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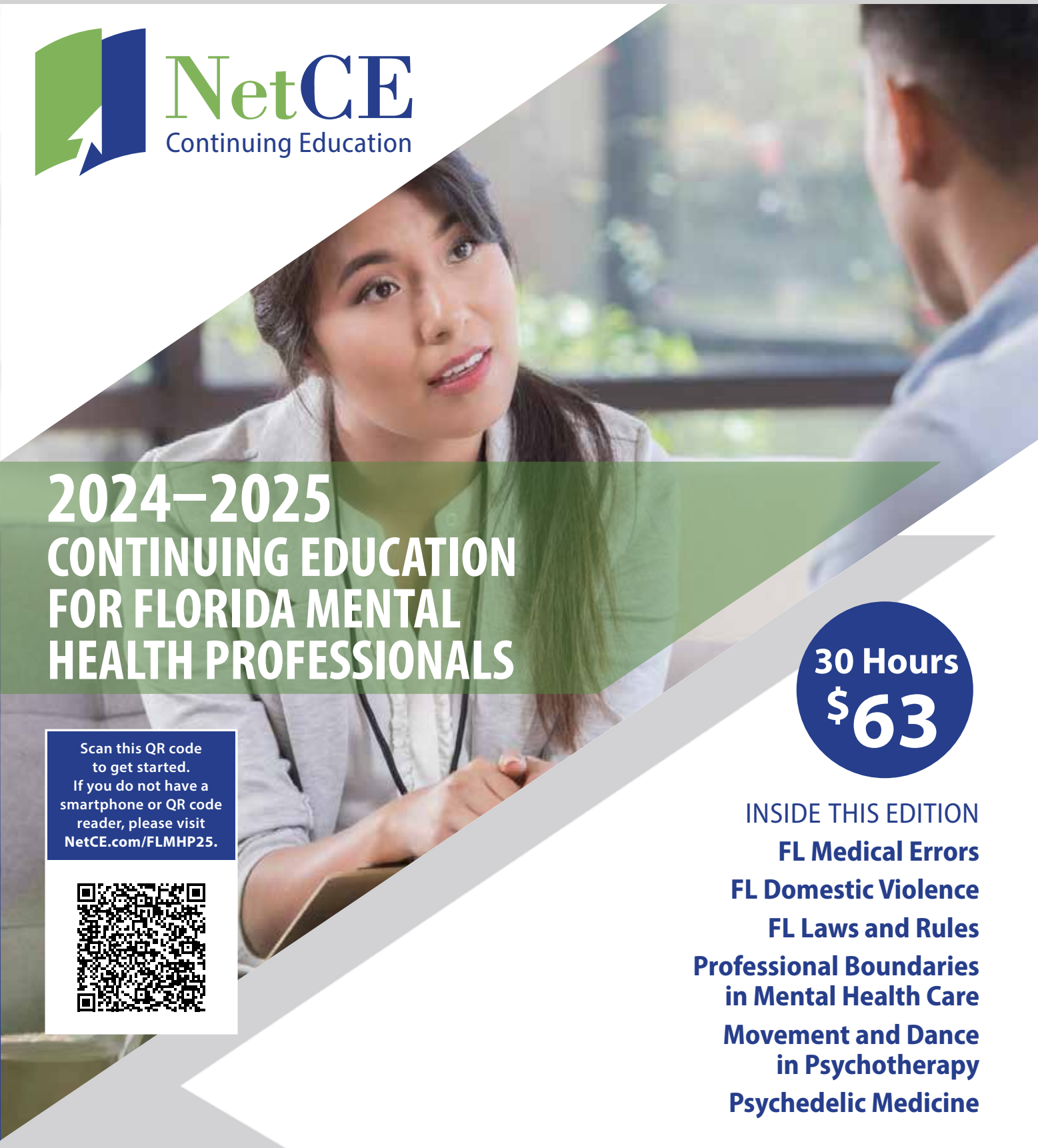

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Medical Error Prevention for Mental Health Professionals

This course fulfills the Florida requirement for 2 hours of education on the Prevention of Medical Errors.

Audience
This course is designed for all licensed behavioral and mental health professionals, including social workers, counselors, and therapists, particularly those in Florida.

Course Objective
The purpose of this course is to satisfy the requirement of the Florida law and provide all licensed mental health professionals with information regarding the root cause analysis process, error reduction and prevention, and patient safety.

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

1. Define "medical error."
2. Describe the root cause analysis process, and identify the most common sentinel events.
3. Evaluate the most common errors in psychological or behavioral settings and strategies to prevent these errors.
4. Identify potential psychological consequences of medical errors.

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Marjorie Conner Allen, BSN, JD, received her Bachelor of Science in Nursing degree from the University of Florida, Gainesville, in 1984. She began her nursing career at Shands Teaching Hospital and Clinics at the University of Florida, Gainesville. While practicing nursing at Shands, she gave continuing education seminars regarding the nursing implications for dealing with adolescents with terminal illness. In 1988, Ms. Allen moved to Atlanta, Georgia where she worked at Egleston Children's Hospital at Emory University in the bone marrow transplant unit. In the fall of 1989, she began law school at Florida State University. After graduating from law school in 1992, Ms. Allen took a two-year job as law clerk to the Honorable William Terrell Hodges, United States District Judge for the Middle District of Florida. After completing her clerkship, Ms. Allen began her employment with the law firm of Smith, Hulsey & Busey in Jacksonville, Florida where she has worked in the litigation department defending hospitals and nurses in medical malpractice actions. Ms. Allen resides in Jacksonville and is currently in-house counsel to the Mayo Clinic Jacksonville.

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INTRODUCTION

The Institute of Medicine's (IOM) 1999 publication *To Err is Human: Building a Safer Health System* illuminated the unfortunate reality of medical errors in the healthcare industry. The report reviewed the prevalence of medical errors in the United States and highlighted measures that should be taken to prevent them. Specifically, the authors of the report noted that at least 44,000 and perhaps as many as 98,000 Americans were dying in hospitals each year as a result of medical errors [1]. They further noted that even when using the lower estimate of 44,000, deaths in hospitals due to medical errors exceeded the annual deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297), or acquired immunodeficiency syndrome (16,516) [1]. A 2013 literature review stated that the average number of annual in-hospital deaths attributable to medical error may actually be much higher, at 210,000 to 400,000, which would make medical errors the third leading cause of death in the United States [2]. This was supported by findings of a 2016 study [3].

As part of an effort to address medical error incidents, Florida law mandates that all healthcare professionals and those working as members of an extended healthcare team in Florida complete a two-hour course on the topic of prevention of medical errors [4]. This continuing education course is designed to satisfy the requirements of the Florida law and provide all licensed behavioral and mental health professionals with information regarding the root cause analysis process, error reduction and prevention, and patient safety.

DEFINING "MEDICAL ERROR"

The IOM Committee on Quality of Healthcare in America defines error as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim" [1]. It is important to note that medical errors are not defined as intentional acts of wrongdoing and that not all medical errors rise to the level of medical malpractice or negligence. Errors depend on two kinds of failures: either the correct action does not proceed as intended, which is described as an "error of execution," or the original intended action is not correct, which is described as an "error of planning" [1]. A medical error can occur at any stage in the process of providing patient care, from diagnosis to treatment, and even while providing preventative care. Not all errors will result in harm to the patient. Medical errors that do result in injury are sometimes called preventable adverse events or sentinel events. These events are considered "sentinel" because they signal the need for immediate investigation and response [5].

Preventable adverse events or sentinel events are defined as events that cause an injury to a patient as a result of inaction on the part of the healthcare provider or as a result of an action/intervention whereby the injury cannot reasonably be attributed to the patient's underlying medical condition [1]. For example, if a patient has a surgical procedure and dies postoperatively from pneumonia, the patient has suffered an adverse event. But was that adverse event preventable? Was it caused by medical intervention or inaction? The specific facts of the case must be analyzed to determine whether the patient acquired pneumonia as a result of poor handwashing techniques of the medical staff (i.e., an error of execution), which would indicate a preventable adverse event, or whether the patient acquired pneumonia because of age and comorbidities, which would indicate a nonpreventable adverse event.

Healthcare professionals can learn much by closely scrutinizing and evaluating adverse events that lead to serious injury or death. The evaluation of such events would also enable healthcare professionals to improve the delivery of health care and reduce future mistakes. In addition, healthcare professionals must have a process in place to evaluate those instances in which a medical error occurred and did not cause harm to the patient. By reviewing these processes, healthcare professionals are afforded the unique opportunity to identify system improvements that have the potential to prevent future adverse events. The Joint Commission, recognizing the importance of analyzing both preventable adverse events and near-misses, has established guidelines for recognizing these events and requires healthcare facilities to conduct a root cause analysis to determine the underlying cause of the event [6].

ROOT CAUSE ANALYSIS PROCESS

The Joint Commission is a national organization with a mission to improve the quality of care provided at healthcare institutions in the United States. It accomplishes this mission by providing accredited status to healthcare facilities. Accreditors play an important role in encouraging and supporting actions within healthcare organizations by holding them accountable for ensuring a safe environment for patients. Healthcare organizations should actively engage in a cooperative relationship with The Joint Commission through this accreditation process and participate in the process to reduce risk and facilitate desired outcomes of care.

A root cause analysis identifies basic or causal factors that result in an undesired outcome (adverse event), including the occurrence or possible occurrence of a sentinel event [5]. Based on 2022 data from The Joint Commission, 88% of sentinel events occur in hospitals, emergency departments, or ambulatory care centers. This represents a 19% increase in events from 2021. Leading event types associated with the hospital setting included falls (45%), unintended retention of foreign object (7%), and wrong surgeries (6%). In the behavioral health setting, leading event types were patient suicide (23%), falls (18%), and delays in treatment (16%) [7].

The Joint Commission defines a sentinel event as "a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm (regardless of severity of harm), or severe harm (regardless of duration of harm) [7]. An event is also considered sentinel if it is one of the following [7]:

- Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the healthcare organization's emergency department
- Unanticipated death of a full-term infant
- Homicide of any patient receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Homicide of a staff member, licensed practitioner, visitor, or vendor while on site at the organization or while providing care or supervision to patients
- Any intrapartum maternal death
- Severe maternal morbidity (leading to permanent harm or severe harm)
- Physical assault (leading to death, permanent harm, or severe harm) of any patient receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Any elopement (i.e., unauthorized departure) of a patient from a staffed around the-clock care setting, leading to death, permanent harm, or severe temporary harm to the patient
- Abduction of any patient receiving care, treatment, and services
- Discharge of an infant to the wrong family
- Rape, assault (leading to death or permanent loss of function), or homicide of any patient receiving care, treatment, and services
- Rape, assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at a healthcare organization
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Surgery on the wrong patient or wrong body part
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Severe neonatal hyperbilirubinemia (bilirubin >30 mg/dL)
- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment operated and used by the organization. To be considered a sentinel event, equipment must be in use at the time of the event; staff do not need to be present.
- Fall in a staffed-around-the-clock care setting or fall in a care setting not staffed around the clock during a time when staff are present resulting in: any fracture; surgery, casting, or traction; required consult/management or comfort care for a neurological or internal injury; a patient with coagulopathy who receives blood products as a result of the fall; or death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)

(For further definition of terms, please refer to the Joint Commission's Sentinel Event Policy and Procedures at https://www.jointcommission.org/sentinel_event_policy_and_procedures.)

As part of the accreditation standards, the Joint Commission requires that healthcare organizations have a process in place to recognize these sentinel events, conduct thorough and credible root cause analyses that focus on process and system factors, and document a risk-reduction strategy and internal corrective action plan that includes measurement of the effectiveness of process and system improvements to reduce risk [8]. This process must be completed within 45 days of the organization having become aware of the sentinel event [5].

The Joint Commission will consider a root cause analysis acceptable for accreditation purposes if it focuses primarily on systems and processes, not individual performance. In other words, the healthcare organization should minimize the individual blame or retribution for involvement in a medical error [8]. In addition, the root cause analysis should progress from special causes in clinical processes to common causes in organizational processes, and the analysis should repeatedly dig deeper by asking why, then when answered, why again, and so on. The analysis should also identify changes that can be made in systems and processes, either through redesign or development of new systems or processes, which would reduce the risk of such events occurring in the future. The Joint Commission requires that the analysis be thorough and credible. To be considered thorough, the root cause analysis must include [5]:

- The analysis repeatedly asks a series of "why" questions, until it identifies the systemic causal factors associated with each step in the sequence that led to the sentinel event
- The analysis focuses on systems and processes, not solely on individual performance
- A determination of the human and other factors most directly associated with the sentinel event and the process(es) and systems related to its occurrence

- The analysis of the underlying systems and processes through the series of "why" questions determines where redesign might reduce risk
- An inquiry into all areas appropriate to the specific type of event
- An identification of risk points and their potential contributions to this type of event
- A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist

To be considered credible, the root cause analysis must meet the following standards [5]:

- The organization's leadership and the individuals most closely involved in the process and systems under review must participate in the analysis.
- The analysis must be internally consistent; that is, it must not contradict itself or leave obvious questions unanswered.
- The analysis must provide an explanation for all findings of "not applicable" or "no problem."
- The analysis must include consideration of any relevant literature.

Finally, as previously discussed, after conducting this root cause analysis, the organization must prepare an internal corrective action plan. The Joint Commission will accept this action plan if it identifies changes that can be implemented to reduce risk or formulate a rationale for not undertaking such changes and if, where improvement actions are planned, it identifies who is responsible for implementation, when the action will be implemented, and how the effectiveness of the actions will be evaluated [5].

The Joint Commission provides a root cause analysis and action plan template that can help guide organizations through a comprehensive systematic analysis of an adverse or sentinel event and identify potential corrective actions [9].

FLORIDA LAW

Mental health professionals have an obligation to report preventable adverse events to leadership and ensure that employers have processes in place to satisfy the Joint Commission requirement. In Florida, certain serious adverse incidents must also be reported to Florida's Agency for Health Care Administration (AHCA). Florida law requires that licensed facilities, such as hospitals, establish an internal risk management program and, as part of that program, develop and implement an incident reporting system, which imposes an affirmative duty on all healthcare providers and employees of the facility to report adverse incidents to the risk manager or to his or her designee.

The risk manager must receive these incident reports within 3 business days of the incident, and depending on the type of incident, the risk manager may have to report the incident to AHCA within 15 days of receipt of the report.

Florida Statute 395.0197 specifically defines an adverse incident as [10]:

An event over which healthcare personnel could exercise control and which is associated in whole or in part with medical intervention rather than the condition for which such intervention occurred, and which:

a) Results in one of the following injuries:
   - Death
   - Brain or spinal damage
   - Permanent disfigurement
   - Fracture or dislocation of bones or joints
   - A resulting limitation of neurologic, physical, or sensory function that continues after discharge from the facility
   - Any condition that required specialized medical attention or surgical intervention resulting from nonemergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent
   - Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient's condition prior to the adverse incident
b) Was the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition
c) Required the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process
d) Was a procedure to remove unplanned foreign objects remaining from a surgical procedure

In 2022, the Florida AHCA reported that a total of 185 deaths occurred as a result of hospital error, which comprised 22% of the 842 adverse incidents reported for the year [11]. The next most common incidents in 2022 were fracture dislocation (21.1%), transfer of the patient to a unit providing a more acute level of care due to the adverse incident (17.6%), surgical procedures unrelated to the patient's diagnosis or medical needs (10%), and surgical procedure to remove a foreign object from a previous surgical procedure (9.4%) [11]. The following adverse incidents must be reported to the AHCA within 15 calendar days after their occurrence [10]:

- The death of a patient
- Brain or spinal damage to a patient
- Performance of a surgical procedure on the wrong patient
- Performance of a wrong-site surgical procedure
- Performance of a wrong surgical procedure
- Performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition
- Surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process
- Performance of procedures to remove unplanned foreign objects remaining from a surgical procedure

Each incident will be reviewed by the AHCA, which will then determine the penalty to be imposed upon the responsible party [10]. All Florida healthcare professionals who practice in licensed facilities should familiarize themselves with these requirements and ensure that the facility in which they practice has processes in place to ensure compliance.

Unlike Florida's mandatory reporting of serious adverse incidents, the Joint Commission recommends that healthcare organizations voluntarily report sentinel events, and it encourages the facilities to communicate the results of their root cause analyses and their corrective action plans. As a result of the sentinel events that have been reported, the Joint Commission has compiled Sentinel Event Alerts, which it provides to all accredited organizations. These alerts are intended to provide healthcare organizations with important information regarding reported trends and, by doing so, highlight areas of potential concern so an organization may review its own internal processes to maximize error reduction and prevention with regard to a particular issue [12].

ERROR REDUCTION AND PREVENTION

Between 2005 and the second quarter of 2019, the Joint Commission had reviewed 14,925 reported sentinel events impacting 12,520 patients and resulting in 6,258 patient deaths [3]. (Some events, such as fire, can impact multiple patients.) In 2022, The Joint Commission received 1,441 reports of sentinel events [7]. The most common categories of sentinel events were patient falls (42%), delay in treatment (6%), unintended retention of a foreign body (most commonly sponges) (6%), wrong-site/wrong-patient/wrong-procedure (6%), and patient suicide (5%) [7]. Of these, patient suicide, delay in treatment, and patient fall are the most pertinent to mental or behavioral health practice.

These are all errors with modifiable risk factors. Error reduction may be accomplished by applying the root cause analysis methodology, through extra diligence by healthcare professionals, and by adopting a willingness to identify personal shortcomings and to evolve. As identified in Florida Administrative Code Rule 64B19-13.003, the most serious potential errors in psychological or behavioral settings include "inadequate assessment of suicide risk, failure to comply with mandatory abuse reporting laws, and failure to detect medical conditions presenting as a psychological disorder" [13]. Failure to detect medical conditions presenting as a psychological disorder is akin to delay in treatment. These errors affect pediatric, adolescent, adult, and senior patients alike.

PATIENT SUICIDE

It is possible that the event with the greatest emotional impact on mental health professionals (and patients' families) is patient suicide. In general, the suicide rate is increasing, with a nearly 37% higher rate in 2022 compared with 1999 [14]. According to a 2010 Joint Commission Sentinel Event Alert, 75% of inpatient suicides occurred in psychiatric hospitals or behavioral health units of general hospitals [15]. The next greatest number occurred in surgical, intensive care, telemetry, or oncology units (14.25%); emergency departments (8%); and home care, rehabilitation units, and long-term or residential care facilities (2.5%). In 2022, 55% of the 73 sentinel events classified as suicide occurred offsite within 72 hours of discharge from an accredited healthcare organization, 40% occurred in an inpatient setting, and 4% while in the emergency department. In the behavioral health setting 23% of sentinel events were patient suicide [7]. General hospitals are inherently less safe for suicidal patients than psychiatric hospitals or units, as they offer the patient more time alone and a number of potential suicide options (e.g., jumping, intentional drug overdose, cutting with a sharp object, hanging, strangulation) and means (e.g., tubing, bandages, plastic bags) that are designed out of psychiatric settings [15].

In general, patient suicide is highest among males 75 years of age or older [16]. In 2020–2021, American Indian/Alaska Native men and boys had the highest rates of suicide. The rates increased by 17% during this period, compared with an 11% increase for Black men/boys and a 3% increase for White men/boys [16]. For both sexes, American Indian/Alaska Natives had the highest rates of suicide in 2021 compared with other groups [16]. Of patients 17 to 39 years of age admitted to hospitals for one medical condition, suicidal ideation increases from a baseline of 16.3% in the general population to 25%; the rate increases to 35% for those admitted with two or more conditions [17]. The most common root cause of patient suicide in a staffed, round-the-clock healthcare setting (including 72 hours post-discharge) is inadequate assessment [18].

The Joint Commission recommends a number of risk reduction strategies, including [18]:

- Screening all patients for suicide ideation
- Responding to patients in acute suicidal crisis with immediate action and a safety plan
- Meeting patient needs for continuing care and treatment after discharge or transfer
- Collaborating with the patient's other providers, family, and friends as appropriate
- Developing treatment and discharge plans that directly target suicidality
- Using evidence-based interventions
- Educating staff about how to identify and respond to patients with suicidal ideation

A simple review of these measures demonstrates that healthcare and mental health providers can avoid the devastating impact of an inpatient suicide by implementing fairly routine preventative strategies, such as removing harmful items and careful screening through the admission process [19].

Suicide Risk Assessment

There are many suicide risk assessment tools for use by health and/or mental health professionals but few have been tested empirically. If and when they are used, all too often an assessment tool is insufficient in preventing suicide. A thorough assessment by a trained mental health professional is often the best choice, but even these professionals are not infallible. Of those who die from suicide, 20% have had contact with a mental health provider in the last month [14]. Many reasons have been identified for inadequate professional assessments or lack thereof [20]:

- Suicide risk assessment training was never provided to the mental health professional, physician, or nurse.
- The risk of suicide is minimized or over-looked by the professional due to personal anxiety related to suicide in general.
- The professional has a fear of documenting thought processes because those actions could come under scrutiny in a malpractice suit.
- Risk assessment is performed but not documented.
- The task of suicide risk assessment is delegated to another professional who is incapable of performing an adequate assessment or who does not complete the task.
- Suicide risk assessment is simply not indicated.
- A systematic suicide risk assessment is never performed.
- The professional is reluctant to assess suicide risk due to excessive false positives.

It is recommended that all patients be screened using a systematic, personalized suicide risk assessment by a trained professional and that the results of the assessment be diligently documented [20]. The assessment should be within the scope of practice and competence of the individual performing the task. When a professional, such as a social worker or counselor, identifies a client who is at risk for suicide, he or she has an obligation to protect the client from self-harm and must consult with a supervisor or other colleague. This can be perceived to be in contradiction to the principle of confidentiality, but preventing harm is an ethical obligation with greater importance and should be taken as seriously as threats made against another person.

Although some professionals are uncomfortable with suicidal clients, 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 client, even though many others may be scheduled. Showing a willingness to help begins the process of establishing a positive rapport. 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."

A thorough assessment involves not only totaling suicide risk factors (acute and chronic) but should consider other factors, such as the patient's job contentment and their satisfaction from interpersonal relationships, which are considered protective [21]. As noted, suicide ideation increases with the severity of an individual's injuries (e.g., traumatic brain injury with enduring sequelae, amputation or loss of limb, loss of motor function), chronic pain syndromes, and poor prognoses (e.g., Alzheimer disease, cancer, autoimmune diseases) [22]. Warning signs of suicidal thought include threatening self-harm, actively seeking suicide means (e.g., medications, medical instruments or other objects, removing IV lines or life-sustaining apparatus), and expressing thoughts about death, dying, and suicide. These patients should be considered at high risk of suicide. When assessing for suicide, it is important to be cautious of misleading information or false improvement [23]. When an agitated patient suddenly appears calm, he or she may have made the decision to complete suicide and feels calm after making the decision. Denial is another important consideration. Patients may deny harboring very serious intentions of killing themselves.

Reluctance or even outright refusal to implement a systematic suicide risk assessment program has been demonstrated in a study of attending hospital psychiatrists (one of the few studies that exist on the topic) [21]. As an advocate for clients, all mental health professionals, including social workers, counselors, therapists, and psychologists, should ensure that a suicide risk assessment is performed and documented and that follow-up assessments are completed on a regular basis.

MEDICATION ERRORS

Unquestionably, medication errors are one of the most common causes of avoidable harm to patients. These errors may occur at three critical points: when ordered by a physician or psychologist, dispensed by a pharmacist, or administered.

The National Coordinating Council for Medication Error Reporting and Prevention defines a medication error as "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer. Such events may be related to professional practice, healthcare products, procedures, and systems, including prescribing; order communication; product labeling; packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use" [24].

A number of medication errors can be linked to the prescriber who continually uses potentially dangerous abbreviations and dose expressions. Despite repeated warnings by the Institute for Safe Medication Practices about the dangers associated with using certain abbreviations when prescribing medications, this practice continues [25].

Other factors contributing to prescriber errors are illegible or confusing handwriting and, a frequently cited cause of many adverse and sentinel events, the failure of healthcare providers to assess risk and prevent errors. Facilities should implement appropriate guidelines, policies, and procedures to ensure safe medication administration practice. These policies should include [26]:

- Reconciling medications at transition points (e.g., admission, discharge, transfer)
- Keeping an accurate medication list (including over-the-counter and com-plementary and alternative medications)
- Asking patients to bring their medications in periodically
- Informing the patient of indications for all medications
- Asking regularly whether patients are taking their medications, including as-needed drugs, as nonadherence may signal issues other than knowledge deficits, practical barriers, or attitudinal factors
- Considering that new complaints may represent side effects of medications
- Explaining common or significant side effects
- Asking regularly about side effects or adverse drug events
- Avoiding abbreviations
- Working as a team with pharmacists, physicians, and nurses
- Adhering to Class I clinical indications and guidelines
- Using special caution with high-risk medications
- Exercising particular caution in high-risk situations (e.g., when stressed, sleep-deprived, angry, supervising inexperienced personnel)
- Reporting errors and adverse drug events
- Including medications when transferring patients between providers
- Standardizing communication about prescriptions within the practice
- Actively monitoring the patient for response to medication therapy, using validated instruments when possible
- Minimizing the use of free samples

Finally, facilities should have proper quality assurance measures in place to monitor medication administration practices. Included among these would be protocols and guidelines for use with critical and problem-prone medications to help optimize therapies and minimize the possibility of adverse events and to integrate "triggers" to indicate the need for additional clinical monitoring [27].

FAILURE TO REPORT ABUSE

In Florida, as in other states, workers in many occupations are designated as "professionally mandatory reporters" including teachers, nurses, physicians, and law enforcement officials [28]. Social workers, psychologists, and all mental health professionals are included among those who are required to report abuse, neglect, abandonment, and exploitation of children and adults [28]. Additionally, suspected maltreatment is to be reported.

There were 588,229 unique cases of child abuse reported in the United States in 2021 resulting in 1,820 deaths [29]. The vast majority of perpetrators of abuse were parents or legal guardians. Approximately 67% of the referrals of abuse were generated by a mandated professional, including legal and law enforcement personnel (21.8%), education personnel (15.4%), and medical personnel (12.2%). Nonprofessionals submitted 17.1% of reports, with the largest category being parents (6.5%), other relatives (6.2%), and friends and neighbors (3.9%). Unclassified sources submitted the remaining 16% [29].

Only 17.8% of all reports of child abuse or suspected child abuse result in a substantiation or indication of actual maltreatment according to state law [29]. However, this should not discourage the professional from intervening. It is never punishable to submit a report in good faith; furthermore, all reports are confidential (except among protective services personnel) until indicated in a judicial proceeding [28]. In addition to breaching the ethical duty to protect clients from harm (and, subsequently, the professional consequences of this ethics violation), there are legal consequences for those who fail to comply with mandatory abuse reporting requirements. Diligent reporting and documenting of abuse better protects professionals from legal action resulting from inaction.

Adult abuse encompasses self-abuse, domestic abuse, and abuse/exploitation by caregiver(s) of a vulnerable adult [28]. Exploitation refers to the misuse of moneys, taking or selling of property, the inappropriate use of guardianship/power of attorney, and the failure to use the vulnerable adult's funds for their care. A vulnerable adult is defined in Florida as "a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to disability, brain damage, or the infirmities of aging" [28]. Vulnerable adults and children are abused at a rate between 4 and 10 times greater than that of the general population and are themselves less likely to report abuse due to a variety of fears, including not being believed, reprisals, and caretaker abandonment [30]. Mental health professionals are often the individuals to whom the abuse is reported. With the aforementioned statistics and somewhat unique fears in mind, it is reasonable that a slightly higher index of suspicion be employed when working with this cohort.

Emotional changes or suspicious injuries that are noticed in adult clients should be documented and reported. Marks and bruises in various stages of healing should be noted, especially those that resemble objects such as belts or electrical cords or those that reoccur regularly; cigar/cigarette burns; burns in the shape of an object (e.g., clothes iron); missing clumps of hair; marks from being tied down; and other injuries with no reasonable explanation [31]. Other signs of abuse include recurrent poor hygiene among those in the care of others, medical conditions left untreated, food hoarding, age-inappropriate sexual behavior/knowledge of sex, unexplained fear of persons/places, unaccounted for injury or disease of the genitals. Psychological abuse may be harder to detect, but in some cases there are physical manifestations of psychological abuse. Studies of the long-term physical effects of intimate partner violence or child abuse have found an increased risk of asthma, chronic pain, sexually transmitted infections, stomach ulcers, liver disease, and high blood pressure among victims [32; 33].

Compliance with abuse reporting laws is not optional, and reporting suspected abuse to a supervisor does not satisfy this requirement [28]. Abuse must be reported to the Florida Abuse Hotline by telephone (1-800-962-2873 or TDD 1-800-453-5145), by fax (1-800-914-0004), or online (https://reportabuse.myflfamilies.com/s/) when knowledge of abuse or suspected reasonable cause exists. Telephone is the preferred contact method and should always be used in emergency situations. It is up to the Florida Department of Children and Families counselors to determine if the report meets the legal requirements for further action [28]. If a counselor refuses the report, a supervisor can be requested for further discussion.

FAILURE TO IDENTIFY MEDICAL CONDITIONS PRESENTING AS PSYCHOSIS

A large number of medical conditions can cause acute psychiatric symptoms in patients with no history of mental illness and can exacerbate the severity of or create new psychiatric symptoms in individuals with pre-existing mental illness [34]. These conditions include, but are not limited to, central nervous system (CNS) disorders (e.g., seizure, aneurysm, subdural hematoma, tumor); infections (e.g., urinary tract infection, pneumonia, sepsis); cardiopulmonary disorders (e.g., hypoxia, myocardial infarction); metabolic/endocrine disorders (e.g., thyroid, adrenal, renal, hepatic disorders); adverse reactions to medications (e.g., corticosteroids, dopamine agonists); illicit drug use or withdrawal (e.g., cannabis, amphetamines, heroin); and chemical and plant toxicities (e.g., caffeine, psilocybin, aromatic hydrocarbons) [35].

Patients who solely have medical conditions but who present to emergency departments of general hospitals (or psychiatric hospitals) with psychiatric symptoms without medical complaints should be successfully and expediently differentiated from those with psychosis due to mental illness. This can be challenging considering the number of potential diagnoses that must be ruled out during a standard medical clearance at a psychiatric hospital or following a mental status exam at an emergency department. Differentiation is further complicated by comorbid conditions (e.g., a schizophrenic patient with pneumonia) and the grey area between some medical conditions and psychiatric illnesses (e.g., seizure disorders) [34]. Furthermore, the increasing workload of hospital psychiatrists and physicians, administrative bureaucracy, advancing age of the country's population, complex drug regimens, widespread prescription and illicit drug use, and psychiatric evaluations performed by individuals not possessing competency have been identified as causative factors of a missed medical diagnoses or delays in treatment. Morbidity and mortality can be significantly increased for many conditions the longer they remain undiagnosed as a result of focusing on psychiatric aspects of care.

In one study, 3% of psychiatric admissions are actually due to a medical condition; this number is likely higher for older individuals [36]. For example, elderly patients or patients with intellectual disabilities with various infections often present to emergency or urgent care facilities with no other symptoms other than psychosis due to delirium; these infections may be initially overlooked as the healthcare team focuses on the psychological symptoms [37; 38]. Urinary tract infections and pneumonia are the most frequent causes of sudden change in mental status in elderly patients, but these patients are often initially diagnosed with dementia based on their age [39]. Other possible causes include electrolyte imbalances, thyroid dysfunction, organ failure, and medications.

In addition to standard medical testing and mental status examination, it is important for hospital staff to gain as much relevant history from family members, caregivers, and acquaintances about the patient's usual mental status to aid in diagnosis. Social workers and mental health professionals familiar with patients can be valuable substitutes if family members or other acquaintances are unavailable.

PSYCHOLOGICAL CONSEQUENCES OF MEDICAL ERRORS

According to the Institute for Healthcare Improvement, there are approximately 6 million survivors of medical errors each year [40]. As a result of these errors and the way they are handled, patients can lose trust in the healthcare system, and some may never feel a sense of safety in the care of anyone (including mental health professionals) again [41]. These same sentiments can carry over into the psyche of family members and even the general public. Stress reactions, anxiety disorders, worsening of existing mental health conditions, drug dependence, and suicidal ideation may develop in victims of medical errors, even as the result of "less serious" events, such as a breech in confidentiality. Feelings of anger, guilt, loss, and fear may persist long after the event [40].

Many individuals are reluctant to accept the risk of seeking help for mental, social, or medical issues, but certain groups have traditionally been wary of trusting professionals in these occupations. In the United States, Black individuals have historically been and continue to remain wary and even suspicious of the medical/mental health care system [42; 43; 44]. For example, 40% of Black Americans feel that prescribed medications are a form of undisclosed experimentation (compared to 28% of White Americans), and this demographic tends to underutilize health care, especially preventative care [43]. The cause of this suspicion is partially distrust of institutions in general; however, medical errors and gross ethical violations (e.g., the Tuskegee syphilis study, personal experience with discrimination) may also be to blame [42]. It is important that clients be encouraged to seek preventative care for health issues, especially those that disproportionately affect their gender and race.

As part of the movement to bring greater transparency to the practice of medicine, along with an improved effort to reduce the post-traumatic effects of medical errors, mental health professionals are increasingly being relied upon to assist patients and families with coping following serious errors [40].

A growing number of institutions have put into place support programs for professionals who have committed medical errors as the result of studies showing significant personal impact (e.g., guilt, reduced job satisfaction, burnout, sleep disturbances, loss of confidence, anxiety about committing future errors, depression) and lack of support following these events [40; 45; 46; 47]. However, many victims and perpetrators of medical errors may seek help on their own. Social workers and mental health providers should refer clients to specialists when indicated.

It is important that patients and professionals understand that risk and trust are a part of everyday life. It is necessary for clients to regain trust or self-trust and learn to rethink in a more complex way. Cognitive-behavioral therapy has been shown to be one of the more successful methods of reducing post-traumatic stress or anxiety and may be useful for these clients [48; 49].

Individuals with high levels of anxiety are particularly difficult to engage and may be reluctant to participate in psychological interventions. Using a Socratic dialogue to prompt basic realizations and then beginning cognitive-behavioral therapy can be very useful as a treatment approach for those with anxiety disorders and post-traumatic stress following a medical error. Maladaptive and negative automatic thoughts, such as, "I can't trust anyone/myself," should be explored and replaced with positives [48]. Other therapy components (e.g., exposure therapy, behavioral family therapy) may be considered on an individual basis.

CONCLUSION

The topic of medical errors is especially disconcerting because, by nature, they are a violation of the primary ethic of the various medical and helping professions—the duty to cause no harm. That being said, medical errors will continue to affect healthcare delivery for years to come, but to say that they are unavoidable is somewhat erroneous. In order to ensure client and patient safety through error reduction, mental health and healthcare professionals should make a conscious effort to maintain and improve their knowledge of their profession, accept criticism, recognize personal limitations, build competencies, work as team members, notice and correct insufficiencies in service delivery, practice self-care, effectively manage workloads, and be proactive in creating solutions that may reduce errors. These are some of the keys to a safer healthcare system.

Customer Information, Answer Sheet, and Evaluation are located on pages 118–120.

TEST QUESTIONS
#71313 MEDICAL ERROR PREVENTION FOR MENTAL HEALTH PROFESSIONALS

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

This 2 clock hour activity must be completed by December 31, 2026.

1. Medical errors are caused by what two types of failures?
- A) *Errors of execution and negligence*
- B) *Errors of execution and sentinel events*
- C) *Errors of planning and errors of judgment*
- D) *Errors of planning and errors of execution*

2. The IOM Committee on Quality of Healthcare in America defines sentinel events as events
- A) *that cause injury to a patient as a result of inaction.*
- B) *that cause injury to a patient as a result of an action/intervention.*
- C) *where the injury cannot reasonably be attributed to the patient's underlying medical condition.*
- D) *All of the above*

3. What percentage of sentinel events that occur in the behavioral health setting are suicides?
- A) *10%*
- B) *23%*
- C) *53%*
- D) *81%*

4. In the behavioral health setting, the leading sentinel event types in 2021 were patient suicide, falls, and delays in treatment.
- A) *True*
- B) *False*

5. The organization must prepare an internal corrective action plan before conducting a root cause analysis.
- A) *True*
- B) *False*

6. Where do most inpatient suicides occur?
- A) *Hospice care*
- B) *Emergency departments*
- C) *Residential care facilities*
- D) *Psychiatric hospitals or behavioral health units*

7. The Joint Commission recommends screening all patients for suicide ideation.
- A) *True*
- B) *False*

8. Several reasons for inadequate suicide risk assessments have been identified, including all of the following, EXCEPT:
- A) *The patient refused a suicide risk assessment.*
- B) *There is reluctance to assess suicide risk because of excessive false positives.*
- C) *Anxiety and/or denial is aroused in the professional, and the risk of suicide is minimized or overlooked.*
- D) *Suicide risk assessment training was never provided to the mental health professional, physician, or nurse.*

9. Medication errors may occur at three critical points: when ordered by a physician or psychologist, dispensed by a pharmacist, or administered.
- A) *True*
- B) *False*

10. Which of the following statements regarding mandatory abuse reporting is TRUE?
- A) *Compliance with abuse reporting laws is optional.*
- B) *Suspected abuse should not be reported unless maltreatment is admitted by the client or patient.*
- C) *Mental health professionals must personally report abuse or suspected abuse to the Florida Abuse Hotline.*
- D) *Abuse or suspected abuse should be reported to a supervisor, who will then contact the proper authorities.*

11. If a Florida Abuse Hotline counselor refuses an abuse report but the reporter disagrees with the decision, he or she should
- A) *berate the counselor.*
- B) *ask to speak to a supervisor.*
- C) *accept the counselor's decision.*
- D) *call back later and hope for another counselor.*

Test questions continue on next page ➞

12. On average, medical conditions are the actual cause of what percentage of psychiatric admissions?
- *A) 0.1%*
- *B) 3%*
- *C) 21%*
- *D) 53%*

13. Which of the following is the most frequent cause of sudden change in mental status in elderly patients?
- *A) Multiple sclerosis*
- *B) Thyroid dysfunction*
- *C) Traumatic head injury*
- *D) Urinary tract infection*

14. Stress reactions, anxiety disorders, worsening of existing mental health conditions, drug dependence, and suicidal ideation may develop in victims of medical errors, even as the result of "less serious" events, such as a breech in confidentiality.
- *A) True*
- *B) False*

15. One of the more successful interventions for post-traumatic stress and anxiety disorders following an experience with a medical error is
- *A) Gestalt therapy.*
- *B) electroshock therapy.*
- *C) cognitive-behavioral therapy.*
- *D) body-oriented psychotherapy.*

Be sure to transfer your answers to the Answer Sheet located on pages 119–120.
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.

Domestic Violence: The Florida Requirement

This course fulfills the Florida requirement for 2 hours of Domestic Violence education every third renewal cycle.

Audience

This course is designed for all Florida healthcare professionals required to complete domestic violence education.

Course Objective

The purpose of this course is to enable healthcare professionals in all practice settings to define domestic violence and identify those who are affected by domestic violence in the United States. This course describes how a victim can be accurately diagnosed and identifies the community resources available in the state of Florida for domestic violence victims.

Learning Objectives

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

1. Define domestic violence and its impact on health care.
2. Cite the general prevalence of domestic violence on a national and state level and identify state laws pertaining to the issue.
3. Describe how to screen and assess individuals who may be victims or perpetrators of domestic violence, including the importance of conducting a culturally sensitive assessment.
4. Identify community resources presently available for domestic violence victims and their perpetrators throughout Florida concerning legal aid, shelter, victim and batterer counseling, and child protection services.

Faculty

Marjorie Conner Allen, BSN, JD, received her Bachelor of Science in Nursing degree from the University of Florida, Gainesville, in 1984. She began her nursing career at Shands Teaching Hospital and Clinics at the University of Florida, Gainesville. While practicing nursing at Shands, she gave continuing education seminars regarding the nursing implications for dealing with adolescents with terminal illness. In 1988, Ms. Allen moved to Atlanta, Georgia where she worked at Egleston Children's Hospital at Emory University in the bone marrow transplant unit. (A complete biography can be found at NetCE.com.)

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

Faculty Disclosure

Contributing faculty, Marjorie Conner Allen, BSN, JD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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

Division Planners

John M. Leonard, MD
Jane C. Norman, RN, MSN, CNE, PhD

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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Designations of Credit

Social workers completing this intermediate-to-advanced course receive 2 Clinical continuing education credits.

NetCE designates this continuing education activity for 1 NBCC clock hour.

Individual State Behavioral Health Approvals

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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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EVIDENCE-BASED PRACTICE RECOMMENDATION

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

INTRODUCTION

Domestic violence continues to be a prevalent problem in the United States today. Because of the number of individuals affected, it is likely that most healthcare professionals will encounter patients in their practice who are victims. Accordingly, it is essential that healthcare professionals are taught to recognize and accurately interpret behaviors associated with domestic violence. It is incumbent upon the healthcare professional to establish and implement protocols for early identification of domestic violence victims and their abusers. In order to prevent domestic violence and promote the well-being of their patients, healthcare professionals in all settings should take the initiative to properly assess all women for abuse during each visit and, for those women who are or may be victims, to offer education, counseling, and referral information.

Victims of domestic violence suffer emotional, psychologic, and physical abuse, all of which can result in both acute and chronic signs and symptoms of physical and mental disease, illness, and injury. Frequently, the injuries sustained require abused victims to seek care from healthcare professionals immediately after their victimization. Subsequently, physicians and nurses are often the first healthcare providers that victims encounter and are in a critical position to identify domestic violence victims in a variety of clinical practice settings where victims receive care. Accordingly, each healthcare professional should educate himself or herself to enhance awareness of the presence of abuse victims in his or her particular practice or clinical setting.

Specifically, healthcare professionals should be aware of the signs and symptoms associated with domestic violence. In addition, when family violence cases are identified, there should be a plan of action that includes providing information on, and referral to, local community resources related to legal aid, sheltering, victim counseling, batterer counseling, advocacy groups, and child protection.

DEFINING DOMESTIC VIOLENCE

Domestic violence, which is sometimes also referred to as spousal abuse, battering, or intimate partner violence (IPV), refers to the victimization of an individual with whom the abuser has or has had an intimate or romantic relationship. Researchers in the field of domestic violence have not agreed on a uniform definition of what constitutes violence or an abusive relationship. The Centers for Disease Control and Prevention (CDC) defines IPV as, "violence or aggression that occurs in a romantic relationship" [1]. According to the Florida Department of Children and Families, domestic violence is "a pattern of abusive behaviors that adults use to maintain power and control over their intimate partners or former partners. People who abuse their partners use a variety of tactics to coerce, intimidate, threaten, and frighten their victims" [2]. Domestic violence may include physical violence, sexual violence, emotional abuse, economic abuse, isolation, pet abuse, threats relating to children, and a variety of other behaviors meant to increase fear, intimidation, and power over the victim [2]. Florida law defines domestic violence as "any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member" [3]. Family or household members, according to Florida definition, must "be currently residing or have in the past resided together in the same single dwelling unit" [3]. Domestic violence knows no boundaries. It occurs in intimate relationships regardless of race, religion, culture, or socioeconomic status [2].

Whatever the definition, it is important for healthcare professionals to understand that domestic violence, in the form of emotional and psychologic abuse, sexual abuse, and physical violence, is prevalent in our society. Because of the similar nature of the definitions, this course will use the terms "domestic violence" and "IPV" interchangeably.

NATIONAL AND STATE STATISTICS AND LEGISLATION

Domestic violence is one of the most serious public health problems in the United States [4]. More than 36.4% of women and 33.6% of men have a lifetime history of IPV [4]. In Florida, the weighted lifetime prevalence of IPV (including rape, physical violence, and/or stalking) is 37.4% among women and 29.3% among men [5]. Although many of these incidents are relatively minor and consist of pushing, grabbing, shoving, slapping, and hitting, IPV resulted in approximately 1,500 deaths in the United States in 2019, with 214 of those deaths occurring in Florida in the same year. Statistics indicate a slightly higher rate in 2020, with 217 deaths in Florida in 2020 [7; 8]. One of the difficulties in addressing the problem is that abuse is prevalent in all demographics, regardless of age, ethnicity, race, religious denomination, education, or socioeconomic status [2].

Victims of abuse often suffer severe physical injuries and will likely seek care at a hospital or clinic. The health and economic consequences of domestic violence are significant. Statistics vary from report to report, and due to the lack of studies on the national cost of domestic violence, the U.S. Congress funded the CDC to conduct a study to determine the cost of domestic violence on the healthcare system [9]. The 2003 CDC report, which relied on data from the National Violence Against Women Survey conducted in 1995, estimated the costs of IPV by measuring how many female victims were nonfatally

injured; how many women used medical and mental healthcare services; and how many women lost time from paid work and household chores. The estimated total annual cost of IPV against women in the 1995 survey was more than $5.8 billion [9]. When updated to 2017 dollars, the amount was more than $9.3 billion annually. The costs associated with IPV at this time would be considerably more, but no further studies have been conducted [10]. It should be noted that the costs of any one victimization may continue for years; therefore, these statistics most likely underestimate the actual cost of IPV [9].

The national rate of nonfatal domestic violence against women declined 72% between 1993 and 2011 [11]. The rate of overall violent crime fell by nearly 60% in this same time period [11]. Studies reveal that several factors may have contributed to the reduction in violence, including a decline in the marriage rate and decrease of domesticity, better access to federally funded domestic violence shelters, improvements in women's economic status, and demographic trends, such as the aging of the population [13; 14]. Of note, declines in the economy and stress associated with financial hardship and unemployment are significant contributors to IPV in the United States. Following the economic downturn in late 2008, there was a significant increase in the use of the National Domestic Violence Hotline in 2009, with more than half of victims reporting a change in household financial situation in the last year [15]. This trend continued with the COVID-19 pandemic, with stressors from lockdown orders, unemployment, financial insecurity, childcare and homeschool responsibilities, and poor coping strategies (e.g., substance abuse) increasing the rate of domestic violence. Reports showed a 9.7% increase in domestic violence calls for service in the first two months state-mandated lockdowns were imposed; furthermore, the National Commission on COVID-19 and Criminal Justice reported an increase of 8.1% in domestic violence incidents within the first months of mandated stay-at-home orders [6].

FLORIDA

In response to troubling domestic violence statistics, Governor Lawton Chiles appointed a Task Force on Domestic Violence on September 28, 1993, to investigate the problems associated with domestic violence in Florida and to compile recommendations as to how the problems should be approached and ultimately resolved. On January 31, 1994, the Task Force issued its first report on domestic violence. This report recommended standards to accurately measure the extent of domestic violence and strategies for increasing public awareness and education. It identified programs and resources that are available to victims in Florida, made legislative and budgetary suggestions for needed changes, provided a methodology for implementing these changes, and identified areas of domestic violence that require further study.

As a result of this report, Florida enacted legislation during the 1995 session implementing various suggestions of the Task Force. Specifically, the Legislature amended Section 455.222 of the Florida Statutes to require that all physicians, osteopaths, nurses, dentists, dental hygienists, midwives, psychologists, and psychotherapists obtain, as part of their biennial continuing education requirements, a one-hour continuing education course on domestic violence [17]. In June of 2006, Governor Jeb Bush signed into law House Bill 699. The bill, which went into effect July 1, 2006, changed the domestic violence continuing education requirement from one hour every renewal period to two hours every third renewal period.

In 1997, at the request of the Governor's Task Force, a workgroup was established by the Florida Department of Law Enforcement (FDLE) to evaluate the feasibility of tracking incidents of domestic violence in the state [18]. This resulted in the creation of the Domestic Violence Data Resource Center (DVDRC). The original mission of the DVDRC was to collect information related to domestic violence and to report and maintain the information in a statewide tracking system [19]. Domestic Violence Fatality Review Teams were established to examine those cases of domestic violence that resulted in a fatality and identify potential changes in policy or procedure that might prevent future deaths. The teams were comprised of representatives from law enforcement, the courts, social services, state attorneys, domestic violence centers, and others who may come into contact with domestic violence victims and perpetrators [20]. In 2000, the creation of Florida Statute 741.316 required the FDLE to annually publish a report based on the data gathered by the Fatality Review Teams [19]. Due to budgetary constraints, responsibility of compiling this data transferred to the Department of Children and Families in 2008 [21].

As part of Governor Jeb Bush's initiative, the "Family Protection Act" was signed into law in 2001. The act requires a 5-day mandatory jail term for any crime of domestic battery in which the perpetrator deliberately injures the victim. The law also makes a second battery crime a felony offense, treating offenders as serious criminals. Additional legislation, signed into law in 2002, includes Senate Bills 716 and 1974. Senate Bill 716 protects domestic violence victims by including dating relationships of six months in the definition of domestic violence laws. Senate Bill 1974 requires judges to inform victims of their rights, including the right to appear, be notified, seek restitution, and make a victim-impact statement. Governor Bush also created the Violence Free Florida campaign to increase public awareness of domestic violence issues [22].

In 2003, Governor Bush signed House Bill 1099, which transferred funding authority of the Florida Domestic Violence Trust Fund from the Department of Children and Families to the Florida Coalition Against Domestic Violence. According to the Domestic Violence in Florida 2010–2011 Annual

Report to the Legislature, this has strengthened domestic violence services provided by streamlining the process of allocating funds [23].

In 2007, the Domestic Violence Leave Act was signed into law by Governor Charlie Crist [21]. This law requires employers with 50 or more employees to provide guaranteed leave for domestic violence issues.

In 2020, the FDLE reported 106,736 domestic violence offenses [8]. In general, domestic violence rates have been declining since 1998. An estimated 19.5% of domestic violence incidents involved spouses and 27.8% involved cohabitants; 11.6% of the victims were parents of the offenders. Domestic violence offenses resulted in the death of 217 victims in Florida in 2020, a number that has been decreasing since 2014 [8]. Domestic violence accounted for 16.9% of the state's murders in 2020 [8].

In their 2019 Annual Report, Fatality Review Teams summarized 31 cases of domestic violence fatalities and near fatalities [49]. The most significant findings included the following observations [49]:

- The perpetrators were predominantly male (94%) with female victims (90%) and had prior criminal histories, non-domestic-violence-related (67%) and for domestic violence specifically (69%).
- In 31% of fatalities, the perpetrators had a known "do not contact" order filed against them, and 13% of perpetrators had a known permanent injunction for protection against them filed by someone other than the victim.
- Substance abuse histories by the perpetrator was identified in 77% of the cases and diagnosed mental health disorders in 45%.
- In most cases, neither the decedent nor perpetrator sought help from the various intervention programs available to them.

To obtain a copy of the most current Florida Statewide Domestic Violence Fatality Review report, please visit https://www.myflfamilies.com/service-programs/domestic-violence/publications.shtml.

IDENTIFYING GROUPS AT RISK FOR DOMESTIC VIOLENCE

Healthcare professionals are in a critical position to identify domestic violence victims in a variety of clinical practice settings. Nurses are often the first healthcare provider a victim of domestic violence will encounter in a healthcare setting and should therefore be prepared to provide care and support for these victims. Although women are most often the victims, domestic violence extends to others in the household as well. For example, domestic violence includes abused men, children abused by their parents or parents abused by their children, elder abuse, and abuse among siblings [3].

Many victims of abuse sustain injuries that lead them to present to hospital emergency departments. Research has found that 49.6% of women seen in emergency departments reported a history of abuse and 44% of women who were ultimately killed by their abuser had sought help in an emergency department in the two years prior to their death [25; 50]. Another study of 993 police-identified female victims of IPV found that only 28% of the women were identified in the emergency department as being victims of IPV [26]. These alarming statistics demonstrate that healthcare professionals who work in acute care, such as hospital emergency rooms, should maintain a high index of suspicion for battering of the patients that they see. Healthcare professionals who work in these settings should work with hospital administrators to establish and institute assessment mechanisms to accurately detect these victims.

For every victim of abuse, there is also a perpetrator. Like their victims, perpetrators of domestic violence come from all socioeconomic backgrounds, races, religions, and walks of life [1; 4]. Accordingly, healthcare professionals should likewise be aware that seemingly supportive family members may, in fact, be abusers.

PREGNANT WOMEN

Because a gynecologist or obstetrician is frequently a woman's primary care physician, the American College of Obstetricians and Gynecologists (ACOG) recommends that all women be routinely assessed for signs of IPV (i.e., physical and psychologic abuse, reproductive coercion, and progressive isolation), including during prenatal visits, and providers should offer support and referral information for those being abused [25]. According to the ACOG, IPV affects as many as 324,000 pregnant women each year [25]. A meta-analysis of 92 independent studies found that the average reported prevalence of emotional abuse during pregnancy was 28.4%, physical abuse was 13.8%, and sexual abuse was 8% [51]. As with all domestic violence statistics, these estimates are presumed to be lower than the actual incidence as a result of under-reporting and lack of data on women whose pregnancies ended in fetal or maternal death. This makes IPV more prevalent among pregnant women than some of the health conditions included in prenatal screenings, including pre-eclampsia and gestational diabetes [25]. Because 96% of pregnant women receive prenatal care, this is an optimal time to assess for domestic violence and develop trusting relationships with the women. Possible factors that may predispose pregnant women to IPV include being unmarried, lower socioeconomic status, young maternal age, unintended pregnancy, delayed prenatal care, lack of social support, and use of tobacco, alcohol, or illegal drugs [25; 51].

The overarching problem of violence against pregnant women cannot be ignored, especially as both mother and fetus are at risk. At this particularly vulnerable time in a woman's life, an organized clinical construct leading to immediate diagnosis and medical intervention will ensure that therapeutic opportunities are available to the pregnant woman and will reduce the potential negative outcomes [29]. Healthcare professionals should also be aware of the possible psychologic consequences of abuse during pregnancy. There is a higher risk of stress, depression, and addiction to alcohol and drugs in abused women. These conditions may result in damage to the fetus from tobacco, drugs, and alcohol and a loss of interest on the part of the mother in her or her baby's health [16; 30]. Possible direct injuries to the fetus may result from maternal trauma [25].

Control of reproductive or sexual health is also a recognized trend in IPV. This type of abuse includes trying to impregnate or become pregnant against a partner's wishes, refusal to use birth control (e.g., condoms, oral contraceptives), or stopping a partner from using birth control [4].

CHILDREN

Children exposed to family violence are at high risk for abuse and for emotional damage that may affect them as they grow older. The Department of Justice estimates that of the 76 million children in the United States, 46 million will be exposed to some type of violence during their childhood [52]. Results of the National Survey of Children's Exposure to Violence indicated that 11% of children were exposed to IPV at home within the last year, and as many as 26% of children were exposed to at least one form of family violence during their lifetimes [31]. Of those children exposed to IPV, 90% were direct eyewitnesses of the violence; the remaining children were exposed by either hearing the violence or seeing or being told about injuries [31]. Of note, according to Florida criminal law, witnessing domestic violence is defined as "violence in the presence of a child if an offender is convicted of a primary offense of domestic violence, and that offense was committed in the presence of a child under age 16 who is a family or household member with the victim or perpetrator" [32].

A number of studies indicate that child witnesses are at increased risk for post-traumatic stress disorder, impaired development, aggressive behavior, anxiety, difficulties with peers, substance abuse, and academic problems than the average child [33; 54; 55]. Children exposed to violence may also be more prone to dating violence (as a perpetrator or a victim), and the ability to effectively cope with partnerships and parenting later in life may be affected, continuing the cycle of violence into the next generation [34; 56].

In addition to witnessing violence, various studies have shown that these children may also become direct victims of violence, and children who both witness and experience violence are at the greatest risk for adverse psychosocial outcomes [53]. Research indicates that between 30% and 65% of husbands who batter their wives also batter their children [27; 35]. Moreover, victims of abuse will often turn on their children; statistics demonstrate that 85% of domestic violence victims abuse or neglect their children. The 2020 Crime in Florida report found that more than 13% of domestic homicide victims were children killed by a parent [8]. Teenage children are also victimized. According to the U.S. Department of Justice, between 1980 and 2008, 17.5% of all homicides against female adolescents 12 to 17 years of age were committed by an intimate partner [36]. Among young women (18 to 24 years of age), the rate is estimated to be 43% in the United States and 8% to 57% globally. Abused teens often do not report the abuse. Individuals 12 to 19 years of age report only 35.7% of crimes against them, compared with 54% in older age groups [28; 37]. Accordingly, healthcare professionals who see young children and adolescents in their practice (e.g., pediatricians, family physicians, school nurses, pediatric nurse practitioners, community health nurses) should have the tools necessary to detect these "silent victims" of domestic violence and to intervene quickly to protect young children and adolescents from further abuse. Without such critical intervention, the cycle of violence will never end.

ELDERLY

Abused and neglected elders, who may be mistreated by their spouses, partners, children, or other relatives, are among the most isolated of all victims of family violence. In a national study conducted by the National Institute of Justice in 2010, 4.6% of participants (community dwelling adults 60 years of age or older) were victims of emotional abuse in the past year, 1.6% physical abuse, 0.6% sexual abuse, 5.1% potential neglect, and 5.2% current financial abuse by a family member [38]. A 2017 study found a self-reported incidence of 11.6% psychological abuse, 2.6% physical abuse, 6.8% financial abuse, 4.2% neglect, and 0.9% sexual abuse [59]. The estimated annual incidence of all elder abuse types is 2% to 10%, but it is believed to be severely under-measured. According to one study, only 1 in 24 cases of elder abuse are reported to the authorities [39].

The prevalence rate of elder abuse in institutional settings is not clear. However, in a 2019 review of nine studies, 64% of elder care facility staff disclosed to having perpetrated abuse against an elderly resident in the past year [40]. In a random sample survey, 24.3% of respondents reported at least one incident of elder physical abuse perpetrated by a nursing home staff member [57].

As healthcare professionals in Florida, which leads the nation in percentage of older residents, it is important to understand that the needs of older Floridians will increase as will the numbers of elder victims of domestic violence. Because elder abuse can occur in family homes, nursing homes, board and care facilities, and even medical facilities, healthcare professionals should remain keenly aware of the potential for abuse. When abuse occurs between elder partners, it is primarily manifested in one of two ways: either as a long-standing pattern of marital violence or as abuse originating in old age. In the latter case, abuse may be precipitated by issues related to advanced age, including the stress that accompanies disability and changing family relationships [39].

It is important to understand that the domestic violence dynamic involves not only a victim but a perpetrator as well. For example, an adult son or daughter who lives in the parents' home and depends on the parents for financial support may be in a position to inflict abuse. This abuse may not always manifest itself as violence but can lead to an environment in which the elder parent is controlled and isolated. The elder may be hesitant to seek help because the abuser's absence from the home may leave the elder without a caregiver [39]. Because these elderly victims are often isolated, dependent, infirm, or mentally impaired, it is easy for the abuse to remain undetected. Healthcare professionals in all settings should remain aware of the potential for abuse and keep a watchful eye on this particularly vulnerable group.

The U.S. Preventive Services Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all older or vulnerable adults.

(https://jamanetwork.com/journals/jama/fullarticle/2708121. Last accessed July 26, 2022.)

Strength of Recommendation: I (Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.)

MEN

Statistics confirm that domestic violence is predominantly perpetrated by men against women; however, there is evidence that women also exhibit violent behavior against their male partners [4]. Studies demonstrate approximately 5% of homicides against men are perpetrated by intimate partners [36]. It is persuasively argued that the impact on the health of female victims of domestic violence is generally much more severe than the impact on the health of male victims [42]. Approximately 512,770 women were raped and/or physically assaulted by an intimate partner in 2008, compared to 101,050 men [58]. In addition, 1 in 4 women has been physically assaulted, raped, and/or stalked by an intimate partner, compared with 1 out of every 10 men [1]. Rape, non-contact unwanted sexual experiences, and stalking against men are primarily perpetrated by other men, while other forms of violence against men were perpetrated mostly by women [5]. Male victims of IPV experienced 3 victimizations per 1,000 boys and men 12 years of age or older in 1994, and this rate decreased by 64%, to 1.1 per 1,000, in 2010 [11]. Of all homicides committed against men between 1980 and 2008, 7.1% were committed by an intimate partner [36]. Although women are more often victims of IPV, healthcare professionals should always keep in mind that men can also be victimized and assess accordingly.

LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER/QUESTIONIONG VICTIMS

Domestic violence exists in lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) communities, and the rates are thought to mirror those of heterosexual women—approximately 25% [43]. However, women living with female intimate partners experience less IPV than women living with men [8]. Conversely, men living with male intimate partners experience more IPV than do men who live with female intimate partners [8]. In addition, 78% of IPV homicide victims reported in 2017 were transgender women or cisgender men [24]. This supports other statistics indicating that IPV is perpetrated primarily by men. A form of abuse specific to the gay community is for an abuser to threaten or to proceed with "outing" a partner to others [41; 43].

Transgender individuals appear to be at particular risk for violence. According to a large national report, transgender victims of IPV were 1.9 times more likely to experience physical violence and 3.9 times more likely to experience discrimination than other members of the LGBTQ+ community [24].

In 2017, an annual national report recorded 52 incidences of hate violence-related homicides of LGBTQ+ people, the highest incident number recorded in its 20-year history [24]. This increasing prevalence of anti-LGBTQ+ violence can exacerbate IPV in LGBTQ+ communities. For example, a person who loses their job because of anti-trans bias may be more financially reliant on an unhealthy relationship. An abusive partner may also use the violence that an LGBTQ+ person experiences from their family as a way of isolating that person further [24].

Because of the stigma of being LGBTQ+, victims may be reticent to report abuse and afraid that their sexual orientation or biologic sex will be revealed. In one study, the three major barriers to seeking help were a limited understanding of the problem of LGBTQ+ IPV, stigma, and systemic inequities [41]. Many in this community feel that support services (e.g., shelters, support groups, crisis hotlines) are not available to them due to homophobia of the service providers. Unfortunately, this results in the victim feeling isolated and unsupported. Healthcare professionals should strive to be sensitive and supportive when working with homosexual patients.

CHARACTERISTICS OF PERPETRATORS OF DOMESTIC VIOLENCE

Abuser characteristics have been studied far less frequently than victim characteristics. Some studies suggest a correlation between the occurrence of abuse and the consumption of alcohol. A man who abuses alcohol is also likely to abuse his mate, although the abuser may not necessarily be inebriated at the time the abuse is inflicted [44]. Domestic violence assessment questionnaires should include questions that explore social drinking habits of both victims and their mates.

Other studies demonstrate that abusive mates are generally possessive and jealous. Another characteristic related to the abuser's dependency and jealousy is extreme suspiciousness. This characteristic may be so extreme as to border on paranoia [12]. Domestic violence victims frequently report that abusers are extremely controlling of the everyday activities of the family. This domination is generally all encompassing and often includes maintaining complete control of finances and activities of the victim (e.g., work, school, social interactions) [12].

In addition, abusers often suffer from low self-esteem and their sense of self and identity is directly connected to their partner [12]. Extreme dependence is common in both abusers and those being abused. Due to low self-esteem and self-worth, emotional dependence often occurs in both partners, but even more so in the abuser. Emotional dependence in the victim stems from both physical and psychologic abuse, which results in a negative self-image and lack of self-worth. Financial dependence is also very common, as the abuser often withholds or controls financial resources to maintain power over the victim [1; 4].

SCREENING FOR DOMESTIC VIOLENCE AND ABUSE

There is no universal guideline for identifying and responding to domestic violence, but it is universally accepted that a plan for screening, assessing, and referring patients of suspected abuse should be in place at every healthcare facility. Guidelines should review appropriate interview techniques for a given setting and should also include the utilization of assessment tools. Furthermore, protocols within each facility or healthcare setting should include referral, documentation, and follow-up. This section relies heavily on the guidelines outlined in the Family Violence Prevention Fund's *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings*; however, protocols should be customized based on individual practice settings and resources available [35]. The CDC has provided a compilation of assessment tools for healthcare workers to assist in recognizing and accurately interpreting behaviors associated with domestic violence and abuse, which may be accessed at https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf [45].

The U.S. Preventive Services Task Force recommends that that clinicians screen for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services.

(https://jamanetwork.com/journals/jama/fullarticle/2708121. Last accessed July 26, 2022.)

Strength of Recommendation: B (There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.)

Several barriers to screening for domestic violence have been noted, including a lack of knowledge and training, time constraints, lack of privacy for asking appropriate questions, and the sensitive nature of the subject [35]. Although awareness and assessment for IPV has increased among healthcare providers, many are still hesitant to inquire about abuse [46]. At a minimum, those exhibiting signs of domestic violence should be screened. Although victims of IPV may not display typical signs and symptoms when they present to healthcare providers, there are certain cues that may be attributed to abuse. The obvious cues are physical. Injuries range from bruises, cuts, black eyes, concussions, broken bones, and miscarriages to permanent injuries such as damage to joints, partial loss of hearing or vision, and scars from burns, bites, or knife wounds. Typical injury patterns include contusions or minor lacerations to the head, face, neck, breast, or abdomen and musculoskeletal injuries. These are often distinguishable from accidental injuries, which are more likely to involve the extremities of the body. Abuse victims are also more likely to have multiple injuries than accident victims. When this pattern of injuries is seen, particularly in combination with evidence of old injury, physical abuse should be suspected [44].

In addition to physical signs and symptoms, domestic violence victims also exhibit psychologic cues that resemble an agitated depression. As a result of prolonged stress, various psychosomatic symptoms that generally lack an organic basis often manifest. For example, complaints of backaches, headaches, and digestive problems are common. Often, there are reports of fatigue, restlessness, insomnia, or loss of appetite. Great amounts of anxiety, guilt, and depression or dysphoria are also typical. Women who experienced IPV are also more likely to report asthma, irritable bowel syndrome, and diabetes [4]. Healthcare professionals should look beyond the typical

ASSESSMENT OF IMMEDIATE SAFETY FOR DOMESTIC VIOLENCE VICTIMS
Are you in immediate danger?
Is your partner at the health facility now?
Do you want to (or have to) go home with your partner?
Do you have somewhere safe to go?
Have there been threats or direct abuse of the child(ren) (if applicable)?
Are you afraid your life may be in danger?
Has the violence gotten worse or is it getting scarier? Is it happening more often?
Has your partner used weapons, alcohol, or drugs?
Has your partner ever held you or your child(ren) against your will?
Does your partner ever watch you closely, follow you or stalk you?
Has your partner ever threatened to kill you, him/herself or your child(ren)?
Source: [35] *Table 1*

symptoms of a domestic violence victim and work within their respective practice settings to develop appropriate assessment mechanisms to detect victims who exhibit less obvious symptoms.

The unique relationship dynamics of the abuser and abused are not easily detected under the best of circumstances. They may be especially difficult to uncover in circumstances in which the parties are suspicious and frightened, as might be expected when a victim presents to the emergency department. The key to detection, however, is to establish a proper assessment tool that can be utilized in the particular setting and to maintain a keen awareness for the cues described in this course. Screening for IPV should be carried out at the entry points of contact between victims and medical care (e.g., primary care, emergency services, obstetric and gynecologic services, psychiatric services, and pediatric care) [35].

The key to an initial assessment is to obtain an adequate history. Establishing that a patient's injuries are secondary to abuse is the first task. Clearly, there will be times when a victim is injured so severely that treatment of these injuries becomes the first priority. After such treatment is rendered, however, it is important that healthcare professionals not ignore the reasons that brought the victim to the emergency department [35].

ASSESSING DOMESTIC VIOLENCE AND ABUSE

Healthcare providers have reported that even if routine screening and inquiry results in a positive identification of IPV, the next steps of assessing and referring are often difficult, and many feel that they are not adequately prepared [46]. According to the Family Violence Prevention Fund, the goals of the assessment are to create a supportive environment, gather information about health problems associated with the abuse, and assess the immediate and long-term health and safety needs for the patient to develop an intervention [35].

Assessment of domestic violence victims should occur immediately after disclosure of abuse and at any follow-up appointments. Assessing immediate safety is priority. Having a list of questions readily available and well-practiced can help alleviate the uncertainty of how to begin the assessment (***Table 1***). If the patient is in immediate danger, referral to an advocate, support system, hotline, or shelter is indicated [35].

If the patient is not in immediate danger, the assessment may continue with a focus on the impact of IPV on the patient's mental and physical health and the pattern of history and current abuse [35]. These responses will help formulate an appropriate intervention.

CULTURALLY SENSITIVE ASSESSMENT

During the assessment process, a practitioner should be open and sensitive to the patient's worldview, cultural belief systems and how he/she views the illness [47]. This may reduce the tendency to over-pathologize or minimize health concerns of ethnic minority patients.

Pachter proposed a dynamic model that involves several tiers and transactions [48]. The first component of Pachter's model calls for the practitioner to take responsibility for cultural awareness and knowledge. The professional should be willing to acknowledge that he/she does not possess enough or adequate knowledge in health beliefs and practices among the different ethnic and cultural groups he/she comes in contact with. Reading and becoming familiar with medical anthropology is a good first step.

The second component emphasizes the need for specifically tailored assessment [48]. Pachter advocates the notion that there is tremendous diversity within groups. For example, one cannot automatically assume that a Cuban immigrant adheres to traditional beliefs. Often, there are many variables, such as level of acculturation, age at immigration, educational level, and socioeconomic status, that influence health ideologies. Finally, the third component involves a negotiation process between the patient and the professional [48]. The negotiation consists of a dialogue that involves a genuine respect of beliefs. It is important to remember that these beliefs may affect symptoms or appropriate interventions in the case of domestic violence.

Culturally sensitive assessment involves a dynamic framework whereby the practitioner engages in a continual process of questioning. By incorporating cultural sensitivity into the assessment of individuals with a history of being victims or perpetrators of domestic violence, it may be possible to intervene and offer treatment more effectively.

INTERVENTIONS FOR DOMESTIC VIOLENCE AND ABUSE

After the assessment is complete, the patient may or may not want immediate assistance or referral. It is important for healthcare providers to assure patients in a nonjudgmental manner that the decision of what they would like in terms of assistance is their choice and that the provider will help regardless of the decisions they are currently ready to make [35].

If the patient would like to immediately implement a plan of action, information for referral to a local domestic violence shelter to assist the victim and the victim's family should be readily available. The acute situation should be referred immediately to local law enforcement officials. Other resources in an acute situation include crisis hotlines and rape relief centers. After a victim is introduced into the system, counseling and follow-up are generally available by individual counselors who specialize in the care of battered women and their spouses and children. These may include social workers, psychologists, psychiatrists, other mental health workers, and community mental health services. The goals are to make the resources accessible and safe and to enhance support for those who are unsure of their options [35].

In Florida, a 24-hour domestic violence hotline is available for toll-free counseling and information. The number is 800-500-1119. The counselors answering the toll-free line may refer the victim to her or his local domestic violence center. A list of Florida certified domestic violence centers organized by county may also be found on the Florida Department of Children and Families website at https://www.myflfamilies.com/service-programs/domestic-violence. Florida's domestic violence centers provide information and referral services, counseling and case management services, a 24-hour hotline, temporary emergency shelter for more than 24 hours, educational services for community awareness relative to domestic violence, assessment and appropriate referral of resident children, and training for law enforcement personnel.

DOCUMENTATION AND FOLLOW-UP

It is imperative that healthcare professionals document all findings and recommendations regarding domestic violence in the victim's medical record, including a patient's denial of abuse, if applicable. If domestic violence is disclosed, documentation should include relevant history, results of the physical examination, findings of laboratory and other diagnostic procedures, and results of the assessment, intervention, and referral. The medical record can be an invaluable document in establishing the credibility of the victim's story when seeking legal aid [35].

Healthcare professionals should offer a follow-up appointment if disclosure of past or current abuse is present. Reassurance that assistance is available to the patient at any time is critical in helping to break the cycle of abuse [35].

Customer Information, Answer Sheet, and Evaluation are located on pages 118–120.

COURSE TEST - #97923 DOMESTIC VIOLENCE: THE FLORIDA REQUIREMENT

This is an open book test. Please record your responses on the Answer Sheet.
A passing grade of at least 70% must be achieved in order to receive credit for this course.
(Social Workers, Counselors, and Therapists must achieve a passing grade of at least 80%.)

This 2 contact hour/credit activity must be completed by July 31, 2025.

1. **Most healthcare professionals will encounter patients in their practice who are victims of domestic violence.**
   A) *True*
   B) *False*

2. **The Florida Department of Children and Families' definition of domestic violence may include pet abuse, physical abuse, and/or emotional abuse.**
   A) *True*
   B) *False*

3. **Florida law defines domestic violence exclusively as spouse abuse or battering.**
   A) *True*
   B) *False*

4. **House Bill 1099 strengthened domestic violence services by streamlining the process of allocating funds.**
   A) *True*
   B) *False*

5. **Domestic violence resulted in 217 deaths in Florida in 2020.**
   A) *True*
   B) *False*

6. **The majority of children exposed to intimate partner violence are direct eyewitnesses.**
   A) *True*
   B) *False*

7. **Domestic violence injury patterns are more likely than accidental injuries to involve the extremities of the body.**
   A) *True*
   B) *False*

8. **In addition to physical signs and symptoms, domestic violence victims may also exhibit psychologic cues that resemble an agitated depression.**
   A) *True*
   B) *False*

9. **Assessment of domestic violence victims should occur immediately after disclosure of abuse and at any follow-up appointments.**
   A) *True*
   B) *False*

10. **Florida does not presently have a toll-free domestic violence hotline, although this was a recommendation of the Governor's Task Force on Domestic Violence.**
    A) *True*
    B) *False*

Be sure to transfer your answers to the Answer Sheet located on pages 119–120
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.

Florida Laws and Rules for Mental Health Professionals

This course fulfills the Florida requirement for 3 hours of Laws and Rules education every third renewal cycle.

Audience
This course is designed for all mental health professionals in Florida, including social workers, therapists, and counselors.

Course Objective
The purpose of this course is to provide basic knowledge of the laws and rules governing the practice of mental health in Florida in order to increase compliance and improve client care.

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

1. Discuss the importance of confidentiality and record keeping for mental health professionals.
2. Describe the legal and ethical boundaries established for supervision in the mental health professions.
3. Identify issues that may arise in the psychotherapist-client relationship.
4. Outline the standards of practice for mental health professionals in Florida.
5. Review disciplinary actions that may be taken against mental health professionals who violate state laws.

Faculty
Dana Friedlander, Esq., PA, is a practicing attorney in Tampa, Florida. She completed her undergraduate education at Vanderbilt University in Nashville, Tennessee, before completing her law studies at University of Florida, College of Law, in Gainesville, Florida. She worked as an Assistant State Attorney in the 13th Judicial District from 1995 to 2003, after which she entered into private practice. Ms. Friedlander is a member of the Florida Bar and the Florida Association of Criminal Defense Lawyers.

Faculty Disclosure
Contributing faculty, Dana Friedlander, Esq., PA, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Senior Director of Development and Academic Affairs
Sarah Campbell

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NetCE designates this continuing education activity for 1 NBCC clock hour.

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Special Approval
This course fulfills the Florida requirement for 3 hours of education on Laws and Rules.

A full Works Cited list is available online at www.NetCE.com. ***Mention of commercial products does not indicate endorsement.***

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INTRODUCTION

The Florida Department of Health and the Florida Legislature have enacted laws and rules to safeguard the public by ensuring that minimum safety requirements are met by every mental health professional practicing in the state. This course presents portions of the Florida Administrative Code (FAC) Division 64B4 and Florida Statutes (FS) Chapter 491, both of which pertain specifically to mental health professions, in addition to sections covering Chapter 456 of the Florida Statutes, which includes general laws for all healthcare professions [1; 2; 3]. These include laws and rules governing standards of practice, licensure and certification, and violations and penalties.

Chapter 491 of the Florida Statutes established the Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling as an authority to adopt rules, develop standards for education programs, and discipline licensees who violate regulations [3]. Professionals who fall below Florida's required minimum competency or who present a danger to clients, coworkers, or others will be prohibited from working in the state. The FAC is a collection of rules set forth by the state's regulatory agencies (e.g., the Department of Health), while the Florida Statutes are a collection of state laws. The Florida Department of Health rules comprise Department 64 of the Administrative Code, and Division 64B4 relates specifically to the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.

The laws and rules discussed in this course have been chosen because they are among the most pertinent and apply specifically to professionals renewing their license. In addition to the benefit to the public, periodically reviewing the laws and rules that govern the profession can help to safeguard against disciplinary action, litigation, and/or termination resulting from unauthorized, inappropriate, erroneous, unethical, or illegal behavior or practice. This course fulfils the requirement of the Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling that board-licensed professionals complete continuing education coursework regarding state laws and rules governing mental health care every third biennium after initial licensure.

CONFIDENTIALITY AND RECORD KEEPING

Confidentiality, the duty to respect privacy, trust, and self-determination, is one of the most important ethical and legal requirements of mental healthcare professions [4; 5]. Confidentiality is a concern in each of the following cases:

- A client refers a friend or family member for treatment.
- Information regarding clinical treatment of a client is overheard.
- Patient records are stolen from a parked car.
- A family member requests information regarding a client's issues.
- A release of records is requested for one member of a couple being seen jointly, and the records contain information about the other member as well.

Violation of confidentiality is not tolerated under ordinary circumstances. However, in certain instances, such as if a client expresses intent to physically harm him- or herself, another individual, or society and that threat is perceived by the professional to be real and imminent, client communications may cease to be privileged. Under Florida law, confidential information can be shared with certain family members, potential victims, law enforcement, and other authorities in these instances.

Confidentiality applies not only to live conversations and their written documentation, but also to all other forms of data storage, including e-mail, audio/video recording, and assessment/test data. Permission to engage in each alternate form of documentation must be granted by the client. All of this documented information becomes part of the client's record, and this record is protected. The following Florida laws and rules pertain to confidentiality and client records [1; 2; 3].

FS 491.0147 Confidentiality and Privileged Communications

Any communication between any person licensed or certified under this chapter and her or his patient or client shall be confidential.

1. This privilege may be waived under the following conditions:
    a. When the person licensed or certified under this chapter is a party defendant to a civil, criminal, or disciplinary action arising from a complaint filed by the patient or client, in which case the waiver shall be limited to that action.
    b. When the patient or client agrees to the waiver, in writing, or, when more than one person in a family is receiving therapy, when each family member agrees to the waiver, in writing.
    c. When a patient or client has communicated to the person licensed or certified under this chapter a specific threat to cause serious bodily injury or death to an identified or readily available person, and the person licensed or certified under this chapter makes a clinical judgment that the patient or client has the apparent intent and ability to imminently or immediately carry out such threat, and the person licensed or certified under this chapter communicates the information to the potential victim. A disclosure of confidential communications by a person licensed or certified under this chapter when communicating a threat pursuant to this subsection may not be the basis of any legal action or criminal or civil liability against such person.
2. This privilege must be waived, and the person licensed or certified under this chapter shall disclose patient or client communications to the extent necessary to communicate the threat to a law enforcement agency, if a patient or client has communicated to such person a specific threat to cause serious bodily injury or death to an identified or readily available person, and the person licensed or certified under this chapter makes a clinical judgment that the patient or client has the apparent intent and ability to imminently or immediately carry out such threat. A law enforcement agency that receives notification of a specific threat under this subsection must take appropriate action to prevent the risk of harm, including, but not limited to, notifying the intended victim of such threat or initiating a risk protection order. A disclosure of confidential communications by a person licensed or certified under this chapter when communicating a threat pursuant to this subsection may not be the basis of any legal action or criminal or civil liability against such person.

CLIENT RECORDS

FS 491.0148 Records

Each psychotherapist who provides services as defined in this chapter shall maintain records. The board may adopt rules defining the minimum requirements for records and reports, including content, length of time records shall be maintained, and transfer of either the records or a report of such records to a subsequent treating practitioner or other individual with written consent of the client or clients.

FAC 64B4-9.001 Requirements for Client Records

1. A licensed clinical social worker, marriage and family therapist, or mental health counselor, including any registered intern or provisional licensee, shall maintain responsibility for all records relating to his clients as provided in Section 456.057 of the Florida Statutes. All such records shall remain confidential except as provided by law or as allowed pursuant to a written and signed authorization by the client specifically requesting or authorizing release or disclosure of records in his office or possession.
2. A full record of services shall be maintained for 7 years after the date of the last contact with the client or user.
3. When a clinical social worker, marriage and family therapist, or mental health counselor terminates practice or relocates and is no longer available to clients or users, the clients or users shall be notified of such termination or relocation and unavailability by the licensee's causing to be published in the newspaper of greatest general circulation in the county in which the licensee practices or practiced, a notice which shall contain the date of termination or relocation and an address at which the licensee's client or user records are available to the client, user, or to a licensed mental health professional designated by the client or user. The notice shall appear at least once a week for 4 consecutive weeks. The records shall be retained for 2 years after the termination or relocation of the practice.
4. If the termination was due to the death of a licensee, records shall be maintained at least two years after the licensee's death. At the conclusion of a 22-month period from the date of the licensee's death, the executor, administrator, personal representative, or survivor shall cause to be published once during each week for 4 consecutive weeks, in the newspaper of greatest general circulation in each county in which the licensee practiced, a notice indicating to the clients or users of the deceased licensee that the licensee's records will be disposed of or destroyed 4 weeks or later from the last day of the final week of publication of the notice.

FS 456.057 Ownership and Control of Patient Records; Report or Copies of Records to be Furnished; Disclosure of Information

1. As used in this section, the term "records owner" means any healthcare practitioner who generates a medical record after making a physical or mental examination of, or administering treatment or dispensing legend drugs to, any person; any healthcare practitioner to whom records are transferred by a previous records owner; or any healthcare practitioner's employer, including, but not limited to, group practices and staff-model health maintenance organizations, provided the employment contract or agreement between the employer and the healthcare practitioner designates the employer as the records owner.
2. As used in this section, the terms "records owner," "healthcare practitioner," and "healthcare practitioner's employer" do not include any of the following persons or entities; furthermore, the following persons or entities are not authorized to acquire or own medical records, but are authorized under the confidentiality and disclosure requirements of this section to maintain those documents required by the part or chapter under which they are licensed or regulated:
   a) Certified nursing assistants
   b) Pharmacists and pharmacies
   c) Dental hygienists
   d) Nursing home administrators
   e) Respiratory therapists
   f) Athletic trainers
   g) Electrologists
   h) Clinical laboratory personnel
   i) Medical physicists
   j) Opticians and optical establishments
   k) Insurance organizations
3. As used in this section, the term "records custodian" means any person or entity that:
   a) Maintains documents that are authorized in subsection (2); or
   b) Obtains medical records from a records owner.
4. Any healthcare practitioner's employer who is a records owner and any records custodian shall maintain records or documents as provided under the confidentiality and disclosure requirements of this section.
5. This section does not apply to facilities licensed under chapter 395 (i.e., hospitals and other licensed facilities).
6. Any healthcare practitioner licensed by the department or a board within the department who makes a physical or mental examination of, or administers treatment or dispenses legend drugs to, any person shall, upon request of such person or the person's legal representative, furnish, in a timely manner, without delays for legal review, copies of all reports and records relating to such examination or treatment, including x-rays and insurance information. However, when a patient's psychiatric, chapter 490 psychological, or chapter 491 psychotherapeutic records are requested by the patient or the patient's legal representative, the healthcare practitioner may provide a report of examination and treatment in lieu of copies of records. Upon a patient's written request, complete copies of the patient's psychiatric records shall be provided directly to a subsequent treating psychiatrist. The furnishing of such report or copies shall not be conditioned upon payment of a fee for services rendered.

7. (a) Except as otherwise provided in this section and in s. 440.13(4)(c), such records may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient, the patient's legal representative, or other healthcare practitioners and providers involved in the patient's care or treatment, except upon written authorization from the patient. However, such records may be furnished without written authorization under the following circumstances:

    1. To any person, firm, or corporation that has procured or furnished such care or treatment with the patient's consent.
    2. When compulsory physical examination is made pursuant to Rule 1.360, Florida Rules of Civil Procedure, in which case copies of the medical records shall be furnished to both the defendant and the plaintiff.
    3. In any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice to the patient or the patient's legal representative by the party seeking such records.
    4. For statistical and scientific research, provided the information is abstracted in such a way as to protect the identity of the patient or provided written permission is received from the patient or the patient's legal representative.
    5. To a regional poison control center for purposes of treating a poison episode under evaluation, case management of poison cases, or compliance with data collection and reporting requirements and the professional organization that certifies poison control centers in accordance with federal law.
    6. To the Department of Children and Families, its agent, or its contracted entity, for the purpose of investigations of or services for cases of abuse, neglect, or exploitation of children or vulnerable adults.

    b) Absent a specific written release or authorization permitting utilization of patient information for solicitation or marketing the sale of goods or services, any use of that information for those purposes is prohibited.

    c) Information disclosed to a healthcare practitioner by a patient in the course of the care and treatment of such patient is confidential and may be disclosed only to other healthcare practitioners and providers involved in the care or treatment of the patient, if allowed by written authorization from the patient, or if compelled by subpoena at a deposition, evidentiary hearing, or trial for which proper notice has been given.

    d) Notwithstanding paragraphs (a)-(c), information disclosed by a patient to a healthcare practitioner or provider or records created by the practitioner or provider during the course of care or treatment of the patient may be disclosed:

        1. In a medical negligence action or administrative proceeding if the healthcare practitioner or provider is or reasonably expects to be named as a defendant;
        2. As part of informal discovery in actions related to medical negligence, pursuant to s. 766.106(6)(b)5.;
        3. As provided for in the authorization for release of protected health information filed by the patient pursuant to s. 766.1065; or
        4. To the healthcare practitioner's or provider's attorney during a consultation if the healthcare practitioner or provider reasonably expects to be deposed, to be called as a witness, or to receive formal or informal discovery requests in a medical negligence action, presuit investigation of medical negligence, or administrative proceeding.

            a. If the medical liability insurer of a healthcare practitioner or provider described in this subparagraph represents a defendant or prospective defendant in a medical negligence action:

                (I) The insurer for the healthcare practitioner or provider may not contact the healthcare practitioner or provider to recommend that the healthcare practitioner or provider seek legal counsel relating to a particular matter.

                (II) The insurer may not select an attorney for the practitioner or the provider. However, the insurer may recommend attorneys who do not represent a defendant or prospective defendant in the matter if the practitioner or provider contacts an insurer relating to the practitioner's or provider's potential involvement in the matter.

(III) The attorney selected by the practitioner or the provider may not, directly or indirectly, disclose to the insurer any information relating to the representation of the practitioner or the provider other than the categories of work performed or the amount of time applicable to each category for billing or reimbursement purposes. The attorney selected by the practitioner or the provider may represent the insurer or other insureds of the insurer in an unrelated matter.

b. The limitations in this subparagraph do not apply if the attorney reasonably expects the practitioner or provider to be named as a defendant and the practitioner or provider agrees with the attorney's assessment, if the practitioner or provider receives a presuit notice pursuant to chapter 766, or if the practitioner or provider is named as a defendant.

8. (a) 1. The department may obtain patient records pursuant to a subpoena without written authorization from the patient if the department and the probable cause panel of the appropriate board, if any, find reasonable cause to believe that a healthcare practitioner has excessively or inappropriately prescribed any controlled substance specified in chapter 893 in violation of this chapter or any professional practice act or that a healthcare practitioner has practiced his or her profession below that level of care, skill, and treatment required as defined by this chapter or any professional practice act and also find that appropriate, reasonable attempts were made to obtain a patient release. Notwithstanding the foregoing, the department need not attempt to obtain a patient release when investigating an offense involving the inappropriate prescribing, overprescribing, or diversion of controlled substances and the offense involves a pain-management clinic. The department may obtain patient records without patient authorization or subpoena from any pain-management clinic required to be licensed if the department has probable cause to believe that a violation of any provision of s. 458.3265 or s. 459.0137 is occurring or has occurred and reasonably believes that obtaining such authorization is not feasible due to the volume of the dispensing and prescribing activity involving controlled substances and that obtaining patient authorization or the issuance of a subpoena would jeopardize the investigation.

2. The department may obtain patient records and insurance information pursuant to a subpoena without written authorization from the patient if the department and the probable cause panel of the appropriate board, if any, find reasonable cause to believe that a healthcare practitioner has provided inadequate medical care based on termination of insurance and also find that appropriate, reasonable attempts were made to obtain a patient release.

3. The department may obtain patient records, billing records, insurance information, provider contracts, and all attachments thereto pursuant to a subpoena without written authorization from the patient if the department and probable cause panel of the appropriate board, if any, find reasonable cause to believe that a healthcare practitioner has submitted a claim, statement, or bill using a billing code that would result in payment greater in amount than would be paid using a billing code that accurately describes the services performed, requested payment for services that were not performed by that healthcare practitioner, used information derived from a written report of an automobile accident to solicit or obtain patients personally or through an agent regardless of whether the information is derived directly from the report or a summary of that report or from another person, solicited patients fraudulently, received a kickback, violated patient brokering provisions, or presented or caused to be presented a false or fraudulent insurance claim, and also find that patient authorization cannot be obtained because the patient cannot be located or is deceased, incapacitated, or suspected of being a participant in the fraud or scheme, and if the subpoena is issued for specific and relevant records.

4. Notwithstanding subparagraphs 1.-3., when the department investigates a professional liability claim or undertakes action, the department may obtain patient records pursuant to a subpoena without written authorization from the patient if the patient refuses to cooperate or if the department attempts to obtain a patient release and the failure to obtain the patient records would be detrimental to the investigation.

b) Patient records, billing records, insurance information, provider contracts, and all attachments thereto obtained by the department pursuant to this subsection shall be used solely for the purpose of the department and the appropriate regulatory board in disciplinary proceedings. This section does not limit the assertion of the psychotherapist-patient privilege

in regard to records of treatment for mental or nervous disorders by a medical practitioner who has primarily diagnosed and treated mental and nervous disorders for a period of not less than 3 years, inclusive of psychiatric residency. However, the healthcare practitioner shall release records of treatment for medical conditions even if the healthcare practitioner has also treated the patient for mental or nervous disorders. If the department has found reasonable cause under this section and the psychotherapist-patient privilege is asserted, the department may petition the circuit court for an in-camera review of the records by expert medical practitioners appointed by the court to determine if the records or any part thereof are protected under the psychotherapist-patient privilege.

9. a) All patient records obtained by the department and any other documents maintained by the department that identify the patient by name are confidential and exempt and shall be used solely for the purpose of the department and the appropriate regulatory board in its investigation, prosecution, and appeal of disciplinary proceedings. The records shall not be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the department or the appropriate board.

   b) Notwithstanding paragraph (a), all patient records obtained by the department and any other documents maintained by the department that relate to a current or former Medicaid recipient shall be provided to the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request.

10. All records owners shall develop and implement policies, standards, and procedures to protect the confidentiality and security of the medical record. Employees of records owners shall be trained in these policies, standards, and procedures.
11. Records owners are responsible for maintaining a record of all disclosures of information contained in the medical record to a third party, including the purpose of the disclosure request. The record of disclosure may be maintained in the medical record. The third party to whom information is disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representative.
12. Notwithstanding the provisions of s. 456.058, records owners shall place an advertisement in the local newspaper or notify patients, in writing, when they are terminating practice, retiring, or relocating and no longer available to patients, and offer patients the opportunity to obtain a copy of their medical record.
13. Notwithstanding the provisions of s. 456.058, records owners shall notify the appropriate board office when they are terminating practice, retiring, or relocating, and no longer available to patients, specifying who the new records owner is and where medical records can be found.
14. Whenever a records owner has turned records over to a new records owner, the new records owner shall be responsible for providing a copy of the complete medical record, upon written request, of the patient or the patient's legal representative.
15. Licensees in violation of the provisions of this section shall be disciplined by the appropriate licensing authority.
16. The Attorney General is authorized to enforce the provisions of this section for records owners not otherwise licensed by the state, through injunctive relief and fines not to exceed $5,000 per violation.
17. A healthcare practitioner or records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section shall charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department when there is no board.
18. Nothing in this section shall be construed to limit healthcare practitioner consultations, as necessary.
19. A records owner shall release to a healthcare practitioner who, as an employee of the records owner, previously provided treatment to a patient, those records that the healthcare practitioner actually created or generated when the healthcare practitioner treated the patient. Records released pursuant to this subsection shall be released only upon written request of the healthcare practitioner and shall be limited to the notes, plans of care, and orders and summaries that were actually generated by the healthcare practitioner requesting the record.
20. The board with department approval, or the department when there is no board, may temporarily or permanently appoint a person or entity as a custodian of medical records in the event of the death of a practitioner, the mental or physical incapacitation of the practitioner, or the abandonment of medical records by a practitioner. Such custodian shall comply with this section. The department may contract with a third party to provide these services under the confidentiality and disclosure requirements of this section.

SUPERVISION

Supervisor/supervisee relationships are an important learning tool for individuals new to their profession and, for individuals who are supervisors, a key part of their ethical duty to clients, colleagues, practice settings, their profession, and society as a whole. In addition to monitoring the welfare of clients and monitoring and evaluating supervisee performance, one of the integral supervisory roles is assuring that supervisees adhere to all applicable state and federal laws [5]. Additionally, supervisors must assure that their own behavior and actions fall within the confines of the laws and rules of Florida and the United States. The following two rules from FAC Chapter 64B4-2 pertain to supervision in the mental health professions [1].

FAC 64B4-2.002 Definition of "Supervision" for Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling

Supervision is the relationship between the qualified supervisor and intern that promotes the development of responsibility, skills, knowledge, attitudes, and adherence to ethical, legal, and regulatory standards in the practice of clinical social work, marriage and family therapy, and mental health counseling. Supervision is contact between an intern and a supervisor during which the intern apprises the supervisor of the diagnosis and treatment of each client, client cases are discussed, the supervisor provides the intern with oversight and guidance in diagnosing, treating, and dealing with clients, and the supervisor evaluates the intern's performance.

1. An intern shall be credited for the time of supervision required if the intern:
    a) Received at least 100 hours of supervision in no less than 100 weeks; and
    b) Provided at least 1,500 hours of face-to-face psychotherapy with clients; and
    c) Received at least 1 hour of supervision every two weeks.
2. The supervision shall focus on the raw data from the intern's face-to-face psychotherapy with clients. The intern shall make the raw data directly available to the supervisor through such means as written clinical materials, direct observation, and video and audio recordings. Supervision is a process that is distinguishable from personal psychotherapy or didactic instruction.
3. The supervisor and intern may utilize face-to-face electronic methods (not telephone only communication) to conduct the supervisory sessions; however, the supervisor and intern must have in-person face-to-face contact for at least 50% of all of the interactions required in paragraph (1) above. Prior to utilizing any online or interactive methods for supervision, the supervisor and the intern shall have at least one in-person face-to-face meeting. The supervisor and the intern are responsible for maintaining the confidentiality of the clients during both in-person and online or interactive supervisory sessions.
4. If an intern obtains group supervision, each hour of group supervision must alternate with an hour of individual supervision. Group supervision must be conducted with all participants present in-person. For the purpose of this section, individual supervision is defined as one qualified supervisor supervising no more than two (2) interns and group supervision is defined as one qualified supervisor supervising more than 2 but a maximum of 6 interns in the group.
5. A qualified supervisor shall supervise no more than 25 registered interns simultaneously.
6. "Face-to-face psychotherapy" for clinical social workers, marriage and family therapists, and mental health counselors registered pursuant to Section 491.0045, F.S., includes face-to-face by electronic methods so long as the registered intern establishes and adheres to the following:
    a) The registered intern has a written telehealth protocol and safety plan in place with their current qualified supervisor which includes the provision that the qualified supervisor must be readily available during the electronic therapy session; and
    b) The registered intern and their qualified supervisor have determined, through their professional judgements, that providing face-to-face psychotherapy by electronic methods is not detrimental to the patient is necessary to protect the health, safety, or welfare of the patient, the registered intern, or both, and does not violate any existing statutes or regulations.
7. Notwithstanding subsections (3) and (4) above a qualified supervisor may utilize face-to-face electronic methods, including telephone only communication, to conduct all supervisory sessions for internship hours if the qualified supervisor determines, through their professional judgment, that such methods are not detrimental to the registered intern's patients and are necessary to protect the health, safety, or welfare of the qualfied supervisor, the registered intern, or both. Any clinical hours obtained via face-to-face psychotherapy by electronic means shall be considered clinical hours for the purpose of meeting internship requirements.
8. No later than 90 days prior to June 30, 2026, the Board shall review and amend, modify, or repeal subsections (6) and (7) above if it determines that same creates barriers to entry for private business competition, is duplicative, outdated, obsolete, overly burdensome, imposes excessive costs, or otherwise negatively impacts the quality of psychotherapy received by Florida citizens.

FAC 64B4-2.003 Conflict of Interest in Supervision

Supervision provided by the applicant's therapist, parents, spouse, former spouses, siblings, children, employees, or anyone sharing the same household, or any romantic, domestic, or familial relationship shall not be acceptable toward fulfillment of licensure requirements. For the purposes of this section, a supervisor shall not be considered an employee of the applicant if the only compensation received by the supervisor consists of payment for actual supervisory hours.

THE PROFESSIONAL RELATIONSHIP

A professional relationship exists when services are provided to clients or patients. In health professions, this relationship is founded on several ethical principles, including autonomy (i.e., self-determination), beneficence (i.e., doing good), competence (i.e., possessing the knowledge and ability to perform services), confidentiality, nonmaleficence (i.e., doing no harm), and veracity (i.e., truthfulness). Judgment must not be impaired by inappropriate relationships; this includes rendering services to family members, close acquaintances, or individuals with prior romantic or sexual involvement [5]. The professional relationship must begin and remain non-exploitive (i.e., not taking advantage of an individual for personal gain). Professional ethical codes address these issues in detail, and the state of Florida has specific laws and rules regarding professional relationships. Most, including those discussed in this course, focus specifically on inappropriate sexual involvement with clients, patients, and supervisees [1; 3].

FAC 64B4-10.003 Psychotherapist-Client Relationship

A psychotherapist-client relationship is established between a psychotherapist and a person once a psychotherapist renders, or purports to render, clinical social work, marriage and family therapy, or mental health services including, but not limited to, psychotherapy, counseling, assessment, or treatment to that person. A formal contractual relationship, the scheduling of professional appointments, and payment of a fee for services are not necessary conditions for the establishment of a psychotherapist-client relationship, although each of these may be evidence that such a relationship exists.

1. Sexual misconduct with a client is prohibited.
2. For purposes of determining the existence of sexual misconduct, the psychotherapist-client relationship, once established, is deemed to continue for a minimum of 2 years after termination of psychotherapy or the date of the last professional contact with the client. However, beyond that 2-year time period, the mere passage of time since the client's last visit with the psychotherapist is not the sole determinative of whether or not the psychotherapist-client relationship has been terminated. Some of the factors considered by the board in determining whether the psychotherapist-client relationship has terminated include, but are not limited to, the following:
    a) Formal termination procedures;
    b) Transfer of the client's case to another psychotherapist;
    c) The length of the professional relationship;
    d) The extent to which the client has confided personal or private information to the psychotherapist;
    e) The nature of the client's problem; and
    f) The degree of emotional dependence that the client has on the psychotherapist.
3. The psychotherapist shall not engage in or request sexual contact with a former client at any time if engaging with that client would be exploitative, abusive, or detrimental to that client's welfare or if the sexual contact is a result of the exploitation of trust, knowledge, influence, or emotions derived from the professional relationship.
4. A client's consent to, initiation of, or participation in sexual behavior or involvement with a psychotherapist does not change the nature of the conduct nor lift the prohibition.

FS 491.0111 Sexual Misconduct

Sexual misconduct by any person licensed or certified under this chapter, in the practice of her or his profession, is prohibited. Sexual misconduct shall be defined by rule.

FAC 64B4-10.002 Definition of Sexual Misconduct

1. It is sexual misconduct for a psychotherapist to engage, attempt to engage, or offer to engage a client in sexual behavior, or any behavior, whether verbal or physical, that is intended to be sexually arousing, including kissing; sexual intercourse, either genital or anal; cunnilingus; fellatio; or the touching by either the psychotherapist or the client of the other's breasts, genital areas, buttocks, or thighs, whether clothed or unclothed.
2. It is sexual misconduct for a psychotherapist to encourage the client to engage in sexual conduct with a third party unless:
    a) Such encouragement is consistent with the planned treatment of the client's specifically diagnosed mental, social, or sexual dysfunctions or disorders; and
    b) Treatment is provided in accordance with generally accepted professional standards for psychotherapy in Florida.

FAC 64B4-10.004 Sexual Misconduct Not Involving Client Contact

1. It is sexual misconduct for a supervisor to engage a supervisee in sexual behavior as defined in Rule 64B4-10.002 FAC, during the period a supervisory relationship exists.
2. It is sexual misconduct for a psychotherapist to engage in sexual behavior as defined in Rule 64B4-10.002 FAC, with any immediate family member or guardian of a client during the period of time psychotherapeutic services are being provided to the client.
3. "Immediate family" shall be defined as spouse, child, parents, parents-in-law, siblings, grandchild, grandparents, and other household members.

STANDARDS OF PRACTICE

A licensed professional offering general (and specific) mental health services must possess the ability, knowledge, and skill to perform them in a manner that is beneficial to clients or patients. This follows the ethical principle of competence. Examples of services that require additional training and qualification include hypnosis, sex therapy, and juvenile sexual offender therapy.

Licensed professionals are required by law to display their credentials at each location where they practice and are required to use their appropriate professional title (e.g., "LMFT" for licensed marriage and family therapist) on all promotional materials (e.g., cards, brochures, stationery, advertisements, signs) naming the licensee [3]. It should be remembered that promotional materials must never include a guarantee that beneficial results from any treatment will be guaranteed [1]. The following sections are drawn from FAC Chapter 64B4-7 and FS Chapter 491 [1; 3].

FAC 64B4-7.002 Qualifications Necessary for Clinical Social Workers, Marriage and Family Therapists, and Mental Health Counselors to Practice Hypnosis

1. Before practicing hypnosis for any therapeutic purpose, a clinical social worker, marriage and family therapist, or mental health counselor shall have successfully completed at least 50 hours of instruction in concepts of and misconceptions of hypnosis induction techniques, contraindications to hypnosis, and the relationships of personality dynamics, psychopathology, and ethical issues to hypnosis. Such instruction must have met the standards for approval of continuing education courses set forth in the FAC and, in addition, must have been taught by qualified teachers.
2. An intern may not practice hypnosis unless practicing under the supervision of a qualified supervisor who has met the requirements to practice hypnosis.

FS 491.0149 Display of License; Use of Professional Title on Promotional Materials

1. (a) A person licensed under this chapter as a clinical social worker, marriage and family therapist, or mental health counselor, or certified as a master social worker shall conspicuously display the valid license issued by the department or a true copy thereof at each location at which the licensee practices his or her profession.

   b) 1. A licensed clinical social worker shall include the words "licensed clinical social worker" or the letters "LCSW" on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the licensee.

   2. A licensed marriage and family therapist shall include the words "licensed marriage and family therapist" or the letters "LMFT" on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the licensee.

   3. A licensed mental health counselor shall include the words "licensed mental health counselor" or the letters "LMHC" on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the licensee.

2. (a) A person registered under this chapter as a clinical social worker intern, marriage and family therapist intern, or mental health counselor intern shall conspicuously display the valid registration issued by the department or a true copy thereof at each location at which the registered intern is completing the experience requirements.

   (b) A registered clinical social worker intern shall include the words "registered clinical social worker intern," a registered marriage and family therapist intern shall include the words "registered marriage and family therapist intern," and a registered mental health counselor intern shall include the words "registered mental health counselor intern" on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the registered intern.

3. (a) A person provisionally licensed under this chapter as a provisional clinical social worker licensee, provisional marriage and family therapist licensee, or provisional mental health counselor licensee shall conspicuously display the valid provisional license issued by the department or a true copy thereof at each location at which the provisional licensee is providing services.

b) A provisional clinical social worker licensee shall include the words "provisional clinical social worker licensee," a provisional marriage and family therapist licensee shall include the words "provisional marriage and family therapist licensee," and a provisional mental health counselor licensee shall include the words "provisional mental health counselor licensee" on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the provisional licensee.

DISCIPLINE

As discussed, it is the intent of these laws and rules to safeguard the public, other professionals, and the professions under the authority of the Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. The rules in FAC Chapter 64B4-5 describe specific offenses that can result in disciplinary action by the board, including fines, probation, and suspension/revocation of licensure [1]. However, in the following section, the fine and punishment schedules for each offence have been omitted. The complete section, including dollar amounts of fines, probationary periods, license suspension times, and offences that can result in license revocation, may be viewed online at https://www.flrules.org/gateway/RuleNo.asp?id=64B4-5.001 [1]. These penalties are in addition to the results of any legal or civil proceedings that may be brought by the state or by clients or other affected parties.

FAC 64B4-5.001 Disciplinary Guidelines

The board has identified actions that warrant disciplinary action, with varying levels of severity depending on the perceived or actual harm resulting from the action and the number of times the licensee has violated the law. These actions include [1]:

- Attempting to obtain, obtaining, or renewing a license by bribery or fraudulent misrepresentation or through an error of the Board or the Department.
- Having a license or certificate to practice a comparable profession or any regulated profession revoked, suspended, or otherwise acted against, including the denial of certification or licensure by another state, territory, or country.
- Being convicted or found guilty, regardless of adjudication, or having entered a plea of *nolo contendere* to a crime in any jurisdiction that directly relates to the practice of the licensee's profession or the licensee's ability to practice that profession.
- False, deceptive, or misleading advertising or obtaining a fee or other thing of value on the representation that beneficial results from any treatment will be guaranteed.
- Advertising, practicing, or attempting to practice under a name other than one's own.
- Maintaining a professional association with any person whom the applicant or licensee knows, or has reason to believe, is in violation of Chapter 491, FS, or of a rule of the Department or this Board.
- Knowingly aiding, assisting, procuring, or advising a non-licensed person to hold oneself out as licensed.
- Failing to perform any statutory or legal obligation placed upon a licensed person.
- Willfully making or filing a false report or record; failing to file a report or record required by state or federal law; willfully impeding or obstructing the filing of a report or record; or inducing another person to make or file a false report or record or to impede or obstruct the filing of a report or record.
- Paying or receiving a kickback, rebate, bonus, or other remuneration for receiving a patient or client or referring a patient or client to another provider of mental healthcare services or to a provider of healthcare services or goods; referring a patient or client to oneself for services on a fee-paid basis when those services are already being paid for by some other public or private entity; or entering into a reciprocal referral agreement.
- Committing any act upon a patient or client that would constitute sexual battery or which would constitute sexual misconduct.
- Making misleading, deceptive, untrue, or fraudulent misrepresentations in the practice of any profession licensed or employing a trick or scheme in or related to the practice of a profession.
- Soliciting patients or clients personally, or through an agent, through the use of fraud, intimidation, undue influence, or a form of over-reaching or vexatious conduct.
- Failing to make available to a patient or client, upon written request, copies of tests, reports, or documents in the possession or under the control of the licensee which have been prepared for and paid for by the patient or client.
- Failing to respond within 30 days to a written communication from the department or the board concerning any investigation by the department or the board, or failing to make available any relevant records with respect to the investigation about the licensee's conduct or background.

- Being unable to practice the profession for which one is licensed with reasonable skill and competence as a result of any mental or physical condition or by reason of illness, drunkenness, or excessive use of drugs, narcotics, chemicals, or any other substance.
- Violating provisions of Florida Statutes Chapter 491 (governing clinical, counseling, and psychotherapy services) or 456 (general provisions governing health professions and occupations)
- Performing any treatment or prescribing any therapy that by the prevailing standards of the mental health professions in the community would constitute experimentation on human subjects, without first obtaining full, informed, and written consent.
- Failing to meet the minimum standards of performance in professional activities when measured against generally prevailing peer performance, including the undertaking of activities for which the licensee is not qualified by training or experience.
- Delegating professional responsibilities to a person whom the licensee knows or has reason to know is not qualified by training or experience to perform such responsibilities.
- Violating a rule relating to the regulation of the profession or a lawful order of the department or the board previously entered in a disciplinary hearing.
- Failure of a licensee to maintain in confidence any communication made by a patient or client in the context of services, except by written permission or in the face of clear and immediate probability of bodily harm to the patient or client or to others.
- Making public statements that are derived from test data, client contacts, or behavioral research and that identify or damage research subjects or clients.
- Having been found liable in a civil proceeding for knowingly filing a false report or complaint with the department or the agency against another licensee.
- Except when explicitly permitted, failing to report to the department any person whom the licensee knows is in violation Florida Statutes or the rules of the department or the board.
- Exercising influence on the client for the purpose of financial gain of the licensee or a third party.
- Improperly interfering with an investigation or inspection authorized by statute or with any disciplinary proceeding.
- Intentionally violating any rule adopted by the board or the department, as appropriate.
- Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities the licensee knows, or has reason to know, the licensee is not competent to perform.
- Violating a lawful order of the department or the board, or failing to comply with a lawfully issued subpoena of the department.
- Failing to comply with the requirements for profiling and credentialing, including, but not limited to, failing to provide initial information, failing to timely provide updated information, or making misleading, untrue, deceptive, or fraudulent representations on a profile, credentialing, or initial or renewal licensure application.
- Using information about people involved in motor vehicle accidents derived from accident reports made by law enforcement officers for the solicitation of the people involved in the accidents.
- Failing to report to the board within 30 days after the licensee has been convicted or found guilty of, or entered a plea of *nolo contendere* to, regardless of adjudication, a crime in any jurisdiction.
- Testing positive for any drug on any confirmed preemployment or employer-ordered drug screening.
- Failing to inform the department of any change of address of either the place of practice or current mailing address of any applicant or licensee.
- Being terminated from a treatment program for impaired practitioners for failure to comply, without good cause, with the terms of the monitoring or treatment contract entered into by the licensee, or for not successfully completing any drug treatment or alcohol treatment program.
- Being convicted of, or entering a plea of guilty or *nolo contendere* to, any misdemeanor or felony, regardless of adjudication, relating to the Medicaid program.
- Failing to remit the sum owed to the state for any overpayment from the Medicaid program pursuant to a final order, judgment, or stipulation or settlement.
- Being terminated from the state Medicaid program, any other state Medicaid program, or the federal Medicare program, unless eligibility to participate in the program from which the practitioner was terminated has been restored.
- Being convicted of, or entering a plea of guilty or *nolo contendere* to, any misdemeanor or felony, regardless of adjudication, a crime in any jurisdiction that relates to healthcare fraud.

- Willfully failing to comply with coverage requirements for services provided by nonparticipating providers, payment collection limitations, or requirements for providing emergency services and care with such frequency as to indicate a general business practice.
- Providing information, including written documentation, indicating that a person has a disability or supporting a person's need for an emotional support animal without personal knowledge of the person's disability or disability-related need.
- Being convicted or found guilty of, entering a plea of guilty or *nolo contendere*, regardless of adjudication, or committing or attempting, soliciting, or conspiring to commit an act that would constitute a violation of the offenses listed in Florida Statute Section 456.074(5) or a similar offense in another jurisdiction.
- Failure to comply with the parental consent requirements when caring for minor children.

In instances when a registrant or applicant is found guilty of any offenses involving fraud or making a false or fraudulent representation, the board shall impose a fine of $10,000.00 per count or offense. Based upon consideration of aggravating and mitigating factors present in an individual case, the board may deviate from the penalties recommended above. The following may be considered aggravating or mitigating factors:

- The danger to the public
- The length of time since the date of the violation(s)
- Prior discipline imposed upon the licensee
- The length of time the licensee has practiced
- The actual damage, physical or otherwise, to the patient
- The deterrent effect of the penalty imposed
- The effect of the penalty upon the licensee's livelihood
- Any efforts for rehabilitation
- The actual knowledge of the licensee pertaining t o the violation
- Attempts by the licensee to correct or stop violations or failure of the licensee to correct or stop violations
- Related violations against the licensee in another state, including findings of guilt or innocence, penalties imposed, and penalties served

CONCLUSION

It is the responsibility of the Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling to enforce the laws and rules regulating the practice of licensees as the law is currently stated—not how individuals may wish the law to be. However, as mental health professionals are affected by these rules and regulations, they have the responsibility to keep informed of regulatory changes and provide public comment regarding regulations. Board meetings are held quarterly and are open to the public; a schedule is available at https://floridasmentalhealthprofessions.gov/meeting-information [6]. The full board meetings include disciplinary cases, petitions, application reviews, correspondence items, rule discussion, and other necessary board action. For more information, please contact the board at 850-488-0595 or https://floridasmentalhealthprofessions.gov.

Customer Information, Answer Sheet, and Evaluation are located on pages 118–120.

TEST QUESTIONS
#71103 FLORIDA LAWS AND RULES FOR MENTAL HEALTH PROFESSIONALS

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

This 3 clock hour activity must be completed by August 31, 2026.

1. Client confidentiality applies to in-person conversations, written documentation, and
- A) *e-mail.*
- B) *assessment/test data.*
- C) *audio/video recording.*
- D) *All of the above*

2. In therapy with more than one family member, confidentiality may be waived
- A) *by the oldest family member.*
- B) *if at least two family members agree to the waiver.*
- C) *if each family member agrees to the waiver verbally.*
- D) *if each family member agrees to the waiver in writing.*

3. A full record of services shall be maintained for how many years after the date of the last contact with the client or user?
- A) *2 years*
- B) *5 years*
- C) *7 years*
- D) *10 years*

4. Which of the following persons are NOT authorized to acquire or own medical records?
- A) *Pharmacists*
- B) *Psychiatrists*
- C) *Social workers*
- D) *Marriage and family therapists*

5. A conflict of interest in supervision exists if the supervisee is
- A) *a student.*
- B) *from another state.*
- C) *older than the supervisor.*
- D) *a former spouse of the supervisor.*

6. Which of the following is a factor considered by the board in determining whether the psychotherapist-client relationship has terminated?
- A) *Formal termination procedures*
- B) *The length of the professional relationship*
- C) *Transfer of the client's case to another psychotherapist*
- D) *All of the above*

7. Which of the following statements regarding sexual misconduct is TRUE?
- A) *Kissing a client is not considered sexual misconduct.*
- B) *Accepting a client's offer of sexual relations is not considered sexual misconduct*
- C) *Verbal comments intended to sexually arouse clients are permitted if the therapy session is over.*
- D) *Under certain instances, such as part of a client's treatment plan during licensed professional sex therapy, encouraging the client to engage in sexual behavior with a third party is allowed.*

8. Sexual misconduct not involving client contact is defined as
- A) *sexual misconduct with coworkers.*
- B) *sexual misconduct outside the workplace.*
- C) *making verbal sexual advances toward a client.*
- D) *sexual involvement between supervisor/supervisee during the time of supervision, and/or sexual contact with any immediate family member or guardian of a client.*

Test questions continue on next page ➞

9. Before practicing hypnosis for any therapeutic purpose, a clinical social worker, marriage and family therapist, or mental health counselor shall have successfully completed how many hours of relevant hypnosis training?

A) 10 hours
B) 50 hours
C) 100 hours
D) 500 hours

10. Which of the following actions by a licensee may result in disciplinary action by the board?

A) Advertising, practicing, or attempting to practice under his or her own name
B) Soliciting patients or clients personally, or through an agent, through the use of fraud, intimidation, undue influence, or a form of over-reaching or vexatious conduct
C) Discontinuing professional association with a person whom the licensee knows is in violation of a rule of the department or board
D) Providing a client, upon written request, copies of tests, reports, or documents in the possession or under the control of the licensee which have been prepared for and paid for by the patient or client

Be sure to transfer your answers to the Answer Sheet located on pages 119–120
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.

Professional Boundaries in Mental Health Care

This course fulfills the Florida requirement for 3 hours of Professional Boundaries and Ethics education.
Need Telehealth? Go online to complete the Telehealth edition of this offer.

Audience
This course is designed for social workers, counselors, and marriage and family therapists in all practice settings.

Course Objective
The purpose of this course is to educate mental health professionals on how to provide compassionate and competent care within the boundaries of appropriate practice.

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

1. Define professional competence.
2. Outline components of the therapeutic relationship.
3. Define empathy and describe the difference between empathy and sympathy.
4. Define transference and countertransference and discuss their implications for the mental health professional.
5. Identify the functions of professional boundaries in the therapeutic relationship and multiple relationships.
6. Discuss the guidance on giving and receiving gifts provided by professional ethics codes.
7. Discuss the legal and ethical considerations of providing distance therapy.

Faculty
Lisa Hutchison, LMHC, has more than 15 years of experience providing individual and group counseling with adults. She specifically focuses on teaching assertiveness, stress management, and boundary setting for empathic helpers. Ms. Hutchison graduated from the University of Massachusetts, Boston, with a Master's degree in education for mental health counseling.

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

Division Planners
Alice Yick Flanagan, PhD, MSW
James Trent, 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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NetCE designates this continuing education activity for 1.5 NBCC clock hours.

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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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- Complete the test questions at the end of the course.
- Return your Customer Information/Answer Sheet and payment to NetCE by mail, or complete online at **www.NetCE.com/FLMHP25**.
- A full Works Cited list is available online at www.NetCE.com.

INTRODUCTION

Mental health professionals can make a significant, positive impact in the lives of those with whom they work, and the practice of therapy can be highly rewarding and gratifying. However, it can also be emotionally demanding, challenging, and stressful. These professionals are at risk for occupational stress from a variety of sources, including [1]:

- The demands of clinical and professional responsibility
- The challenges of managing the client/counselor relationship
- The role characteristics that make counselors prone to burnout (e.g., high level of involvement)
- Vulnerability to vicarious traumatization
- The changing standards and business demands of the profession (e.g., increased documentation requirements, increased intrusion of legal/business concerns into therapeutic practice)
- The intersection of personal and professional demands

Healthy boundaries are a critical component of self-care. Setting boundaries can help counselors manage occupational stressors and maintain the delicate balance between their personal and professional lives. Boundaries also demonstrate competency in clinical practice and help counselors avoid ethical conflicts [2].

Please note, throughout this course the term "counselor" is used to refer to any professional providing mental health and/or social services to clients, unless otherwise noted.

COMPETENCE

Professional associations representing the various fields of clinical practice have codes of ethics that provide principles and standards to guide and protect both the mental health professional and the individuals with whom they work. For example, the American Psychological Association (APA), the American Counseling Association (ACA), the National Association of Social Workers (NASW), the National Board of Certified Counselors (NBCC), and the National Certification Commission for Addiction Professionals (NCCAP) each has an ethics code created to identify core values, inform ethical practice, support professional responsibility and accountability, and ensure competency among its members [3; 4; 5; 6; 7].

Competency is defined as "the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects" [8]. It is the scope of the professional's practice. According to the ethics codes of the APA, the ACA, and the NASW, members are to practice only within their boundaries of competence [3; 4; 5].

THE THERAPEUTIC RELATIONSHIP

Many situations that occur in the counseling office are not written about in textbooks or taught in a classroom setting. Counselors learn through hands-on experience, intuition, ongoing supervision, and continuing education. One constant is the therapeutic relationship. Every therapeutic relationship is built on trust and rapport. Counselors teach their clients what a healthy relationship is through the compassionate care and limit setting that occurs within the therapeutic context. Counselors model acceptable behavior in the office so their clients are equipped to emulate and apply that behavior in the outside world. In many cases, counselors are teaching self-regulation to clients who are learning how to control impulses or regulate behavior in order to improve their connection to other people.

Bandura has described self-regulation as a self-governing system that is divided into three major subfunctions [9]:

- Self-observation: We monitor our performance and observe ourselves and our behavior. This provides us with the information we need to set performance standards and evaluate our progress toward them.
- Judgment: We evaluate our performance against our standards, situational circumstances, and valuation of our activities. In the therapeutic setting, the counselor sets the standard of how to interact by setting limits and upholding professional ethics. The client then compares the counselor's (i.e., "the expert's") modeled behavior with what they already have learned about relationship patterns and dynamics (i.e., referential comparisons).
- Self-response: If the client perceives that he or she has done well in comparison to the counselor's standard, the client gives him- or herself a rewarding self-response. The counselor should reinforce this response by delivering positive reinforcement and affirmation for the newly learned behavior. For example, if the client arrives to therapy habitually late and then makes an effort to arrive on time, the counselor can remark, "I notice that you are working hard to arrive on time for session. That is great." The counselor's positive reinforcement and acknowledgment can have a positive impact on the client's self-satisfaction and self-esteem.

According to Rogers, "individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behavior" [10]. To facilitate a growth-promoting climate for the client, the counselor should accept, care for, and prize the client. This is what Rogers refers to as "unconditional positive regard," and it allows the client to experience whatever immediate feeling is going on (e.g., confusion, resentment, fear, anger, courage) knowing that the professional accepts it unconditionally [10]. In addition to unconditional positive regard, a growth-promoting therapeutic relationship also includes congruence and empathy.

CONGRUENCE

Trust is built and sustained over time through consistent limits that are maintained within the sacred space of each therapeutic hour. When a counselor is observed as consistent and congruent, the client notices. Being authentic is part of being compassionate and empathic. Clients know when a counselor's words and actions do not match. These actions can be overt, such as cutting short the therapeutic time or going over the time allotted. They also can be subtle, as when leaked out and expressed through a stressed vocal tone, facial expression, or other body language indicator (e.g., arms folded across the chest). To the highly aware client, these actions can result in a loss of trust.

Nevertheless, counselors are not perfect and can err from time to time. This is why it is important for counselors to be self-aware, acknowledge when their words and actions do not match, and discuss that within the therapeutic relationship. If a client notices one of these cues of incongruence and expresses it to the counselor, it is essential that the counselor listen openly and validate the client's experience. Any defensiveness on the part of the counselor will decrease relationship trust. Conversely, this admission of human failure can actually build a stronger bond of trust. Clients see that counselors are, like themselves, human and imperfect. This presents an opportunity for clients to learn and then model this type of integrity in their own relationships. "Congruence for the therapist means that he (or she) need not always appear in a good light, always understanding, wise, or strong" [10]. It means that the therapist is his or her actual self during encounters with clients. Without façade, he or she openly has the feelings and attitudes that are flowing at the moment [10]. The counselor's being oneself and expressing oneself openly frees him or her of many encumbrances and artificialities and makes it possible for the client to come in touch with another human being as directly as possible [10]. As discussed, this involves self-observation and self-awareness on the counselor's part.

This does not mean that counselors burden clients with overt expression of all their feelings. Nor does it mean that counselors disclose their total self to clients. It means that the counselor is transparent to the client so that the client can see him or her within the context of the therapeutic relationship [11]. It also means avoiding the temptation to present a façade or hide behind a mask of professionalism, or to assume a confessional-professional attitude. It is not easy to achieve such a reality, as it involves "the difficult task of being acquainted with the flow of experiencing going on within oneself, a flow marked especially by complexity and continuous change" [10].

EMPATHY

There is great power in empathy. It breaks down resistance and allows clients to feel safe and able to explore their feelings and thoughts. It is a potent and positive force for change [10]. Empathy serves our basic desire for connection and emotional joining [12]. Empathy may be defined as the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another. It is a deeper kind of listening in which the counselor senses accurately the feelings and personal meanings that the client is experiencing and communicates this understanding to the client [10]. Empathy is not parroting back the client's words or reflecting only the content of those words. It entails capturing the nuances and implications of what the client is saying, and reflecting this back to the client for their consideration using clear, simply connotative language in as few words as possible [13]. Counselors also can show empathy in nonverbal ways to their clients by, for example, looking concerned, being attentive, leaning forward, and maintaining eye contact [13].

Empathy is a multi-level process of relating to others. It encompasses both an emotive experience and a cognitive one. It includes an intellectual component (namely, understanding the cognitive basis for the client's feelings), and it implies the ability to detach oneself from the client's feelings in order to maintain objectivity [14]. While engaged in empathic listening, mental health professionals should remain responsive to feedback and alter their perspective or understanding of the client as they acquire more information [14]. Empathy may be summarized by the ability to [15]:

- See the world as others see it.
- Be nonjudgmental.
- Understand another person's feelings.
- Communicate your understanding of that person's feelings.

Empathy should not be confused with sympathy, which may be defined as an affinity, association, or relationship between persons wherein whatever affects one similarly affects the other. Compared with empathy, sympathy is a superficial demonstration of care. With sympathy, you feel sorry for the client; with empathy, you feel the client's pain. Although a counselor can get caught up in the client's feelings, he or she should always strive to empathically understand what the client is experiencing while maintaining emotional detachment. This potentially provides a broader perspective that extends beyond the client's situational distress. Mental health professionals want to employ the best tools in order to affect change in their clients without causing harm, and empathy surpasses sympathy in terms of effectiveness. Research has validated the importance of empathy, unconditional positive regard, and congruence for achieving an effective therapeutic relationship [16].

Compassion-focused therapy is a rapidly growing, evidence-based form of psychotherapy that pursues the alleviation of human suffering through psychological science and engaged action [17]. According to Gilbert, the following are attributes of compassion-focused therapy [18]:

- Sensitivity: Responsive to distress and needs; able to recognize and distinguish the feelings and needs of the client.
- Sympathy: Being emotionally moved by the feelings and distress of the client. In the therapeutic relationship, the client experiences the counselor as being emotionally engaged with their story as opposed to being emotionally passive or distant.
- Distress tolerance: Able to contain, stay with, and tolerate complex and high levels of emotion, rather than avoid, fearfully divert from, close down, contradict, invalidate, or deny them. The client experiences the counselor as able to contain her/his own emotions and the client's emotions.
- Empathy: Working to understand the meanings, functions, and origins of another person's inner world so that one can see it from her/his point of view. Empathy takes effort in a way that sympathy does not.
- Nonjudgment: Not condemning, criticizing, shaming, or rejecting. It does not mean nonpreference. For example, nonjudgment is important in Buddhist psychology, which emphasizes experiencing the moment "as it is." This does not mean an absence of preferences.

Empathic Boundaries

Counselors strive to achieve empathy with their clients while maintaining boundaries that protect their own energies. Professionals should "sense the client's private world as if it were [their] own, without ever losing the 'as if' quality," and while not becoming entangled with their perception of the client [10; 19]. It takes work to maintain a healthy distance emotionally while feeling and intuiting what the client is saying.

Too much sympathy, or working with empathy without proper boundaries in the therapeutic relationship, drains the counselor of energy and leads to burnout. In a study of 216 hospice care nurses from 22 hospice facilities across Florida, it was found that trauma, anxiety, life demands, and excessive empathy (leading to blurred professional boundaries) were key determinants of compassion fatigue risk [20]. In other words, there can be too much of a good thing. In order to motivate client change, there should be a limit to the use of empathy in therapy. Empathy is but one tool that a compassionate mental health professional can use to ensure client growth.

TRANSFERENCE AND COUNTERTRANSFERENCE

The term transference was coined by Freud to describe the way that clients "transfer" feelings about important persons in their lives onto their counselor. As Freud said, "a whole series of psychological experiences are revived, not as belonging to the past but applying to the person of the physician at the present moment" [21]. The client's formative dynamics are recreated in the therapeutic relationship, allowing clients to discover unfounded or outmoded assumptions about others that do not serve them well, potentially leading to lasting positive change [22]. Part of the counselor's work is to "take" or "accept" the transferences that unfold in the service of understanding the client's experience and, eventually, offer interpretations that link the here-and-now experience in session to events in the client's past [23]. The intense, seemingly irrational emotional reaction a client may have toward the counselor should be recognized as resulting from projective identification of the client's own conflicts and issues. It is important to guard against taking these reactions too personally or acting on the emotions in inappropriate ways [24]. Therapists' emotional reactions to their patients (countertransference) impact both the treatment process and the outcome of psychotherapy.

REFLECTION

It also is important to be reflective rather than reactive in words and actions. Use of the mindfulness technique can help counselors to become reflective rather than reactive and can help counselors unhook from any triggering material and maintain appropriate limits and boundaries. Reflection demands a reasonable level of awareness of one's thoughts and feelings and a sound grasp of whether they deviate from good professional behavior. Reflection includes [25]:

- A questioning attitude towards one's own feelings and motives
- The recognition that we all have blind spots
- An understanding that staff are affected by clients
- An understanding that clients are affected by staff behavior
- A recognition that clients often have strong feelings toward staff

Clients are more accepting of transference interpretations in an environment of empathy. Transference interpretation is most effective when the road has been paved with a series of empathic, validating, and supportive interventions that create a holding environment for the client [26].

Freud believed transference to be universal, with the possibility of occurring in the counselor as well as the client. He described this "countertransference" as "the unconscious counter reaction to the client's transference, indicative of the therapist's own unresolved intrapsychic conflicts" [27]. Freud felt that countertransference could interfere with successful treatment [22]. Since the 1950s, the view of countertransference has evolved. It is no longer believed to be an impediment to treatment. Instead, it is viewed as providing important information that the professional can use in helping the client [22].

Empathy allows the counselor to experience and thus know what the client is experiencing. Countertransference emerges when the client's transference reactions touch the counselor in an unresolved area, resulting in conflictual and irrational internal reactions [28]. Good indicators of countertransference are feelings of irritability, anger, or sadness that seem to arise from nowhere. Countertransference frequently originates in counselors' unresolved conflicts related to family issues, needs, and values; therapy-specific areas (e.g., termination, performance issues); and cultural issues [29]. When feelings have intensity or when they persist, this is an indicator for future work and healing.

The counselor's work is to bear the client's transferences and interpret them. When the counselor refuses the transference, there is often a mutual projective identification going on, in which both counselor and client project part of themselves onto the other. Refusal may also mean that one of the counselor's own blind spots has been engaged. As Shapiro explains, "a rough edge of our character has been 'hooked' by a bit of what the patient is struggling with, and we act out a bit of countertransference evoked in us by the transference" [30]. In a group therapy setting, family dynamic re-enactments can emerge as transferences. Managing these complex dynamics can raise the counselor's anxiety and mobilize his or her defenses, compromising a usually thoughtful stance. When counselors experience intense reactions in trauma groups that pull them out of the present moment, they should investigate whether they are responding to traumatic content, personal unresolved issues, or individual or collective transference [31]. Counselors who find themselves ruminating about a previous session's content, a client's welfare, or their own issues should talk with a trusted, objective colleague. Countertransference issues for the mental health professional should be resolved apart from the therapeutic environment to avoid burdening and potentially harming clients [27]. One study of countertransference found that therapists' self-reported disengaged feelings over a treatment period adversely impacted the effect of transference work for all patients, but especially for patients with a history of poor, nonmutual, complicated relationships [32].

SELF-AWARENESS

Problems arise when the professional lacks awareness or refuses to devote the necessary time to process the personal emotions and thoughts that arise within the therapeutic relationship. Feelings of anger, grief, jealousy, shame, injustice, trauma, and even attraction can, when they touch a wound from the past, trigger reactions within even experienced professionals. Clients' experiences can replicate the professional's past relationships and trigger emotions that have not been worked on or addressed. If this occurs, the professional can, without disrupting the client's session, make a mental note of the feelings. This allows the professional to attend to the present moment. After the client's session has ended, the professional can arrange to talk to a colleague or supervisor for processing. If the countertransference continues, it may be necessary for the professional to seek counseling. Self-awareness helps the professional to reflect back to the client's true emotions. It also is an important component of training, development, and effectiveness [33]. Mental health professionals need to possess certain values, qualities, and sensitivities, and should be open-minded and have an awareness of their comfort levels, values, biases, and prejudices [34].

As stated in the ethics codes of the ACA [4]:

> Therapists are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors. They respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when their values are inconsistent with the client's goals. They refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner. When they become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance and determine whether they should limit, suspend, or terminate their work-related duties.

BOUNDARIES AND LIMITS

Generally speaking, a boundary indicates where one area ends and another begins. It indicates what is "out of bounds" and acts to constrain, constrict, and limit. In the therapeutic relationship, a boundary delineates the "edge" of appropriate behaviors and helps to rule in and out what is acceptable, although the same behaviors might be acceptable or even desirable in other relationships [35; 36]. Boundaries have important functions in the therapeutic relationship, helping to build trust, empower and protect clients, and protect the professional.

BUILDING TRUST

An inherent power differential exists in the therapeutic relationship between the client, who is placed in a position of vulnerability as she or he seeks help, and the practitioner, who is placed in a position of power because of her or his professional status and expertise [36]. When the client sees the counselor sitting in a chair, with a diploma or licensure on the wall, it can be intimidating. To help mitigate these feelings with the client, it is important to maintain a sense of professionalism while working to build trust and rapport. Part of that professionalism includes setting limits and explaining what they are in the context of therapy.

The familiarity, trust, and intensity of the therapeutic relationship create a powerful potential for abuse that underscores the need for careful attention to the ethical aspects of professional care [36]. Trust is the cornerstone of the therapeutic relationship, and counselors have the responsibility to respect and safeguard the client's right to privacy and confidentiality [4]. Clients have expressed what they believe to be essential conditions for the development of trust in the therapeutic relationship. These include that the clinician [37]:

- Is perceived as available and accessible
- Tries to understand by listening and caring
- Behaves in a professional manner (evidenced by attributes such as honesty in all interactions)
- Maintains confidentiality
- Relates to the client as another adult person rather than as an "expert"
- Remains calm and does not over-react to the issue under discussion

Only when satisfied that the clinician is sufficiently experienced, professional, flexible, and empathic can a foundation for therapy be laid. Clients acknowledge that this takes time and that the trustworthiness of the therapeutic relationship may be tested. If the relationship is perceived to be wanting, clients indicate that they would have difficulty continuing it [37].

THE VALUE OF FLEXIBILITY

Rigid boundaries can negatively reinforce the power differential that exists between the client and the counselor. Rigid boundaries may serve the fears and needs of counselors who are new to the profession and/or concerned with the implications of boundary violations. However, rigid boundaries can lead to harm for the client who perceives that the "rules" are more important than his or her welfare. While rigidity and remoteness on the counselor's part may help ensure that boundaries are intact, they do not accurately reflect the intended role of boundaries in clinical practice. Boundaries should never imply

coldness or aloofness. As stated, clients value flexibility, caring, and understanding. Within conditions that create a climate of safety, flexible boundaries can accommodate individual differences among clients and counselors and allow them to interact with warmth, empathy, and spontaneity [38]. Firm, intractable boundaries may be a comfort to the helping professional; however, fixed rules cannot capture the complex reality of the therapeutic relationship [36].

EMPOWERING AND PROTECTING THE CLIENT

Boundaries and effective limit setting in sessions help to empower and protect clients by teaching and reinforcing the skills they need to become healthy. Boundaries set the parameters and expectations of therapy, so it is important to articulate them in such a way that each client's understanding of them is clear. Counselors should constantly and actively make judgements about where to draw lines that are in the client's best interests [39].

Boundaries begin the moment a client enters the room. Indicate which chair is yours and where it is acceptable for the client to sit. Take note of where your seat is in relation to the door should an emergency arise. Be sure to maintain an appropriate amount of space between yourself and the client. Too much space can feel impersonal and too little can feel invasive. Consider the décor of the setting. Clients may become distracted by the counselor's personal artifacts and family photographs and may place their focus on the counselor rather than on their own therapeutic work. Some clients with poor boundaries may become preoccupied with the counselor's family, which can become a source of transference.

Clients often enter therapy with a history of prior boundary violations (e.g., childhood sexual abuse, domestic violence, inappropriate boundary crossings with another professional) that leave them with persisting feelings and confusion regarding roles and boundaries in subsequent intimate relationships [40]. Consequently, they may test the boundaries as children do. The counselor should recognize these boundary dilemmas and manage them by reiterating the boundaries calmly and clearly [39]. The counselor must also set and maintain boundaries even if the client threatens self-harm or flight from therapy. This can be extremely challenging when faced with a client's primitively motivated, intense demands. However, counselors should recall that one description of the tasks with clients with primitive tendencies is to resist reinforcing primitive strivings and to foster and encourage adult strivings [41]. Winnicott refers to this as a "holding relationship," wherein the counselor acts as a "container" for the strong emotional storms of the client. The act of holding helps reassure the client that the clinician is there to help the client retain control and, if necessary, assume control on his or her behalf [42].

Due to the potential issues and challenges that the client brings to therapy (e.g., cognitive deficits, substance abuse/addictions, memory issues, personality disordered manipulations), it is important to maintain a record of instances when the articulated boundaries and limits have been ignored or violated. For example, a client is habitually late, despite knowing that it is unacceptable to arrive more than 10 minutes late to session. The first instance of a late arrival might simply warrant a reminder of the 10-minute limit, whereas repeated instances would require that the limit be enforced. The clinician who overidentifies with a client might experience a need to do things for the client rather than help the client learn to do things for him- or herself. While this behavior may appear relatively harmless, it suggests overinvolvement with a client and potential boundary problems [43]. Such behavior inhibits the client's ability to learn personal responsibility and how to resolve conflict [44]. It also may impede the reflective and investigative character of an effective helping process [45]. Mental health professionals should take reasonable steps to minimize harm to clients where it is foreseeable and unavoidable [3; 4]. They also should facilitate client growth and development in ways that foster the interest and welfare of the client and promote the formation of healthy relationships [4].

PROTECTING THE PROFESSIONAL

As stated, professional associations that represent the various fields of clinical practice have codes of ethics that provide principles and standards to guide and protect the professional and the individuals with whom they work [3; 4; 5; 6; 7]. Client welfare and trust in the helping professions depend on a high level of professional conduct [3; 4]. Professional values, such as managing and maintaining appropriate boundaries, are an important way of living out an ethical commitment [4].

Some situations in therapy are clear with regard to boundaries (e.g., no sexual relationships with clients). Other situations may be not as clear or may be ambiguous (e.g., receiving gifts from clients). When faced with such situations, professionals should engage in an ethical decision-making process that includes an evaluation of the context of the situation and collaboration with the client to make decisions that promote the client's growth and development [4]. Supervision and colleague support also may be necessary to reach the best decision. Such a process helps clinicians maintain justice and equity and avoid implications of favoritism in dealing with all of their clients [46].

Professionals who deliver services in nontraditional settings, such as those who have home-based practices, face unique challenges related to boundaries and limit setting. As with office-based therapy, some situations cannot be prepared for and will need to be addressed in the moment. While delivering services in nontraditional settings may benefit some clients, when working in homes or residences, the professional is advised to emphasize informed consent, particularly with

regard to therapeutic boundaries. Whenever possible, the impact of crossing boundaries on therapy and on the therapeutic relationship should be considered ahead of time [47].

BOUNDARY CROSSINGS AND VIOLATIONS

A boundary crossing is a departure from commonly accepted practices that could potentially benefit clients; a boundary violation is a serious breach that results in harm to clients and is therefore unethical [48]. Professional risk factors for boundary violations include [49]:

- The professional's own life crises or illness
- A tendency to idealize a "special" client, make exceptions for the client, or an inability to set limits with the client
- Engaging in early boundary incursions and crossings or feeling provoked to do so
- Feeling solely responsible for the client's life
- Feeling unable to discuss the case with anyone due to guilt, shame, or the fear of having one's failings acknowledged
- Realization that the client has assumed management of his or her own case

Denial about the possibility of boundary problems (i.e., "This couldn't happen to me") also plays a significant role in the persistence of the problem [49]. Lack of self-care and self-awareness also can leave the mental health professional vulnerable to boundary crossings and/or violations.

Whatever the reason the professional has to cross a boundary, it is of utmost importance to ensure that it will not harm the client. Each boundary crossing should be taken seriously, weighed carefully in consultation with a supervisor or trusted colleague, well-documented, and evaluated on a case-by-case basis. Intentional crossings should be implemented with two things in mind: the welfare of the client and therapeutic effectiveness. Boundary crossing, like any other intervention, should be part of a well-constructed and clearly articulated treatment plan that takes into consideration the client's problem, personality, situation, history, and culture as well as the therapeutic setting and context [50]. Boundary crossings with certain clients (e.g., those with borderline personality disorder or acute paranoia) are not usually recommended. Effective therapy with such clients often requires well-defined boundaries of time and space and a clearly structured therapeutic environment. Dual or multiple relationships, which always entail boundary crossing, impose the same criteria on the professional. Even when such relationships are unplanned and unavoidable, the welfare of the client and clinical effectiveness will always be the paramount concerns [50].

Some counselors may consider a boundary crossing when it provides a better firsthand sense of the broader clinical context of their client, such as visiting the home of a client that is ailing, bedridden, or dying; accompanying a client to a medically critical but dreaded procedure; joining a client/architect on a tour of her latest construction; escorting a client to visit the gravesite of a deceased loved one; or attending a client's wedding [50]. Many mental health professionals will not cross these boundaries and will insist that therapy occur only in the office. Each professional should operate according to the parameters with which he or she is comfortable. As stated, the best interests of the client, including client confidentiality, and the impact to therapy should be of paramount importance when considering whether to cross a boundary.

To be in the best position to make sound decisions regarding boundary crossings, mental health professionals should develop an approach that is grounded in ethics; stay abreast of evolving legislation, case law, ethical standards, research, theory, and practice guidelines; consider the relevant contexts for each client; engage in critical thinking and personal responsibility; and, when a mistake is made or a boundary decision has led to trouble, use all available resources to determine the best course of action to respond to the problem [51]. The risk management strategy also should include discussions with supervisors, colleagues, and the client. Each step should be documented and should include supervisory recommendations and client discussion regarding the benefits versus the risks of such actions. Although minor boundary violations may initially appear innocuous, they may represent the foundation for eventual exploitation of the client. If basic treatment boundaries are violated and the client is harmed, the professional may be sued, charged with ethical violations, and lose his/her license [52].

MULTIPLE RELATIONSHIPS

Examples of multiple relationships include being both a client's counselor and friend; entering into a teacher/student relationship; becoming sexually involved with a current or former client; bartering services with a client; or being a client's supervisor. Even when entering into a multiple relationship seems to offer the possibility of a better connection to a client, it is not recommended. Multiple relationships can cause confusion and a blurring of boundaries and risk exploitation of the client.

The issue of multiple relationships is addressed by the codes of ethics of mental health professions. According to the APA's ethics code [3]:

> A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person. A psychologist refrains from entering into a multiple relationship if the multiple relationships could reasonably be expected to impair the psychologist's objectivity, competence or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

The ethics code of the NASW (standard 1.06 Conflicts of Interest) defines dual or multiple relationships as occurring "when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively" [5]. It also states that "social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries" [5]. The code further states that it is the professional's responsibility to "be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment" and that counselors should "inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible" [5]. In some instances, this may require "termination of the professional relationship with proper referral of the client" [5].

The ACA ethics code states that [4]:

> Counselors are prohibited from engaging in counseling relationships with friends or family members with whom they have an inability to remain objective. They also are prohibited from engaging in a personal virtual relationship with individuals with whom they have a current counseling relationship (e.g., through social and other media). When a counselor agrees to provide counseling services to two or more persons who have a relationship, the counselor clarifies at the outset which person or persons are clients and the nature of the relationships the counselor will have with each involved person. If it becomes apparent that the counselor may be called upon to perform potentially conflicting roles, the counselor will clarify, adjust, or withdraw from roles appropriately.

Mental health professionals who practice in small, rural communities face special problems in maintaining neutrality, fostering client separateness, protecting confidentiality, and managing past, current, or future personal relationships with clients [53]. Whether the practice is located in a small town or a big city, there will be times when counselors and clients will encounter one another outside the office. To ignore a client who is reaching out in a social setting may cause the client harm. However, it also is important to avoid violating the client's privacy. The best way to minimize the potential awkwardness of such an encounter is to prepare ahead of time. For example, a counselor might incorporate a conversation about such an encounter into the initial evaluation process by telling the client: "If I happen to be at a store or a restaurant and see you, I won't say hello because I respect your confidentiality and want to protect your privacy. However, if you want to smile or say hello to me, I will respond in kind." Explain to the client that the conversation or acknowledgment must be brief to prevent any violation of the client's privacy. After an encounter in public, address the event in your next session, discuss any feelings the client had about the encounter, and note the discussion in the client record. Such an encounter would not fall under the category of dual/multiple relationships unless, for example, the counselor and client went grocery shopping at the same time every week and interacted each time. In this instance, the counselor is advised to change his or her shopping day and/or time in order to avoid risking loss of client confidentiality.

BOUNDARY VIOLATIONS WITHIN MULTIPLE RELATIONSHIPS

Mental health professionals are forbidden to exploit any person over whom they have supervisory, evaluative, or other similar authority. This includes clients/patients, students, supervisees, research participants, and employees [3; 4]. Professional ethics codes outline specific instances of behaviors and actions (some that are expressly prohibited) that have exploitative potential, including [3; 4; 5]:

- Bartering with clients
- Sexual relationships with students or supervisees
- Sexual intimacies with current or former clients
- Sexual intimacies with relatives/significant others of current therapy clients
- Therapy with former sexual partners or partners of a romantic relationship
- Romantic interactions or relationships with current clients, their romantic partners, or their family members, including electronic interactions or relationships
- Physical contact with clients (e.g., cradling or caressing)

There are times when a client has an emotional session and hugs the counselor unexpectedly before leaving the office. This physical contact should be noted in the client's record along with what precipitated it. It should be revisited with the client at the next session, with this discussion recorded in the client's record. While you may prefer no physical contact, you can try to respond positively to the desire for closeness. For example, make personal contact with your hand as you hold the client at a distance, make eye contact, and tell the client that while physical reaching out is positive and welcome, you cannot allow it [10].

The ACA ethics code prohibits sexual and/or romantic counselor/client interactions or relationships with former clients, their romantic partners, or their family members for a period of five years following the last professional contact. This prohibition applies to both in-person and electronic interactions or relationships [4]. The APA ethics code indicates that this period should be "at least two years after cessation or termination of therapy," and that "psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances" [3]. Mental health professionals who choose to engage in relationships with former clients have the burden of demonstrating that there has been no exploitation, in light of all relevant factors [3]. Factors to consider include the amount of time passed since termination of therapy; the client's personal history and mental status; the likelihood of an adverse impact on the client; and statements or actions made by the counselor during therapy suggesting or inviting a possible sexual or romantic relationship with the client [3].

Standards regarding sexual relationships and physical contact also are addressed by the NASW ethics code [5]:

1.09 Sexual Relationships

(a) Social workers should under no circumstances engage in sexual activities, inappropriate sexual communications through the use of technology or in person, or sexual contact with current clients, whether such contact is consensual or forced.

(b) Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers—not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(d) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.

1.10 Physical Contact

Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

The safest course of action is to continue to maintain established boundaries and limits indefinitely after therapy ends. In addition to the noted relevant factors, counselors should keep in mind that the client may return for further treatment. If the counselor has become involved in a business or social relationship with a former client, he or she deprives the client of the opportunity to return for additional treatment. It is vital to be mindful of the potential to exploit the client's vulnerability in a post-termination relationship [54].

Mental health professionals who find themselves attracted to a client should seek supervision around this issue. It is normal for feelings to develop in any type of relational context. It is not the feelings of attraction that are the problem, but rather actions taken. Mental health professionals should never act on these feelings, but instead discuss them with a trusted supervisor or colleague, exploring the possibility of countertransference as well as the potential trigger for the attraction. If the attraction causes intense feelings, it is advisable to seek personal therapy. If the feelings interfere with one's ability to treat a client, the client should be transferred to another professional, and work with the client terminated.

GIFTS

It is not unusual during the course of therapy for a client to present a counselor with a token of appreciation or a holiday gift, and receiving gifts from clients is not strictly prohibited by professional ethics codes. Instead, the ethics codes advise professionals to consider a variety of factors when deciding whether to accept a client's gift.

Section A.10.f (Receiving Gifts) of the 2014 ACA Code of Ethics states that [4]:

> Counselors understand the challenges of accepting gifts from clients and recognize that, in some cultures, small gifts are a token of respect and gratitude. When determining whether to accept a gift from clients, counselors take into account the therapeutic relationship, the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift.

The National Board for Certified Counselors Code of Ethics: Directive #4 provides similar guidance to its members [6]:

> National certified counselors (NCCs) shall not accept gifts from clients except in cases when it is culturally appropriate or therapeutically relevant because of the potential confusion that may arise. NCCs shall consider the value of the gift and the effect on the therapeutic relationship when contemplating acceptance. This consideration shall be documented in the client's record.

In the code of ethics of the Association for Addiction Professionals, Principle I-40: The Counseling Relationship states that [7]:

> Addiction professionals recognize that clients may wish to show appreciation for services by offering gifts. Providers shall take into account the therapeutic relationship, the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift.

As noted in these excerpts, the effect on the therapeutic relationship should be a primary consideration when considering whether to accept a gift. Gifts can mean many things and also can fulfill social functions. The counselor's task is to identify the contextual meaning of the gift and determine when the gift is not merely a gift. To do so, the counselor must draw out from the client information to discern the possibility of a metaphorical or culturally significant meaning for the gift giving [55]. Counselors should consider the client's motivation for gift-giving as well as the status of the therapeutic relationship. Gifts that may seem intended to manipulate the counselor are probably best refused, whereas rejection of a gift intended to convey a client's appreciation may harm the relationship [56].

If the counselor is most comfortable with a "no-gift policy," it is best that the policy be discussed at the beginning of therapy. To wait until a client is presenting a gift to state that it is your policy to decline gifts may harm the client and damage the therapeutic relationship. Clear communication, both written and spoken, of the policy with clients as they enter therapy may help avert difficult later interactions around gifts. If clients have an understanding as they begin therapy what the counselor's approach will be, misunderstandings may be avoided [57]. While restrictive guidelines might be unhelpful, confusion surrounding gifts seems to be exacerbated by a lack of professional discussion about the topic [58].

Many professionals try to keep gifts "alive" throughout client sessions. This often involves putting the gift "on hold" (including decisions about acceptance and rejection) until the best moment for exploration with the client occurs. This allows that gifts given during therapy (where possible) remain part of therapy (i.e., they stay in the room and are available for future sessions) [58]. When considering whether to discuss the gift as part of therapy, the counselor should evaluate pertinent factors, such as the client's time in therapy, the context and frequency of gifts, and client dynamics. While not all gifts warrant full discussion (e.g., those given to show appreciation or of modest financial value), some, such as repeated or expensive gifts, do. Although counselors should be careful not to make too much of a gift, especially those that clients at least initially see as being given simply as a way to say thank you, such conversations may enable both members of the dyad to attain greater insight into the gift's intention and meaning and thereby prove helpful to the continued therapy work [59].

Gifts can range from physical objects, to symbols or gestures. As stated, consider the monetary value of the gift, the client's motivation for giving the gift, and the counselor's motivation for wanting to accept or decline the gift [4; 5; 7]. If there are concerns about any of these factors, it may be best to explore the intent of the gift in session. If a gift is deemed inappropriate, the counselor is advised to decline to accept it. In these cases, counselors should express appreciation for the thought and gesture, explain why they are unable to accept the gift, return it with kindness, and note the encounter in the client's record.

Professionals who work with children have unique challenges regarding gifts. Rejecting a child's gift or trying to explain a "no-gift policy" can cause the child to feel confused or rejected; children do not have the same levels of cognition and understanding that adults have. For play counselors, potential compromises include incorporating the gift into the other materials and toys in the playroom or directly sharing the gift with the child [59]. An important factor affecting the decision to accept a gift is the kind of gift presented by the child. Artwork or something created by the child is an extension of the child and therefore can be viewed as an extension of emotional giving. Accepting non-purchased items (e.g., a flower picked by a child or a child's drawing) would be acceptable in most cases [60].

Clients with personality disorders present unique challenges regarding the issue of gifts. Generally, these clients exhibit manipulation, poor boundaries, and fixed or rigid patterns of relating, and gift giving can be a feature of the clinical picture for such clients. Accepting a gift from such a client may reinforce patterns of manipulative or self-debasing behaviors that are symptomatic of the problematic levels of functioning. In such instances, counselors should discern which course of action is truly in the client's best interests [55].

Often, a small token may be given or received at the termination of therapy for a long-term client. A touchstone that has meaning for the client, such as a meditation CD, book, or greeting card, is appropriate. As with all gifts, the gift and the context in which the gift was given or received should be noted in the client's record, along with your own intent and how you think the client perceived the gift.

TECHNOLOGY AND DISTANCE THERAPY

We live in a rapidly changing world, especially where technology is concerned. In the past, therapy was offered only through in-person interaction in an office setting. Then, gradually, some professionals began to offer telephone sessions. Today, counseling is offered through video conferencing and online message boards, and paper client records are being replaced with electronic records. Competent counseling includes maintaining the knowledge and skills required to understand and properly use treatment tools, including technology, while adhering to the ethical code of one's profession.

The APA has created guidelines to address the developing area of psychologic service provision commonly known as telepsychology [61]. The APA defines telepsychology as the "provision of psychological services using telecommunication technologies. Telecommunication technologies include, but are not limited to, telephone, mobile devices, interactive videoconferencing, email, chat, text, and Internet (e.g., self-help websites, blogs, and social media)" [61]. The APA guidelines are informed by its ethics code and record-keeping guidelines as well as its guidelines on multicultural training, research, and practice. The guidelines allow that telecommunication technologies may either augment traditional in-person services or be used as stand-alone services. The guidelines also acknowledge that telepsychology involves "consideration of legal requirements, ethical standards, telecommunication technologies, intra- and interagency policies, and other external constraints, as well as the demands of the particular professional context" [61]. When one set of considerations may suggest a different course of action than another, the professional should balance them appropriately, with the aid of the guidelines [61]. The complete guidelines are available online at https://www.apa.org/practice/guidelines/telepsychology.

The 2014 ACA Code of Ethics also addresses distance counseling, technology, and social media. It states [4]:

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

The ACA code also addresses legal considerations, informed consent and disclosure, confidentiality, security, and multicultural and disability considerations as they relate to technology.

The NBCC recognizes that distance counseling presents unique ethical challenges to professional counselors; related technology continues to advance and be used by more professionals; and that the use of technology by professionals continues to evolve. In light of this information, the NBCC revised its Internet counseling policy and developed the NBCC Policy Regarding the Provision of Distance Professional Services [62]. This policy replaces previous editions.

The revised policy includes use of the term "distance professional services" to include other types of professional services that are being used more in distance formats. The policy addresses telephone-, email-, chat-, video-, and social network-based distance professional services that may be conducted with individuals, couples, families, or group members. The policy also identifies specific actions that NCCs should take when providing distance services. The policy supplements the directives identified in the NBCC Code of Ethics [6; 62]. The policy is available at https://www.nbcc.org/Assets/Ethics/NBCCPolicyRegardingPracticeofDistanceCounselingBoard.pdf.

According to the NASW ethics code, social work services assisted by technology "include any social work services that involve the use of computers, mobile or landline telephones, tablets, video technology, or other electronic digital technologies [that] includes the use of various electronic or digital platforms, such as the Internet, online social media, chat rooms, text messaging, e-mail and emerging digital applications" [5]. Professionals are advised to "keep apprised of emerging technological developments that may be used in social work practice and how various ethical standards apply to them" [5]. In general, the ethical standards articulated in the NASW Code of Ethics are "applicable to all interactions, relationships, or communications, whether they occur in person or with

the use of technology" [5]. Professionals who are involved in discoverable (by the client) "electronic communication with groups based on race, ethnicity, language, sexual orientation, gender identity or expression, mental or physical ability, religion, immigration status, and other personal affiliations may affect their ability to work effectively with particular clients" [5].

Professionals interested in providing online interventions also should consider the potential for boundary confusion, inappropriate dual relationships, or harm to clients [5]. For example, instant message systems can alert clients each time the professional is online, allowing the client to send chat requests. Clients might access a professional's personal webpage or sign onto online discussion groups to which the professional also belongs. Some may continue to send the professional emails after the termination of the relationship. E-counselors should consider their response to such ongoing contact. Potentially more seriously, clients may use the Internet to harass or stalk current or former counselors [63]. The best way to prevent potential problems is to discuss the boundaries with clients during the initial assessment. Being up front and clear with clients about limits and policies regarding the use of technology and social networking is recommended [64].

Miscommunication is a commonplace occurrence in the online world. Even the simplest things (e.g., punctuation marks) can be misinterpreted. Studies reveal that 7% of any message is conveyed through words, 38% through certain vocal elements, and 55% through nonverbal elements (e.g., facial expressions, gestures, posture) [65]. Some technology-based forms of communication can result in the loss of important nonverbal and vocal cues, leading to an increased risk for miscommunication between client and counselor. Interactive communication, such as texting and email, involves the loss of nonverbal social cues that provide valuable contextual information and interpretation of meaning. Loss of these physical social cues may also increase the client's tendency to project personal psychologic material onto the blankness of the communication. While this may be helpful in some forms of psychotherapeutic interventions and it may offer advantages over in-person communication, it also presents a potential risk for increased miscommunication [63].

The compassionate professional strives to communicate nonverbally to clients that he or she is listening to and in the moment with the client. Physical cues, such as nodding and eye contact, have been shown to be positively associated with the degree that clients feel the counselor is respectful and genuine [66; 67]. Much attention also is paid to the voice, as it carries the verbal message and people often believe the voice to be a more reliable indicator of one's true feelings [68]. Because research exploring how empathy is experienced in an online environment is minimal, counselors should check with their clients to determine if the empathy is being transmitted in their text-based communications [10].

No matter what type of counseling is offered, a thorough initial evaluation should be completed to assess whether a client is appropriate for distance counseling. Practicing within recommended guidelines does not release counselors from the personal responsibility to be aware of, and to independently evaluate, the variety of ethical issues involved in the practice of online therapy [63]. Certain clients (e.g., those with suicidal, homicidal, or substance abuse history, clients with personality disorders) would not be suited to online therapy.

LEGAL AND ETHICAL CONSIDERATIONS

The challenges of online therapy lead to legal and ethical concerns associated with the delivery of mental health services via the Internet. Those opposed to online or distance therapy worry about licensure issues related to doing therapy across jurisdictional boundaries, legal responsibility in the event of a crisis, and the appropriateness of client anonymity [69].

Providing services across state lines is one of the biggest unresolved issues. Although communication technologies allow counselors to reach clients anywhere, state licensing laws generally do not permit out-of-state counselors to provide services via these methods. Some states offer guest licensure provisions, but most states require that the counselor hold a license in his or her own state and in the client's state. Providing distance therapy within one's own state is simpler, and it allows mental health professionals to reach people who would not otherwise have access to services (e.g., rural residents, people with certain disabilities) as well as those who want to receive services from home. To confidently provide distance services [70]:

- Abide by all applicable licensing requirements and professional standards of care.
- Understand the technology being used.
- Periodically check your state legislature's website for the latest telehealth laws and regulations.
- Check for a board policy statement that provides guidance on telepractice.
- Check whether your state licensing board has issued policies related to telepractice.
- Confirm that telehealth services (both in-state and across jurisdictional lines) are covered under your malpractice policy.

The COVID-19 public health emergency increased demand for mental and behavioral health services while driving most of those services to telehealth platforms. In response to this, in 2020, the APA led a campaign to maximize the availability of telepsychology services [71]. In March 2020, the federal government designated psychologists as critical, essential workers, and the Centers for Medicare and Medicaid Services (CMS) improved access to care for Medicare beneficiaries. CMS issued further guidance to waive key telehealth requirements. Because the new legislation cannot supersede state licensing laws (e.g., those that prohibit psychologists from using telehealth to provide services across state lines), the APA drafted letters to governors in all 50 states urging them to temporarily suspend state licensing laws and regulations regarding telepsychology services to ensure continuity of care. Within weeks of receiving the APA letter [71]:

- 12 states issued executive orders calling for expansion of telehealth service rates.
- 14 states issued executive orders allowing patients to receive telehealth services in their own homes.
- 16 states temporarily lifted licensing requirements.
- 22 states either expanded their policies for out-of-state providers to temporarily practice in their states or instituted emergency expedited registration for out-of-state providers.

SOCIAL MEDIA

With the advent of social media, clients can now search for and find the Facebook or Twitter page of their counselor, if one exists. Counselors who accept a client's "friend request" are in essence agreeing that the counselor and client are now friends, creating a multiple relationship. As discussed, when clients have access to their counselor's social media sites, both intentional and unintentional self-disclosures can occur. Modern social networking systems (e.g., Facebook, Instagram) exemplify intentional self-disclosure without a particular client focus. In contrast, Internet search engines (e.g., Google, LexisNexis) may allow unintended disclosure of personal details of the professional's life. Professionals should be aware and cognizant of social media involvement, including what information is public. Many sites offer ways to post minimal information if a connection to other professionals is desired. Avoid posting a profile photo that includes your family or other personal details, as these are public [72].

CONCLUSION

Competent counselors are well-educated and well-versed in the ethics of their profession. They understand that trust is built over time in the therapeutic relationship, with the help of limits and boundaries, and that it is reinforced by empathic response. Competent, compassionate professionals are both self- and other-aware and able to seek appropriate supervision and consultation when necessary. They establish self-care boundaries in order to protect their own compassionate, empathic response as well as their physical, emotional, and spiritual well-being. This enables counselors to most effectively help their clients.

RESOURCES

American Association for Marriage and Family Therapy Code of Ethics
https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx

APA Ethical Principles of Psychologists and Code of Conduct
https://www.apa.org/ethics/code

ACA Code of Ethics
https://www.counseling.org/resources/aca-code-of-ethics.pdf

NAADAC Code of Ethics
https://www.naadac.org/code-of-ethics

NBCC Code of Ethics
https://www.nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf

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

Customer Information, Answer Sheet, and Evaluation are located on pages 118–120.

TEST QUESTIONS
#77560 PROFESSIONAL BOUNDARIES IN MENTAL HEALTH CARE

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

This 3 clock hour activity must be completed by October 31, 2026.

1. Competency is defined as
- A) *the educational level of a therapist.*
- B) *the extent to which a therapist understands all of the cultural and social pressures in his or her clients.*
- C) *the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects.*
- D) *None of the above*

2. Which of the following statements regarding therapeutic relationships is FALSE?
- A) *Every therapeutic relationship is built on a legally binding contract.*
- B) *Counselors teach their clients what a healthy relationship is through the compassionate care and limit setting that occurs within the therapeutic context.*
- C) *Counselors model acceptable behavior in the office so their clients are equipped to emulate and apply that behavior in the outside world.*
- D) *In many cases, counselors are teaching self-regulation to clients who are learning how to control impulses or regulate behavior in order to improve their connection to other people.*

3. Which of the following is NOT one of the major sub-functions of self-regulation, as defined by Bandura?
- A) *Judgment*
- B) *Self-response*
- C) *Self-observation*
- D) *Cultural competence*

4. A growth-promoting therapeutic relationship consists of all of the following, EXCEPT:
- A) *Empathy*
- B) *Congruence*
- C) *Negative reinforcement*
- D) *Unconditional positive regard*

5. Which of the following best describes the concept of empathy?
- A) *Repeating back a client's words*
- B) *Reflecting only the content of a client's words*
- C) *An affinity, association, or relationship between persons wherein whatever affects one similarly affects the other*
- D) *Understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another*

6. While engaged in empathic listening, counselors should
- A) *remain judgmental.*
- B) *not respond to feedback.*
- C) *keep a distance from the experiences being expressed by the client.*
- D) *alter their perspective of the client as they acquire more information.*

7. Which of the following is one of the attributes of compassion-focused therapy?
- A) *Empathy*
- B) *Sensitivity*
- C) *Nonjudgment*
- D) *All of the above*

8. Reflection demands a reasonable level of awareness of one's thoughts and feelings and a sound grasp of whether they deviate from good professional behavior.
- A) *True*
- B) *False*

9. Clients are more accepting of transference interpretations in an environment of
- A) *empathy.*
- B) *judgment.*
- C) *group therapy.*
- D) *vicarious trauma.*

Test questions continue on next page ➞

10. In the therapeutic relationship, a boundary
- A) *helps to determine what is acceptable.*
- B) *delineates the "edge" of appropriate behaviors.*
- C) *clearly defines what is appropriate with every client at every time.*
- D) *Both A and B*

11. Which of the following clinician attributes has been identified by clients as essential for the development of trust in the therapeutic relationship?
- A) *Is not readily available*
- B) *Maintains confidentiality*
- C) *Relates to the client as an "expert"*
- D) *Reacts strongly to every issue under discussion*

12. All of the following factors indicate a history of prior boundary violations, EXCEPT:
- A) *Divorce*
- B) *Domestic violence*
- C) *Childhood sexual abuse*
- D) *Intimate relationship with a previous counselor*

13. Which of the following is a professional risk factor for boundary violations?
- A) *Crises in one's own life*
- B) *Feeling solely responsible for a client's life*
- C) *Feeling unable to discuss the case with anyone*
- D) *All of the above*

14. All of the following behaviors/actions have strong exploitative potential, EXCEPT:
- A) *Referrals*
- B) *Bartering with clients*
- C) *Physical contact with clients*
- D) *Sexual relationship with supervisee*

15. The safest course of action to prevent boundary violations within multiple relationships is to
- A) *retain clients after a romantic relationship is initiated.*
- B) *keep meticulous notes about interactions in the client's record.*
- C) *maintain established boundaries and limits indefinitely after therapy ends.*
- D) *wait two years before initiating a personal or business relationship with a client.*

16. When considering whether to accept a gift from a client, the primary consideration should be
- A) *sentimentality.*
- B) *the monetary value of the gift.*
- C) *your personal need for the gift.*
- D) *the effect on the therapeutic relationship.*

17. Which of the following should be considered when deciding what action to take when a client gives a gift?
- A) *The monetary value of the gift*
- B) *The client's motivation for giving the gift*
- C) *The counselor's motivation for wanting to accept or decline the gift*
- D) *All of the above*

18. For which of the following reasons do clients with personality disorders present unique challenges regarding the issue of gifts?
- A) *Gift giving is outside of the usual clinical picture for such clients.*
- B) *Gifts from such clients are considered an extension of emotional sharing.*
- C) *Generally, these clients exhibit manipulation, poor boundaries, and fixed or rigid patterns of relating.*
- D) *Accepting a gift from such a client may contradict patterns of manipulative or self-debasing behaviors that are symptomatic of the problematic levels of functioning.*

19. Competent counseling includes maintaining the knowledge and skills required to understand and properly use treatment tools, including technology.
- A) *True*
- B) *False*

20. According to the ACA Code of Ethics, the profession of counseling is limited to in-person, face-to-face interactions.
- A) *True*
- B) *False*

Be sure to transfer your answers to the Answer Sheet located on pages 119–120
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.

Movement and Dance in Psychotherapy

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

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

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

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

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

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

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Sarah Campbell

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EVIDENCE-BASED PRACTICE RECOMMENDATION

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

INTRODUCTION

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

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

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

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

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

FOUNDATIONS: MOVEMENT AND HEALING

A MULTICULTURAL VIEW OF MOVEMENT AS A HEALING ART FORM

Eye movement desensitization and reprocessing (EMDR) is one of the most popular and researched therapies in the treatment of PTSD. In brief review, the therapy makes use of back-and-forth eye movements, audio tones, or tapping (of the feet, legs, or arms) to induce emotional and somatic processing more expeditiously. For dancers or drummers, as well as EMDR practitioners, the idea of EMDR and its bilateral mechanism of action makes a great deal of sense. In many Native American traditions, drumming and dancing, typically done in communal ceremony, have been the two most used approaches to treat warriors returning from battle.

Many similarities exist in cultures on the Asian continent, from which the tribal nations of North America share a common origin. Traditions of dance as emotional empowerment or communal gathering occur globally: the Haka, a dance of the Maori of New Zealand, the Umoya of South Africa, and even the bouncy circle dances or *kolos* of Slavic traditions are known to many, even in the modern era.

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

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

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

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

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

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

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

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

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

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

EARLY IDEAS ON MOVEMENT IN THE HELPING AND DANCE PROFESSIONS

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

Alexander Lowen

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

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

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

Fritz Perls

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

The Gestalt therapist is actively involved with the client, often engaging in their own disclosure, unlike the distance established in psychoanalysis [10]. The Gestalt therapist uses an active array of methods to engage the client, including promoting body awareness and making use of behavioral tools, like movement. Experimentation is encouraged to ultimately allow the client to work through unfinished trauma or issues. Yontef and Jacobs identify Gestalt psychotherapy as the first truly holistic approach to Western psychotherapy, making use

of affective, sensory, interpersonal, and behavioral components [10]. The Gestalt approach draws from existential, humanistic, and Zen philosophy, and it can be common for a Gestalt session to work with body alignment, awareness, and movement. It is also common for Gestalt psychotherapists to also work with dance or movement modalities. For an example of a therapist who is integrating the two because of their obvious overlap, visit https://gestaltdance.com.

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

Moshé Feldenkrais

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

F.M. Alexander

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

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

Florence Noyes

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

Martha Graham

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

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

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

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

MARIAN CHACE AND THE DISCOVERY OF DANCE AND MOVEMENT THERAPY

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

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

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

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

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

THE CONSCIOUS DANCE MOVEMENT

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

As noted, Gabrielle Roth is generally credited as the mother of the conscious dance movement. Like Lowen, Perls, and Feldenkrais, much of her work is traced to the Esalen Institute in Big Sur, California. She developed her own practice, which is now called 5Rhythms, because she was asked to put together a movement program for residents and retreatants at the institute while she resided there. In one of her books, *Sweat Your Prayers: Movement as Spiritual Practice*, Roth wrote (in describing her early years of developing the practice): "Sometimes two

hours of moving are as powerful as two years on the couch. I discovered that the body can't lie; put it in motion and the truth kicks in" [5].

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

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

THE IMPACT OF MOVEMENT ON HEALING

REFLECTION

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

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

A BRIEF PRIMER ON UNHEALED TRAUMA AND THE LIMBIC BRAIN

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

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

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

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

help, support, or validation sooner rather than later can assist a person with this process of integration, thus decreasing the chances of long-term consequences.

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

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

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

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

To summarize, when the limbic brain is activated, the prefrontal lobes are not. For optimal healing to occur, all three brains must be able to work together. Neurologically, unprocessed trauma creates disconnection in the brain. However, it is important to keep in mind that complex interventions are not necessary to encourage whole-brain interaction. Consider that deep breathing is a whole-brain intervention. Breath originates in the primal, reptilian region of the brain. Any movement-based or body-based intervention automatically works with the limbic and reptilian brains. The action parts of one's experience (and conversely the inaction or freeze responses that can result from unhealed trauma) are regulated by the limbic brain and brain stem. Thus, some of the most basic interventions for healing involve taking action.

HOW MOVEMENT AND RITUAL ENHANCE HEALING

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

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

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

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

THE ROLE OF MINDFULNESS, MOVEMENT, AND YOGA

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

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

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

Strength of Recommendation: Neither for nor against

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

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

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

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

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

Since the early 2000s, the field of traumatic stress studies has taken special notice of mindfulness and other Eastern practices like yoga and the martial arts as healing channels. A major reason for this interest relates to neurobiology. Mindfulness practices play a key role in activating the prefrontal cortex and promoting a greater sense of concentration; concentration problems are common among trauma survivors, with the DSM-5-TR identifying them as a heightened arousal symptom [22; 23]. Mindfulness can calm a client's inner experience and promote greater introspection, an important feature considering that disorganized memory structure may be one process that impedes access to, and modification of, trauma-related cognitive schema [24; 25]. Structured mindfulness practice can cause positive structural changes in the brain related to learning and memory (hippocampus) and can cause a thinning

in the amygdala, lessening the charge of fear-based responses [26; 27]. There is also evidence that mindfulness meditation practices lead to decreases in ruminative thinking, alter the neural expression of sadness, positively influence change in neural activity, and positively impact working memory capacity and affective experience [28; 29; 30; 31].

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

Considerations for Clients Who Fear the Body/Movement

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

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

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

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

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

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

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

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

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

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

SIMPLE MOVEMENT TECHNIQUES IN CLINICAL WORK

REFLECTION

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

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

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

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

This section will explore other simple movement activities that correspond well with time-honored counseling and recovery techniques. Specific instructions are given to guide. Clinicians are encouraged to weave them into work with clients in whatever order may make sense. It can also be helpful to try these strategies yourself first, as you read this course. The key to being able to effectively pass these techniques along to clients, whether in an individual context or in a group setting, is to make sure that you have tried and understand the motions.

CLENCH-AND-RELEASE TECHNIQUE/ PROGRESSIVE MUSCLE RELAXATION

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

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

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

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

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

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

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

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

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

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

BILATERAL MOVEMENTS FOR STRETCHING AND CLEANSING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Rub your hands together for at least 30 seconds (or longer if you want). Really work up some heat!

- Pull your hands apart and bring them to your forehead. You can close your eyes, and place the base of your palms over your eyes; let the rest of your hands curl over your forehead to the top of the forehead. Or you can rest the base of your palms on your cheeks and go around your eyes. Choose a variation that is comfortable and helps facilitate relaxation.
- Settle in and feel the energy you generated in your hands move into your brain. Just allow the head to exist without judgement.
- Hold as long as you like.

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

Other options and variations on this core exercise include:

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

USING HAND GESTURES AND POSTURING FOR TEACHING NEW BEHAVIORS

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

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

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

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

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

Case Example

Client A presents to therapy with several goals, one of which is improved, positive assertiveness in her work setting. The client reports a high degree of stress about an abusive boss. Even after many years in his employ, she continually struggles with feeling heard by him, and she knows that the power dynamic he casts is reminiscent of how she related to a previous spouse with alcohol use disorder. Although she identifies that these older wound issues will need to be addressed and healed later in therapy, her therapist begins, during stabilization, to help her develop some skills to better cope in her work setting.

The therapist asks Client A if she is sitting or standing during these difficult conversations with her boss. She replies that he always summons her into his office and that the available chair is lower than the boss's own. When the therapist asks her to visualize herself in this scenario and recall how it makes her feel, she reports that she feels small in his presence, and because of that, she has a natural tendency to curl or cower inward. Inspired by work with trauma-informed chair yoga, the therapist/client dyad spends some time in the session working on how to sit with confidence: sitting forward in the chair so that her feet can remain firmly planted and grounded on the floor, spine upright and straight, shoulders relaxed away from her ears. In the first part of the exercise, Client A simply practices this posture, specifically practicing coming into it from her natural position, which is to sit back in the big chair and cower inward while her shoulders are spiking up toward her ears. After the client feels confident with the posture, she then visualizes sitting in this more confident posture while in her boss's presence. As a homework assignment, the therapist advises her to practice coming into this seated posture every day, pairing it with some of the breath exercises, other safeguard visualizations, and other positive affirmations she is learning in her therapy/healing. When it comes time to actually speak to her boss again, Client A is able to use this simple shift in her posture, which she reports allows her to speak more confidently and feel less affected by the boss's natural critical countenance.

SITTING AND STANDING WITH INTENTION

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

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

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

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

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

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

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

- Begin with a healthy inhale with your nose that allows the belly to expand as fully as possible.
- Exhale vigorously, allowing the tongue to hang out. Feel the jaw and cheeks loosen. Open the eyes widely and let them roll back slightly to help with the sensation of letting go.

- Try at least three to five sets, taking time to adjust to the level of your physical comfort. With each set, see if you can allow your tongue to hang out further. Bring your hands up like lion paws to fully get into the character of the breath.

Following attempt of this exercise, individuals should experience a loosening in the jaw on both sides. We often discuss how important it is to stretch the joints, but the jaw, one of the most powerful joints in the human body, tends to be overlooked. It is often said that when a trauma or other stressor has silenced someone, it is felt somatically through jaw pain or throat tension. Doing an exercise like lion breathing, and practicing it with consistently, is a way to promote movement in the somatic and energetic body and resultantly serve as an aid in building confidence. After teaching lion breathing in the office setting, clients can be advised to craft a few minutes each day where they can practice the exercise on their own. As a variation option, adding a musical track that one finds empowering can take the exercise to a new dimension. Although going into a difficult conversation with a boss or other person while doing lion breathing is generally not advised, taking a few minutes to do some lion breaths before going into these types of interactions can make a significant difference.

With lion breathing or any of the strategies, you never want to engage in them to the point of physical pain. Hence, starting with a simple one or two sets of the breath is generally advised until you see how well a person will tolerate the technique. The same spirit of encouraging clients to listen to their body's own limits must also be taken into the next series of exercises.

RITUAL MOVEMENTS FOR LETTING GO AND RELEASE

There can be healing power for many in both ritual and ceremony. For many indigenous cultures, the idea of helping a person to heal without involving ceremony would not be possible. Although one could argue that there is a certain ceremony to the process of coming to an office and sitting down in the therapist's chair, it is a ceremony that has become more of a mindless ritual in modern society. For clinicians committed to bringing in more creativity and movement into their practice of psychotherapy, the essential question is: How can I make the process more dynamic and engaging for my clients?

REFLECTION

Scan your memory of your practice. What are some of the memories that stick out to you about when you've worked with the client to come up with a creative solution to a problem at hand? What role did creativity, specifically invoking some type of ritual or ceremony, play in that solution? Take time to make notes of how these approaches might inform work with your current clients.

A time-honored psychotherapy technique from the Gestalt tradition is the unsent letter technique. In this process, a person writes, in letter form, everything that s/he would like to say to a person who was a source of trauma or offense. When making use of this technique, clients are encouraged to get it all out—avoid censoring language or judging emotional content. Assuming that the client is stable and ready enough to handle this process, they should be supported in really letting it all out. Together, after they've released the emotions through the physical process of writing, devise a method for best releasing the unsent letter. This is where movement, ceremony, and ritual can be introduced to enhance the process. Some people choose to rip their letters up and leave them in the trash bin in the office (again, symbolizing letting go and leaving it behind), whereas others may choose to burn the letter, noticing the rising smoke as a symbolic releasing of the pain in the letter to God/Higher Power/nature. Others may choose to leave unsent letters at a cemetery, if the letter is to someone who has passed away. The options here are endless; the common denominator is that the physical processes involved with these activities powerfully activate the brain to help with the overall sense of release.

Such a ceremonial process may be particularly helpful if a person is struggling with complicated mourning issues, especially if there were words left unsaid or the client/mourner was unable to say goodbye in the way that they would have wished. Taking an unsent letter to a gravesite may be sufficient, but others may want to invite others in to witness the process. Perhaps bringing in the element of fire to burn the letter and setting the intention of it rising to the heavens with the smoke can add to the richness of the ceremony. Bringing in loved ones' favorite songs may also add a dimension to the ceremony.

Experts have also identified a variety of ideas for incorporation of elements of traditional ceremony and ritual into the Western counseling process [4; 7]. This can include Native American customs and ceremonies, traditional Chinese medicine practices, and yogic traditions. For example, the text *Yoga Skills for Therapists* provides examples of how psychotherapists can weave elements of yoga into their own practices without formal training [38].

Although this course will cover direct dance strategies for letting go and release in the next section, a simple movement technique can also be useful as a ritual/ceremony for "shaking off" negativity or stress. Inspired by Cornelius Hubbard, this exercise is referred to as noodling. Like running in place, it can have a similar effect to getting a person whose attention has drifted or who has become overwhelmed to refocus. The following is a sample script for teaching noodling [33].

Haven't you ever envied a cooked noodle? The way it just moves free and easy, without stress, is an admirable quality that can teach us how to practice the attitude of letting go. Think of how fun, and potentially beneficial, it could be to take on the role of a noodle.

- For optimal benefit, rise to your feet (although you can also do this sitting or lying down).
- With your next breath, think of taking on the qualities of a noodle…it is suggested that you begin in your shoulders and then let the "noodling" move through the rest of your body.
- Keep noodling, in an intentional way, practicing beginner's mind, nonjudgment, and non-striving for at least three minutes.
- When you have completed this exercise, allow yourself to be still for a few moments longer (either standing, sitting, or lying down), and notice how it feels.
- Although you can do this in silence, one potential creative modification is to put on some music that can bring out your inner noodle. You can also bring scarves, ribbons, or others props into the action—this is an especially fun exercise to engage children.

As with many of the exercises covered thus far, the dialogue with clients following their attempts of these exercise can be powerful. Comments from clients following an attempt at noodling can lead to an amazing discussion about how hypervigilence plays a role in mental health and body sensations. Clients may begin to get a sense of the extent to which somatic hypervigilence is engrained and how it keeps them from fully "relaxing into" and ultimately enjoying life.

DANCING MINDFULNESS

In 2010, I worked to develop "dance-based" interventions that can be woven into traditional psychotherapy through the lens of a practice called Dancing Mindfulness. Dancing Mindfulness is an approach that uses the human activity of spontaneous dance as a mechanism for teaching and practicing mindfulness meditation. The practice adapts the classic practices of mindfulness in Eastern philosophy for a more Westernized audience using an expressive art form [39]. While various articles and writings within the field of dance therapy reference mindful movement, Dancing Mindfulness exists outside of the structured precepts of dance therapy. Whereas dance therapy approaches may draw upon mindfulness, Dancing Mindfulness is a modern approach to mindfulness meditation that draws on dance as the vehicle for practicing the present-focused meditation. Meditation is any activity that helps one systematically regulate attention and energy, thereby influencing and possibly transforming the quality of experience in service of realizing the full range of humanity and of relationships to others in the world [27]. There are numerous ways to meditate, with different approaches having nuanced effects for individual practitioners [40]. A study consisting of interviews with both nuns and laywomen led Buddhist teacher Batchelor to conclude that the specific techniques of meditation used do not seem to matter as much as one's sincerity in practicing the Dharma, or "the body of principles and practices that sustain human beings in their quest for happiness and spiritual freedom" [41].

Although the phrase Dancing Mindfulness has been coined to describe an approach to mindfulness meditation, cultures around the globe have collectively drawn on the power of dance and present-moment meditation since the dawn of time. Dancing Mindfulness is a wellness practice that grew from my clinical experiences working with trauma and addiction. It can be learned in a group class and practiced in community as well as individually; experience in yoga, meditation, or dance is not required to practice. Participants are simply asked to come as they are with attitudes of open-mindedness. Structured classes begin with a facilitator gently leading participants through a series of breathing and body awareness exercises. Following a mindful stretch series, the facilitator leads participants up to their feet for letting go and dancing with the freedom one might tap into by simply turning on some music and dancing around their houses. Many participants find this practice, especially when supported by the energy of other practitioners who are also taking risks, a cathartic experience. Although some find themselves overwhelmed and intimidated, they are encouraged to just acknowledge their experience, without judgment, and can choose to opt out of a certain dance or use their breath and movement as vehicles for moving through the discomfort. Safety is imperative to Dancing Mindfulness practice—facilitators emphasize that no one ought ever feel forced to participate in any component of the practice.

The primary attitudes cultivated by mindful practice, as identified by Kabat-Zinn in his synthesis of mindfulness research, are used as thematic guidelines in structuring classes: acceptance, beginner's mind, letting go, non-judging, non-striving, patience, and trust [27]. Any of these attitudes may be used as a thematic guide in choosing music for the class, or the facilitator may call upon a series of these attitudes in dancing with an element. The elements of Dancing Mindfulness are networks through which mindfulness can be practiced: breath, body, mind, spirit, sound, story, and fusion of all the elements. A facilitator may elect to start the class working with breath in silence, advising participants that when they use their bodies to come up to their feet and dance, their breaths are with them as a guiding force. Using breath to guide movement is a way, for example, to cultivate the attitude of trust.

Although Dancing Mindfulness was developed within a group context, the attitudes and elements of dancing mindfulness can be used as part of a daily wellness practice and in individual work with clients. Many Dancing Mindfulness facilitators use the practice as an adjunctive activity in clinical settings, bringing moving meditations inspired by Dancing Mindfulness into individual sessions with clients. The following sections will outline versions of some of these mindfulness-informed approaches. Learners are encouraged to try the interventions out first and then determine if they can or should be weaved into work within clients in their existing therapy setting and therapeutic approach. When it comes to physical safety, be sure to advise clients to listen to the feedback that their bodies give them about how far or how fast they are going. In terms of your own clinical scope of practice, if any of these exercises are going to be used for more of a cathartic experience, be sure that you feel comfortable addressing, within your existing therapeutic orientation, what may come up during the movement process.

Clench-and-Release Variation

One Dancing Mindfulness-inspired approach is to take the clench-and-release exercise (discussed previously) to a more dynamic, "dancey" place. The purpose of this dance is to consider whatever it is you are holding onto: anger, resentment, hatred. It is up to the individual to decide what they want to work with. After this selection is made, the dancer is instructed to take two stress balls and grip their hands tightly around them. As the music inspires, they should move through the space and notice the experience of holding on. It is important to allow time for this process. In addition, the choice of music is very important here; "angstier" music can generate more tension in dancers, which is useful here. When the song ends, the client should be instructed to release the stress balls, notice them leave their hands, and drop to the floor. Ask the client to take a moment to notice how good it can feel to let go and to let the earth absorb any of the negativity that arose in the room.

It is generally a good idea to choose the next song as a counterpoint, one that continues to work with the power of release. As a caution: Not everyone likes this dance; some may feel that it is "too much." For those attempting this facilitation in a group or within an individual counseling setting, remind your group or individual client that opting out is always an option. As a variation, the individual could do the same dance without stress balls—simply have people clench their fists and when you invite the release, have them notice how good it feels to release the grip on the hands. Encourage the opening of the hands to trickle into the rest of the body and then dance with that sense of release.

Mindful Music Listening

If an exercise like this seems too advanced or risky for your clients, consider working with the client in the context of a mindful listening exercise and then adding in some movement if it seems organic. Too often, music is in the background. In this exercise, the client can explore how really paying attention to the music in a nonjudgmental manner can usher in a new experience. Clinicians are encouraged to try all four parts of this exercise, in order, before attempting it with clients. It can be an excellent exercise for personal practice in addition to working on it with clients or students.

To start, ask clients to get into a comfortable yet alert position, as if about to do a seated or lying down meditation. Then, cue up a piece of music that the client has never heard before. For the length of the song, their only task is to pay attention to the song, listening mindfully. Just be with the experience.

After a few minutes of silence, cue up the song again and let the music connect with breath. Be open to movement should it happen, and just go with it. Some clients will only be inspired to sway and swivel a little bit; others may break out into a full-on dance routine. Whatever happens, just honor the experience.

Now, find a piece of music that the client knows very well, preferably something that they connect with emotionally. Instruct the listener to return to a sitting or lying meditative position and listen to this piece of music with total awareness, as if it is the first time they are hearing it. Once again, just be with the experience and notice what happens within when listening with mindful ears.

Finally, replay the song, only this time being open to movement. Just go with it, and notice what happens.

FURTHER TRAINING & COLLABORATION

REFLECTION

"Almost all creativity involves purposeful play."

–Abraham Maslow

Consider for a moment how purposeful play in the form of dancing and movement might inspire your clinical practice. How do your own experiences with movement inform your understanding of other individuals and cultures?

IS FURTHER TRAINING RIGHT FOR MY CLINICAL PRACTICE?

If the interventions outlined in this article excite you, there is a chance that you may want to pursue further training in dance and/or movement modalities as part of your continuing education. There are several avenues that you can explore—the conscious dance routes (e.g., 5Rhythms, Dancing Mindfulness); the more structured dance, movement, and expressive arts therapies routes; and finally, approaches to psychotherapy that typically are not viewed as dance/movement therapy, but certainly incorporate movement and somatic work (e.g., EMDR therapy, somatic experiencing). This section will provide a very brief overview of available avenues and resources for further information.

If you are interested in the conscious dance route, consider visiting https://consciousdancer.com, the official website of Conscious Dancer Magazine and the DanceFirst Association. Of particular interest may be the Upshift Guide, which lists summaries and training requirements for more than 100 conscious dance modalities operating around the world. The training lengths for each modality vary, although it is not unrealistic to complete full training in some modalities within several weekend modules. Conscious dance training is generally ideal for those who seek to bring movement practices into the larger community (e.g., yoga studios, churches, schools, wellness fairs, festivals) and not just in a clinical setting. In addition, those who work in a clinical setting that is open-minded to practices like this, having some training in a conscious dance form will generally suffice to support the incorporation of dancing approaches into clinical practice.

For those who are looking for a more structured experience in dance/movement or expressive arts therapy, there are options available through the ADTA (https://www.adta.org) and the International Expressive Arts Therapy Association (https://www.ieata.org). Both entities offer formal training programs, many of which come with continuing professional education. For the ADTA route, to become a registered dance and movement therapist, a period of working with an approved supervisor is required. The ADTA also lists Master's degree programs that they recognize in dance and movement therapy for fulfilling much of these requirements, although a post-Master's training route is available for those wishing to register as a dance/movement therapist after having completed a general clinical Master's degree. The IEATA model allows for individuals to become certified through both traditional and non-traditional models of demonstrating their training and education. These paths are recommended for clinicians who truly want to deepen their educational experience and those who are likely to work in settings where formal accreditations are expected and/or required.

A final, and perhaps the most career-advantageous, path could be to explore the newer wave modalities of psychotherapy that utilize somatic interventions and creative affect tolerance modalities. Many of these, like dialectical behavioral therapy and EMDR therapy, are recognized in the SAMHSA Evidence-Based Practices Resource Center. Others, such as sensorimotor psychotherapy, are increasingly gaining credibility based on their grounding in the latest findings in trauma-informed care and neurobiology. In addition to the traditional modalities in movement discussed in the first section of this course, clinicians should also consider checking out the regulatory websites of these modalities for information about training and formation:

- EMDR therapy: https://www.emdria.org
- Dialectical behavior therapy: https://dbt-lbc.org
- Somatic experiencing: https://traumahealing.org/professional-training
- Sensorimotor psychotherapy: https://sensorimotorpsychotherapy.org
- Psychomotor psychotherapy: https://pbsp.com
- Hakomi mindful somatic psychotherapy: https://hakomiinstitute.com
- Body psychotherapy: https://www.usabp.org

The imperative here is not that all persons interested in incorporating movement into their clinical practice must seek training in every one of these modalities. Rather, they offer a potential avenue for blending somatically informed movement work into a psychotherapy practice. Learners are encouraged to visit the sites, read about each, watch demonstration videos, and if possible, arrange to have some work in each modality done. This process of inquiry will provide a good idea of which approach best resonates and will likely prove to be the best fit for your practice.

COLLABORATING WITH OTHER PROVIDERS

After participating in this course, clinicians should be empowered to, at least, try out some of these movement practices themselves. Even those who do not foresee incorporating movement or dance approaches into work with clients are encouraged to experiment with making them a part of their own self-care. In between stressful meetings or client appointments, consider if you might incorporate a little movement to improve posture or to shake the stress away.

In addition, clinicians should consider the option of collaboration with other professionals. Even if pursuing formal training is not appealing, consider exploring some of the websites and organizations provided. They might be able to direct you to providers in your area who are willing to work with you col-

laboratively. Especially if it seems like you have exhausted the extent of your clinical repertoire with a certain client, sending them for some supplemental sessions in one of the modalities described here may be a good fit. Many conscious dance or yoga classes offered in communities have a healing spin that is appropriate for clients. Bringing these to clients' attention as resources they can seek out for coping can be helpful, as long as you check back in with them after they sought out the suggestion to make sure that it was not unproductively triggering in any way. This follow-up feedback can be used to continue working with them on wellness measures.

CONCLUSION

The intent of this course was to inspire creative thought processes related to how to work movement and dance modalities into an existing psychotherapy practice. There are many options available using various traditions and levels of movement engagement. The creative descriptions are intended to be resources to support work on some of these skills. Before passing them along to clients, it is important to have first tried them. If you have been able to incorporate movement or dance exercises into your daily life and wellness practice, you are in an even better position to be an ambassador for movement.

APPENDIX 1: MULTICULTURAL AWARENESS AND COMPETENCE

As discussed throughout this course, dance and movement have long cultural traditions around the world, and the healing properties of movement have been a staple in ancient and modern communities. With this in mind, all clinicians should be mindful of the role of clients' cultural identity, beliefs, and traditions as well as of the cultural roots of modalities.

In its Code of Ethics and Standards, the American Dance Therapy Association has established criteria for providing culturally competent dance/movement therapy [42]. Although this code applies to certified dance therapists, it provides a good guideline for all clinicians incorporating movement, dance, and/or somatic techniques into their practice. The Code includes the following requirements for clinicians [42]:

- Dance/movement therapists should consider the role of cultural context in the practice of therapy and continuously attend to developing the awareness, knowledge, and skills needed to competently work with diverse client groups.
- Dance/movement therapists examine the meaning of their ethnic and cultural backgrounds and how they may affect cross-cultural therapy dynamics.
- Dance/movement therapists develop awareness of their own worldviews, values, and beliefs and seek to understand the worldviews, values, and beliefs of their clients.
- Dance/movement therapists actively engage in broadening their knowledge of all cultures and in particular acquire information about the cultural group(s) with whom they are working, with attention to the inherent strengths of the cultural group. Dance/movement therapists seek this knowledge from multiple sources.
- Dance/movement therapists are sensitive to individual differences that exist within a cultural group and understand that individuals may have varying responses to cultural norms.
- Dance/movement therapists consider the impact of societal dynamics of power, privilege, and oppression on individual client experience and behavior.
- Dance/movement therapists inquire about client concerns, including perceptions of racism, language barriers, or cultural differences, which the client may experience as compromising trust and communication in the therapy relationship or treatment setting.

While these ethical standards do not vary significantly from the codes of ethics governing the various behavioral and mental health professions, there are unique considerations when considering the inclusion of culturally bound traditions. For example, tribal dance has been a vital component of many Native American communities, and clients from these backgrounds (and potentially beyond) may express interest in incorporating indigenous dance into mindfulness practices and/or therapeutic work. Behavioral health service providers should recognize that Native American tribes represent a wide variety of cultural groups that differ from one another in many ways [6]. Each Native American culture has its own specific healing practices, and not all of those practices are necessarily appropriate to adapt to behavioral health treatment settings. However, many traditional healing activities and ceremonies have been made accessible during treatment or effectively integrated into treatment settings. These practices include sacred dances (such as the Plains Indians' sun dance and the Kiowa's gourd dance) [6]. Clinicians from outside of these communities should seek consultation with a Native expert and/or refer clients to a culturally appropriate community or professional resource.

BEST PRACTICES FOR CULTURALLY RESPONSIVE CARE

The U.S. Department of Health and Human Services has outlined steps important to incorporate in evaluation and treatment planning processes to ensure culturally competent clinical and programmatic decisions and skills [6].

The first step is to engage clients. In nonemergent situations, it is important to establish rapport before asking a series of assessment questions or delving deeply into history taking. Providers should use simple gestures as culturally appropriate (e.g., handshakes, facial expressions, greetings) to help establish a first impression. The intent is that all clients feel understood and seen following each interaction. Culturally responsive interview behaviors and paperwork should be used at all times [6].

When engaging in any client teaching, remember that individuals may be new to the specific language or jargon and expectations of the diagnosis and care process. Clients should be encouraged to collaborate in every step of their care. This consists of seeking the client's input and interpretation and establishing ways they can seek clarification. Client feedback can then be used to help identify cultural issues and specific needs. If appropriate, collaboration should extend to include family and community members.

Assessment should incorporate culturally relevant themes in order to more fully understand clients and identify their cultural strengths and challenges. Themes include [6]:

- Immigration history
- Cultural identity and acculturation
- Membership in a subculture
- Beliefs about health, healing, and help-seeking
- Trauma and loss

In some cases, it may be appropriate and beneficial to obtain culturally relevant collateral information, with the client's permission, from sources other than the client (e.g., family or community members) to better understand beliefs and practices that shape the client's cultural identity and understanding of the world.

Practitioners should work to identify screening and assessment tools that have been translated into or adapted for other languages and have been validated for their particular population group(s). An instrument's cultural applicability to the population being served should be assessed, keeping in mind that research is limited on the cross-cultural applicability of specific test items or questions, diagnostic criteria, and concepts in evaluative and diagnostic processes [6].

Typically, culturally responsive care establishes holistic treatment goals that include objectives to improve physical health and spiritual strength; utilizes strengths-based strategies that fortify cultural heritage, identity, and resiliency; and recognizes that treatment planning is a dynamic process that evolves along with an understanding of client history and treatment needs. In addition to these general approaches, specific considerations may be appropriate for specific populations.

CREATING A WELCOMING AND SAFE ENVIRONMENT

Ensuring clients feel comfortable enough to participate in therapy, including movement and/or dance approaches, begins with client comfort. This can be facilitated, in part, by providing a welcoming environment. The basis of establishing a safe and welcoming environment for all clients is security, which begins with inclusive practice and good clinician-client rapport. Shared respect is critical to a client's feeling of psychological well-being. Security can also be fostered by a positive and safe physical setting. As such, therapy environments should be controlled in a way to minimize traumatic stress responses. Providers should keep this in mind when structuring the environment (e.g., lighting, arrangement of space), creating processes (e.g., layout of appointments or care systems, forms), and providing staff guidance (e.g., nonverbal communication, intonation, communication patterns). During each encounter, the client's perception of safety is impacted by caretakers and ancillary staff.

Experts recommend the adoption and posting of a nondiscrimination policy that signals to both clinicians and clients that all persons will be treated with dignity and respect [43]. Also, checklists and records should include options for the client defining their race/ethnicity, preferred language, gender expression, and pronouns; this can help to better capture information about clients and be a sign of acceptance to that person. If appropriate, providers should admit their lack of experience with client subgroups and seek guidance from clients regarding their expectations of the visit.

Front office staff should avoid discriminatory language and behaviors. For example, staff should avoid using gender-based pronouns, both on the phone and in person. Instead of asking, "How may I help you, sir?" the staff person could simply ask, "How may I help you?" Offices that utilize electronic health records should have a system to track and record the gender, name, and pronoun of all clients. This can be accomplished by standardizing the notes field to document a preferred name and pronoun for all clients [44]. Persons who identify as nonbinary (i.e., neither or both genders) or with dissociative identity disorder may prefer that plural pronouns (e.g., they) be used.

Questions should be framed in ways that do not make assumptions about a client's culture, gender identity, sexual orientation, or behavior. Language should be inclusive, allowing the client to decide when and what to disclose. Assurance of confidentiality should be stressed to the client to allow for a more open discussion, and confidentiality should be ensured if a client is being referred to a different healthcare provider. Asking open-ended questions can be helpful during a history and physical.

APPENDIX 2: DANCE IN THE CONTEXT OF EXPRESSIVE GROUP THERAPY

When practiced as a formal group modality, dance and movement therapy is included in the larger umbrella of expressive groups, which includes a range of therapeutic activities that allow clients to express feelings and thoughts—conscious or unconscious—that they might have difficulty communicating with spoken words alone. The purpose of expressive therapy groups is generally to foster social interaction among group members as they engage either together or independently in a creative activity. These groups therefore can improve socialization and the development of creative interests. Further, by enabling clients to express themselves in ways they might not be able to in traditional talking therapies, expressive therapies can help clients explore their substance abuse, its origins, the effect it has had on their lives, and new options for coping. These groups can also help clients resolve trauma that may have been a progenitor of their current presenting problem. For example, clinical observation has suggested benefits for female clients with substance use disorder involved in dance therapy [45]. Expressive therapy groups often can be "a source of valuable insight into clients' deficits and assets, both of which may go undetected by treatment staff members concerned with more narrowly focused treatment interventions" [45].

The actual characteristics of an expressive therapy group will depend on the form of expression clients are asked to use. Expressive therapy may use music, dance, or free movement. Expressive group leaders generally will have a highly interactive style in group. They will need to focus the group's attention on creative activities while remaining mindful of group process issues. The leader of an expressive group will typically need to be trained in the particular modality to be used (e.g., dance therapy). In some cases, expressive therapies can require highly skilled staff, and, if a program does not have a trained staff person, it may need to hire an outside consultant to provide these services. Any consultant working with the group should be in regular communication with other staff, because expressive activities need to be integrated into the overall program, and group leaders need to know about each client if they are to understand their work in the group. Expressive therapies can stir up very powerful feelings and memories. The group leader should be able to recognize the signs of reactions to trauma and be able to contain clients' emotional responses when necessary. Group leaders need to know as well how to help clients obtain the resources they need to work though their powerful emotions [45].

Finally, it is important to be sensitive to a client's ability and willingness to participate in an activity. To protect participants who may be in a vulnerable emotional state, the leader should be able to set boundaries for group members' behavior. For example, in a movement therapy group, participants need to be aware of each other's personal space and understand what types of touching are not permissible.

After clients have spent some time working on their creative activity (e.g., dance), the group comes together to discuss the experience and receive feedback from the group leader and each other. In all expressive therapy groups, client participation is a paramount goal. All clients should be involved in the group activity if the therapy is to exert its full effect [45].

Another point to consider is the role of touch. Touch in a group is never neutral. People have different personal histories and cultural backgrounds that lead to different interpretations of what touch means. Consequently, the leader should evaluate carefully any circumstance in which physical contact occurs, even when it is intended to be positive. In most groups, touch (handholding or hugs) as part of group rituals is not recommended, though in an expressive therapy or dance group, touch may be acceptable and normative. Naturally, group agreements always should include a clause prohibiting physical violence. Whenever the therapist invites the group to participate in any form of physical contact, individuals should be allowed to opt out without any negative perceptions within the group. All members uncomfortable with physical contact should be assured of permission to refrain from touching or having anyone touch them [45].

Leaders also should make sure that suggestions to touch are intended to serve the clients' best interests and not the needs of the therapist. Under no circumstances should a counselor ask for or initiate physical contact. Like their clients, counselors need to learn that such impulses affect them as well. It is wrong for those providing psychotherapy to allow feelings of attraction to dictate or influence their behavior [45].

Customer Information, Answer Sheet, and Evaluation are located on pages 118–120.

TEST QUESTIONS
#78250 MOVEMENT AND DANCE IN PSYCHOTHERAPY

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

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

1. According to trauma scholar and innovator, Bessel van der Kolk the purpose of trauma treatment is
- A) *catharsis.*
- B) *stabilization.*
- C) *to get engaged in the most innovation treatment possible for resolution.*
- D) *to help people fundamentally experience greater safety in their own body.*

2. What common adage fundamentally offers solid direction for holistic trauma resolution?
- A) *Let go and let God.*
- B) *Actions speak louder than words.*
- C) *God helps those who help themselves.*
- D) *What doesn't kill you makes you stronger.*

3. Which of the following best represents the multicultural value of using dance/movement work in therapy?
- A) *Indigenous cultures around the globe have been making use of dance/movement techniques long before modern psychology was invented.*
- B) *Many techniques in dance and movement are true cultural universals.*
- C) *Learning the movement and dance traditions of a client's culture can be an excellent way to open up conversation and promote understanding.*
- D) *All of the above*

4. What is a traditional folk dance of the Maori people of New Zealand?
- A) *Kolo*
- B) *Haka*
- C) *Umoya*
- D) *Shapiro*

5. Who is best known for the memoir he wrote detailing his service with Native American tribes and the lessons that they taught him on healing?
- A) *Fritz Perls*
- B) *Alexander Lowen*
- C) *Moishe Feldenkrais*
- D) *Carl Hammerschlag*

6. Who is the founder of the 5Rhythms conscious dance practice?
- A) *Marian Chace*
- B) *Gabrielle Roth*
- C) *Francine Shapiro*
- D) *Florence Noyes*

7. The National Institutes of Health recognize Native American healing approaches as
- A) *unfounded.*
- B) *homeopathic.*
- C) *a whole medical system.*
- D) *a complementary medical system only.*

8. The healing systems/practices of yoga and Ayurveda originated in
- A) *India.*
- B) *Pakistan.*
- C) *South Africa.*
- D) *New Zealand.*

9. Bioenergetic analysis (BA) is a body-based psychotherapy rooted in the principles of mind-body connection.
- A) *True*
- B) *False*

10. Alexander Lowen, the founder of Bioenergetics, studied originally in
- A) *Gestalt psychotherapy.*
- B) *Jungian psychoanalysis.*
- C) *Freudian psychoanalysis.*
- D) *Native American psychology.*

11. Lowen, Perls, and Feldenkrais primarily worked on bringing their innovative work and approaches to prominence at
- *A) Harvard University.*
- *B) the Esalen Institute.*
- *C) the Omega Institute.*
- *D) the University of Vienna.*

12. Which approach to Western psychotherapy was the first truly holistic system of psychotherapy because of its use of affective, sensory, interpersonal, and behavioral components?
- *A) Psychoanalysis*
- *B) EMDR therapy*
- *C) Gestalt psychotherapy*
- *D) Body-centered psychotherapy*

13. Perls incorporated which Eastern philosophical approach into the Gestalt approach to psychotherapy?
- *A) Tao*
- *B) Christianity*
- *C) Zen Buddhism*
- *D) Tibetan Buddhism*

14. Who developed a system of somatic education that is now practiced by dancers, bodyworkers, and psychotherapists?
- *A) Fritz Perls*
- *B) Francine Shapiro*
- *C) Alexander Lowen*
- *D) Moshé Feldenkrais*

15. F.M. Alexander originally honed his ideas when he was working as a(n)
- *A) actor*
- *B) musician*
- *C) physician*
- *D) psychoanalyist*

16. Which contemporary dancers are considered to be forerunners of modern-day dance therapy?
- *A) Ruth St. Denis*
- *B) Martha Graham*
- *C) Florence Noyes*
- *D) All of the above*

17. Pesso, the developer of psychomotor psychotherapy, was a dancer in whose performance company?
- *A) Florence Noyes*
- *B) F.M. Alexander*
- *C) Martha Graham*
- *D) Ruth St. Denis*

18. Who is considered to be the founder of the formal practice of dance therapy and the American Dance Therapy Association?
- *A) Florence Noyes*
- *B) Martha Graham*
- *C) Marian Chace*
- *D) Gabrielle Roth*

19. Dance and movement therapy, as defined by the American Dance Therapy Association, may be practiced in
- *A) nursing homes.*
- *B) day care centers.*
- *C) mental health hospitals.*
- *D) All of the above*

20. Movement with an intention towards higher awareness is typically a definition given for
- *A) 5 Rhythms.*
- *B) Zumba fitness.*
- *C) conscious dance.*
- *D) Dance and movement therapy.*

21. In linking clients with dance resources in the community for their own health and wellness, dance/movement therapy is generally more accessible and available than conscious dance and fitness dance practices.
- *A) True*
- *B) False*

22. What are the three "brains" in MacLean's triune brain model?
- *A) Animal, vegetable, mineral*
- *B) Neocortex, limbic, R-complex*
- *C) Prefrotal lobe, midbrain, R-complex*
- *D) Amygdala, hippocampus, hypothalamus*

23. According to the triune brain model, what part of the brain is generally described as having no rational time clock?
- *A) the limbic brain*
- *B) the neocortex*
- *C) the prefrontal cortex*
- *D) the R-complex*

24. Cognitive or any reason-based interventions primarily target the
- *A) limbic brain.*
- *B) amygdala.*
- *C) neocortex.*
- *D) R-complex.*

Test questions continue on next page ➞

25. What is the major reason cognitive therapies alone are generally ineffective for processing trauma?
- A) *Cognitive therapies are outdated for trauma.*
- B) *People cannot process information cognitively.*
- C) *Research shows that cognitive therapies are not as effective for trauma as EMDR, dance, and other, newer therapies.*
- D) *Cognitive therapies primarily target the frontal lobe of the brain, an area that shuts down when a person is viscerally triggered by traumatic memories.*

26. Talking, connecting with others, and self-knowledge are all examples of what types of interventions for healing?
- A) *Technology*
- B) *Top-down methods*
- C) *Bottom-up methods*
- D) *All of the above*

27. Allowing the body to have experiences that deeply and viscerally contradict the helplessness, rage, and collapse that result from the trauma are examples of what types of interventions for healing?
- A) *Technology*
- B) *Top-down methods*
- C) *Bottom-up methods*
- D) *All of the above*

28. Yoga has been found to help traumatized individuals
- A) *to promote a greater sense of creativity.*
- B) *to promote an outlet for exercise that helps you work through physical fear.*
- C) *to tolerate physical and sensory experiences associated with fear and helplessness and to increase emotional awareness and affect tolerance.*
- D) *None of the above*

29. Nikki Myers is associated with combining which two healing practices?
- A) *Dance and yoga*
- B) *Yoga and 12-step recovery*
- C) *Psychoanalysis and yoga*
- D) *12-step recovery and dance*

30. What slogan is used by Nikki Myers in her movement work?
- A) *Easy does it.*
- B) *The body never lies.*
- C) *The issues live in our tissues.*
- D) *Actions speak louder than words.*

31. Mindfulness practices create which benefit(s) in the human brain?
- A) *Calm a client's inner experience and promote greater introspection*
- B) *Play a key role in activating the pre-frontal cortex and promoting a greater sense of concentration*
- C) *Practice can cause positive structural changes in the brain related to learning and memory (hippocampus) and can cause a thinning in the amygdala, lessening the charge of fear-based responses*
- D) *All of the above*

32. Which group concluded that, in the treatment of trauma, "optimization of outcomes also includes exploration of novel treatment approaches such as complementary medicine strategies that focus on somatosensory experience and the mind-body relationship, for which there is emerging evidence regarding efficacy"?
- A) *The National Institute of Mental Health (NIMH)*
- B) *The American Psychological Association (APA)*
- C) *The American Dance Therapy Association (ADTA)*
- D) *The International Society of Traumatic Stress Studies (ISTSS)*

33. In general, when working with new clients and assessing the appropriateness of movement and dance modalities, one can ask general questions about the role of exercise and/or spirituality in their life.
- A) *True*
- B) *False*

34. Which term is generally defined as always being on guard for something bad to happen?
- A) *Hypoarosal*
- B) *Hypervigilience*
- C) *Heightened startle response*
- D) *None of the above*

35. It is important not to force dance-based interventions on clients or to tell them that they have to seek out a dance class, although it may be worth exploring why a person may be open to other movement strategies but closed off when it comes to dance or other more creative movement modalities.
- A) *True*
- B) *False*

36. According to Winton-Henry, which of the following is NOT a reason clients may resist dance and movement interventions?
- A) *Dancing is not important.*
- B) *It is too embarrassing to dance.*
- C) *Dancing is unfounded in science.*
- D) *The body is a Pandora's box and not to be trusted.*

37. What is a primary reason that a structured movement practice may be a better fit for a client who is a newcomer to movement work, especially when compared with the conscious dance practices?
- A) *It is time-tested.*
- B) *The communal setting is healing.*
- C) *The Latin music makes it more fun*
- D) *There is a greater degree of structure which newcomer's may need to feel safe moving.*

38. In working with clients who might be more resistant to movement activities, one should
- A) *be open to client feedback.*
- B) *respect the art of variations and adjustments.*
- C) *provide more opportunities for instruction/ structure.*
- D) *All of the above*

39. Which of the following is a cognitive-behavioral coping technique that pairs a visualization of a traditional stop sign and an intention to not engage a distressing negative cognition?
- A) *Guided imagery*
- B) *Thought stopping*
- C) *Diaphragmatic breathing*
- D) *None of the above*

40. Clinicians who are new to movement work can begin by adding a gesture to the thought stopping technique.
- A) *True*
- B) *False*

41. Progressive muscle relaxation, as a technique, originated in which therapeutic tradition/ technique in the 1920s?
- A) *Psychoanalysis*
- B) *Bioenergetics*
- C) *Hypnotherapy*
- D) *The Alexander technique*

42. The technical phrase for back-and-forth motion used in EMDR therapy is
- A) *bilateral stimulation.*
- B) *left-to-right attention.*
- C) *dual attention stimulus.*
- D) *None of the above*

43. Which of the following activities includes bilateral motion and may be useful in therapy?
- A) *Sitting and meditating quietly*
- B) *Doing jumping jacks*
- C) *Taking a walk*
- D) *None of the above*

44. Besides movement, what may be one of the other primary psychotherapeutic benefits of taking a walk with a client during a session?
- A) *Physical exercise*
- B) *Not having to look the therapist in the eye*
- C) *Self-induced EMDR therapy benefits*
- D) *None of the above*

45. Which approach to psychotherapy is built upon the value of experiential education for improving self-esteem, positive self-concept, and other pro-social behavioral like cooperation, often in wilderness-based settings?
- A) *Gestalt psychotherapy*
- B) *Bioenergetics*
- C) *Adventure therapy*
- D) *Dance and movement therapy*

46. One technique that can be helpful for promoting boundary setting comes from the yoga mudra named
- A) *self-confidence.*
- B) *mountain pose.*
- C) *seal of knowledge.*
- D) *None of the above*

47. Which yoga pose consists of standing with a sense of embodied purpose?
- A) *Warrior pose*
- B) *Child's pose*
- C) *Mountain pose*
- D) *Pidgeon pose*

Test questions continue on next page ➞

48. What yoga breath technique can be helpful for releasing jaw tension?
- A) *Diaphragmatic breathing*
- B) *Lion breathing*
- C) *Ujjayi breathing*
- D) *Tension release breathing*

49. The unsent letter technique comes from which primary psychotherapeutic tradition?
- A) *Bioenergetics*
- B) *Dance and movement therapy*
- C) *Psychoanalysis*
- D) *Gestalt therapy*

50. Dancing Mindfulness, an approach to movement meditation, draws on the attitudes of mindfulness identified by
- A) *Martine Bachelor.*
- B) *Thich Nhat Hanh.*
- C) *Jon Kabat-Zinn.*
- D) *Ram Dass.*

51. Clinicians who are interested in furthering their education in dance/movement modalities can explore
- A) *the conscious dance routes.*
- B) *the more structured dance, movement, and expressive arts therapies routes.*
- C) *approaches to psychotherapy that typically are not viewed as dance/movement therapy but that incorporate movement and somatic work.*
- D) *Any of the above*

52. Which area of dance/movement would be the most optimal area of training for those interested in taking dance into the community beyond clinical settings?
- A) *Conscious dance*
- B) *An ADTA-approved Master's degree program*
- C) *Somatic experience or related training*
- D) *No training is discussed for this kind of work*

53. Which of the following is part of the American Dance Therapy Association's Code of Ethics and Standards?
- A) *Dance/movement therapists should consider the role of cultural context in the practice of therapy.*
- B) *Dance/movement therapists examine the meaning of their ethnic and cultural backgrounds and how they may affect cross-cultural therapy dynamics.*
- C) *Dance/movement therapists consider the impact of societal dynamics of power, privilege, and oppression on individual client experience and behavior.*
- D) *All of the above*

54. Which of the following statements regarding incorporation of Native American approaches into clinical therapy is TRUE?
- A) *Native American cultures have similar universal healing practices.*
- B) *All Native American practices are appropriate to adapt to behavioral health treatment settings.*
- C) *Clinicians from outside of Native communities can effectively adopt these practices without consultation and/or referral.*
- D) *Many traditional healing activities and ceremonies have been made accessible during treatment or effectively integrated into treatment settings.*

55. The purpose of expressive therapy groups is generally to
- A) *foster social interaction among group members as they engage either together or independently in a creative activity.*
- B) *to resolve the conflicts and ambiguities that result from the failure to integrate features of the personality.*
- C) *to produce rapid and effective change while the client maintains equilibrium during and between sessions.*
- D) *help you deal with overwhelming problems in a more positive way by breaking them down into smaller parts.*

Be sure to transfer your answers to the Answer Sheet located on pages 119–120
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 all members of the interprofessional team, including mental health professionals, physicians, physician assistants, 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, is a teacher of the year, translational researcher, author, mentor, and inventor best known for his work on the brain systems underlying the effects of opiate drugs, cocaine, and food. Dr. Gold was a Professor, Eminent Scholar, Distinguished Professor, Distinguished Alumni Professor, Chairman, and Emeritus Eminent Scholar during his 25 years at the University of Florida. He was a Founding Director of the McKnight Brain Institute and a pioneering neuroscience-addiction researcher funded by the NIH-NIDA-Pharma, whose work helped to de-stigmatize addictions and mainstream addiction education and treatment. He also developed and taught courses and training programs at the University of Florida for undergraduates and medical students. (A complete biography 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.

Division Planners
Alice Yick Flanagan, PhD, MSW

Senior Director of Development and Academic Affairs
Sarah Campbell

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NetCE designates this continuing education activity for 3 NBCC clock hours.

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

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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].

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

LEADING CAUSE OF DEATH IN THE UNITED STATES FOR SELECT AGE GROUPS, 2019							
Rank	Age (in Years)						
	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.

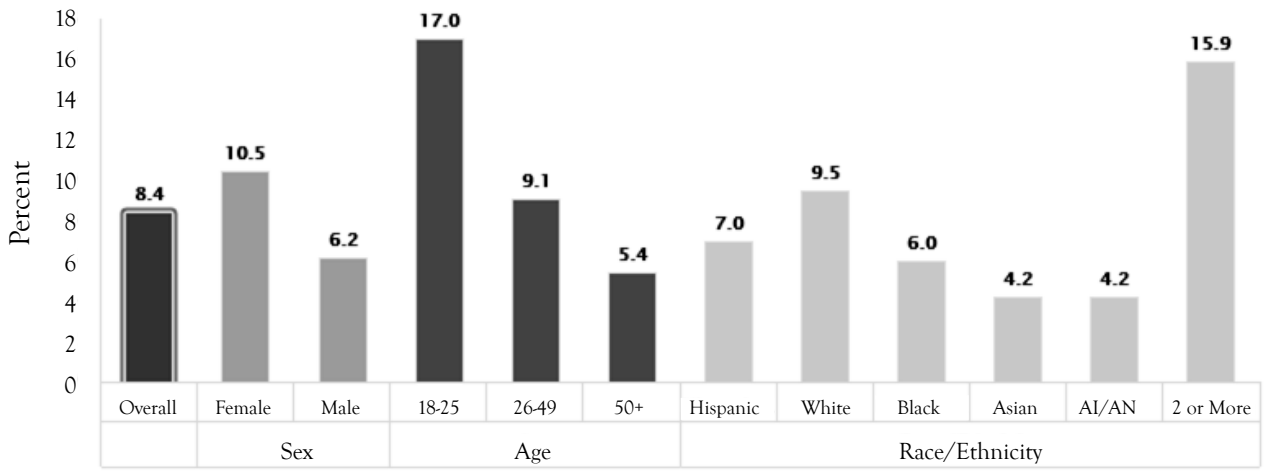
Source: [10] *Table 1*

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 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

PAST YEAR PREVALENCE OF MAJOR DEPRESSIVE EPISODE AMONG U.S. ADULTS, 2020

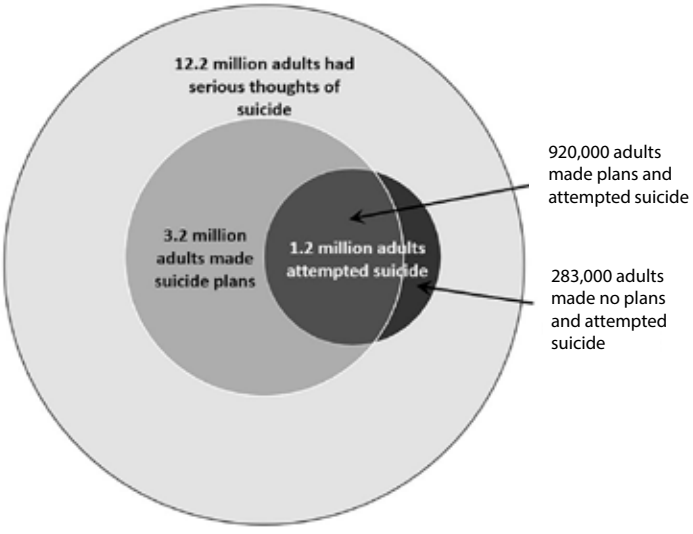


AI/AN = American Indian/Alaska Native

Source: [11]

Figure 1

SUICIDAL BEHAVIORS IN THE UNITED STATES, 2020



Source: [10; 12; 14]

Figure 2

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

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*

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.

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 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.

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*

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.

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]:

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*

> 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 circuitry.

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.)

EVIDENCE-BASED PRACTICE RECOMMENDATION

For patients with major depressive disorder who have not responded to several adequate pharmacologic trials, the Department of Veterans Affairs suggests ketamine or esketamine as an option for augmentation.

(https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFinal508.pdf. Last accessed July 8, 2022.)

Strength of Recommendation: Weak for

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 psychotropic 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 suffering—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].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The National Institute for Health and Care Excellence recommends clinicians consider electroconvulsive therapy (ECT) for the treatment of severe depression if the person chooses ECT in preference to other treatments based on their past experience of ECT and what has previously worked for them OR a rapid response is needed (e.g., if the depression is life-threatening) OR other treatments have been unsuccessful.

(https://www.nice.org.uk/guidance/ng222. Last accessed July 8, 2022.)

Level of Evidence: Expert Opinion/Consensus Statement

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].

Customer Information, Answer Sheet, and Evaluation are located on pages 118–120.

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 CE Credit 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.*

Test questions continue on next page ➞

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*

Test questions continue on next page ➞

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 pages 119–120
DO NOT send these test pages to NetCE. Retain them for your records.
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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.

FRONTOTEMPORAL DEMENTIA
#76103 • 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.

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.

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Course Availability List *(Cont'd)*

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.

CLINICAL SUPERVISION FOR MENTAL HEALTH PROFESSIONALS IN FLORIDA
Supervision

#76831 • 4 ASWB Hours, 1.5 NBCC Hours

Book By Mail – $32 • ONLINE – $24

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: Lauren E. Evans, MSW
Audience: This course is designed for professional clinicians in Florida, including counselors, social workers, therapists, and pastoral counselors, who supervise others, clinically and/or administratively.
Special Approval: This course fulfills the Florida requirement for supervisor training.

AN OVERVIEW OF FEMINIST COUNSELING
#76884 • 5 ASWB Hours, 3 NBCC Hours

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to increase the level of awareness and knowledge base of clinicians about the role of gender bias in construction of abnormality and the diagnostic and therapeutic process. Principles of feminist therapy/counseling, interventions, and ethics will be reviewed.
Faculty: Alice Yick Flanagan, PhD, MSW
Audience: This course is designed for social workers, psychologists, therapists, and mental health counselors of the interdisciplinary team who want to gain an overview of feminist therapy/counseling.

RACIAL TRAUMA: THE AFRICAN AMERICAN EXPERIENCE
#76921 • 5 ASWB/APA/NAADAC Hours, 1.5 NBCC Hour

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to provide mental and behavioral health professionals with the knowledge and skills necessary to provide trauma-informed care to African American clients.
Faculty: Tanika Johnson, EdD, MA, LPC-MHSP, LMHC, NCC, BC-TMH, CCTP
Audience: This course is designed for mental and behavioral health professionals who provide services to African American clients who have experienced racial trauma.

ELDER ABUSE: CULTURAL CONTEXTS AND IMPLICATIONS
#77824 • 5 ASWB Hours, 3.5 NBCC Hours

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to increase the knowledge base of social workers, counselors, therapists, and other professionals about elder abuse, assessment, and intervention. This curriculum will focus on abuse against elders in domestic settings perpetrated by family members.
Faculty: Alice Yick Flanagan, PhD, MSW; John M. Leonard, MD
Audience: This course is targeted to counselors, therapists, social workers and other mental health professionals who may identify and intervene in cases of elder abuse.

FAMILIES OF PATIENTS WITH CHRONIC ILLNESS
#91694 • 10 ASWB Hours, 3.5 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 chronically ill patients 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 chronically ill patients.

AUTISM SPECTRUM DISORDER
#92204 • 5 ASWB Hours, 2 NBCC Hours

Book By Mail – $38 • ONLINE – $30

Purpose: Autism spectrum disorder (ASD) has a significant impact on daily functioning and quality of life and has significant morbidity and disability associated with severe cases. However, it often goes unrecognized and is commonly underdiagnosed. The purpose of this course is to educate healthcare professionals about the epidemiology, diagnosis, and management of ASD. Additionally, this course will provide the information necessary to screen children seen in primary care for ASD in order to appropriately refer patients and their families for more expansive assessment and treatment referral as rapidly as possible in order to avoid unnecessary morbidity and mortality.
Faculty: Sharon M. Griffin, RN, PhD; Mary Franks, MSN, APRN, FNP-C
Audience: This course is designed for healthcare professionals in all practice settings who may be involved in the care of patients with an autism spectrum disorder.

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

Course Availability List *(Cont'd)*

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ONLINE COUNSELING AND THERAPY: CRITICAL ISSUES

Telehealth

#96734 • 5 ASWB/APA/NAADAC Hours, 3 NBCC Hour

Book By Mail – $38 • ONLINE – $30

Purpose: As Internet technologies continue to expand and become more accessible to the general public, their use in clinical helping professions will surely continue to grow. Due to the increasing prevalence of the Internet and its use in clinical practice, the purpose of this course is to provide an overview of the practice issues, strengths and limitations, and legal and ethical issues pertaining to online counseling.
Faculty: Alice Yick Flanagan, PhD, MSW
Audience: This course is designed for social workers, therapists, mental health counselors, nurses, and other allied health professionals who work in a clinical practice setting.
Special Approval: This course fulfills the Florida requirement for telehealth education.

INTERCULTURAL COMPETENCE AND PATIENT-CENTERED CARE

#97510 • 4 ASWB/APA Hours/NAADAC Hours, 3 NBCC Hours

Book By Mail – $32 • ONLINE – $24

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

CANNABINOID OVERVIEW

#98010 • 3 ASWB/APA Hours, 1 NBCC Hour

Book By Mail – $26 • ONLINE – $18

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

PARKINSON DISEASE

#98772 • 10 ASWB/APA Hours, 4 NBCC Hours

Book By Mail – $68 • ONLINE – $60

Purpose: The purpose of this course is to provide physicians, nurses, and other members of the interprofessional healthcare team a review of pathogenesis, disease progression, diagnosis, and management of Parkinson disease, in order to improve patient care and quality of life.
Faculty: Mark Rose, BS, MA, LP
Audience: This course is designed for all healthcare providers in the primary care setting who may encounter patients with Parkinson disease.

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.

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☐	77560	Professional Boundaries in Mental Health Care / 3 Hours	$18
☐	78250	Movement and Dance in Psychotherapy / 10 Hours	$60
☐	96790	Psychedelic Medicine and Interventional Psychiatry / 10 Hours	$60

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☐	72254	Childhood Obesity / 4	$32	☐	77824	Elder Abuse: Cultural Contexts and Implications / 5	$38
☐	76103	Frontotemporal Dementia / 2	$23	☐	91694	Families of Patients with Chronic Illness / 10	$68
☐	76182	Anxiety Disorders / 15	$98	☐	92204	Autism Spectrum Disorder / 5	$38
☐	76233	Fundamentals of Trauma Processing / 8	$56	☐	96734	Online Counseling and Therapy: Critical Issues / 5	$38
☐	76412	Behavioral Addictions / 15	$98	☐	97510	Intercultural Competence & Patient-Centered Care / 4	$32
☐	76564	Alcohol and Alcohol Use Disorders / 10	$68	☐	98010	Cannabinoid Overview / 3	$26
☐	76831	Clinical Supervision for Florida MHPs / 4	$32	☐	98772	Parkinson Disease / 10	$68
☐	76884	An Overview of Feminist Counseling / 5	$38	☐	99204	Geriatric Failure to Thrive / 5	$38

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Answer Sheet

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- **Information on the Customer Information form must be completed**.

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#71313 MEDICAL ERROR PREVENTION FOR MENTAL HEALTH PROFESSIONALS—2 HOURS

Please refer to pages 11–12.

Expiration Date: 12/31/26

May be taken individually for $15

	A	B	C	D		A	B	C	D		A	B	C	D
1.	❍	❍	❍	❍	6.	❍	❍	❍	❍	11.	❍	❍	❍	❍
2.	❍	❍	❍	❍	7.	❍	❍	❍	❍	12.	❍	❍	❍	❍
3.	❍	❍	❍	❍	8.	❍	❍	❍	❍	13.	❍	❍	❍	❍
4.	❍	❍	❍	❍	9.	❍	❍	❍	❍	14.	❍	❍	❍	❍
5.	❍	❍	❍	❍	10.	❍	❍	❍	❍	15.	❍	❍	❍	❍

#97923 DOMESTIC VIOLENCE: THE FLORIDA REQUIREMENT—2 HOURS

Please refer to page 23.

Expiration Date: 07/31/25

May be taken individually for $15

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

#71103 FLORIDA LAWS AND RULES FOR MENTAL HEALTH PROFESSIONALS—3 HOURS

Please refer to pages 37–38.

Expiration Date: 08/31/26

May be taken individually for $18

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

#77560 PROFESSIONAL BOUNDARIES IN MENTAL HEALTH CARE—3 HOURS

Please refer to pages 53–54.

Expiration Date: 10/31/26

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.	❍	❍	❍	❍

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Answer Sheet *(Continued)*

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#78250 MOVEMENT AND DANCE IN PSYCHOTHERAPY—10 HOURS Please refer to pages 78–82.

Expiration Date: 03/31/27 *May be taken individually for $60*

	A	B	C	D		A	B	C	D		A	B	C	D		A	B	C	D
1.	❍	❍	❍	❍	16.	❍	❍	❍	❍	31.	❍	❍	❍	❍	46.	❍	❍	❍	❍
2.	❍	❍	❍	❍	17.	❍	❍	❍	❍	32.	❍	❍	❍	❍	47.	❍	❍	❍	❍
3.	❍	❍	❍	❍	18.	❍	❍	❍	❍	33.	❍	❍	❍	❍	48.	❍	❍	❍	❍
4.	❍	❍	❍	❍	19.	❍	❍	❍	❍	34.	❍	❍	❍	❍	49.	❍	❍	❍	❍
5.	❍	❍	❍	❍	20.	❍	❍	❍	❍	35.	❍	❍	❍	❍	50.	❍	❍	❍	❍
6.	❍	❍	❍	❍	21.	❍	❍	❍	❍	36.	❍	❍	❍	❍	51.	❍	❍	❍	❍
7.	❍	❍	❍	❍	22.	❍	❍	❍	❍	37.	❍	❍	❍	❍	52.	❍	❍	❍	❍
8.	❍	❍	❍	❍	23.	❍	❍	❍	❍	38.	❍	❍	❍	❍	53.	❍	❍	❍	❍
9.	❍	❍	❍	❍	24.	❍	❍	❍	❍	39.	❍	❍	❍	❍	54.	❍	❍	❍	❍
10.	❍	❍	❍	❍	25.	❍	❍	❍	❍	40.	❍	❍	❍	❍	55.	❍	❍	❍	❍
11.	❍	❍	❍	❍	26.	❍	❍	❍	❍	41.	❍	❍	❍	❍					
12.	❍	❍	❍	❍	27.	❍	❍	❍	❍	42.	❍	❍	❍	❍					
13.	❍	❍	❍	❍	28.	❍	❍	❍	❍	43.	❍	❍	❍	❍					
14.	❍	❍	❍	❍	29.	❍	❍	❍	❍	44.	❍	❍	❍	❍					
15.	❍	❍	❍	❍	30.	❍	❍	❍	❍	45.	❍	❍	❍	❍					

#96790 PSYCHEDELIC MEDICINE AND INTERVENTIONAL PSYCHIATRY—10 HOURS Please refer to pages 111–114.

Expiration Date: 06/30/25 *May be taken individually for $60*

	A	B	C	D		A	B	C	D		A	B	C	D		A	B	C	D
1.	❍	❍	❍	❍	16.	❍	❍	❍	❍	31.	❍	❍	❍	❍	46.	❍	❍	❍	❍
2.	❍	❍	❍	❍	17.	❍	❍	❍	❍	32.	❍	❍	❍	❍	47.	❍	❍	❍	❍
3.	❍	❍	❍	❍	18.	❍	❍	❍	❍	33.	❍	❍	❍	❍	48.	❍	❍	❍	❍
4.	❍	❍	❍	❍	19.	❍	❍	❍	❍	34.	❍	❍	❍	❍	49.	❍	❍	❍	❍
5.	❍	❍	❍	❍	20.	❍	❍	❍	❍	35.	❍	❍	❍	❍	50.	❍	❍	❍	❍
6.	❍	❍	❍	❍	21.	❍	❍	❍	❍	36.	❍	❍	❍	❍	51.	❍	❍	❍	❍
7.	❍	❍	❍	❍	22.	❍	❍	❍	❍	37.	❍	❍	❍	❍	52.	❍	❍	❍	❍
8.	❍	❍	❍	❍	23.	❍	❍	❍	❍	38.	❍	❍	❍	❍	53.	❍	❍	❍	❍
9.	❍	❍	❍	❍	24.	❍	❍	❍	❍	39.	❍	❍	❍	❍	54.	❍	❍	❍	❍
10.	❍	❍	❍	❍	25.	❍	❍	❍	❍	40.	❍	❍	❍	❍	55.	❍	❍	❍	❍
11.	❍	❍	❍	❍	26.	❍	❍	❍	❍	41.	❍	❍	❍	❍					
12.	❍	❍	❍	❍	27.	❍	❍	❍	❍	42.	❍	❍	❍	❍					
13.	❍	❍	❍	❍	28.	❍	❍	❍	❍	43.	❍	❍	❍	❍					
14.	❍	❍	❍	❍	29.	❍	❍	❍	❍	44.	❍	❍	❍	❍					
15.	❍	❍	❍	❍	30.	❍	❍	❍	❍	45.	❍	❍	❍	❍					

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