].

ETHICAL/LEGAL ISSUES

Ethical concerns and legal considerations can influence counseling at the end of life. Health and mental health providers are on the frontline supporting and guiding the patient and the patient's family through the dying process.

Autonomy

Autonomy, as viewed from the perspective of patients at the end of life, includes two core domains: "being normal" and "taking charge" [138]. These two domains account for the circumstances and clinical realities of people with life-limiting illness and allow clinicians to better understand their needs. Autonomy is, however, not just a concern when making choices of treatment for end-of-life care but also when supporting patients in their daily lives and active preparations for dying. This support can help relieve the patient of stress and the fear of being a burden to family [138]. When a patient expresses a fear over the loss of autonomy, it is important for clinicians to determine the source of the fear. Common sources of such fear include fear of becoming physically dependent on life-supporting technology; fear of losing independence; and fear of loss of engagement in meaningful activity. Often, the patient is simply expressing a desire to preserve self-determination regarding end-of-life care and planning [45]. The healthcare team respects patients' autonomy by giving them the information needed to understand the risks and benefits of a proposed intervention, as well as the reasonable alternatives (including no intervention), so that they may make independent decisions [139].

Distributive Justice

Distributive justice is the fair, equitable, and appropriate distribution of healthcare resources. It requires impartiality in the delivery of health service. Issues of distributive justice encountered in healthcare settings include the allotment of scarce resources, care of uninsured patients, conflicts of interest based on religious or legal grounds, and public health and safety issues. Despite these constraining influences, healthcare providers have an ethical obligation to advocate for fair and appropriate treatment of patients at the end of life [140; 141].

Beneficence

The principle of beneficence is the obligation of health and mental health professionals to act in the best interest of the patient [137]. Beneficence also includes preventing and avoiding harm and defending the most useful intervention for the patient [140; 141]. Beneficence is fundamental to dilemmas about the discontinuation, withholding, or withdrawal of medical treatment [137]. When wishes about end-of-life care are not known or cannot be communicated by the patient, end-of-life decisions should be made by the healthcare team as a result of consultations with the family or healthcare proxy [137].

Nonmaleficence

Nonmaleficence is the principle of refraining from causing unnecessary harm (i.e., first, do no harm) [137]. It also refers to the moral justification behind an intervention that might cause some pain or harm; harm is justified if the benefit of the intervention is greater than the harm to the patient and the intervention is not intended to harm [137]. The emphasis in nonmaleficence is on relieving the symptoms that harm the patient [142]. Health and mental health providers can exercise nonmaleficence by having an understanding of the moral principles and ethical codes governing end-of-life care. They can prevent undue harm by being as knowledgeable as possible about impending illnesses through relationships with the interprofessional team [137].

CULTURALLY COMPETENT CARE AT THE END OF LIFE

The clinician/patient discussion about end-of-life care is often a challenge and one that can be further complicated when the patient's cultural norms differ from that of the clinician. As discussed, values of medical care emphasize autonomy and individual rights to make life choices [143]. The Patient Self Determination Act of 1990 ensured that those rights are protected. This includes the rights to treatment choices, informed consent, truth-telling, open communication with healthcare

providers, and control over the individual's own life and death [143; 144]. However, these core values may be in conflict with the values of many ethnic and culturally diverse groups in the United States and may lead to health disparities, fragmented care, inadequate or inappropriate symptom management, miscommunication with the patient and family, and a difficult and poor death for the patient [143].

Enhanced cultural competency in end-of-life issues continues to be identified as a need for clinicians who provide care for patients at the end of life [143]. Healthcare providers should understand and recognize the specific influences that culture has on a patient's behavior, attitudes, preferences, and decisions about end-of-life care. It is important to note that a patient's identification as a member of a particular ethnic group or religion does not necessarily mean that the patient or patient's family adheres to beliefs associated with that ethnicity or religion [143]. Other factors (e.g., age, race, sex, ethnicity, health status, religion) also can influence how patients approach the end of life, and their cultural and religious backgrounds influence their definitions of and perceptions about what constitutes quality of life, suffering, and pain [145].

Other areas of end-of-life care that vary culturally include the method used for communicating "bad news," the locus of decision making, and attitudes toward advance directives and end-of-life care specifics [146]. In contrast to the emphasis on "truth telling" in the United States, it is not uncommon for healthcare professionals outside the United States to conceal serious diagnoses from patients, because disclosure of serious illness may be viewed as disrespectful, impolite, or even harmful to the patient. The emphasis on patient autonomy may conflict with the patient's preferences for family-based, physician-based, or shared family-physician-based decision making. Lower rates of completion of advance directives by patients of some ethnic backgrounds suggests a distrust of the healthcare system, healthcare disparities, and underutilization of health care [146; 147; 148].

An assessment should be made of how acculturated a patient and family are, their language skills, and whether an interpreter is needed [143]. The clinician should assess for [149]:

- Openness/willingness of the patient/family to discussing/accepting the diagnosis, prognosis, and death
- How decisions are made and what influences decision making (e.g., age, gender, hierarchy, quality of interfamily communication)
- What does physical pain mean and how should it be managed?
- Is there spiritual pain? Does the patient desire the help of a spiritual advisor? Does the patient/family want time and space for praying, meditation, and other rituals?
- The relevance of religious beliefs regarding the meaning of death

- How the body should be handled following death

The clinician also can take advantage of available resources, including community or religious leaders, family members, and language translators [149]. It is important to note that using professional interpreters for patients and with limited English proficiency will help ensure quality care. Convenience and cost lead many clinicians to use "ad hoc" interpreters (e.g., family members, friends, bilingual staff members) instead of professional interpreters. However, professional interpreters are preferred for several reasons. Several states have laws about who can interpret medical information for a patient, so healthcare professionals should check with their state's health officials about the use of ad hoc interpreters [150]. Even when allowed by law, the use of a patient's family member or friend as an interpreter should be avoided, as the patient may not be as forthcoming with information and the family member or friend may not remain objective [150]. Children should especially be avoided as interpreters, as their understanding of medical language is limited, and they may filter information to protect their parents or other adult family members [150]. Individuals with limited English language skills have actually indicated a preference for professional interpreters rather than family members [151].

Also important is the fact that clinical consequences are more likely with ad hoc interpreters than with professional interpreters [152]. A systematic review of the literature showed that the use of professional interpreters facilitates a broader understanding and leads to better clinical care than the use of ad hoc interpreters, and many studies have demonstrated that the lack of an interpreter for patients with limited English proficiency compromises the quality of care. The use of professional interpreters improves communication (errors and comprehension), utilization, clinical outcomes, and patient satisfaction with care [151; 153]. One review of case studies regarding professional interpretation noted that "patients with limited English proficiency in the United States have a legal right to access language services, and clinicians have legal and ethical responsibilities to communicate through qualified interpreters when caring for these patients" [154].

Culturally competent counseling for patients at the end of life begins with understanding their differing cultural, religious, and other important influential factors. It involves listening to and learning about patients' varying attitudes, preferences, and practices in order to integrate them into an appropriate plan of care [155]. Clinicians should treat all patients with dignity, respecting their rich cultural traditions and incorporating them into the plan of care. It means communicating with the patient and the patient's family in advance about how the plan of care is aligned with their beliefs, concerns, values, and preferences [145]. To deny the expression of different cultural worldviews in the context of end-of-life care would be to rob patients of the security and serenity that their cultural beliefs give them when faced with uncertainty and fear [156].

CONCLUSION

Health and mental health professionals provide services to diverse individuals in a variety of settings, including end-of-life settings, as part of an interprofessional team. In the end-of-life setting, these professionals help dying patients and their families prepare for death with education and supportive therapeutic interventions that address the patient's physical, emotional, social, spiritual, and practical needs using a patient-centered, culturally sensitive approach [10; 157]. Clinicians can regularly promote communication and education about end-of-life care issues by taking the initiative and discussing each patient's goals for end-of-life care [55]. The better informed the patient and family are, the more likely their decisions about end-of-life care will reflect their beliefs, values, and the best interests of the patient. This means having difficult conversations. All professionals should work to become comfortable with the most uncomfortable of topics. This work is not done alone. It is essential to lean on and consult colleagues and other members of the care team. End-of-life care often involves interactions between caregivers and various professionals (e.g., physicians, nurses, social workers, mental health professionals, clergy) who have distinct roles in preparing caregivers for the patient's death [158]. Aligning on key concepts and approaches to care can help to ensure that the best possible care and support are given at the end of life.

Customer Information, Answer Sheet, and Evaluation are located on pages 123–128.

TEST QUESTIONS
#77770 COUNSELING PATIENTS AT THE END OF LIFE

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

This 5 hour activity must be completed by April 30, 2026.

1. The goal of palliative care is to
   A) avoid pursuing curative treatment.
   B) provide care only as close to diagnosis as possible.
   C) provide care for the last few weeks or months of a patient's life.
   D) improve the quality of life of patients and their families when faced with life-threatening illness.

2. Which of the following professionals can provide end-of-life counseling?
   A) Counselors
   B) Hospice workers
   C) Critical care nurses
   D) All of the above

3. Reducing mental health symptoms
   A) is not important in end-of-life care.
   B) can improve participation of end-of-life decisions.
   C) should be the only focus of clinicians at the end of life.
   D) can help patients disengage from painful conversations.

4. Which of the following is a universal experience for patients at the end of life?
   A) Intractable pain
   B) Spiritual epiphany
   C) Psychological suffering
   D) Reconnection with family

5. Parents of young children with life-limiting illness often are consumed with all of the following, EXCEPT:
   A) What and how much to tell their ill child
   B) How to cope with the loss of the child's future
   C) The impact of the child's illness on other siblings
   D) Dependence upon parents or other adult figures

6. Which two concepts combined define dignity at the end of life?
   A) Meaning and hope
   B) Serenity and respect
   C) Control and independence
   D) Interdependence and connection

7. What is a possible negative effect of denial in patients at the end of life?
   A) Wish to hasten death
   B) Focus on realistic treatment goals
   C) Excessive reliance on the healthcare team
   D) Failure to make legal, financial, and healthcare arrangements

8. Economic circumstances have been found to be a major stressor for patients and their families, often resulting in a decline in family economic well-being.
   A) True
   B) False

9. Which of the following statements regarding post-traumatic stress disorder (PTSD) at the end of life is TRUE?
   A) Most therapies for PTSD can be completed within a typical hospice period.
   B) Even if PTSD is diagnosed, it typically does not complicate the dying process.
   C) Practitioners have good awareness of the occurrence and/or manifestation of PTSD at the end of life.
   D) Traditional evidence-based, trauma-focused treatments may not be feasible or advisable for patients with PTSD at the end of life.

10. Anticipatory grief is the experience of grieving the loss of a patient or loved one in advance of their death.
    A) True
    B) False

11. Elevated anticipatory grief was found in families characterized by all of the following, EXCEPT:
    A) Higher education
    B) Relational dependency
    C) Poor grief-specific support
    D) Discomfort with closeness and intimacy

12. When anticipatory grief is an expression of past or current trauma, it may develop into complicated grief if left untreated.
    A) True
    B) False

13. Thanatophobia is an extreme fear of
    A) a loved one's death.
    B) life-saving medical care.
    C) death or the dying process.
    D) being present when someone dies.

14. Treating pain at the end of life means caring for all possible manifestations, including physical symptoms as well as psychological symptoms and reduced well-being.
    A) True
    B) False

15. Some patients believe that being diagnosed with depression will cause their medical providers to treat their physical symptoms more aggressively.
    A) True
    B) False

16. Diagnosis with which of the following conditions is associated with increased risk of suicide?
    A) Low-survival cancer
    B) Degenerative neurological conditions
    C) Chronic obstructive pulmonary disease
    D) All of the above

17. Which of the following statements regarding end-of-life discussions is TRUE?
    A) Patients prefer to initiate end-of-life discussions themselves.
    B) End-of-life discussions should take place only at end of a patient's life.
    C) Most Americans have had conversations about their end-of-life wishes.
    D) Most Americans say it is important to discuss their wishes for end-of-life care.

18. Helping a patient appoint a surrogate decision maker is part of which step in an end-of-life conversation?
    A) Initiation of the discussion
    B) Clarification of the prognosis
    C) Identification of end-of-life goals
    D) Development of the treatment plan

19. Optimal end-of-life care begins with an honest discussion between clinicians and patients about disease progression and prognosis.
    A) True
    B) False

20. Honoring patients' end-of-life wishes involves all of the following, EXCEPT:
    A) avoiding expectations.
    B) providing education about options.
    C) allowing patients to have control over decision making.
    D) identifying what a patient wants through open communication and end-of-life care planning.

21. Which of the following statements regarding clinician-related barriers to end-of-life discussions is FALSE?
    A) Clinicians may have a lack of confidence in their own judgment of their patient's true condition.
    B) Clinicians generally have extensive communication training and skills, particularly in the delivery of bad news.
    C) Clinicians might avoid end-of-life discussions with their patients because they are reluctant to cause pain or be the bearers of bad news.
    D) Clinicians may fear confrontation and/or disagreement with the patient's family, particularly if they feel ill-prepared for such discussions.

22. In dignity therapy, patients
    A) are taught mindfulness techniques.
    B) endure systematic confrontation of feared stimuli, with the aim of reducing fear of dying.
    C) are invited to reflect on and later discuss what aspects of their life they most want recorded and remembered.
    D) engage in a structured program of psychotherapy with a strong educational component designed to provide skills for managing end-of-life stresses.

23. Compassion-based therapy changes the focus of therapy from individual thoughts or unconscious conflicts toward the development of affiliative and prosocial functioning.
    A) True
    B) False

24. Research that has been published on short-term life review (STLR) has suggested increases in spiritual well-being, sense of hope, and death preparedness among patients with terminal cancer.
    A) True
    B) False

25. **All of the following statements regarding spiritual care at the end of life is TRUE, EXCEPT:**
    A) *Spiritual care is considered a basic tenet of palliative care.*
    B) *Patients and caregivers often refuse spiritual care when offered.*
    C) *Spiritual care is a responsibility of mental health professionals only.*
    D) *Patients who receive good spiritual care report greater quality of life, better coping, and greater well-being at the end of life.*

26. **The FICA acronym to guide spiritual assessments consists of**
    A) *fidelity, insistence, culture, and alignment.*
    B) *fostering religiosity, inspirational quality, connection, and adherence.*
    C) *family involvement, integration of beliefs, consistency of practice, and aspects of spirituality.*
    D) *faith, importance/influence of beliefs, community involvement, and addressing issues of care.*

27. **Intense yearning or longing for the deceased (often with intense sorrow and emotional pain) and preoccupation with thoughts or memories of the deceased must continue how long to be considered prolonged grief disorder in adults?**
    A) *Three months*
    B) *Six months*
    C) *One year*
    D) *Five years*

28. **Health and mental health professionals can help caregivers and/or family by**
    A) *offering grief counseling when desired.*
    B) *treating symptoms of burnout and stress.*
    C) *preparing them for their loved one's death.*
    D) *All of the above*

29. **Beneficence is fundamental to dilemmas about the discontinuation, withholding, or withdrawal of medical treatment.**
    A) *True*
    B) *False*

30. **Which of the following statements about interpreters is TRUE?**
    A) *Interpreters should always engage in cultural brokering.*
    B) *The use of professional interpreters improves communication, utilization, clinical outcomes, and patient satisfaction with care.*
    C) *Any person fluent in a family's native language is as effective as a professional interpreter.*
    D) *Families prefer to have information interpreted by another family member rather than by a professional interpreter.*

Be sure to transfer your answers to the Answer Sheet located on page 124.

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.*

Suicide Assessment and Prevention

This course meets the Pennsylvania requirement for suicide prevention education.

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. (A complete biography can be found at NetCE.com.)

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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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].

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 involving 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

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_

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].

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 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

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].

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].

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 discom-fort, 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
- **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 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].

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].

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*			

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].

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.

- Clear and comprehensive: It is important to ensure that all documentation is clear and comprehensive, with specific notes regarding the patient's own words.

- Intent: The intentions of any suicide attempt(s) or intentional self-harm should be noted.

- Discussions 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.

- Educate, 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 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.

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; fam-

ily 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].

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].

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, and Evaluation are located on pages 123–128.

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 clock 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.*

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.*

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

Be sure to transfer your answers to the Answer Sheet located on page 124.

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.*

Psychedelic Medicine and Interventional Psychiatry

Audience

The course is designed for mental health professionals and all members of the interprofessional team, including physicians, physician assistants, and nurses, involved in caring for patients with mental disorders resistant to traditional treatment approaches.

Course Objective

The purpose of this course is to provide medical and mental health professionals with the knowledge and skills necessary to effectively treat mental disorders using emerging psychedelic and interventional techniques.

Learning Objectives

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

1. Outline factors that have contributed to the rise in interest in psychedelic and interventional psychiatry.

2. Define terms related to the discussion of psychedelic and interventional psychiatry.

3. Discuss the history of psychedelics in medical care.

4. Evaluate factors that may impact the provision of psychedelic or interventional psychiatry techniques, including stigma, setting, and culture.

5. Outline the role of psilocybin and ketamine in psychiatric care.

6. Describe how MDMA and ibogaine may impact mental health.

7. Review the clinical effects of kratom, LSD, and mescaline.

8. Discuss the potential clinical role of nitrous oxide, ayahuasca, and dimethyltryptamine (DMT).

9. Describe how psychedelics may be incorporated into the treatment of mental health disorders, including treatment-resistant depression, post-traumatic stress disorder, and substance use disorders.

10. Identify interventional approaches that may be used in the treatment of mental health disorders.

Faculty

Mark S. Gold, MD, DFASAM, DLFAPA. (A complete biography can be found at NetCE.com.)

Faculty Disclosure

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

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INTRODUCTION

A new and intense interest in psychedelic drugs and interventional medicine is occurring now in the United States and worldwide, as scientists are exploring and discovering innovative ways to treat challenging psychiatric problems, including treatment-resistant depression, suicidal major depressive disorder, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), and substance use disorders, as well as multiple other psychiatric problems that have largely been impervious to traditional treatment. Psychedelic medicine refers to the use of drugs that are hallucinogenic and/ or anesthetic and that have a unique action on the brain. These approaches may be used only in research situations or may be in current and active use as treatments. In contrast, interventional psychiatry refers to the use of brain-stimulating therapies to treat severe psychiatric disorders. These therapies include electroconvulsive therapy (ECT), repetitive transcranial magnetic stimulation (rTMS), vagus nerve stimulation (VNS), and deep brain stimulation (DBS). As with psychedelic medicine, interventional medicine may be used to provide relief for patients with multiple major and previously unremitting severe psychiatric disorders, although there is still much to learn about these therapies. This course will provide an overview of both of these forms of treatment, with an emphasis on psychedelic medicine.

Today, psychedelics like N, N-dimethyltryptamine (DMT), psilocybin, 3,4-methylenedioxymethamphetamine (MDMA), and lysergic acid diethylamide (LSD) are being explored to treat various psychiatric disorders. Trials of these drugs are in different stages, and the timeline for U.S. Food and Drug

Administration (FDA) approval is not always obvious. While ketamine was approved in 2020, most experts believe the first psychedelic approval will come in 2024, likely for PTSD rather than treatment-resistant depression, even though treatment with psilocybin was found to relieve symptoms of major depressive disorder for at least one year for some patients in a 2022 Johns Hopkins study [1]. The safety and efficacy of MDMA-assisted therapy is currently under Phase 3 investigation, but concerns remain regarding efficacy and potential adverse effects. As of 2022, the Multidisciplinary Association of Psychedelic Studies (MAPS) is sponsoring MAPP2, the second of two Phase 3 trials to support FDA approval of MDMA as a breakthrough-designated therapy for the estimated 9 million adults in the United States who experience PTSD each year. In MAPS's first Phase 3 study, 88% of participants with severe PTSD experienced a clinically significant reduction in PTSD diagnostic scores two months after their third session of MDMA-assisted therapy, compared with 60% of placebo participants. Additionally, 67% of participants in the MDMA group no longer met the criteria for PTSD two months after the sessions, compared with 32% of participants in the placebo group [2].

When effective, psychedelic medicine is analogous to a "resetting" of the brain. It is somewhat like when a computer runs awry, and nothing of many actions that the user tries improves the situation. In frustration, the user shuts off the machine, but when the device is turned back on, everything works perfectly. The machine has reset itself. Similarly, psychedelic drugs, when effective, may aid the brain in a sort of resetting. Depending on the individual and the drug, the person may find they have marked improvements in symptoms of depression, PTSD, addiction, or other severe psychiatric problem.

As a result of today's research renaissance on psychedelic drugs, there is a new era of hope for people with major psychiatric disorders who have been largely unresponsive to traditional treatments.

One concern about psychedelic medicine is that many of the drugs may induce hallucinations, even in the low doses used for depression. Mental health professionals who prescribe or administer the drugs will need to ensure patients are monitored adequately. In some cases, the person receiving the drug is hospitalized, but in others, the drug is administered and changes observed in an office setting.

Ketamine's efficacy and protocols to ensure safety have resulted in thousands of patients being treated and reporting excellent responses for treatment-resistant depression. However, the ideal drug would provide the benefits without the hallucinatory side effects. In one unique experiment with mice, researchers effectively blocked 5-HT2A, the serotonin-detecting receptor, and this action appeared to stop mice being administered psilocybin from hallucinating ("tripping"). The antidepressant effects were unaltered in this study, as evidenced by the mice resuming consumption of sugar water, an act they had abandoned while depressed [5]. This is an area of great interest, with

the potential that the hallucinations induced by psychedelic drugs could be blocked and increase the acceptability of these agents in the general treatment of depression.

Of course, there are many who believe that the psychedelic trip itself, hallucinations and all, is the crucial experience that allows people to experience psychic relief. These individuals believe that eliminating the crucial experience of hallucination would essentially block the full efficacy of the drug. This issue is likely to continue to be discussed and debated as the science advances.

Psychedelic drugs are often divided into two categories: classic and non-classic or dissociative. The classic psychedelics are usually derived from naturally occurring compounds and include such drugs as psilocybin, LSD, and DMT, an active component of ayahuasca, an increasingly popular sacramental drink originating from South America. The dissociative psychedelics are typically newer analogs and include ketamine, phencyclidine (PCP), MDMA, mescaline, *Salvia divinorum*, and dextromethorphan (DXM). While considered drugs of abuse, most agents being tested in psychedelic medicine clinical trials are not self-administered by laboratory animals, the usual test for abuse and dependence liability. If anything, hallucinogens tend to lose their ability to produce changes in the person over time and with regular use. These drugs are all variations on tryptamine, and while they may increase dopamine, they tend to do this through an indirect mechanism.

In their 1979 publication, Grinspoon, Grinspoon, and Bakalar define a classic psychedelic drug as [6]:

> A drug which, without causing physical addiction, craving, major physiological disturbances, delirium, disorientation, or amnesia, more or less reliably produces thought, mood, and perceptual changes otherwise rarely experienced except in dreams, contemplative and religious exaltation, flashes of vivid involuntary memory, and acute psychosis.

While the classic versus non-classic designation is of interest to researchers, it is likely not an important distinction for prescribers or patients.

THE IMPORTANCE OF PSYCHEDELIC AND INTERVENTIONAL MEDICINE

There are multiple reasons health and mental health professionals would benefit from education about both psychedelic and interventional medicine. Psychedelic medicine is a multi-billion-dollar industry and is rapidly growing. It is likely that many healthcare professionals will become involved with these approaches as they enter more widespread use.

Many people in the United States suffer from severe depression, and suicide is a public health problem. In 2020, 21,570 people in the United States died from homicide, a significant increase from the number just one year earlier [7]. However,

it did not come close to the suicide rate. In 2020, 45,855 people in the United States died from suicide. The annual U.S. suicide rate increased 30% between 2000 and 2020 [7]. As such, depression and suicide are major health problems in the United States today, and approaches to reverse depression rapidly and safely are greatly needed.

It is also important to consider the frustration of many patients with treatment-resistant depression and other disorders, many of whom have turned to cannabis to obtain relief. The majority of states have enacted laws approving medical marijuana, although its efficacy in the treatment of PTSD, depression, and other psychiatric disorders is often lacking [8]. Patients are clearly open to seeking help wherever it may be, whether evidence and healthcare professionals support the approaches. As such, it is vital that clinicians be aware of and knowledgeable regarding novel uses of psychedelic drugs and interventional psychiatry to best serve their patients.

Academic experts, universities, and medical groups continue to research psychedelic medicine, with exciting major breakthroughs in the treatment of depression/anxiety at the end of life and providing relief to patients with treatment-resistant depression, PTSD, and other disorders that most psychiatrists consider difficult to treat. This research will be detailed later in this course.

TREATMENT-RESISTANT DEPRESSION AND THE RISK OF SUICIDE

As noted, the suicide rate in the United States is more than twice as high as the homicide rate [7]. In 2019, suicide was the second leading cause of death for people 10 to 34 years of age and the tenth leading cause of death across all age groups (*Table 1*). Overall, suicide accounts for 1.7% of all deaths in the United States. Although official national statistics are not compiled on attempted suicide (i.e., nonfatal actions), it is estimated that 1.2 million adults (18 years of age and older) attempted suicide in 2020 [9]. Overall, there are roughly 25 attempts for every death by suicide; this ratio changes to 100 to 200:1 for the young and 4:1 for the elderly [9].

People with depression may experience suicidal ideation and behaviors, which can subsequently lead to suicide completions. As illustrated by *Figure 1*, in 2020, adults 18 to 25 years of age had the highest risk for a major depressive episode, followed by those 25 to 49 years of age. In addition, individuals of two or more races had the highest risk for depression (15.9%), followed by White individuals (9.5%).

Suicidal behaviors are a major problem in the United States, as depicted in the converging circles shown in *Figure 2*. This figure demonstrates that 12.2 million adults seriously considered suicide in 2020, represented by the outer circle, while 3.2 million adults made suicide plans, and 1.2 million adults attempted suicide. Of those adults who attempted suicide in 2020, 920,000 had made a suicide plan; 285,000 adults had made no such plan prior to the attempt [10; 12].

	Age (in Years)						
Rank	10–14	15–24	25–34	35–44	45–54	55–64	All Ages
1	Unintentional injury (778)	Unintentional injury (11,755)	Unintentional injury (24,516)	Unintentional injury (24,070)	Malignant neoplasms (35,587)	Malignant neoplasms (111,765)	Heart disease (659,041)
2	Suicide (534)	Suicide (5,954)	Suicide (8,059)	Malignant neoplasms (10,695)	Heart disease (31,138)	Heart disease (80,837)	Malignant neoplasms (599,601)
3	Malignant neoplasms (404)	Homicide (4,774)	Homicide (5,341)	Heart disease (10,499)	Unintentional injury (23,359)	Unintentional injury (24,892)	Unintentional injury (173,040)
4	Homicide (191)	Malignant neoplasms (1,388)	Malignant neoplasms (3,577)	Suicide (7,525)	Liver disease (8,098)	CLRD (18,743)	CLRD (156,979)
5	Congenital anomalies (189)	Heart disease (872)	Heart disease (3,495)	Homicide (3,446)	Suicide (8,012)	Diabetes (15,508)	Stroke (150,005)
6	Heart disease (87)	Congenital anomalies (390)	Liver disease (1,112)	Liver disease (3,417)	Diabetes (6,348)	Liver disease (14,385)	Alzheimer disease (121,499)
7	CLRD (81)	Diabetes (248)	Diabetes (887)	Diabetes (2,228)	Stroke (5,153)	Stroke (12,931)	Diabetes (87,647)
8	Influenza/ pneumonia (71)	Influenza/ pneumonia (175)	Stroke (585)	Stroke (1,741)	CLRD (3,592)	Suicide (8,238)	Nephritis (51,565)
9	Stroke (48)	CLRD (168)	Complicated pregnancy (532)	Influenza/ pneumonia (951)	Nephritis (2,269)	Nephritis (5,857)	Influenza/ pneumonia (49,783)
10	Benign neoplasms (35)	Stroke (158)	HIV (486)	Septicemia (812)	Septicemia (2,176)	Septicemia (5,672)	Suicide (47,511)

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

Source: [10]   _Table 1_

Clearly, action is needed to help address depression and suicide in the United States, and psychedelic and interventional medicine may have a role.

POOR RESPONSE TO ANTIDEPRESSANTS

When they were first introduced, the monoamine oxide (MAO) inhibitors and tricyclic antidepressants were perceived as wonder drugs for depression. However, MAO inhibitors require strict dietary constraints, and both drug classes are associated with multiple troubling side effects. In contrast, when selective serotonin reuptake inhibitors (SSRIs) were introduced, they were much easier to prescribe and expanded treatment approaches to include primary care. Unfortunately, for many patients, SSRIs did not help as much as expected—or indeed at all, in some cases. Today, it is clear that non- or under-response to pharmacotherapy for major depression is far more common than was realized at the time. For example, researchers have found that antidepressants are ineffective for at least one-third of individuals who take them [2]. Suboptimal responses are also common. Many patients for whom the drugs do not work will recalibrate their expectations and accept the treatment response as the best they can hope to achieve. Treatment discontinuation is common among frustrated patients.

It is also important to note that even when antidepressants actually are efficacious, it usually takes at least three or four weeks for the drug to begin to take effect. Tricyclic antidepressants, MAO inhibitors, SSRIs, and serotonin and norepinephrine reuptake inhibitors (SNRIs) all share this issue of a delayed onset of action. Psychiatrists and neuroscientists have been unable to develop faster-acting medications for depression to date. This means that many people with severe depression

PAST YEAR PREVALENCE OF MAJOR DEPRESSIVE EPISODE AMONG U.S. ADULTS, 2020
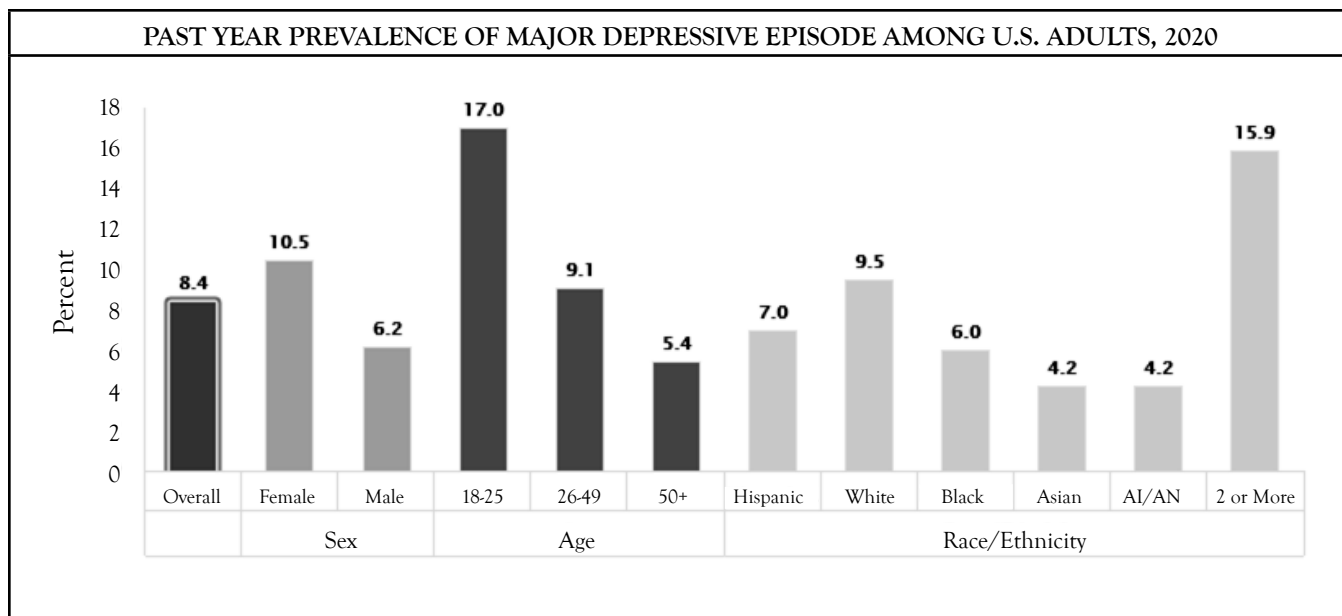
AI/AN = American Indian/Alaska Native

Source: [11]

Figure 1

SUICIDAL BEHAVIORS IN THE UNITED STATES, 2020
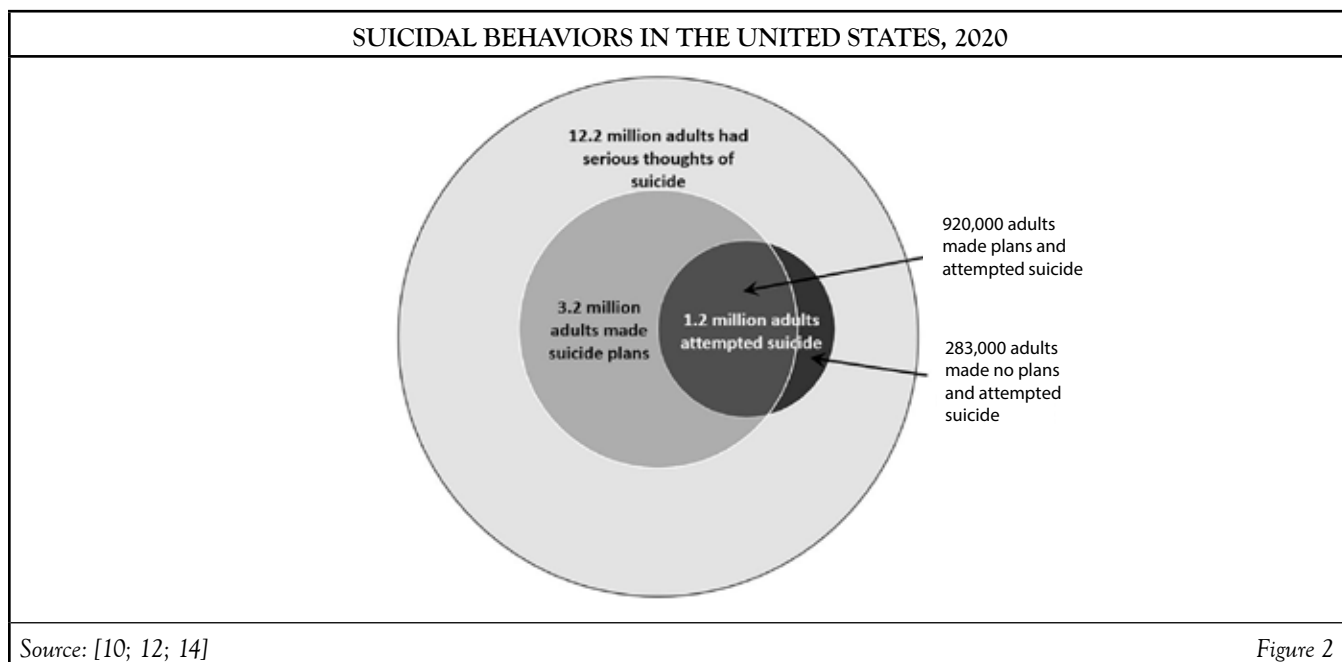
Source: [10; 12; 14]

Figure 2

could take an antidepressant very faithfully for weeks without any relief. These patients may give up hope and halt treatment or try again with another antidepressant or medication combination.

As with any pharmacotherapy, antidepressants have many possible adverse effects, including weight gain, anorgasmia, sluggishness, anxiety, insomnia, and suicidal ideation. As such, a patient may experience no improvements in depression symptoms while also developing adverse drug effects. This is not the end of consequences; discontinuation symptoms are

also a concern. Antidepressant discontinuation symptoms can be very challenging. For example, abruptly ending fluoxetine can cause nightmares, vomiting, and irritability. In most cases, patients who no longer wish to take an antidepressant should taper off the drug on a defined schedule [3].

To recap, patients may take antidepressants for months without significant improvements in depression symptoms while also experiencing side effects, and when they stop taking these ineffective drugs, they suffer more side effects unless they carefully taper off. In contrast, some psychedelic drugs have the potential

to provide relief in a few sessions, with lasting efficacy over months or even years, although further research is needed. This contrast is the main reason that so many mental health professionals and patients are intrigued about the possibilities of psychedelic medicine, particularly for more difficult cases.

It is not clear why antidepressants work for some patients and not for others. Some have hypothesized it may be related to the size and shape of a person's neurons, which can vary considerably [3]. Another possible contributing factor is the similar mechanisms of action among the different classes of antidepressants. These agents increase blood levels of serotonin, dopamine, or norepinephrine. In contrast, some psychedelic drugs, such as ketamine, are *N*-methyl-D-aspartate (NMDA)/glutamate receptor antagonists. This represents a completely different target for antidepressant mechanism of action and also a novel approach to treating depression.

There is also some evidence that ketamine can reverse suicidality or depression after a single dose, which suggests that the drug reverses a neurochemical deficit that is close to the problem. Ketamine and psychedelic drugs are effective at promoting plasticity, reconnections, and healing within the brain, a feat beyond the capabilities of traditional antidepressants or most other drugs. Researchers have found that neuroplastic changes, specifically atrophy of neurons in the prefrontal cortex, are an underlying etiology of depression and other mood disorders. The extent to which these drugs, and ketamine in particular, are able to promote structural and functional plasticity in the prefrontal cortex is believed to underlie the fast-acting antidepressant properties [4]. Other drugs, such as LSD and DMT, may stimulate the formulation of synapses [4]. Psychedelic drugs may also create new connections within the brain, although much more research is needed to understand how and why these drugs may be effective in treating serious psychiatric disorders in some who have heretofore not proven responsive to traditionally effective treatments.

A GROWING MARKET

Certainly, psychedelic medicine is regarded as a major and burgeoning healthcare market. Data Bridge Market Research has estimated that the market for psychedelic drugs will more than triple, from about $2 billion in 2019 to nearly $7 billion by 2027 [13]. Other estimates are even more favorable; a report from Research and Markets anticipates a market of $10.75 billion in psychedelic drugs by 2027 [13]. In a post-COVID world in which the numbers of people with reported depression have increased by as much as three times, potentially effective treatment options should not be ignored.

It has been estimated that at least 50,000 therapists will be needed by 2031 to provide psychedelic-assisted therapy to patients, and as a result, some organizations have already begun to increase their hiring. The key types of therapies used will be cognitive-behavioral therapy (CBT), acceptance and commitment therapy (ACT), or other types of therapy adapted to psychedelic treatment [15].

The current high interest in psychedelic medicine may stimulate pharmaceutical companies to research and develop novel drug treatments for major psychiatric problems beyond the traditional classes of drugs that solely target serotonin, norepinephrine, and dopamine, which would be yet another positive consequence.

CONSUMER INTEREST

At the same time that the federal government has somewhat loosened its tight reins on psychedelic medicine and researchers and medical professionals have begun to explore the use of these agents, there has been a dramatic increase in interest among consumers in Schedule I drugs, particularly in cannabis, but also in psilocybin and other psychedelic drugs. As of 2022, 37 states as well as the District of Columbia and four U.S. territories allow the medical use of cannabis ("medical marijuana") [16]. (Note that medical use of cannabis is a bit of a misnomer, as prescribers generally have little or no involvement with patients who take the drug and it has not attained FDA approval for any condition.) In addition, the U.S. House of Representatives passed a bill to decriminalize cannabis use in 2022 [17]. In addition, 18 states, the District of Columbia, and 2 U.S. territories have legalized the recreational use of cannabis for adults [18]. This followed several years of decriminalization at the local and state levels. While cannabis is not considered a psychedelic drug, its shift toward decriminalization and medicinal use is a sign that a similar path may be beginning for other Schedule I drugs with potential psychiatric benefit. Further, in states that allow medical or recreational use of cannabis for adults, the federal government has largely backed away from taking any punitive measures against individuals who use the drug, even though cannabis remains illegal at a federal level.

This movement may already be advancing with psychedelic drugs. This began with the decriminalization of psilocybin in Denver, Colorado, in 2019, followed by Oakland and Santa Cruz, California. In 2021, the city of Cambridge, Massachusetts, passed a law decriminalizing all "entheogenic plants," which includes the drugs ayahuasca, ibogaine, and psilocybin [19]. As of 2022, the largest city to decriminalize psilocybin is Seattle, Washington [19]. In 2020, the state of Oregon approved the use of psilocybin by consumers [20]. Also in 2020, the District of Columbia decriminalized the use of psilocybin mushrooms as well as other substances found in peyote and ayahuasca [20]. Other states are considering taking similar actions. In 2021, Health Canada, the premier health agency in Canada, approved trials of MDMA-assisted therapy for the treatment of PTSD [15]. It is important to note that it can be dangerous for psilocybin and other psychedelic drugs to be used by individuals who do not understand its risks. As popularity and interest in the medical use of these agents increases, clinicians have a responsibility to educate themselves and their patients about the safe and appropriate use of psychedelics.

PSYCHEDELIC PSYCHIATRY TRAINING PROGRAMS
Hopkins-Yale-NYU https://medicine.yale.edu/news-article/grant-supports-development-of-training-for-psychiatrists-in-psychedelic-medicine
MAPS https://mapspublicbenefit.com/training
Mount Sinai https://icahn.mssm.edu/research/center-psychedelic-psychotherapy-trauma-research/training-education
Source: Compiled by Author   Table 2

A major factor in the popularity of psychedelic drugs is frustration resulting from unrelenting depression, anxiety, chronic pain, or other health and mental health conditions. Some patients may have already tried cannabis to address these conditions, with varying levels of success.

GROWING BODY OF RESEARCH FROM RESPECTED ACADEMIC AND PHYSICIAN LEADERS

Although researchers have historically chosen to avoid or been blocked from researching psychedelics because of bans by the federal government, this has changed in the past few decades. For example, in 2006, Johns Hopkins Medicine began their research on psychedelic medicine, subsequently producing more than 80 peer-reviewed clinical studies by 2020 [21]. A new home for the Center for Psychedelic and Consciousness Research was created in 2020, the first such establishment in the United States [21]. Private donors provided funding to launch the Center, and since its opening, the Center has also received federal funding for research. In addition, Yale, Massachusetts General Hospital/Harvard, and other psychiatric and research excellence centers are studying psychedelic medications as treatment options for serious psychiatric disorders.

In addition, training programs focusing on psychedelic psychiatry are being established (*Table 2*). Johns Hopkins, New York University, and Yale are collaborating to create a psychedelics-psychiatrist program funded by a grant facilitated by Heffter Research Institute [22].

DEFINITIONS

Clear definitions of the concepts related to psychedelic drugs and interventional psychiatry are helpful. The following is a glossary of terms used throughout this course.

Classic psychedelic: Refers to older hallucinogenic drugs, such as psilocybin and LSD. These agents are often derived from natural sources.

Deep brain stimulation: With the use of implanted electrodes, the brain is stimulated to treat such psychiatric problems as treatment-resistant depression.

Electroconvulsive therapy (ECT): Stimulation of the brain causing a seizure. This therapy is administered under sedation and is used to help patients with severe psychiatric diagnoses.

Hallucinogen: Drug that may cause the user to experience visual, auditory, or other types of hallucinations.

Neuromodulation therapy: The use of noninvasive or invasive means to stimulate the brain in order to treat serious psychiatric problems.

Psychedelic medicine: The use of mind-altering (typically but not always hallucinogenic or dissociative) drugs by mental health professionals to improve or even provide remission from severe psychiatric problems, such as depression, PTSD, anxiety, and substance use disorders.

Set: Refers to the patient's mindset. For example, a person who is anxious and fearful is less likely to have a positive experience with psychedelic medicine than a person who has an open and positive outlook.

Setting: Refers to the overall ambiance in which psychedelic medicine is administered. A pleasant atmosphere that makes the individual feel safe is best.

Transcranial magnetic stimulation: A noninvasive form of therapy that uses large magnets external to the patient to stimulate the brain.

Vagus nerve stimulation: Invasive stimulation of the vagus nerve in order to treat serious, treatment-resistant psychiatric diagnoses.

PONDERING PSYCHEDELICS

More than 50 years have passed since the federal Controlled Substances Act first criminalized the use of psychedelics in the United States in 1970. The initial use (and misuse) of psychedelic drugs in that era was primarily associated with Timothy Leary, a Harvard professor who promoted the nonmedical use of LSD, a practice subsequently adopted by the amorphous "hippie" counterculture movement of the 1960s and 1970s. Dr. Leary was famously noted as advising his followers to "turn on, tune in, and drop out," scandalizing much of the conservative population of the time. Numerous events led to Leary's loss of reputation, academic standing, and position, but his impact during this period was indisputable. In response to this movement, drugs such as LSD, DMT, psilocybin, and mescaline were all placed in the Schedule I drugs category under the Controlled Substances Act 1970 (*Table 3*).

The categorization of psychedelics as Schedule I drugs immediately halted intense scientific research on psychedelics, which had begun in the 1950s. This prohibition on psychedelic drug research significantly delayed advances in medical

PSYCHEDELIC DRUG SCHEDULING	
Drug	**Schedule**
Ayahuasca/DMT	I
Ibogaine	I
Ketamine	III
Kratom	Not scheduled
LSD	I
Mescaline	I
Nitrous oxide	Not scheduled
Psilocybin	I
MDMA ("Molly," "Ecstasy")	I
Source: [23]	_Table 3_

knowledge on the therapeutic uses of these agents. While much of the focus at that time was on Timothy Leary and the counterculture's recreational LSD use, some researchers had demonstrated beneficial effects with psychedelic medicine in end-of-life care as well as in the treatment of addiction and other severe psychiatric problems [24].

This research did not restart in the United States in any meaningful way until the 21st century. In this new wave of research, researchers in Phase 2 and 3 clinical trials of psychedelic medications have found the possibility of remission in diverse psychiatric populations (including in patients with PTSD, depression, eating disorders, and substance use disorders) as well as reduction in end-of-life anxiety and despair in those with terminal diagnoses [25]. At the same time, researchers have explored the use of older drugs (e.g., nitrous oxide, ketamine) to treat unrelenting psychiatric disorders.

Another interesting avenue of research has been in the field of addiction medicine. There is some evidence that certain psychedelic drugs, particularly psilocybin, may act as a sort of "anti-gateway drug." Years ago, there was a belief that some (or all) drugs were "gateway drugs," leading inevitably to taking other drugs; for example, this perspective holds that people who smoked marijuana would eventually progress to using "harder" drugs, injecting heroin or other opioids. This theory has largely been discredited and devalued. In fact, several studies have indicated that persons who use hallucinogens are less likely to progress to harder drugs. In one study, researchers used data from nearly 250,000 respondents from the National Survey on Drug Use and Health over the period 2015–2019. Respondents were asked about their past use of classic psychedelics, and these results were then compared to their later abuse (or non-use) of opioids. Individuals who had used psilocybin ("magic mushrooms") in the past had a significantly lower rate (30% lower than average) of opioid misuse and abuse later. This finding was not replicated with other psychedelic drugs [26]. An earlier study using National Survey on Drug Use and

Health data for the period 2008–2013 found that past use of classic psychedelics decreased the risk for past-year opioid dependence by 27% and of opioid abuse by 40% [27].

Both of these studies relied on individuals reporting on their past use of psychedelic drugs, and there are multiple possible issues with this type of retrospective reporting. But the idea that past use of drugs such as psilocybin could be protective against opioid misuse and dependence in the future is promising, given the ongoing opioid epidemic in the United States.

A BRIEF HISTORY OF PSYCHEDELICS

It is unclear how long the various psychedelic substances have been used worldwide, but it is safe to say that some have been used for thousands of years in religious and tribal ceremonies. The earliest known written record of the use of psilocybin mushrooms appeared in the Florentine Codex, a manuscript of ethnographic research of Mesoamerica, particularly of Mexico and the Aztecs, compiled between 1529 and 1579. Psilocybin, mescaline, and ayahuasca (a concoction often brewed in a tea and that includes the psychedelic chemical DMT) have all been used in religious ceremonies in indigenous societies in South and Central America for centuries. The hallucinogenic effects of some plants and fungi also have been known by indigenous cultures and were deliberately exploited by humans for thousands of years. Fungi, particularly some types of mushrooms, are the principal source of naturally occurring psychedelics. Historically, the mushroom extract psilocybin has been used as a psychedelic agent for religious and spiritual ceremonies and as a therapeutic option for neuropsychiatric conditions [28].

Early Days of LSD

Modern pharmaceutical research on psychedelics started in earnest in 1930s Basel, Switzerland, with research chemist Albert Hofmann. Seeking to create a synthetic alkaloid to the ergot fungus, he developed LSD-25 in 1938. The uses of the drug were not immediately obvious, so it sat on a shelf for five years until Hofmann decided to repeat his synthesis of the chemical. Despite his care, Hofmann accidentally contaminated himself with the drug and thereafter experienced highly unusual sensations as well as dizziness. He described his experience as [29]:

> I lay down and sank into a not unpleasant intoxicated-like condition, characterized by an extremely stimulated imagination. In a dreamlike state, with eyes closed (I found the daylight to be unpleasantly glaring), I perceived an uninterrupted stream of fantastic pictures, extraordinary shapes with intense, kaleidoscopic play of colors. After some two hours, this condition faded away.

Hofmann decided to experiment on himself with what he believed to be a very low dose of LSD, but the dose was high enough for him to experience what he perceived to be demonic possession and other lurid sensations. His physician was called and only noted that Hofmann had extremely dilated pupils, with normal blood pressure and vital signs. When Hofmann related his experiences to his colleagues, they were dubious

that he had measured correctly, but to be safe, they took even lower doses. Each experienced what were later referred to as psychedelic mind "trips" [29].

In 1947, Sandoz began marketing and distributing LSD, under the brand name Delysid, as a possible psychiatric drug to treat neurosis, alcoholism, criminal behavior, and schizophrenia. In addition, LSD-25 was also used to treat autism and verbal misbehavior [28; 30]. In his book, Hofmann described how LSD helped provide relief to people who were dying of cancer and in severe pain for whom major analgesics were ineffective. He hypothesized that the analgesic effect was not inherent to the drug but was a result of patients dissociating from their bodies such that physical pain no longer affected them [29].

However, early studies on LSD did not always inform patients about the potential risks. For example, in some cases, patients with schizophrenia were given LSD and not told about the possible risk for a psychotic break [31]. Patients at the Addiction Research Center in Lexington, Kentucky, were often given the drug without being told what it was or the possible effects. Researchers who believed in the importance of "set and setting" (the patient's mindset and the setting where the drug was administered) were more likely to inform patients about possible risks and benefits. The 1962 Kefauver-Harris Amendments required that all patients provide informed consent for therapeutic interventions and research participation. Despite this, the "informed consent" of the 1960s was not as comprehensive as informed consent today. Some have posited that the primary goal was to release researchers from legal responsibility rather than to provide ensure the safety of patients and prospective subjects of clinical trials [31].

For about a decade, Hofmann and Sandoz believed that LSD might provide breakthroughs in psychiatry. However, with the major social change of the 1960s, characterized by protests for social change and against the Vietnam War and increasingly liberal attitudes regarding drugs among young people, the focus shifted to recreational rather than medical use of LSD, and in 1965, Sandoz stopped manufacture and marketing of LSD. In 1966, Sandoz gave their remaining supplies to the National Institute of Mental Health [31].

Early Days of Psilocybin

In 1957, Hofmann received a sample of dried *Psilocybe mexicana* mushrooms from a mycologist in Huautla de Jiménez in Oaxaca, Mexico. The mycologist, R. Gordon Wasson, had received a sample of the mushrooms and information regarding the sacred rituals of the Mazatec people from a curandera to whom he promised secrecy; this promise was obviously not kept, and Wasson's actions resulted in retaliation against the indigenous woman who he betrayed [138]. Hofmann used paper chromatography to separate the various components of whole extracts of mushrooms and ingested each separated fraction. The active fraction was then chemically characterized, crystallized, and named psilocybin. In 1958, Hofmann and his colleagues subsequently elucidated the structure and synthesis of psilocybin and psilocin, a minor component of the extract

that is a dephosphorylated form of psilocybin. In the 1960s, Sandoz Pharmaceuticals began to distribute Indocybin, a psychotherapeutic drug in pill form, containing 2-mg psilocybin. This period also saw research focusing on psilocybin as a probe for brain function and recidivism and as an entheogen used by religious people (divinity students).

During this era, psilocybin, LSD, mescaline, and other psychedelics were used by some individuals with psychiatric diseases, and they were also used extensively by some psychiatrists to treat patients before the drugs were categorized as Schedule I of the U.N. Convention on Drugs in 1967, which preceded the Controlled Substances Act in the United States. Today, the medical value of hallucinogens is being tested in rigorous trials in settings such as Roland Griffith's Johns Hopkins research program. The experts from the psilocybin research group at Johns Hopkins University have described the importance of trained psychedelic therapists and other components of a psychedelic treatment session to optimize patient safety in hallucinogen research [32].

CONSIDERING PSYCHEDELIC-ASSISTED PSYCHOTHERAPY AS A TREATMENT OPTION

For most mental health professionals, the idea of psychedelic-assisted psychotherapy is a major paradigm shift and leap from current practices of providing pharmacotherapy or psychotherapy to individuals or groups. At the same time, it may represent a new opportunity to combine the talents and skills of therapists with the proven benefits of a psychedelic drug. Combined psychotherapy/pharmacotherapy is the treatment of choice for most patients with mental health disorders, so interprofessional collaboration is a typical (and vital) part of treatment. Psychedelic medicine requires that diverse disciplines collaborate closely and communicate to clearly ensure that the therapy is safely and effectively administered.

LEGAL AND REGULATORY BARRIERS

Today, the federal government has provided limited permission or even grants to study Schedule I drugs and their possible role in the treatment of patients. Outside of these limited cases, researchers find it difficult to obtain the needed drug for testing purposes. To avoid legal and regulatory issues, a good amount of research is performed outside of the United States.

"SET" AND "SETTING" IN PSYCHOTHERAPY-ASSISTED PSYCHEDELIC TREATMENT

Since the 1960s, therapists have noted that the response to psychedelic drugs is impacted by the patient's mindset as well as the setting where the psychedelic drug is administered. For example, if the person feels confident that the experience will be a positive one, then this "set" is considered more conducive to a good experience while under the influence of a psychedelic drug compared with when persons are extremely apprehensive and fearful beforehand. By extension, if patients are in an office

setting with a therapist or other practitioner with whom they feel safe, the outcome is generally better than in those who feel unsafe. Research has shown a better outcome with patients receiving psychedelics in a therapeutic setting versus receiving the drug while undergoing a positron emission tomography (PET) scan [33]. These researchers stated [33]:

> The finding that the PET environment was strongly associated with anxious reactions could be partially explained by the perceived atmosphere. Whereas non-PET experiments were mostly conducted in laboratory rooms that were furnished in an aesthetically pleasing way, the environment at the PET center was much more clinical and "antiseptic" (i.e., lots of technical equipment, white walls, personnel in white lab coats). Our results are therefore in support of current safety guidelines, which recommend avoiding "cold" and overly clinical environments in human hallucinogen research in order to reduce the risk of anxious reactions.

Another element of setting, and one that is also used to enhance set, is the use of music while the patient undergoes therapy with psychedelic medicine. Johns Hopkins has developed a "psilocybin playlist" lasting nearly eight hours that is used for patients who are undergoing treatment with psilocybin [34].

In many cases, psychedelic therapy is administered after a therapeutic session. Psychotherapy is often also provided during the course of the drug's effects and at integration sessions that occur after the drug was given to help the patient to give meaning and context for the experience [35]. This provision of multiple hours of psychotherapy over a short period of time can translate to higher costs. This scenario might be less appealing to insurance carriers than traditional therapies (e.g., antidepressants or other drugs), but this is yet to be seen.

It should also be noted that in some areas, there are clear manualized approaches to treating patients that carefully consider both set and setting; this is particularly the case for MDMA in the treatment of PTSD. However, these approaches are yet to be developed for most other psychedelic drugs. Again, this field offers burgeoning opportunities for psychiatrists, psychologists, primary care providers, and other mental health practitioners.

ADVISING PATIENTS CONSIDERING PSYCHEDELIC MEDICINE

Some patients will approach their primary care providers to discuss the possibility of seeking care at a ketamine or MDMA (or other) clinic. It is important not to dismiss these treatment options out of hand. Instead, it may be best to ask the patients the following questions to help assess if the option would be helpful and if the facility is set up to provide optimal care:

- Who is the expert or experts running this clinic? What experience(s) make this person or team experts? What outcome data are provided?

- Does the patient have a severe and intractable diagnosis, such as treatment-resistant depression, substance use disorder, or PTSD? If not, then conventional medicine is still best.

- Does the clinic ensure professional observation after the drug is administered? This is always advisable in case the patient experiences adverse events.

- How soon after a drug is administered are patients discharged from the facility? Minimal times (e.g., 15 minutes) are not long enough to ensure safety.

- Does the facility offer psychotherapy before, during, and after the drug is administered? Combining psychotherapy with psychedelic medicine is the proven best practice.

- Is there a required follow-up?

- Are the costs for treatments clearly delineated? If not, patients should request, in writing, an estimate of total costs. Psychedelic medicine is likely not covered by health insurance and may be costly. Also, the cost may fluctuate significantly from one clinic to another.

- Has the patient experienced a psychotic break in the past or does the patient have first-degree relatives with a history of psychosis? Psychedelics have the potential to trigger an underlying predisposition for psychosis, although it can be temporary. Still, even a short-term psychotic break is a terrifying experience.

ADDRESSING STIGMA

For many people, including some clinicians, the phrase "psychedelic medicine" evokes images of free love, 1960s counterculture, and recreational intoxication. In reality, these therapies typically look much more pedestrian, consisting of a patient sitting or lying on a couch while a clinician guides the person through the experience in order to treat their severe psychiatric disorder. Although many of the drugs described in this course can and do induce hallucinations, subjects have reported that these experiences were integral and allowed them to resolve psychiatric issues that have been resistant to traditional treatments and that have significant impact on their lives. If further studies continue to bear these findings out, it would be unwise to ignore the benefits that may accrue.

EMERGING PSYCHEDELIC TREATMENTS

The key psychedelic drugs actively being researched and/or currently in use today include psilocybin, ketamine, MDMA, ibogaine, kratom, LSD, mescaline, and ayahuasca (*Table 4*). In addition, nitrous oxide, a gas used for many years by dentists as both an anesthesia and analgesic for patients undergoing painful procedures, has also been found effective as a treatment for some psychiatric disorders.

MAJOR PSYCHEDELIC RESEARCH CENTERS IN THE UNITED STATES
Johns Hopkins Center for Psychedelic and Consciousness Research https://hopkinspsychedelic.org
National Institutes of Health Funding https://pubmed.ncbi.nlm.nih.gov/34624734
Yale University https://medicine.yale.edu/psychiatry/education/residency/interest/psychedelic_science_group
Mount Sinai https://www.mountsinai.org/about/newsroom/2021/mount-sinai-health-system-launches-center-for-psychedelic-research
Stanford University https://med.stanford.edu/spsg.html
University of California, San Francisco https://neuroscape.ucsf.edu/psychedelics
Duke University https://dukepsychedelics.org
University of Texas at Austin https://dellmed.utexas.edu/units/center-for-psychedelic-research-and-therapy
Washington University in St. Louis (WUSTL) https://healthymind.wustl.edu/items/washington-universitys-program-in-psychedelic-research
Harvard/Massachusetts General Hospital https://www.massgeneral.org/psychiatry/treatments-and-services/center-for-the-neuroscience-of-psychedelics
Source: Compiled by Author   *Table 4*

PSILOCYBIN

Beginning in the 2010s, psilocybin has been undergoing an era of increased research attention, and this compound remains under active investigation. Psilocybin occurs in nature in hundreds of species of mushrooms as 4-phosphoryloxy-*N*,*N*-dimethyltryptamine. However, when used by researchers, the drug is nearly always a chemically synthesized compound to maintain a standard dosage as well as the purity of the drug. In 2020, COMPASS Pathways announced that it had gained a patent in the United States for COMP360, its form of synthetically derived psilocybin [15].

According to a 2022 report from the Associated Press, some states, even in conservative areas (e.g., Utah), have approved studying psilocybin as a treatment. This movement has largely been driven by increasing rates of treatment-resistant PTSD among military veterans [36].

Psilocybin was first studied during the 1960s to establish its psychopharmacologic profile; it was found to be active orally at around 10 mg, with more potent effects at higher doses, with a four- to six-hour duration. Psilocybin is rapidly metabolized to psilocin, a full agonist at serotonin 5-HT1A/2A/2C receptors, with 5-HT2A receptor activation directly correlated with human hallucinogenic activity. Time to onset of effect is usually within 20 to 30 minutes of ingestion. As a drug, it is about 20 times stronger than mescaline but much less potent than LSD [37].

In animal studies of the use of psilocybin, a link has been identified between reduced prefrontal mGluR2 function and both impaired executive function and alcohol craving. Psilocybin also restored healthy mGluR2 expression and reduced relapse behavior in mice [38]. Mice and humans do not always respond equivalently, but this finding may explain why psilocybin is effective in treating induced alcoholism in mice and provides an interesting research avenue in the investigation of psilocybin as a treatment for alcohol use disorder in humans, because relapse is a significant problem; even when a patient has abstained from alcohol for years, the underlying craving remains. If this craving could be reduced or altogether eliminated, this could revolutionize substance use disorder treatment.

In a study at King's College London, researchers studied the effects of psilocybin on the emotional and cognitive functions in healthy subjects in a Phase 1 randomized double-blind controlled study with 89 subjects (average age: 36.1 years). Subjects were randomized to receive placebo or 10 mg or 25 mg of psilocybin. Therapists were available to the subjects throughout the sessions. Six subjects at a time received the drug. The study showed that there were no short- or long-term adverse effects to the emotional processing or cognitive functioning

of the subjects [39]. In this study, 70% of the subjects who received 25-mg psilocybin experienced visual hallucinations, compared with 60% of those who received 10-mg psilocybin and 6.9% of those who received placebo. The second most common treatment-emergent adverse event was illusion, which was experienced by 60% of subjects receiving 25-mg psilocybin and 63.3% of those receiving 10-mg psilocybin; 13.8% of those receiving placebo reported experiencing this effect. Other treatment-emergent adverse events reported more commonly among the treatment groups included mood alteration, headache, fatigue, and euphoric mood, all of which were lower or altogether non-existent in the placebo group. Also absent in the placebo group were auditory and tactile hallucinations [39]. The researchers concluded [39]:

> This study demonstrated the feasibility of one-to-one psychological support from specially trained therapists during [the] simultaneous administration of psilocybin in a supervised clinical setting in healthy volunteers. A single dose of psilocybin 10 mg or 25 mg elicited no serious adverse effects and did not appear to produce any clinically relevant detrimental short- or long-term effects, compared with placebo, in cognitive or social functioning or emotional regulation in this study in health volunteers.

In studies using psilocybin, the most common adverse reactions were found to be headache, nausea, and hypertension, and events were considered to be equivalent to those found with the use of SSRIs [40]. However, it should also be noted that the subjects in psilocybin clinical trials are usually screened for a family history of schizophrenia, major depression with psychotic features, high risk for suicide, and severe personality disorders before inclusion [40].

Another study at Johns Hopkins evaluated the efficacy and safety of psilocybin for the treatment of major depressive disorder. In this randomized study, 24 patients 21 to 75 years of age with moderate-to-severe unipolar depression were randomized to either immediate or delayed treatment. Subjects were administered two doses of psilocybin along with supportive psychotherapy. Researchers found a greater than 50% reduction in depressive symptoms, as measured by the GRID-Hamilton Depression Rating Scale (GRID-HAMD), in the treatment group. Before initiating psilocybin therapy, subjects first received six to eight hours of preparation with trained facilitators. The psilocybin was administered at doses of 20 mg/70 kg and 30 mg/70 kg, about two weeks apart, while subjects were in a comfortable room supervised by two facilitators. There were also follow-up counseling sessions [1]. The mean scores on the GRID-HAMD decreased from an average of 22.8 at the pretreatment level to 8.7 at 1 week, 8.9 at 4 weeks, 9.3 at 3 months, 7.0 at 6 months, and 7.7 at 12 months. These data indicate that the psilocybin provided persistent relief to many patients [1].

In a 2018 British study, 26 patients, 20 of whom were diagnosed with severe treatment-resistant depression, were administered separate doses of 10- and 25-mg psilocybin one week apart;

administration took place in a supportive setting. Nineteen subjects completed the treatment process, including psychological support, and all of the completers reported improved symptoms based on Quick Inventory of Depressive Symptoms (QIDS-SR16) and HAM-D scores. Four patients experienced remission of their depression at week five. Many completers continued to benefit from treatment at three months and six months. Suicidality scores among the patients also significantly fell within the two weeks after treatment [41].

Not all researchers have offered a ringing endorsement of the use of psilocybin. A 2021 study studied 59 patients with moderate-to-severe major depressive disorder. The subjects were administered either two doses of 25-mg psilocybin three weeks apart plus placebo (30 patients) over six weeks, or they were given escitalopram (an SSRI) for six weeks (29 patients). All the patients also received psychological assistance. No significant differences were noted in depression symptoms between the two groups, and the researchers concluded that further studies with larger populations were needed. Even the adverse events in the two groups were somewhat similar; the most common adverse effect in both groups over the course of the study was headache, followed by nausea [42]. Even in this study, psilocybin was about as effective as antidepressant therapy. This is remarkable, in that this new treatment is about as effective as the established criterion standard treatment for major depressive disorder.

Although studies have supported the hypothesis that psilocybin provided under research conditions by physicians has a positive effect on depressive symptoms, until recently, the mechanism by which this improvement has occurred was largely unknown. However, in a study of 16 individuals with treatment-resistant depression, researchers used functional magnetic resonance imaging (fMRI) to assess functional brain changes both at baseline and one day after the study group received 25-mg psilocybin. The researchers found brain network modularity was reduced within just one day after the psilocybin was administered [43]. In a second study by the same researchers, 59 patients with major depressive disorder were randomized to either two doses of 25-mg psilocybin three weeks apart plus six weeks of daily placebo or to six weeks of 10- to 20-mg escitalopram per day plus 1-mg psilocybin (an ineffective dose). In this study, 29 subjects were in the escitalopram arm, although the group ultimately decreased to 21 subjects (28% dropout rate). The 30 patients in the psilocybin group decreased to 22 subjects (27% dropout rate) [43]. The researchers noted that [43]:

> It is plausible that this putative liberating effect of psilocybin on cortical activity occurs via its direct agonist action on cortical 5-HT2A receptors, dysregulating activity in regions rich in their expression. We surmise that chronic escitalopram does not have the effect on brain modularity due to its more generalized action on the serotonin system and predominant action on inhibitory postsynaptic 5-HT1A receptors, which are richly expressed in limbic circuity.

The researchers found that the antidepressant effect of the psilocybin was sustained and rapid and that it also corresponded with decreases in fMRI brain network modularity. This indicates that the antidepressant effect of psilocybin, when it works, is linked with a global increase in brain network integration. In contrast, the response to the escitalopram was mild and caused no changes to the brain network [43].

KETAMINE

Ketamine is a derivative of phencyclidine (PCP), which itself was originally developed as an anesthetic. However, the major adverse effects of PCP, such as aggression, psychosis, and dysphoria, made it an undesirable and unacceptable anesthetic choice [44]. In contrast, ketamine was effective as an anesthetic and had few adverse effects. PCP subsequently became a drug of abuse.

While ketamine has been used in operative analgesia for decades, it has also become a drug of abuse and misuse [45]. Most notoriously, ketamine became known as a "date-rape drug," because it was administered in drinks to unknowing victims who were subsequently sexually assaulted by their predators. Because ketamine causes amnesia, victims have little or no memory of what occurred to them, although they often experienced after-effects, such as pain. As a result of this growing criminal use, Congress passed the Drug-Induced Rape Prevention and Punishment Act of 1996. During this period and the decade following, there was increased awareness of the dangers of ketamine and other drugs that were used in a similar manner, such as flunitrazepam (Rohypnol) and gamma hydroxybutyric acid (GHB) [46]. As a result, ketamine developed a stigma, and this negative view may persist in many minds.

Ketamine is a Schedule III drug that is a combination of s-ketamine (esketamine) and r-ketamine (arketamine). In 2019, the use of esketamine as a nasal spray (brand name Spravato) was approved by the FDA for the treatment of treatment-resistant depression. Since then, it has also been approved to treat suicidal depression. However, it should be noted that this nasal spray formulation is not available at most pharmacies; instead, it is provided solely through a restricted distribution system. The FDA also requires that patients be overseen for a minimum of two hours after treatment, in order to allow sufficient time to identify and address and adverse reactions that develop in patients. (It is not clear if all ketamine clinics adhere to this provision.)

After treatment with ketamine, patients should not leave the facility until they are cleared to do so by a healthcare provider and they should also be cautioned to avoid driving or using heavy equipment until the following day. In addition, patients are not allowed to take the nasal spray home, because it may only be used in the medical office while under the supervision of qualified staff members [47].

Intravenous ketamine has been used off-label for treatment-resistant depression by some clinicians, and ketamine clinics are established in many parts of the United States, although their fees vary widely. The effects of intravenously administered ketamine may last for hours, days, or even weeks in some patients. Some believe that intravenous ketamine is significantly more effective than its intranasal form because it includes both the s and r forms of the drug.

Some researchers have found that the mental state of the patient (set) prior to receiving treatment with ketamine may affect the outcome of treatment. In a 2019 study, 31 patients with major depressive disorder were treated with ketamine infusions. Researchers used multiple instruments to measure the mental state of subjects prior to and after receiving treatment, including the Montgomery-Asberg Depression Rating Scale (MADRS) and the Beck Hopelessness Scale. In this study, 17 subjects (55%) responded to the ketamine, while 14 (45%) had no response [48]. Non-responders had significantly higher rates on anxiety scales than responders. The researchers stated [48]:

> The present study showed for the first time that non-responders had more anxiety-related experiences induced by the first ketamine infusion than responders confirming our initial hypothesis of significantly different subjective experiences as a function of treatment response. Specifically, we found that it was the extent of ketamine-induced anxiety that was negatively predictive of a treatment response after a series of six infusions on average.

They also noted that providing a calm treatment environment to patients might be sufficient to reduce anxiety levels in patients to improve outcomes. This is the goal of treatment providers as well as researchers who emphasize the importance of set (mindset) and setting, as discussed. In this study, there was no follow-up after the last infusion, which may also have improved efficacy [48].

In another study of 30 individuals with PTSD of a median duration of 15 years, half of subjects were randomized to a ketamine group and half were assigned to a midazolam (a benzodiazepine) group. The subjects received six infusions over the course of two weeks of either ketamine (0.5 mg/kg) or midazolam (0.045 mg/kg). The subjects were evaluated with the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) at baseline and also at the end of treatment [49].

The average CAPS-5 total scores following the infusions were 11.88 points lower among the subjects in the ketamine group compared with the midazolam group. About two-thirds of the ketamine subjects (67%) responded to the treatment, versus only 20% of treatment responders in the midazolam group. The median time to loss of treatment following the two-week ketamine treatment period was 27.5 days. However, in outlier cases, two subjects still had not lost their response; improvements continued at 50 days and 102 days since the last infusion. The ketamine group experienced a major reduction in symptoms of depression as well as in clinical ratings of global psychiatric illness severity. The researchers concluded that the findings from this study support the assertion that "repeated ketamine infusions are safe and generally well tolerated among

individuals with chronic PTSD, with only transient emergence of psychoactive and hemodynamic side effects" [49].

In a French study, ketamine was explored as a treatment for individuals with severe suicidal ideation in a double-blind randomized clinical trial. In this six-study report, published in 2022, 156 patients were given either a 40-minute infusion of ketamine or placebo (saline solution). The administration was repeated 24 hours later. The groups were also divided into subjects with bipolar disorder, depressive disorder, and other diagnoses. Of patients in the ketamine group, 93.1% had a past history of the commission of a suicidal act, as did 86.6% of the subjects in the placebo arm [50].

On day 3, nearly two-thirds (63%) of the patients in the ketamine group achieved full remission from suicidal thoughts. In contrast, 31.6% of the patients in the placebo group were in remission. In nearly 44% of the ketamine subjects, remission occurred within two hours after the first infusion, compared with 7.3% of the placebo group. Ketamine was particularly effective in the bipolar group, while its effect was not significant in the group with major depressive or other psychiatric disorders. The researchers speculated that ketamine might provide an analgesic kind of effect to mental pain [50].

MDMA

In the past and even to date, MDMA (also referred to as "Ecstasy" or "Molly") has been largely a drug of abuse. According to the National Institute on Drug Abuse, about 2.6 million people in the United States 12 years of age and older reported past-year use of MDMA in 2020 [51]. The drug was originally developed by Merck in 1912, and in the 1970s, it was found to be useful in combination with psychotherapy [52]. However, because of considerable active abuse of the drug in the United States, in 1985, MDMA was categorized as a Schedule I drug under the Controlled Substances Act in an emergency ban, and consequently research on this drug largely halted until the 2010s [53].

Today, researchers have demonstrated the efficacy of combination psychotherapy and MDMA in treating PTSD. The FDA has granted "breakthrough therapy" permission for MDMA therapeutic treatment, largely as a result of the findings of several small studies. Clinicians who use MDMA-assisted psychotherapy to treat individuals with PTSD have access to a manual outlining best practices for this therapeutic use. In the 2017 revision of this manual, the following explanation is given [54]:

> The basic premise of this treatment approach is that the therapeutic effect is not due simply to the physiological effects of the medicine; rather, it is the result of an interaction between the effects of the medicine, the therapeutic setting, and the mindsets of the participant and the therapists. MDMA produces an experience that appears to temporarily reduce fear, increase the range of positive emotions toward self and others, and increase interpersonal trust without clouding the sensorium or

inhibiting access to emotions. MDMA may catalyze therapeutic processing by allowing participants to stay emotionally engaged while revisiting traumatic experiences without being overwhelmed by anxiety or other painful emotions. Frequently, participants are able to experience and express fear, anger, and grief as part of the therapeutic process with less likelihood of either feeling overwhelmed by these emotions or of avoiding them by dissociation or emotional numbing. In addition, MDMA can enable a heightened state of empathic rapport that facilitates the therapeutic process and allows for a corrective experience of secure attachment and collaboration with the therapists.

In six double-blind, randomized clinical studies conducted between 2004 and 2017, 72 subjects are administered 75–125 mg of MDMA in two or three sessions, comparing these results with 31 patients who received placebo; all the patients had diagnosed PTSD. The drug was administered following 90-minute sessions of psychotherapy and three to four therapy sessions were also provided during follow-up after MDMA therapy [55].

Members of the treatment group reported significantly reduced scores on the CAPS-5 compared with the control group. In addition, after two sessions, 54.2% of those who received MDMA no longer met the criteria for PTSD—they were in remission. In contrast, only 22.6% of the control group experienced remission. The researchers noted that "MDMA-assisted psychotherapy was efficacious and well tolerated in a large sample of adults with PTSD" [55].

In another randomized, double-blind, placebo-controlled phase 3 clinical trial with 90 individuals with severe PTSD, the subjects received manualized therapy with either MDMA or placebo. Three preparatory sessions occurred before the administration of the drug, and there were nine integrative therapy sessions afterwards. Subjects in the MDMA treatment group experienced a significant decrease in CAPS-5 (-24.4) scores compared with placebo subjects (-13.9). Scores on the Sheehan Disability Scale (SDS) also significantly improved in the MDMA subjects compared with the placebo subjects [56]. The researchers noted [56]:

> Given that PTSD is a strong predictor of disability in both veterans and community populations, it is promising to note that the robust reduction in PTSD and depressive symptoms identified here is complemented by a significant improvement in SDS score (for example, work and/or school, social and family functioning). Approximately 4.7 million U.S. veterans report a service-related disability, costing the U.S. government approximately $73 billion per year. Identification of a PTSD treatment that could improve social and family functioning and ameliorate impairment across a broad range of environmental contexts could provide major medical cost savings, in addition to improving the quality of life for veterans and others affected by this disorder.

Because major problems with sleep quality are common among patients with PTSD, some researchers have studied the effects of MDMA-assisted psychotherapy to determine its effects on sleep disorder. In a series of four studies with 63 subjects at sites in the United States, Canada, and Israel, subjects were randomized to two or three sessions of MDMA-assisted psychotherapy or to a control group. PTSD symptoms were assessed with the CAPS-IV, and the Pittsburgh Sleep Quality Index (PSQI) was used to measure changes in sleep quality. At the conclusion of the study, the CAPS-IV severity scores had decreased by 34 points in the MDMA group, compared with a decrease of 12.4 points for the control group. In addition, sleep quality improved significantly in the experimental group compared with the control group. In the treatment group, 53.2% of subjects reported a PSQI score drop of 3 or more points, compared with 12.5% in the control group [57].

Although there appears to be a benefit for MDMA therapy in the management of PTSD, especially for patients who have failed other therapies, the durability of this affect has been questioned. One study indicated improvement may be persistent for a considerable period of time for some subjects. In a study involving 107 subjects with PTSD, individuals were administered either two or three doses of MDMA (75–125 mg) during blinded or open-label therapy sessions. The subject's PTSD symptoms were evaluated 1 to 2 months after the last MDMA session and again after 12 months. The researchers reported that at the 12-month follow-up time, nearly all (97.6%) of the subjects said they had benefited from the treatment, and 53.2% reported large benefits that had lasted or even increased. A minority of subjects reported unfavorable results; 8.4% reported harms. However, in 86% of these cases (six of seven subjects), the harms were rated as a 3 or less on a 5-point scale. There were no reports of severe harm, and all the subjects who reported harm also reported one or more benefits. The most common harm reported was worsened mood (3.6%) [58]. The researchers noted that, "Overall findings from the present analyses support MDMA-assisted psychotherapy as an efficacious treatment for PTSD with symptom improvements that were sustained at 1 to 3.8 years post-treatment. These findings corroborate and expand preliminary results from the first phase 2 trial of this treatment" [58].

IBOGAINE

Largely derived from the Western African shrub *Tabernanthe iboga*, ibogaine has been explored as a possible treatment for opioid use disorder, although there are many caveats to be considered, including the fact that ibogaine is a Schedule I drug. Given the current climate surrounding opioid misuse and use disorder in the United States, possible treatment options are a major focus. According to the Centers for Disease Control and Prevention, more than 70% of drug overdoses in the United States in 2019 were related to opioid use [59]. Ibogaine apparently acts to eliminate craving for opioids and rapidly detoxifies individuals with opioid dependence, although much further study with larger populations is needed. Most people who seek treatment with ibogaine have opioid use disorder, but some have been dependent on stimulants such as cocaine.

The anti-addictive capabilities of ibogaine were first noted by Howard Lotsof in 1962 as a result of his own experience with the drug as well as reports from others. Lotsof, a man in recovery from heroin use disorder from New York City who unexpectedly found relief and remission with ibogaine, subsequently actively and tirelessly lobbied researchers to study the drug. He eventually succeeded, and multiple researchers using both animal and human studies have demonstrated ibogaine's apparent ability to induce recovery in some persons struggling with substance use disorders [60; 61].

Metabolism of ibogaine is purportedly mediated by the p450 cytochrome enzyme CY2D6. Because of genetic differences, an estimated 10% of persons of European heritage (predominantly White Americans in the United States) lack the necessary gene to synthesize this enzyme. Among this group, including the many individuals who do not realize they lack this gene, administration of ibogaine can result in plasma levels as much as twice as high as those in persons with the gene. As a precaution, a test dose of the drug may be given to subjects to assess the response. Another option is genotype screening of subjects who seek treatment with ibogaine, to ensure safety and to aid in treatment decisions [62].

Although it provides insufficient data from which to draw major conclusions, a study of the use of ibogaine in two adults with opioid use disorder is interesting. The experiences of one of the patients are described here, although it should be noted that both patients have remained abstinent for several years [62]. The first patient developed an opioid use disorder secondary to pain from chronic pancreatitis. His physician was concerned about potential misuse and weaned the patient off opioids; however, the patient began taking large quantities of oxycodone tablets he purchased illegally. As the substance use disorder progressed, this patient was actively resistant to conventional treatment despite clear physical and psychosocial consequences. Eventually, he agreed to experimental treatment with ibogaine.

The patient was screened with an electrocardiogram prior to treatment and administered a test dose of ibogaine. During the first four days of treatment, he was administered oxycodone (legally obtained via prescription). The opioid doses were steadily titrated down and on day 4, all opioid medications stopped. During this same period, the patient was given increasing doses of ibogaine. On day 4, the patient was given a "flood dose" of both iboga and ibogaine (variations of the same drug). Between treatments, diazepam was given to support sleep and assuage anxiety. Treatment lasted for six days, and the patient remained at the clinic for a total of eight days. At three-year follow-up, the patient had remained abstinent from opioids, as indicated by negative drug screens. Interestingly, after the flood dose of ibogaine, the client also reported that his chronic pain issues ended, and they have not recurred [62]. The reasons for this finding are unknown.

In a study of 14 individuals with opioid use disorder, subjects were given staggered doses of 200-mg ibogaine capsules at two different clinics. Because ibogaine is a stimulant, most patients were given benzodiazepines or sleep aids so they could attain sufficient hours of sleep. The first dose administered was a test dose given when the patient was in a withdrawal state from opioids; then, a larger dose of up to 600 mg of ibogaine was given one to four hours later. This was followed by smaller dosages of 200 mg given at 20-minute intervals until ended by the provider. The subjects were interviewed pretreatment, immediately post-treatment, and 12 months later. The outcome was that 12 of the 14 subjects (85.7%) had either a marked reduction in opioid use or ended use of the drug altogether [61].

In a larger study of 191 adults wishing to detoxify from opioids or cocaine, a single dose of ibogaine was administered during a medically supervised period of detoxification. According to the researchers, the goals of the study were to safely detoxify the subjects from opioids or cocaine, to provide motivational counseling, and to refer the patients to aftercare and 12-step programs [63]. All subjects received a physical examination, and a medical history was taken. Laboratory tests were administered, as were electrocardiograms. The subjects were drug tested at the beginning of the program, and all tested positive for either opioids or cocaine. A licensed therapist worked with the subjects during and after ibogaine was administered. The average age of subjects was 36 years, and all were habitual users. The subjects were given one dose oral (gel capsule) ibogaine 8–12 mg/kg. In this study, the most common adverse effect was headache, reported by 7% of the subjects; orthostatic hypotension occurred in 5% of the subjects. About 2% of adverse events were considered to be moderately severe.

After the ibogaine was administered, its effects began about 30 to 45 minutes later. According to the researchers [63]:

> Sensory and perceptual changes included reports of visual images, changes in the quality and rate of thinking, and heightened sensitivity to sound. Most subjects reported a dream-like experience lasting between four and eight hours, after which there was an abrupt change in the sensory experience to a more quiet period of deep introspection.

Approximately 92% of subjects reported benefits from the experience. They also reported that both drug craving and depression symptoms improved with doses of 500–1,000 mg. One shortcoming of this study, however, was a lack of follow-up. It would be especially helpful to know if these individuals remained abstinent 6 to 12 months later. Unfortunately, this was not among the goals of the researchers [63].

Ibogaine is difficult to obtain in the United States, and travel to other countries to obtain treatment has been reported, which can be very costly. Assuming that ibogaine were to be equal in efficacy to clonidine or lofexidine for detoxification from opioids or acute discontinuation, it is still unclear what long-term effects or level of continued abstinence can be expected. Naltrexone (Vivitrol) following detoxification might be facilitated. But, data supporting the use of suboxone and methadone in reducing overdoses, deaths, and emergency department visits are clear, including both short- and long-term outcomes. It is important to compare ibogaine to buprenorphine or methadone treatment, just as psilocybin was compared to SSRI therapy [64].

KRATOM

Kratom is a drug derived from *Mitragyna speciosa*, an evergreen tree native to Southeast Asia, where it has been used for generations, largely by locals who chew on the leaves or brew it into a tea and reportedly use the drug for an energizing purpose (e.g., to facilitate longer work periods), much as Americans use caffeine. Kratom is used by consumers in the United States as a drug of abuse and, less commonly, to manage depression. As of 2022, the drug is not scheduled by the U.S. Drug Enforcement Administration (DEA), although the DEA did consider categorizing kratom constituents mitragynine and 7-hydroxymitragynine under Schedule I in 2016. This effort was met with considerable resistance and was abandoned. As such, the product remains available locally in smoke and "head" shops, although many purchase the drug over the Internet. Kratom is banned in six states, including Arkansas, Indiana, Tennessee, Vermont, Wisconsin, and most recently in Alabama [65].

Experts exploring the potential psychiatric uses of kratom have expressed optimism. According to McCurdy, kratom "seems to have mood lifting and elevating properties in addition to its ability to seem to move people off of hardcore opiates" [66]. Although the drug is traditionally used as a stimulant, it has a sedative or opioid-like effects in very high doses. It has been hypothesized that kratom might have a role in the treatment of opioid use disorder, although much more study is needed.

It is important to note that kratom products available in the United States are very different from those that are used by people in their native environments. For example, the kratom used in Southeast Asia is almost always derived from fresh leaves, while in the United States, the products are freeze-dried leaves, concentrated extracts, or liquid "energy shots." As a result of these differences, concentrations and adulteration are concerns. Some individuals in the West who consume kratom products have displayed blood serum levels of mitragynine (the key alkaloid in kratom) 100 to 1,000 times higher than in those found in consumers in Southeast Asia [67].

Another issue is one of purity. In an analysis of eight samples of the drug, researchers found that all the samples tested positive for varying levels of *Mitragyna*, ranging from 3.9–62.1 mg/g, which is a wide range that could significantly alter efficacy and toxicity [68]. In addition, six of the samples tested positive for fungi and bacteria. Most (seven) of the samples were positive for significant levels of toxic heavy metals, including nickel, lead, and chromium. The presence of lead was particularly troubling, as lead has many potentially toxic effects, particularly in terms of potential problematic neurologic effects in children and young adults as well as a variety of cognitive, developmental, immunologic, renal, and cardiovascular effects

[68]. Although this study did not find evidence of *Salmonella* contamination, in 2018, a *Salmonella* outbreak originating from kratom products was reported to affect 199 people spanning 41 states [69]. It is clear that the purity of kratom purchased in the United States is highly questionable, largely because there are no federal constraints on its production by the FDA or other federal agencies. Healthcare professionals who know or suspect that their patients are using kratom may wish to warn them about these findings.

LSD

As discussed, LSD is a compound synthesized from ergot. It is usually administered as an oral solution. LSD takes effect within 20 to 40 minutes after ingestion, and its effects may last for up to 12 hours. Flashbacks may also occur with this drug, defined as a feeling of re-experiencing an event or emotion that occurred during the course of the LSD "trip." LSD is about 2,000 times more potent than mescaline [37].

Prior to the Controlled Substances Act passage in 1970, there were numerous research studies on LSD as a treatment for depression, substance use disorder, and other psychiatric diagnoses, although some of these studies were not scientifically rigorous by today's standards. Fewer studies on LSD are published today, but several merit some attention. For example, a 2022 study assessed the impact of LSD on stressed mice [70]. Anxious mice were administered low doses of LSD for seven days, during which their anxiety levels decreased. In addition, researchers found that the mice given LSD showed signs of increased production of new dendritic spines, a sign of brain plasticity. The researchers also found that the LSD increased the production of serotonin in the treated mice, in a somewhat similar manner to SSRI antidepressants [70].

In an earlier study of the effects of LSD on humans with life-threatening diseases, 8 of the 12 subjects were given 200 mcg of LSD and a control group was given 20 mcg, an insufficient dose to generate significant response. After the initial blinded study was unmasked, the control group subjects were also given 200 mcg of LSD. All subjects had a score of higher than 40 on the state or trait scale of the Spielberger State-Trait Anxiety Inventory before the study. In addition, half the subjects had diagnosed generalized anxiety disorder. A therapist was present for two sessions conducted two to three weeks apart. The experimental sessions lasted eight hours, and patients left only to use the restroom [71]. Subjects who received the 200-mcg dose of LSD displayed a decrease in anxiety as measured by multiple instruments, and this decrease persisted at the 12-month follow-up evaluation. Overall, the subjects experienced a 78% drop in anxiety scores and a 67% increase in quality of life scores after one year. They also reported better access to and control of their own emotions [72].

While this research is interesting and points to areas for future research, it remains to be seen if LSD (or a similar compound) will ever be in clinical use for anxiety and depression. In addition to overcoming stigma and issues with adverse effects, significant additional research on efficacy is necessary.

MESCALINE

3,4,5-trimethoxyphenethylamine, also known as mescaline, is a psychedelic drug that is mainly found in *Lophophora williamsii*, or the peyote cactus. Its effects upon ingestion are similar to the effects found with LSD or psilocybin, including hallucinations and euphoria [37]. The drug is known to have been used for thousands of years for these and perceived spiritual or medical effects; archaeologists have found evidence of this drug in Texas dating back 5,700 years [73]. Today, it is a Schedule I drug, but it may be used legally in religious ceremonies of the Native American Church. Mescaline has been suggested as a potentially effective treatment for a variety of mental health conditions, including depression, OCD, anxiety, and substance use disorder; however, research has yet to be conducted to support these claims.

The average dose of mescaline ranges from 20–500 mg, and the duration of action is about 10 to 12 hours. Individuals suffering from mescaline toxicity (typically seen with doses of 20 mg/kg or greater) may experience tachycardia, hypertension, seizures, hyperthermia, respiratory depression, and rarely death [73]. Concomitant use of mescaline with stimulant drugs (e.g., nicotine, cocaine, ephedrine, amphetamines) may increase the risk of adverse central nervous system effects.

In a survey of 452 individuals who reported using mescaline, researchers found that the drug was usually used once per year or less frequently, and only 9% of users reported a craving for mescaline. About 50% of users reported established psychiatric diagnoses, including anxiety and depression, and of this group, more than 65% reported that these problems improved after taking mescaline [74]. Clinical studies are necessary to confirm or refute these findings.

In another analysis of these data, nearly 50% of respondents reported their experience with mescaline was either the most meaningful experience of their lives or in the top five most meaningful experiences. Respondents who said they had experienced improvement in psychiatric problems were significantly more likely to also report experiencing mystical/spiritual experiences and psychological insight [75].

NITROUS OXIDE

Nitrous oxide (chemical formula N_2O) is a component familiar to many, as it is commonly used today to facilitate comfort and address anxiety in dental settings. Historically, it has been used in both dental and medical interventions. The origins of nitrous oxide are attributed to Joseph Priestley's discovery in 1772, who referred to it as "dephlogisticated nitrous air" [76]. Anesthetic use of nitrous oxide was discovered by a dentist in 1844, and it was used for this purpose almost solely until the 1980s. The first research into the use of nitrous oxide for neuropsychiatric purposes was published between 1920 and 1950, and in the early 1980s, low-dose titration of nitrous oxide was introduced into medical practice as a possible adjunct to the treatment of psychiatric disorders, including substance use disorders [77]. Before then, it was limited to use as an anesthetic or for analgesia during childbirth. In 1994, the term psychotro-

pic analgesic nitrous oxide was introduced in order to better distinguish anesthetic and nonanesthetic preparations [77].

The anxiolytic action of nitrous oxide is believed to be due to binding at select gamma-aminobutyric acid (GABA) receptors, an action similar to the benzodiazepines [78]. The mild analgesic effect appears to be linked to the endogenous opioid receptor system, as experimental studies have shown that the introduction of opioid receptor antagonists to the brain decreases the analgesic efficacy of nitrous oxide [79].

The route of administration is inhalation via a mask secured to the patient's nose. In the dental setting, the concentration of nitrous oxide is 25% to 50% (usually 30% to 40%) nitrous oxide with oxygen. When utilized in obstetrics, a fixed 50% concentration with oxygen is used [77]. Onset of action can occur in as quickly as 30 seconds, with the peak effects seen in five minutes or less. Unlike the benzodiazepine medications, nitrous oxide is not metabolized in the body. It is eliminated via respiration within minutes after 100% oxygen is inhaled at the conclusion of the intervention [78]. Repeated doses could be problematic, as extended use of nitrous oxide has been linked to vitamin B12 deficiency [76]. As such, serum vitamin B12 level may need to be measured before and after treatment.

Nitrous oxide has been demonstrated to improve the condition of individuals with treatment-resistant depression. A study of 20 subjects with treatment-resistant depression were randomly placed in either a nitrous oxide treatment group (10 subjects) or placebo group (10 subjects). The nitrous oxide group inhaled 50% nitrous oxide/50% oxygen, and the placebo group received 50% nitrogen/50% oxygen. There were two sessions one week apart. At the end of the study, four patients (40%) had a decrease in symptoms of depression and three patients (30%) experienced full remission. In contrast, one patient improved after receiving the placebo (10%) and none of the placebo patients remitted from their depression. The improvements in the nitrous oxide group were rapid, occurring in some cases within as little as two hours of receiving the drug [80]. Adverse events were mild and included nausea and vomiting, headache, and dizziness/lightheadedness. At the time of the second session, some patients in the treatment group experienced a carryover effect from the first week's treatment, as evidenced by sustained improvements in their scores on the Hamilton Depression Rating Scale (HDRS-21).

A separate study was undertaken to determine whether a single solution of 25% nitrous oxide would be as beneficial as a 50% solution. This study included 24 subjects with treatment-resistant depression who were randomly placed in one of three groups. Each group received either 50% nitrous oxide therapy, 25% nitrous oxide therapy, or placebo each month; each patient had the opportunity to receive all three treatments. At the end of the study, 55% of the subjects reported improvement in at least half of their symptoms, while 40% reported full remission [81]. Of interest, the 25% nitrous oxide solution had about the same level of efficacy in reducing depression as the 50% solution; however, there were significantly lower levels of adverse events in the 25% group. For example, 21% of those who had received 50% nitrous oxide concentration reported nausea; this decreased to 5% in the group that received 25% concentration. Further, the incidences of headache and dizziness were 17% and 13%, respectively, in the 50% concentration group, while the rates were 10% and 0% in the 25% group [82]. The study made it clear that with nitrous oxide, a 25% solution administered over one hour could improve treatment-resistant depression. Most of the study patients had failed an average of 4.5 antidepressants before the study, so the results were significant for a group in need of additional treatment options.

AYAHUASCA/DIMETHYLTRYPTAMINE (DMT)

Ayahuasca is a brew derived from the leaves of *Psychotria viridis*, a shrub found in Amazonian South America, and which contains DMT, a hallucinogenic alkaloid. The brew is also made with the *Banisteriopsis caapi* vine, the bark of which contains ingredients that act as MAO inhibitors.

In a Brazilian study involving 29 subjects with treatment-resistant depression, patients were randomized to receive a dose of either ayahuasca or placebo. Subjects were evaluated on the MADRS at the following points: baseline, day 1, day 2, and day 7 after dosing. They found MADRS scores were significantly lower in the ayahuasca group at all points and all individuals in this group experienced improvements. In contrast, 27% of patients in the placebo group developed worse depression symptoms. However, ayahuasca sickens many people, and most of the subjects who were given this substance felt nauseous and 57% vomited [83].

In another small Brazilian study, six subjects with recurrent major depressive disorder (without psychotic symptoms) were assessed for response to ayahuasca therapy. All individuals were inpatients at a psychiatric unit and were not taking any psychiatric or recreational drugs. The ayahuasca used by the volunteers was plant-based and refrigerated before the study, and each person drank 120–200 mg [84]. All subjects experienced decreases in depression symptoms on days 1 and day 7 of treatment. There were significant decreases in the Brief Psychiatric Rating Scale (BPRS), indicating improvements in both depression and anxiety. There were also statistically significant decreases in scores on the HAM-D and the MADRS. For example, on day 1, there was a 62% decrease on the HAM-D, and a 72% decrease by day 7. On day 14, however, depression symptoms increased. Similar changes were seen with the MADRS scores [84]. About half the volunteers did vomit; however, vomiting did not appear to impact the efficacy of the drug [84]. If ayahuasca is to be considered as a therapeutic option, a way to counteract the emetic effects and make the drug more tolerable to patients is necessary. To date, experts have hypothesized that antiemetic drugs might interfere with the action of ayahuasca.

Another problem with the scientific study of ayahuasca is that the effects of the drug depend on the concoction and there are no standardized dosages. If the drug could be provided in a synthesized form, it would become easier to evaluate and study in patients with depression and other disorders. In Barker's report on DMT, he states [85]:

While ayahuasca obviously holds promise in many social, cultural, and therapeutic paradigms, including treatment of addiction, anxiety, and depression in psychiatry and many other possible applications, it is, nonetheless, a complex mixture of perhaps thousands of compounds.

DMT has been identified in additional substances. The Sonoran Desert toad (*Bufo alvarius*), native to Texas, California, and Mexico, excretes a venom when threatened that contains a naturally occurring form of DMT. This venom, which can be made into crystals and smoked, is popular for inducing psychedelic trips among recreational users. However, this venom is unsafe, and some have died after smoking it. Further, harvesting this venom has reduced the population of the toad in some areas. Overall, experts recommend that people not attempt to capture the toads or harvest the venom [86].

DIAGNOSES AND PSYCHEDELIC MEDICINE

This section will outline the possible role of psychedelics in the management of specific psychiatric diagnoses, including diagnoses not previously discussed. It is important to remember that most of these uses are investigational.

TREATMENT-RESISTANT DEPRESSION AND SUICIDE

Depression and suicidal depression are major problems in the United States. As noted, at least 30% of persons with depression do not respond to psychotherapy and/or medication. Psilocybin has proven effective at providing breakthroughs with treatment-resistant depression as well as in treating suicidal depression [41; 42]. Nasal spray esketamine (Spravato) is FDA-approved as an adjunct treatment in addition to a conventional antidepressant for treatment-resistant depression and/or major depressive disorder with suicidal ideation or behavior [87]. The nasal spray formulation of esketamine is administered in two sprays (28 mg) per device. The recommended dosage for adults with treatment-resistant depression is 56 mg on day 1, then 56–84 mg twice per week for four weeks, reducing to once per week for the next four weeks, and then once weekly or once every two weeks thereafter. This drug is only administered under medical supervision, and patients should remain under observation for at least two hours following administration.

There are concerns regarding misuse, excessive sedation, and diversion, and a Risk Evaluation and Mitigation Strategy (REMS) has been established. The full document is available online at https://www.accessdata.fda.gov/drugsatfda_docs/rems/Spravato_2022_01_03_REMS_Document.pdf.

PTSD

MDMA and ketamine are well on their way to being proven safe and effective in the treatment of PTSD, and further studies on other psychedelics are likely to provide even more breakthrough information. According to the National Center for PTSD, an estimated 12 million adults in the United States have PTSD in a given year; 8% of women and 4% of men develop PTSD in their lifetime [88]. However, PTSD is very difficult to treat with medications and psychotherapy.

The usual dosage of ketamine for the treatment of persistent PTSD is 0.5 mg/kg given via a 40-minute IV infusion. The regimen typically consists of multiple sessions per week for two to four weeks [89].

In the research setting, MDMA for PTSD is typically given during or immediately preceding a psychotherapy session. The usual dose is 75–125 mg in a single dose [90]. As a Schedule I drug, MDMA is only used in clinical trials and research settings.

SUBSTANCE USE DISORDERS

To date, psychedelic drugs such as ibogaine have not been proven effective in treating opioid use disorder and may not compare well to existing and approved treatments. However, limited studies have shown decreased substance use after administration of psilocybin and ketamine. A 2014 open-label pilot study married a 15-week smoking cessation program with several doses of psilocybin. This study included 15 smokers who were considered psychiatrically healthy adults who had smoked an average of 19 cigarettes per day for an average of 31 years [91]. Psilocybin was administered during the 5th, 7th, and 13th week of the study. During the first four weekly meetings, cognitive-behavioral therapy was provided as was preparation for receiving psilocybin. A target quit date was set to occur with the first dosage of psilocybin during week five, when the subjects were given 20 mg/70 kg of psilocybin. Weekly meetings continued, and then on the seventh week, a higher dose of 30 mg/70 kg was given. During the 13th week, the higher dose of psilocybin was made optional for the subjects. Before the psilocybin was administered, subjects noted their motivational statement for smoking cessation. The subjects also participated in a guided imagery exercise at the end of the first psilocybin session [91]. At six-month follow-up, 80% of the former smokers (12 of 15) were abstinent from tobacco, as verified by breath and urine tests. This was a much higher abstinence rate than seen with traditional smoking cessation programs [91].

The researchers returned to their subjects later, reporting on smoking abstinence at 12 months and over the long term, with an average of 30 months after the study. They found that at the 12-month point, 67% were abstinent from smoking. At the long-term point, 60% were still smoking-abstinent, an excellent success rate [92].

In an older study of single versus repeated sessions of ketamine-assisted psychotherapy in 59 subjects who had detoxified from heroin, subjects were divided into two groups. The subjects in the first group received two addiction counseling sessions with ketamine, followed by two ketamine-assisted psychotherapy sessions, with sessions held at monthly intervals. The subjects in the second group received two addiction counseling sessions without ketamine and one ketamine therapy session. At the one-year follow-up point, 50% of subjects in the first group

were still abstinent from heroin, versus 22.2% of subjects in the second group. The researchers concluded that three sessions in the ketamine-assisted psychotherapy program was more effective in promoting abstinence from heroin than one session followed by counseling [93]. There are also emerging data showing positive effects in alcohol use disorders and other substance use disorders.

It is important to keep in mind comparable efficacy. For opioid use disorder, it is vital to know both short- and long-term safety and efficacy comparisons to the standard of care (medication-assisted treatment plus therapy). Also consider that psychedelics will not be proved safe and effective by a professional consensus but rather by the FDA. It may be that psychoactive substances are legalized much in the same fashion cannabis has, but whether they are approved for clinical use will depend on the outcomes of Phase 2 and 3 FDA-qualifying clinical trials and safety and comparable efficacy trials. As of 2022, these trials are ongoing.

ANXIETY AND DEPRESSION RELATED TO LIFE-THREATENING DIAGNOSES

As discussed, research has demonstrated that psilocybin can be effective in improving mood and quality of life of patients with terminal cancer diagnoses. This aspect of cancer care has been largely overlooked and undertreated. Agrawal notes that, "Oncologists are well-equipped to fight the physical threats of cancer with powerful, yet sometimes imperfect tools including chemotherapy, radiation, and surgery, but they often feel helpless when it comes to treating the intense psychological agony many patients experience" [94]. A seminal study published in 2016 explored the use of a modest dose of psilocybin given to patients with terminal cancer under the supervision of trained therapists. The findings demonstrated that more than 80% of 51 patients who had received life-threatening cancer diagnoses and who subsequently developed depression or anxiety experienced significant and sustained improvements in mood and quality of life six months after taking psilocybin. In addition to feeling calmer and happier, the participants reported forging a closer connection with their friends and family [95]. This study demonstrated the careful and controlled use of psilocybin might be a safe and effective treatment for existential anxiety and despair that often accompany advanced-stage cancers. In addition, in limited studies, LSD has been found to significantly decrease anxiety levels in patients with life-threatening diseases.

Oncology and palliative care specialties have been associated with relatively high burnout rates, at least in part from seeing the psychological distress of patients with potentially terminal diagnoses. In this setting, any therapy that can improve patients' experiences and mood would be beneficial, and initial results of research incorporating psilocybin, LSD, and other psychedelics has been positive [94]. Agrawal further states [94]:

> I have never witnessed the sort of dramatic response to any medical intervention as I have with some patients through psychedelic-assisted therapy. It is not a magic bullet or cure for a cancer patient's suf-fering—and it won't change their prognosis or life expectancy. But it could be a spark that begins their healing journey, helping them come to terms with their most difficult fears.

The use of psychedelic medications in end-of-life care is logical and should be tested compared to the standard treatment (counseling) in randomized, blind clinical trials and other investigations to facilitate FDA approval.

OBSESSIVE-COMPULSIVE DISORDER

OCD can be an extremely debilitating disorder that is often difficult to treat. In a 2006 study of nine subjects with treatment-resistant OCD who were treated with psilocybin, the subjects experienced a significant decrease (range 23% to 100%) in OCD symptoms. One of the subjects experienced an issue with temporary hypertension. These are positive findings; however, it is obviously a very small study and additional research would be needed to replicate findings in a larger and more diverse group [96].

Other researchers have discussed the potential for the use of ketamine and esketamine in treating OCD [97]. In a 2013 randomized, double-blind, placebo-controlled, crossover study of drug-free adults with OCD, subjects were given two 40-minute intravenous infusions, one of saline and one of ketamine (0.5 mg/kg), spaced at least one week apart [98]. Individuals who received ketamine reported significant improvement in obsessions (measured by OCD visual analog scale) during the infusion compared with those given placebo. One-week post-infusion, 50% of those who had received ketamine met the criteria for treatment response (defined as a 35% or greater reduction in Yale-Brown Obsessive-Compulsive Scale scores); no subjects receiving placebo displayed treatment response after one week. The authors of this study concluded that "rapid anti-OCD effects from a single intravenous dose of ketamine can persist for at least one week in some patients with constant intrusive thoughts" [98]. However, other studies have found no effect on OCD symptoms [99]. Solid evidence is lacking and requires greater and more rigorous research.

SOCIAL ANXIETY IN PATIENTS WITH AUTISM

In a study of 12 adults with autism and issues with severe social anxiety, subjects were randomized to receive either MDMA (75 mg or 125 mg) or placebo during the course of two 8-hour psychotherapy sessions. The MDMA was administered after a guided progressive muscle relaxation exercise. The experimental sessions were held one month apart and separated by three nondrug sessions of psychotherapy. The patients were provided with as few sensory interruptions as possible, such as soft lights, noise abatement, and fidget objects to help them with self-regulation through repeated actions (i.e., "stimming") [100]. On the Leibowitz Social Anxiety Scale, the MDMA group experienced a significantly greater improvement in social anxiety scores compared with the placebo group. Improvements persisted at six-month follow-up. The researchers said of the follow-up, "social anxiety remained the same or continued to improve slightly for most participants in the MDMA group after completing the active treatment phase" [100].

Social anxiety disorder is relatively common among the general population; about 12% suffer from this disorder at some point in their lives [101]. If it is determined to be an effective treatment, MDMA-assisted psychotherapy could be an option for these patients who have not responded to traditional psychotherapy or pharmacotherapy.

ANOREXIA NERVOSA

Anorexia nervosa is a severe eating disorder characterized by restriction of energy intake relative to an individual's requirements, typically resulting in low body weight and malnutrition. It is notoriously difficult to treat and has a high mortality rate. Experts have continued to search for more effective treatment options for this population.

In one study, the authors treated 15 patients (23 to 42 years of age) with treatment-resistant anorexia nervosa with infusions of 20 mg/hour of ketamine over 10 hours. The subjects were also given 20 mg twice per day of nalmefene. The subjects showed a marked decreased in scores on compulsion. Before the ketamine was administered, the average scores were 44.0; after treatment, mean compulsion scores dropped to 27.0. Nine of the subjects (60%) showed remission after two to nine ketamine infusions over the course of five days to three weeks [102]. The authors reported the following details on three specific patients [102]:

> Patient 4 increased her weight after three treatments but agreed to more in the hope that her compulsion score would come down further. After a year in follow-up with a normal weight, she then started work and remained in a stable state while followed-up for nine months.

> Patient 5 was a married woman and reached a normal weight after five treatments. As an outpatient, her periods returned and she had a successful pregnancy. Patient 6 had a long history of alternating anorexia and bulimia. After four treatments and despite only a small fall in compulsion score, she became able to control her eating and her weight. She held a responsible job with no relapse during two years of follow-up.

In a 2020 study with only one subject, the researchers treated a patient, 29 years of age, who had developed anorexia nervosa at 14.5 years of age and had been unable to attain remission. The researchers prescribed a ketogenic diet along with intravenous ketamine infusions. (A ketogenic diet was chosen because it had proven in the past to prevent starvation, a real risk with anorexia.) The patient sustained complete recovery and continued her ketogenic diet while maintaining a normal weight [103]. After three months, the woman remained on the ketogenic diet and reported feeling significantly better but still suffered from anorexic compulsions. At that time, she was sent for ketamine infusions. The patient reported that within one hour of her first infusion the "anorexic voice" inside her was decreasing and she felt more like herself. The patient had

three more infusions over the next 14 days. After the fourth infusion, the patient stated [103]:

> I know this sounds ridiculous, but I am no longer anorexic. I had so many rules I didn't even know them. But they are gone. I can exercise because it feels good. It isn't that I have to. I can stop when I want to.

Because this study had two potentially essential factors (ketamine and the ketogenic diet), it is unclear if either or both are responsible for the single patient's improvements. As is the case for many of these novel treatments, additional research is warranted.

CLUSTER HEADACHES

Cluster headaches, which affect less than 1% of adults, are considered to be the most painful of all headaches and can last for a week or longer, potentially becoming a chronic health issue [104]. Traditional treatment approaches include triptan medications and oxygen therapy. Understandably, most sufferers seek quick relief and would prefer to never experience another attack.

In one report, the authors interviewed 53 people with cluster headaches who had self-medicated with psilocybin or LSD. (This is not recommended or considered safe.) Of 26 patients who used psilocybin, 22 said the drug successfully aborted their headache attacks. Of five people who said they used LSD to treat their headaches, four reported experiencing remission [105]. Based on these findings, the authors recommend further study of psychedelics as a possible treatment for cluster headaches. It is important to remember that self-reports are no basis for concluding that psilocybin or LSD is effective at improving a cluster headache condition. There is a current clinical trial underway examining the role of LSD as a possible treatment for cluster headaches [106].

In another study of 77 patients with treatment-resistant migraines or new daily headaches, all of whom had failed aggressive outpatient and inpatient treatment, patients were infused with ketamine. According to the researchers, the mean headache pain rating at the start of the study was 7.1; this fell to 3.8 upon discharge. Most of the patients responded well to the ketamine. Researchers concluded [107]:

> Pending higher level evidence and given that ketamine is generally well-tolerated, ketamine may be considered a reasonable acute treatment for well-selected headache patients for whom standard therapies are either ineffective or medically contraindicated.

OTHER DISORDERS

Some psychiatric disorders, particularly those with psychotic features such as schizophrenia, schizophreniform disorder, brief psychotic disorder, schizoaffective disorder, and delusional disorder, should certainly not be treated with psychedelic drugs. It is unclear if other psychiatric conditions would be amenable

to psychedelic treatment. This can only be determined by clinical trials that administer these drugs under scientific rigor and with a sufficiently high number of patients. Many of the studies published to date have included very small numbers of patients, though this is largely because of necessity. It may have been that few individuals with the disorder could be recruited into a trial consisting of experimental treatment with a psychedelic drug. As the knowledge base grows based on clinical trials, it is hoped that it will become increasingly more feasible to test psychedelics on patients with a multitude of psychiatric disorders, particularly for those individuals whose conditions have been challenging to treat.

INTERVENTIONAL PSYCHIATRY: BRAIN STIMULATION THERAPIES

Electroconvulsive therapy has been in use for nearly a century and continues to be used in psychiatric treatment today. Newer forms of brain stimulation are increasing popular options for patients—or likely will be soon at major medical centers, including rTMS, VNS, and DBS. New brain mapping techniques may help eliminate the need for more invasive procedures. Interventional psychiatry represents an opportunity to help patients who otherwise have found no relief from pharmacotherapy and standard treatments [108].

For health professionals interested in the latest techniques on neuromodulation to aid patients with refractory psychiatric disorders, interventional psychiatry may be the answer. In order for physicians to effectively enter this field, experts recommend an additional year of training with an emphasis on interventional psychiatry.

ELECTROCONVULSIVE THERAPY

ECT has been used to treat depression, bipolar disorder, schizophrenia, and other psychiatric diagnoses for many years, starting in the first half of the 20th century. The goal of ECT is to induce a seizure through applied electric shocks. The procedure was initially introduced in the late 1930s in Italy, and in the 1940s through the 1960s, ECT became popular in the United States as a mainstream treatment [109]. However, early treatments did not provide anesthesia and sometimes led to physical and psychological trauma [110]. Physicians later learned that significantly milder shocks could achieve the same goals.

Today, the procedure is used for treatment-resistant depression and major depression with suicidal ideation or behaviors, as well as for schizophrenia and schizoaffective disorder. A team of professionals are involved, including a psychiatrist, a neurologist, an anesthesiologist, and a nurse [110]. Some believe that ECT should be used before psychedelics or newer brain intervention therapies are attempted, although agreement on this subject is not universal. It should also be noted that there is some residual fear/concern of ECT itself that persists among many patients (and some healthcare professionals), largely because ECT was historically traumatic. However, ECT has proven highly effective at treating both major depressive disorder and suicidal depression. About 100,000 patients receive ECT each year, and most of them are residents in psychiatric hospitals or psychiatric units of hospitals [111].

The modern use of ECT consists of [112]:

> induction of brief general anesthesia (typically lasting less than 10 minutes), pharmacologic muscle relaxation, and continuous monitoring of oxygen saturation, blood pressure, and heart rate, and rhythm. An electrical charge is delivered to the brain through scalp electrodes, which results in a generalized seizure typically lasting for 20 to 60 seconds. Most patients receive between 6 and 12 treatments spaced over a period of 2 to 4 weeks as an initial course of treatment.

Patients who receive ECT may have mild-to-moderate cognitive side effects that generally resolve within days or weeks after the course of treatment has ended [112]. Improvement in depressive symptoms is apparent as soon as the third treatment, and remission rates may be as high as 60% among patients with treatment-resistant depression [113].

In a study of 31 patients with major depressive disorder who received ECT treatment, neurocognitive function was assessed with multiple tests, such as the MATRICS Consensus Cognitive Battery, the Everyday Memory Questionnaire, and the MADRS. These instruments were used before ECT, six weeks after ECT, and six months after the procedure. There was a significant decrease in depression scores six weeks and six months after ECT. Patients also exhibited significantly improved neurocognitive abilities six weeks subsequent to the ECT; these improvements were maintained at six months. The researchers concluded that improvements in depression and stability of subjectively reported memory function indicate that the antidepressant effects of ECT do not occur at the expense of cognitive function [114].

A Swedish analysis of 254,906 sessions of ECT conducted with 16,681 individuals between 2012 and 2019 found that fewer than 1% of individuals suffered broken teeth incurred as a result of their treatment. More specifically, the rate was 0.3% per individual, and there were no differences found between patients by age, gender, or diagnosis, although the dental fracture group had a greater number of treatments. Despite the low rate, bite guards and muscle relaxants are recommended to be used as a safety precaution during treatment with ECT [115].

In a 2021 survey of 192 ECT physician practitioners in the United States, 30% of the survey respondents had graduated from one of 12 residency programs in the United States. Several barriers to ECT programs were identified, stigma against ECT on the part of patients and problems with patient transportation, because patients cannot drive themselves home after treatment [116]. With regard to starting a new ECT program, barriers included lack of well-trained ECT practitioners, lack of institutional support or interest in leading the initiative, and insufficient physical space at the facility. The highest

concentration of ECT providers were based in New England, and the lowest concentration was in the southern central region of the United States. Overall, the researchers were able to identify a variety of institution-related barriers (e.g., finances, bureaucracy, stigma, lack of understanding) that prevent enthusiastic adoption of this intervention. As a result, although ECT potentially could provide relief to many patients with treatment-resistant depression and other disorders, it may not be an option for many patients who live remotely from centers that offer this service.

In a 2018 study, a MarketScan database of more than 47 million patients was analyzed to determine the incidence of ECT. Of about 1 million patients with a mood disorder, 2,471 (0.25%) had received ECT. Individuals who had received ECT were five times more likely to have additional comorbid psychiatric disorders and twice as likely to have comorbid substance use disorder [117]. Whether ECT should be used more frequently is beyond the scope of this course, but it is important to understand that is can be an effective treatment even though it remains rarely used.

TRANSCRANIAL MAGNETIC STIMULATION (TMS)

TMS, a noninvasive form of neural modulation, was initially developed in the 1980s. Later, it was discovered that repeated sessions of TMS (rTMS) were more effective than a single treatment. In 2008, the FDA approved rTMS to treat major depressive disorder; in 2018, it was approved to treat OCD [118]. Trials are also investigating the efficacy of rTMS in the treatment of substance use disorders with alcohol, opioids, cannabis, tobacco, methamphetamine, and cocaine [119]. The procedure is also used to treat patients with neurologic disorders, including Parkinson disease, multiple sclerosis, and stroke [120].

An increasingly popular procedure in the United States and other Western countries, rTMS is available at major medical centers throughout the country. This procedure uses large magnets to stimulate the neurons in the prefrontal cortex of the brain. An electromagnetic coil is placed on the patient's forehead at the site of the left prefrontal cortex, an area of the brain that often displays reduced activity in persons with severe and refractory depression. Nonpainful electromagnetic pulses pass through the skin and to the brain. There is no anesthesia needed or given with this procedure, and the only potential adverse effects are headache and minor discomfort in the scalp.

In a U.S. study involving 247 adults with severe treatment-resistant depression, the efficacy of rTMS in improving psychiatric symptoms was evaluated. The average age of the subjects was 43 years, and the average Patient Health Questionnaire-9 score was 21.7. The subjects received single 37-minute sessions over six weeks, up to a maximum of 30 total sessions [121]. Following rTMS therapy, there was a remission rate of 72% after three weeks, with no differences in response by sex of the subject, but age was a factor, with older individuals taking a longer time to achieve remission of their depression. In addition, remission correlated with past suicide attempts, previous psychiatric hospitalizations, and substance use disorder, illustrating that the procedure was highly effective for individuals with severe and/or comorbid disease. In this study, there was a higher efficacy with the MagVenture device compared with the NeuroStar device.

A Dutch study randomized 14 patients with alcohol use disorder to 10 days of rTMS therapy and 16 patients to sham rTMS. The patients were subsequently evaluated for alcohol craving and alcohol use. For a period of time, subjects in the rTMS treatment group reported lower levels of alcohol craving and use than those in the control group. Differences in alcohol craving in the study group were most prevalent 3 months after treatment; at the 12-month point, there were no differences between the two groups, indicating the beneficial effects of rTMS may fade over time [122].

Because rTMS is a safe and effective FDA-approved treatment for depression, some experts have recommended turning the treatment algorithm for depression upside down, putting TMS in a first-choice position. Rather than requiring patients to undergo months of potentially ineffective antidepressant trials, starting with TMS (with an artificial intelligence component to ensure the right dose and optimal targeting) may be a better option [123]. Additional studies are underway to examine TMS and expand evidence-based access to this treatment [123].

Another form of TMS, Stanford accelerated intelligent neuromodulation therapy (also known as Stanford neuromodulation therapy or SAINT), has been associated with an extremely high success rate in patients with treatment-resistant depression. In a 2022 study, nearly 80% of 29 subjects who had been depressed for a mean period of nine years experienced remission in just four weeks. This is a much quicker response time than traditional antidepressant therapy. The difference between SAINT and other TMS procedures lay with a greater number of treatments for a shorter time frame, such as 10-minute sessions 10 times per day. These treatments are also more targeted to the patient's brain circuitry [124].

VAGUS NERVE STIMULATION

VNS is an invasive form of neuromodulation consisting of implantation of a device that sends electrical pulses to the vagus nerve of the brain. The vagus nerve (also referred to as cranial nerve X) is very long and extends from the brain into the neck, chest, and abdomen. This nerve has many effects and impacts such diverse functions as mood, digestion, blood pressure, heart rate, immune function, saliva production, and taste [125].

The first VNS event occurred in the 1880s in New York, when James Corning applied an electrical current to a carotid compression fork, believing this approach would prevent or end seizures [126]. The procedure has evolved drastically to become the sophisticated procedure used today.

In 2005, the FDA approved VNS for the management of treatment-resistant depression [127]. Since then, a transcutaneous form of VNS has been developed, eliminating the need for surgery. However, this approach was not approved by the FDA as of 2022.

Some researchers have noted that cognitive dysfunction may accompany depression and be a factor in the associated reduced work productivity. A Canadian study analyzed the cognitive performance of individuals with treatment-resistant depression subsequent to their treatment with VNS. In 14 subjects, both the learning capabilities and memory of the subjects improved significantly after one month of receiving VNS. These cognitive improvements persisted for years subsequent to treatment with VNS. After VNS, 29% of the subjects experienced remission from treatment-resistant depression after 1 month, 50% after 3 months, 57% at 12 months, and 64% at 24 months. As such, at the end of the study, nearly two-thirds of patients had recovered with VNS therapy [128]. The researchers stated [128]:

> Improvements were observed in measures of psychomotor speed, verbal fluency, attention, and executive functioning, as well as verbal and visual memory. We observed clear differences in improvement rate between cognitive measure. Memory measures, such as recall of a complex figure, as well as learning and recall of a word list, show more than 25% improvement after two months of treatment.

DEEP BRAIN STIMULATION THERAPIES

An invasive form of therapy that is used infrequently, DBS has proven effective at treating severe depression and OCD. DBS is also approved to treat some patients with severe, refractory neurologic disorders, such as epilepsy and Parkinson disease. DBS is also under investigation for the treatment of schizophrenia, Alzheimer disease, substance use disorder, and other challenging psychiatric disorders [129].

The first documented use of DBS occurred in 1948, when neurosurgeon J. Lawrence Pool implanted an electrode into the brain of a women with anorexia and depression. Results were initially positive, until the wire broke several weeks later [130]. Today, DBS involves the permanent implantation of electrodes that send regular and continuous electrical impulses to stimulate a specific part of the brain. Some describe DBS as a sort of brain pacemaker to correct imbalances, comparable to a heart pacemaker that corrects cardiac abnormalities. It should be noted that DBS is an invasive and expensive procedure that is only available to very few individuals, and it is not approved for the treatment of depression by the FDA as of 2022.

The electrodes used in DBS are made of platinum-iridium wires and nickel alloy connectors, which are enclosed in a polyurethane sheath [129]. Some patients may worry about the potential for hacking into a DBS system in today's connected world and the possibility of control over individuals, referred to as "brainjacking." This does not appear to be a problem at this time of very limited use of DBS, but it is a subject worthy of consideration in the future.

In a nationwide database of 116,890 hospitalized patients in the United States with major depressive disorder, patients receiving DBS represented 0.03% [131]. The average age of participants was 49.1 years; all were White, and 88% were female. Patients stayed in the hospital for 1 to 1.6 days. The highest rate of DBS use occurred in the southern United States, followed by the northeast and west. Patients receiving DBS either had private insurance or they were self-pay patients [131].

In a study of five patients with severe OCD who received DBS over the period 2015–2019, not only did the patients experience improvement in their OCD symptoms after DBS, but they also experienced a 53% improvement in their levels of depression (on the MADRS scale) and a 34.9% improvement on the Hamilton Anxiety Rating scales. In addition, patients also improved on the Quality of Life Enjoyment and Satisfaction Questionnaire [132]. The researchers reported anecdotal evidence of improvement as well, such as this report from one of the five patients [132]:

> Despite persistent low body mass index [BMI] of 14, she has remained out of the hospital for 29 months, the longest time period since onset of OCD and anorexia. She is working part-time as a research assistant, is active in her church, and though she wishes for further reduction in symptoms, she notes her quality of life and mood is better than prior to DBS. In addition, she no longer engages in self-injurious behaviors and no longer experiences suicidal ideation.

In another study, DBS was used to treat seven patients with treatment-resistant depression [133]. Researchers specifically targeted the bilateral habenula, which is the seat of the anti-reward system [133]. After one month, depression and anxiety symptoms had decreased by 49%, and the patients reported a dramatic improvement in their quality of life.

In a one-person study of an individual treated with DBS for treatment-resistant depression, the patient experienced continuous improvement until depressive symptoms remitted by the 22nd week. At 37 weeks, the subject was randomized to continuous treatment or discontinuation. When treatment was stopped, the patient reported increasingly worse depression and anxiety until he met rescue criteria, resulting in the resumption of treatment. The depression symptoms rapidly abated when treatment restarted [134].

CAUTIONS

Although the news about both psychedelics and brain stimulation techniques is generally positive, caution is important, particularly in the case of psychedelic drugs. Patients should be actively discouraged from trying psychedelic drugs on their own, because these drugs can trigger an underlying psychosis in individuals who would otherwise likely have remained healthy, particularly because dosage and purity of the illicit drug is unpredictable. In addition, FDA-approval processes, regulated pharmaceutical drugs rather than street drugs, and comparable efficacy can help identify the safest and most effective medication or interventional treatment for a particular patient at a particular time. In essence, buying MDMA and taking it is not the same as being administered MDMA in a PTSD clinical trial at a research institution. Today, adulteration of street drugs is of great concern, particularly with potentially lethal doses of fentanyl [135].

Patients have no idea what dosage is in a street drug and could take a suboptimal dose (to no effect) or take an excessively high dose of the drug, which could cause inadvertent harm. Importantly, patients under the influence of such drugs require supervision, lest they take actions that might be potentially dangerous to themselves or others.

For patients considered for psychedelic or interventional psychiatric options who are not proficient in English, it is important that information regarding the risks associated with the use of psychedelics and/or interventional procedures and available resources be provided in their native language, if possible. When there is an obvious disconnect in the communication process between the practitioner and patient due to the patient's lack of proficiency in the English language, an interpreter is required. Interpreters can be a valuable resource to help bridge the communication and cultural gap between patients and practitioners. Interpreters are more than passive agents who translate and transmit information back and forth from party to party. When they are enlisted and treated as part of the interdisciplinary clinical team, they serve as cultural brokers who ultimately enhance the clinical encounter. In any case in which information regarding treatment options and medication/treatment measures are being provided, the use of an interpreter should be considered. Print materials are also available in many languages, and these should be offered whenever necessary.

CONCLUSION

It is apparent that psychedelic medicine is now in a renaissance period, and this time could not have come too soon. Many people in the United States and around the world suffer from severe psychiatric disorders, including depression, PTSD, substance use disorders, anxiety disorders, OCD, anorexia nervosa, and multiple other psychiatric disorders that are not readily responsive to treatment with pharmacotherapy and/or psychotherapy [136]. In the aftermath of the COVID-19 pandemic, depressive disorders are more prevalent, and people are urgently and actively seeking effective treatments. Exploration of novel interventional and psychedelic therapies may be a path to recovery for patients with mental health disorders who have not improved on traditional approaches [137].

TEST QUESTIONS

#96790 PSYCHEDELIC MEDICINE AND INTERVENTIONAL PSYCHIATRY

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

This 10 hour activity must be completed by June 30, 2025.

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

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

3. In the United States, suicide is the
   A) leading cause of death.
   B) fifth leading cause of death.
   C) tenth leading cause of death.
   D) fifteenth leading cause of death.

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

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

6. There is also some evidence that ketamine can reverse suicidality or depression after a single dose, which suggests that the drug reverses a neurochemical deficit that is close to the problem.
   A) True
   B) False

7. By 2027, Data Bridge Market Research has estimated that the market for psychedelic drugs will
   A) remain stable.
   B) decrease by half.
   C) more than triple.
   D) depend on the rate of treatment-resistant depression.

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

9. Deep brain stimulation consists of
   A) invasive stimulation of the vagus nerve.
   B) stimulation of the brain causing a seizure.
   C) stimulation of the brain with the use of implanted electrodes.
   D) use of large magnets external to the patient to stimulate the brain.

10. A hallucinogen is
    A) an illicit drug of abuse in all cases.
    B) any substance that allows for intensified experiences.
    C) a drug that is used to facilitate guided imagery exercises.
    D) any drug that may cause the user to experience visual, auditory, or other types of hallucinations.

11. In the context of psychedelic medicine, set refers to
    A) the patient's mindset.
    B) the process of providing effective therapy.
    C) the environment in which therapy is provided.
    D) the manual of best practices established for therapy.

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

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

14. **Which of the following statements regarding hallucinogen and other illicit drug use is TRUE?**
    A) *Past use of any psychedelic drug is associated with a lower risk of opioid use disorder.*
    B) *History of cocaine or opioid misuse and abuse is a common precursor to hallucinogen use.*
    C) *A history of psychedelic use, particularly psilocybin, increases the risk of escalation to harder drug use.*
    D) *Individuals who used psilocybin in the past have a significantly lower rate of opioid misuse and abuse later.*

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

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

17. **In the 1940s, LSD was marketed under the brand name Delysid for the treatment of**
    A) *neurosis.*
    B) *alcoholism.*
    C) *schizophrenia.*
    D) *All of the above*

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

19. **Patients who receive psychedelic therapy experience better outcomes if the therapy is administered in settings in which**
    A) *they feel safe.*
    B) *they are completely alone.*
    C) *everything is new or unfamiliar.*
    D) *hallucinogenic effects are promoted by loud music and flashing colors.*

20. **Which of the following is an aspect of psychedelic medicine setting that can enhance set?**
    A) *Music*
    B) *Lighting*
    C) *Presence of a supportive healthcare professional*
    D) *All of the above*

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

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

23. **Which of the following statements regarding psilocybin is FALSE?**
    A) *The duration of action is four to six hours.*
    B) *It is active orally at doses of around 10 mg.*
    C) *Time to onset of effect is usually within 20 to 30 minutes of ingestion.*
    D) *It is about 20 times stronger than LSD but much less potent than mescaline.*

24. **In animal studies of the use of psilocybin, a link has been identified between reduced prefrontal mGluR2 function and both impaired executive function and alcohol craving.**
    A) *True*
    B) *False*

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

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

27. **The antidepressant effect of psilocybin has been found to correspond with**
    A) *increased neuroplasticity.*
    B) *increased expression of serotonin.*
    C) *suppression of dopamine overproduction.*
    D) *decreases in fMRI brain network modularity.*

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

29. Nasal spray esketamine is approved by the FDA for the treatment of
    A) schizophrenia.
    B) cluster headaches.
    C) opioid use disorder.
    D) treatment-resistant and/or suicidal depression.

30. After treatment with ketamine, patients should not leave the facility until they are cleared to do so by a healthcare provider, and they should also be cautioned to avoid driving or using heavy equipment until the following day.
    A) True
    B) False

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

32. Some believe that intravenous ketamine is significantly more effective than its intranasal form because it includes both the s and r forms of the drug.
    A) True
    B) False

33. Researchers have demonstrated the efficacy of combination psychotherapy and MDMA in the treatment of
    A) PTSD.
    B) depression.
    C) end-of-life anxiety.
    D) obsessive-compulsive disorder.

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

35. Which of the following statements regarding ibogaine is TRUE?
    A) It is a derivative of phencyclidine (PCP).
    B) It is FDA-approved for the treatment of opioid use disorder.
    C) Its metabolism is purportedly mediated by the p450 cytochrome enzyme CY2D6.
    D) It is easiest to obtain in the United States, and travel from other countries to obtain treatment is common.

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

37. Which of the following statements regarding kratom products in the United States is TRUE?
    A) All kratom products are considered Schedule I drugs.
    B) The products are typically freeze-dried leaves, concentrated extracts, or liquid "energy shots."
    C) Products marketed in the United States have been tested for purity and uniform concentration.
    D) While kratom products are available locally in smoke and "head" shops, they cannot be legally purchased over the Internet.

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

39. Which of the following statements regarding LSD is TRUE?
    A) It is a compound synthesized from Cannabis.
    B) It is usually administered as an intravenous solution.
    C) It is about 2,000 times more potent than mescaline.
    D) It takes effect within 2 to 4 minutes after ingestion.

40. Mescaline is a psychedelic drug mainly found in _Lophophora williamsii,_ or the peyote cactus.
    A) True
    B) False

41. Mescaline toxicity can result in
    A) bradycardia.
    B) hypotension.
    C) hypothermia.
    D) respiratory depression.

42. The anxiolytic action of nitrous oxide is believed to be due to binding at select gamma-aminobutyric acid (GABA) receptors, an action similar to the benzodiazepines.
    A) True
    B) False

43. Repeated doses of nitrous oxide improve efficacy and are not associated with any untoward effects.
    A) True
    B) False

44. Nitrous oxide has been demonstrated to improve the condition of individuals with
    A) PTSD.
    B) psychosis.
    C) treatment-resistant depression.
    D) attention deficit Hyperactivity disorder.

45. The most common adverse effect of ayahuasca is
    A) flashbacks.
    B) severe headache.
    C) nausea and vomiting.
    D) respiratory depression.

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

47. The recommended initial dose of nasal spray esketamine for adults with treatment-resistant depression is
    A) 5 mg.
    B) 56 mg.
    C) 150 mg.
    D) 500 mg.

48. MDMA for PTSD is typically given during or immediately preceding a psychotherapy session.
    A) True
    B) False

49. Research indicates that a modest dose of psilocybin given to patients with terminal cancer under the supervision of trained therapists can improve
    A) prognosis.
    B) life expectancy.
    C) mood and quality of life.
    D) tumor size and associated pain.

50. Which of the following psychedelics has been studied for the treatment of social anxiety in persons with autism?
    A) MDMA
    B) Ibogaine
    C) Mescaline
    D) Psilocybin

51. Of the following disorders, which is not amenable to a possible treatment approach incorporating psychedelic agents?
    A) Schizophrenia
    B) Anorexia nervosa
    C) Major depressive disorder
    D) Post-traumatic stress disorder

52. The goal of electroconvulsive therapy (ECT) is to
    A) stimulate the prefrontal cortex.
    B) provide a competing traumatic experience.
    C) induce a seizure through applied electric shocks.
    D) induce the creation of new dendrites in the brain.

53. Which of the following statements regarding transcranial magnetic stimulation (TMS) is TRUE?
    A) Anesthesia is required and is given with this procedure.
    B) This procedure uses large magnets to stimulate the neurons in the amygdala.
    C) The only potential side effects of TMS are headache and minor discomfort in the scalp.
    D) TMS consists of painful electromagnetic pulses that pass through the skin and to the brain.

54. Deep brain stimulation
    A) is dangerous and potentially painful.
    B) is the subject of intense research for the treatment of eating disorders.
    C) has been proven effective in amelioration of severe depression in large randomized controlled trials.
    D) involves the permanent implantation of electrodes that send regular and continuous electrical impulses to stimulate a specific part of the brain.

55. Patients should be actively discouraged from trying psychedelic drugs on their own, because these drugs can trigger an underlying psychosis in individuals who would otherwise likely have remained healthy, particularly because dosage and purity of the illicit drug is unpredictable.
    A) True
    B) False

Be sure to transfer your answers to the Answer Sheet located on page 124.

DO NOT send these test pages to NetCE. Retain them for your records.

PLEASE NOTE: Your postmark or facsimile date will be used as your test completion date.

Course Availability List

MANAGING AND PREVENTING BURNOUT
#71464 • 4 ASWB/APA/NAADAC Hours, 1 NBCC Hour
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 ASWB/APA Hours, 1.5 NBCC 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.

AN INTRODUCTION TO EMDR AND RELATED APPROACHES IN PSYCHOTHERAPY
#76032 • 6 ASWB Hours, 2.5 NBCC Hours
Book By Mail – $44 • ONLINE – $36

Purpose: The purpose of this course is to provide an overview of the EMDR approach to treatment of trauma-related psychopathology in order for clinicians to evaluate its appropriateness for their clients.

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

Audience: This course is designed for counselors, social workers, and therapists who are interested in incorporating EMDR-related approaches into their work with clients.

FRONTOTEMPORAL DEMENTIA
#76102 • 2 ASWB/APA Hours, 1 NBCC Hour
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.

ANXIETY DISORDERS
#76182 • 15 ASWB/APA/NAADAC Hours, 6.5 NBCC Hours
Book By Mail – $98 • ONLINE – $90

Purpose: The purpose of this course is to provide mental health professionals with the knowledge and skills necessary to appropriately identify and treat patients with anxiety disorders, addressing knowledge gaps, enhancing clinical skills, and improving patient outcomes.

Faculty: Mark Rose, BS, MA, LP

Audience: This course is designed for behavioral and mental health providers involved in the identification, treatment, and care of patients with anxiety disorder.

FUNDAMENTALS OF TRAUMA PROCESSING
#76233 • 8 ASWB/APA/NAADAC Hours, 3 NBCC 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.

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

Course Availability List *(Cont'd)*

BEHAVIORAL ADDICTIONS
#76412 • 15 ASWB/APA/NAADAC Hours, 6 NBCC 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 ASWB/APA/NAADAC Hours, 4 NBCC 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.

INCORPORATING MUSICAL STRATEGIES INTO CLINICAL PRACTICE
#76823 • 5 ASWB/APA/NAADAC Hours, 2 NBCC Hours

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to demonstrate how simple musical strategies can be incorporated into various treatment settings in order to enhance the overall healing process.
Faculty: Jamie Marich, PhD, LPCC-S, REAT, RYT-500, RMT
Audience: This course is designed for counselors, social workers, chemical dependency counselors, therapists, and pastoral counselors, especially because music holds special meaning for so many of the people that are served by these professions. This course will be especially relevant to professionals who seek creative methods for working with their clients.

CLINICAL SUPERVISION: A PERSON-CENTERED APPROACH
#76863 • 10 ASWB Hours, 3 NBCC Hours

Supervision

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.

MOVEMENT AND DANCE IN PSYCHOTHERAPY
#78250 • 10 ASWB/APA Hours, 3 NBCC Hours

Book By Mail – $68 • ONLINE – $60

NEW!

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

FAMILIES OF PATIENTS WITH CHRONIC ILLNESS
#91694 • 10 ASWB/APA Hours, 5 NBCC Hours

Book By Mail – $68 • ONLINE – $60

Purpose: The purpose of this course is to increase the knowledge base of social workers, physicians, nurses, marriage and family therapists, and other allied healthcare professionals who work with patients with chronic illness and their families, in order to effectively address the impact of chronic illness on the entire family system.
Faculty: Alice Yick Flanagan, PhD, MSW
Audience: This course is designed for physicians, nurses, social workers, marriage and family therapists, and any healthcare professionals involved in the care of patients with chronic illness.

ALZHEIMER DISEASE
#96154 • 15 ASWB/APA Hours, 7.5 NBCC Hours

Book By Mail – $98 • ONLINE – $90

Purpose: In order to increase and maintain a reasonable quality of life for patients with Alzheimer disease throughout the course of the disease, caregivers must have a thorough knowledge and understanding of the disease. The purpose of this course is to provide clinicians with the skills to care for patients with Alzheimer disease in any setting as part of the interdisciplinary team.
Faculty: Joan Needham, MSEd, RNC
Audience: This course is designed for clinicians who come in contact with patients with Alzheimer disease in hospitals, long-term care facilities, home health care, and the office.

GERIATRIC FAILURE TO THRIVE: A MULTIDIMENSIONAL PROBLEM
#99204 • 5 ASWB/APA 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.

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	96790	Psychedelic Medicine and Interventional Psychiatry / 10 Hours	$60

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☐	76032	An Introduction to EMDR / 6	$44	☐	76863	Clinical Supervision: A Person-Centered Approach / 10	$68
☐	76102	Frontotemporal Dementia / 2	$23	☐	78250	Movement and Dance in Psychotherapy / 10	$68
☐	76182	Anxiety Disorders / 15	$98	☐	91694	Families of Patients with Chronic Illness / 10	$68
☐	76233	Fundamentals of Trauma Processing / 8	$56	☐	96154	Alzheimer Disease / 15	$98
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- Darken only one circle per question.
- Use pen or pencil; please refrain from using markers.
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#97542 CHILD ABUSE IDENTIFICATION & REPORTING: THE PENNSYLVANIA REQUIREMENT —3 HOURS Please refer to pages 17–18.

Expiration Date: 07/31/25 *MAY BE TAKEN INDIVIDUALLY FOR $18*

	A	B	C	D			A	B	C	D
1.	○	○	○	○	6.		○	○	○	○
2.	○	○	○	○	7.		○	○	○	○
3.	○	○	○	○	8.		○	○	○	○
4.	○	○	○	○	9.		○	○	○	○
5.	○	○	○	○	10.		○	○	○	○

#97664 ONLINE PROFESSIONALISM AND ETHICS —3 HOURS Please refer to pages 32–33.

Expiration Date: 04/30/27 *MAY BE TAKEN INDIVIDUALLY FOR $18*

	A B C D		A B C D		A B C D		A B C D
1.	○ ○ ○ ○	6.	○ ○ ○ ○	11.	○ ○ ○ ○	16.	○ ○ ○ ○
2.	○ ○ ○ ○	7.	○ ○ ○ ○	12.	○ ○ ○ ○	17.	○ ○ ○ ○
3.	○ ○ ○ ○	8.	○ ○ ○ ○	13.	○ ○ ○ ○	18.	○ ○ ○ ○
4.	○ ○ ○ ○	9.	○ ○ ○ ○	14.	○ ○ ○ ○	19.	○ ○ ○ ○
5.	○ ○ ○ ○	10.	○ ○ ○ ○	15.	○ ○ ○ ○	20.	○ ○ ○ ○

#93010 MATERNAL HEALTH DISPARITIES—4 HOURS Please refer to pages 46–48.

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.	○ ○ ○ ○

#77770 COUNSELING PATIENTS AT THE END OF LIFE—5 HOURS Please refer to pages 65–67.

Expiration Date: 04/30/26 *MAY BE TAKEN INDIVIDUALLY FOR $30*

	A B C D		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.	○ ○ ○ ○	26.	○ ○ ○ ○
2.	○ ○ ○ ○	7.	○ ○ ○ ○	12.	○ ○ ○ ○	17.	○ ○ ○ ○	22.	○ ○ ○ ○	27.	○ ○ ○ ○
3.	○ ○ ○ ○	8.	○ ○ ○ ○	13.	○ ○ ○ ○	18.	○ ○ ○ ○	23.	○ ○ ○ ○	28.	○ ○ ○ ○
4.	○ ○ ○ ○	9.	○ ○ ○ ○	14.	○ ○ ○ ○	19.	○ ○ ○ ○	24.	○ ○ ○ ○	29.	○ ○ ○ ○
5.	○ ○ ○ ○	10.	○ ○ ○ ○	15.	○ ○ ○ ○	20.	○ ○ ○ ○	25.	○ ○ ○ ○	30.	○ ○ ○ ○

#76442 SUICIDE ASSESSMENT AND PREVENTION —6 HOURS Please refer to pages 89–91.

Expiration Date: 03/31/26 *MAY BE TAKEN INDIVIDUALLY FOR $36*

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

#96790 PSYCHEDELIC MEDICINE AND INTERVENTIONAL PSYCHIATRY —10 HOURS Please refer to pages 117–120.

Expiration Date: 06/30/25 *MAY BE TAKEN INDIVIDUALLY FOR $60*

	A B C D		A B C D		A B C D
1.	○ ○ ○ ○	21.	○ ○ ○ ○	41.	○ ○ ○ ○
2.	○ ○ ○ ○	22.	○ ○ ○ ○	42.	○ ○ ○ ○
3.	○ ○ ○ ○	23.	○ ○ ○ ○	43.	○ ○ ○ ○
4.	○ ○ ○ ○	24.	○ ○ ○ ○	44.	○ ○ ○ ○
5.	○ ○ ○ ○	25.	○ ○ ○ ○	45.	○ ○ ○ ○
6.	○ ○ ○ ○	26.	○ ○ ○ ○	46.	○ ○ ○ ○
7.	○ ○ ○ ○	27.	○ ○ ○ ○	47.	○ ○ ○ ○
8.	○ ○ ○ ○	28.	○ ○ ○ ○	48.	○ ○ ○ ○
9.	○ ○ ○ ○	29.	○ ○ ○ ○	49.	○ ○ ○ ○
10.	○ ○ ○ ○	30.	○ ○ ○ ○	50.	○ ○ ○ ○
11.	○ ○ ○ ○	31.	○ ○ ○ ○	51.	○ ○ ○ ○
12.	○ ○ ○ ○	32.	○ ○ ○ ○	52.	○ ○ ○ ○
13.	○ ○ ○ ○	33.	○ ○ ○ ○	53.	○ ○ ○ ○
14.	○ ○ ○ ○	34.	○ ○ ○ ○	54.	○ ○ ○ ○
15.	○ ○ ○ ○	35.	○ ○ ○ ○	55.	○ ○ ○ ○
16.	○ ○ ○ ○	36.	○ ○ ○ ○		
17.	○ ○ ○ ○	37.	○ ○ ○ ○		
18.	○ ○ ○ ○	38.	○ ○ ○ ○		
19.	○ ○ ○ ○	39.	○ ○ ○ ○		
20.	○ ○ ○ ○	40.	○ ○ ○ ○		

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Compliance with APA, NBCC, and 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?

In accordance with the reporting requirements of Act 31, please provide the following information for course #97542:
16. Please provide the last four digits of your social security number.
17. Please provide your date of birth.

#97542
PA Child Abuse
3 Hours
1. ☐New ☐Review
2. _____ Hours
3. ☐Yes ☐No
4. ☐Yes ☐No
5. ☐Yes ☐No
6. ☐Yes ☐No
7. ☐Yes ☐No
8. ☐Yes ☐No
9. ☐Yes ☐No
10. ☐Yes ☐No
11. ☐Yes ☐No
12. ☐Yes ☐No
13. ☐Yes ☐No
14. ☐Yes ☐No
15. ☐Yes ☐No ☐N/A
16. ___ ___ ___ ___
17. ___/___/_____
(mm/dd/yyyy)

#97664
Online Professionalism & Ethics
3 Hours
1. ☐New ☐Review
2. _____ Hours
3. ☐Yes ☐No
4. ☐Yes ☐No
5. ☐Yes ☐No
6. ☐Yes ☐No
7. ☐Yes ☐No
8. ☐Yes ☐No
9. ☐Yes ☐No
10. ☐Yes ☐No
11. ☐Yes ☐No
12. ☐Yes ☐No
13. ☐Yes ☐No
14. ☐Yes ☐No
15. ☐Yes ☐No ☐N/A

#93010
Maternal Health Disparities
4 Hours
1. ☐New ☐Review
2. _____ Hours
3. ☐Yes ☐No
4. ☐Yes ☐No
5. ☐Yes ☐No
6. ☐Yes ☐No
7. ☐Yes ☐No
8. ☐Yes ☐No
9. ☐Yes ☐No
10. ☐Yes ☐No
11. ☐Yes ☐No
12. ☐Yes ☐No
13. ☐Yes ☐No
14. ☐Yes ☐No
15. ☐Yes ☐No ☐N/A

#97542 Child Abuse Identification and Reporting: The Pennsylvania Requirement – Do you have any additional comments or suggestions? _____
_____
_____

#97664 Online Professionalism and Ethics – Do you have any additional comments or suggestions? _____
_____
_____

#93010 Maternal Health Disparities – Do you have any additional comments or suggestions? _____
_____
_____

Signature _____

Signature required to receive continuing education credit.

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Last Name _____ First Name _____ MI _____

State _____ License # _____ Expiration Date _____

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

Compliance with APA, NBCC, and ASWB 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?
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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?

#77770 Counseling Patients at the EOL 5 Hours	#76442 Suicide Assessment and Prevention 6 Hours	#96790 Psychedelic Medicine 10 Hours
1. ☐ New ☐ Review	1. ☐ New ☐ Review	1. ☐ New ☐ Review
2. ____ Hours	2. ____ Hours	2. ____ Hours
3. ☐ Yes ☐ No	3. ☐ Yes ☐ No	3. ☐ Yes ☐ No
4. ☐ Yes ☐ No	4. ☐ Yes ☐ No	4. ☐ Yes ☐ No
5. ☐ Yes ☐ No	5. ☐ Yes ☐ No	5. ☐ Yes ☐ No
6. ☐ Yes ☐ No	6. ☐ Yes ☐ No	6. ☐ Yes ☐ No
7. ☐ Yes ☐ No	7. ☐ Yes ☐ No	7. ☐ Yes ☐ No
8. ☐ Yes ☐ No	8. ☐ Yes ☐ No	8. ☐ Yes ☐ No
9. ☐ Yes ☐ No	9. ☐ Yes ☐ No	9. ☐ Yes ☐ No
10. ☐ Yes ☐ No	10. ☐ Yes ☐ No	10. ☐ Yes ☐ No
11. ☐ Yes ☐ No	11. ☐ Yes ☐ No	11. ☐ Yes ☐ No
12. ☐ Yes ☐ No	12. ☐ Yes ☐ No	12. ☐ Yes ☐ No
13. ☐ Yes ☐ No	13. ☐ Yes ☐ No	13. ☐ Yes ☐ No
14. ☐ Yes ☐ No	14. ☐ Yes ☐ No	14. ☐ Yes ☐ No
15. ☐ Yes ☐ No ☐ N/A	15. ☐ Yes ☐ No ☐ N/A	15. ☐ Yes ☐ No ☐ N/A

#77770 Counseling Patients at the End of Life – Do you have any additional comments or suggestions? _____

_____

#76442 Suicide Assessment and Prevention – Do you have any additional comments or suggestions? _____

_____

#96790 Psychedelic Medicine and Interventional Psychiatry – Do you have any additional comments or suggestions? _____

_____

Signature _____

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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):

#97542 CHILD ABUSE IDENTIFICATION AND REPORTING: THE PENNSYLVANIA REQUIREMENT–3 HOURS (Course expires 07/31/25)

- Summarize the historical context of child abuse. ☐A ☐B ☐C ☐D ☐F
- Discuss the emergence of the child welfare system in Pennsylvania. ☐A ☐B ☐C ☐D ☐F
- Define child abuse and neglect and identify the different forms of child abuse and neglect. ☐A ☐B ☐C ☐D ☐F
- Discuss the scope of child abuse and neglect in the United States and specifically in Pennsylvania. ☐A ☐B ☐C ☐D ☐F
- Identify measures to decrease explicit and implicit bias at the interpersonal and institutional levels. ☐A ☐B ☐C ☐D ☐F

#97664 ONLINE PROFESSIONALISM AND ETHICS–3 HOURS (Course expires 04/30/27)

- Define Internet usage patterns and common Internet technologies. ☐A ☐B ☐C ☐D ☐F
- Analyze how various Internet technologies are utilized in clinical practice. ☐A ☐B ☐C ☐D ☐F
- Define professionalism. ☐A ☐B ☐C ☐D ☐F
- Evaluate how the use of specific Internet technologies can affect professionalism and ethics. ☐A ☐B ☐C ☐D ☐F
- Discuss how the use of Internet technologies can impact issues of boundaries, self-disclosure, privacy/confidentiality, and professional relationships. ☐A ☐B ☐C ☐D ☐F
- Identify best practices for using Internet technologies as a clinical practitioner. ☐A ☐B ☐C ☐D ☐F

#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

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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):

#77770 COUNSELING PATIENTS AT THE END OF LIFE—5 HOURS (Course expires 04/30/26)

- Define palliative and end-of-life care. .... □A □B □C □D □F
- Outline the role of health and mental health professionals in end-of-life counseling. .... □A □B □C □D □F
- Identify psychological concerns present at the end of life. .... □A □B □C □D □F
- Discuss key components of end-of-life conversations. .... □A □B □C □D □F
- Analyze mental health interventions that can be incorporated into end-of-life care and bereavement. .... □A □B □C □D □F
- Describe practical, ethical, and legal issues that can arise in the provision of end-of-life care. .. □A □B □C □D □F
- Examine the impact of culture and culturally competent care on end-of-life decisions and support. .... □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

#96790 PSYCHEDELIC MEDICINE AND INTERVENTIONAL PSYCHIATRY—10 HOURS (Course expires 06/30/25)

- Outline factors that have contributed to the rise in interest in psychedelic and interventional psychiatry. .... □A □B □C □D □F
- Define terms related to the discussion of psychedelic and interventional psychiatry. .... □A □B □C □D □F
- Discuss the history of psychedelics in medical care. .... □A □B □C □D □F
- Evaluate factors that may impact the provision of psychedelic or interventional psychiatry techniques, including stigma, setting, and culture. .... □A □B □C □D □F
- Outline the role of psilocybin and ketamine in psychiatric care. .... □A □B □C □D □F
- Describe how MDMA and ibogaine may impact mental health. .... □A □B □C □D □F
- Review the clinical effects of kratom, LSD, and mescaline. .... □A □B □C □D □F
- Discuss the potential clinical role of nitrous oxide, ayahuasca, and dimethyltryptamine (DMT). .... □A □B □C □D □F
- Describe how psychedelics may be incorporated into the treatment of mental health disorders, including treatment-resistant depression, post-traumatic stress disorder, and substance use disorders. .... □A □B □C □D □F
- Identify interventional approaches that may be used in the treatment of mental health disorders. .... □A □B □C □D □F

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