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WHAT’S INSIDE

Chapter 1: Best Practices with Lesbian, Gay & Bisexual Youth and Their Families, Updated 1st Edition
[3 Contact Hours] ______ **1**

The purpose of this course is to provide human services and mental and behavioral health professionals with definitional information, historical and sociopolitical frameworks impacting the lives of LGB youth, as well as the influences of community and family contexts.

Chapter 2: Cultural Humility for All Healthcare Professionals
[2 Contact Hours] ______ **19**

This course presents an introduction to cultural humility and offers tools for healthcare professionals to use when working with diverse patients in a culturally humble manner. The course highlights the importance of cultural humility and the reasons why it is necessary and outlines a quantifiable set of attitudes that allow healthcare professionals to work effectively within the cultural context of each patient. There is an understanding that cultural humility is an ongoing process and is a prerequisite for cultural competency.

Chapter 3: Ethics in Behavioral Health Documentation: Reasons, Risks, and Rewards
[3 Contact Hours] ______ **34**

This intermediate–level course will help novice and seasoned practitioners approach documentation in a way that is guided not solely by what is mandated, but by what is mutually beneficial to the practitioner, the agency, the funding source, and most of all, the clients.

Chapter 4: Professional Ethics and Law
[4 Contact Hours] ______ **58**

With increasing frequency, military personnel and veterans experience mental health problems upon return from deployment. This intermediate-level course sensitizes mental health providers to military cultural norms. The course describes postdeployment transition, reintegration, and adjustment, and identifies common mistakes that clinicians make in treating this population. Military families are discussed, including marital satisfaction and the effects of military life on the spouse and children. Assessment and treatment methods for PTSD, depression, suicide risk, substance use disorders, and traumatic brain injury are all described. The various treatment methods are explained in detail, and include case vignettes to illustrate client and therapist interactions.

Chapter 5: Suicide Risk in Adults: Assessment and Intervention, 2nd Edition
[3 Contact Hours] ______ **90**

The purpose of this course is to assist clinicians in understanding factors that contribute to suicidal behavior, conducting comprehensive suicide risk assessments, and engaging patients in brief, empirically-supported interventions to reduce risk of death. This course meets an increasing demand of many mental health professionals seeking information about working with suicidal clients and conducting empirically-supported suicide risk assessments. This intermediate-level course is designed for social workers, mental health counselors, marriage and family therapists, educators, community-based program administrators, providers, and psychologists. The course will cover major risk factors, demographics and warning signs for suicidal behavior, as well as provide guidance on clinical risk assessment and options for intervention. Although the information presented here is useful to many mental health providers, no continuing education course can provide all the information that may be required in working with each individual who comes for help. It is therefore important that mental health providers consult knowledgeable colleagues, review the most recent articles and books on the topic of suicide, read and understand the risk-management practices of their agency, and maintain awareness of applicable local and state laws concerning the management and referral of suicidal persons. References and resources for those interested in pursuing further education on this topic are provided at the end of the course.

FREQUENTLY ASKED QUESTIONS

What are the requirements for license renewal?

License Expires	Contact Hours and Mandatory Subjects
Varies depending on state.	See state requirement chart on the following pages.

How much will it cost?

COURSE TITLE	CONTACT HOURS	PRICE	COURSE CODE
Chapter 1: Best Practices with Lesbian, Gay & Bisexual Youth and Their Families, Updated 1st Edition	3	$27.00	SWUS03BP
Chapter 2: Cultural Humility for All Healthcare Professionals	2	$18.00	SWUS02CH
Chapter 3: Ethics in Behavioral Health Documentation: Reasons, Risks, and Rewards	3	$27.00	SWUS03ET
Chapter 4: Professional Ethics and Law	4	$32.00	SWUS04PE
Chapter 5: Suicide Risk in Adults: Assessment and Intervention, 2nd Edition	3	$27.00	SWUS03SR
Best Value - Save $56.05 - All 15 Hours	**15**	**$74.95**	**SWUS1523**

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Are you an approved provider?

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Important information for licensees:

Always check your state's board website to determine the number of hours required for renewal, mandatory topics (as these are subject to change), and the amount that may be completed through home-study. Also, make sure that you notify the board of any changes of address. It is important that your most current address is on file.

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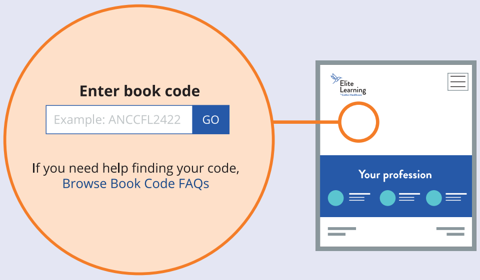
- Follow the online instructions to complete your final exam. Complete the purchase process to receive course credit and your certificate of completion. Please remember to complete the online survey.



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Course Name	Course Code
All 15 Hours in the book	**SWUS1523**
Best Practices with Lesbian, Gay & Bisexual Youth and Their Families, Updated 1st Edition	SWUS03BP
Cultural Humility for All Healthcare Professionals	SWUS02CH
Ethics in Behavioral Health Documentation: Reasons, Risks, and Rewards	SWUS03ET
Professional Ethics and Law	SWUS04PE
Suicide Risk in Adults: Assessment and Intervention, 2nd Edition	SWUS03SR

How Many Continuing Education Hours do I Need?

NOTE: CE Rules can change. Always check your state board for the most up-to-date information.

STATE	HOURS REQUIRED	HOURS ALLOWED BY HOME-STUDY	MANDATORY
Alabama	30	20	3 hours in ethics; 3 hours in clinical (if licensee has a clinical designation).
Alaska	40	0	6 hours in substance abuse education; 6 hours in cross-cultural education, of which three hours include issues relating to Alaska Natives; 3 hours in professional ethics; and 3 hours in teletherapy practice.
Arizona	30	40	3 hours in behavioral health ethics or mental health law; 3 hours in cultural competency and diversity.
Arkansas	30	15	3 hours of ethics.
California	36	36	6 hours of laws and ethics each renewal; 7 hours of HIV/AIDS (required first renewal only); 3 hours of Telehealth (one time requirement for renewals after 7/1/2023). Marriage and Family Therapy (6 hours) per BPC section 4999.20 *Only required for the following LPCCs – otherwise course is not required: • LPCCs who choose to assess or treat couples or families. • LPCCs supervising an MFT trainee or Associate MFT. • LPCCs supervising an LPCC or Associate PCC gaining experience with couples or families.
Colorado	40	20	None.
Connecticut	15	10	1 hour on cultural competency; 2 hours mental health conditions common to veterans and family members of veterans, including (1) determining whether a patient is a veteran or family member of a veteran, (2) screening for conditions such as post-traumatic stress disorder, risk of suicide, depression and grief, and (3) suicide prevention training (first renewal and once every six years thereafter).
Delaware	40	40	6 hours in ethics; 1 hour in mandatory reporting.
District of Columbia	40	40	6 hours in ethics, 2 hours in LGBTQ, 2 hours in COVID CEs, 4 hours in relevant topics designated as D.C. Health Public Health Priorities. In person CEUs waived for 2023 renewal.
Florida	30	30	2 hours Preventing Medical Errors in Behavioral Health (each renewal); 3 hours Ethics & Boundaries in Psychotherapy - or - 3 hours Teletherapy (each renewal); 2 hours Domestic Violence (required every third renewal); 3 hours Florida Laws and Rules (required every third renewal); Supervisors: 4 hours Qualified Supervision Training (every third renewal).
Georgia	35	10	5 hours of ethics relating to professional counseling, social work, marriage or family therapy (must be in an interactive format: live or synchronous). 15 hours have to relate to specialty/profession.
Idaho	20	20	1 hour of ethics.
Illinois	30	15	3 hours of ethics; 3 hours of cultural competency, 1 hour of sexual harassment prevention; 1 hour of implicit bias.
Indiana	40	40	At least 20 hours of Category I Continuing Education and 2 hours of Category I Ethics Continuing Education.
Iowa	27	27	3 hours in ethics.
Kansas	40	40	3 hours in ethics; 6 hours related to the diagnosis and treatment of mental disorders.
Kentucky	30	30	3 hours of ethics; 6 hours of suicide assessment, treatment and management (every six years); 3 hours in domestic violence and elder abuse; 1.5 hours in pediatric abusive head trauma (every six years); 3 hour supervision course for supervisors.
Louisiana	20	10 (limit waived through 8/31/2023)	3 hours in ethics; 10 hours in diagnosis and treatment (LCSW); 3 hours in clinical supervision if designated a supervisor.
Maine	25	10	4 hours in ethics (6 hours for conditional licensees); 12 hours in family and intimate partner violence (one time requirement).
Maryland	40	20	3 hours in ethics and professional conduct, including boundary issues, or pertaining to the standards of practice and laws governing the profession of social work in Maryland; 3 hours in supervision if a supervisor.

STATE	HOURS REQUIRED	HOURS ALLOWED BY HOME-STUDY	MANDATORY
Massachusetts	30	30	2 hours in anti-racism with a focus on oppression; 1 hour in anti-discrimination; 2 hour Board-approved training in domestic and sexual violence (one time requirement).
Minnesota	40	20	1 hours in ethics; 4 hours in cultural responsiveness.
Mississippi	40	20	4 hours of ethics; 2 hours of cultural diversity/multicultural issues/cultural competency awareness; 1 hour in mandated reporting for all client populations.
Missouri	30	15	3 hours of ethics; 2 hours of suicide assessment, referral, treatment, and management; 3 hours in explicit or implicit bias, diversity, inclusion, or cultural awareness/competency/humility.
Montana	20	20	2 hours related to suicide prevention.
Nebraska	32	20	2 hours of mental health ethics.
Nevada	30	30	2 hours in suicide prevention and awareness; 2 hours in cultural competency, diversity, equality and inclusion; 4 hours in ethics (LCSW and LISW require 36 CE hours).
New Hampshire	40	20	6 hours of ethics and 3 hours of suicide prevention (Category A).
New Jersey*	40	40	5 hours of ethics; 3 hours of social and cultural competence; 1 hour of prescription opioid drugs* *Not all courses contained in this book are approved for New Jersey. New Jersey accepts courses that are approved by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) programs, these courses can be found online at: https://www.elitelearning.com/social-work/new-jersey/
New Mexico	30	30	6 hours in cultural awareness.
New York	36	12	3 hours in appropriate professional boundaries.
North Carolina	40	20	4 hours of ethics.
North Dakota	30	10	2 hours of ethics; LPCCs require an additional 10 clinical hours.
Ohio	30	30	3 hour of ethics; 3 hours of supervision training for supervising professional counselors.
Oklahoma	16	8	3 hours of ethics; 3 hours of supervision for supervisors. *Oklahoma does not accept NBCC approval for Counselor continuing education credit.
Oregon	40 - LCSW 30 - LMSW 20 - RBSW	40 - LCSW 30 - LMSW 20 - RBSW	6 hours of ethics (4 hours LMSW, 3 hours RBSW); 6 hours of cultural competency (4 hours LMSW, 3 hours RBSW); 2 hours of suicide risk assessment, training and management (all).
Pennsylvania	30	30	3 hours in ethics; 2 hours in state-approved child abuse recognition and reporting; 1 hour in suicide prevention.
Rhode Island	30	8	3 hours in ethics; 3 hours in cross-cultural practice.
South Carolina	40	40	Supervisor must complete 10 hours of supervision oriented continuing education during every two-year licensure period.
South Dakota	30	30	None.
Tennessee	15	10	3 hours of ethics; 2 hours of Board-approved suicide prevention (every 4 years); 1 hour rules and regulations of the Board.
Texas	30	30	6 hours of ethics (completion of Texas jurisprudence exam will count as 1 hour of continuing education in counselor ethics); 1 hour of human trafficking prevention; 6 hours of supervision if licensee has supervisor status; 3 hours in cultural diversity or competency.
Utah	40	15	6 hours of ethics; 2 hours of suicide prevention.
Vermont	20	5	1.5 hours in ethics.
Virginia	15	15	3 hours in ethics or the standards of practice or laws.
Washington	36	26	6 hours of professional ethics; 6 hours of training in suicide assessment, treatment and management. The training must be repeated once every six years.
West Virginia	30	10	3 hours of ethics and 2 hours must be specific to veterans and family members of veterans; 3 hours of supervision of clinical counseling if have supervisor status.
Wisconsin	30	26	4 hours of ethics and professional boundaries (must be in an interactive format: live or synchronous).
Wyoming	45	45	3 hours of ethics; 3 hours of suicide assessment or intervention.

NOTE: CE Rules can change. Always check your state board for the most up-to-date information.

Chapter 1: Best Practices with Lesbian, Gay & Bisexual Youth and Their Families, Updated 1st Edition

3 Contact Hours

Release Date: March 26, 2019 **Expiration Date:** March 26, 2024

Upon successful completion of this course, continuing education hours will be awarded as follows:
Social Workers and Psychologists: 3 Hours
Professional Counselors: 3 Hours

Faculty

Author:
Gayle Mallinger, PhD, MSW, is an associate professor in social work at Western Kentucky University. She earned her MSW and PhD in social work at the University of Pittsburgh. Her research focuses on examining the influence of intersecting contexts on individual, family, and community resilience. Specifically, she investigates the determinants of social injustice and the evaluation of interventions aimed at promoting equity. Her current work is centered on the efficacy of varied pedagogical strategies in preparing social work students to successfully practice with lesbian, gay, bisexual, and transgender client systems.

Gayle Mallinger, PhD, MSW has disclosed that she has no significant financial or other conflicts of interest pertaining to this course book.

Mitchell Rosenwald, PhD, LCSW, is an associate professor of social work at Barry University in Miami Shores, FL. He received his MSW and PhD in social work from the University of Maryland at Baltimore, his MA in sociology from Syracuse University in Syracuse, NY, and his BA in sociology and economics from Salisbury University in Salisbury, MD. Dr. Rosenwald has worked with children and families and co-facilitated youth groups for lesbian, gay, bisexual, and transgender youth. He has presented on key issues in adolescent development for this population and his publication topics include practice with the LGBT population in child welfare settings and psychotherapy groups. He is the co-author of Advocating for Children in Foster and Kinship Care.

Mitchell Rosenwald has no significant financial or other conflicts of interest pertaining to this course book.

Content Editor:
Rebecca G. Harvey, PhD, has been affiliated with the Marriage and Family Therapy Program at Seton Hill University in Greensburg, PA, as an assistant professor since 2004 and as its program director since 2009. Dr. Harvey received her MSW in 1996 and her PhD in marriage and family therapy in 2007, both from Syracuse University in Syracuse, NY. In addition to her academic appointments, Dr. Harvey has had more than 15 years of clinical experience, including as a family therapist, support group facilitator, crisis counselor, and health education coordinator. She maintains private family therapy practices in Beverly, MA, Syracuse, NY, and Greensburg, PA. Dr. Harvey has written extensively and presented throughout the United States, Canada, and Mexico on topics related to sexual identity, sexual health, and gay and lesbian youth.

Rebecca G. Harvey has no significant financial or other conflicts of interest pertaining to this course.

Behavioral Health Planner: Lys Hunt, MSW, LICSW
The planner who worked on this continuing education activity has disclosed that they have no significant financial or other conflicts of interest pertaining to this course.

How to receive credit

- Read the entire course online or in print.
- Depending on your state requirements you will be asked to complete:
  - A mandatory test (a passing score of 75 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- Provide required personal information and payment information.
- Complete the mandatory Course Evaluation.
- Print your Certificate of Completion.

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INTRODUCTION

Learning objectives

After completing this course, the learner will be able to:

- Discuss lesbian, gay, and bisexual (LGB) youth development.
- Explain contemporary challenges facing LGB youth and their families.
- Differentiate the family therapy models used with LGB youth and their families.
- Identify additional interventions for LGB youth and their families.

Course overview

While lesbian, gay, and bisexual (LGB) youth have always existed, it is only within the past few decades that their visibility as a population, and a fuller exploration into their development, have been the focus of psychological and social inquiry. Gathering prevalence information is fraught with difficulty; however, many behavioral health and healthcare professionals in the United States, knowingly or unknowingly, have or are likely to encounter LGB youth and their families in their practice. These professionals are in a unique position to help these youth and their families through the various transitions and other issues that they may encounter. Indeed, research suggests that the more these families accept their children, the better off the children will be in their health and well-being (Ryan & Diaz, 2011).

This basic-level course begins its exploration of this youth population with a definition of terms, a model of identity development, and a focus on diversity considerations. The course then discusses four major areas that affect LGB youth in their development as adolescents. Because issues facing any adolescent are commonly also family issues, particular focus is paid to interventions from a family systems perspective, including an in-depth exploration of three models of family therapy (structural, solution-focused, and narrative) that can be applied to work with LGB youth and their families.

The purpose of this course is to provide current information on issues and dynamics that affect LGB youth and their families, as well as best practices for working with this population. The target audience for this course is behavioral health and healthcare professionals, including psychiatric-mental health nurses, social workers, mental health counselors, marriage and family therapists, and psychologists; however, other professionals who interact with LGB youth will find this course useful.

After successfully completing this course, the learner will have an increased knowledge and understanding of the LGB youth population, the issues that LGB youth face, and specific models of family and other interventions that may be used in working with these youth and their families. It is hoped that this course inspires practitioners to pursue advanced knowledge and skills that will strengthen their interventions with this population.

LGB YOUTH DEVELOPMENT

Understanding youth sexual orientation

Although lesbian, gay, and bisexual (LGB) youth have always existed in the population, in the past few decades there has been a significant increase in the visibility of LGB adolescents. Counting the number of LGB youth in the United States is a particular challenge because responses to survey questions on sexual orientation tend to underreport LGB identity and the populations surveyed tend not to be nationally representative; moreover, youth may indeed not come out with LGB identification in adolescence. However, it is helpful to have some "ballpark" statistics to know that the chance of a professional working with an LGB youth is not only quite possible but also very probable. According to the American Academy of Pediatrics (AAP), up to 10% of the population may be lesbian, gay, or bisexual (AAP, 2014). It is very likely that there are many more youth who will question their identification and ultimately "come out" who are also not counted in surveys. Given this reality, it is vital that families provide stability and support for these youth as they develop their sexual orientation. Indeed, it is essential that practitioners help families identify supportive measures that optimize outcomes, as well as reject behaviors that can result in poor health and mental health outcomes for the youth (Ryan & Diaz, 2011).

Origins of sexual orientation

A common question is why someone is lesbian or gay. Of course, asking this question illuminates a larger question as to why someone is interested in the origins of a homosexual or bisexual orientation – after all, individuals tend not to ask about why someone is heterosexual. Nonetheless, the latest research suggests that a number of factors may be responsible for determining sexual orientation. The American Academy of Pediatrics believes sexual orientation is fixed and is created by a combination of factors, including genetic predisposition (AAP, 2014). Summing up the research, the American Psychological Association (APA; 2008) states:

> *There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles; most people experience little or no sense of choice about their sexual orientation* (APA, 2008, p. 2).

In summary, it is important to recognize that there are probably many reasons for a person's sexual orientation, and research in this area continues. It is also important to emphasize that an LGB sexual orientation is *not* pathological but, instead, is reflective of human variance. It is vital for practitioners to know that focusing on why youth (and adults) are LGB might be interesting, but distracts from the larger goal of assisting them with normative development.

Definitions

It is important to begin with a clear understanding of definitions, which have caused confusion among professionals. *Sexual orientation* is the romantic/emotional and sexual attraction and affiliation that an individual experiences toward another. Heterosexual orientation (attraction to the opposite sex) has historically been perceived to be the only "normal" sexual orientation; however, as norms have changed and the American Psychological Association removed "homosexuality" from its *Diagnostic and Statistical Manual of Mental Disorders, Second Revision (DSM-II)*, list of psychological disorders in 1973 (and other mental health and medical associations followed suit), homosexual and bisexual sexual orientations have increasingly been seen as legitimate and genuine alternatives.

As the terms associated with sexual orientation are reviewed, it is important for clinicians to keep in mind that as youth begin, and continue, their process of self-realization with respect to sexual orientation, the youth's self- identification may develop in ways that are more flexible or fluid, and less rigid, than some of these terms indicate. Therefore, *sexual minority* is an umbrella term that can apply to this population of youth who are in the process of exploring and defining their sexual orientation that is outside of heterosexuality. Clinicians should be aware of this fluid self-identification process and be mindful of not being too rigid when helping youth and families work with the following labels.

It is also important for clinicians to be mindful and think beyond the word "sexual" (which is part of the common terminology of *sexual orientation* and *sexual minority*) when working with this population. This means that a youth's attraction and behavior toward another person has emotional and romantic components as well, which are very important dynamics to assess and address in the clinical setting.

Lesbian is a term some females use to describe their sexual orientation and attraction to other females, while *gay* is a term used by many males and some women to describe their same-sex sexual orientation and attraction. *Bisexual* is a term used by some individuals to describe their sexual orientation and attraction to both sexes. Bisexuality for some may be a step in the process on the way to recognizing her or his sexual orientation, or it may be the final recognition of identity itself for a person whose sexual orientation extends to individuals of both sexes.

Heterosexism is a term that refers to the social belief that the world is and should be heterosexual. Heterosexism in the United States is presented in various forms, from the current federal restriction on the definition of "marriage" as between a woman and a man (in the Defense of Marriage Act) to popular love songs and Valentine's Day greeting cards offering only heterosexual options. Heterosexism is the pervasive yet sometimes subtle social view or force that reinforces heterosexuality as the only "normal" and therefore "acceptable" sexual orientation; this force becomes very important to LGB youth, as this course will later discuss.

Homophobia is prejudice and/or discrimination toward individuals based on their perceived or actual sexual orientation. Such homophobia is grounded ultimately in fear of this social subgroup and it reinforces heterosexism at the societal level. A number of issues that LGB youth experience relate to coming of age in a world where homophobia is still fairly pervasive and threatens their well-being and sense of safety. Internalized homophobia is an intrapsychic barrier and a task to be surmounted by youth who are coming to terms with their uncertainty or shame about their LGB identity.

The *closet* is the dynamic in which homophobia or internalized homophobia prevents an individual from recognizing her or his nonheterosexual orientation. *Coming out* is the process by which an individual acknowledges to himself or herself, and to the people in their lives, that they are not heterosexual. It is important to note that they may also identify as *questioning* or *queer*, or choose not to identify. Assuming any one of the "labels" that have been discussed in this section is an extremely complex process. It is during this important process that behavioral health professionals can often be helpful, although the youth's journey and self-identification likely began long before discussing it with anyone.

While this course focuses on youth with LGB sexual orientations and their families, it is important to note that the concept of *gender identity* is, at times, confused with sexual orientation. Gender identity is separate from sexual orientation and refers to an individual's internal sense of femaleness or maleness (which encompasses any gendered thought and/or behavior). Individuals who feel that their sense of gender "matches" their biological sex can be referred to as *cisgender*. Conversely, individuals who feel some incongruence with the sex with which they were born and with their inner sense of maleness or femaleness may identify with the opposite gender. This is referred to under the umbrella term of *transgender*, commonly abbreviated as "T" (Mallon, in press). Individuals who are transgender express their gender identity in a variety of ways, including occasionally dressing as a member of the opposite gender, living as a member of the opposite gender, and sometimes physically changing their anatomy through an operation or operations. Gender identity issues are largely misunderstood by society, and this lack of understanding has led some people to alienate and feel hateful toward youth who are transgender. Transgender individuals can also face prejudice and/or discrimination called *transphobia*.

The development of gender identity and sexual orientation may at times overlap. A youth may articulate gender identity concerns ("I should have been a girl"), which during the development process can continue into a transgender identity but may also often transition into an LGB sexual orientation. It is important for clinicians to remember that although these concepts are related and overlapping, they are distinct. Not all individuals who are transgender are LGB, and not all LGB people are transgender. One's inner sense of maleness or femaleness is quite different from the object of one's romantic or sexual attraction. Although these two groups often share an experience of being stigmatized because their life experiences are challenging to traditional notions of gender, sex, and sexuality (and this may create affinity), these two groups are in fact so different that some LGB individuals exhibit prejudice toward those who are transgender. The reason that individuals who are LGB and those who are transgender are considered together is more for increased visibility in society and the advancement of civil rights than because of any other affiliation.

LGB youth and individuals in general will identify as lesbian, gay, or bisexual; however, others may identify as questioning or queer (Q). Thus, when this population is referred to with a Q in the label, it pertains to *questioning* – in which case the youth is wondering about his or her sexual orientation but has not come to a conclusion, or *queer* – in which case the youth is using, through reclaiming, a previously homophobic term. Still other youth wish not to identify with any of these labels because they perceive sexual orientation as being fluid. One of the most important and difficult issues for sexual minority youth is that they must develop a healthy identity in the midst of great stigma. Therefore, the difference between how they label themselves versus how others label them is an integral part of this process of healthy development. The uses of Q can be meaningful because youth eventually get to claim or reject labels as they see fit. One of the most fundamental and powerful things a professional can do for youth is to create a space where they are allowed to explore identity without forcing any labels.

At times the clinician might also encounter the acronym "LGBTQQIS." Aside from the aforementioned definitions, the I refers to *intersex* (youth who are born with genitalia of both genders and are typically raised as females), and the S refers to *straight* (heterosexual allies – those heterosexual individuals who advocate for greater acceptance for this population). From a cultural perspective, some males, particularly in African American and Hispanic communities, might state they are on the "down low" and, while having same-sex behavior with males, do not identify as gay or bisexual. Finally, *Two Spirit* is a term specific to the Native American community in which some individuals believe they are born with and thus embody both genders. Table 1 presents, for reference, some of the core definitions that have been described.

Table 1: Definitions	
Bisexual ("B")	A term used by some individuals to describe their sexual orientation and attraction to both sexes.
Cisgender	A term used to describe individuals who feel some congruence with the gender with which they were born (assigned gender) and their inner sense of maleness or femaleness.
Coming Out	The process by which individuals acknowledge to themselves and to the people in their lives that they are lesbian, gay, or bisexual. They may also identify as questioning or queer, or choose not to identify.

Table 1: Definitions	
Gay ("G")	A term used by many males to describe their sexual orientation and attraction to other males. Some females also utilize this word.
Gender Identity	An individual's internal sense of femaleness or maleness.
Heterosexism	The pervasive yet sometimes subtle social view or force that reinforces heterosexuality as the only "normal" and therefore "acceptable" sexual orientation.
Heterosexual	Individuals whose sexual orientation is attraction to the opposite sex.
Homophobia	Prejudice and/or discrimination toward individuals based on their perceived or actual sexual orientation.
Internalized Homophobia	An intrapsychic barrier and a task to be surmounted by youth who are coming to terms with their uncertainty or shame over their LGB identity.
Intersex ("I")	Youth who are born with genitalia of both genders and are typically raised as females.
Lesbian ("L")	A term some females use to describe their sexual orientation and attraction to other females.
Queer ("Q")	A term some individuals use to identify a nonheterosexual identity. This reclaims a previously homophobic term.
Questioning ("Q")	A term used by an individual who wonders about her or his sexual orientation but has not come to a conclusion.
Sexual Orientation	The romantic/emotional and sexual attraction and affiliation that an individual experiences toward another.
The Closet	The dynamic in which homophobia or internalized homophobia prevents an individual from recognizing her or his nonheterosexual orientation.
Transgender ("T")	A term used to describe individuals who feel incongruence with the gender with which they were born (assigned gender) and their inner sense of maleness or femaleness. The person innately identifies with the opposite gender.
Transphobia	Prejudice and/or discrimination directed toward transgender individuals.

LGB youth identity development

Adolescence – specifically early adolescence, on which this course will focus – is the developmental period between the ages of 12 and 18 (Newman & Newman, 2015). In this period, youth "[confront] a new psychosocial conflict, in which pressures to ally oneself with specific groups and to learn to be comfortable functioning as a member of a group are major preoccupations. This conflict is called *group identity versus alienation*" (Newman & Newman, 2015, p. 365). While this normative task applies to all youth, it is complicated by the reality that LGB youth face an additional developmental task that is unique to their population; this task addresses the need to accept a nonheterosexual sexual orientation in a social context that, although showing signs of easing, is still replete with heterosexism and homophobia. Although a central limitation of any model is that there cannot be a "one size fits all" application, the following model does present some core considerations that can assist practitioners in understanding and empathizing with LGB youth.

Models of LGB identity development

A classic model of identity development among LGB youth is Troiden's model (Troiden, 1989). The first stage is *sensitization*, in which children might have an experience or experiences that provide beginning awareness that they may be different, but they likely lack the understanding to describe or articulate this to themselves or to others. The second stage is *identity confusion*, in which a youth is increasingly aware that he or she is not heterosexual. During this stage the youth begins to become aware of and directly face pervasive stigma, heterosexism, and his or her own internalized homophobia. Because of this, it can be very difficult for the youth to acknowledge an LGB sexual orientation. It might be safer to avoid, conceal, or even reimagine past same-sex behaviors. The third stage is *identity assumption*. In this stage, youth begin to feel more comfortable in taking on a nontraditional sexual orientation. Often they have created a space in which to begin safely exploring and questioning whether they could in fact begin to identify as LGB. The final stage is *commitment*. In this stage, internalized homophobia has decreased as the youth continues to feel more comfortable integrating a lesbian, gay, or bisexual identity with his or her self-concept. Here, the individual is able to come out to self and others to the extent he or she chooses (Troiden, 1989).

Table 2 presents the model of homosexual identity development that can be applied to LGB youth and has possible application to bisexual identity development.

Table 2: Stages of Homosexual Identity Development
1. Sensitization. 2. Identity Confusion. 3. Identity Assumption. 4. Commitment.
Note. From Troiden, R. R. (1989). The formation of homosexual identities. *Journal of Homosexuality, 17*(1), 43-74.

Consistent with more recent thinking on any stage model, identity development among LGB youth does not necessarily always proceed linearly through subsequent stages without returning to an earlier stage. Moreover, a caution regarding stage theory models is that they focus clinicians, families, and even youth themselves on individual factors and de-emphasize the contextual elements that have vital implications for the development of healthy sexual identities for LGB youth. For example, a youth might be approaching the final stage of commitment and yet, after being bullied at school for being out as a gay teen, the youth might believe that, for safety purposes, he might return to the closet of the identity confusion stage.

Yet another youth might have such great social support and personal resiliency that she practically skips the identity confusion stage and commits to being lesbian. For others still, a commitment might be to a "queer" identity or no identity at all because some youth question the need and utility of categories of sexual orientation in the first place.

Since the introduction of Troiden's model of homosexual identity development (Troiden, 1989), further scholarship has provided additional insight. After reviewing a number of earlier theoretical models, in 2006 Margaret Rosario and colleagues concluded that:

> *"[I]dentity formation consists of becoming aware of one's unfolding sexual orientation, beginning to question whether one may be LGB, and exploring that emerging LGB identity by becoming involved in gay-related social and sexual activities" (Rosario, Schrimshaw, Hunter, & Braun, 2006, pp. 46-47).*

In their research, Rosario and her colleagues also found that two types of development occur: youth can maintain their sexual orientation over time from an earlier age, or they can more gradually change to another sexual orientation. For example, in their study, youth who identified as gay/lesbian and bisexual earlier in life were more likely to identify as only gay or lesbian when they were older, while those who exclusively identified as bisexual when younger were more likely to continue to identify as bisexual as they became older.

Role of cultural diversity in identity development

Aside from this general discussion of identity formation and development, LGB youth are not an otherwise uniform group. Cultural diversity is present within the whole of the human experience and its presence within the LGB youth population is no exception. The culturally diverse variables of gender, gender identity, race, and class are some additional factors affecting identity development that need to be considered. Ability, national origin, and religion are other such variables. It is well known that gender plays a highly significant part in the development of children and adolescents; females are expected to embody more feelings (be affect-oriented), whereas males are socialized to be more task-oriented. With LGB youth, the influence of gender on sexual orientation can play out such that it might be easier for girls to "come out" than boys because, for example, it is more acceptable in the United States to see women rather than men walking hand-in-hand and showing affection. In Rosario and colleagues' 2006 study, female youth were more likely than male youth to identify as gay/lesbian.

Race plays a very important role with regard to sexual orientation. Heterosexism is still pervasive in African- American and Latino communities. Youth of color may struggle to manage the stigma associated with holding two "minority" statuses – sexual orientation and race (Kuper, Coleman, & Mustanski, 2014). This is made more complicated by those who identify as "down low" (described earlier as a label that refers to an individual's same-sex attraction and behavior without identification of being gay or bisexual; Kuper et al., 2014). Racism in the LGB community continues to exist (Balsam, Molina, Beadnell, Simoni, & Walters, 2011). The civil rights movement for LGB individuals has largely been a Caucasian endeavor. This does not mean that people of color have been completely ignored, but it is only in recent years that LGB organizations have been making better efforts to include discussions of race.

Finally, class is relevant, particularly in the context of access to supports. Kosciw, Greytak, and Diaz (2009) found that LGB youth who were poverty-stricken were less likely to have supportive school environments and more likely to encounter homophobia at school. Identity development is linked to social supports, and some of these social supports come at a cost. Because some LGB or questioning youth are concealing their identities from their families, they may be more self-reliant on their own funds to access social supports. For example, although smartphones and computers with Internet connections are commonplace, some individuals have limited or no access to such technologies due to their associated costs. Much social support for LGB youth is generated through Internet connections; therefore, not having full access to these potential supports might hinder identity development.

To reduce the barriers of poverty and increase the numbers of youth who receive the benefits of social supports, many resources for LGB youth are purposely free of charge. However, even free supports have associated costs. Those youth with more means are more likely to have the finances to arrange transportation and pay other costs associated with attending LGB youth community meetings typically found in more urban regions. Those with fewer funds might again face difficulty obtaining this support and, even with means, this difficulty may be further compounded if these individuals live in rural areas (Leedy & Connolly, 2008).

Identity development among LGB youth is a complex process. At its core, it is about an individual's safe exploration, confusion and questioning, and commitment to an LGB sexual orientation. It is further complicated by the diversity of the youth involved based on gender, race, age, class, and other variables. The best practice for a practitioner is to have some familiarity with these developmental issues and processes, knowledge of the youth's environmental context unique to his or her region (e.g., different school districts' responses to LGB students), and associated supportive resources for LGB youth in the region. As always, the practitioner needs to begin with the client's identification of goals he or she would like to achieve.

CONTEMPORARY CHALLENGES

Coming out

Impact on youth

As described earlier, *coming out* refers to the process by which an individual consciously discloses to herself or himself, and to others, the identification that he or she is lesbian, bisexual, or gay. (Coming out can also refer to transgender acceptance.) Research shows that youth are coming out at younger ages, usually in the early-to mid- teen years. This is younger than in earlier cohorts and the trend shows that the age of coming out continues to get younger over time (Drasin et al., 2008). This occurs for a variety of reasons. The exponential growth in the use of the Internet and social networking has created instantaneous groups in which youth can build community. In-person communities, whether Gay/Straight Alliances (GSAs) in school and/or youth support groups affiliated with social service or mental health agencies are also on the rise. The increased presence of contemporary adult role models who are public about their identity and/or relationships, including NFL football player Michael Sam, U.S. Senator Tammy Baldwin, actors Neil Patrick Harris and Jodie Foster, and other celebrities, provide more positive images of adults who can be successful, adjusted, and open about being LGB. In addition, state regulations related to marriage equality have widened the national dialogue concerning discrimination based on sexual orientation in the media, schools, and communities.

Nevertheless, certain factors also contribute to keeping youth *in the closet* or *closeted* – that is, forced to hide or even making it difficult to admit to themselves an LGB orientation. For example, the role of religion is complex and can present a very strong viewpoint that nonheterosexual orientation is immoral. However, in recent years, many religions and denominations have developed organizational subentities that are affirming of LGB individuals. Additionally, the role of family members can also be complex, and the degree to which a youth feels comfortable to come out is based in part on the family's acceptance of the LGB sexual orientation. Sometimes youth will actually come out to relatives who are not their parents, saving the perceived most-difficult disclosure for last.

Family response

The response of the family, particularly the parents, is typically so central to a youth's identity development that it can be a common issue when LGB or questioning youth and their families have family therapy, especially upon the youth's coming out. Ideally, parents (or adult caregivers) showcase their unconditional love for their children and instantly embrace their child, regardless of any sexual orientation. Although this does occur sometimes and should be celebrated, it is common for even supportive parents and family members to experience a grieving process. Ironically, a youth's coming out to parents commonly serves as a forced catalyst to the family's own coming out process (their public acknowledgment that they have an LGB family member) and the sometimes sudden onset of grief in particular (Parents, Families and Friends of Lesbians and Gays [PFLAG], 2014). Of course, when a family comes out, they also do so in the context of heterosexism and homophobia as they currently exist in the larger society. Parents will often need to grieve that their children will not grow up and marry a person of the gender that the parents thought they would; their children may not have children (although plenty of LGB adults have their own children) or may have children in non-traditional ways; and the realization that they (the parents) will need to either hide their child's LGB identity or come out to their own friends, other relatives, and so forth when one day asked why their child is not married (to the opposite gender). The challenges heterosexism and homophobia present regarding these tasks should be acknowledged and addressed as part of the family's or parents' own coming out process (Saltzburg, 2009).

It should be noted that the above is applicable when a youth explicitly comes out. There are other situations in which, for many reasons, families might "suspect" for years (even into adulthood) that their children or siblings are LGB, including that they never date someone of the other gender and/or they have a close "companion" of the same sex. In these cases, the youth is at least partially closeted and, therefore, the family's perception (which may not be confirmed) is that the youth is LGB. To show support, families can help normalize same-sex relationships by asking if their loved one has "someone special" in her or his life (instead of an assumed gender-specific role). Additionally, families can create an atmosphere of support by clarifying their affirming view of LGB people in general, discussing LGB people and lives in everyday conversation, including well-known personalities such as Ellen DeGeneres, and/or by viewing age-appropriate LGB characters and stories in the media (e.g., television programs such as *Modern Family* and *Glee*), and affirming support of marriage equality or other issues of interest to the LGB community.

Parents may learn of their own child's LGB identification at the same time they learn their child is involved in a romantic relationship. Although sometimes the parents are instantly accepting of their child and their child's girlfriend or boyfriend, often this information can be overwhelming. Whenever possible, parents and other relatives need to avoid the "exceptionalization" argument in which parents make an "exception" for their child being LGB. In other words, parents might accept their child being LGB because the child is "not like" other LGB individuals. Parents might cite their love for the child and/or the child's adherence to gender conformity, which allows them to accept their child being LGB while still maintaining a homophobic stance toward other LGB individuals. When this attitude is pervasive, it can negatively affect the youth and her or his relationship as the parents accept their child but not the child's boyfriend or girlfriend. In actuality, this indicates that the parents have not completely accepted their child's LGB sexual orientation because, if they did, such acceptance would encompass all of the child's life, including choice of relationship and the romantic partner as well.

Many parents and other relatives gradually become more comfortable with having an LGB family member and can go through a self-reflective process that reminds them that the unconditional love they have for the youth will see their family through this "adjustment." In these cases, family therapy as well as adjunct therapies can be extremely helpful. However, for other families, their grief process becomes stuck on anger, emotional abuse, physical abuse, and perhaps abandonment (where the youth is forced to leave the family home). Although such negative responses to stress may be temporary in some families, for others they serve as permanent wedges and cause a lifetime of estrangement. Unlike most other forms of prejudice where, for example, parents provide support for their children who are experiencing challenges associated with racism, LGB youth cannot always assume that their parents will be sources of support. Indeed, this support can vary and change so much over time that the safe anchor that parents typically provide for their children cannot be automatically assumed. What is clear is that parental rejection of a child who comes out increases that youth's risks, whereas supportive parent-child relations better protect LGB youth from the challenges they face (Ryan & Diaz, 2011). Family therapy is therefore an increasingly important intervention for youth because even small improvements in family relations can be pivotal for their self-esteem and development.

Violence and bullying

Impact on youth

Tragically, individuals are still targeted for violence because they are gay, lesbian, or bisexual (as well as transgender). According to Federal Bureau of Investigation (FBI) statistics, 20.2% of reported hate crimes in 2013 were based on sexual orientation (FBI, 2014). While this percentage does not break down the age range of those who were victimized, it does depict a social reality in which LGB youth know that violence can occur and they need to be somewhat vigilant for their safety. In 2009, President Obama signed the Matthew Shepard and James Byrd, Jr., Hate Crimes Prevention Act, which expands federal definitions of hate crimes to include those related to sexual orientation (U.S. Department of Justice, n.d.).

Violence also occurs in school in the form of bullying. According to the Human Rights Campaign, youth who are LGB (as well as transgender youth) are twice as likely to report being bullied in the forms of verbal harassment, physical assault, and online harassment (cyberbullying) as non-LGBT students (Human Rights Campaign [HRC], n.d.). Bullying takes place both in person and as cyberbullying through social media like Facebook and Myspace (HRC, 2011). This genuine fear of bullying and other violence can result in LGB youth avoiding school or having difficulties concentrating on their schoolwork because they are understandably concerned for their safety and avoiding harassment. In some schools, a common prevention/intervention for bullying is having "safe spaces" in school in which a student can report bullying behavior. In essence, the school administration should appropriately intervene without bias to address this form of bullying; however, the reality is that schools range widely in how aware of and concerned they are about the bullying of LGB students. This presents an additional challenge for students enduring bullying because they are identified as LGB. Fortunately, if "out" youth can forge ahead despite bullying at school, they can experience better long-term well-being (Russell, Toomey, Ryan, & Diaz, 2014).

Finally, violence can at times occur in the home, where parents might physically abuse and/or neglect their children upon finding out they are LGB. Youth may either be forced to leave their homes or they choose to run away from a violent household. It is estimated that 15% to 30% of homeless youth are LGB (as well as questioning and transgender) and face major challenges of surviving on the streets, including survival sex, substance misuse, homophobia, suicide risk, and sexual exploitation (Rosario, Schrimshaw, & Hunter, 2012; Sherouse, 2015; Winter, Elze, Salzburg, & Rosenwald, in press). Federal programs are beginning to respond to the need to help this population (Winter et al., 2015).

Family response

The ideal family response is one of complete support. Parents and other relatives should create an atmosphere in which their children feel safe to report that they have been a victim of a hate crime or have been bullied at school. Youth who are not out to their parents may actively hide the fact that they are being bullied precisely because to disclose this would highlight that they are being targeted for their sexual orientation, which would risk outing them before they are ready. Most parents who are aware of their child's LGB identity are very concerned about their children's safety after they come out. They can take the lead in maintaining open lines of communication and periodically checking to see how safe their children feel in the school and the community. Additionally, parents can maintain strong ties with the school staff so that if and when bullying occurs in school, they can more easily advocate on behalf of their children.

For those parents who love their children but are struggling in their own coming out process as parents of an LGB child, the family system can be disrupted, and it is important that any conflicts be resolved in a constructive, peaceful manner. Parents or other relatives who are upset with the youth should be very aware of how their position affects not only the child but also other family members. Families can be greatly aided during this difficult time by counseling and community support, which can help provide a stable anchor for the families.

Mental health

Impact on youth

This problem was clearly brought to the national forefront in 2010 when, within a one-month period, five LGB youth in separate incidents all committed suicide as a result of being bullied. As a minority group, LGB youth experience prejudice and discrimination that not only affect their development into adulthood, but also can, for some, negatively affect their mental health (CDC, 2014b). The resilience of LGB youth varies tremendously based on the amount and degree of experienced stigma, sense of self-esteem, and social supports. Some youth progress well through early adolescence as they successfully negotiate the "group identity versus alienation" developmental task. Others experience varying degrees of alienation that may result in depression or even suicide, reflecting the affected youths' perception that ending life would be the best way to end their pain. It is important to note that LGB youth have a higher attempted suicide rate than heterosexual youth (CDC, 2014b). It is therefore essential to be attuned to the emotional and perhaps psychological impact that the coming out process and homophobia can have on youth. LGB youth also have a higher substance use rate than their heterosexual peers (Mustanski & Liu, 2013).

Family response

Families are a major protective factor for LGB youth. When parents respond effectively and supportively, it decreases the other risks their child faces because of being LGB (Ryan & Diaz, 2011). Ideally, families should be the stable entity that provides the support for LGB youth to explore their sexual orientation in combination with their overall development. When parents are rejecting, it often springs from their hope that this will actually help their child to fit in and be happier (Ryan & Diaz, 2011). Clinicians can therefore engage parents about their hopes to help their children, and underscore the importance of their acceptance and affirmation of their children. Moreover, clinicians can guide parents away from behaviors that, while meant to help, actually increase the risk of negative outcomes for their children.

Questions that parents can ask themselves in preparation for talking with their children appear in Table 3. These questions are important for parents, caregivers, and other relatives to be aware of; their genuine concern is vital and will certainly provide much-needed guidance and stability for youth.

Although this varies by culture, parents may be open to suggesting to their child that counseling, including individual and family counseling, might be helpful. The youth should have a choice about whether or not to go to counseling. Other supports include Gay/Straight Alliances at schools, online blogging, and LGBTQ community youth groups that provide other support in lieu of, or in combination with, counseling. Parents can also be mindful that focusing exclusively on the child's mental health can be myopic and might serve to neglect the real factor that they, themselves, may be "part of the problem" and that the family as a whole may need treatment.

Table 3: Questions for Parents to ask Themselves

- *Are they aware of any emotional challenges that their child might be facing? How well can they talk to their child about these challenges?*
- *What are their hopes for their child?*
- *In what ways are they or have they tried to be helpful to their child?*
- *What gets in their way of being more effective when talking with their child? Do they know how to seek professional assistance?*
- *Are they aware that they, as a family system, might need assistance?*
- *Is their child showing symptoms of depression, anxiety, substance dependence, or an eating disorder?*
- *Are they able to talk to their child about safe sex, contraceptives, and sexually transmitted diseases?*

One final statement is crucial regarding those professionals who persist in believing and advocating that a gay, lesbian, or bisexual sexual orientation can and should be changed. Neither is true; these archaic attitudes reflect a continued homophobia and are particularly dangerous when held by mental health practitioners because of the influence they have on LGB and questioning youth and their families. Specifically, such practitioners endorse the benefits of *reparative therapy*, which espouses the view that nonheterosexual orientation is both immoral and can be changed. Such an approach to treatment is antithetical, of course, to current understanding of sexual orientation as human variance rather than a psychological disorder. As discussed earlier, the American Psychological Association removed "homosexuality" from its list of "disorders" in 1973; in 1997 the same organization stated that reparative therapy was not an appropriate practice intervention because it can cause harm (APA Council of Representatives, 1997). Other major mental health organizations have followed suit.

Physical health

Impact on youth

While mental health is very important, attending to LGB youth's physical health is just as important. As youth think about and become sexually active, they are at increased risk of engaging in sexually risky behavior, which can lead to increased risk for contracting HIV and other sexually transmitted infections (STIs) (Whitmore et al., 2012). According to the Centers for Disease Control and Prevention, HIV infection rates have recently increased among young men who have sex with men (MSM), particularly among black/African American gay youth (Whitmore et al., 2012). Despite major education efforts, factors that account for this increase include a gap in education on disease transmission, lack of knowledge of HIV or STI status, substance use, and an overall lack of concern that they are at risk for infection (CDC, 2014a). Along with HIV, youth contracting other STIs is a further area of concern when youth are sexually active.

Hepatitis, syphilis, and gonorrhea are among the STIs that need immediate attention. As with HIV, individuals may not know they have an STI when they are sexually active.

Family response

For some families, one of the largest concerns upon learning that their child is LGB (particularly as a gay male) is that he or she will contract HIV. While this is a stereotype because certainly not all gay or bisexual youth have HIV, it is most important for parents to begin to create a supportive atmosphere in which youth can feel comfortable dialoguing about safe sex. For some, the youth may take the lead in this conversation, but for others it will likely be up to the parent or some other trusted relative or family friend to initiate this conversation. While potentially embarrassing, it is critically important to have this conversation. When possible, it is important for families to have a frank, yet supportive, discussion with their child, sooner rather than later, about "safe sex." This includes discussion of a range of options including abstinence, nonsexual intimacy, and sexual activity with the use of condoms or other contraceptives. Parents should contact their child's pediatrician or local health department for the "facts" on safe sex.

Additionally, the attentive parent or caregiver will pay particular attention to ensuring that their child's pediatrician is "LGB-friendly," meaning that he or she is sensitive to and respectful of LGB youth. If families live in more urban areas, chances are there will be an LGB community center or a publication with some references to LGB-friendly physicians. These community centers or physicians can be contacted about referrals to similarly sensitive pediatricians if there are none immediately identified. In more rural areas, a search on the Internet, followed by a telephone or in-person screening, can also help ensure that an LGB-friendly physician is found.

Although this course focuses on the needs of LGB youth, it is important to note in this section that those transgender youth who are interested in physically transitioning from male to female (MTF) or female to male (FTM) are only legally able to do so as adults. A similar search for a respectful and knowledgeable pediatrician or physician is paramount for addressing these youths' medical needs.

Child welfare

Impact on youth

As mentioned, one of the negative consequences of a youth coming out is the lack of acceptance by the family. At the extreme, this nonacceptance manifests with verbal and physical abuse, including ordering the child to leave the home, resulting in the child's homelessness. In such cases it is hoped that the proper authorities, including child welfare social workers (and in extreme cases, the police), become involved in these youths' lives to ensure their safety, well-being, and access to a permanent, stable place to reside.

When youth enter the child welfare system, they may receive care in a variety of settings, including foster care or group homes. It is important that the care providers have received proper diversity training on sexual orientation (as well as on gender identity). Fortunately, the major private nonprofit organizations and public entities (e.g., the National Foster Parent Association, the Child Welfare League of America), and increasingly the federal government, have excellent supports and resources for helping LGB youth in care. One such resource is T*wenty Things Supervisors Can Do to Support Workers to Competently Practice with LGBTQ Children, Youth, and Families* (National Resource Center for Permanency and Family Connections, 2014).

However, despite these good intentions, LGB youth in care are often at the mercy of the culture of individual child welfare constituencies with respect to supporting them. Foster parents have been found to have a range of attitudes, from acceptance to rejection (Clements & Rosenwald, 2007). Further, a national study of child welfare agencies found similarly mixed results. This is particularly alarming considering that when children of different genders or race enter care, it is assumed that child welfare agencies do not discriminate; yet, with respect to sexual orientation and gender identity, such prejudice and discrimination are alive and well (Rosenwald, 2009). As this issue receives more and more attention, LGB-friendly foster homes, group homes, and emergency shelters are slowly becoming more realistic options for LGB youth. Given that initial experiences of child maltreatment may have already traumatized LGB youth, placement planning needs to include considerations for sexual orientation and gender identity so that these children do not experience additional homophobia and other discrimination in supposedly safe environments.

Family response

The notion of "family response" in this context needs to be expanded to include the foster parents, group home staff, and the larger community's support for LGB youth. As mentioned, agency and state mandates vary as to what they require for youth. It is incumbent on childcare professionals (foster parents, group home staff, etc.) to be comfortable working with and being respectful of LGB youth. The National Foster Parent Association and the Child Welfare League of America have excellent materials for working with these newly constructed families.

Not all LGB youth who reside in foster care stay there. For some, it is a temporary situation and the youth returns home, under supervision, as long as the parents can ensure their safety and agree (whether voluntarily or under court mandate) to address the factors that resulted in the past maltreatment. Various professionals will commonly be involved in monitoring the family's functioning, and will provide family therapy (discussed in the next section) to help identify the family dynamics that led to the abuse and ensure that these dynamics are changed so the maltreatment is not repeated. Other youth, unfortunately, become homeless and need community services. In these cases the community needs to think about the need for creating homeless shelters and transitional living services, for both LGB youth and LGB young adults, to help provide structure and increased optimism for their lives and well-being.

FAMILY THERAPY

Practitioners working with LGB youth and their families are invited into the families' lives, and even their homes, to assist them with, at times, very intimate and sometimes very painful information during tumultuous periods in their individual and family development. Although it might seem daunting to help an entire family, the skilled family practitioner is well equipped to provide assistance.

Practitioner readiness

Prior to the following presentation of the three family therapy models discussed in this course, four considerations must be addressed. First, the concept of the *identified patient* from family therapy is useful when working with any family, regardless of the model to be used. The identified patient is the family member who is assumed, typically by the relative arranging the family therapy, to be the reason for all of the problems and distress that the family is experiencing. The family systems view, however, holds that no one person is responsible for the existence of a problem. Rather, the family must be viewed in its entirety as a system wherein members each play a role in the maintenance of a problem as well as its solution.

Second, it is important for practitioners to be mindful that they (the practitioners) are providing assistance to the families; they are not solving problems for them. It is up to families themselves to define what they want to work on and then to do this work. This honors *self-determination*, and all of the models of family therapy rely on this perspective.

Third, practitioners have a range of models to select from in their work with families. Practitioners choose models they are familiar with and are competent to practice, and which have underlying assumptions that best match their own worldview. Practitioners often consider the *fit of a model* with each family's unique presenting issues.

The fourth consideration, *countertransference*, is particularly important for practitioners working with LGB youth and their families. Regardless of the model of practice used, families will typically look to the therapist as the "expert" and imagine that the therapist possesses great authority and influence over the family members' lives. Therefore, it is incumbent upon the therapist to self-reflect on her or his own views of working with lesbian, gay, and bisexual youth. Such self-reflection is useful to combat countertransference – those feelings that are brought up within the therapeutic encounter which trigger subconscious feelings in the therapist. Therapists, like all members of society, live in a world where heterosexism and homophobia are common, and they need to be both aware of and work to change such deeply instilled attitudes and beliefs. To be most helpful in conducting family therapy, and to make sure they are not doing harm, therapists should initiate this process and perhaps attend diversity training or their own counseling to ensure that they have extinguished their own heterosexism and homophobia to the extent possible.

A final consideration relates to current understandings of trauma because some of the youth with whom practitioners work – and some of these youth's family members as well – might have diagnoses that include PTSD, acute stress disorder, or even dissociative identity disorder (DID). In this "Age of the Brain," groundbreaking research is uncovering the extent to which psychological trauma – from abuse, neglect, and similar experiences – impacts individuals' brain development and functioning (Van der Kolk, 2014). Neurological research currently focuses on trauma's impact on brain components such as the amygdala (which regulates emotion) and the hippocampus (which stores memories), as well as a host of neurotransmitters (including the "stress hormone" cortisol and the "bonding" hormone oxytocin). There is also promise that positive interactions and activities such as therapy can mitigate the negative effects of trauma on the brain (Van der Kolk, 2014). Therefore. practitioners are encouraged to seek additional continuing education in the dynamic field of trauma-informed care because it enhances their work with all clients, including work with LGB youth and their families.

Structural family therapy

Theory

Structural family therapy is currently the most influential model of family therapy in the United States and abroad (Nichols, 2014). Originated by Salvador Minuchin and developed by Minuchin and his colleagues in their work with families in Wisconsin and later in Philadelphia, structural family therapy "[recognizes] the overall organization that regulates [family] … interactions" (Nichols, 2014, p. 110). (For additional readings on this model of therapy, see the Resources section of this course.) The goal of structural family therapy is for the family and the therapist to reorganize the family's structure in order to improve the experiences of all family members (Minuchin, 1974). Table 4 shows the central concepts and intervention skills associated with structural family therapy.

Table 4: Concepts and Intervention Skills of Structural Family Therapy

Concepts

- Family structure.
- Subsystems.
- Boundaries:
    - Rigid (Disengagement).
    - Clear (Normal).
    - Diffuse (Enmeshment).

Intervention Skills

- Joining and accommodating.
- Enactment.
- Structural mapping.
- Highlighting and modifying interactions.
- Boundary making.
- Unbalancing.
- Challenging unproductive assumptions.

Note. From Nichols, M.P. (2014). The essentials of family therapy (6th ed.). Boston: Pearson; and Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.

This model focuses on three central concepts: 1) family structure, 2) subsystems, and 3) boundaries (Minuchin, 1974; Nichols, 2014). Family structure relates to the overall expected patterns of family interaction as well as the relationship patterns in its subsystems. Subsystems contain smaller units of family members such as the parental system, the parent/child system, the female system (mother and daughters), and the sibling system. Boundaries refer to the type of relationships that exist between and within subsystems; boundaries can range from "rigid" to "clear" to "diffuse" (Minuchin, 1974). Neither boundary extreme is that helpful in family functioning because rigid boundaries reflect "disengagement," in which nurture is limited, while diffuse boundaries reflect "enmeshment," in which independence is limited. In the middle of these extremes is the clear boundary, which promotes a healthy combination of nurture and independence.

The following brief family description demonstrates these concepts. The family consists of a mother, father, and two children – a 15-year-old daughter and a 14-year-old son. The parents have decided to seek family therapy because the son has been suspended from school for fighting and "they need help." In family therapy it is revealed that the son was actually fighting in self-defense because he was bullied for being gay.

This family's structure includes three subsystems: the "couple" subsystem (the wife and husband); the "parents/children" subsystem (which includes the various subsystems of "father/son," "father/daughter," "mother/son," and "mother/daughter"); and the "sibling" subsystem (the sister and brother). The couple's boundary is rigid, meaning the couple are emotionally distant with one another and therefore tend to be disengaged. In the parent/child subsystem, the boundary between the mother and her children is also rigid (she is more emotionally distant with her children), while the father's boundary with his children is more enmeshed (he is overly emotionally involved with his children). The siblings have a clearer boundary with one another; they care for one another appropriately as well as honor each other's need to be independent.

General information on the hypothetical Davis/Leonard Family is presented in the vignette below. As structural family therapy, solution-focused family therapy, and narrative family therapy are discussed, the various skills and interventions appropriate to each of these models will be applied to this family that is in the midst of the coming out process.

> *The Davises are a middle-class African American family who reside in Denver, Colorado. Danielle Leonard is a 15- year-old girl who has recently come out to her family as a lesbian. Danielle is the daughter of Mrs. Davis and her first husband, Mr. Leonard, who has sporadic contact with his daughter.*

> *Danielle is a sophomore in high school and an A student. Mrs. Davis, Danielle's mother, is 46 years old. She works as an accountant for a law firm in the city. Mrs. Davis is married to Mr. Davis, 42, a construction foreman who works in the neighboring county. Mrs. Davis has no other children; Mr. Davis has two children from a previous relationship who live three hours away.*
>
> *The Davises have been married for 10 years. The family has been fairly close-knit. One of the major activities they do as a family is to attend church weekly. For Mrs. Davis, church attendance is very important because her father is a retired Baptist minister. Mrs. Davis's father lives next door and stays with Danielle when the Davises are away for any extended period of time.*
>
> *This portrait of a "typical" American family was ruptured when Danielle told her mother that she is attracted to other teenage girls, and in fact has been dating Ashley for the past three months. Mrs. Davis was completely stunned by this announcement and told Danielle that she was not happy about her choice and some things would need to change in the house.*
>
> *Highly upset, Mrs. Davis told her husband and her best friend about Danielle's revelation. Both were surprised as well about Danielle's announcement.*
>
> *Danielle said she would not stay in a house with an unsupportive mother and would seek out her "real" father and go live with him if the Davises did not get their act together and accept her relationship with Ashley. Mrs. Davis's friend suggested that the family might benefit from family counseling and referred her to a therapist she had used herself for a different matter.*
>
> After two days of composing herself, Mrs. Davis gave the therapist a call and hired her to help the family "sort out this mess."

The following shows how a practitioner would apply the structural family therapy model in practice with the Davis/Leonard family.

> *For the practitioner working with the Davis family, the first phase was to join and accommodate with the family. The therapist took time to talk not just with Mrs. Davis but also with Mr. Davis and Danielle. (Danielle's biological father was not part of the sessions.) Mrs. Davis was happy that the practitioner came to the home and expected her to side with her and her husband, both of whom were quite unhappy with Danielle's "choice." The therapist did indeed offer empathy and support to the couple and yet also empathized with Danielle, who stated that there was nothing wrong with being lesbian and that her parents were the ones with the problem, namely, being homophobic. Once the therapist established some rapport with the family members, she helped the family members articulate more specifically what they would like to have happen in their family therapy. Danielle was able to say that she would like her mom and stepfather to be less judgmental, and the therapist suggested that perhaps the parents would like to better understand how Danielle had come to understand herself as a lesbian.*
>
> *Enactment was the next step to occur. In the second session, the therapist asked Mrs. Davis why she was so angry over Danielle's announcement. Mrs. Davis responded that she did not want Mr. Davis to be upset. Mr. Davis thanked his wife for looking out for him. Danielle shared how "stupid" her mother was for putting her husband's happiness over her (Danielle's) welfare. This natural enactment provided assessment information to the therapist that Mrs. Davis seemed to defend her husband over her daughter's mental health and that Mrs. Davis seems to interrupt Danielle. Moving on to structural mapping, the therapist remembered that Danielle's coming out as lesbian was not the "sole" problem in the family; in fact, the therapist formulated a hypothesis that the Davis couple subsystem was actually somewhat disengaged in that Mrs. Davis appeared to be afraid to talk to her husband about Danielle's coming out (or other matters) because Mrs. Davis feared that Mr. Davis would leave her.*
>
> *The consequence of this was that Mrs. Davis had an enmeshed relationship with Danielle and wanted to control Danielle's life because Mrs. Davis was actually afraid of confronting her husband. This information was gained through a variety of sessions with each family member privately as well as with different combinations of the family subsystems (e.g., Danielle and her mother, Mr. and Mrs. Davis, Danielle and Mr. Davis, and Danielle alone) and the family as a whole.*
>
> *Turning to Step 4, highlighting and modifying interactions, the practitioner suggested (drawing on knowledge of LGB development as well as structural family theory) that if the family wanted to understand Danielle's experience they had to accept that she had the right to live her own life. Furthermore, the therapist told the family that as a lesbian teen Danielle would need their help and guidance to manage the prejudice and discrimination she would likely face. If they hoped to be this support and to have continued influence on her life, they had to respect her life experience. The Davises were surprised by the therapist's directness. Additionally, the practitioner reminded Danielle that she had known about her sexual identity a lot longer than her mom and stepfather had. While she had become used to the idea, the information was new to her parents. The therapist told Danielle that she needed to figure out how to respect her mother and stepfather while she was continuing to explore her identity and new romantic relationship. The practitioner used a combination of "intensity" and "empathy" to do this.*
>
> *As the therapist and the family entered Step 5, boundary making, the therapist suggested that two subsystems in the family – the couple subsystem and the parents/child subsystem – could benefit from clearer boundaries. Danielle and her stepfather tended not to speak much (having a rigid boundary), while Danielle and her mother were fairly enmeshed. Additionally, the couple's boundary with each other was somewhat rigid. The therapist suggested to Mrs. Davis that she might want to concentrate on talking with her husband more and being less concerned about the "problem" of Danielle's coming out. Indeed, the therapist hypothesized that Mrs. Davis communicating with her husband more and trying to control her daughter less could be healthier for the family. Using empathy, the therapist could communicate this in a way that Mrs. Davis could hear.*
>
> *Moving to Step 6, the therapist shifted to unbalancing, in which Mrs. Davis and Danielle shared some of the pain that predated Danielle's coming out; Mrs. Davis had wanted to control Danielle because Mrs. Davis felt guilty about divorcing Danielle's father. Danielle was unaware of this but knew she didn't like being controlled and interrupted by her mother. Separately, the therapist worked with Danielle's and her stepfather's relationship, as well as the couple's relationship with each other. The goal of this work was to create clearer boundaries. The culmination of this stage was that Danielle's coming out served as a catalyst for an intervention, the outcome of which was that Danielle felt empowered to become more independent and assertive in her continuing coming out process and new romantic relationship. She did so in a manner that was more respectful to her mother and stepfather. Mrs. Davis, in turn, apologized to her daughter for trying to control her for years; Mr. Davis stated he recognized ways in which Mrs. Davis was controlling of Danielle. Further, he regretted that he had benefited from Mrs. Davis controlling Danielle. He may have even encouraged it since it got him out of having tense discussions.*

Rather, in the future, he could just stay out of it and let Danielle and Mrs. Davis handle any conflicts that arose. The couple was inspired to begin healthier communication with one another.

As the family began to experience clearer boundaries, increased communication, and independence, Mr. and Mrs. Davis were asked by the therapist to look at some of their assumptions about the meaning of Danielle's lesbian identity. Mrs. Davis realized that she was proud of her daughter no matter what, and while it would still take some adjustment, she wanted to support her daughter. Both Danielle and Mrs. Davis listened more to Mr. Davis's honest concern with loving his stepdaughter and his wife and yet still needing to reconcile this with his religion. The therapist suggested that the family seek spiritual support through consultation with a minister who was affiliated with a congregation that welcomed participation by LGB individuals. Although this path was not quick or easy, the three family members became more respectful of each other with increased communication, Danielle's increased independence, and more mutual respect.

Intervention skills

The structural family therapy model can be used in sessions with all family members present and in separate sessions with individuals and subsystems. There are seven key steps that encompass the assessment and therapeutic interventions of this model (Nichols, 2014).

Step 1: Joining and accommodating

The first step is for assessment to occur and this is achieved by the family practitioner "joining and accommodating." This means that because often not all family members will initially welcome the practitioner, or even the idea of family therapy, it is incumbent upon the therapist to build rapport with each member. This is achieved by genuinely soliciting each family member's view of the problem, which will very likely conflict with the views of other family members. To aid in the joining and accommodating process, the therapist will often talk with each family member separately as well as with all family members together.

The therapist solicits each parent's view of the problem, which they both identify as their son's fighting. The son says his view of the problem is that everybody is focusing too much on his fighting and making a big deal out of the fighting and that they should just forget it because he isn't going to do it again, because he will just ignore the people who were bothering him. The daughter says that being home "stresses her out" because of all the arguing and she didn't fight so she doesn't know why she needs to even be there.

Step 2: Enactment

The second step is "enactment." In this step, the practitioner wants to see the family's patterns of interaction live and in the moment; the practitioner sets this in motion by asking questions of each family member and seeing the "natural" interplay that occurs. This allows the therapist to observe how family members respond to one another and reveals information about the boundaries and family structure.

The therapist observes that when the son is asked why he fought in school, the father interrupts his son and states that his son had a lapse of judgment.

Step 3: Structural mapping

As the practitioner gains insight into the family structure, it is time to proceed to the third step, "structural mapping." In structural mapping, the practitioner makes tentative hypotheses about the subsystems and types of boundaries in the family, and views the problem as one that resides in this interwoven system rather than in any particular family member who needs to exclusively undergo all the change.

When the parents argue with each other about why their son is fighting, they blame one another, a response that reveals their own disappointments with themselves and each other. In the structural mapping stage the practitioner may suggest to the family that the parents' fairly rigid boundary with each other has influenced their son's sense that he could not come out to them in the past and, as a result of not having this support, he had a quicker response to fight at school.

Step 4: Highlighting and modifying interactions

Following the practitioner's discovery of these patterns, she or he then identifies them and suggests how to change the interaction. This refers to the fourth step: "highlighting and modifying interactions." Practitioners use intensity, which is a blunt intervention that challenges family members to reflect on their own roles in the problem. As an alternative intervention, practitioners may use empathy through listening and recognition to help family members become more reflective about their roles in the underlying problem (Nichols, 2014).

The therapist shares her observation that the more the mother yells at her son, the more the son ignores her and the more distant they become – mirroring the parental subsystem's interactions. The son's fighting, as well as his subsequent self-disclosure in therapy that he is gay, has forced the parents to interact and communicate with each other, which differs from their typical disengagement from each other.

Step 5: Boundary making

As a family's insight increases, the practitioner is ready to take the lead on the fifth step, "boundary making." Boundaries should be "clear" within a family (Minuchin, 1974). With the goal of creating clearer boundaries within the family structure as a whole, the practitioner could point out that disengaged families with rigid boundaries tend to have avoided conflict in the past (Nichols, 2014). The following examples reflect the essence of boundary making.

The therapist works with the father (who models enmeshed boundaries with his children) and both children, to help the father provide space for his children to voice their independence. The therapist also works with the mother and children together, as well as with the couple separately, on encouraging each subsystem to open up to each other, discuss their differences, take responsibility for their part in the current family dynamic, and have more positive interactions in trying to create healthy boundaries and more open communication in the family.

Step 6: Unbalancing

With "unbalancing," the sixth step, the practitioner focuses on changing the relationship within a subsystem. Because dynamics within a subsystem influence boundaries in the overall family structure, it is the intention of this step to ensure that the subsystem, and its boundaries, are as clear as possible. This is achieved by the practitioner temporarily "siding" with each subsystem member in series. The intention of this intervention is to shift the dynamics so that insight is possible in the final step.

The therapist sides with the wife when the husband is chastising her for contributing to their son's secrecy. When the husband yells at the wife, the therapist interrupts the father and tells him he needs to take responsibility for his part in contributing to the family's problem.

Step 7: Challenging unproductive assumptions

The final step, "challenging unproductive assumptions," draws on the earlier efforts at boundary making and unbalancing by providing opportunities for reflection and insight to reframe the problem. Practitioners can use educational interventions that support positive characteristics and downplay negative characteristics. These and other exchanges have the potential to help families form clearer boundaries and promote healthier family functioning.

> *The therapist empowers the children 1) to speak to their mother about their wishing she was more positively involved in their lives, rather than only becoming involved when there is "a problem" (this reduces the rigid boundary), and 2) to speak to their father about wishing he would not emotionally "smother" them (this reduces the diffuse boundary) and that he would spend more time in positive communication with his wife, rather than always arguing and then relying on his relationships with his children for a sense of connection and camaraderie.*

Solution-focused family therapy

Theory

Solution-focused therapy was founded by Steve de Shazer and his colleagues at the Milwaukee, Wisconsin, based Brief Family Therapy Center. Beginning in 1979, they worked to derive a model of time-limited, brief therapy; many publications have been written on the model's application, including de Shazer's 1985 book Keys to Solution in Brief Therapy (de Shazer, 1985; see Resources section for additional reading on this theory). The goal of this therapy model is to promote the client's already existing abilities to solve his or her own problem with the therapist's guidance (de Shazer, 1988). The concepts and skills used in solution-focused family therapy are presented in Table 5.

Table 5: Concepts and Intervention Skills of Solution-Focused Family Therapy

Concepts
- Focus on present.
- Exceptions.
- Solution-talk.
- Client as expert.
- Resiliency and resourcefulness.

Intervention Skills
- Describing the problem.
- Setting goals and using "the miracle question."
- Exploring exceptions.
- Using scaling questions.

Note. Adapted from Nichols, M.P. (2014). The essentials of family therapy. (6th ed.). Boston, MA: Pearson; and de Shazer, S. (1988). Clues: Investigating solutions in brief therapy. New York, NY: W.W. Norton.

The solution-focused model relies on five concepts. Its *focus on the present* helps to ensure that the client seeks solutions that can resolve the problem in the present rather than dwelling on the causes of the problem in the past. *Exceptions* are those instances in the past (or even the present) the client identifies as when the problem was reduced or absent; identifying such exceptions provides the client some optimism with respect to goal completion. While some description of the problem is required, the solution-focused practitioner will structure the session on the present and focus the families on what is called *solution-talk*. Solution-talk is based on the premise that families have the solutions to their problems within them, and that sometimes it just takes a practitioner to help "mine" these solutions. Such an assumption reflects a belief in the *client* as *expert* rather than the practitioner as expert. Indeed, solutions generated by a practitioner could very likely not be long-lasting because they are given "to" a family rather than found from within the family by the family themselves. Finally, families are both resourceful and resilient. *Resourcefulness* means that families are capable of thinking of and pursuing resources (otherwise known as "strengths") that can help them survive and even flourish; *resilience* refers to the family's continued ability to cope and endure despite challenging times.

The following vignette shows how a practitioner would apply the solution-focused family therapy model in practice with the Davis/Leonard family described earlier.

> *Using the solution-focused model, the therapist met with the Davis family and began with a problem description, asking the family to describe the problem. Danielle stated that her mother and stepfather needed to "get a grip" on her being lesbian and stop panicking. Danielle was hurt that they were not being supportive. Mrs. Davis believed the problem was that Danielle had only casually thought about this decision and did not think about the repercussions it would have on the family as "people would talk." Mr. Davis had a very hard time reconciling Danielle's coming out with his religious views. In essence, Danielle seemed upset with Mrs. and Mr. Davis, and the couple was shocked and dismayed by Danielle's revelation. The therapist summarized that the family seemed to be having a really difficult time with Danielle's coming out; Danielle was having problems with Mr. and Mrs. Davis's reaction and they were having difficulty accepting her coming out.*
>
> *Moving to goal setting, the practitioner asked, regarding the session, "What needs to occur so that our counseling session will be successful?" Indeed, the therapist's earlier assessment of the problem was accurate because Danielle stated she wanted acceptance from the adults and the couple stated they wanted to be the same family as they were before. An important point in goal setting is that the goals need to be realistic. In response to Mr. Davis's idea that Danielle could change her sexual orientation, the practitioner gently explained the view of mental health and medical associations that sexual orientation cannot be changed and that it is not pathological. The couple stated that they wanted Danielle to accept their views. Therefore, the first goal was for the family to be more accepting of each other's views. (Note: The therapist did not want to be complicit with honoring homophobia but, true to solution- focused therapy, the solutions needed to originate with the family. The therapist saw that it was a process in which views could be accepted for what they were and they could possibly change.) Mrs. Davis stated that she wanted everyone to get along like before Danielle's coming out, because this was a very distressing situation for her. The others agreed, so the second goal was for the family to get along like before Danielle's coming out. The therapist suggested rephrasing this goal as "to get along like they did before they experienced this current stress" (to take the onus off Danielle and reframe it as an experience that the family was sharing).*
>
> *Exploring exceptions was a very useful technique for the family because it helped them recall other challenging times in the past and how they "survived" them. The practitioner asked three questions: "When have you not experienced this problem?"; "Are there times when you don't have this problem?"; and "What do you notice is different when the problem is not there?" Of course, Mr. Davis replied that everything was fine when Danielle had not come out and the family got along well. The therapist reminded the family that again it was not realistic for Danielle to change her sexual orientation. However, the therapist then explored variations of these questions by asking, "What times in the past had the family experienced stress and yet survived well as a family?" The family recalled that Mr. Davis had been in a terrible accident at work and Danielle and Mrs. Davis had shown him tremendous support. The therapist suggested that while the situations were different, what was most important to remember was that the family provided each other with support during a time of unexpected stress and that the family could draw on this experience and apply it to the current "stress" that the couple was experiencing in response to Danielle's announcement.*
>
> *In a subsequent session, all three family members were asked to rate progress in achieving the two stated goals, namely: 1) to accept each other's views more, and 2) to get along like they did before. The scaling technique was used to measure the family's progress on their goals.*

> *When asked how accepted she felt by her mother and stepfather, Danielle rated their progress toward this goal as a 2 on a scale of 1 to 10. Mr. Davis and Mrs. Davis believed that Danielle did not accept their views much either, and they rated her progress as a 2 as well. The family also believed that collectively they rated as a 2 for the second goal. The practitioner stated that this was a good sign because a 2 is higher than a 1; based on the scale, the family was doing better than their conversation would suggest. This surprised all three members but gave them a bit of hope. The practitioner then asked what it would take for them to get to a 3 on both goals and expressed confidence that they could achieve this based on the fact that they had survived another stressful situation in the past with Mr. Davis's accident. The family agreed that they would continue the family sessions, communicate with each other more, and have ground rules to not yell at each other. This was incremental improvement, but the family was on their way to achieving their goals.*

Intervention skills

Four sets of skills are part of the solution-focused practitioner's approach to working with families: problem description, goal setting (including the "miracle question" described below), exploring exceptions, and scaling questions.

Problem description refers to the initial assessment in which the practitioner asks the family to describe how they see the problem. While the family may be accustomed to a problem-oriented focus, the practitioner learns of their past efforts in addressing the problem; this reminds the family that they have the capacity to resolve their problems.

The practitioner then asks what has and has not worked in the past to solve the problem, thus introducing the idea that the family has the capacity to resolve their problems (Nichols, 2014).

> *Drawing on the earlier example of the family whose son was fighting in self-defense over being bullied for being gay, the therapist asks for a brief history from the different family members' perspectives and then explores how they have previously tried to solve challenges the family faced.*

Goal setting is an extremely important technique in solution-focused family therapy because it enables both the client and the therapist to know when the problem is solved and to measure progress from session to session (de Shazer, 1988). Good questions for the therapist to ask include: "Specifically, how will you be doing this?" and "What specifically will tell you that you've solved your problem (or reached your goal)?" (Nichols, 2014, p. 231). Such goal setting is optimistic in nature because it presumes the family's ability to solve their problem.

A very common goal-setting strategy is asking the *miracle question*, which is a question to elicit a family's vision of when the problem is solved. The therapist can ask: "Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different?" (de Shazer, 1988, p. 5). Such a question forces families to focus on the absence of the problem and how achievement of their goals could help them attain a future without the problem. The goals do need to be realistic.

> *The therapist asks the miracle question of the family, and the parents report that they would spend more time with their son and daughter to ensure that their children felt loved, and would advocate with the principal for their children's safety at school. It is important to note that the goals need to be very realistic; therefore, wanting someone to change a sexual orientation (or wanting someone to be alive when he or she is not, etc.) are not examples of realistic goals.*

Exploring exceptions is a technique in which the focus is on the family identifying a time when something went well versus what has gone wrong. This promotes family resourcefulness and reinforces the idea of the family as the expert on their particular circumstance. Examples of questions that explore exceptions include: "When in the recent past might the problem have happened but didn't (or was less intense or more manageable)?" and "What was different about those times when the problem didn't happen?" (Nichols, 2014, p. 355).

> *The therapist asks the family to describe an earlier time when they overcame a challenge. The family shares that several years ago the daughter had been hospitalized for a month due to an illness and the family had been able to*

Scaling is a technique in which the family members are asked to use a scale to identify their progress toward a goal (e.g., a scale of 1 to 10, with 1 representing the "least progress" and 10 representing the "most progress"). This technique provides a practical way for families to measure their own progress on goals both within and between sessions, and can provide a strong sense of optimism and encouragement for families. It is noteworthy that small change on a scale (e.g., a one-point difference) is recognized, and a realistic question, such as "What will it take for you to move from a 4 to a 5?" helps clients focus on realistically continuing their short-term goals.

> *When asked by the therapist about their progress on this scale, the family states that they are a 2 on the scale of accomplishing their goal of spending more time together, and they brainstorm and select ideas to increase that score to a 4 over the next week.*

Narrative family therapy

Theory

Narrative therapy is the newest of the three models presented. The concepts of narrative therapy were originated by Michael White and David Epston; together they co-authored Narrative Means to Therapeutic Ends (White & Epston, 1990). Over the last 30 years narrative therapy has come to be a mainstream model for working with families with various presenting issues. The concepts and intervention skills of narrative family therapy appear in Table 6.

> *The goal of narrative family therapy is to help families "transform … identities from flawed to preferred, not by getting family members to confront their conflicts but by separating persons from problems and then uniting the family to fight a common enemy" (Nichols, 2014, p. 247).*

While there are many elements associated with narrative family therapy, the three central concepts are deconstruction, unique outcomes, and reconstruction. These concepts can be used to assist family members with reconceptualizing the problems that are present in their families.

The first concept, *deconstruction*, refers to helping families understand how they live their lives based on the stories they have told themselves. Instead of focusing on family pathology, deconstruction looks at the roots of the problem as being outside of the family and the family as simply narrating their story based on a social construction. Specifically, deconstruction exposes the problem-saturated stories that can infiltrate a family and make life difficult for them, often without their knowledge of the stories' origin. Deconstructing these problem-saturated stories provides an opportunity for families to fully understand how their lives have been narrated by a particular message that they have unwittingly internalized and acted upon. The process of deconstructing sets the stage for families to gain a new perspective.

Table 6: Concepts and Intervention Skills of Narrative Family Therapy
Concepts ● Deconstruction. ● Unique outcomes. ● Reconstruction. **Intervention Skills** ● Mapping the influence of the problem on the family. ● Externalizing conversations. ● Deconstructing destructive cultural assumptions. ● Relative influence questions. ● Reading between the lines of the problem story. ● Reauthoring. ● Reinforcing the new story.
Note. From Nichols, M.P. (2014). The essentials of family therapy (6th ed.). Boston, MA: Pearson; and White, M., & Epston, D. (1990). Narrative means to therapeutic ends. New York, NY: W.W. Norton.

The concept of unique outcomes provides a bridge that links deconstruction and reconstruction. Unique outcomes are those instances in which an individual or a family finds exceptions to their problem-saturated story. They are based on the belief that families have the potential to resist, and have previously resisted, these harmful stories by serving as "building blocks" for preferred stories, or the stories that the families want for their lives (White & Epston, 1990; Nichols, 2014). This insight can help motivate families to enter reconstruction, which occurs when families create new stories (i.e., narratives) that empower them rather than disempower them. Reconstruction provides new ways for families to move forward by freeing themselves of the problem.

Intervention skills

The central skills used by a narrative family therapist include

- Mapping the influence of the problem on the family.
- Externalizing conversations.
- Deconstructing cultural assumptions.
- Asking "relative influence" questions.
- Reading between the lines of the problem story.
- Reauthoring.
- Reinforcing the new story.

Mapping the influence of the problem on the family is the first step of assessment, in which the practitioner explores the family's understanding of the problem's negative influence on them. However, the flexibility of this model is such that the skills do not appear sequentially, but rather co-occur during various phases of the therapy.

In conjunction with the first step is a related step of having *externalizing conversations.* Here the practitioner asks questions to help the family isolate the problem from the family.

> *Returning to the son who is fighting at school and has kept his sexual orientation a secret from his parents, the therapist asks, "Were there times in the past where 'Secrecy' tried to get the better of you, but you didn't let it?"*

Because problems are sometimes so intrinsic to a family's thinking, the forced separation of the problem (by making the externalized problem the focus versus the family member) allows a family to put the role of the problem in perspective.

> *During mapping, the therapist asks about the family's anger with the son's secrecy. The therapist asks the family how "Anger with Secrecy" has affected the family, perhaps illuminating that "Anger with Secrecy" compels them to disconnect and be distant from one another or, conversely, that "Anger with Secrecy" has prompted them to engage in arguments.*

During mapping and externalizing conversations, it is sometimes important for the practitioner to engage in *deconstructing cultural assumptions*, which means challenging stereotypes of gender, appearance, sexual orientation, and other stereotypes that are reflective of dominant yet harmful cultural narratives (Nichols, 2008). Here the therapist asks how the family members were taught and received messages about different groups of people in society. This can promote self-reflection on attitudes and stereotypes for which self-reflection did not exist before.

> *The practitioner helps the family recognize that cultural assumptions about what it means to be gay had influenced the family's views, and messages about sexual orientation had contributed to their anger about the son's secrecy. Indeed, such a question might spur insight that the parents themselves had internalized these cultural assumptions, namely that the parents should be angry about having a son who identifies as gay and therefore should keep this knowledge secret.*

Asking *relative influence questions* assesses how deeply the problem has disrupted the family's life. Asking these questions promotes the externalizing conversations and "is initiated at the outset of the first interview, so that persons are immediately engaged in the activity of separating their lives and relationships from the problem" (Epston & White, 1990, p. 42). This provides the family with a useful gauge to see the problem's influence.

> *The therapist asks the parents: "How often does 'Anger with Secrecy' appear in your interaction with your son?"*

As families are sharing the impact of the problem on their lives, a therapist who is *reading between the lines of the problem story* helps the family explore those times when the problem has not been present (similar to exceptions in the solution-focused model) (Nichols, 2014). This investigation provides an opportunity for the practitioner to assist them in looking for the unique outcomes, namely, those times when the problem did not occur.

> *In the example, the therapist would explore with the son a time when "Anger with Secrecy" was not present, as well as ask the parents about times when they had not been angry about their son not directly sharing his sexual orientation with them.*

The following vignette shows how a practitioner would apply the narrative family therapy model in practice.

> The narrative therapy family practitioner began working with the Davis family by mapping the influence of the problem on the family. *For Danielle, the problem was the homophobia displayed by her mother and stepfather; for her mother and stepfather, the problem was Danielle's "homosexuality," although this was more of a problem for Mr. Davis than for Mrs. Davis. Moving toward externalizing conversation about how the family perceived Danielle's coming out, the therapist assessed the family and helped them identify that Danielle and Mr. and Mrs. Davis, respectively, were perceiving Danielle's coming out from two very different perspectives. Though it was challenging to the family members, the practitioner explored the problems as the family presented them; however, being aware that the problem was not same-sex attraction in itself but, rather, the reaction to it, the practitioner suggested that the family explore the consequences of homophobia and homosexuality. The therapist also deconstructed the destructive cultural assumption of homosexuality by educating the couple that same-sex attraction and love is representative of human variance and is not pathology-based, as they may have been socialized to believe through their religion and society as a whole.*
>
> *The therapist helped the family move toward a common understanding of the problem by continuing to look at its impact. What were the consequences of homophobia from Danielle's perspective? She felt alienated from Mrs. and Mr. Davis. What were the consequences of "homosexuality" from the couple's perspective? Both terms, homosexuality and homophobia, might have been very sensitive words for the various family members.*

> *If so, perhaps the common "problem" was how the family members were disappointed in one another and how this disappointment (note the separation from person) was affecting their family. They agreed that the common "problem" was labeled "disappointment related to coming out" (DRCO), and the coming out process could be explored to the extent DRCO had affected the family. All family members shared that this DRCO affected them a great deal. Asking relative influence questions served to further provide information on the impact of DRCO on the family members' lives, including DRCO's interaction with the family members' faith.*
>
> *Shifting to reconstruction, the practitioner read between the lines of the problem story and sought unique outcomes such as times the couple did not feel in conflict with their religious beliefs when loving and supporting their daughter. The practitioner asked the couple if there was a time when they were not DRCO and Mrs. Davis said there was one time, when she had hugged her daughter and told her she loved her anyway, even though she was still in shock. The practitioner recognized this as significant. Mr. Davis said there was never such a time for him. Then the practitioner creatively expanded the unique outcomes to see if there was a time when the family was not disappointed with each other, and they shared a number of positive moments when they had been proud of each other. Going with this new story, the practitioner acknowledged that if they had pride in each other before, they could have pride in each other again, and encouraged them to have hope for their survival as a family unit.*
>
> *This belief by the therapist provided inspiration for the family to continue to think about how to "reauthor" their story in family therapy* by continuing to explore how, as a family, they could be proud of each other amidst the news of Danielle's coming out. This remained a challenging process but the therapist reinforced the new story by writing a letter to the family explaining that they were on a journey that, while challenging, filled everyone with optimism because they were doing the hard work to ensure that they could be proud of each other as a family again. The practitioner also recommended that the family could visit a Parents, Friends and Families of Lesbians and Gays (PFLAG) meeting (a support group for families of LGBT youth) to find support from other families who were also reconstructing their stories and engaging in the healing process.

When reconstructing the new story, two other skills are used, reauthoring and reinforcing the new story. Reauthoring refers to "the process of persons' entering their stories, taking them over and making them their own" (White & Epston, 1990, p. 13). Via the unique outcomes (building blocks to new narratives) that the families have identified, and awareness of the social influence of the problem on their behavior, families create new stories or narratives.

> *The therapist helps the family create a new story in which they replace "Anger with Secrecy" with "Compassion" when they think of their son/brother (and when the child thinks of himself). This reauthoring shifts the focus by empowering the family so that they can address and provide support on overcoming the family's contribution to the reasons that left the son feeling a need to keep his sexual orientation secret.*

Of course, building a new narrative is not easy because families have been socialized, at times for years and decades, into the problem-saturated story. Therefore, it is important for the practitioner to lead the family in reinforcing the new story. The practitioner can assist by actually writing a letter to the family, telling them of their progress in shifting stories that will help them heal. Other examples include providing the family with certificates which announce their new stories, and sharing the new story with others who will support the family in their new view as witnesses to or allies in the new story (Nichols, 2014).

> *These additional social supports can help the family in adhering to their new story of being compassionate with one another and deciding, with the son/brother, that they want to provide support to him and be a source of compassion and stability for one another while they make this new journey together. The therapist could write the family a letter recognizing the new story that they have decided to live by. The therapist could also encourage the family to share this news with a few trusted extended family members and friends to help reinforce their new story.*

OTHER MODALITIES WITH LGB YOUTH AND THEIR FAMILIES

While the focus of this course is on using specific therapeutic models in working with LGB youth and their families, other interventions are helpful at times in working with this population. The knowledgeable practitioner will increase her or his competence by having general knowledge about these interventions because questions about them might arise in the course of family therapy.

Crisis intervention

A spate of teen suicides in the U.S. LGB community in 2010 brought important attention to the needs of youth who are in crisis. At times, healthcare professionals may encounter an LGB youth who is suicidal – the intervention would be no different from that for those who are not LGB: ensure safety, establish rapport, identify positive options, make referrals, and follow up. Interventions can range from ensuring that parents are monitoring their child and have access to appropriate hotlines, such as the Trevor Project (see Resources), to, in the most extreme cases, arranging for involuntary hospitalization of the youth. While suicidal ideation requires urgent attention, other crises include child maltreatment where the child is at imminent risk for physical harm, neglect, or being forced to leave the family home. In these cases, healthcare professionals should call the regional child abuse hotline and, in the most urgent of situations, contact the police.

Individual therapy

Individual therapy or counseling is another common intervention with this population. The practitioner might identify one or more family members who would benefit from private counseling. These needs might include further assistance with self-acceptance related to coming out, further assistance with accepting a family member who is LGB, and potential conflict between an individual's culture or religion and sexual orientation. If this is the case, the family members can consider this additional option. Models of individual therapy that can be used in working with LGB youth or their individual family members include solution-focused therapy and narrative therapy (discussed earlier), as well as cognitive-behavioral therapy, psychodynamic therapy, and motivational interviewing.

It is important to reiterate that reparative or conversion therapy, in which an LGB individual is encouraged to "renounce" his or her LGB status, is not recommended by any major medical or mental health associations because it operates from the assumption that LGB status is immoral and because counseling based on this assumption can be harmful (AAP, 2013).

Group work

Coming out and facing the variety of issues related to being LGB can be daunting, and many individuals (both youth and parents) do not wish to face them alone. While many seek some form of informal social support, some individuals benefit from participation in formal group work.

Group work can be led by formal facilitators or be self-led. Groups for this population include working with youth as well as the nationally known PFLAG. The purposes of group work include support, socialization, and therapy. A popular model of group work for this population is "mutual aid," in which the group provides mutual support, respectful challenging, and rehearsal to assist group members in attaining their goals (Rosenwald, in press). Additionally, in this Internet age, online groups have become increasingly popular and greatly assist families in more rural areas where real-time support and therapy groups do not exist.

Information and referral

As the topic of LGB youth becomes more commonplace in the public arena, more resources are being created. The healthcare professional who works with LGB youth and their families should have a general awareness of local, state, and national resources that can provide assistance to this population. A comprehensive guide to these resources appears in the Resources section, which covers a wide range of information including youth advocacy, family support, legal advice, and religious and spiritual considerations. Knowing this information and conveying it to LGB youth and their families can provide assistance both during and after the practitioner has ended the professional relationship with the family.

At times, a practitioner might be directly involved in the referral process or might provide the information to the youth or family so that they may self-refer. "Outing" the youth or family is a major ethical violation, and specific permission in the form of assent from the youth and consent from the parents is required if disclosing the child's sexual orientation is directly or indirectly part of the referral. When making the referral directly, it is important to respect confidentiality and foster trust in families for mental health supports. For example, if a school counselor is connecting the family with a therapist who specializes in work with LGB youth, she can specifically ask the family to sign a release allowing her to talk with the therapist. In addition, the school counselor can tell the family specifically what she will say, as in "I think it will be helpful to tell the therapist about how coming out has been affecting everyone. That way the therapist can be most helpful." If a youth wants to be out but his or her parents do not, the school counselor can work with the family to find wording they are comfortable with. If an agreement cannot be reached, the school counselor can simply provide referral information to the family and let them communicate directly with the therapist.

Often it is helpful for youth and families to be referred to supports that are geared specifically to LGB youth and their families. This can be very helpful but also challenging because for some people it will be the first time they will attend something that has the potential to "out" them. Examples of such supports are a community or school LGB youth support group or a PFLAG meeting. When referring clients to these resources, it is a good idea to talk with the family about how it will be for them to attend a meeting with other LGB youth or family members. What would be hard about it? How would they handle this? It is also important to note that for some youth whose families are not supportive, they may need to be referred to supports that do not require parental permission and will protect their confidentiality.

Conclusion

This course provided an overview of lesbian, gay, and bisexual youth development and contemporary issues that affect youth. Additionally, the course provided three models of family therapy (structural family therapy, solution- focused therapy, and narrative therapy) and applied the three therapeutic models to helping the family portrayed in the corresponding vignette. Finally, the course offered brief discussion about additional interventions to assist LGB youth and their families, including crisis intervention, individual therapy, group work, and information and referral.

While the models presented here provided the basics of intervention, those interested in implementing these interventions are strongly encouraged to take additional course work on the family therapy models presented as well as to seek additional information on the other interventions described.

Further, behavioral health and healthcare professionals are encouraged to be "change agents" in their personal and professional lives with respect to this population. This means that these professionals must constantly be aware of heterosexism and homophobia that occur in society and seek to reduce them, whether by conversing with a colleague or writing a letter to one's legislator. Indeed, this can apply to any form of prejudice and discrimination that is encountered. The increased attention to the issues facing LGB youth is an encouraging sign, but much work remains to ensure that LGB youth – and their families – are as safe, supportive, and healthy as possible.

Resources

- **American Academy of Pediatrics**
  Medical organization that provides information, including relating to LGBT youth.
  Website: http://www.aap.org
- **Dulwich Centre**
  International center for narrative therapy and community work.
  Website: http://dulwichcentre.com.au
- **Family Acceptance Project**
  Organization focused on interventions with LGBT youth and their families.
  Website: http://familyproject.sfsu.edu/home
- **Human Rights Campaign**
  Resource for education and lobbying for the LGBT population.
  Website: http://www.hrc.org
- **It Gets Better Project**
  Organization that provides mentorship and support to LGBT youth.
  Website: http://www.itgetsbetter.org
- **Minuchin Center for the Family**
  Organization devoted to training and consultation on structural family therapy.
  Website: http://minuchincenter.org
- **National LGBTQ Task Force**
  Organization devoted to LGBTQ civil rights and policy.
  Website: http://thetaskforce.org
- **Parents, Families and Friends of Lesbians and Gays (PFLAG)**
  Resource for support individuals for the LGBTQ population.
  Website: http://pflag.org

- **Solution-Focused Brief Therapy Association.**
  Organization devoted to solution-focused brief therapy.
  Website: http://www.sfbta.org
- **The Gay, Lesbian & Straight Education Network (GLSEN)**
  Organization that provides support for LGBTQ youth in schools.
  Website: http://www.glsen.org
- **The Trevor Project**
  Online resource and hotline that helps youth who are contemplating suicide and provides answers to general questions about youth sexual orientation and gender identity.
  Telephone: 866-4.U.TREVOR [866.488.7386]
  Website: http://www.thetrevorproject.org

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BEST PRACTICES WITH LESBIAN, GAY & BISEXUAL YOUTH AND THEIR FAMILIES, UPDATED 1ST EDITION

Final Examination Questions

Select the best answer for each question and complete your test online at **EliteLearning.com/Book**

1. What percentage of the youth population is estimated to identify as gay or lesbian?
   a. Less than 5%.
   b. 10%.
   c. 25%.
   d. 30%.

2. Homophobia refers to the:
   a. Prejudice and/or discrimination toward individuals based on their perceived or actual sexual orientation.
   b. Social structure that privileges heterosexual identities and discounts same-sex interactions.
   c. Process by which an individual becomes comfortable with his or her sexual orientation.
   d. Dynamic that occurs when a person questions her or his gender identity.

3. Which of the following terms describes the process of an individual admitting to himself or herself and to other people that he or she is lesbian, gay, or bisexual?
   a. Resiliency.
   b. Coming out.
   c. Boundary making.
   d. Heterosexism.

4. An additional developmental challenge for LGB youth is:
   a. The shift to adults as their primary social influence.
   b. Determining the origin of their sexual orientation and seeking to extinguish it.
   c. Assessing family structure to determine the implications of identity development in a narrative family context.
   d. Accepting a primarily nonheterosexual sexual orientation in a social context that is still characterized by heterosexism and homophobia.

5. One stage of Troiden's model on homosexual identity development is identity:
   a. Clarity.
   b. Despair.
   c. Assumption.
   d. Formation.

6. Diversity includes attention to variance in the LGB population by race, gender, and:
   a. Intelligence.
   b. Boundaries.
   c. Class.
   d. Height.

7. Which of the following is a true statement about the coming out process?
    a. This process only affects the youth in question.
    b. This process affects bisexual youth more than lesbian and gay youth.
    c. This process can prompt families to enter a grieving process.
    d. This process occurs at older ages than ever before.
8. "The Matthew Shepard and James Byrd, Jr., Hate Crimes Prevention Act addresses which of the following issues affecting LGB individuals?"
    a. Heterosexism.
    b. Violence.
    c. Relationships.
    d. Coming out.
9. Which of the following is a true statement about LGB youth and suicide attempts?
    a. LGB youth attempt suicide at a rate similar to that of their heterosexual peers.
    b. LGB youth have a higher suicide attempt rate than their heterosexual peers.
    c. LGB youth have a lower suicide attempt rate than their heterosexual peers.
    d. The relationship between suicide attempt rates and an LGB identity in youth is unclear.
10. Reparative therapy is an intervention model that is considered:
    a. Helpful with upper-class families.
    b. Particularly useful for lesbian youth.
    c. In need of more research to determine its utility.
    d. Damaging to a client's health and well-being.
11. When working with LGB youth in foster care, practitioners should:
    a. Expand the notion of "family" to include foster parents, group home staff, the child's community, and others involved in the child's care.
    b. Assume that the youth will never return home due to safety concerns.
    c. Feel confident that heterosexism and homophobia faced at home do not occur in child welfare settings.
    d. Reduce their involvement so as not to conflict with the foster care worker.
12. Subsystems are a central concept associated with:
    a. Narrative family therapy.
    b. Structural family therapy.
    c. Solution-focused family therapy.
    d. Mutual aid therapy.
13. When a boundary within the family system is rigid, the family is characterized by:
    a. Enmeshment.
    b. Clarity.
    c. Cloudedness.
    d. Disengagement.
14. Asking the "miracle question" is a technique used in:
    a. Mutual aid therapy.
    b. Narrative family therapy.
    c. Solution-focused family therapy.
    d. Structural family therapy.
15. The use of "scaling" is an important technique associated with:
    a. Structural family therapy.
    b. Narrative family therapy.
    c. Solution-focused family therapy.
    d. Mutual aid therapy.
16. "Deconstruction" is a central concept of:
    a. Narrative family therapy.
    b. Structural family therapy.
    c. Cognitive-behavioral therapy.
    d. Reparative therapy.
17. Narrative family therapy techniques include:
    a. Externalizing conversations.
    b. Joining and accommodating.
    c. Exception seeking.
    d. Enactment.
18. A central component of crisis intervention is:
    a. Providing self-disclosure.
    b. Reviewing mutual aid.
    c. Identifying enmeshment.
    d. Ensuring safety.
19. The purpose of group work with the LGB population includes socialization, therapy, and:
    a. Engagement.
    b. Enmeshment.
    c. Support.
    d. Structure.
20. Information and referral are:
    a. Important services commonly offered by the practitioner.
    b. Unnecessary because clients are experts in their lives.
    c. Quite challenging because few resources exist.
    d. The task of the parent(s) in helping their children.

Chapter 2: Cultural Humility for All Healthcare Professionals

2 Contact Hours

Release Date: May 10, 2022 **Expiration Date**: May 10, 2027

Upon successful completion of this course, continuing education hours will be awarded as follows:

- **Social Workers and Psychologists: 2 Hours**
- **Professional Counselors: 2 Hours**

Faculty

Adrianne E. Avillion, D.Ed, RN, is an accomplished nursing professional development specialist and healthcare author. She earned a doctoral degree in adult education and an MS in nursing from Penn State University, and a BSN from Bloomsburg University. Dr. Avillion has held a variety of nursing positions as a staff nurse in critical care, physical medicine, and rehabilitation settings, as well as numerous leadership roles in professional development. She has published extensively and is a frequent presenter at conferences and conventions devoted to the specialty of continuing education and nursing professional development. Dr. Avillion owns and is the CEO of Strategic Nursing Professional Development, a business that specializes in continuing education for healthcare professionals and consulting services in nursing professional development.

Adrianne E. Avillion has disclosed that she has no significant financial or other conflicts of interest pertaining to this course.

How to receive credit

- Read the entire course online or in print.
- Depending on your state requirements you will be asked to complete:
  - A mandatory test (a passing score of 75 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- Provide required personal information and payment information.
- Complete the mandatory Course Evaluation.
- Print your Certificate of Completion.

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Resolution of conflict of interest

Colibri Healthcare, LLC implemented mechanisms prior to the planning and implementation of the continuing education activity, to identify and resolve conflicts of interest for all individuals in a position to control content of the course activity.

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The information provided in this activity is for continuing education purposes only and is not meant to substitute for the independent medical judgment of a healthcare provider relative to diagnostic and treatment options of a specific patient's medical condition.

Learning objectives

After completing this course, the learner will be able to:

- Define cultural humility.
- Describe dimensions of diversity in the United States.
- Identify factors that can interfere in the healthcare professional/patient relationship with patients of diverse cultural backgrounds.
- Explain cultural humility from the perspectives of oppression, privilege, and marginalization.
- Describe the process of providing patient care with cultural humility.
- Differentiate between multicultural competency and cultural humility.

Course overview

This course presents an introduction to cultural humility and offers tools for healthcare professionals to use when working with diverse patients in a culturally humble manner. The course highlights the importance of cultural humility and the reasons why it is necessary and outlines a quantifiable set of attitudes that allow healthcare professionals to work effectively within the cultural context of each patient. There is an understanding that cultural humility is an ongoing process and is a prerequisite for cultural competency.

INTRODUCTION

In the context of healthcare services cultural humility is defined as "a process of being aware of how people's culture can impact their health behaviors and, in turn, using this awareness to cultivate sensitive approaches in treating patients" (Prasad et al., 2016). In contrast, cultural competency is described as ensuring that healthcare professionals learn a quantifiable set of attitudes that allow them to work effectively within the cultural context of each patient. There is an end point to cultural competency. It ends with the termination of the healthcare professional-patient relationship. On the other hand, cultural humility is an ongoing process, which requires continual self-reflection and self-critique. Cultural humility is a prerequisite to cultural competency. It forms a basis for effective, harmonious healthcare professional-patient relationships (Prasad, 2016).

Cultural humility involves entering into a professional relationship with a patient by honoring the patient's beliefs, customs, and values. Cultural competency is described as a skill that can be taught, trained, and achieved. This approach is based on the concept that the greater the knowledge a healthcare professional has about another culture, the greater the competence in practice. Cultural humility de-emphasizes cultural knowledge and competency and focuses on lifelong nurturing of self-reflection and self-critique, promotion of interpersonal sensitivity, addressing power imbalances, and promoting the appreciation of intracultural variation and individuality (Stubbe, 2020). This humility exemplifies respect for human dignity.

An important part of cultural humility is identifying one's own biases, self-understanding, and interpersonal sensitivity. It is important that healthcare professionals nurture an appreciation for the many facets of each patient, including culture, gender, race, ethnicity, religion, sexual identity, and lifestyle. According to Yancu (2017), healthcare professionals need both process (cultural humility) and product (cultural competence) to effectively provide care and interact with a culturally diverse society.

Healthcare Professional Consideration: A culturally humble healthcare professional needs to be able to provide services that transcend culture, ability, LGBTQ status, and class, as well as integrate healthcare professional-stated cultural and other considerations into treatment. Moreover, the healthcare professional must recognize the roles that power, privilege, and oppression play in both the counseling relationship and the experiences of patients (Sue & Sue, 2021).

Self-Assessment Quiz Question #1

Which of the following statements pertains to the definition of cultural humility?

a. Healthcare professionals must learn a quantifiable set of attitudes.
b. Cultural humility is an ongoing process.
c. Cultural humility is a skill that can be taught.
d. Healthcare professionals know that there is an end point to cultural humility.

DIMENSIONS OF DIVERSITY IN THE UNITED STATES

Definitions

Diversity is a multidimensional concept that refers to many aspects of an individual that combine to comprise an overall sense of self. Moreover, diversity occurs within a cultural and social context where variances within the general population are treated differentially based on the social, political, and cultural constructs existing within a society. Some dimensions of diversity include race, socioeconomic class, gender, sexual orientation (i.e., identifying as lesbian, gay, bisexual, queer/questioning [LGBQ]), gender identification (i.e., identifying as transgender), and disability. Although this is not an exhaustive list of all elements of individual diversity, it does address many prominent dimensions of diversity an individual may have as well as determine where that individual falls within the societal hierarchy. Dimensions of diversity also serve to privilege and empower some members of society while oppressing and marginalizing other members of society (Sue & Sue, 2021).

Intersectionality is a concept that is used to describe how these various dimensions come together to privilege or oppress individuals and groups of individuals. Intersectionality is defined as "multiple, intersecting identities and ascribed social positions (e.g., race, gender, sexual identity, class) along with associated power dynamics, as people are at the same time members of many different social groups and have unique experiences with privilege and disadvantage because of those intersections" (Rosenthal, 2016, p. 475).

Each individual has a multitude of diverse identities; some Each individual has a multitude of diverse identities; some are visible and some are not readily identifiable. Each of the identities intersects with the other identities. The multiple intersections can serve to foster further oppression and marginalization or further power and privilege, and/or they could mitigate one another, providing some facets of privilege and others of oppression. For example, an African American college professor who is a heterosexual woman with a doctoral degree is often oppressed and marginalized because of her race and gender; however, as a highly educated academic who is not gay, she experiences power and privilege, particularly in the academic classroom setting as the course professor. Another example is a female student who has experienced poverty on and off throughout her life cycle and identifies as biracial and gay; she may experience multiple identities that compound her oppression and marginalization (i.e., female, poor, gay, biracial). The concept of intersectionality provides a useful framework for healthcare professionals, as it helps them to understand the complexity of patients' diverse identities. Further, it provides a structure for understanding the multitude of factors that may cause a patient to be oppressed and/or privileged within the context of American society. In this same manner, it is important to recognize that culture is best described as fluid and subjective, as will be discussed in greater detail with respect to providing patient care with cultural humility.

Race, ethnicity, and immigration

The United States (US) is a nation of immigrants. The racial, ethnic, and immigrant diversity within American society is often cited as one of its greatest strengths. However, it has also been a challenge for America and for Americans in terms of fully accepting and embracing the broad array of immigrant groups that have become American. Historically, every new immigrant group has experienced various degrees of prejudicial and discriminatory treatment and exclusion from mainstream society. However, the experience of many European (e.g., Irish, Italian, German) immigrants was one of initial discrimination followed by swift acculturation and assimilation, likely aided by the physical appearance and language similarities to those of earlier settlers. Asian and Latina/o immigrants have experienced prejudicial treatment, possibly because of readily identifiable physical and language differences. Historical evidence of mistreatment is well documented, with perhaps one of the most egregious examples being the internment of Japanese Americans during World War II (Nagata et al., 2015).

Although Americans often think of the journey of voluntary immigration of the many ethnic groups that come to America to build a "better" life, the legacy of the forced immigration of African American slaves is often overlooked. African Americans endured 250 years of enslavement followed by 60 years of a status of "separate but equal" as well as continuing racist practices in education, housing, health, and criminal justice system. The systemic and continuous oppression of African Americans is a direct legacy of this forced immigration and has resulted in enduring educational, health, and wealth disparities (Bunch, 2016).

"New" immigrants from Afghanistan, Haiti, and other war-torn or environmentally impacted countries are experiencing prejudicial treatment in society and healthcare. The economic and social burden of caring for these immigrants, in addition to the typical flow of immigrant populations, has aroused discriminatory attitudes in society and even in healthcare professionals that may already be stressed by COVID patient care.

Healthcare professionals' understanding of the differential treatment of current and past immigrant groups based upon ethnic, racial, religious, and linguistic background is paramount to their understanding of their patients. The way in which individuals and groups are treated from a sociopolitical (macro) level and from a daily individual interactional level (micro) necessarily affects their views and understanding of the world in which they live. From a person in environment perspective, individuals act upon the environment and the environment acts and reacts to the individual. Thus, while individuals help shape the environment around them, the environment also shapes the individual (Hutchison, 2021).

A demographic breakdown of the diversity in the US is provided in Tables 1 and 2. This breakdown may help healthcare professionals better conceptualize the potential diversity of experiences among their patients.

Demographics

The US has more immigrants than any other country in the world. Currently, more than 40 million people living in the US were born in another country. This figure represents one-fifth of the world's immigrants. Nearly every country in the world is represented among US immigrants (Pew Research Center, 2020b).

In 2018, there were a record 44.8 million immigrants living in the US. This figure represents 13.7% of the nation's population. Since 1965, the number of immigrants living in the US has more than quadrupled. Since 1970, the number of immigrants has nearly tripled (Pew Research Center, 2020a). Table 1 provides a breakdown of the US foreign-born population by national origin..

Table 1: Foreign-Born Population by Place of Birth 2018

Region	Number of People	Percentage
Mexico	11,182,111	25%
East and Southeast Asia	8,648,525	19.3%
Europe	4,848,270	10.8%
Caribbean	4,463,891	10%
South America	3,304,380	7.4%
Central America	3,590,330	8%
South Asia	3,668	8.2%
Sub-Saharan Africa	2,032,470	4.5%
Middle East-North Africa	1,784,898	4%
Canada and Other North America	827,093	1.8%
Oceania	246,371	0.6%
Central Asia	131,854	0.3%
Total	**44,760,622**	**100%**

(Based on data from the Pew Research Center [2020a]).

Tables 2-4 provides a breakdown of the US population by race.

Evidence-based practice! Data show that the population varies significantly by place of birth and race. Healthcare professionals must be aware of the populations they serve to practice cultural humility.

Table 2: Population by Race Self-Identification 2018

Race	Number of People	Percentage
White	236,102,692	72.2%
Black or African American	41,683,829	12.7%
Asian	18,449,856	5.6%
Some Other Race	16,273,008	5%
Two or More Races	11,224,731	3.4%
Native American Indian and Alaska Native	2,826,336	0.9%
Native Hawaiian and other Pacific Islander	606,987	0.2%

(Pew Research Center, 2020a)

Table 3: Population by Race Self-Identification US Born

Race	Number of People	Percentage
White	215,726,882	76.4%
Black or African American	37,413,425	13.2%
Two or More Races	10,169,825	3.6%
Some Other Race	9,655,701	3.4%
Asian	2,627,659	2.2%
Native American Indian and Alaska Native	2,627,659	0.9%
Native Hawaiian and other Pacific Islander	460,543	0.2%

(Pew Research Center, 2020a)

Table 4: Population by Race Self-Identification Foreign Born

Race	Number of People	Percentage
White	20,375,810	45.5%
Asian	12,097,155	27%
Some Other Race	6,617,226	14.8%
Black or African American	4,270,404	9.5%
Native American Indian and Alaska Native	198,677	0.4%
Native Hawaiian and Other Pacific Islander	146,444	0.3%
Two or More Races	460,543	0.2%

(Pew Research Center, 2020a)

Self-Assessment Quiz Question #2

In 2018, from which country/region did the highest number of foreign-born people residing in the US come from by place of birth?

a. South America.
b. East and Southeast Asia.
c. Mexico.
d. Sub-Saharan Africa.

Healthcare professionals must be careful not to make sweeping generalizations regarding characteristics or needs of any population. Further, patients are influenced by a variety of factors including level of acculturation (to be discussed later), immigration experience, experiences with discrimination, and ability to speak English. Therefore, it is imperative for healthcare professionals to ask patients about their personal experiences and important events in their lives. Some cultural generalizations may help clinicians increase their knowledge of specific cultures and enhance their understanding of a portion of patients' differing experiences. However, this is not intended to shift the healthcare professionals focus away from developing a better understanding of the dynamics of race, immigration, and other facets of diversity within the current social, economic, and political environment of the United States. Healthcare professionals are better prepared to both understand and help their patients if they are able to understand the cultural climate in which their diverse patients live and that climate's role in accommodating or marginalizing them. Moreover, healthcare professionals will provide better care for their patients if they develop a better understanding of how they personally are accommodated and marginalized by American culture. Race, ethnicity, and immigration status are only a few of the facets of diversity that affect patients. Other facets of diversity include socioeconomic status, disability, sexual orientation, religion, and gender identification. These facets of diversity can serve as dimensions that marginalize and/or oppress patients as well.

Poverty

Poverty is often a consequence of immigrants who have fled war zones, disaster areas, and regions of extreme high unemployment. The official poverty rate in 2020 was 11.4%, up 1% from 2019. This is the first increase in poverty after five consecutive annual declines. In 2020, there were 37.2 million people in poverty, about 3.3 million more than in 2019 (U.S. Census Bureau, 2020).

Evidence-based practice! Research shows that the poverty rate in the US is increasing. Healthcare professionals must be aware of data relating to poverty and work to decrease the growing problem of poverty.

Key points of the 2020 income and poverty in the US include the following (U.S. Census Bureau, 2020):

- Between 2019 and 2020, the poverty rate increased for non-Hispanic Whites and Hispanics. Among non-Hispanic Whites, 8.2% were in poverty in 2020, while Hispanics had a poverty rate of 17.0%. Among the major racial groups examined in this report, Blacks had the highest poverty rate (19.5%) but did not experience a significant change from 2019. The poverty rate for Asians (8.1%) in 2020 was not statistically different from 2019.
- Poverty rates for people under the age of 18 increased from 14.4% in 2019 to 16.1% in 2020. Poverty rates also increased for people aged 18 to 64 from 9.4% in 2019 to 10.4% in 2020. The poverty rate for people aged 65 and older was 9.0% in 2020, not statistically different from 2019.
- Between 2019 and 2020, poverty rates increased for married-couple families and families with a female householder. The poverty rate for married-couple families increased from 4.0% in 2019 to 4.7% in 2020. For families with a female householder, the poverty rate increased from 22.2% to 23.4%. The poverty rate for families with a male householder was 11.4% in 2020, not statistically different from 2019.

Income data from this report include the following information (U.S. Census Bureau, 2020):

- Median household income was $67,521 in 2020, a decrease of 2.9% from the 2019 median of $69,560. This is the first statistically significant decline in median household income since 2011.
- The 2020 real median incomes of family households and nonfamily households decreased 3.2% and 3.1% from their respective 2019 estimates.
- The 2020 real median household incomes of non-Hispanic Whites, Asians, and Hispanics decreased from their 2019 medians, while the changes for Black households were not statistically different.
- In 2020, real median household incomes decreased 3.2% in the Midwest and 2.3% in the South and the West from their 2019 medians. The change for the Northeast was not statistically significant.

Women in Poverty

More women than men are living in poverty in the US. Men who have migrated for employment or to avoid conscripted military work often have left women behind. Migrating across hundreds of miles and difficult terrain is not feasible for women and children. Basic information about women in poverty includes the following (Bleiweis et al., 2020):

- Of the 38.1 million people living in poverty in 2018, 56%, or 21.4 million, were women.
- Nearly 10 million women live in deep poverty defined as falling below 50% of the federal poverty line.
- The highest rates of poverty are experienced by Native American Indian or Alaska Native (AIAN) women, Black women, and Latinas. About one in four AIAN women live in poverty. This is the highest rate of poverty among women or men of any racial or ethnic group.
- Unmarried mothers have higher rates of poverty then married women, with or without children, and unmarried women without children. Nearly 25% of unmarried mothers live below the poverty line.
- In 2018, 11.9 million children under the age of 18 lived in poverty. This accounts for 31.1% of those living in poverty.
- Poverty rates for women and men are almost even throughout childhood. However, the gap grows significantly for women ages 18 to 44 (during prime childbearing years) and again for women age 75 and older.
- Women with disabilities are more likely to live in poverty than both men with disabilities and persons without disabilities. Women with disabilities have a poverty rate of 22.9%, compared to 17.9% for men with disabilities and 11.4% for women without disabilities.
- LGBTQ women experience higher rates of poverty than cisgender (sense of personal identity and gender correspond with their birth sex) straight women and men because of the intersections of discrimination based on gender, sexual orientation, and gender identity or expression.

Reasons why women live in poverty

The impact of sexism and racism on society limit the employment opportunities available to women. Some of the causes of poverty in women include the following issues.

Wage gap

Based on 2018 data, women working full-time, year-round earn on average 82 cents for every dollar earned by their male counterparts. This gap continues throughout the lifespan, leaving women with fewer resources and savings than men (Bleiweis et al., 2020).

Occupational segregation into low-paying jobs

Women are disproportionately represented in certain occupations, especially low-paying jobs. This is due, in part, to the perception of gender roles that assume women's work is low skilled and undervalued. This is especially true for women of color (Bleiweis et al., 2020).

Lack of work-family policies

Issues such as insufficient paid family and medical leave and earned paid sick leave impact a woman's ability to manage work and caregiving. Childcare is expensive and sometimes hard to access. These issues further compound problems associated with work-family challenges. The coronavirus has exacerbated the caregiving burden on women because of essential school and childcare provider closures, which contributes to higher job loss among women (Bleiweis et al., 2020).

Disability

Disability may cause, as well as be a consequence of; poverty. People with disabilities must deal with barriers to employment as well as lower earnings. Only 16.4% of women who have disabilities were employed in 2018, compared with 60.2% without a disability (Bleiweis et al., 2020).

Domestic violence

In the US, domestic violence is the cause of women's losing an average of eight million days of paid work per year. The Violence Against Women Act (VAWA) has led to lowered rates of gender-based violence in the US thanks to its programs and services. Unfortunately, the programs and services of the VAWA are not able to meet ongoing needs of domestic violence survivors without more funding and expansion of resources (Bleiweis et al., 2020).

Self-Assessment Quiz Question #3

Which of the following persons is most likely to live in poverty?

a. A woman who self-identifies as Alaska Native.
b. A man who is 45 years of age.
c. A married man with two children.
d. An unmarried woman without children.

Disability

Physical, intellectual, mental health, and other long-term disabilities constitute another facet of diversity within the United States. According to the Centers for Disease Control and Prevention (CDC; 2020), 61 million adults (26% of adults) in the US live with a disability.

According to the Equal Employment Opportunity Commission's (EEOC; 2021) Enforcement and Litigation Statistics and Agency Financial Report for Fiscal Year (FY) 2020, retaliation was the most frequently alleged discriminatory claim, accounting for 55.8% of all charges. Disability (36.1%) was the next most alleged category of discrimination, followed by race and sex. The percentage of each category decreased or remained stable compared to FY 2019 except for claims of retaliation, disability, color, and genetic information (EEOC, 2021).

Table 5 shows the percentage of adults with specific categories of disability in the US.

The CDC (2020) points out that:

- Two in five adults age 65 years of age and older have a disability.
- One in four women have a disability.
- Two in five non-Hispanic, Native American Indians/Alaska Natives have a disability.

Evidence-based practice! Research shows that adults living with disabilities are more likely to smoke, have obesity, have heart disease, and/or diabetes (CDC, 2020). Healthcare professionals must be alert to the diseases linked to disability. These diseases can compound the challenges that people with disabilities face.

People with disabilities face several barriers to accessing healthcare. These include the following (CDC, 2020):

- One in three persons does not have a primary healthcare provider (Age group: 18-44 years).
- One in three people has an unmet healthcare need because of cost in the past year (Age group: 18-44 years).
- One in four people did not have a routine check-up in the past year (Age group: 45-64 years).

Disability often compounds issues of poverty and access that can lead to an array of health consequences such as substance abuse, domestic violence, malnutrition, and even chronic mental health conditions.

Table 5: Percentage of Adults with Functional Disability Types in the US

Functional Disability	Description	Percentage
Mobility	Serious difficulty walking or climbing stairs.	13.7%.
Cognition	Serious difficulty concentrating, remembering, or making decisions.	10.8%.
Independent Living	Difficulty doing errands alone.	6.8%.
Hearing	Deafness or serious difficulty hearing.	5.9%.
Vision	Blindness or serious difficulty seeing.	4.6%.
Self-Care	Difficulty bathing or dressing.	3.7%.

(CDC, 2020)

Lesbian, gay, bisexual, transgender, queer/questioning population (LGBTQ)

The LGBTQ population is another historically oppressed group in the US. Until the 2015 Supreme Court decision legalizing same-sex marriage, LGBTQ individuals were not able to marry in most states.

There are more than 5.5 million LGBTQ individuals living in the US. The LGBT community face barriers to fair and equal access to employment, housing, healthcare, and public accommodation. There are several nondiscrimination laws on federal, state, and local levels that protect people from discrimination based on such factors as age, sex, and national origin. However, until 2020, federal law did not protect individuals from discrimination based on sexual orientation or gender identity (Roebig, 2020).

The Center for American Progress conducted a national public opinion study on the state of the LGBTQ community in 2020. The survey included interviews with 1,528 self-identified LGBTQ adults ages 18 and older. The project was funded and operated by the National Opinion Research Center (NORC) at the University of Chicago (Gruberg et al., 2020).

Major findings from the survey include the following (Gruberg et al., 2020):

- More than one in three LGBTQ Americans faced discrimination of some kind in the past year.
- More than three in five transgender Americans faced discrimination of some kind in the past year.
- Discrimination adversely impacted the mental and economic well-being of many LGBTQ Americans, including one in two participants who reported moderate or significant negative psychological impacts.
- More than half of LGBTQ Americans reported hiding a personal relationship to avoid experiencing discrimination.
- An estimated 3 in 10 LGBT Americans faced difficulties accessing necessary medical care because of cost issues.

- Fifteen percent of LGBTQ Americans reported postponing or avoiding medical treatment because of discrimination.
- Transgender individuals faced unique obstacles to accessing healthcare, including one in three who had to teach their physicians about transgender people.
- LGBTQ Americans may have also experienced significant mental health issues that are related to the COVID-19 pandemic.

Self-Assessment Quiz Question #4

All the following statements are accurate EXCEPT:

a. In the US 61 million adults live with a disability.
b. The type of functional disability that has the highest percentage is that of cognition.
c. More than half of LGBTQ Americans report hiding a personal relationship.
d. Transgender individuals face unique obstacles to accessing healthcare.

The complexity of individual diversity is inclusive of not just of racial and ethnic identity but also of variables such as socioeconomic class, disability, and LGBTQ status. While these facets of diversity are not exhaustive, they do represent some important categories of diversity. Healthcare professionals must consider the unique array of diverse identities that are represented within each individual encountered in each therapeutic relationship. The complexity embodied within each patient affects the way that the patient understands and views the healthcare professional and the professional relationship, just as the complexity of the healthcare provider's diversity dimensions affects the way that the healthcare professional understands and views each patient. It is impossible to provide information that allows healthcare professionals to gain knowledge about categories of people and how they behave or view the world, because not only is the variation within individual ethnicities and races endless, but the variation within each individual also is endless. Instead, healthcare professionals should aim to understand the societal landscape that privileges and oppresses individuals. The experiences of oppression experienced by various diverse groups are likely to provide them with a unique perspective on both the larger society and on the relationship with healthcare professionals.

OPPRESSION, PRIVILEGE, AND MARGINALIZATION

Understanding the concepts of oppression, privilege, and marginalization is essential for practicing with cultural humility. There are various aspects of individual identities that oppress or privilege people and their marginalization or empowerment.

Oppression can be defined as "unjust or cruel exercise of authority or power" (Merriam-Webster, 2021). A person or group that knowingly or unknowingly abuses a specific group. Oppression is a pervasive system. It has its foundation in history and is maintained via individual and institutional systematic discrimination, personal bias, bigotry, and social prejudice. Oppression leads to a condition of privilege for the person or the group that is the oppressor(s). National Conference for Community and Justice (NCCJ; 2021).

Privilege is a central concept within the healthcare professions. The concept of White privilege and male privilege was clearly articulated and widely disseminated through McIntosh's work in the 1980s. McIntosh articulated White male privilege as "an invisible package of unearned assets which he can count on cashing in each day, but about which he was 'meant' to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, assurance, tools, maps, guides, codebooks, passports, visas, clothes, compass, emergency gear, and blank checks" (McIntosh, 1998, p. 1). Privileging is "a process where chances or odds of being offered an opportunity are altered or skewed to the advantage of members of certain groups" (Minarik, 2017, p. 55). Essentially, privilege functions by providing some groups of individuals (e.g., White, male, heterosexual, abled, middle class) with preferred treatment in the form of special opportunities and advantages, while withholding that preference from other individuals (e.g., African American, female, LGBTQ, disabled). Privilege can include many advantages including being given the benefit of the doubt and feeling a sense of belongingness (Minarik, 2017). Individuals who are not privileged experience the opposite – such as being an automatic suspect or having to prove belonging (Minarik, 2017). Privilege is not a guarantee of success for those groups who receive it; however, it is an advantage that other groups do not receive and allows for opportunities that others are denied (Minarik, 2017). A final key aspect regarding privilege is that it is not necessarily visible to those who receive it. The invisibility of privilege is the key component that allows it to continue. More simply, when those who receive privilege do not recognize it, they are unable to take actions to change it. Once people become aware of privilege, they choose to use the benefits of privilege to advocate for marginalized populations.

Self-Assessment Quiz Question #5

When discussing oppression and privilege, healthcare professionals should know that:

a. Privilege is the commission of an unjust or cruel exercise of authority or power.
b. Privilege is a guarantee of success for groups receiving it.
c. Oppression's foundation is in the "me too" movement.
d. Oppression leads to a condition of privilege for the person or the group that is the oppressor(s).

Marginalization is an important concept in the delivery of patient care. Marginalization is the "act of placing a person or group in positions of lesser importance, influence, or power" (Dictionary.com, 2021). Examples of groups that have been, and are being, marginalized include ethnic and racial minorities, immigrants, the LGBTQ population, persons who are disabled, and the economically disadvantaged.

Some experts have identified the following three themes of marginalization (Baah et al., 2019):

1. **Creation of margins**: Margins act as barriers and connections between a person and the environment. Margins construct physical, emotional, and psychological boundaries that people experience during interactions with society. Enforcement and maintenance of boundaries divide the political and socioeconomic resources in an uneven fashion. This also facilitates the unbalanced distribution of critical resources such as healthcare (Baah et al., 2019). This illustrates the concept of social determinants of health (SDH), which is defined as "the circumstances in which people are born, live, work and age and the systems put in place to deal with illness" (World Health Organization [WHO], 2010).
2. **Living between cultures**: Living between cultures is another factor that links marginalization to SDH. Although the boundary or margin separates the dominant and peripheralized group, incomplete integration leads to a person or group that lives between cultures. Incomplete integration creates a situation where a person or group relinquishes characteristics of the marginalized group in order to bond with the dominant society, but is unable to do so. Examples of living between cultures are the ways of life of most immigrants, migrant farm workers, and other vulnerable groups. People living between cultures tend to live in areas characterized by limited employment and educational opportunities (Baah et al., 2019).

3. **Creation of vulnerabilities**: Creation of vulnerabilities are created by the cumulative impact of the creation margins and living between cultures. Vulnerability is defined as a state of being exposed to and unprotected from health-damaging environments (Baah et al., 2019.

Marginalized groups often do not receive the same access to societal resources such as high- quality education, healthcare, housing, or equal access to voting as those groups that are not marginalized. The marginalization of oppressed groups prevents them from having a voice and helps to sustain the status quo in the United States in which White, economically well-off, and able-bodied individuals control access to social, economic, and political power.

Healthcare Professional Consideration: Healthcare professionals should recognize the power imbalances that result from oppression, privilege, and marginalization and work to correct the imbalances within the delivery of healthcare services and within the broader institutional and societal context.

Self-Assessment Quiz Question #6

When discussing themes related to marginalization, the concept of being exposed to and unprotected from health-damaging environments is referred to as:

a. Creation of margins.
b. Living between cultures.
c. Vulnerability.
d. Boundaries.

PROVIDING PATIENT CARE WITH CULTURAL HUMILITY

The concept of cultural humility was first discussed in the medical world to better understand and address health inequities and disparities (Tervalon & Murray-García, 1998). The concept has evolved to include ideas related to the creation of a broader and more inclusive society. Unlike the concepts of cultural competency and multicultural competency, which focus on gaining knowledge about cultural groups differing from the individual's own with the hopes of better understanding those cultures and thus better meeting the needs of different groups who enter counseling, cultural humility focuses on the cultural context within America that marginalizes and oppresses some groups of people, while privileging and empowering other groups of people (Foronda et al., 2016).

Attending to diversity

Critical Thinking Exercise

Trinh, a 17-year-old first-generation American of Hmong decent, is graduating first in her high school class. Her school counselor has encouraged her to apply to top-level colleges, several of which are hours from home. When Trinh asks about some nearby colleges, the counselor simply tells her that they are "well below her abilities," even though one is highly regarded. She is accepted by the top-level colleges to which she applied, including two Ivy League schools. Despite generous financial aid packages, Trinh does not accept offers from any of these schools. Past the deadline to apply to the local 4-year colleges, Trinh decides to go to the local community college and live at home. Her counselor tries to persuade Trinh to reconsider one of the Ivy League schools. Trinh tells the counselor that she needs to stay home to help care for younger siblings and translate for her parents during doctors' visits. The counselor engages Trinh in a role play to help her tell her parents that she needs to make her own decisions and go away to college.

Although school counselors do want their students to succeed, what underlying values might have clouded the counselor's judgment in working with Trinh? Trinh had given the counselor signals that she was not ready to move hours away when she asked about local colleges. Perhaps the counselor, working from a belief that individualism is preferred, ignored these clues, hoping not to play into Trinh's "separation anxiety." If the counselor had viewed her Trinh and her family as both being her clients, rather than only a young woman needing to be more independent, she could have worked with the family to make a decision that addressed both Trinh's needs and those of her family. By ignoring Trinh's cultural background and her sense of responsibility to the family, the counselor could not help in an informed way.

Given the vast diversity within the United States, both healthcare professionals and counselors must develop cultural humility as they work with individuals whose life experiences vary in myriad ways based on many intersecting dimensions of diversity. A primary component of cultural humility is self-awareness. As a healthcare professional, completely exploring one's own identity is of extreme importance. It is through knowing and understanding oneself that counselors and healthcare professionals can uncover their beliefs, values, and, moreover, their implicit biases.

Implicit bias is defined as an unconscious and unintentional bias (van Nunspeet et al., 2015). Individuals may not be aware of their implicit biases (Byrne & Tanesini, 2015). These biases are the result of combinations of factors including an individual's early experiences and learned cultural biases. Thus, ongoing critical self-reflection that understands the existence of implicit biases within everyone is necessary. Repeated and evolving processes of self-reflection make healthcare professionals' implicit biases explicit and, therefore, subject to examination and change (Byrne & Tanesini, 2015). In addition to understanding their own implicit biases, healthcare professionals, especially those from dominant societal groups (e.g., White, heterosexual, male), need to explore their own racial, ethnic, sexual, and class identity. Individuals from dominant cultural paradigms often consider themselves without racial, ethnic, sexual, or class identity as they have privilege; their identities are considered the norm. However, without deep exploration of intersecting aspects of personal diversity, it is difficult to understand oneself and where biases might insert themselves into healthcare professional relationships (Fisher-Borne et al., 2015).

Self-reflection and self-critique

Self-reflection and self-critique are ongoing, lifelong processes that allow healthcare professionals to continually refine their understanding of themselves and their actions and reactions within counseling contexts and to continually broaden and deepen their cultural understanding through introspection (Foronda et al., 2016). Through ongoing self-reflection and critique, the healthcare professional develops a better understanding of the dynamics within and outside the healthcare arena and of the ways these dynamics affect the patient's life, the healthcare professional's life, and the interactions between healthcare professional and patient.

Self-reflection is defined as deliberately paying attention to one's own thoughts, emotions, decisions, and behaviors. It is important for healthcare professionals to be able to self-reflect in "real time" as they deal with the variety of situations encountered in an ever-changing healthcare environment (Wignall, 2019).

Self-critique is the process of critically examining oneself to continually refine their understanding of themselves and their actions and reactions and to continually broaden and deepen their cultural understanding through introspection. Self-reflection and self-critique are best incorporated into practice on a reflexive basis. That is, the ongoing process of self-reflection should result in an automatic process or reflection as an integral part of practice. (Foronda et al., 2016).

Respectful partnerships

Developing respectful partnerships is key to providing healthcare services with cultural humility and, more generally, to developing a relationship within the counseling setting that allows work to begin and to continue in a productive fashion. Respectful partnerships include discussing and addressing such difficult topics and issues as race, socioeconomic class, gender, sexual identity, and disability. These discussions are uncomfortable for many; they bring up feelings, often passionate, associated with "isms," group identification, prejudice, quotas, and affirmative action. Yet these differences between healthcare professional and patient are a presence in the room and, when ignored, have the potential to interfere with an honest and open exchange (Minarik, 2017).

Healthcare professionals often attempt to take the emphasis off race, class, gender, and other areas of difference by denying the effect these aspects of diversity have on patients (e.g., "The only race I know is the human race"), or by trying to show that they understand the patient's experience because they, too, are a member of an oppressed group. For example, the African American patient may not feel that the healthcare professional, as a bisexual Jewish woman, understands subtle racial insults from personal experiences. Some healthcare professionals imply that because they personally do not discriminate against oppressed groups, no personal or societal problems exist associated with race, class, LGBTQ status, or disability; this attitude negates the experience the patients may have in the larger society, where they experience various degrees of marginalization based on their intersecting identities (Minarik, 2017).

Respectful partnerships are developed when the healthcare professional facilitates a dialogue that illustrates an understanding of and attends to the complex dynamics related to privilege, oppression, and marginalization present within the patient/healthcare professional relationship and embedded within the larger society. The healthcare professional levels the playing field by conveying a respect for the patient and the patient's lived reality while inviting the patient to enter an equal partnership with the healthcare professional.

Healthcare Professional Consideration: The development of respectful partnerships is ongoing and acknowledges that the healthcare professional does not know what the patient's identity, life, or struggles look like but is eager to learn from the patient. Further, healthcare professionals who are developing respectful partnerships recognize that they may make mistakes and are open to patient feedback regarding those mistakes.

Self-Assessment Quiz Question #7

All the following statements concerning self-reflection, self-critique, and respectful partnerships are true EXCEPT:

a. Discussing and addressing topics and issues such as race and sexual identify may be uncomfortable for many people.
b. Healthcare professionals seldom attempt to take emphasis off race, gender, and other areas of differences.
c. Self-reflection and self-critique are ongoing, lifelong processes.
d. Self-reflection should result in an automatic process as an integral part of practice.

Lifelong learning

The commitment to lifelong learning within the ethical standards requires healthcare professionals to participate in activities that keep them current on issues and interventions within healthcare and that allow them to provide patients with the most appropriate care and service. Lifelong learning in the context of cultural humility emphasizes the importance of current issues inclusive of a multicultural perspective that encompass aspects of critical self-reflection and advocacy involving continued growth and learning. According to Fisher-Borne and colleagues (2015), "Cultural humility considers the fluidity and subjectivity of culture and challenges both individuals and institutions to address inequalities.

Cultural humility requires self-reflection and taking risks, discovering new information, and using patients and others as resources (Obiakor & Algozzine, 2016). Culturally humble learners understand that they will both make mistakes and learn from those mistakes because, as healthcare professionals, they are in a constant state of becoming. Lifelong learning allows the healthcare professional to integrate shifting paradigms and embark on continual reflection and reeducation regarding dominant perspectives on marginalized populations and communities (Obiakor & Algozzine, 2016). Finally, it requires that healthcare professionals separate themselves from thinking about patients from a deficit perspective and instead think of patients as fellow humans with rich intellectual, cultural, ethnic, and class backgrounds and with a myriad of strengths (Obiakor & Algozzine, 2016). Recognizing and reflecting on one's own possible biases, religious values, and family values may help to limit the influence of those biases on their patient interactions.

White identity

White identity theory was first developed by Helms in the 1980s and 1990s as a tool for White healthcare professionals to "create meaning about their identities as Caucasians, particularly in terms of how they think about, respond to, react to and interact with patients from different racial/ethnic groups" (Chung & Bemak, 2012, p. 67). In other words, the theory's formation was based on the idea that White people are so immersed in the dominant culture that they are unaware of the influence of the dominant culture's ethnocentric images and ideals. Being White makes it easier to assimilate into the dominant culture and to partake in unearned privileges many White people enjoy but do not acknowledge. Most White people perceive themselves as unbiased, but such self-perception may truly impede one from taking responsibility for one's own prejudices (Sue & Sue, 2016). White healthcare professionals have a special responsibility to understand their own privileges, biases, racism, and discrimination so that they may develop a positive relationship within counseling sessions.

Healthcare Professional Consideration: National surveys do not have a historical track record of asking White people meaningful questions about their racial identity (Schildkraut, 2017). Healthcare professionals should promote research that includes questions about racial identity.

Self-Assessment Quiz Question #8

When exploring one's own beliefs about White identify, it is important to acknowledge that:

a. Most White people perceive themselves as biased.
b. White identity theory was first developed to discount the idea that White identity exists.
c. National surveys often ask White people questions about their racial identity.
d. Being White makes it easier to assimilate into the dominant culture.

Assessment and treatment

It is important for healthcare professionals to approach every individual patient with a cognizance of the possible various intersecting identities within the patient, but without a stereotype of the patient based on preconceived notions of these intersecting identities (e.g., race, ethnicity, LGBTQ status). Implementing the practice of cultural humility may flummox healthcare professionals as they approach patients in a clinical setting (Schildkraut, 2017).

The following example from Wyatt (n.d.) illuminates some key elements of providing patient care with cultural humility. An interracial couple, an African American father and a White mother, come into therapy because their child was kicked out of school for fighting and the father was called into child protective services for spanking his child. When they entered the office, the father was very angry and the mother was getting extremely upset, trying to calm him down. The White therapist suggested meeting with the father alone first. When he met with the father, rather than trying to silence his rage, he joined with him by stating, "It sounds like you're furious with the situation that's happened; you're tired of it." The father was able to calm down at that point, as the White therapist was allowing him to be angry in his presence and was acknowledging that there might be a reason for anger. The therapist then asked the father if his disciplining method had anything to do with wanting to protect his child. The father responded that, yes, he was afraid his child, "a Black kid," was at risk of going to prison if he was fighting at school. The father did not want that for his child and was frightened. By providing room for the father to express his rage and his fear, the therapist was able to make the clinical session more meaningful.

Healthcare professionals who practice cultural humility also recognize that assessment tools and treatment protocols may not be appropriate for all patients. Historically, many therapeutic strategies employed in patient care were developed without empirically supported research with ethnic minorities (Sue & Sue, 2016). However, healthcare professionals should not rely solely on manualized treatment protocols to guide their interventions, as such an approach can fail to appreciate patients' unique experiences and the effect of differing social environments. Rather, when employing a research-based therapeutic practice, healthcare professionals should adapt the approach in accordance with the patients' values, experiences, and preferences while understanding the influence of the broader societal context (Jackson, 2015). Through facilitating a respectful partnership that allows patients to take the lead in narrating their experiences and in identifying personal treatment goals, healthcare professionals can create an environment that appreciates patients' perspectives. Table 6 outlines the important aspects of the multicultural perspective in clinical settings.

The considerations outlined in Table 6 require healthcare professionals to balance many different facets of patients and their lived experiences. It is especially important in treatment to adhere to these guidelines, as it sets up a therapeutic environment in which healthcare professional and patients are equal, while forcing healthcare professionals to consider the validity of various worldviews and the structural inequities that contribute to the problems and issues patients bring into therapeutic relationships.

Table 6: Multicultural Perspectives in Providing Healthcare

1. Provides the opportunity for two persons – from different cultural perspectives – to disagree without one being right and the other wrong.
2. Tolerates and encourages a diverse and complex perspective.
3. Allows for more than one answer to a problem and for more than one way to arrive at a solution.
4. Recognizes that a failure to understand or accept another worldview can have detrimental consequences.
5. Takes a broad view of culture by recognizing the following variables: ethnographic (ethnicity, race, nationality, religion, language usage, ability, LGBTQ status); demographic (age, gender, gender identity, place of residence); status (social, economic, educational factors); affiliations (formal memberships, informal networks).
6. Conceives of culture as complex when we count the hundreds or perhaps even thousands of culturally learned identities and affiliations that people assume at one time or another.
7. Conceives of culture as dynamic as one of such culturally learned identities replaces another in salience.
8. Uses methods and strategies and defines goals constituent with life expectations and values.
9. Views behaviors as meaningful when they are linked to culturally-learned expectations and values.
10. Acknowledges as significant within-group differences for any particular ethnic or nationality group.
11. Recognizes that no one style of counseling – theory of school – is appropriate for all populations and situations.
12. Recognizes the part that societal structures play in patient's lives.

Note. Adapted in part from Gonzale et al., 1994.

Self-Assessment Quiz Question #9

Multicultural perspectives in providing healthcare include all the following EXCEPT:

a. Provides opportunities for two persons from the same cultural perspective to disagree.
b. Takes a broad view of culture by recognizing variables.
c. Uses methods and strategies and defines goals constituent with life expectations.
d. Views behaviors as meaningful when they are linked to culturally learned values.

Healthcare professional roles

Culturally humble healthcare professionals need to work toward understanding themselves and their patients within the context of privilege, oppression, and marginalization. A healthcare professional's work engages patients as equal partners and addresses social inequalities and injustices on institutional and societal levels. The culturally humble healthcare professional sees their role in the provision of "therapeutic interventions" and addresses systems that serve to oppress marginalized communities to promote optimal well-being for patients, communities, and society. The healthcare professional can fulfill many roles. Because multicultural patient care is closely linked to the values of social justice, the need for a social justice orientation in patient care is apparent (Sue & Sue, 2016).

Social justice counseling is defined as "an active philosophy and approach aimed at producing conditions that allow for equal access and opportunity; reducing or eliminating disparities in education, health care, employment, and other areas that lower the quality of life for affected populations; encouraging the healthcare professional to consider micro, mezzo, and macro levels in the assessment, diagnosis, and treatment of patient and patient systems; and broadening the role of the helping professional to include not only caregiver/patient therapist but advocate, consultant, psycho-educator, change agent, community worker, and so on" (Sue & Sue, 2016, p. 134). The social justice perspective requires healthcare professionals to assess and intervene with a perspective that balances the individual patient and the system(s) in which the patient is experiencing difficulties (Sue & Sue, 2016).

The healthcare professional can act as advocate and actively speak with and, when necessary, for members of populations who are oppressed by the dominant society. These populations are confronted with institutional and societal oppression. Healthcare professionals can also be effective as "change agents" working to transform oppressive features of the institutional and societal environments. Rather than attributing patient problems to individual deficits, the healthcare professional works with the patient to identify external contributors to the problem and to remediate the consequences of oppression.

Further, critical self-reflection in the context of cultural humility includes analysis of power differentials and how those differentials may play out on both individual and institutional levels (Fisher-Borne et al., 2015). Practicing with cultural humility suggests that healthcare professionals go beyond the confines of their offices to address differences in power and privilege that affect patients in very tangible ways.

Healthcare professionals need to be self-aware and realize that patients react positively to healthcare professionals who display personal warmth, authenticity, credibility, and respect and who strive for human connectedness. Practicing with cultural humility provides the following:

> A promising alternative to cultural competence … as it makes explicit the interaction between the institution and the individual and the presence of systemic power imbalances. It further calls upon practitioners to confront imbalances rather than just acknowledge they exist. Cultural humility challenges us to ask difficult questions instead of reducing our clients to a set of norms we have learned in a training or course about "difference." We believe that asking critical questions … challenge our own practice as well as our organizations and institutions and will provide a deeper well from which to approach individual and community change and effective long-term practice (Fisher-Borne et al., 2015, p. 177).

Institutional and societal accountable: Social justice

Healthcare delivery takes place within and reflects the larger culture. Although healthcare delivery can certainly aid in the wellness of patients, it does not occur in a vacuum. Wellness cannot be achieved when social injustice is present.

Traditionally some healthcare professionals may consider issues of social justice outside the realm of their practice; however, if social justice is relegated to a select few, oppression will flourish and efforts to heal communities will be blocked. The healthcare professional practicing within a social justice framework would not locate the problem within the individual but would look to the environmental factors that contribute to the actions and reactions of the individual (Sue & Sue, 2016).

Social justice is the view that everyone deserves equal economic, political, and social rights and opportunities. Social justice depends on economic justice. Proponents of social justice explain that there must be fair and compassionate distribution of economic growth. Social justice requires that all persons be provided with access to what is good for the person and in associations with others. According to the principles of social justice, all people have a personal responsibility to work with others to design and continually perfect societal institutions for both personal and social development (San Diego Foundation, 2016).

Although there are variations among the definitions of social justice, there are three factors that are part of all definitions. These are (San Diego Foundation, 2016):

- Equal rights.
- Equal opportunity.
- Equal treatment.

In other words, social justice mandates equal rights and equal opportunities for everyone.

It is imperative that healthcare professionals ask themselves key questions that facilitate the acquisition of social justice. Examples of such questions include the following:

- How do my behaviors within patient interactions actively challenge any power imbalances and involve communities experiencing marginalization?
- How, as healthcare professionals, do we address inequalities?
- How am I extending my responsibility beyond individual patients?
- How am I advocating for policy and practice changes at institutional, community, state, and national levels?
- What institutional structures are in place that address inequalities?
- What training and professional development activities are offered at our institution or in our community that address inequalities?
- How can we engage our community to make sure its voice is heard in this work?

(Adapted and updated from Fisher-Borne et al., 2015, p. 176)

These types of questions can provide a starting point for healthcare professionals to address social injustices. Healthcare professionals can use their positions to advocate for changes in society to promote social justice. Working toward social justice, patients are empowered and can help create an environment in which equal rights, treatment, and opportunity are available to all.

Self-Assessment Quiz Question #10

The factors that are common to all definitions of social justice include:

a. White identity.
b. Equal opportunity.
c. Equal incomes.
d. Diversity in all groups.

DIFFERENCES BETWEEN MULTICULTURAL COMPETENCY AND CULTURAL HUMILITY

Cultural humility is a conceptual framework that was first developed and utilized in the field of medicine and nursing in the 1990s. Since that time, it has become more widely applied to all helping professions. The framework is intended to address some of the shortcomings within the cultural competency and multicultural counseling frameworks. The approach of cultural humility differs from the multicultural competency approach in that it recognizes that knowledge of different cultural backgrounds is not sufficient to develop an effective patient/healthcare professional relationship with each individual. The cultural competency and multicultural counseling frameworks are most often criticized for creating a model that serves to "other" ethnic, racial, and various minority groups (Carten, 2016, p. xlii) while not acknowledging "Whiteness" as an identity and as a culture. "Othering" is the term used for the "biased assumptions about populations viewed as 'the other' at various times in the country's history" as well as in the present (Carten, 2016, p. xlii).

Othering assumes that various oppressed and marginalized populations are different from the American "norm," commonly understood as a White, middle class, able-bodied, straight, male, and individually responsible for any difficulties they may experience. Multicultural patient care delivery and cultural competency frameworks commonly assume that the healthcare professional is White and that patients are the "other" and set out to describe what various racial and ethnic groups believe and how they act as a group. On the other hand, a cultural humility framework emphasizes self-understanding as primary to understanding others. To facilitate self-understanding, cultural humility encourages ongoing critical self-reflection, asking the healthcare professionals to delve into their cultural identity and its effect on the delivery of patient care. Cultural humility makes no assumption regarding the healthcare professional's identity and especially challenges White practitioners to explore and understand their "White identity" (Carten, 2016). Table 7 illustrates the differences between (multi)cultural competence and cultural humility frameworks.

Table 7: (Multi) Cultural Competence and Cultural Humility

	(Multi) Cultural Competence	**Cultural Humility**
Perspectives on Culture	• Acknowledges layers of cultural identity. • Recognizes danger of stereotyping.	• Acknowledges layers of cultural identity. • Understands that working with cultural differences is an ongoing, lifelong process. • Emphasizes understanding self as well as understanding patients.
Assumptions	• Assumes the problem is a lack of knowledge, awareness, and skills to work across lines of difference. • Individuals and organizations develop the values, knowledge, and skills to work across lines of difference.	• Assumes an understanding of self, communities, and colleagues is needed to understand patients. • Requires humility and a recognition and understanding of power imbalances within the patient-healthcare professionals' relationship and in society.
Components	• Knowledge. • Skills. • Values. • Behaviors.	• Ongoing critical self-reflection. • Lifelong learning. • Institutional accountability and change. • Addressing and challenging power imbalances.
Stakeholders	• Practitioner.	• Patient. • Practitioner. • Institution. • Larger community.
Critiques	• Suggests an end point. • Can lead to stereotyping. • Applied universally rather than based on a specific client's experience(s). • Issues of social justice not adequately addressed. • Focus on gaining knowledge about specific cultures.	• A "young concept". • Empirical data in early stages of development. • Conceptual framework still being developed.

Note. Adapted from Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education, 34*, 165-181.

Although the intent to understand the diversity within the United States is meant to be helpful to healthcare professionals, it often leads to strengthening the status quo (i.e., "White" as the norm and all other racial and ethnic groups as outside that norm). Because of the desire to describe various racial and ethnic norms, multicultural patient care delivery and cultural competency frameworks tend to overlook the diversity within ethnic and racial minority groups and within "White" groups (Carten, 2016; Fisher-Borne, 2015).

The multicultural counseling and cultural competency frameworks also tend to neglect the intersecting dimensions of diversity. By focusing on ethnic and racial groups, these models neglect the complexity of group and individual identity. Complex identities include a multitude of dimensions of diversity, such as race, ethnicity, socioeconomic class, LGBTQ status, dis/ability, religion, regionality (e.g., southern, northern, western, eastern regions of the United States), age, gender, religion, etc. These dimensions of diversity intersect in many ways. The intersectionality of a multitude of dimensions that are oppressed or marginalized identities within one individual may result in experiencing much discrimination (Rosenthal, 2016). On the other hand, the intersection of a multitude of dimensions that are privileged within one individual may result in experiencing much opportunity. Moreover, the intersectionality of dimensions of diversity results in an infinite number of individual identities that are difficult, if not impossible, to categorize (Rosenthal, 2016).

Multicultural counseling and cultural competency frameworks have been further criticized for focusing on having healthcare professionals gain knowledge regarding differing racial and ethnic groups and assuming that there is an end point in cultural training, where the healthcare professionals' competency is deemed competent (Fisher-Borne et al., 2015). However, culture is fluid and ever-changing, with a complex array of interacting dimensions. Thus, it is not possible to reach an end point and to be deemed competent

The final major criticism of multicultural patient care delivery and cultural competency frameworks is that they do not present a social change/social justice perspective (Fisher-Borne et al., 2015). These frameworks assume that the lack of knowledge and understanding of oppressed and marginalized groups is commonly responsible for inadequate and/or ineffective healthcare delivery. The frameworks fail to address the power imbalances present in society and its institutions that are integral to many challenges and/or issues that patients bring to healthcare interactions. Cultural humility requires patient care professionals to recognize the power imbalances within the healthcare community and in society. Moreover, cultural humility demands that practitioners hold institutions accountable and asks that healthcare professionals work to right social injustices on community and national levels to achieve wellness for patients that can only be realized through working toward a more equitable society (Foronda et al., 2016).

It is important to note that the healthcare professions are It is important to note that healthcare professions are committed to cultural competency and increasingly understand the need to adopt a cultural humility framework as well. Healthcare professions incorporate cultural competency and cultural humility within their ethical and educational guidelines for competent practice (APA, 2017; ASCA, 2016; NASW, 2021). The professions share some commonalities within their guidelines for culturally sensitive practice. There is a need to continually develop an understanding of the diversity of patients and to commit to lifelong learning.

Case study: James Choi

James Choi is a 25-year-old Korean American, a new college graduate who recently accepted a job as a fund-raiser at the Humane Society. He was adopted when he was 8 months old into a middle-class White family. He seeks therapy because he feels that he is not achieving as much as he would like with his career. James is feeling anxious and has some symptoms of depression. His family physician has prescribed an antidepressant and encourages James to participate in mental health therapy. He is seeing Denise, a clinical psychologist who works in a large mental health counseling practice. Denise is a 30-year-old White woman. She is a recent graduate who has learned a bit about Asian American culture in her graduate coursework. On James's first visit, Denise asks him what brings him to counseling. James explains that he is disappointed in himself for not achieving more in his career. He explains that he has been feeling anxious and depressed and identifies the antidepressant that he is taking. Denise nods in understanding and remembers that Asian American families often have high academic standards and family members have a difficult time seeking therapy, concerned about losing face. As a result, Denise compliments James on being brave enough to seek therapy. James seems confused by Denise's response but manages to say thank you. James then proceeds to tell Denise that his parents encouraged him to seek therapy, as they thought that he was showing signs of depression. Denise is surprised that an Asian family would encourage their son to seek counseling but knows that she may have been stereotyping based on his ethnicity.

Denise continues with the questions, as she does want to know more about his feelings regarding not achieving as much as he would like in his career as well as his symptoms of anxiety and depression. She asks James why he is feeling that he is not achieving as much as he should be. James shrugs and says he thought he would be at a higher position after completing college. Denise knows that Asian Americans often expect high achievement from their children, so she asks James how his parents feel about his success thus far. James surprises her again when he says his parents are extremely proud of him and think he has landed a great first job. Denise is baffled and asks James to share more about his disappointment given his parents' support and his success at both graduating from college and getting a job so quickly. She remembers again to be careful not to stereotype. When the session concludes, she asks James to schedule another session so they can explore his concerns further. James says he will on his way out and thanks Denise for her help. Yet, he never returns to counseling.

Questions

1. What are some of the reasons James might not have pursued further therapy with Denise?
2. How could Denise have prepared differently for her session with James?
3. How might she have applied some of the facets of cultural humility in her counseling?
4. How do you think James thinks the healthcare professional perceives him? Is it helpful to the therapeutic relationship?

This case illustrates how unintentional stereotyping can hinder the development of a therapeutic relationship. Denise is aware that she may be stereotyping but is having difficulty changing her thinking about Asian Americans. James's experiences in life are vastly different from what Denise imagines they are, and thus he feels as if he is not being understood or helped by Denise. Denise might be helped by engaging in critical self-reflection after her session with James. She might ask herself what went wrong. She might further explore her stereotypical reaction to James and how that might have alienated him rather than engaged him in working with her. Denise might have had more success if she had questioned him more about his background and his family and had engaged him as an expert on his own life as she forged a respectful partnership with him. It seems as if Denise felt she had to be the expert and display cultural competency, which may have prevented her from being able to listen to James and discover the unique diversity in his life.

Case study: Linda Rogers

Linda Rogers is a 28-year-old White woman who has two children, ages seven and three. She and her fiancé live in a trailer park in a rural area. She comes into the county mental health clinic because she is experiencing headaches and dizziness and often has severe stomachaches. The clinic physician suggested Linda make an appointment because, upon examination, she could not find a physical reason for Linda's headaches and stomach problems. During the intake, Linda reports that she often skips meals or eats something from the vending machine at work for lunch; she also admits to smoking. Linda also reports that she typically feels fine and tries to limit her visits to the clinic. When Janine, the African American, upper-middle-class mental health nurse practitioner, asks Linda what she feels her stomachaches are caused by, Linda seems unsure and on the verge of tears. Janine compliments Linda for coming to therapy and asks her to discuss her problems more fully. Linda states that she has a lot of stress in her life as she has two minimum-wage jobs and two kids. She states that her fiancé is supportive, but he experiences a great deal of stress, too. Janine is empathetic and agrees that there is a lot of stress in Linda's life. Janine asks Linda what she does to reduce stress. Linda states that her breaks at work give her the opportunity to smoke and that smoking temporarily relieves her stress and her physical symptoms. Janine feels strongly that smoking is a bad habit, and although it might temporarily relieve stress, Linda should attempt healthy stress relief techniques. Linda nods in agreement but acknowledges it has been difficult to quit smoking.

Janine asks what Linda likes to do in her free time. Linda states that she does not have much free time between work and her kids. Janine asks Linda if she would like information about a smoking-cessation class offered at the clinic to help her stop smoking. Linda nods and accepts the pamphlet Janine offers. They spend the rest of the session brainstorming about other ways to reduce the stress in Linda's life. Linda is engaged in the brainstorming and agrees to try to use her work breaks to walk off her stress. At the end of the session, Janine again affirms Linda, telling her she is glad that she came in and that it is wonderful she will begin smoking-cessation classes and use her work breaks to decrease her stress by taking a short walk.

Linda misses the next several sessions with Janine. She shows up for a session with Janine several months later. Janine greets Linda warmly and says she has missed her at her previously scheduled sessions. Janine then asks Linda about her stress and her headaches and stomachaches. Linda says she is still very stressed and continues to experience headaches and stomachaches. Janine gently asks whether she attended any smoking-cessation sessions. Linda states that she doesn't have the time or energy to attend the classes. Janine asks whether Linda has been walking during work breaks. Linda looks abashed but admits that she is still using breaks to smoke. Janine is a bit frustrated and asks Linda what she thinks they should work on in session today to reduce stress. Linda doesn't seem to know what to do, so Janine suggests they try other options to reduce stress. Linda agrees. The rest of the session is spent coming up with a detailed plan to reduce stress through breathing exercises and a plan to try to attend smoking-cessation sessions.

When Linda returns to counseling several weeks later, she again admits to not following through on Janine's suggestions. She is still stressed. Janine is frustrated at the lack of progress but continues to try to help Linda with her stress through offering a variety of self-care options. Linda continues to agree to try a variety of techniques and agrees to continue to meet, but with little enthusiasm.

Questions

1. What cultural forces might have affected Linda and Janine's interactions?
2. How might Janine have explored Linda's stress more comprehensively?
3. How did the therapy techniques reflect a middle-class perspective?
4. If you were the nurse practitioner, what would you do? Why?

It is not surprising that Linda sought help from the clinic doctor first because her poverty likely afforded her little opportunity to seek therapy. Fortunately, the clinic she went to had counseling services available and Linda was able to meet with a therapist. Although Janine is empathetic and caring, she fails to make headway with Linda's stress and is frustrated by Linda's lack of follow-through. Janine neglects to thoroughly explore the role that poverty plays, both in Linda's stress response and in her ability to pursue stress reduction in the way that someone with more resources might be able to. Linda does not have the luxury of time, and smoking provides her quick relief. Although Linda may want to stop smoking, it is unlikely that she has the time to devote to smoking-cessation classes. Janine might have wanted to work with Linda on some of the stressors in her life that require advocacy outside the office. For example, Linda's inadequate diet may be the result of not being able to afford enough food. Janine could have explored this with Linda and helped Linda access various governmental and nonprofit programs to help her obtain sufficient food. Although Linda agreed to continue to work with Janine, she may have done so because she does not feel that she had an option.

Conclusion

When working with patients from diverse backgrounds, healthcare professionals must be willing to continuously look at personal dimensions of diversity and at how those dimensions affect their worldview and their view of their patients. Thus, healthcare professionals enter the professional relationship with a solid base of self-knowledge and a continuous commitment to critical self- reflection. Healthcare professionals also enter into patient interactions with an open mind and curiosity regarding patient's lived experience. Healthcare professionals do not pretend to know or understand each patient's unique combination of facets of diversity and do not assume that the patient will behave or believe in any way based on those facets of diversity. In fact, the culturally humble healthcare professional "cultivate(s) openness to the other person by regulating one's natural tendency to view one's beliefs, values, and worldview as superior, indeed, the culturally humble healthcare professional strives to cultivate a growing awareness that one is inevitably limited in knowledge and understanding of patients' backgrounds" (Hook et al., 2016, p. 152).

This stance of openness and equality provides an environment for healthcare professionals to enter respectful and equitable partnerships with patients. Moreover, the culturally humble healthcare professional considers how the societal structures in the United States serve to oppress some individuals and groups while empowering other individuals and groups. Patients are affected by the inequality within the United States. They are affected by living in a society where racism, sexism, classism, homophobia, and discrimination based on a variety of other diverse identities, including disability and gender identity, are expressed in a multitude of ways; this discrimination obstructs access to resources and opportunities and impedes interpersonal relationships. The power imbalances within society and institutions and as experienced by patients require the culturally humble healthcare professional to take an active role in righting those imbalances. Cultural humility challenges healthcare professionals to ask difficult questions and encourages them not to reduce patients to a preconceived set of cultural norms that have been learned in trainings about diversity and difference (Foronda et al., 2016). Finally, the culturally humble healthcare professional will engage in lifelong learning that supports effective practice.

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CULTURAL HUMILITY FOR ALL HEALTHCARE PROFESSIONALS

Self-Assessment Answers and Rationales

1. The correct answer is B.
Rationale: Cultural humility is an ongoing process, which requires continual self-reflection and self-critique. Cultural humility is a prerequisite to cultural competency.

2. The correct answer is C.
Rationale: The highest number of foreign-born people came from Mexico. They represented 25% of the population of foreign-born people by country of birth residing in the US. There were 11,182,111 people belonging to this group.

3. The correct answer is A.
Rationale: The highest poverty rates are experienced by Native American Indians, Alaska Natives, Black women, and Latinas. About one in four Alaska Native women live in poverty.

4. The correct answer is B.
Rationale: The type of functional disability that has the highest percentage is mobility. The percentage of people with mobility disability is 13.7%.

5. The correct answer is D.
Rationale: Oppression is a pervasive system. It has its foundation in history and is maintained via individual and institutional systematic discrimination, personal bias, bigotry, and social prejudice. Oppression leads to a condition of privilege for the person or the group that is the oppressor(s).

6. The correct answer is C.
Rationale: Creation of vulnerabilities are created by the cumulative impact of the creation margins and living between cultures. Vulnerability is defined as a state of being exposed to and unprotected from health-damaging environments.

7. The correct answer is B.
Rationale: Healthcare professionals often attempt to take the emphasis off race, class, gender, and other areas of difference by denying the effect these aspects of diversity have on patients' (e.g., "The only race I know is the human race"), or by trying to show that they understand the patient's experience because they, too, are a member of an oppressed group.

8. The correct answer is D.
Rationale: Being White makes it easier to assimilate into the dominant culture and to partake in unearned privileges many White people enjoy but do not acknowledge.

9. The correct answer is A.
Rationale: Multicultural perspectives provide the opportunity for two persons – from different cultural perspectives – to disagree without one being right and the other wrong.

10. The correct answer is B.
Rationale: Although there are variations among the definitions of social justice, there are three factors that are part of all definitions. These are equal rights, equal opportunity, and equal treatment. In other words, social justice mandates equal rights and equal opportunities for all.

CULTURAL HUMILITY FOR ALL HEALTHCARE PROFESSIONALS

Final Examination Questions

Select the best answer for each question and complete your test online at **EliteLearning.com/Book**

21. An important part of cultural humility is to:
    a. Identify one's own biases.
    b. Learn a skill that can be taught.
    c. Establish an end point.
    d. Emphasize knowledge acquisition.

22. A concept that is used to describe how various dimensions of diversity come together to privilege or oppress individuals is:
    a. Cultural humility.
    b. Forced assimilation.
    c. Intersectionality.
    d. Immigration.

23. Poverty rates for women and men are almost even throughout:
    a. Young adulthood.
    b. Persons who are 65 and older.
    c. Persons aged 22-35.
    d. Childhood.

24. According to a NORC survey, all the following statements about the LGBTQ population in 2020 are true EXCEPT:
    a. More than 1 in 3 LGBTQ Americans faced discrimination.
    b. Fewer than 25% of LGBTQ Americans felt the need to hide a personal relationship.
    c. 15% of LGBTQ Americans reported postponing or avoiding medical treatment because of discrimination.
    d. More than 3 in 5 transgender Americans faced discrimination of some kind.

25. The unjust or cruel exercise of authority or power is:
    a. Privilege.
    b. Oppression.
    c. Marginalization.
    d. Vulnerability.

26. The process of deliberately paying attention to one's own thoughts, emotions, decisions, and behaviors is:
    a. Self-critique.
    b. Marginalization.
    c. Self-reflection.
    d. Privilege.

27. Culturally humble learners understand that:
    a. They will both make mistakes and learn from mistakes.
    b. Mistakes have no benefit.
    c. They must think of patients according to a deficit perspective.
    d. They have failed to practice with cultural humility.

28. During assessment and treatment, healthcare professionals who practice cultural humility recognize that:
    a. Assessment tools and treatment protocols are appropriate for all patients.
    b. Historically, many therapeutic strategies were developed without empirically supported research with ethnic minorities.
    c. They should rely solely on manualized treatment protocols.
    d. They should fixate on one answer to a problem.

29. Social justice requires all the following EXCEPT:
    a. Achieving wellness even when social injustice is present.
    b. Ensuring that all people have equal opportunities.
    c. Equal rights.
    d. Equal treatment.

30. When differentiating cultural competence and cultural humility, it is important to know that:
    a. Only cultural competence acknowledges layers of cultural identify.
    b. Cultural humility requires ongoing self-reflection.
    c. Cultural humility suggests an end point.
    d. Cultural competency assumes an understanding of self is needed.

31. Which term does the following defintion describe: "multiple, intersecting identities and ascribed social positions (e.g., race, gender, sexual identity, class) along with associated power dynamics, as people are at the same time members of many different social groups and have unique experiences with privilege and disadvantage because of those intersections" (Rosenthal, 2016, p. 475)?
    a. Intersectionality.
    b. Privilege.
    c. Cultural Competency.
    d. Dimensions of diversity.

32. How many people living in the US were born in a another country?
    a. 10 million.
    b. 20 million.
    c. 30million.
    d. 40+million.

33. What are ways Healthcare professionals can be effective as "change agents" working to transform oppressive features of the institutional and societal environments?
    a. The healthcare professional can act as advocate and actively speak with and, when necessary, for members of populations who are oppressed by the dominant society.
    b. The healthcare professional works with the patient to identify external contributors to the problem and to remediate the consequences of oppression.
    c. The healthcare professional engages in critical self-reflection in the context of cultural humility includes analysis of power differentials and how those differentials may play out on both individual and institutional levels.
    d. All of the above.

34. How does the approach of cultural humility differ from the multicultural competence approach?
    a. Multicultural patient care delivery and cultural competency frameworks do NOT assume that the healthcare professional is White and that patients are the "other" and set out to describe what various racial and ethnic groups believe and how they act as a group. On the other hand, a cultural humility framework emphasizes self-understanding as primary to understanding others.
    b. There is no difference between these approaches.
    c. The approach of cultural humility differs from the multicultural competency approach in that it recognizes that knowledge of different cultural backgrounds is not sufficient to develop an effective patient/healthcare professional relationship with each individual.
    d. Cultural competence encourages ongoing critical self-reflection, asking the healthcare professionals to delve into their cultural identity and its effect on the delivery of patient care.

35. What is NOT a criticism of multicultural patient care delivery and cultural competence frameworks?
    a. They do not present a social change/social justice perspective (Fisher-Borne et al., 2015).
    b. Focus on having healthcare professionals gain knowledge regarding differing racial and ethnic groups and assuming that there is an end point in cultural training.
    c. Having a created model that serves to "other" ethnic, racial, and various minority groups (Carten, 2016, p. xlii) while not acknowledging "Whiteness" as an identity and as a culture.
    d. Emphasizes understanding self as well as understanding patients.

Chapter 3: Ethics in Behavioral Health Documentation: Reasons, Risks, and Rewards

3 Contact Hours

Release Date: March 28, 2019 **Expire Date:** March 28, 2024

Upon successful completion of this course, continuing education hours will be awarded as follows:

- **Social Workers and Psychologists: 3 Hours**
- **Professional Counselors: 3 Hours**

Faculty

Author:

Claudia J. Dewane, DEd, LCSW, is a former associate professor in the School of Social Work at Temple University in Philadelphia. She received a doctorate in adult education and health psychology from Pennsylvania State University and a master's degree in social work from Columbia University. Dr. Dewane is a licensed clinical social worker, maintains board-certified diplomate status in clinical social work, and has a certificate in advanced clinical supervision. She is the founder of Clinical Support Associates, a private firm providing supervision, consultation, and training to professional social workers. She has presented numerous workshops on clinical, supervisory, and ethical issues in social work. Dr. Dewane has also taught and published on ethics and supervision. She serves on the Ethics Committee of the Pennsylvania Society for Clinical Social Work.

Claudia J. Dewane has no significant financial or other conflicts of interest pertaining to this course.

Peer Reviewer:

Elizabeth B. Russell, PhD, LCSW, is an assistant professor of social work at The College at Brockport (State University of New York). Before her appointment at Brockport, she was a tenured associate professor at Nazareth College and the Greater Rochester Collaborative Master of Social Work Program. Dr. Russell teaches classes on practice, research, and policy, as well as electives in sexual health, creativity in social work, evidence-based practice, and addictions. She is a licensed clinical social worker in New York State and maintains a small private practice working with adults. Dr. Russell has contributed to several books, written peer-reviewed articles, and presented her research both nationally and internationally. Her current research foci include women and low sexual desire, cultural humility in social work graduate programs, and sexual health in professional social work practice. She holds a master's degree in social work from the University of Michigan – Ann Arbor and a doctor of philosophy degree in education and counseling from the University of Rochester.

Elizabeth B. Russell has no significant financial or other conflicts of interest pertaining to this course.

Behavioral Health Planner: Lys Hunt, MSW, LICSW

The planner who worked on this continuing education activity have disclosed that they have no significant financial or other conflicts of interest pertaining to this course book.

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INTRODUCTION

Learning objectives

After completing this course, the learner will be able to:

- Explain the rationale for high-quality documentation.
- Describe the content of good clinical documentation.
- Identify aspects of clinical documentation that present potential ethical problems.
- Recognize documentation risks specific to digital record keeping.
- Describe decision making in ethical documentation.

Course overview

Although documentation has been described as one of the most important skills in behavioral health practice, most clinicians receive minimal training in this aspect of their work (Sidell, 2015; Reamer, 2018b). The lack of knowledge and skill regarding documentation is a potential liability. For this and other reasons, documenting according to ethical standards is relevant to all clinicians. With technological advances, digital documentation has become increasingly the norm; however, electronic health records and other forms of electronic communication pose their own ethical risks in documenting services.

For social workers, counselors, marriage and family therapists, and psychologists, documentation is equally important before, during, and after a clinical encounter. A common adage states: "If it isn't written, it didn't happen." Although documentation serves multiple essential purposes, it is fraught with risk and liability.

Sidell (2015) advises that proper documentation is one way to protect both clients and practitioners. Alfred Kadushin, a pioneer who authored seminal works on the social work encounter, suggests that "the interview begins before it starts" (Kadushin & Kadushin, 2013, p. 125), meaning that clinicians often formulate impressions and speculations about clients or patients before they ever speak to them in person. For example, paperwork is often completed by an intake or clerical staff worker long before the clinician actually meets with clients in person for the first time. This preliminary documentation may direct the assessment and treatment process. What is written about the client may appropriately assist the practitioner or, conversely, it may provide a detour from providing the best treatment. Imagine that a medical technician inaccurately records a patient's blood pressure and that the patient is put on medication for hypertension unnecessarily, has a reaction to the medication, and dies. In response to the tragedy of an unnecessary death, the family sues the practitioner and practice agency; as a result, several lives are changed forever. Although this example is an extreme worst-case scenario, equally harmful documentation missteps are possible in the behavioral health field. Consider the following example:

> *A social worker on a specialty cardiac unit speaks with a client who is tethered to a left ventricular assist device (LVAD) while waiting for a transplant. In her attempt to be accurate in documenting their conversation, she charts the client's exact words: "Sometimes I just want to pull the plug." She continues to assess for suicide and deems that the patient is not in imminent risk but just feels understandably discouraged sometimes. She charts, "We processed his emotions and ambivalence living with an LVAD." When other team members read her note, a psychiatric emergency evaluation is arranged, upsetting the patient even more. He tells the social worker, "You knew what I meant. I wasn't going to kill myself. I will never confide in you again!"*

What might the social worker have done differently to avoid the upsetting response to her documentation? She had the option of not recording the client's exact words and charting more about exploring his discouragement and frustration. She could have included more about her suicide assessment and her conviction that he was not a danger to himself. So in this instance, either documenting more or documenting less could have influenced the outcome considerably.

Practitioners usually know what is minimally required in documentation; however, what is least required may differ significantly from what is recommended or optimal. Optimal documentation includes information that is relevant to the clinical services being provided and that addresses legal, ethical, and administrative obligations. Agency practice and time demands often result in practitioners documenting only what is required. This practice may leave the agency and practitioner open to scrutiny and risk and, at the same time, shortchange the client's services. This intermediate – level course will help practitioners approach documentation in a way that is guided not solely by what is mandated, but by what is mutually beneficial to all stakeholders in the documentation process: the practitioner, the agency, the funding source, and most of all, the clients.

Graduate training rarely includes course content on documentation skills (Leon & Pepe, 2013; Savaya, 2010; Swain & Rice, 2009). Sidell recommends that social workers begin their careers well prepared to document, but most often they do not. The years 1920 to 2008 saw the publication of only six textbooks about case documentation, and limited attention is given to the subject in practice textbooks (Sidell, 2015). Although social work education requires that the field placement or practicum experience teach documentation skills, documentation requirements may differ according to the agency setting and may or may not be equally applicable across professional settings and roles. Too often, practitioners are left to learn the complexities of appropriate documentation on the job, and individuals who supervise their work may have received equally limited training. Leon and Pepe (2013, p. 116) suggest that one way to remedy this problem is to provide more continuing education workshops that help to "develop and maintain those essential skills," specifically the legal, ethical, and professional accountability in appropriate documentation, as well as what should be included in each note, plan, or document. Their study on the effects of a two-part continuing-education documentation workshop for hospital psychosocial staff members (the name they have given to licensed master-level practitioners) showed a significant increase in staff knowledge of documentation in the areas of progress notes and discharge summaries. In addition to knowledge, continuing education also improved practitioners' confidence in completing the documentation, an important factor in effectively writing the documentation.

These authors point out the scarcity of research on reliable and valid documentation measures and underscore the need for more continuing education and research in this area. Based on their evaluation of an earlier documentation workshop, Dziegielewski, Green, and Hawkins (2002) also demonstrated a need to train individuals in all disciplines on issues of documentation regardless of their professional license. To help fill the void in training on documentation found by several authors, this course illuminates the complex nuances of writing for the clinical record and assists the practitioner in determining when, what, and how much to document. In addition, summaries related to documentation from the codes of ethics of the American Association of Marriage and Family Therapy (AAMFT), the American Counseling Association (ACA), the American Psychological Association (APA), the National Association of Social Workers (NASW), and National Board for Certified Counselors (NBCC) are included in the Appendix.

This course is intended for both novice and seasoned human service and healthcare professionals, including social workers, mental health counselors, marriage and family therapists, and psychologists. The purpose of this course is to introduce the reader to the importance of ethical and intentional clinical documentation. The course provides strategies for adhering to ethical guidelines and for avoiding risks related to documentation. Participants will gain increased confidence and skill in providing clinical and ethical documentation that simultaneously benefits and protects the consumer, the agency, and the practitioner.

The course presents participants with the information necessary to understand the rationale, risks, and rewards of documentation. This knowledge is particularly relevant for protecting practitioners from litigious complaints and for protecting consumers from unwarranted and potentially harmful inaccuracies in the documentation of presenting issues and services delivered, particularly with respect to the risks inherent in documentation that makes use of technological advances.

THE RATIONALE FOR DOCUMENTATION

Pope (2015) makes a poignant and powerful statement about the importance of documentation, going so far as to say that clinical records have "life-changing power."

> *A record's facts, inferences, conclusions, gaps, inaccuracies, wording, and tone can affect whether a person keeps custody of a child, gets a security clearance, receives life-saving help in a crisis, or secures needed accommodations at work for a disability. When a record's security is breached, the content – diagnosis, medications, clinical history, and a patient's most sensitive and private information – may find its way to an array of people and organizations, perhaps exposing the patient to gossip, ridicule, identity theft, exposure of private information on social media, and worse. For example, after learning that an employee hates her job and boss, a company may "reorganize" so that the employee's position is no longer needed. If records of a clinical psychologist's own therapy leak out, it might damage the psychologist's alliance with his or her own therapist and could influence current and future patients' decisions to consult another therapist. A battered woman's husband may discover that she was seeing a therapist, despite his threat that he would kill everyone in their family if she did so (p. 348).*

Frederic G. Reamer (2018b), one of the architects of the current National Association of Social Workers (NASW) Code of Ethics, describes documentation as one of the most important skills in behavioral health practice. The clinical need for thorough, accurate, and timely documentation to ensure quality service delivery cannot be overemphasized. In addition, given the growing demands of managed care and utilization review, documentation is increasingly more important in healthcare settings as accountability, clinical accuracy, and treatment outcomes determine funding and the level of authorized services. Significant changes in the way that clinical services are provided require an update and development of new standards addressing the implications of technological advances on practice (Reamer, 2018a). The 2018 NASW Code of Ethics reflects the impact of technology on practice, including storing, retrieving, and documenting client data, particularly in electronic health records.

The following vignette illustrates many of the reasons for good clinical documentation, as well as some of the ethical risks, fears, mistakes, and myths of documenting in the helping professions:

> *A therapist is seeing a middle-aged man who initially presented for assistance regarding marital conflict. The man has admitted to multiple affairs during the 19-year marriage and, although he denies overuse of alcohol, the therapist suspects he also has a substance addiction. After approximately 2 months of therapy, during which the client does not demonstrate a high level of engagement, he offhandedly reveals that he is under a grand jury investigation for Federal Trade Commission violations in his role as CEO of a small company. He adamantly denies any wrongdoing and reports that the investigation is just another nuisance in a life of annoyances.*

The therapist immediately starts thinking:

- *What if I am subpoenaed in this grand jury investigation? What records will they demand?*
- *Is he seeing me only to look good for court proceedings?*
- *Maybe if I don't write much, my records won't be subpoenaed.*
- *What did I write? Maybe I should look over my notes tonight and take out anything that could hurt him or me. My suspicion of substance abuse really could hurt or help him in court.*
- *Maybe I could put some notes in a private folder and put others in an "official" chart. They can't subpoena the private notes.*
- *What drives documentation? Who is it for? Whose interest does it serve?*

Record keeping is a safeguard for both the practitioner and the client. Good clinical documentation primarily meets the needs of the client, practitioner, and agency; however, it is also intended to meet the needs of the supervisor, professional boards, regulatory organizations, and accrediting bodies. O'Rourke (2010) provides a unique perspective in describing the record as an "exercise of observation and interpretation of the clients' behavior" (p. 29). As such, it affords the practitioner power, often focusing solely on the client, not on the interaction between the client and clinician. Access to records – by clients, agencies, and courts – serves to diminish this power by providing a window into the behavior of the practitioner. The power resides in the recorded information.

Kagle and Kopels (2008) suggest that clinical record keeping has primary, secondary, and sometimes tertiary functions. The primary function is to satisfy accountability; the secondary purpose is to support practice and professional education. Tertiary functions of record keeping involve research and data analyses.

Barnett and Molzon (2014) identify some of the purposes of documentation and record keeping as:

- Helping the busy clinician remember important information about the client's treatment from session to session.
- Keeping all of the members of the treatment team informed to help them coordinate services.
- Making sure that a client who leaves treatment and then returns has continuity of care.
- Recording, for purposes of risk management, all of the services provided, consultations received from other providers, the decision making process of the clinician, the role the client played in treatment, and the treatment outcomes.
- Promoting the provision of high quality services.
- Meeting the requirements of the clinician's code of ethics.
- Complying with laws, regulations, and institutional policies.

In addition to the above, it is important to note that record keeping represents practitioners' values as well as those of the agencies in which they work. Thus, it is important for practitioners to abide by their profession's ethical and legal guidelines for documentation as well as practice.

How does the record represent agency or practitioners' values? The values of beneficence, nonmaleficence, autonomy, justice, and fidelity are often cited as basic principles undergirding ethical decision-making standards of care in behavioral health. Common questions include:

- Do the records reflect those values?
- Is what is documented in the best interest of the client (beneficence)?
- Does the documentation do no harm (non-maleficence)?
- Does it reflect fidelity (loyalty, integrity, truthfulness)?
- Do the records indicate protection of a client's self-determination (autonomy) and fairness, nondiscriminating language, and equal service (justice)?

Good record keeping entails more than the dreaded paperwork required by agency regulations, although required paperwork often serves the same purposes as good documentation in client records. Bodek (2010) offers seven purposes of documentation, all of which have ethical implications:

1. To document professional work.
2. To serve as the basis for continuity of care by the treating provider.
3. To serve as the basis for continuity of care for subsequent providers.
4. To manage the risk of malpractice complaints and assist in the defense of such complaints.
5. To comply with legal, regulatory, and agency requirements.

6. To facilitate quality assurance.
7. To facilitate coordination of care among members of the treatment team.

There are clinical, administrative, and legal domains of providing mental health services, all of which are related, overlapping, and affected by ethical documentation. Each of these related domains, and the rationale for their documentation, is discussed in turn.

Clinical rationale

Record keeping is both a process and a product. Although overlap exists, the process of recording generally serves as a guide for the clinician and client; the clinical elements in a client's record can provide guidance for the practitioner concerning the direction of the client's ongoing or future therapeutic work, and the product of documentation serves as proof of this clinical interaction for administrative purposes. The American Psychological Association's (APA) *Record Keeping Guidelines* (2007) state that through record keeping a provider assures good care, assists collaborating professionals in delivery of care, ensures continuity of professional service, chronicles needed supervision or training, provides requisite documents for reimbursement, documents decision making (especially in high-risk situations), and manages litigation risk.

Ideally, the process of documenting serves as a quality assurance tool by making clinicians reflect upon and evaluate their clients and their work. Quality record keeping of clinical services is valuable in facilitating quality treatment. "Through the recording process, which involves selecting, reviewing, analyzing and organizing information, the practitioner comes to a better understanding of the client-need-situation" (Kagle & Kopels, 2008, p. 10).

In addition to being the compilation of case history and activity, records provide a planning tool for future interventions with a client (Martin & Moriarty, 2012). Most practitioners have large caseloads and need to rely on records for keeping track of case information and details. Notes allow the clinician to discern patterns of behavior or interpersonal styles that can direct treatment. Through ongoing documentation, patterns of behavior are uncovered that provide evidence of need for additional assessments, referrals, and collaterals. Clinical documentation can also be utilized for monitoring and tracking treatment progress. Extreme views on the importance of documentation suggest that the quality of the record will reflect the quality of the care.

Certainly, documenting is an important tool for the training and education of behavioral health providers in clinical skill development. Professional social work, for example, has historically relied on the case method and process recording as a means for training students in "communication and relationships, and processes of assessment, intervention, and evaluation" (Kagle & Kopels, 2008, p. 17). These methods allow for the analysis and processing of interactions and provide a basis for improvement, additional education, and directions for future studies.

Diagnostic impressions

Records typically include the client's relevant history and the clinician's diagnostic impressions – usually recorded within the first few sessions. Some practitioners prefer not to attach labels to people, particularly their clients. Although this approach may seem altruistic in some ways, it can be misguided. Providing a presumptive diagnosis may assist the practitioner in developing a blueprint for treatment and guidance in selecting best practice interventions for that particular disorder. Bodek (2010) warns that the lack of a thorough initial assessment is likely to result in inadequate or inappropriate treatment. In many instances, the client may actually appreciate a label that validates what he or she is experiencing, just as a patient who goes to the doctor wants to know "what's wrong." Identifying the problem will help determine the treatment and cure. However, strengths-seeking, solution-focused, feminist, and humanistic practitioners prefer to look at what is "right" about the client's functioning and behavior and often view diagnoses as pathologizing what could otherwise be considered adaptive behavior. Some reluctance to diagnose may also stem from a practitioner's lack of confidence and competence in diagnostic skills.

In light of the managed care environment, a diagnosis may be considered a necessary evil because reimbursement for services from health-insurance companies can be secured only for a billable diagnosis. Before authorizing treatment, some managed care organizations may also require documentation of client need based on diagnosis. Those clinicians reluctant to diagnose because they feel it is too pathologizing might try to reframe diagnosing as providing the rationale for the clinician's and client's choice in treatment approaches, including strengths-based, client-centered treatments. Clinicians who choose not to accept insurance reimbursement are still professionally obligated to provide adequate documentation of services provided.

Clinical guidance

Clinical documentation has typically aligned with the "medical model," a colloquial term for the taxonomy of causalism, in which a linear causality of pathology is sought and described. The term "medical model" is in contrast to social work concepts of holism. *The Social Work Dictionary* (Barker, 2014) defines the *medical model* as:

> *An approach to helping people that is patterned after the orientation used by many physicians. This includes looking at the client as an individual with an illness to be treated, giving relatively less attention to factors in the client's environment, diagnosing the condition with fairly specific labels, and treating the problem through regular clinical appointments (p. 264).*

Although the holistic strengths-based view is compatible with the profession's most fundamental principles of practice, it is incompatible with the traditional disease-oriented focus of the medical profession. The medical model is further reflected in the traditional problem-oriented medical record (POMR), which documents treatment according to each "problem/diagnosis" assigned to a client. Practitioners are forced to focus on problems rather than solutions.

The medical model relies almost exclusively on documentation to reflect patients' needs, services, and progress (Leon & Pepe, 2013). This causal model, as described by Zachar and Kendler (2007), is "rooted in infectious diseases with one clear etiologic agent," and "is simply inappropriate for complex conditions such as psychiatric disorders" (p. 557). Clinicians face challenges documenting in ways that represent a shift from a medical model to a health-oriented paradigm (Weick, 2009). Behavioral health, particularly social work, extends the medical model to add contextual information relevant to the patient's needs, services, and progress.

Of course, diagnostic impressions are not just clinical diagnoses, and a thorough assessment of the client's situation is not captured with only a diagnostic label.

One approach that is often employed as a framework for documentation is person-centered planning. In the traditional medical model, practitioners tend to decide the course of treatment based on their assessment of what is best for the client. Decisions are not always made collaboratively, and the practitioner-client relationship often fosters dependency rather than self-reliance. When using a person-centered approach to treatment and documentation, practitioners work in a collaborative manner that validates clients' experiences and desires for their own treatment, thus improving treatment outcomes (Adams & Grieder, 2014). Documentation is written using the principles of wellness and recovery, along with data from both the practitioner and the client. Hence, outcomes are based on the dynamic changes that occur and not solely on predetermined outcomes such as medication compliance, abstinence, or stability (Adams & Grieder, 2014).

Although they should be concise and appropriate, details in the notes are necessary and provide context to what transpired. The service plan, along with other forms of documentation, is a shared vision between the practitioner and the client. This shared plan lessens the power imbalance between practitioner and client. Also, with a shared vision and service plan, clients who ask to see their records are less likely to be surprised by what is documented (Adams & Grieder, 2014).

Administrative rationale

> *A practitioner believes that to be consistent with a "strengths-based perspective" she should never document anything that could be perceived as negative about her clients' behavior or ideation. As a result of a serious car accident, she is out of work for several months. The practitioner assuming her caseload reviews the client records and is at a loss as to the purpose of the therapy and the progress of the clients for whom he is now responsible.*

One of the primary functions of documentation is to "provide a record of the encounter between client and provider" (Kane, 2001, p.56).

This record is used for clinical purposes and, increasingly, for administrative purposes. Third-party requirements such as the funding stipulations of managed care or regulatory bodies for accreditation are often the driving force behind documentation. Additionally, funding sources are demanding more evidence-based practice (EBP) and outcome-oriented interventions. Documentation practices are becoming "more aligned with EBP so that treatment activities provided by workers and the treatment outcomes observed in clients are clearly documented" (Martin & Moriarty, 2012, p. 521). Increasingly, funding streams require proof of EBP for approval and reimbursement of services. Funding sources look for accountability of monies allocated through evidence of service effectiveness. Three areas in which EBP is supported by documentation are client needs and presenting factors, services (treatment activities), and client outcomes (Martin & Moriarty, 2012). Luepker (2012) points out that, in addition to meeting the contractual obligations with third party payers, "a clear record of events facilitates writing appropriate reports about patients" (p. 2).

A major administrative reason for documentation is to satisfy managed care utilization review requirements. Records are reviewed prospectively for authorization of services, concurrently for monitoring services, and retrospectively for billing purposes or report writing. Interestingly, ethical concerns have increased in the managed care milieu as the restrictions imposed by "managing" care are perceived as "limiting" care and the temptation to embellish records to justify even minimal care presents itself as an option. Critical incidents often showcase the advocacy skills that are needed to confront the funding restrictions that govern what is considered necessary and what is authorized (Kane et al., 2002). When securing continued services, the clinician must advocate for the client, rather than inflating the records or the problems documented within them.

Program accountability

Administratively, records provide accountability on several levels: to the client, funding sources, the agency, regulatory bodies, and the profession. In an ideal world, records might also provide quality assurance. Usually, no one is observing services offered. Thus, records may provide an indirect window through which to observe and monitor the quality of service. Records also provide the means for securing resources; that is, documenting "billable" services substantiates reimbursement and can also justify the need for additional services.

Good documentation provides cumulative data that can be used to demonstrate gaps in service delivery or in the continuing education needs of staff. The data can be employed to evaluate program effectiveness and demonstrate successes. Accrediting and regulatory bodies rely almost exclusively on records to provide oversight and assessment of agency efficiency and quality. This aspect of documentation lends itself to a high risk of ethical violation as staff may be instructed or encouraged to "write for the reviewer," and the temptation to falsify or alter records is high. The unethical practice of backdating notes or embellishing data to secure funding or accreditation may be rationalized by thinking, "If we don't get the funding, we can't continue providing service."

Records also meet the needs of the management team, as they are often used to assist in workload planning and distribution, and for internal reviews to evaluate compliance with both internal and external stipulations.

Supervision

Good record keeping not only protects the client and the process, but also facilitates the practitioner's professional development. A supervisor's review of records is a valuable tool for evaluating and remediating the practitioner's knowledge and skills (Luepker, 2012). In a strong supervisory relationship, the supervisor will use the supervisee's documentation to highlight noteworthy aspects of a particular case or assess the practitioner's caseload (Kagle & Kopels, 2008). In contrast to the more common use of records to demonstrate inadequacies, this approach uses the record constructively to encourage reflection and ultimately improve practice.

Sidell (2015) emphasizes that documentation should always be a topic in supervision. It should be valued as a skill, equal to any clinical skill in the worker's repertoire. Furthermore, vicarious liability concerns should cause supervisors to document every supervisory encounter with supervisees. However, documenting the supervision itself is a commonly neglected task. Although supervisors may demand thorough documentation of clinical encounters from their supervisees, supervisors often give far less attention to documenting their own work with staff. In the spirit of parallel process, supervision sessions should be documented for the same reasons that client interaction is documented. Supervisors should document time, date, and content of supervisory sessions. Social work administrators should document any discussions pertaining to ethical decision making (Reamer, 2005b).

All supervision encounters should be documented (Association of Social Work Boards, 2009; Barnett & Molzon, 2014; Munson, 2012). Recording supervision protects supervisor, supervisee, agency, and, indirectly, clients. According to Barnett and Molzon, documentation of supervision can:

a. Help reduce the chance of misunderstandings occurring.
b. Help increase accountability on the part of the supervisee.
c. Be an excellent aide for both parties when reviewing to track progress both of the supervisee's clients and the supervisee's professional development.
d. Serve an important risk management role in providing a tangible record of what has transpired in supervision and the supervisor's efforts to provide high quality clinical supervision (2014, p, 1057).

Themes noted, cases discussed, educational needs, and supervisor's impressions and recommendations are all appropriate content for a supervision note. Documenting supervision for licensure purposes is particularly important for potential audits.

Sidell (2015) proposes a guide to structure supervisory notes using the acronym **SUPERS**:

- **S** – Supervisee-initiated items.
- **U** – Useful feedback or suggestions from the supervisor.
- **PE** – Performance expectations that have been discussed.
- **R** – Recommendations for future goals.
- **S** – Strengths of the supervisee (p. 191).

Sidell also provides a sample format for documenting group supervision that records date, participants, topics explored, follow-up, and next meeting.

Administrative compliance

> *An insurance reviewer denies additional services for a client seen in private practice. Upon appeal, the reviewer states that the clinical record contains insufficient information regarding the number of sessions used for treating the particular diagnosis. Additionally, no changes in diagnosis or treatment plan were explained. The appeal for additional services is denied.*

Of the seven purposes of documentation identified by Bodek (2010), the last four could be viewed as administrative in nature. Again, these purposes are:

- To manage against the risk of malpractice complaints and to assist in the defense of such complaints.
- To comply with legal, regulatory, and agency requirements.
- To facilitate quality assurance.
- To facilitate coordination of care among members of the treatment team.

Consider this example:

> *In discussing copayments with a group of colleagues, one mental health clinician at an agency that offers no sliding scale or reduced fee revealed that when a copayment is very high (e.g., $50) and the client is obviously struggling financially, she often reduces the copayment, taking less money for herself as a result. However, she enters the higher amount (which she didn't take) in her records and keeps knowledge of the reduced fee between herself and the client. The agency is still reimbursed for the session by the insurance company for the usual amount, which does not include the copayment.*

This scenario presents risks on all three levels: clinical, administrative, and legal. Clinically, the worker is trying to do something helpful for the client, but Reamer (2001) suggests that altruism is frequently at the root of the unethical situations in which practitioners find themselves. What if other clients somehow discover this practice and perceive it as preferential treatment? Will they expect the same? Will the client interpret this as having a "special" relationship with the clinician? Will the client feel indebted to the clinician for the reduced fee? Administratively, the mental health clinician's actions could be seen as deceptive bookkeeping practices. If the worker's supervisor learns of the practice, might she question other documentation provided by the worker? Legally, could an argument be made that insurance fraud is being perpetrated?

Legal rationale

The profession of social work has not escaped the increasingly litigious reach of our society. Astute record keeping is the best protection from baseless claims (Luepker, 2012). Careful documentation may mean the difference between a legal judgment for or against a worker or an agency (Moline, Williams, & Austin, 1998; Swain & Rice, 2009). Legally, records protect the therapist by demonstrating that the treatment provided was within the professional standard of care. Thorough records assist in clarifying and justifying questionable actions by the therapist or agency. In fact, the NASW (NASW Assurance Services, 2018) lists documentation clarity in the practitioner's notes as one of the organization's tips for avoiding malpractice. Reamer (2006) gives an example in which a plaintiff may file a lawsuit against a social worker, claiming the worker was negligent about properly obtaining informed consent before releasing confidential information. Accurate and timely documentation of obtaining informed consent is the only protection the clinician has.
Swain and Rice (2009) assert that "professional accountability, justification of services and protection from legal or professional sanction rely in no small part upon the adequacy of practitioners' records" (p. 68). However, such emphasis encourages providers to write defensively (insurer-focused) instead of clinically (client-focused).

Obtaining informed consent is not a perfunctory and merely obligatory part of documentation. There are actually risks associated with it. Although it is a legal and ethical requirement in health care, true informed consent is difficult to obtain and substantiate. The level of understanding and decision-making capacity of the client can vary across time and situations. Although a client may give consent for disclosure of information, for example, that disclosure may inadvertently backfire, possibly causing the client harm. Clients may be harmed by released health information that is improperly disclosed by the third-party recipient or when the information is used against them in court proceedings. Even when properly released and disclosed, the information now made public may have residual effects for the client. In our digital world, informed consent should now include explanation for clients regarding the use of technology "to gather, manage and store protected health and other sensitive information" (Reamer, 2018a, p. 75).

Liability insurers report that the most frequent licensing board complaints stem from perceived conflicts or damages resulting from divorce. When therapists are involved in seeing couples, this risk is salient. To obviate this risk, it is recommended that practitioners "create a documented record of resistance to disclosure" (NASW Assurance Services, 2018, p. 1). This added informed consent requires signatures from all parties, permitting the practitioner to resist disclosing records in good faith. In couples therapy, this statement of neutrality protects the practitioner from being drawn into "taking sides" (e.g., of having records subpoenaed to harm the other partner). In essence, the statement explains that the practitioner is an "unbiased intermediary … and shall not act as an advocate for or against any party" (NASW Assurance Services, 2018, p. 1).

Consider this example:

> *A couple with two young children was being seen for marital therapy. Although the counseling appeared to be going well, when one partner revealed infidelity, the other filed for divorce. The counseling was terminated and a child custody battle ensued. Hoping to prove the spouse to be an unfit parent, one partner wanted to use information known to be in the therapist's notes about an emotional outburst by the other partner that occurred during a session. The therapist's records were subpoenaed. In this case, with the help of her liability lawyer, the therapist was able to resist the subpoena on the basis of the informed consent/statement of neutrality and resistance to disclose that was signed at the beginning of the couples' treatment.*

In determining what is reasonable and customary for the public to expect from a particular profession, the courts look to the "industry standard" for guidance. Most "standards of care" are outlined by a profession's code of ethics. Several organizations' professional codes of ethics are recognized as the industry standard within the helping professions. These include the codes issued by the APA, the NASW, the American Counseling Association (ACA), the American Psychiatric Association (APsyA), the American Association for Marriage and Family Therapy (AAMFT), the Association for Specialists in Group Work (ASGW), and the National Board for Certified Counselors (NBCC).

Many clinicians like to keep two sets of notes on clients: one for the official record and a second set with personal comments, interpretations, and cues for clinical intervention. This second set of notes is commonly referred to as "personal notes" or "shadow records" (Sidell, 2015) for legal purposes, but the distinction between the official record and personal notes varies by state. Most states make no distinction, and thus both sets of records are subject to subpoena; states that recognize a distinction do not require that personal notes be considered under a subpoena. Practitioners are advised to check their state's law on what is considered part of the "mental health record." Sidell (2015) advises that the safest risk management approach is to destroy informal notes after using them as aids for recording the official notes in the case file.

Subpoenas are often anxiety-producing for practitioners, but erring on the side of documenting too little or too much can exacerbate the situation. It is advisable to keep all documentation, including electronic communications, for protection in a lawsuit. It is also important not to make any changes to the record after receipt of a subpoena.

Certain risk management strategies will help reassure the practitioner who fears revealing records in legal proceedings. Managing risk in documentation involves four areas:

1. Content.
2. Language.
3. Credibility.
4. Access.

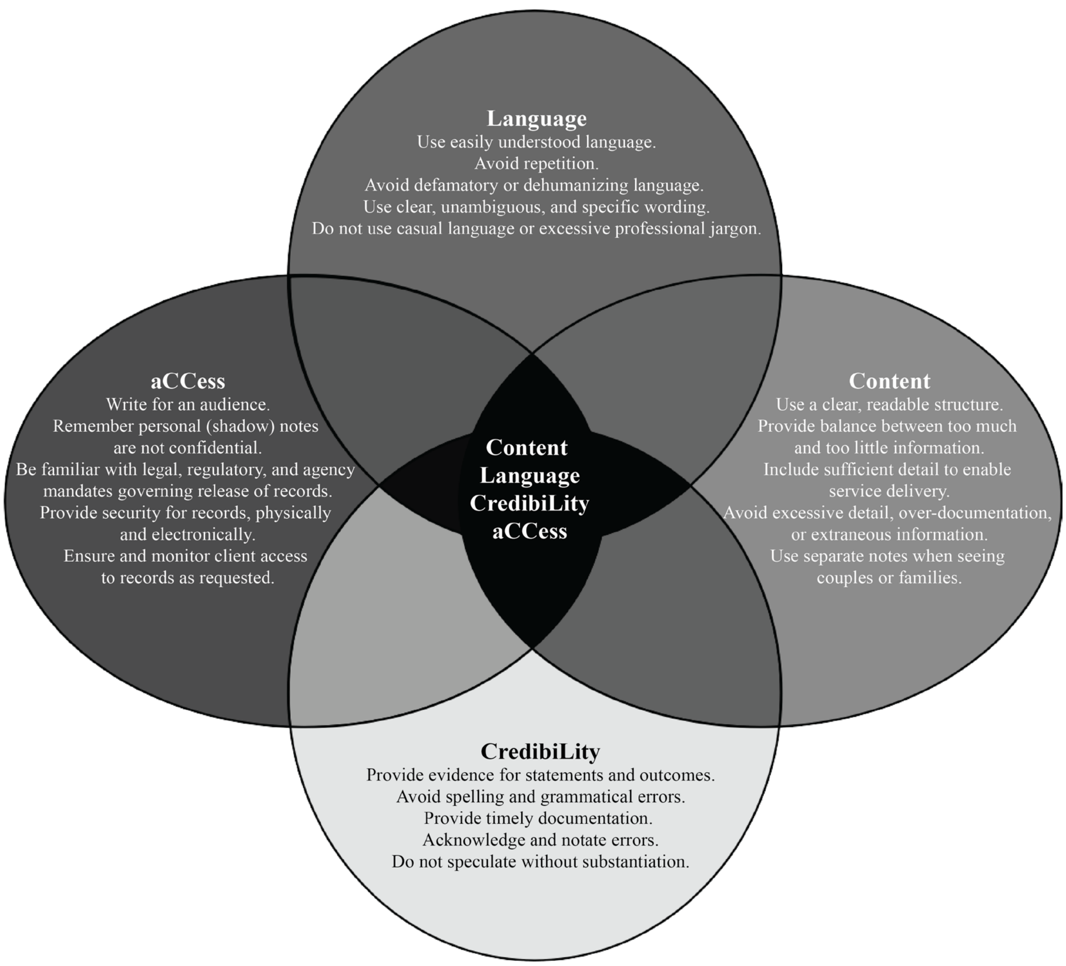
Suggestions for risk management in documentation offered by Reamer (2005a) and Swain and Rice (2009) are shown in Figure 1.

Sidell (2015) gives specific examples of "people-first language" to avoid any hint of defamation or discrimination. For instance, most contemporary practitioners are aware that the emphasis should be on "having" a condition, rather than "being" a condition and would write, "He has a mental health condition" instead of "He is mentally ill," or "She has a diagnosis of autism" instead of "She is autistic." However, more vague references might escape even the most conscientious worker, who might write, "He was born with a birth defect," instead of the preferred, "He has a congenital disability" (Sidell, 2015, p. 49). Further, Mitchell (2007) warns against using "conclusionary terms," meaning modifiers without substantiation, such as deeming a client "disorganized" or "aggressive" or "uncooperative" without evidence. Professional opinions need to be verifiable.

Finally, because documenting psychotherapy has evolved from the medical model, it is the accepted standard in most clinical work to keep accurate, timely, and sufficient records. Both what is written and what is not written can be potentially problematic. Malpractice claims can be brought based on acts of commission (actions taken) and omission (actions not taken). Documentation can verify what has or has not taken place in a therapeutic encounter, and the risk of legal repercussions extends also to what is or is not written in the documentation itself. In resolving legal claims, courts may consider issues of malfeasance and nonfeasance. Malfeasance is when an action is performed in a flawed way, such as conducting an incomplete suicide assessment; nonfeasance is when a required action is not performed at all, such as not performing a suicide assessment when indicated. Only solid documentation can exonerate a practitioner from the suspicion of malfeasance or nonfeasance or protect a client's best interests.

Simply put, good records benefit the client, the clinician, the agency, and the profession. They "serve and protect all parties" (Reamer, 2005a, p. 328).

Figure 1: Risk Management Documentation Strategies



Language
Use easily understood language.
Avoid repetition.
Avoid defamatory or dehumanizing language.
Use clear, unambiguous, and specific wording.
Do not use casual language or excessive professional jargon.

aCCess
Write for an audience.
Remember personal (shadow) notes are not confidential.
Be familiar with legal, regulatory, and agency mandates governing release of records.
Provide security for records, physically and electronically.
Ensure and monitor client access to records as requested.

Content
Use a clear, readable structure.
Provide balance between too much and too little information.
Include sufficient detail to enable service delivery.
Avoid excessive detail, over-documentation, or extraneous information.
Use separate notes when seeing couples or families.

Content
Language
CredibiLity
aCCess

CredibiLity
Provide evidence for statements and outcomes.
Avoid spelling and grammatical errors.
Provide timely documentation.
Acknowledge and notate errors.
Do not speculate without substantiation.

CONTENT OF DOCUMENTATION

Good documentation requires organization, decision making, critical conceptualization, and effective writing. Good clinical documentation contains specific elements of organization and writing (Bodek, 2010).

According to Kagle and Kopels (2008), good clinical records will demonstrate these fifteen principles:

1. **Balance:** Of the valued but competing goals of accountability, practice improvements, efficiency, and client privacy.
2. **Focus on the mission**: With content relevant to the agency mission or program objectives.
3. **Risk management**: Achieved by good compliance with agency policy, legal standards, practice guidelines, and professional ethics.
4. **Accountability**: With a focus on service delivery, impact, and outcome.
5. **Abridgemen**t: Exclusion of information that is not pertinent to purpose, goals, or outcome of service.
6. **Objectivity**: Presentation of information that is fair and impartial, and that includes observation, sources of information, criteria used in assessment, and appraisal.
7. **Client involvement**: Documentation of the client's role in all aspects of the process.
8. **Sources:** Provision of sources for all information.
9. **Cultural context**: Inclusion of cultural factors influencing the client situation or service.
10. **Access**: Information written with the assumption that anyone may have access to it.
11. **Usability**: Organization of records, usually chronologically, in a reader-friendly way.
12. **Currency**: Records kept current with periodic reviews and updates.
13. **Rationale**: Provided for all service decisions.
14. **Urgent situations**: Full documentation of emergencies or crises.
15. **Exclusion:** Of irrelevant, extraneous, opinionated, or speculative information.

The minimally required content for good clinical documentation in a case record would include agency-specific templates and formats, such as documentation of informed consent and confidentiality limits, case notes, assessments, and diagnostic codes (Reamer, 2005a,b). Sometimes agencies provide templates for certain parts of a case record (e.g., consents, releases of information, assessments) to increase the uniformity of the record; however, the quality of case notes in particular is largely dependent upon the individual clinician's skill in documentation apart from his or her interviewing skills and ability to elicit the information that is necessary and relevant to the therapy. Discerning what is sufficient, necessary, and relevant for documentation is as much a practitioner skill as learning therapeutic techniques. The clinician's interpretation of information to document, and the method by which to document it, determines the quality of the documentation. Practitioners should document with the expectation that a much wider audience than expected may read what is written. The content of excellent clinical documentation provides insight into client needs, justifies and chronicles the course of intervention, and demonstrates progress and outcomes.

Mitchell (2007) takes the stance of charting for the reader. He proposes basic principles to create a useful record for colleagues and clients:

1. Language should be clear and specific, avoiding irrelevant statements or excess verbiage.
2. Whenever possible, use the client's own words. Write what is heard.
3. Write what could be comfortably shared with the client.
4. Records must be written logically. Ensure that charting has some relevance to the presenting problem or the guiding treatment plan. If charted information is not pertinent to either, it should not be included. "Usefulness requires specificity, and vague writing might be construed as indicating incompetence." (p. 31).
5. Avoid modifiers (such as "soon" or "sometime") that are abstract or could leave room for doubt.

Put simply, according to Mitchell (2007): Records should be understandable and accountable.

Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not specify what is required in a medical record, according to Groshong and Phillips (2015), the following must be included to meet behavioral health guidelines:

- Billing information and payment records.
- Formal evaluations.
- Collateral contacts, including release of information (ROI) for all.
- Records from other providers with ROI.
- Counseling session dates, with start and stop times.
- Modalities and frequency of treatment.
- Medications.
- Diagnoses.
- Functional status (activities of daily living [ADL], ability to work, interpersonal capacity).
- Medical/physical problems.
- Community contacts, including phone calls, emails or texts.
- Treatment plan and goals.
- Symptoms and prognosis.
- Progress in each session.
- Disclosure forms and informed consents signed by the licensed professional and client.
- Presenting problem(s) or purpose of visit.
- Referrals to and results of formal consultations.
- Progress notes sufficient to support responsible clinical practice for the type of orientation/ therapy used.

All digital medical records should be backed up regularly and kept in encrypted format, with frequent changes in passwords. Although there can be both a medical record and psychotherapy notes, information cannot be put into psychotherapy notes to avoid putting it into the medical record (Groshong & Phillips, 2015).

Overall chart organization

Chart organization and content may differ across settings. Agencies usually require specific and structured information, whereas private practitioners have more flexibility concerning order and organization.

Bodek (2010) provides a framework for organizing a patient record for healthcare settings and advises that a file folder exclusive to each patient be maintained. The folder would consist of:

- Demographic information, including insurance and referral information.
- Intake information, including assessment, evaluation, and initial history.
- Service or treatment plan.
- Progress notes.
- Referrals or consultations made, collateral reports, and test results.
- Correspondence from other practitioners.
- Correspondence with patient or collaterals.
- Billing records.
- Informed consents/authorizations or other privacy-related information releases.

Consents and authorizations do expire, so records should contain original and updated forms so that the history of consent to services, communications, and any other relevant aspects of treatment are evident (U.S. Department of Health and Human Services [HHS], 2013). In addition, it is recommended that a HIPAA compliance folder for each patient be maintained separately from the patient's clinical record and psychotherapy notes.

Another organizing framework, offered by Sidell (2015), for a thorough clinical record includes these five categories:

1. Identifying information.
2. Consents and releases.
3. Assessments and treatment plans.
4. Progress notes and service reviews.
5. Communication with and about clients.

In the early days of psychosocial intervention, the purpose of documentation was client service delivery. As patients' rights gained prominence in the 1980s, the importance of clients' rights to privacy was recognized. The 2003 implementation of HIPAA's Privacy Rule actually legalized parameters of documentation content, such as confidentiality, informed consent, and distribution.

The Health Insurance Portability and Accountability Act regulations have affected how client records are organized and what may be included. Documentation is often considered synonymous with record keeping; however, documentation encompasses many aspects, formats, and types of record keeping. To distinguish among the various types of records, the following definitions are offered:

- **Mental health records**: These are patient records related to the evaluation or treatment of a mental disorder. These records include, but are not limited to, substance abuse (drugs and/or alcohol) records (Moline et al., 1998, p. 174). Typically, behavioral health documentation is noted in a separate section of the electronic health record (EHR).
- **Patient medical records**: These are records maintained in any form or medium, by or in the custody of a healthcare provider, which relate to a patient's health history or diagnosis, or the treatment provided. Patient records do not include information given in confidence by a person other than another healthcare provider or the patient.
- **Psychotherapy notes**: Psychotherapy notes, according to HIPAA regulations, are notes recorded in any medium by a healthcare provider who is a mental health professional that (a) document or analyze the content of conversations that took place during a private counseling session or a group, joint, or family counseling session and (b) are separated from the rest of the client record. Psychotherapy notes (as compared to medical records) do not include medication prescription and monitoring; counseling session start and stop times; the modalities and frequencies of treatment furnished; results of clinical tests; or any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date (HIPAA Survival Guide, 2003). Several mental health provider associations have debated this ruling. The Health Insurance Portability and Accountability Act specifies that "psychotherapy notes are held to a higher standard of protection because they are not part of the medical record and never intended to be shared with anyone else" (Bodek, 2010, p. 16). If it were true that psychotherapy notes were not intended to be shared, there certainly would be less cause for concern.

In addition to the client record, a HIPAA compliance folder for each client must be maintained. Furthermore, HIPAA specifies that psychotherapy notes are to be kept separate from the rest of the individual's medical record, including the HIPAA compliance folder (Bodek, 2010). This regulation sets up a baffling conundrum in that healthcare facilities usually maintain a single consolidated medical record for each client that includes all consultations, including behavioral health interventions. As a result, the therapist may maintain his or her own clinical or shadow notes, which may be considered "personal," but are nevertheless subject to the same legal scrutiny as the official record. Some states protect personal notes from legal discovery, yet keeping such notes does pose a risk. Mitchell (2007) describes a case in which a practitioner naïvely kept the second set of notes in a foreign language as protection. Of course those notes could be translated. Other practitioners may conclude that "what they don't know won't hurt me" and keep the personal notes a secret. If asked under oath if all records have been provided, however, the consequences of perjury and ethical misconduct may be worse than what was written in the notes.

Some clinicians argue from a minimalist perspective that the less that is written, the less there is that can hurt the clinician or the client. Under the guise of protecting client confidentiality, these clinicians may err on the side of maintaining too little documentation. Some practitioners have argued against keeping detailed records, based on the contention that confidentiality can be best protected as a way to avoid litigation with no documentation at all, particularly if the client requests minimal documentation. This argument may be shortsighted in the present digital and litigious era; in fact, lack of documentation could potentially make a practitioner more liable and simultaneously do a disservice to the client.

Other clinicians may err on the side of too much documentation, thinking that more is better. This practice may also be problematic in that superfluous information may confound what is crucial to the client's treatment.

It is difficult to imagine that behavioral health practitioners can remember every detail about a client without referring to their records. For example, imagine the therapeutic rupture that would result if a therapist in session confused one client's history with that of another client. The clinician's review of his or her thoughtful records prevents such an unnecessary error. Imagine the reaction of a patient who visited his physician and found that nothing was charted about his medical history, current complaints, or prescribed medications. Likewise, in behavioral health, good record keeping can help establish rapport as a client sees that what he has to say is worth noting, literally and figuratively.

Record-keeping content and especially format may vary considerably across settings. Agencies dictate the format. The APA's revised guidelines for record keeping suggest that for practitioners, in agencies or private practice, "records document the nature, delivery, process, and results of services" (Drogin, 2010, p. 237).

Therefore, three kinds of content should exist across settings:

1. General file information, such as demographics and reasons and goals for service.
2. Substantive contacts, including date and duration with client and collaterals; the context and approach to services; tests and progress.
3. Supplemental information, such as assessment results, measurements or tests, and client journals or drawings.

Informed consent

An informed consent has been called the "quintessential document" in the provision of mental health services (Bradshaw, Donohue, & Wilks, 2014). In addition to being one of the first documents to comprise a record, it is one of the best risk-management tools. Informed consent in today's healthcare milieu demands details not previously considered, including potential benefits and risks of engaging in treatment, the nuances of technology use, limitations on confidentiality, and mandated reporting. "Failure to obtain or document consent can result in serious consequences, including problems in the therapeutic relationship and legal action" (Bradshaw et al., 2014, p. 3).

Relevant history

Social work emphasizes treating people in context. This is known as the person-in-environment approach and relies on gathering and documenting relevant history from the patient and collateral sources. Psychosocial assessments that include a client's history, along with tools such as genograms, document the context for establishing a case formulation of a client's current functioning. The combination of medical and psychosocial information provides an important history that contributes to the clinician's understanding of the patient's current level of functioning. Information relevant to the client's life history includes childhood development, cultural identities and intersectionalities, school, family and other significant relationships, employment, socioeconomic status, sexuality, and substance abuse. Exploration of the presenting problem requires an examination of the history of the problem, including the onset, context, and events triggering current help-seeking (Luepker, 2012).

A well-documented assessment, however, presumes that the documenter has interviewing skills that will elicit the important information needed in good documentation (Leon & Pepe, 2013). Yet it also depends on the practitioner knowing what and how to document.

The bio-psychosocial-spiritual assessment is the foundation of a clinical record. It encompasses multiple areas of history and functioning of the client. Essentially, the assessment unpacks the presenting problem, describes it in context, documents relevant developmental, family, medical, interpersonal, educational, employment, and social history, and identifies client strengths and limitations, including risk and protective factors.

Progress notes

Progress notes are written documentation detailing every session. Although progress notes are highly susceptible to error, good progress notes protect practitioners against future litigation regarding misdiagnosis or treatment. What constitutes a good progress note? A good progress note not only proves that an encounter took place, but also details the type and effect of treatment so that any reader can ascertain a client's issues, diagnosis, and progress in therapy. Progress notes should include information about each session's content or topics, relevance to treatment plan objectives and goals, and use of interventions and their outcomes. Progress notes should reflect the current status (based on the therapist's clinical observation during the session) of a client's diagnosis, the medical necessity of services, and progress or setbacks in relation to treatment objectives and goals (Wiger, 2011).

Sidell (2015) cites Kagle and Kopels (2008), who recommend that progress notes should include the following information:

- Any new information about the client's needs.
- The practitioner's assessment of the client's status with regard to needs.
- The client's actions or activities related to the service plan.
- Services provided by the practitioner.
- Evaluation of progress.
- Any changes necessary in meeting the goals of the service plan.

Frequency of progress notes varies by setting and agency policy (Sidell, 2015). Building on Kagle and Kopels (2008), Sidell (2015) reports that practitioners should:

- Document critical incidents within 24 hours.
- Document significant changes in client needs as soon as possible, within 3 days at the latest.
- Regularly note indicators of progress toward service goals following every third contact.
- Record contact with other service providers regarding active cases weekly.
- Update progress notes regularly, following every third service contact or at least monthly.
- Update notes before any planned practitioner absence, case transfer, release of information or case review.

Although these guidelines might seem overwhelming to the hurried practitioner, who has 5 minutes between sessions to record his or her notes, they are an aspirational goal for documenting. A medical analogy can illustrate the importance of such attentive record keeping: For a patient receiving a medication, the failure of the practitioner to record the setbacks, limitations, progress, plans, adverse effects, and clinical observations might cause the treatment to be futile or, worse, dangerous. The chances of the practitioner being accused of negligence would be high.

To satisfy managed care insurers, progress notes are "expected to provide information about the client, the implementation of the intervention, and goal progress or attainment" (Kane et al., 2002, p. 204). Notations are best if documenting observable or measurable behavior.

Acceptable progress notes would include five elements:

1. The contact.
2. The client's behavior and/or affect.
3. Client reactions to interventions.
4. Reactions of others.
5. Significant events (Kane et al., 2002).

Ethical dilemmas in documentation arise in a managed care environment when protecting client confidentiality conflicts with disclosing sufficient information to satisfy managed care requirements.

Progress notes are often organized in one of two recognized formats: SOAP (Subjective, Objective, Assessment, Plan) or DAP (Data, Assessment, Plan). Another format serves to help in training novice workers: STIPS (Symptoms, Topics of discussion, Interventions, Progress and plans, Special issues). These structured/semi-standardized formats assist providers in focusing documentation.

The following is a case example designed to demonstrate good documentation of a session:

> *Samantha is a client who has been receiving counseling from Darlene, a seasoned practitioner, for the past year. Samantha sought out Darlene's services at the recommendation of her attorney following the state's removal of her three children, ages 4, 6, and 9, due to severe neglect. At the start of treatment, Samantha explained that at the time of her children's removal she was experiencing severe depression precipitated by the children's father abandoning them and Samantha's mother dying within the same month. The children's removal further exacerbated her depression. Fourteen months later Samantha has stabilized, and reunification with her children has begun. It is expected that the children will return to her full custody in about 3 months.*
>
> *Samantha is looking forward to the transition, but she is also scared and anxious about being overwhelmed with parenting responsibilities. Samantha meets with Darlene weekly, and Darlene is in regular contact with Samantha's caseworker and attorney, as well as the children's therapists. Samantha and Darlene have discussed openly the limits of confidentiality in her therapy, and Samantha sometimes chooses to withhold information from Darlene that might reflect negatively on her in her client record because she knows that other professionals involved in her family's care will see it. She has been reluctant to share the extent of her anxiety about the upcoming transition; however, Darlene is familiar with these types of reunifications and is able to normalize Samantha's concerns and introduce salient interventions without Samantha having to feel overexposed. At their most recent session, they discussed Samantha's relationship with her boyfriend, who has recently lost his job and is at risk of losing his apartment, and anticipated*

possible changes to the relationship as the children return home. In addition, they reviewed self-soothing and relaxation techniques for Samantha to use during times of increased anxiety, problem-solved parenting dilemmas, and discussed some of Samantha's friendships.

The following is an example of the progress note for this session using the SOAP format:

S – Client reports looking forward to her children returning home and says that her boyfriend and friends are excited for her. She reports that her weekend visit with the children went very well, although she is worried that her 9-year-old has been getting into a lot of trouble in the foster placement.

O – The reunification efforts have included increasing Samantha's unsupervised time with all 3 children at once. A primary social support of Samantha's is experiencing stressors that have impacted the relationship. Samantha did not confirm or deny that she is experiencing increased stress. Samantha is concerned about her oldest daughter.

A – This time of reunification typically includes an increase in parental stress. Although Samantha did not endorse feeling an increase in stress based on previous discussions, I suspect this is because she does not want to do or say anything that will jeopardize the reunification. As the experience of increased stress was normalized, Samantha wanted to revisit previous stress management skills. She continues to show determination in demonstrating behaviors that would lead to reunification. She thoughtfully engaged in a discussion about analyzing various social supports and their usefulness to her during this important time. The session ended with Samantha asking for help in problem-solving her concerns about her oldest daughter.

P – Continue to meet with Samantha weekly to prepare for the upcoming reunification; fortify stress management and social and parenting skills.

How did Darlene navigate the various confidentiality concerns in this progress note? Confidentiality was protected by disclosing no identifying information about collaterals. The language is not harming, discriminatory, or judgmental, and contains a tone of identifying progress and strengths.

Is there, however, room for improvement? Two areas might warrant reconsideration:

1. The Objective section note is more about Samantha than the process that took place in the session and/or what the practitioner did; and
2. The Plan could be more specific in terms of demonstrable plans or outcomes. What will preparation for the upcoming reunification consist of? What stress management tools will be provided? Which parenting or social skills will be the focus? These questions might be covered in a treatment plan, and referral to that treatment plan would be appropriate.

Wiger (2011) outlines common problems with progress notes, including vagueness, irrelevant information, and inability to elicit essential information from uncooperative clients, all of which can lead to ethical issues. In addition, taking shortcuts in documentation, such as not charting a separate note for each member attending a group or family therapy session, can be problematic.

A simple framework for objectively assessing clinical notes is that another reader should be able to discern:

- What brought the client to seek help?
- What was done about that presenting problem?
- What were the interventions and results?
- What was the disposition? (Martha St. Enterprises, Inc., 2009).

Information from others

Documenting information received from collateral contacts varies according to the purpose of the information and the manner and setting in which it is received. In forensic assessment, third-party information is particularly important (Otto, Slobogin, & Greenberg, 2007; Heilbrun, NeMoyer, King, & Galloway, 2015). Likewise, child-custody evaluations and investigations of domestic violence rely on third-party informants (Bow & Boxer, 2003; Bow & Quinell, 2002). Documenting third-party information is a significant aspect of clinical record keeping in these situations.

Parents or other caregivers are almost always involved in coordinating a child's care in terms of scheduling appointments or coordinating with other providers. All of these contacts must also be recorded in a client's record.

However, clinicians will also encounter collateral information under less life-altering circumstances. For example, a relative of a client leaves a voicemail for the therapist providing unsolicited, potentially important, possibly damaging, information. In such a case, is it necessary for the clinician to document anything?

The decision concerning whether to document material received by collateral informants is based on clinical, legal, and therapeutic determinants. Consider the following case scenario:

> *The grandmother of a 23-year-old client contacts her grandson's therapist and leaves a voicemail advising that he is having a sexual relationship with a 16-year-old girl, who is also the babysitter for his young child. The girl's parents, who recently learned of the situation, are enraged. The grandmother wants the therapist to intervene, but doesn't want her grandson to know that she is the one who told the therapist. State law delimits age of consent at 16.*

Does the therapist have to document the call? Should she? This information may be clinically important, and it is a potential legal bombshell. The therapist's records could be involved if there is a civil suit. A practitioner might be tempted to ignore the unsolicited information. However, not discussing or documenting the call also carries risk. To cover all bases, it would be prudent for the therapist, first, to recognize that she does not have a duty to keep the grandmother's disclosure confidential. If the grandmother had spoken directly to the therapist instead of leaving a message, the therapist could have advised the grandmother that her disclosure is not confidential. In addition, without the consent of the client, the therapist can neither confirm nor deny that her grandson is a client. Next, the therapist should discuss the phone call with her client and document the results of that discussion. The therapist is then in a better position to assess the reliability of the information, its potential significance for the therapeutic work, and the liability risk.

Consider, also, the following scenario:

> *An agency that provides trauma treatment to children recognizes that to be truly trauma-informed the staff needs education and support. They arrange to have a social worker, also an employee, provide an educational debriefing group weekly to paraprofessional staff about trauma-informed practice. It is clearly delineated that this service is not therapy or counseling. Most of the staff do not have advanced clinical degrees and know little about trauma-informed practice. A participant in the group asks to talk to the social worker after the group and reveals her serious depressive symptoms. The social worker is sufficiently concerned to have the person identify supports but intentionally does not assess for suicide lethality since that would be outside the scope of this assigned duty. He is also concerned about the suitability and competence of this person to do the work and worries that she is a potential harm to clients. He seeks consultation from another social worker, wondering if he has a "duty to warn" administrators about possible impairment of the*

> *colleague and if he has an ethical obligation to protect against suicide. Since this is not a therapeutic group and is not being documented in a clinical record, he doesn't know if he has the obligation to document the serious discussion with the individual somewhere.*

This situation represents a moral issue, with legal and ethical nuances. Legally, the worker is under no obligation to "warn" or to document. Duty to warn requires that the worker have a fiduciary relationship with the other person. In this case, the worker has not entered into a fiduciary relationship; he has no responsibility for the participant. In essence, he is a coworker. His license or code of ethics does not mandate responsibility in this instance. Morally, the worker may feel concern and act as any caring colleague might in providing resources, support, or connection, which he has done. In addition, the worker decided to periodically check in with the colleague as a kind of watchful waiting and, if the situation seemed to escalate, was prepared to bring it to the attention of supervisors.

Unnecessary information

Kane (2001) states that documentation should be:

1. Accurate and helpful.
2. Thorough and complete.
3. Legible.
4. Timely.
5. Without editorializing comments.

Editorializing comments may be the most concerning for liability purposes. Consider this progress note by a clinician treating an 11-year-old boy for separation anxiety:

> *Used non-directive play therapy with Josh today. His drawings indicate isolation and reclusiveness and never include his mother, who one would expect might be present in the pictures to represent security. After meeting with mother today, it is understandable that Josh doesn't have her in his pictures as she seems to have her own anxiety issues and Josh gets easily agitated around her.*

What is potentially harmful about this note? It may be clinically correct that Josh's separation anxiety is connected to his attachment with his mother, and it is generally accepted that mothers provide security to children. Therefore, the comment "who one would expect might be present in the pictures to represent security" might be acceptable. However, if Josh is the client, should the clinician be giving a diagnostic impression of the mother, as in "she seems to have her own anxiety issues"? The clinician is making an evaluative statement without any corroborating information. Unnecessary information increases liability risk, as irrelevant information may breach client privacy.

What might go wrong as a result of this documentation, even if it is true that the mother has been diagnosed with or treated for anxiety? The mother might say, "Well, I've been treated for anxiety myself, so it's no wonder Josh has problems." This information may be relevant to Josh's condition in that his own anxiety is both learned and inherited, but it is important for the clinician to reflect on whether it is necessary to document the statement and if documenting it could be a risk. In fact, it is not necessary to document the statement. Furthermore, documenting it could indeed be a risk. What if the pediatrician or school personnel or another therapist reads the records? What if the father, in a custody dispute, subpoenas the records and uses the comment about the mother to prove she is not fit to have custody? One clinical statement, although likely to be true, has gone terribly awry. The mother's privacy has been violated. Reamer (2008) suggests that such editorializing is tantamount to defamation of character and potential grounds for malpractice or other litigation. Information included in records should not be gratuitous or extraneous to the situation. Savaya (2010) cautions against including distorted, inaccurate, excessive, or irrelevant information. Standard 3.04 of the NASW Code of Ethics counsels that documentation must be accurate, timely, and reflective of services provided, as well as protective of client privacy. These goals can be accomplished by recording only information that is "directly relevant to the delivery of services" (NASW, 2018).

Recall the four categories of risk management in documentation suggested by Reamer: content, language, credibility, and access. Mitchell (2007) advised against using conclusionary terms, modifiers, or abbreviations. Problematic notes might use modifiers such as "seems," which could create doubt, or adjectives such as "extremely," which would suggest opinion rather than fact.

Moline and colleagues (1998) describe the minimum and maximum content criteria for treatment records, including what not to document or keep in the file. Material that might prove embarrassing to the client or to the therapist – such as information that might easily be misinterpreted by another reader – is best left out of documentation. Such information might include personal opinions, discussion about a third party (hearsay), sensitive information that is irrelevant, specific information about client family members, or past criminal behavior.

Mental health practitioners who are self-employed as consultants or work independently in private practice should keep case notes, although these notes are not subject to agency or supervisory scrutiny. Independent practitioners should adhere to guidelines established by the state regulatory body in which they are licensed and/or their professional organization (Green & Simon, 2012). Although keeping case notes is an important task for all practitioners, what to include varies based on a multitude of factors. In general, the record is "written for different purposes and different readerships, which results in competing tensions in its construction" (O'Rourke, 2010, p. 125). In sum, regardless of the setting, recording is a demanding but vital task in the delivery of clinical services.

ETHICAL ISSUES IN RECORD-KEEPING AND DOCUMENTATION

Using case examples, this section will present specific dilemmas in record keeping and documentation. Issues unique to private practice, clients' access to records, and electronic records and use of technology will be explored.

Case scenario

> *A long-term client reveals in detail to her practitioner that decades ago she committed a capital crime. Of course the practitioner, who believes the client, is concerned about her duty to report this incident. She is assured by her supervisor that, to honor confidentiality, she is under no obligation to report the crime. However, the issue of documenting the discussion is a cause for disagreement. The practitioner believes she should document something about it, but the supervisor advises her to "pretend you never heard it." What should the practitioner do?*

In this case, determining the purpose of the documentation is paramount. Yes, the revelation is a legal issue, but it is also a clinical issue. Pretending it did not happen does a disservice to the client, who obviously wants to address it. Documenting that it occurred without identifying detail might be the most judicious decision. Attending to the process of the revelation in the present without concentrating on details of the past would be sufficient for current and subsequent evidence of clinical discussion. An example of this is, "*Client revealed seriously regrettable behavior from decades past. Client was visibly shaking while discussing it. The reason for the current focus and need for future exploration and resolution will have to be determined.*"

The note indicates the seriousness of the discussion and its clinical importance, while still protecting the client. Subsequent therapists could pick up on this note and know the client is experiencing current distress over a past incident. What to do with that distress could be a treatment focus.

In addition to knowing what to include, Pope (2015) identified the five most challenging areas in record keeping: confidentiality, informed consent, legal requirements, third-party payers, and the implications of research findings on documentation. The importance of content and security of records also becomes more obvious with certain clientele, as in cases of interpersonal violence (Bradshaw et al., 2014). Systems designed to protect clients, particularly women and children, rely on accurate and secure information. Cases involving homicidal or suicidal intent, abuse, or violence require detailed information regarding safety plans, mandated reporting processes, and monitoring of potential threats. Some providers might intentionally avoid *documenting* or even *reporting* criminal "duty to report" behavior.

Omitting such important information is not only a liability risk for the agency, but indicates negligent practice on the part of the provider, potentially harming the client or family.

Storage, release, and disposal of records

Whereas most codes of ethics address documentation and record keeping, some ethical codes extend their coverage to include topics such as the storage, disposal, and release of records. The Appendix outlines the relevant standards and principles covered by several professions' codes of ethics. The NASW reports that the why, when, and where of keeping clinical records is a complex issue facing social workers (Robb, 2003). Clinicians have four basic questions:

1. How long should clinicians keep records?
2. Where should records be stored?
3. What are guidelines for electronic records?
4. What are the consequences if records are prematurely destroyed?

The NASW Insurance Trust recommends indefinite retention of records (Robb, 2003), although state laws may stipulate differently. There is potential fallout from disposing of records too soon, since an injured party can file suit decades after alleged malpractice. In some instances, such claims may stem from the moment an aggrieved party first recognizes harm, not necessarily from when the harm took place. Although the APA record-keeping guidelines (2007) no longer distinguish between "full" and "summary" records, it is recommended that, even if a practitioner destroys records at the legally permissible time, he or she should keep discharge summaries or reports. Practitioners are also advised to review insurance contracts to meet contractual deadlines for record retention.

All records should be stored in a locked location and accessible only to those who have a need to know. Electronic records need additional security precautions. These precautions include password-protected computers and, for added protection, the storing of records on computer drives not linked to the Internet. Keeping records of deceased clients is important, as they could be helpful in potential litigation. It is prudent to be familiar with federal statutes regarding records, such as HIPAA and the drug and alcohol use confidentiality regulations (the Code of Federal Regulations, Title 42, Part 2 [42 C.F.R. Part 2], known as 42 CFR Part 2, or "Part 2"), and with state laws and regulations pertaining to records (e.g., storage, retention, client access). Federal law governing public health (United States Code, Title 42, §§290dd-2 [1992]) and the above-mentioned federal regulations that implement it guarantee the strict confidentiality of information about all persons receiving substance abuse prevention and treatment services (Cornell Legal Information Institute, n.d.).

Despite the best attempts to store records appropriately, problematic situations can arise and questions as to what happens if they are damaged or destroyed become a major concern. Both paper and electronic records can be damaged by fire, flood, or storms. Natural disasters like tornadoes and hurricanes can result in serious damage to important documents. Counsel for the NASW advises that social workers decrease the risks associated with natural disasters by backing up and recovering data and reconstructing or destroying records (Felton & Polowy, 2017). Contingency plans should be made so that records can be accessed during an emergency. It should be noted that obtaining the services of a restoration company requires a HIPAA business associate agreement (BAA; HHS, 2017a). Reconstructing records may entail compiling information from other sources such as filed claims, billing records, correspondence from collateral contacts, previous providers, or off-site server storage for EHRs. If records are reconstructed or restored, notation must be made to reflect the change and reason for it. Clients should also be informed and may actually be of assistance in reconstructing records with history.

If records are in need of destruction, proper disposal has to comply with HIPAA confidentiality regulations. Documentation of what records were destroyed and how they were destroyed should be kept in new documentation along with pictures that record the damage (Felton & Polowy, 2017). If an outside vendor is used to destroy records, again, a BAA must be obtained.

Storing data using a cloud server can certainly help in backup and restoration, but also carries potential confidentiality breaches and privacy risks (Sidell, 2015). Devereaux & Gottlieb (2012) point out that although "the cloud" has become commonplace, little has been written about how this technology may expose practitioners to unforeseen and previously nonexistent risk. The authors give as an example the situation in which a practitioner may purchase record-keeping software for scheduling and recording. If all goes well, off-site data storage improves efficiency and security, but when an inevitable shutdown or interruption occurs, "the practitioner would be unable to access patient records, contact information, or scheduling calendars rendering him or her unable to manage his or her practice for an indeterminate amount of time" (p. 629). Additionally, if a provider chooses to switch cloud software or companies, proprietary restrictions could cause difficulties with the transfer of data. Researching and implementing best practices regarding cloud computing is judicious for supporting vindication in case of a breach. Sidell (2015) warns that "cloud computing should not be used for any information one would not wish to share with a competitor or with the government" (p. 158). In many instances, there is no way to ensure that data will be kept confidential and protected in these situations. This area needs further research and the creation of ethical guidelines.

Altering records

Consider the following scenario:

> *A client is being seen for erratic behavior, including angry outbursts. The practitioner documents that the client's diagnosis is undetermined, and that there is a history of schizophrenia in the family. The client reports that a previous psychiatrist diagnosed him with schizophrenia. The client later requests his records and, when he sees this notation about schizophrenia, demands that it be stricken from the record. He does not want any mention of schizophrenia in his chart. What does the practitioner do?*

Is altering records risky? Could such an alteration be construed as fraud? There is a difference between altering records and correcting records (Zur Institute, 2016). Reasons for correcting records include mistaken notations regarding any part of the charting, such as assessment, diagnosis, client behavior, therapist intervention, plans, or wrong words or terms. Clearly, corrections are justified in these instances because they are in the best interest of the client. Accuracy is crucial in providing and maintaining appropriate service delivery. Inaccurate records can result in litigation.

However, if a client requests an amendment to the record, is making the change justified? The answer is that performing this action is justified only if there is a compelling and valid reason for it. Imagine that a therapist gets a court-ordered subpoena to turn over records on a client. She reviews the record and notices several comments potentially damaging to the client's effort to retain custody of her child. The therapist removes these comments in a way that makes the original record illegible. Or the notes are redacted without any indication as to why this has been done. This action could be deemed to be inconsistent with the standard of care of documentation, in addition to being unethical and possibly illegal – a type of fraud through omission or concealment.

With today's forensic technology and timestamping of EHRs, records that have been changed, by hand or electronically, can easily be detected.

In the same scenario, as the therapist reviews the record before complying with the subpoena, she notices that she got an important detail wrong in the assessment because, at the time, she misunderstood a part of the family's constellation. In this instance, not only does she have the right to correct the information, but perhaps also the obligation to do so.

Because a standardized way of correcting a record does not exist, consulting an agency legal department is a common way to determine the necessary steps for addressing corrections to a record. Strike-throughs with initials are one way, and providing a dated amendment to an asterisked section is another. Documenting the reasons for the change provides support and explanation for the clinician's actions.

In the scenario regarding the client's demand that any reference to schizophrenia be deleted, is there a compelling reason to agree to the client's request? It could be argued that the therapeutic alliance and the client's peace of mind could be threatened if the request is not met. However, if the therapist deletes the information, she must explain why. Did she make a mistake? Was the information inaccurate? The simple answer is "No." Noting that the client had reported a previous diagnosis of schizophrenia by a psychiatrist and that there is a family history of the illness is relevant to the client's care and pertinent to maintaining a complete record. In this instance, documenting the client's reaction to seeing his records and his request to remove information may be the most appropriate course of action. In actuality, the therapist in this case did delete the information, leaving a blackened space, with a notation that the redaction was at the request of the client after seeing his records. Future providers or third parties reading that record are sure to be mystified about what information was hidden by the redaction.

Service reimbursement or extension

> *A client submitted claims for reimbursement to her insurance company. The company then requested all original notes on the client for the past 10 years. They specifically did not want a summary, but copies of the notes. The practitioner was reluctant to comply.*

The NASW Code of Ethics (2018) specifically addresses ethical breaches regarding documentation and client records. Standard 4.04 speaks to dishonesty, fraud, and deception. Documentation is one area in which dishonesty, fraud, and deception might occur. Clinicians must document only that which is true. Embellishing symptoms to ensure insurance reimbursement is an example of a "white lie" that a practitioner might argue is necessary to secure needed services. The risk is high. Reamer (2018b) suggests that the slippery slope begins when social workers, out of a sense of altruism, exaggerate needs to procure reimbursement or falsely bill under a family member's insurance to extend services. In addition, more blatant forms of deception in documentation exist in exaggerated or misleading claims of effectiveness, falsified records, and deliberate fraudulent insurance submissions, such as documenting and billing for individual sessions for each person seen in a group. "White lies" or other forms of deception are detrimental and could have deleterious ethical and legal implications for the practitioner and, ultimately, the client.

Kane and colleagues (2002) describe the challenges of documentation in a managed care environment. With managed care, emphasis is on limited services that are brief, cost-effective, and empirically based. It is a "pragmatic, medical model derived approach to intervention. Based on cost, need, the outcome of service, and *rigorous documentation* [italics added], providers are reimbursed" (p. 200).

An ethical challenge for providers is when the rigorous documentation that is called for relies on a pathology focus, which is in direct opposition to empowerment and strengths-based approaches inherent in humanistic counseling intervention. A provider finds himself in a position in which a focus on deficits may determine continued service and reimbursement. The ethical risk of overstating a problem with the altruistic goal of securing service for the client is evident.

Pope (2015) suggests that the importance and complexity of third-party issues in clinical documentation cannot be overemphasized with regard to uses, misuses, and unintended consequences. Third-party payers often expect a certain theoretical approach and require that records reflect content that indicates use of that model. This pressure can create ethical tension for practitioners, causing divided loyalties or conflicts of interest. It is as if the client becomes the third-party payer instead of the consumer receiving services (Pope, 2015).

Ethical breaches can be inadvertent, such as accidentally leaving a file open on a computer or a paper chart open on a desk where someone can view it. This type of violation is represented legally as *misfeasance*. Records might contain unintentionally inaccurate or incomplete information or improper storage of records (misfeasance), knowingly recorded false information (malfeasance), or absence of required information such as an informed consent (nonfeasance).

The following scenario was presented by a social work therapist in a large private practice:

> *It has come to my attention that there are some billing practices that appear fraudulent. For example, there is an office manager in charge of billing at our office. It is not an electronic note system. Everything is handwritten, turned in, and then billed to the insurance system or EAP. The number of therapists in our office has grown exponentially, and not all providers have been credentialed and paneled through each insurer. Because of this, it appears that services are being billed under other credentialed providers. Most recently, it appears that a psychologist, licensed as an LPC, had a Medicare client who was transferred to me because Medicare will not approve the LPC. I am approved as an LCSW. I know the LPC has other Medicare clients and I think they are being billed under me. If I address this with the owner and steps to correct billing are taken, what is my obligation to tell the insurance company or clients? Since the private practice owner takes care of credentialing, how culpable am I if that is part of the owner's responsibility?*

This scenario is an example of what is known as "lending a license." How culpable is the practitioner who never saw the client? The LCSW in this situation may indeed have some responsibility, and could risk her own approval rating with the insurance company, in addition to a potential sanction by the licensing board. In addition, the agency is not meeting insurance provider requirements, which could lead to possible revocation of payments.

Documentary evidence

Documentation can make or break a legal case. According to Barsky (2012), many legal proceedings are increasingly relying on "documentary evidence." Barsky defines documentary evidence as:

> *… any document presented and allowed as evidence in a trial or hearing. Although historically, documents referred solely to information written down on paper, documentary evidence may also include information stored on cameras, video or audio recorders, smart phone, computers, the Internet, or similar media (p. 216).*

The most common documents written by practitioners that are used in court are affidavits and reports. A checklist for documenting legal reports is shown in Table 1.

Table 1: Checklist For Legal Reports

Language	Content	Format
• Clear, concise, reader-friendly Disclaimers such as "reported by," when knowledge is indirect. • Unbiased – no language that is judgmental, ethnocentric, or opinionated.	• Sufficient background and information to which the practitioner can testify confidently. • Facts, opinions, and recommendations differentiated. • Explanation for charts/tables; opinions substantiated by research. • Facts relate to legal issues of the case.	• Easily understood tables, charts, appendices. • Easy to follow through ordered sequencing and headings. • Overall professional quality.

Note. Adapted from Clinicians in Court, by A. Barsky (2012). New York, NY: The Guilford Press.

Group notes

Each client seen in group, family, or conjoint therapy must have his or her own clinical record. It is not advisable to write one (the same) note for each person and put the identical notes in separate charts; this form of documentation is inaccurate and incomplete because it is not specific enough to the individual client's treatment. Additionally, clients who are seen in both individual and group sessions should have separate notes about their individual and group participation that in no way reveal the identity of other group members, thus protecting other parties in the group if an individual's records have to be disclosed (Bodek, 2010). Notes documenting group or family sessions should include the clinician's observation about the client's functioning in the group or family session, observing particularly the individual client's involvement in the process. Bodek (2010) sums up group documentation succinctly:

> *The progress/session note for each person in the group, conjoint or family therapy, should focus on that individual's mental status, behavior, participation and functioning in the session, and their reaction and responses to the themes and processes that arose during the sessions. It should avoid to the extent possible, mentioning any identifiable material from or about other particular members of the group, couple, of family, unless this is necessary for clarity (p. 20).*

If it is not feasible to record a note in each group participant's individual record, it may be acceptable to keep a group record, adding to individual files intermittently or to highlight something significant (Sidell, 2015). However, since the group file is also considered a legal document, releasing such a composite group record could violate confidentiality; careful attention to redacting others' information is necessary.

Correspondence to or about clients

Letters to clients should be written carefully, with attention to purpose, and they should contain only information that is necessary and permissible, with the knowledge that this letter could be read by anyone and used in court proceedings. All such correspondence should be produced formally, typically on letterhead, and in business format (Sidell, 2015).

Client access to records

> *A man sought counseling from a social worker to help him copy with a bitter divorce. The man learned from his lawyer that his estranged spouse was planning to seek sole custody of their children. The man worried that the social worker's clinical notes – which included details about the man's suicidal ideation and substance abuse – might be used against him in the custody dispute. The man asked to see the notes and then asked that they be destroyed.*

O'Rourke (2010) views the clinical record as a process for monitoring of services, eventually explained and available to service users. "The very exercise of observation and interpretation of clients' behavior, and the recording of those observations and interpretation, is an exercise in power … the spotlight is on the client, much less so on the practitioner" (p. 29). The social work value of self-determination is reflected legally in freedom of information legislation, meaning that records can be seen by clients. This legislation serves as a way to balance the power differential between clients and providers.

The NASW Code of Ethics (2018), Standard 1.08, addresses client access to records. The Standard is written based on the social work value of self-determination. Essentially, clients should have access to records, although records are ultimately the property of the agency or provider. Typically, the physical record is viewed as the property of the clinician, while the information contained within the physical record is viewed as the property of the client. Generally speaking, clients have the right to view and obtain a copy of their records, although there may be some exceptions, such as access to records of forensic clients or in child protective services settings (APA, 2013; HHS, 2017b). Workers may lean toward paternalism when clients request records, out of concern that reading clinical notes might trigger adverse reactions in clients. Ultimately, the client does have the right to see the record, even though clinically he or she may be seeking only feedback and reassurance, which can be provided without reviewing specific documentation.

Patient access is a current and controversial issue. Not without opposition, OpenNotes (Johns Hopkins Hospital, 2017) is a national initiative working to give patients better access to the clinical-visit notes written by their doctors, nurses, and other clinicians. Medical clinics and primary care offices increasingly are installing patient portals to allow patients to view their complete medical charts online. Following that trend, some medical centers, as part of an ongoing effort to make care more transparent, have begun posting the men tal health notes in patients' electronic medical records, allowing the patients immediate access to the summaries at home (Kowalczyk, 2014).

In general, practitioners are legally and ethically bound to release records to clients. The Health Insurance Portability and Accountability Act stipulates access rights for patients to:

1. View records in a timely manner.
2. Request changes to their records.
3. Know who else has seen the records (HHS, 2017b).

Circumstances do exist in which records can be withheld. Even so, withholding or not releasing records in a timely manner, or releasing records when not permitted, can subject the provider to a licensing complaint, HIPAA complaint, sanctions, or lawsuits.

A particularly challenging issue is parental access to records. Often parents feel entitled to know the course and progress of treatment. Practitioners must abide by the laws of the state in which they practice when, for example, needing to obtain a signed release from the child client after a certain age. Balancing the parental demands, clinical desire for parental involvement, and therapeutic alliance with the client poses a risk for ethical breach.

The Legal Defense Fund of the National Association of Social Workers states:

> *It is important that social workers have a foundational understanding that parents generally have the right to access the medical and mental health records of their minor children. This is considered a parental right and interfering with this right should only be considered after assessing the child's emotional condition and relationship to each parent and based on sufficient knowledge of the applicable legal standards for denying parental access to records as well as the appropriate procedures to follow. State health privacy laws may also provide procedures and/or standards for providing and denying parental access. … (NASW, n.d.)*

Legally, social workers ordinarily covered by HIPAA may deny parents access to children's treatment under certain circumstances:

1. Reasonable suspicion of abuse or neglect.
2. Danger of substantial harm as a result of records disclosure.
3. Separate psychotherapy (shadow) notes.
4. Voluntary parental agreement.

In such cases, documenting justification of the denial is paramount. In addition, the clinician must have another licensed healthcare professional, who is not directly involved in the denial, review the decision to deny access. Documentation of consultation with colleagues or an ethics committee regarding the denial is advised.

Clients can now access their own health information through platforms to the EHR. Although this access can enhance patient-provider communication, barriers still exist, especially with respect to access to sensitive or clinical notations (Nelson & Staggers, 2018).

Documentation in a digital world

An inquiry to an Ethics Committee stated:

> *I am using an electronic records program and want to use dictation for notes. I'm wondering if anyone has done research regarding using a smart phone microphone and whether there are any HIPAA concerns. There is something I read that made me concerned about the digital file being sent to Apple or Samsung, but I'm not sure.*

This situation is certainly unique and contemporary. It represents both the ease and risk of technology. In days past, dictating to a transcription service was taken for granted, with little concern for privacy. Returning to "dictating" now takes on a different perspective. In this case, the Ethics Committee consultant advised against using this application because some information is shared with Apple or Samsung from certain applications to assist with Artificial Intelligence functions such as Autocorrect and Smart Reply, which might involve cloud storage. It was recommended that a third-party recording app might be safer and more transparent, in that the user agreement could be a type of informed consent.

Case scenario

> *A counselor working in a women's prison re-entry program was assisting her client with dressing appropriately for job interviews. She arranged for the client to get a haircut. Since the client had a type of haircut in mind, the therapist sent a magazine picture of the hairdo and a picture of the client to the hairdresser via email.*

Could this ostensibly helpful action be a breach of confidentiality using technology? Of course it is. Even if the client was aware of it, the client's safety is primarily the practitioner's responsibility. The client's status as a former inmate receiving adjustment services is now available to anyone with whom the hairdresser opts to share the information.

Mental health practitioners are increasingly making use of various forms of digital technology in their professional lives. The APA recognized that technology would change so fast that references to specific forms of technology might have to be revised frequently. Thus the choice was to eliminate specific references to types of technology in favor of broad-based terms and suggestions for security and protecting confidentiality, such as separate "psychotherapy notes" in an electronic health record. From marketing a practice on a website to using avatars in counseling, use of digital technology and social media has changed the face of the counseling profession. Frederic G. Reamer, quoted in Pace (2014, p. 4), suggests that the use of technology "fundamentally alters the helping relationship." He has researched the ethical challenges that can result from such digital-based interventions as video counseling, email chat, social networking, texting, phone apps, and self-directed Web-based healing modalities, going so far as to suggest that it is not inconceivable that a practitioner may never see a client in person (Reamer, 2013).

Documenting services provided online or via telephone, and client's access to such documentation, has evolved more quickly than standards to guide or regulate the practice (NASW, 2017).

Using the axiom of "start where the client is," a practitioner might justify engaging with adolescents via their preferred medium of electronic communication (Reamer, 2013). However, the following scenario illustrates the ethical risk and emphasizes the need for informed consent that outlines the confidentiality and access limitations that using technology may pose:

> *A family-based social worker often texts his teenage clients to arrange appointments. After regular duty hours, one of the teenagers sent him a text hinting that she would attempt suicide that night. He didn't see the text until the next morning.*

Texting has become more frequent in clinical practice. In spite of the imminent risk to client privacy and breach of confidentiality, some clients, especially adolescents, prefer this mode of communication. Practitioners using texting as a form of communication should have a clear policy outlining when texting will be used or is acceptable (NASW, 2017). Informed consent should also address and cover this risk. Should texts be included in the health record? The short answer is "Yes." Whether to include the exact text or a summary of text discussion is at the discretion of the provider, but there should be some record of text communication. Texts, much like email, need to reflect the values, ethics, and mission of the practitioner's profession (NASW, 2017; Reamer, 2018b; Sidell, 2015).

Current guidelines for the use of technology are discipline-specific, and clinicians wishing to use technology in their practices should ensure that they are following their profession's ethical and legal standards.

Consider the following scenario:

> *A practitioner has been seeing a client once a week for counseling. During the most recent visit, the client reveals that he has been experiencing increased depression, manifesting as low energy and loss of interest in his usual activities, and he has been giving away some of his belongings because he "just doesn't need them anymore." The practitioner asks the client if he is considering suicide,*

> *and the client answers that he has had passing thoughts but does not have a plan. The practitioner and client engage in creating a safety plan, and the client asks about texting the practitioner between sessions. The practitioner, in an attempt to be helpful, agrees that the client can contact her between sessions. During the week, the client experiences increasing thoughts of suicide and texts the practitioner around 2:00 a.m. one morning. What should the practitioner do?*

The above scenario is complicated and illustrates what can happen when texting occurs in the professional relationship. Although the practitioner was trying to be helpful, the whole situation could have been avoided had the practitioner outlined specifically in her policy when texting was appropriate, and for what purposes, or by simply not allowing texting to occur. Now the practitioner has blurred the boundaries with the client, and the client's safety is of concern. This scenario can become even more complicated, both ethically and legally. For example, consider the ramifications if the practitioner texts the client and the client indicates that he is suicidal, or worse, does not text the practitioner back, or if the practitioner fails to see an urgent text. How does the practitioner assess the safety of the client? What is the ethical responsibility in this scenario? Is the practitioner legally responsible for the client's well-being at this point? These issues are multifaceted and, again, could be avoided by not engaging in texting within the professional relationship. At the very least, the clinician needs to ensure that she includes all text messages in her documentation and case files. When practitioners decide to engage in texting with clients, their policies should be provided to clients during the first session, and they should obtain informed consent.

Using email with clients poses other challenges that need to be addressed with the clients. Although convenient for a number of purposes, including completing necessary paperwork before sessions, scheduling, or answering simple questions without playing "phone tag," email carries inherent confidentiality and boundary risks. The need for informed consent, with its attendant implications and risks, has already been discussed. The added protection of an encryption program, as well as the use of a password or code words or an electronic signature system that verifies clients' identities, could also be considered (Sidell, 2015). Both texting and emailing clients can pose ethical dilemmas and place practitioners at potential risk for favoritism, conflicts of interest, and boundary confusion (NASW, 2017). Furthermore, it is never possible to ensure that the intended person is receiving an electronic communication. Again, referring to professional guidelines for technology, along with ethical and legal standards, is key to effective and appropriate documentation.

The majority of agencies are moving toward electronic record keeping. The assumption is that an EHR "will save time, provide real-time access to patient information at the point of care, facilitate the work of the clinician, provide decision support capabilities, support clinical care and research, and improve quality and safety of care" (Nelson & Staggers, 2018, p. 93). The burgeoning field and profession of Health Informatics encompasses the development and monitoring of electronic health applications (Nelson & Staggers, 2018). Private practitioners usually are not required to use electronic record keeping, but many are choosing to do so via various platforms and software packages. Financial record keeping is equally as important as clinical record keeping. Accuracy in billing records is a risk management safeguard against client complaint. It is recommended that such records include date and type and duration of service provided, with associated charges and dates of receipt of payment or third party reimbursement. Complications arise when modifications are made to fee arrangements, such as sliding scales or other considerations regarding ability to pay. Documentation is particularly important for avoiding misunderstanding or the appearance of preferential treatment.

Cyber-liability is now a concern for behavioral health providers. The most salient risk in electronic record keeping is computer security and breach of client confidentiality when records are stored on agency servers or personal computers. Malpractice insurers list several ways in which technology breaches can put practitioners at risk, including losing a laptop computer or flash drive with stored client information, faxing or emailing information to the wrong recipient, or falling victim to cyber hacks on a data management system. Even if a data storage service loses the information, the practitioner can be held directly liable (NASW Assurance Services, 2014). In addition, using distance counseling platforms presents potential conflict of interests. Clients may assume that practitioners endorse the advertisers and sponsors on the video counseling sites (Reamer, 2013).

Electronic recording poses multiple risks. In her book on social work documentation, Liz O'Rourke (2010) paints a grim picture:

> *The power of databases to enable information about us to be shared by others in ways over which we have no control raises the spectre of Foucault's Panopticon …the all-seeing Panopticon was a means to observe, control and discipline behavior … The social work record may be seen as part of the Superpanopticon which is scrutinizing the service user, but at the same time it may also be a means to scrutinize the practitioner. (p. 31)*

Indeed, applying the metaphor of a panopticon (a building, usually a prison, designed in such a way that people can be observed at any time without their knowledge) to electronic documentation emphasizes that both the client and therapist need to consider that the information contained in a record may be viewed at any time by unknown parties. This awareness should serve to regulate what the therapist records about a client. Although extreme in nature, this metaphor does illustrate the importance of the caution practitioners need to apply when creating client records. The assumed scrutiny speaks to the need for proactive risk management protocols in record keeping and documentation. Both paper-based and electronic records are subject to breaches if access is easy (Bradshaw et al., 2014). Thus, the focus should be on securing records, either physically or through such technology as encryption (NASW, 2017).

Although Reamer (2013) also speaks about the ethical risks of electronic documentation, he advises social workers to document electronically in the same way that they would make a paper record, because encrypted electronic records are actually more secure than traditional charts. He does caution that any clinical encounters via electronic media (email, text, social networking, or telephone) should be charted in the case record.

Behavioral health practitioners working for agencies rely on the institution to provide computer network security systems. With respect to private practitioners, of course, software programs or platforms must be HIPAA compliant and records should be encrypted. In addition, practitioners are advised to ensure that their liability coverage includes digital documentation protection. Liability and billing insurers may recommend certain programs for private practitioners to use for electronic record keeping.

Despite the extensive reach of HIPAA regulations, standardized measures for monitoring electronic records and dissemination of confidential information have yet to be developed (Bradshaw et al., 2014). Quality assurance (QA) programs have focused on service implementation and outcomes, with less focus on managing the quality of records.

Just as the process of record keeping poses ethical risks, so too does the documentation of ethical dilemmas, decision-making processes, and resolutions. See the Resources section of this course for additional guidance on this issue.

Publication

A unique aspect of clinical documentation concerns clinical writing and publishing case material. Bennett (2011) illuminates the ethical dilemmas that emerge when the clinician's responsibility to respect the client's right to privacy competes "with the societal good of educating other professionals about the process of social work practice" (p. 11). Historically, publishing case material was an accepted practice, even without permission from the client, if material was heavily disguised. However, with the enactment of HIPAA regulations and effortless Internet searching, clients can easily find their therapists' publications, recognize themselves in published writing, and perceive that their rights have been violated.

No matter how many safeguards are put in place, such as the use of disguised information or the obtaining of a client's permission, ethical dilemmas can still arise. The utilitarian (teleological) approach to ethics (the greater good prevails) would opt for benefitting the professional community, which conflicts with a more deontological viewpoint that would argue that publication might simply be unethical because it violates the client's privacy.

The request for permission inevitably will alter the therapeutic relationship and may pose undue influence. The client may feel coerced to agree in order to receive services. Thus, clients will not always perceive an informed consent as totally voluntary. Yet the effect of clinical writing on the treatment relationship may also be positive, particularly if the client feels his experience is noteworthy and could help others.

Supervision

Supervising documentation

The following supervision scenario points to the need for recording on two levels: the worker's need to record services and the supervisor's need to record addressing the performance deficiency:

> *A supervisor has administrative and clinical charge over several mental health practitioners. One of them is consistently late in documentation but does exemplary clinical work. She was placed on a performance improvement plan that did not yield positive results. During her performance review, she protests that she is bringing in the most revenue from clients and is known as one of the best clinicians in the agency. She doesn't understand how timely documentation could be any more important than clinical effectiveness and bringing in money.*

Although there are many areas of professionalism for the supervisor to address with this clinician, the supervisor can begin by explaining that by not providing timely documentation of her work she is failing to hold herself accountable and is also placing the clients, the agency, funding streams, and her own reputation in jeopardy. The supervisor can further problem-solve the issue with the clinician and determine various potential causes of the late documentation. For example:

- Does the clinician lack a knowledge base of what constitutes good documentation?
- Does she struggle with time management such that the task of documenting remains undone?
- Is her work with clients crisis-oriented, or does she have so many responsibilities that documentation does not rise to the top of the priority list?
- Does the clinician lack the resources necessary to provide timely documentation?

This analysis will allow a supervisor to intervene more effectively and support the clinician in ways to improve the timeliness of her documentation.

According to Rogers (2018), behavioral health practitioners who also clinically supervise face particular challenges in integrated healthcare settings. These supervisors must bear responsibility for documentation issues of confidentiality, informed consent, self-determination, and format. He goes on to distinguish among three types of documentation for mental health practitioners: progress notes, psychotherapy notes, and process notes. As noted in the Introduction to this course, most graduate training programs do not provide specific courses on documentation, nor on supervision (Leon & Pepe, 2013). These topics are often provided by continuing education that must be sought out by a particular practitioner. This issue places supervisors at risk not only for difficulties with documentation for themselves, but also for their supervisees. It cannot be assumed that supervisors have received training in either of these critical practice areas.

Documenting supervision

Reamer (2001, 2015) advises that supervisors, as evidence of oversight and monitoring, must document any supervision provided. The concept of *respondeat superior* ("the master responds"), the legal principle by which supervisors can be held liable for actions or inactions of their supervisees, demands it. Documentation of routine supervision is one protective risk management strategy.

Barnett and Molzon (2014) advise that informed consents should be a foundational agreement when beginning supervision. According to these authors, this agreement is no simple thing and should include:

> *Expectations, responsibilities, and obligations of both supervisor and supervisee; any fees and financial arrangements relevant to the supervisory relationship; scheduling and emergency contact information; documentation and record keeping requirements; the use of any audio and video recording; evaluation and feedback to include the expectations and requirements for successful completion of the training experience; expectations for confidentiality and any reasonably anticipated limits to confidentiality; legal requirements such as mandatory reporting requirements, expectations for use of the supervisor and when the supervisee should contact him or her; and information about how and when the supervisory relationship will be ended (pp. 1052-1053).*

Barnett and Molzon (2014) also emphasize the importance of documenting each supervision session. They list several reasons for documenting supervision:

- Mitigating the possibility of misunderstandings.
- Fostering accountability for both parties.
- Tracking supervisee's progress with respect to professional development and clinical services provision.
- Managing risk by demonstrating that supervision has occurred.

The American Board of Examiners in Clinical Social Work (ABECSW; 2004) and the NASW (2013) have created guidelines for clinical social work supervision that address the documenting of supervision. Both of these organizations suggest a contractual agreement signed by both supervisor and supervisee, listing the purposes, objectives, and methods of supervision. The ABECSW position statement (2004) asserts:

> *The supervisor understands the responsibility to create and maintain an ongoing record of the supervision. Records must be kept in accordance with state and federal laws as well as agency policy. Accurate and thorough record-keeping is an important aspect of job management, and provides protection in case of a legal challenge to the quality of the services provided (p. 26).*

The NASW *Best Practice Standards in Social Work Supervision* (2013) state:

> *Documentation is an important legal tool that verifies the provision of services. Supervisors should assist supervisees in learning how to properly document client services performed, regularly review their documentation, and hold*

> *them to high standards. Each supervisory session should be documented separately by the supervisor and the supervisee. Documentation for supervised sessions should be provided to the supervisee within a reasonable time after each session. Social work regulatory boards may request some form of supervision documentation when supervisees apply for licensure. Records should be safeguarded and kept confidential (p. 18).*

Supervision/consultation is important for documenting ethical decision making. It is important to consult with colleagues, including supervisors, in formulating an ethical decision, and it is equally important to consult about what to document in the process. The same principles employed to document services to clients apply equally to documenting supervision.

Mitchell (2007) summarizes with a somewhat satirical yet cautionary list of documentation risks that ensure litigation or charges of unethical conduct:

1. Document something that needs to be done; then don't do it.
2. Do not keep records current.
3. Do not complete assessments or develop a comprehensive treatment plan.
4. Establish policies and procedures, but do not follow them.
5. Do not review or audit your records.
6. Nurture a dependent relationship and then cut it off abruptly.
7. Combine a suicidal client with a provider who has a reputation for sexual impropriety.
8. Ignore your code of ethics (p. 18).

DECISION MAKING IN DOCUMENTATION

The following example provides a springboard for ethical decision making in documentation:

> *During a session a client threatened to punch her former boyfriend's present girlfriend in the face. The worker speculated whether this admission met the criteria for a duty to warn. She pondered whether to document the threat, thinking that if she didn't document it there would be no chance of either her client or herself being hurt legally. After the client willingly provided her boyfriend's number, she did call him and his girlfriend and provided the warning to both. She considers her ethical obligation met but still wonders if it is necessary to document the interchange.*

These questions guide the necessity to document:

- For whom is the note written? (Is the information for the agency, the practitioner, collateral or subsequent practitioners, or the client?)
- Is it necessary? (Does the information further the goals of treatment or link other aspects of treatment?)
- Is it useful? (Does the information relate to the treatment goals, or is it extraneous?)
- Is it sufficient?
- Is it true?
- Who might read it?
- Who should/could read it?
- Are there jurisdictional statutes that require it? And perhaps the most important question:
- What might happen if I don't write it?

The concept of negative responsibility is the ethical notion that a person is equally responsible for inaction as for action. Negative responsibility plays into deciding what to document and what not to document. The skill of conceptualizing important themes without potentially damaging detail develops over time with experience.

Mitchell (2007) expands on this concept by assuming the voice of a coworker when documenting. If a coworker were to read the note, would he or she find it sufficiently clear to ensure continuity of care? A client is not served well when a coworker is challenged to interpret incomplete records. Suppose a coworker is charged with covering for a sick colleague.

She reads in the notes: "Client often acts inappropriately in session." The coworker is left wondering if the client laughs inappropriately, makes sexual overtures, or lunges across the room unexpectedly. Mitchell (2007) describes this charting as using "conclusionary terms" without substantiation and goes further to imagine a client reading such powerful, potentially damaging documentation.

Reamer (2012) suggests applying a decision making framework known as *choice architecture* to ethical decision making. This concept can also be applied to decisions about documentation. Choice architecture, which originated in the economics and business fields, has only recently appeared in the behavioral sciences literature. In this framework, choices are constructed in much the same way that steps are placed in strategic areas of building construction; the placement of the steps themselves then influences the choices people make.

The concept of choice architecture can be used to assist in determining what to document in a clinical record. In choice architecture, a clinician should expect error and manage the risk. The architecture of choice in ethical decision making, when applied to clinical record keeping suggests that the clinician should ask:

- What would happen if I don't document? (What would happen if I were to do nothing?)
- Should I consult? (Who should/could be involved in this decision?)
- What if …? (Always anticipate errors and the need for risk management.)

The default decision in building a case for documenting is to do nothing. This decision certainly has its risks, so the next step, to get feedback, is advised. The ultimate step is to expect error and manage the risk, which, after consultation, may result in the default decision.

Reamer (2001, 2007) provides an ethics audit tool to manage risk in an agency in multiple areas. Documentation, in which practitioners' documentation styles and procedures should be assessed, is one area the ethics audit addresses.

The audit notes whether documentation routinely includes these components:

- Social history, assessment, and treatment plan.
- Informed consent.
- Collateral contacts.
- Multidisciplinary consultation.
- Justification for choice of intervention.
- Critical incidents.
- Recommendations to the client.
- All contacts with clients, including type, dates, and times.
- Failed or missed appointments.
- Previous relevant medical history.
- Billing information.
- Termination notes (Reamer, 2001).

In addition, documentation should be evaluated for anything that might imply defamation of character, including libel. "Social workers can be liable for defamation if they say or write something that is untrue, they knew or should have known to be untrue, and caused some injury to the plaintiff" (Reamer, 2015, p. 141).

Evaluating the quality of documentation begins with a thorough assessment of the policies and procedures that dictate record keeping in the setting. Reamer's (2001) audit instrument assesses ethical risks in an agency. Among many areas examined is documentation. An outline used to examine the adequacy of documentation assigns points based on a continuum of no risk to high risk, focusing first on *policies*, and then on procedures to "ensure proper documentation" (p. 54). For risk-management purposes, as a general rule, notes should focus more on what the clinician did than on what the client did in a session.

Conclusion

The importance of clinical documentation rests firmly on clinical, administrative, legal, and ethical grounds. Discerning what is sufficient, necessary, and relevant to document is the ethical responsibility of the practitioner. The complexities and nuances of clinical record keeping demand an informed approach. Documenting in the digital world requires particular attention.

Clinical records serve multiple purposes in the current healthcare arena. In particular, in the increasingly complex and litigious realm of mental health practice, the balancing act required for practitioners to document sufficient, necessary, and helpful information, with risk-management principles in mind, reveals that clinical record keeping should not be taken lightly. The challenge for clinicians is to adhere to the profession's values and ethics, while documenting client information and the therapeutic encounter. Generally, documenting more process and less content is a good risk-management strategy. Records should reflect the clinician's competence, intentionality, decision-making process in weighing options, rationale for treatment, and awareness of relevant clinical, ethical, and legal information.

Given the pivotal role of record keeping in behavioral health practice, and the fact that it often takes up more than half of a practitioner's time, creating an ethical and practical document is not adequately addressed in professional training (O'Rourke, 2010). The complex nature of healthcare documentation in the 21st century requires ongoing education.

In a review of the APA revised record-keeping guidelines, Drogin and colleagues (2010, p. 242) conclude that:

> *Record keeping issues are ever-present and are inextricably bound up in Ethics Code requirements, ignorance of which could lead to very serious consequences for everyone involved. The topics [of record keeping] are of pressing importance, and their complexities merit our close attention.*

This course provides needed attention to the complexities of documentation.

APPENDIX

Summaries of Ethics Codes: Relevant Information Regarding Record Keeping

American Association for Marriage and Family Therapy Code of Ethics (2015)

http://www.aamft.org/imis15/content/legal_ethics/code_of_ethics.aspx

- **Standard II: Confidentiality**
  - 2.5 Marriage and family therapists (MFTs) comply with applicable laws and professional standards with respect to storing, safeguarding, and disposing of records such that clients' confidentiality is protected.
  - 2.6 MFTs arrange for the confidentiality, storage, transfer, safeguard, or disposal of client records in the event of the therapist's move from the area, practice closure, or death in conformance with applicable laws.
- **Standard III: Professional Competence and Integrity**
  - 3.5 MFTs maintain clinical and financial records in accordance with applicable law.
- **Standard VI: Technology-Assisted Professional Services**
  - 6.2 MFTs make clients aware of the risks and responsibilities associated with the use of technology-assisted services in writing.
  - 6.3 MFTs make clients aware of limitations and protections offered by the therapist's technology in writing.
  - 6.4 MFTs ensure that documentation that is stored or transferred electronically adheres to best practices with respect to maintaining confidentiality and quality services. MFTs are to notify clients in writing of the technology's limitations and protections.
- **Standard VIII: Financial Arrangements**
  - 8.6 MFTs may not withhold records because of non-payment for services, except as otherwise provided by law.
- **American Counseling Association Code of Ethics (2014)**
  http://www.counseling.org/Resources/aca-code-of-ethics.pdf

Section A: The Counseling Relationship

- **A.2.a. Informed Consent**
  Clients choose whether or not to enter into or remain in a counseling relationship. Clients should be provided with information verbally and in writing about the counselor and what to expect from the counseling process. Counselors review in writing and verbally with clients the clients' and counselors' rights and responsibilities. Informed consent is revisited and documented throughout the counseling process.
- **A.2.b. Types of Information Needed**
  All services provided by the counselor are explicitly explained to clients. Clients are informed by counselors about the counselor's credentials and experience in service provision and the service's purposes, goals, techniques, procedures, limitations, potential risks, and benefits. Counselors explain about their management plan for a client's services upon the incapacitation or death of a counselor. Counselors ensure that clients have clear information about their records and understand the implications of diagnosis, tests and reports, fees, and billing arrangements. Clients have the right to confidentiality and to be informed of all the limitations to the counselor's maintenance of their confidentiality. Clients have the right to refuse any services and to be advised about the consequences of such action.

Section B: Confidentiality and Privacy

- **B.6. Records and Documentation**
  - **B.6.b. Confidentiality of Records and Documentation**
    Counselors ensure that client records and documentation are secure and can be accessed only by authorized persons.
  - **B.6.c. Permission to Record**
    Counselors must seek and be granted permission to record a client's session through electronic or other methods.
  - **B.6.e. Client Access**
    Counselors provide reasonable access to records and copies of records when competent clients request that they do so. Such access is limited only when compelling information suggests that access would harm the client. All client requests for access are documented by counselors. Withholding any portion of the record is documented with an accompanying rationale. In instances involving multiple clients, counselors do not release confidential information about any other clients to the requesting client.
  - **B.6.g. Disclosure or Transfer**
    Counselors disclose and transfer records to legitimate third parties only when they have obtained written permission from clients for the disclosure, unless exceptions to maintaining confidentiality are present.
  - **American Psychological Association Ethical Principles of Psychologists and Code of Conduct (2017)**
    http://www.apa.org/ethics/code/

6. Record Keeping and Fees

- **6.01 Documentation of Professional and Scientific Work and Maintenance of Records**
  Psychologists create, disseminate, store, retain, and dispose of records related to their professional work that facilitates the provision of services, complies with legal and institutional requirements, and ensures accuracy.

- **6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work**
  a. Psychologists ensure confidentiality in creating, storing, accessing, transferring, and disposing of records under their control regardless of medium (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records).
  b. Psychologists must use coding or other confidentiality-maintaining techniques so that participants may not be identified by others who have access to the record but do not have permission to access the participant's confidential information.
  c. Psychologists make advance plans for confidential record maintenance in the event of their withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)
- **6.03 Withholding Records for Nonpayment**
  Psychologists may not withhold records needed for a client's emergency treatment because of nonpayment.

National Association of Social Workers Code of Ethics (Revised 2017)

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

- **1.07 Privacy and Confidentiality**
  (j) To the extent permitted by law, social workers should protect client confidentiality during legal proceedings. If a legally authorized body orders social workers to disclose confidential or privileged information without a client's consent, and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or seal the records so that they will not be available for public inspection.
  (k) Social workers should protect client confidentiality in the face of requests from members of the media.
  (l) Social workers should protect the confidentiality of sensitive information such as that found in clients' written and electronic records and should take reasonable steps to ensure that clients' records are stored in a secure location and that the records are not available to others who are not authorized to have access.
  (m) Social workers should protect the confidentiality of electronic communications, including information they themselves provide to clients or third parties. Social workers should use applicable safeguards when using electronic communications.
  (n) Social workers should develop policies and procedures for timely notification of clients concerning breaches of confidential information, and they should make those policies and procedures known.
  (o) Social workers should inform clients of unauthorized access to records or information, including unauthorized access to the social worker's electronic communication or storage systems, consistent with laws and professional standards.
  (p) Social workers should develop and inform clients about their policies on the use of electronic technology to gather information about clients. These policies must be consistent with the ethical standards of social work.
  (q) Social workers should search and gather client information electronically only when confronted with compelling professional reasons. If appropriate, the social worker should have the client's informed consent.
  (r) Social workers should not post identifying or confidential information about a client on any type of social media, even professional websites.
  (s) Social workers should protect clients' records when transferring or disposing of them, being sure to protect clients' confidentiality and follow laws governing records and social work licensure.
- **1.08 Access to Records**
  a. Social workers should provide clients with reasonable access to records that concern them. Social workers should provide assistance in interpreting the records, as well as consultation with the client regarding records that might cause harm or misunderstanding. Social workers should not limit clients' access to their records, or portions of their records, unless exceptional circumstances exist in which such access could cause serious harm to the client. Social workers should document in clients' files their requests to see files and any rationale for withholding some or all of the records.
  b. Social workers should develop policies that are consistent with prevailing social work ethical standards on the use of technology to provide clients with access to their records, and they should inform clients of those policies.
  c. If clients are given access to their records, social workers should be sure to protect the confidentiality of other individuals identified or discussed in such records.
- **1.12 Derogatory Language**
  In all written, verbal, or electronic communications, social workers should refrain from using derogatory language either when discussing clients or communicating with them directly, but should use only respectful and accurate language.
- **3.04 Client Records**
  a. Documentation in electronic and paper records should be accurate and reflect the services provided.
  b. Documentation included in the records should be sufficient and timely in order to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.
  c. The documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.
  d. To ensure future access, social workers should store records following the termination of services. Records should be maintained for the number of years required to satisfy the laws, agency policies, and contracts.

National Board for Certified Counselors (2016)

http://www.nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf

- **Directive 1**: National certified counselors (NCCs) will not share information that is obtained through the counseling process without specific written consent, except in the case of clear, imminent danger to the client or others or when required to share information by a court order.
- **Directive 10**: NCCs are to create formal, written procedures for handling client records in the case of death or incapacitation.
- **Directive 16**: Test results and assessments can be released to others only with written client consent, except in the case of imminent danger or in the face of legal requirements.
- **Directive 19**: NCCs must create written practice procedures concerning social media and digital technology, which are to be provided to clients before or at the time of the first session. This information shall be incorporated with other information provided to clients before or during the initial session. The information is to include guidelines for the use of social media and must address such issues as the difference between personal and professional accounts and the practice of "friending."

- **Directive 43**: When providing opinions, NCCs are to ensure the accuracy of all written reports based on direct experience with the client or clients or on documentation from other professionals.
- **Directive 54**: All written communications, including those sent and received through digital technology, must be made part of the client's official record. These communications include those of a clerical nature, such as the scheduling of appointments. Password security and encryption must be used for all electronic therapeutic communications.
- **Directive 55**: Client records must be kept for at least 5 years, unless state or federal law requires storage for a longer period of time. Even the eventual disposal of records must take place in such a way as to ensure client confidentiality.
- **Directive 72**: NCCs must obtain a client's consent prior to the provision of services. In private practice or other similar situations, consent shall be documented in writing in a counseling services agreement, which shall become a part of the client's record.
- **Directive 74**: Client records are to be updated throughout the counseling relationship when changes occur in the treatment plan, including those relating to goals, roles, and techniques. Any updates require the client's written approval.
- **Directive 75**: The primary client must be clearly identified in the client record, as must others receiving related professional services in connection with the primary client.

Resources

- Barnett, J. E., & Johnson, W. B. (2008). *Ethics desk reference for psychologists*. Washington, DC: American Psychological Association. Written for psychologists and useful to cognate professionals, this reference supports mental health professionals in navigating ethical responsibilities.
- Barsky, A. (2009). *Ethics and values in social work: An integrated approach*. New York, NY: Oxford University Press. For practitioners interested in learning more about social work ethics, this resource provides practice vignettes, discussion questions, and role-playing exercises.
- Corey, G., Corey, M. S., & Corey, C. (2018). *Issues and ethics in the helping professions* (10th ed.). Boston, MA: Cengage Learning. This book emphasizes a practitioner's critical thinking as an approach to managing ethical concerns and includes opportunities for self-directed learning.
- Kantrowitz, J. L. (2006). *Writing about patients: Responsibilities, risks, and ramifications*. New York, NY: Other Press. Interviews with psychoanalysts comprise an exposition on the ethical conundrum of publishing cases, balancing the need to advance professional literature with the necessity to protect client confidentiality.
- Martha St. Enterprises, Inc. (2009). *You can learn to write effective, clear and professional case notes*. http://www.become-an-effective-psychotherapist.com/case-notes.html. This website describes charting as the practice of keeping objective documentation on clinical inter- ventions. Numerous and specific examples of different types of case notes are provided.
- National Association of Social Workers (NASW). (2017). *NASW, ASWB, CSWE, & CSWA Standards for Technology in Social Work Practice*. Washington, DC: NASW Press. https://www.socialworkers.org/includes/newIncludes/homepage/PRA-BRO-33617.TechStandards_ FINAL_POSTING.pdf. As social workers' use of technology proliferates, this document represents the work of a task force dedicated to developing technology standards for social work practice. The standards cover the use of technology to (a) communicate with the public, (b) design and deliver services, (c) document work with clients, and (d) educate and supervise social workers.
- National Association of Social Workers. *Legal issue of the month*. https://www.socialworkers.org/about/legal/legal-issue-of-the-month. The "Legal Issue of the Month" addresses a particular legal topic relevant to social work practice, focusing on a recent court decision or emerging legal issue. The site hosts 100 free legal articles for NASW members and addresses commonly asked questions as well as complex current or ethically challenging issues.
- National Association of Social Workers. (2007). *Social workers and e-therapy*. https://www.socialworkers.org/about/legal/legal-issue-of-the-month. This article discusses various electronic modalities of treatment, social work practice standards, and research, and touches on the relationship that other health professions have with electronic media.
- National Board for Certified Counselors. (2016). *National Board for Certified Counselors Policy Regarding the Provision of Distance Professional Services*. https://www.nbcc.org/Assets/Ethics/Policy/RegardingPracticeofDistanceCounselingBoard.pdf. This policy provides information for counselors regarding the use of technology in the delivery of counseling services.
- Reamer, F. G. (2012). *Boundary issues and dual relationships in the human services*. New York, NY: Columbia University Press. This book offers a thorough analysis of common boundary issues in the helping professions. Specific examples with suggested guidance on risk management highlight each chapter.
- Weick, A. (1983). Issues in overturning a medical model of social work practice. *Social Work, 28*(6), 467-471.
- Weick, A. (2009). Issues in overturning a medical model of social work practice. *Reflections: Narratives of Professional Helping, 15*(3), 7-11. Ann Weick examines the issues involved in the shift from a medical model to a health-oriented paradigm and suggests key principles for strengthening this shift.

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ETHICS IN BEHAVIORAL HEALTH DOCUMENTATION: REASONS, RISKS, AND REWARDS

Final Examination Questions

Select the best answer for each question and complete your test online at **EliteLearning.com/Book**

36. Good clinical documentation primarily meets the needs of:
    a. The client, practitioner, and agency.
    b. Accrediting bodies.
    c. Supervisors.
    d. Professional boards and regulatory organizations.

37. The medical model of documentation:
    a. Is based on an agency's policy.
    b. Is used only in hospitals.
    c. Reflects counseling and social work ideology.
    d. Focuses on impairments rather than strengths.

38. Well-written progress notes may protect a therapist from ethical or legal sanction by:
    a. Proving that the therapist has demonstrated excellence.
    b. Validating that the treatment was clinically indicated and appropriately provided.
    c. Protecting client privacy so that records cannot be used in a court of law.
    d. Providing spaces to note the date and time of each session and for both the clinician and client to sign.

39. In determining what is reasonable and customary for the public to expect from a particular profession, the courts look to the "industry standard" for guidance. These standards can be found in:
    a. A profession's code of ethics.
    b. A particular agency's policies.
    c. States' re-licensure requirements related to continuing education.
    d. The literature of a lobbying organization for that profession.

40. Personal notes or shadow records are notes that:
    a. Do not need to be stored according to HIPAA standards.
    b. A student intern creates during training while shadowing a supervising therapist.
    c. Include interpretation by the therapist but are not included in the official file.
    d. Are included in the official file but are not subject to subpoena.

41. Practitioners may be reassured that their notes are good by focusing on four areas in their documentation:
    a. Content, process, countertransference, and formulation.
    b. Legibility, credibility, legality, and security.
    c. Content, language, credibility, and access.
    d. Opinions, subjectivity, speculation, and hunches.

42. Lack of documentation about a client's treatment in his or her record:
    a. Protects the client by ensuring confidentiality.
    b. Protects the clinician from subpoena because there is nothing to present.
    c. Is acceptable if requested by the client in writing.
    d. Increases a practitioner's liability if he or she becomes involved in litigation.

43. The bio-psychosocial-spiritual assessment is the foundation of a clinical record. It describes multiple areas of the client's life, including the:
    a. Presenting problem in context, client strengths and limitations, and relevant history.
    b. Presenting problem, client's goals, treatment progress, expected length of treatment, and desired outcome.
    c. Referral source, collateral information, diagnostic impression, treatment approach, and expected duration of treatment.
    d. Process recording from the first session, collateral contacts, consulting practitioners, and former providers.

44. A good progress note substantiates that:
    a. The client and therapist have a strong therapeutic alliance.
    b. A client's history needs to be the focus of treatment.
    c. An encounter took place and details the type and effect of treatment.
    d. A therapist has the training and skills necessary to implement interventions.

45. The mother of a 13-year-old client texts the therapist, saying that the client is having a bad week. The mother had asked the child's pediatrician to prescribe medication, but the doctor wants to talk to the therapist first. State laws stipulate that only children 14 years old and older have confidentiality rights. The therapist should?
    a. Document the mother's text and text the pediatrician.
    b. Refuse to discuss the client's treatment, citing confidentiality.
    c. Text the mother back, stating that the therapist will not communicate via text.
    d. Document the text and get a signed release for the pediatrician from the mother and client.

46. A practitioner is seeing a woman for depression and anxiety symptoms. Between sessions, the practitioner receives a voice message from the woman's husband, who reports that the client is probably not telling the worker the "whole truth" and reveals that the client has a significant alcohol use problem. What should the practitioner do about documenting this information?
    a. Discuss the phone call with the client at her next session and then document the discussion.
    b. Nothing; the practitioner should ignore it both in the client's session and in the documentation.
    c. Keep notes about the information in the voicemail in a personal or shadow file.
    d. Immediately call the husband back and document the phone call in the file.

47. Documenting unnecessary information may breach client privacy. Which of the following is an example of unnecessary information?
    a. Specific non-clinical information about a client's family member.
    b. The details of the client's affective response to an intervention.
    c. The client's report of her symptoms.
    d. The client's medical history.

48. Information about a third party that is gratuitous, extraneous, or editorializing may be considered:
    a. The most important part of a client's record and necessary for good therapy.
    b. Defamation of character and grounds for litigation against a therapist.
    c. Necessary for a complete bio-psychosocial assessment.
    d. A breach of confidentiality only in the context of couples therapy.

49. Even if state law stipulates that clinical records must be retained for a specific time, clinicians might consider storing records indefinitely because?
    a. Different professions have different regulations.
    b. An injured party can file suit decades after alleged malpractice.
    c. The client may want to come back for service years later.
    d. Old records are often used for training novice practitioners.

50. The unethical and illegal process whereby an agency bills for a client session under a licensed practitioner's name even though the client was seen by another unlicensed provider is called:
    a. Subcontracting.
    b. Lending a license.
    c. Shadow counseling.
    d. Double dipping.

51. In an attempt to streamline record keeping in a fast-paced psychiatric inpatient unit, some clinicians providing group therapy will write one generic note and copy it to put in each patient's chart. This practice represents an ethical violation because the?
    a. Information about group therapy is unnecessary.
    b. Documentation is inaccurate and incomplete.
    c. Group members are often editorializing.
    d. Funding source may want more information.

52. A big risk of digital documentation is:
    a. The brevity necessitated by electronic health records.
    b. Using technology inappropriately.
    c. Confidentiality breaches.
    d. Lack of access for clients.

53. Henry provides administrative and clinical supervision to several mental health practitioners. Susan, one of Henry's supervisees, does great clinical work but is consistently late in documentation. She was placed on a performance improvement plan that did not yield positive results. During her performance review, Susan protests that she is bringing in the most revenue from clients and is known as one of the best clinicians in the agency. She doesn't understand how late documentation could be any more important than clinical effectiveness and bringing in money. Which of the following statements reflects the most appropriate response from Henry?
    a. Documentation is the most important component of her clinical work.
    b. She cannot get a bonus if she is unable to prove what she does.
    c. Insurance companies do not care about the quality of her clinical work.
    d. She is putting clients, the agency, and her own reputation at risk.

54. The concept of negative responsibility applied to documentation counsels that practitioners:
    a. Are responsible both for what they document and what they do not document.
    b. Are responsible for clients' negative reactions to what is written in their records.
    c. Should not document information that can be interpreted negatively.
    d. Have no liability for documenting their clinical opinions.

55. The concept of choice architecture can assist in determining what to document in a clinical record. This concept advises that a clinician:
    a. Expect error and manage the risk.
    b. Do nothing when in doubt.
    c. Leave it out when in doubt.
    d. Document as much as possible.

Course Code: SWUS03ET

Chapter 4: Professional Ethics and Law

4 Contact Hours

Release Date: May 11, 2022

Expiration Date: May 10, 2027

Upon successful completion of this course, continuing education hours will be awarded as follows:

- **Social Workers and Psychologists: 4 Hours**
- **Professional Counselors: 4 Hours**

Faculty

Author:

Simona Pozzetto, LICSW, was born and raised in Italy, where she obtained her bachelor's degree in Psychology. After moving to Massachusetts, Ms. Pozzetto achieved her MSW and completed the Certificate Program in Jewish Communal and Clinical Social Work at Simmons College and Hebrew College in 2003. Ms. Pozzetto worked in community mental health clinics and long-term care facilities as a clinical therapist, initially focusing on children and adolescents, then mostly on adults and the elderly. In 2014, Ms. Pozzetto obtained her LICSW, and after a few years in management, in 2020, opened a private practice. During her career, Ms. Pozzetto has specialized in trauma work, dissociative disorders, mood disorders, and end-of-life issues. In June 2021, Ms. Pozzetto obtained her Certified Grief Informed Professional (CGP) Certification.

Simona Pozzetto has no significant financial or other conflicts of interest pertaining to this course.

How to receive credit

- Read the entire course online or in print.
- Depending on your state requirements you will be asked to complete:
  - A mandatory test (a passing score of 75 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- Provide required personal information and payment information.
- Complete the mandatory Course Evaluation.
- Print your Certificate of Completion.

Disclosures

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Learning objectives

After completing this course, the learner will be able to:

- Understand the importance of professional values and ethics in mental health practice.
- Identify the role and the impact of law in mental health practice.
- Recognize and distinguish between problematic and non-problematic boundary issues in mental health practice.
- Describe ways mental health practitioners can prevent unethical or illegal behaviors in daily practice.
- Identify elements and conditions of informed consent.
- Understand the basic requirements of HIPAA and the Privacy Rule as it relates to practice.
- Understand the impact of genetics and technology on mental health practice and the unique responsibilities that are included.
- Identify a protocol for ethical decision making.

Course overview

In practicing a profession, three interrelated but distinct areas come into play: professional values, ethics, and the law. Although all three areas are related to one another, sometimes they can conflict with one another. Sometimes, also, values can conflict with other values, as can ethics. When ethics conflict, an ethical dilemma results.

When professional values conflict with professional ethics, the organized and generally agreed-upon framework of an ethical code is vital. When ethics and the law collide, it may be necessary to consult the relevant professional organization. The American Medical Association, for example, has become involved when the law required that a physician be present at an execution. The AMA code of ethics explicitly forbids physicians from participating in capital punishment (Henry, 2018).

This intermediate course is intended to provide healthcare professionals such as social workers with an overview of how professional values, ethics, and the law come into play in mental health practice.

PROFESSIONAL VALUES

Professional values are the "guiding beliefs and principles that influence your work behaviour" and that are "usually an extension of your personal values," and though your values may evolve over time, core beliefs should not (Birmingham Community Healthcare, n.d.). Examples of professional values are integrity, honesty, and a striving for social justice.

Although professional values are based on personal values, which are based on such factors as culture and ethnicity, they are also acquired over time – from professional experts, colleagues, the organization, and from actual situations in which an individual works. Values are also prioritized according to a person's surrounding culture and other factors (Poorchangizi, Farokhzadian, Abbaszadeh, Mirzaee, & Borhani, 2017).

Although professional values and ethics may overlap, they are not identical. An individual may feel that it is important to dress in a certain way that he or she regards as professional, even though his or her professional ethical code does not specifically cover this requirement. Professional values may even conflict with professional ethics, as might be the case when an individual believes in complete honesty and openness and a code of ethics emphasizes privacy and confidentiality (Reference.com, 2020).

Because professional values are based on personal values that have their roots in culture and background, it is important in mental health practice to be aware of "beliefs, assumptions and norms, and how these affect practice situations" (Bogg, 2010). Also, because professional values are so varied with individuals, a framework of professional ethics is important for the professional and the practitioner alike.

Ethics and mental health practice

Ethical issues are common in any profession. But mental health work, which relies heavily on relationship building and which can directly impact the health and welfare of its clients, poses even greater responsibilities and challenges.

Mental health practitioners must rely on internal ethical guides through character and integrity, and external ethical guides such as laws and codes of conduct. Consider these two examples:

***Mary**, a mental health counselor, provided counseling services at a community mental health center. Most of her clients did not have insurance nor could afford to pay privately anywhere else. After several years of post-graduate full-time practice, Mary felt competent providing services for most issues.*

After three sessions with one of her clients, her client confessed that he wanted a sex-change operation and would need Mary's support through the process. Mary had taken few graduate level courses in human sexuality and had no other specialized training in this specialized area. If there was another clinician available who specialized in gender reassignment issues, her client could not afford it.

Given her strong belief in client self-determination, the client's belief in her ability to assist, and her willingness to read the literature and consult the Internet on protocol, Mary agreed to revise their plan of treatment and proceed.

* * *

***Joaquin**, a Licensed Clinical Social Worker, and his client, a young man with schizophrenia, have successfully worked together to achieve stability in symptom management and independent living. Joaquin and his client are close in age, have many interests in common and consequently have achieved a strong rapport and mutual trust. Now Joaquin is transferring to a supervisory position, which will effectively end his professional relationship with the client. His client wishes to continue their relationship as friends and Joaquin is tempted to do so.*

In these two examples, each mental health practitioner demonstrates both a compassion for and commitment to their respective clients. They are at a crossroads in their relationship with their clients. When deciding what to do next, they must consider various issues that include what is in the best interest of the client and the client's right to self-determination.

Primary reason for action

What is easiest, most comfortable, and/or desired by these mental health practitioners should never be the primary reason for action. If the needs of the client versus mental health therapist were the only considerations, decision-making would be easy. However, the mental health worker must also consider the ethical guidelines established by various government agencies and national mental health professional associations, as well as the law.

In the first scenario, Mary must balance both her and her client's desire to continue what appears to be a comfortable and trusting therapeutic relationship with the need to provide the most effective service for the client. Clearly Mary is not qualified to provide the service this client needs. Is her plan for a crash course in transgendered treatment adequate? Should she make a referral to a more competent therapist? Should she work with the client to overcome the financial barriers he is facing?

If Mary makes the wrong decision, she might either violate ethical guidelines or the law, or both. She may be committing a medical error and putting her client at risk of harm. Her actions may also result in Mary being sued and/or censured.

Joaquin must ask himself the question, "Am I considering crossing the boundaries of our professional relationship for my own needs or for those of my client?" Clearly both Joaquin and his client value a friendship, but what potential harmful impact could this have on one or both of them?

Ethical decision-making is a complex process, requiring mental health practitioners to look at not just the immediate impact but also the long-term and future consequences of their actions.

Defining ethics

The word "ethics" is derived from both the Greek word "ethos," which means character, and the closely related concept of "morals" derives from the Latin word "mores," meaning customs. Ethics defines what is good for both society and the individual.

Complicating the concept of ethics is the situation of competing ethical theories. On the bright side is that various theories offer various solutions to ethical conundrums (National Health Service [NHS; Scotland], 2018). Some examples are:

- **Consequentialism**: Consequentialism in its most basic form is utilitarianism, in which the end justifies the means. The outcome is all that matters, and the best outcome is characterized as "the greatest good for the greatest number," a quotation often ascribed to the philosopher Jeremy Bentham.
- **Deontology**: This system of ethics, associated with the philosopher Immanuel Kant, values intentions and "focuses on rules, obligations and duties" (NHS, 2018). This ethical theory is rigid and can lead to judgmental or counterproductive behavior.
- **Virtue ethics**: This system relates to "the internalized moral characteristics, rational thought and practical wisdom of a virtuous person who possesses and lives the virtues" (NHS,

2018) The problem with virtue ethics is that it fails to offer clear guidance on how a virtuous person really would act.

- **Principlism**: This system is commonly used in healthcare and biomedical sciences and focuses on "four key ethical principles of autonomy, beneficence, non maleficence, and justice, which are shared by most ethical theories, and blends these with virtues and practical wisdom. This is an attempt to bring together the best elements of ethical theories which are compatible with most societal, individual or religious belief systems" (NHS, 2018; the principles mentioned above will be discussed later in the course).

In the United States, principlism forms the basis of all codes of ethics in the health professions today.

Though closely related, law and ethics do not necessarily have a reciprocal relationship. While the origins of law can often be based upon ethical principles, law does not prohibit many unethical behaviors. Likewise, adherence to certain ethical principles may challenge a mental health practitioner's ability to uphold the law.

For example, documenting that a service has occurred when it hasn't may be unethical but not subject to prosecution. Unfortunately, it may take high-profile adverse consequences of unethical behavior, such as the discovery that a child under protective custody has been missing for months, to create new laws that support ethical standards of behavior. For instance, the State of Florida made the falsification of documentation, e.g., visitations that never took place, illegal for people employed as child welfare workers.

Implications for practice

Ethical standards are, according to Reamer (2006), "created to help professionals identify ethical issues in practice and provide guidelines to determine what is ethically acceptable or unacceptable behavior." What makes mental health work unique is its focus on the person as well as its commitment to the well-being of society as a whole.

The social work profession adopted the first Code of Ethics for the social work profession in 1947. In 1960, following the formation of the National Association of Social Work, another code of ethics was drafted, with multiple revisions in the following years. Ethics have been developed for other national mental health licensing associations and boards that include among others, the American Association for Marriage and Family Therapy, the American Counseling Association, and the American Mental Health Association.

The American Association for Marriage and Family Therapy "strives to honor the public trust in marriage and family therapists by setting standards for ethical practice. … The ethical standards define professional expectations" that are enforced by their own Ethics Committee. In the preamble to its Code of Ethics, the American Counseling Association describes its mission as the use of "the profession and practice of counseling to promote respect for human dignity and diversity." And the primary mission of the National Association for Social Workers is to "enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty."

Being part of a professional association not only brings a wealth of knowledge and expertise to ethical issues but also certain rights and privileges for its members. But those benefits must not overshadow a mental health professionals commitment to promote ethical behavior on behalf of clients.

When an individual identifies with a mental health profession, he or she is pledging to practice in an ethical and responsible manner. In addition to allegiance to the professional ethics and standards of practice it promotes, the individual also has a duty to support the values, rules, laws, and customs of the society of which he or she remains a part.

THE THERAPEUTIC RELATIONSHIP

The relationship between the social worker and client sets the course for providing ethical treatment. Although many issues concerning this topic will be addressed throughout this course, the initial contact with the potential client sets the tone for treatment. For example, the first communication with the client can convey an atmosphere of support that sets the foundation for building trust.

Professionals must also carefully consider that when services begin, the professional relationship should proceed with cultural sensitivity. During the course of treatment, an effort must be made to revisit informed consent issues as the treatment plan evolves, as well as consult with other professionals to avoid the risk of potential ethical conflicts.

Professionals need to take reasonable steps to ensure that clients understand the implications of any diagnosis, assessments, treatment, methods, HIPAA (Health Insurance Portability and Accountability Act) precautions, fees, and billing arrangements.

Ethical dilemmas

Not every issue of ethics can be covered by published standards or by codes of ethics. Social workers may find themselves confused about whether a situation borders on an ethical violation because the issue may not be clearly defined by the code. There also may not be an obvious violation or the social worker may not know how to proceed. These situations represent ethical dilemmas that are likely to occur in every social work practice.

Barsky (2014) defines an ethical dilemma as a situation that creates some tension. He explains that in a true dilemma, there is no clear, single answer that satisfies all of the different ethical and legal imperatives that apply to the case.

This situation may occur when:

- There are two ethical standards or rules that conflict.
- There are conflicts between the values of the social worker and those of the client.
- A conflict occurs between the obligations to an agency, versus the obligations to a client.
- Conflicts may occur due to religious, cultural, or political beliefs.
- No clear answer is apparent to meet the obligations or the ethical and the legal directives of the profession.

One example of a common dilemma involves issues in decision making in end-of-life situations. An individual in an end-of-life stage may claim the right to terminate his or her own life. The laws vary concerning these issues throughout the United States.

As of July 2019, nine states and the District of Columbia recognized legal physician-assisted suicide. Most other states considered the act to be illegal, and a few had left the legality or illegality unclear (ProCon.org, 2019).

Some individuals may support this right; others believe the act would be committing suicide, and therefore wrong. Tensions develop between a social worker's religious beliefs and professional beliefs, as well as what that social worker would do if he or she were either "pro-life" or "pro- choice."

The tension in such an ethical dilemma may be seen as a conflict between the ethical concepts of beneficence and non maleficence. The idea of beneficence is to promote good, and for a suffering patient, death may appear as a mercy, sparing the individual from chronic pain or some other form of suffering.

Non maleficence is best characterized using the sentence "First, do no harm," which is often incorrectly ascribed to the Hippocratic Oath. Allowing a patient to commit suicide may be seen as bringing harm. (The principles of beneficence and non maleficence will be further discussed later in the course.) Also in play in this ethical dilemma is the concept of client self-determination. According to the NASW Code of Ethics (2017), "Social workers may be faced with complex ethical dilemmas that have no simple answers," and for many, physician-assisted suicide fits this characterization.

Another example of an issue that may lead to ethical dilemmas would be abortion. True dilemmas often involve issues that are controversial in our society as well. In these types of dilemmas, the cultural contexts of the community and the client are important factors to consider.

It is important to remember that although each principle in a professional code of ethics has its own merits, the principles do not stand alone. They complement one another but at the same time often conflict with one another when ethical dilemmas occur. An ethical dilemma is a situation in which no best course of action exists; the person must choose between at least two options that have advantages and disadvantages. To solve ethical dilemmas, it is essential to identify which principles apply, how they conflict, and which ones take priority in a given scenario. Practitioners must also consider professional obligations and standards of care. Although professional codes of ethics are based on principlism, a basic understanding of consequentialism, deontology, and even virtue ethics can help in working through an ethical dilemma.

THE LAW AND MENTAL HEALTH

Defining law

According to Saltzman & Furman (2016), law can be defined as those standards, principles, processes and rules – usually written down in some manner – that are adopted, administered, and enforced by governmental authority and that regulate behavior by setting forth what people may and may not do and how they may and may not do it. Simply put, law is a "pronouncement of the rules which should guide one's actions in society" (Gifis, 2016).

Reamer (2005) describes five distinct types of legal requirements and guidelines that may affect practice:

1. **Constitutional Law**: Examples include protection from unreasonable searches and rights of privacy and free speech.
2. **Statutory Law**: This includes laws enacted by federal, state, and local legislative bodies and covers such issues as confidentiality of records and obligations around suspected child or elder abuse.
3. **Regulatory Law**: These are legally enforced guidelines disseminated by government agencies such as the Department of Health and Human Services and Department of Justice.
4. **Court-Made Law and Common Law**: These result from court rulings, for example a recent court ruling in one state that prohibits child welfare workers from using office space for temporary sleeping accommodations for children removed from their homes.
5. **Executive Orders**: Chief governmental executives, such as mayors or governors, may issue orders that resemble regulations – examples being the State of Florida's governor Jeb Bush prohibiting a husband from terminating life support measures in the Terri Schiavo case, or, more recently, several executive orders issued by state governors concerning the coronavirus pandemic.

It is important to remember some of the basic differences between ethics and the law. Laws can change over time, will vary from state to state, and can be significantly influenced by politics and economic interests. Ethical standards, however, transcend all of these considerations. Legal duties are also often ethical duties, but ethical duties may not always be legal obligations. Although individuals may have an ethical obligation to obey the law, the law is often the lower standard even though ethics and the law may draw on the same sources of authority.

Ethics generally provides the foundation for laws, as can be seen in the example of informed consent. A patient's right to personal autonomy is the basis for the healthcare provider's legal obligation to obtain informed consent from patients before commencing treatment. Another example is the legal mandate to report suspected cases of child abuse and neglect. This law is anchored in the principle of beneficence.

Offenses against the law are either civil or criminal (Zarkowski & Roucka, 2015). An offense against a person or group for which some satisfaction is sought, usually in monetary form, is classified as civil. A criminal offense is a wrongful act against society, and criminal law is charged to protect the public as a whole against the harmful acts of others. Most healthcare issues that become legal issues are dealt with as civil offenses.

Civil law can be further broken down into two primary categories: *contract law* and *tort law*. A contract is an agreement between two or more consenting parties to perform or not perform a legal act for which there is sufficient consideration. ("Consideration" is a vital element in contract law; it is the benefit or value bargained for between the parties.) A "breach of contract" occurs if either party fails to comply with the terms of the agreement. Contracts can be expressed orally or in writing or implied by signs, inaction, or silence.

Examples of *professional* contractual responsibilities include:

- Being properly licensed and registered.
- Exercising reasonable skill and judgment in providing care.
- Referring when appropriate.
- Respecting clients' confidentiality.
- Practicing within the standard of care.

A *tort* is defined as an interference with another's right to enjoy his or her person, privacy, or property (Zarkowski & Roucka, 2015). Torts can be *intentional* or *unintentional*. Intentional torts involve an element of intent to cause harm and include such offenses as:

- Assault (threat of bodily harm).
- Battery (unauthorized touching).
- False imprisonment (unlawful restraint).
- Mental distress (purposeful cause of anguish).
- Defamation (damage to a person's reputation).
- Interference with property (damage to a person's property).
- Misrepresentation (incorrect or false representation).

Intentional tort offenses may include:

- Failure to get informed consent (battery).
- Promising a cure or other outcome that is not practically attainable (misrepresentation).
- A client making a derogatory statement about a social worker (defamation).

Unintentional torts include *negligence* (failure to act appropriately) and *malpractice* (acting inappropriately). Although an unintentional tort involves no intention to do harm, the following has taken place:

- A recognized legal duty or responsibility owed to the client was breached.
- The client was harmed, damaged, or injured.
- The breach of duty was the primary or proximate cause of the harm.

Both negligence and malpractice involve practicing below the standard of care.

For social workers, a focus on discussing civil liability is the concept of "duty" (NASW Assurance Services, 2015). Part of an expanded definition of duty requires therapists and their employers to "take affirmative steps to protect others."

The most common types of lawsuits against social workers involve incorrect treatment and sexual misconduct. Issues in other suits include client suicides, confidentiality breaches, and the loss of HIPAA-required data.

According to NASW Assurance Services (2015), in the case of a malpractice suit, the plaintiff's attorney needs to demonstrate five elements:

1. **Failure in legal duty**: It is important to have a written contract defining the scope of treatment and to maintain the professional relationship at all times.
2. **Failure to adhere to a standard of care**: The social worker must meet the average standard of care, and it is important to know the average standard of care in the social worker's jurisdiction, as well as the standard of care for social workers in general.
3. **Breach of duty**: A deviation in the standard of practice can occur when a social worker fails to do something or does something wrong.
4. **Damages**: Such damages as lost wages, wrongful death, and medical costs must be measurable and proven in court.
5. **Proximate cause**: A breach of duty that directly causes measurable harm and damages is the proximate cause.

It is important to bear in mind that the legal aspects of any ethical case should be examined but cannot be the sole consideration in the decision- making process. Providers need to know the law in their jurisdictions, strive to obey it, and always consider it. What is ethical is usually also legal but the converse may not always be true (Ozar & Sokol, 2002). Breaches of the law may constitute unethical behavior, but not necessarily in every situation. As the law and ethics intersect in any given case, the decision maker must look for common ground and points of opposition or intersection, then determine a course of action.

SOCIAL WORKERS IN THE COURTS

Barsky (2012) believes that many social workers who do not have regular contact with the courts in their practice are poorly prepared for court should they be called to testify on behalf of a client or for themselves. He offers the following suggestions from his book, *Clinicians in Court* (2012) for preparing throughout the practice of social work to manage future risks:

- Be sure all notes are "court ready," meaning they are complete, dated, accurate, organized, and contain facts, not opinions.
- Be sure to follow ethical guidelines for confidentiality and know the limits of confidentiality and privilege. Many social workers are practicing in a field that is protected with not just confidentiality, but privilege. "Privilege" is a concept that says the social worker cannot be compelled or required to go to court unless the client consents to his or her appearance in court. In many states, a licensed clinician cannot be required to testify unless the client gives permission.
- In some fields of practice, social workers are more likely to be called into court; it might be part of the work that they are doing. As a child protection worker, for example, the social worker needs to be aware that if an amicable agreement with clients is not possible, he or she might have to defend the case and his or her position in court. Or, when working in an area such as family law, there may be a lot of tension and anger between spouses during separation and divorce. Again, the social worker might be more likely to end up in court.
- Child custody evaluations may be required in an area of practice such as forensic social work. If the social worker interacts with attorneys on litigation cases, he or she should receive specialized training in certain areas and fields of practice in order to be more persuasive and credible when giving testimony in court.
- In a forensic role, the duty is to the legal system. Many social workers do not realize that when they have an obligation to the legal system, their role may be more complex. In a custody evaluation, for example, the therapist cannot provide therapy or counseling to the parents who are going through separation or divorce. And as a social worker, he or she is trained to put the well-being of the client first. This situation may result in tension for the therapist and for the client. The social worker's role as a witness is to help the court, meaning the judge or the jury.
- Social workers need to know the correct way to respond to a subpoena. If a social worker is unsure of how to proceed, he or she should contact a personal attorney or agency attorney for help. There are a number of different types of subpoenas. Some subpoenas are actually a court order compelling an appearance in court with legal consequences. In other cases, a subpoena is a request to appear and is initiated by an attorney for one party or the other; it may not be a valid subpoena and may be challenged.
- Social workers must remember that the client owns confidentiality and privilege and that when a social worker receives a subpoena he or she must let the client know. If the client gives consent to appear in court, then ordinarily the social worker should appear in court on the client's behalf; this honors the client's right to self-determination.
- If the social worker receives a subpoena from a lawyer that is not a court order, after the client gives permission, the lawyer might then contact the person requesting the subpoena. A conversation may be necessary to explain that a court appearance may not be the best option; the information that the social worker has may be second-hand and may not be as strong – or as useful to the court – as the attorney might think.
- If the client has given authority and consent for the social worker to release his or her records, the client may not fully understand that the entirety of his or her records may be released – not just the portions that the client feels are favorable to his or her case. When a client knows he or she cannot control which information or testimony will be given, the client may reconsider.
- Another possibility is to request a motion to quash, a motion to cancel, or a motion to veto the subpoena. This motion would usually be requested by the client, if the client has the means and the attorney to pursue the motion. A social worker might need to help the client locate a resource for information or funding for legal assistance. The agency (and sometimes even the professional association) may have an interest in advocacy for a certain case, so they may file the motion.
- If called to testify, it is important for the social worker to prepare for one of two types of examination: In a direct examination, the social worker is called as a witness for the case. This will include general open-ended questions from the attorney's perspective, geared toward the outcome that the attorney prefers (and most likely the one the social worker and client prefer). The lawyer will ask questions – guiding the testimony – because the information or opinions will support his or her case. The next type is the cross-examination. The other attorney will attempt to impugn the credibility, honesty, perception, memory, or accuracy of the witness testimony. He or she will attempt to create doubts in the minds of the judge or the jurors. In both cases, the objective is to be honest and open, as well as credible and persuasive. The cross-examination is more stressful, because the witness is being challenged. The witness may be called to explain any inconsistencies in written or spoken information.

- It is important to remember that no one is perfect and that there are times when a witness may be unsure. The social worker must be honest, and must slow down, take a deep breath, and use strategies to control stress and anxiety – and he or she must be aware of how body language may be perceived.
- When handling a tough question during cross-examination, the social worker should look the attorney in the eye and should not look at the client or the client's attorney. This behavior may be interpreted as looking for an answer from them. In situations of extreme stress, it may be possible to ask for a short bathroom break to regain composure.
- Social workers can practice skills and prepare in mock sessions before taking the stand, using role play and with legal professionals – preferably with the attorney who is involved in the case. One way to prepare is to actually observe cases that are similar; although child protection hearings are usually closed to the public, it may be possible to ask the court administrator to observe for professional purposes to prepare for testimony.
- Social workers need to be aware that a fact witness is there to provide facts only. An expert witness can be called upon to give opinions; an expert witness is selected by the court based on qualifications. Professional social workers must give testimony only that falls within their area of expertise.
- To avoid situations that may lead to legal proceedings, it is important to pay close attention to informed consent, open communication, and strategies that build trust and open communication with clients from the first session through the last. Social workers need to manage and respond to clients (without judgment) if they have an issue or grievance. Ethical practice dictates that social workers have the obligation never to abandon a client. They need to find out what the client really wants and find a way to resolve the conflict to save the relationship. Sound decision making and professional collaboration should be used to overcome any barriers. The client may simply want to feel as though he or she is being heard, need to know that his or her concerns are validated, and feel that he or she has some input into the personal therapeutic plan.

Impact of law on practice

Currently the United States, including all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, and other countries regulate some form of mental health practice. Many typically regulate practice through statutes, i.e., practice acts, that stipulate who may practice and/or call themselves mental health practitioners (Saltzman & Furman, 2016). State oversight boards give authority to practice to qualified individuals, typically defined by three competencies:

- Education,
- Experience, and a
- Passing score on an examination.

There are also laws that impose legal obligations to abide by practices that further serve to protect the consumer, such as federal and state statutes requiring mandatory child abuse reporting, practices that ensure client confidentiality, and competence to perform certain services.

When conflicts occur between a professional code of ethics and the law, Beaton (2018) advises that the practitioner must:

- Consider the best interest of the client.
- Consider the possibility of negotiating the situation to stay within the law to the greatest extent possible; otherwise, the social worker must consider whether he or she could defend his or her actions in court.
- Consult peers, the ethics board, risk management specialists, or an attorney.
- Be sure that his or her notes explain the decision-making process in detail.

The Association of Social Work Boards (ASWB) is a nonprofit organization composed of, and owned by, the social work regulatory boards and colleges of all 50 U.S. states, the District of Columbia, the U.S. Virgin Islands, Guam, Northern Mariana Islands, and all 10 Canadian provinces (ASWB, 2020). ASWB is dedicated to social work regulation. Its mission is to strengthen the protection of the public by providing support and services to its member boards, including the following:

- Owning and maintaining the social work licensing examinations that are used to test a social worker's competency to practice ethically and safely.
- Developing and maintaining a model practice act that offers regulatory bodies a resource for developing their own laws and regulations.
- Providing services, including the Council on Social Work Education (CSWE, 2015) program for approved continuing education, CE audit contract services, license application and issuance contract services, the Public Protection Database, and Look Up a License Database.
- Publishing a bimonthly electronic newsletter: *The Association News*.
- Partnering with CSWE-accredited schools of social work, to pilot an educational initiative, *Path to Licensure*, which was developed to strengthen student and faculty knowledge of professional regulation, as well as its important connection to public protection and social work values and ethics.

Unlike regulation under the law, adherence to regulations set forth by private credentialing bodies is voluntary. However, the regulations and codes of ethics are universally respected. Mental health professionals also practice in accordance with the professional standards of care established by private professional associations such as the ACA, NASW, and AAMFT.

ESTABLISHING ETHICAL CODES OF CONDUCT

In addition to professional affiliation codes of ethics (such as established within national professional associations), state licensing laws and licensing board regulations identify basic competencies for mental health practice. Failure to follow the ethical codes of one's profession may result in sanctions, fines, even expulsion from the profession, and can result, if sued, in a judgment against the practitioner.

For example, Strom-Gottfried (2000) reviewed 894 ethics cases filed with the NASW between July 1, 1986, and December 31, 1997. About 48% of the cases resulted in hearings, and of those, 62% concluded that violations had occurred, for a total of 781 different violations.

The study clustered those violations into ten categories:

- Violating boundaries.
- Poor practice.
- Competence.
- Record keeping.
- Honesty.
- Confidentiality.
- Informed consent.
- Collegial actions.
- Reimbursement.
- Conflicts of interest.

Of the 267 individuals found to have violated ethical standards, 26% were found to have violated only one ethics category, while 74% had violated between one and eleven categories. Most of the cases (55%) involved boundary violations such as those involving sexual relationships and dual relationships. Given the frequency of these violations (and, remember, this study only examined *reported* violations), we will be exploring these two violation types in more depth later. The findings reflected a variety of inappropriate behaviors that blurred the helping process and exploited clients, including:

- The use of physical contact in treatment.
- The pursuit of sexual activity with clients, either during or immediately after treatment.
- Social relationships.
- Business relationships, and
- Bartering.

Unintended actions

Some mental health professionals may argue that an action is ethical as long as you are not intending harm and/or are not knowingly violating an ethical standard or law. Or, what about those unique situations that don't readily lend themselves to a reference in law or codes of conduct? What defines prudent practice? Grappling with questions about what is unethical and what isn't ethical is a situation faced by any person in the helping professions.

Pope and Vasquez (2016) discuss the tendency to rationalize that an action is acceptable, as it relates to the practice of psychotherapy and counseling:

> This rationalization encompasses two principles:
> 1. Specific ignorance.
> 2. Specific literalization.

It is important to bear in mind that these two "principles" are in reality ethical fallacies used to justify unethical behavior (Pope, 2013).

Specific ignorance

The *principal* of *specific ignorance* states that even if there is a law prohibiting an action, what you do is not illegal as long as you are unaware of the law.

For example:

> *Allison worked with a client who suddenly moved to another state. While in crisis, her client called a mental health practitioner in the other state to make an appointment. This mental health practitioner phoned Allison to gain insight into her new referral. Allison was unwilling to divulge any information without a written release from her client, but the new therapist was adamant about acquiring the information immediately and threatened to report Allison to their national association. Allison assumed that, because her client was in crisis, she could share information. Allison was unaware of their association's ethics rules as they pertained to disclosure during crisis. She grudgingly shared confidential information because she felt her client was at risk.*

Literalization

The *principal of literalization* states that if we cannot find a specific mention of a particular incident anywhere in legal, ethical, or professional standards, it must be ethical.

For example:

> *Harry lived in a state that did not have an ethics board that specifically prohibited socializing with clients. Through Harry's church he often came into contact with his clients because they were referred to him by the church pastor. He felt comfortable socializing on a regular basis with his clients and their families, within and away from church.*

Assisting mental health practitioners in resolving ethical dilemmas that may arise in practice is just one of several purposes for establishing ethical codes of conduct.

Ethical standards of practice for mental health generally benefit both the practitioner and the public and include:

1. Identifying core values.
2. Establishing a set of specific ethical standards that should be used to guide mental health practice.
3. Identifying relevant considerations when professional obligations conflict or ethical uncertainties arise.
4. Providing ethical standards to which the general public can hold mental health professionals accountable.
5. Providing mental health ethical practice and standards orientation to practitioners new to the mental health field.
6. Articulating formal procedures to adjudicate ethics complaints filed against mental health practitioners.

INTERNAL ETHICAL GUIDES THAT DRIVE PRACTICE

Internal ethical values and morals play a large role in the overall conduct of a mental health practitioner. Character underlies ethical practice and bears some discussion.

Right character demonstrates a mental health professional's capacity to discriminate between a client's need and his or her own. In addition, best practice in mental health demands that thorough inquiry is utilized in order to effectively understand and advocate for clients.

In addition, utilizing good character in mental health practice also drives mental health practitioners to live authentically and demonstrate professional behavior. Good character pushes mental health professionals to constantly examine their own motives and intentions, and, when necessary, seek consultation. It is the ethical responsibility of every mental health practitioner to continue to seek professional growth and to examine personal and professional attitudes and behaviors.

Conversely, lack of character in mental health practice reflects rigid and restricted professional growth. In his book, *The Force of Character and the Lasting Life* (2000), James Hillman reflects that "bad character would refer to a person with little insight. … (This) is simply one who does not imagine who he is. In short an innocent. Innocence has no guiding governance but ignorance and denial."

Kitchener (1984) has identified five moral principles that are essential ethics guidelines. These are reflected in current revisions of the NASW and ASWB ethical standards. They include:

1. **Autonomy:** Addresses the concept of independence and the responsibility of a counselor to encourage clients, when appropriate, to make their own decisions and to act on their own values. Two important considerations in encouraging autonomy are: 1) Helping clients understand how their decisions and their values may or may not be received within the context of the society in which they live, and how they may impinge on the rights of others; and 2) the client's ability to make sound and rational decisions.
2. **Non maleficence:** Is the concept of not causing harm to others; it is often explained as, "First, do no harm."
3. **Beneficence:** Reflects the counselor's responsibility to contribute to the welfare of the client by doing good and being proactive, and also to prevent harm when possible.
4. **Justice:** Is treating everyone equally while responding to unique individual differences and needs. If an individual is to be treated differently, the social worker needs to be able to offer an appropriate rationale.
5. **Fidelity:** Involves the notions of loyalty, faithfulness and honoring commitments.

Note that in social work, "self-determination" is a term more likely to be used than "autonomy." In the NASW Code of Ethics, self-determination falls under Standard 1, Social Workers' Ethical Responsibilities to Clients.

> 1.02 Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

Often a sixth moral principle is added to the list: **veracity**, or **truthfulness**. In the past, veracity was often not listed as a virtue because it was considered kinder in some cases not to tell the truth, as when a medical patient was dying and a physician wanted to spare the individual from the harsh reality. However, it is now felt that telling the truth instills trust and shows respect (Amer, 2019). As with other ethical principles, however, veracity can find a place in an ethical dilemma. Sparing an individual from knowledge of a harsh reality can be seen as doing good for that person, or practicing beneficence. Usually, however, the importance of truthfulness is more straightforward. A social worker may not falsify records or inflate his or her résumé or fail to reveal a potential conflict of interest.

It has been said that the Greek philosopher Socrates considered ignorance to be like an arrow missing its target. If mental health practitioners believe that they are "walking a perfect path," they may begin to form habits that bypass thorough inquiry and perhaps miss the mark as it pertains to demonstrating best practice in mental health. They should also be willing to assume responsibility for their mistakes and misjudgments, without blaming others – even when this may place them in vulnerable legal positions.

Core values and ethical principles

Core values make up the basis on which members of an organization, profession, or other group work and conduct themselves. These values remain constant in spite of changes in the world. They do not describe specific behavior, but provide the foundation for that behavior (National Park Service, n.d.).

The core values espoused by mental health ethics codes incorporate a wide range of overlapping morals, values, and ethical principles that lay the foundation for the profession's unique duties. They generally include:

- Service.
- Autonomy – Allowing for Freedom of Choice and Action.
- Responsibility to Clients.
- Responsibility to the Profession.
- Responsibility to Social Justice.
- Responsibility for Doing No Harm.
- Dignity and Worth of the Person.
- Confidentiality.
- Importance of Human Relationships.
- Do Good and Be Proactive.
- Professional Competence.
- Integrity.
- Engagement with Appropriate Informational Activities.
- Treating People in Accordance with Their Relevant Differences.
- Responsibility to Students and Supervisees.
- Fidelity.
- Responsibility to Research Participants.
- Financial Arrangements That Conform to Accepted Professional Practices.

Depending on a particular mental health professional association's code of ethics, ethical professional practice can include:

- Helping people in need.
- Challenging social injustice.
- Respecting the inherent dignity and worth of the person.
- Recognizing the central importance of human relationships.
- Behaving in a trustworthy manner.
- Practicing within areas of competence and developing and enhancing professional expertise.

Some of the principles, such as responsibility to students and supervisees, are what mental health practitioners can aspire to, while others are much more prescriptive, clearly identifying enforceable standards of conduct (Reamer, 2006). For example, an aspirational principle is reflected in Standard 1.01 of the NASW Code of Ethics, making client well-being the most important priority, while an enforceable standard is Standard 1.03, requiring informed consent (Dayton, 2019).

Most ethics codes describe specific ethical standards relevant to six areas of professional functioning. These standards provide accepted standards of behavior for all mental health clinicians concerning ethical responsibilities:

- To clients.
- To colleagues.
- To practice settings.
- As professionals.
- To a particular mental health profession focus.
- To the broader society.

Further, professionals should take responsible steps before practicing interventions or approaches that are new to them or that are an emerging area of practice, with little to no generally recognized standards. Bogle & Coleman (2000) recommend the following strategies for gaining and maintaining professional and ethical competence:

- Learning should never stop. Research and use available education, training, consultation, and supervision opportunities to increase competence.
- Stay informed about the state of the profession through membership in national/ state organizations and the review of professional publications.
- Adhere to state licensing laws prior to service provision.

Overall, mental health practitioners can benefit from the following more specific yet practical recommendations:

- Take proactive responsibility for errors in judgment.
- Avoid blame.
- Manage time effectively.
- Acknowledge clients' time constraints.
- Check record keeping.
- Return phone messages in a timely manner.
- Avoid being late for sessions or meetings.
- Be dependable.
- Make outside resource information available to clients.

This course will continue to look at issues around each of these areas.

Ethical responsibilities to clients

This illustration highlights the complexity of ethical responsibility to clients:

> *A depressed 80-year-old client, suffering from the painful, debilitating effects of arthritis, asks Rene, his mental health therapist, for information on assisted suicide. He tells her that he only needs help downloading information from the Internet and then it is his right to weigh the options of proceeding. Rene believes the client's depression is directly related to the pain, because the client is otherwise of sound mind, and therefore has a right to determine his future.*

Commitment

Client interests are primary. The example above epitomizes the difficulties often faced by mental health practitioners when the principles of law, personal belief, professional codes of ethics, client need, and cultural and societal norms intersect and at times contradict one another. The professional is then faced with a conundrum that offers a multitude of potential decisions, actions, and consequences. We will discuss more about how the worker can best weigh all these considerations to make the most ethical decision later in this course.

Self-determination

Another standard that strongly reflects the mental health practitioner's commitment to a client is that of self-determination. Professionals have an obligation to support and assist clients in accomplishing their goals, only deviating from this standard when a client's goal puts them or others imminently at risk.

Defining risk can be difficult; most mental health professionals cannot argue that suicide or homicide fail to present clear risk to the client or to others. Other client choices such as staying in an abusive relationship or living in squalor or on the streets may challenge a professional's personal values and sincere desire to protect – also known as "professional paternalism" (Reamer, 2006). In the absence of clear and present harm, the client has a right to choose his or her own path and make his or her own decisions, whether we agree or disagree.

Suicide: Right to choose vs. duty to protect

Sometimes a mental health practitioner may be faced with a choice between a client's right to choose suicide and the duty to protect his or her life. The request by the emotionally stable and rational terminally ill client is a good example of a situation that is not as "cut-and-dried" as that involving a severely depressed young woman contemplating suicide.

Would one client deserve individual consideration and thus not be assessed for possible hospitalization over the other? Most workers choose this profession because it supports respect for the strengths and abilities of clients, and thus their ability to learn, make good decisions, and be self-sufficient. But aside from laws prohibiting assisted suicides, workers also rely on intuition and judgment in determining whether to take action to protect a client from harm. This scenario blurs the line between respect for the client's wishes and society's obligation to protect. It also raises the issue of client autonomy versus the professional obligation to prevent discrimination. Thus it is essential that mental health practitioners establish clear procedures that ensure impartial assessment while valuing client autonomy and individual treatment.

Since laws and professional codes of ethics are not always clear and do not always spell out our specific duties and responsibilities, it is recommended that workers not only do everything to assist clients in taking advantage of any options to alleviate their distress, but also rely on practice guidelines that call for:

- Careful evaluation, such as the client's ability to make rational choices based on their medical and mental state and social situation.
- A good therapeutic alliance, and
- Consultation.

A controversial issue is the Duty to Protect, or the Duty to Warn. It addresses the degree of action that a professional – including social workers – must take if a client informs the practitioner that he or she has a plan to harm someone else, and the duty to warn that individual. Laws vary throughout the 50 states.

In California, the case of *Tarasoff v. Regents of the University of California* became a legal milestone in 1974, when the state's Supreme Court ruled that mental health professionals have a duty to warn potential victims. Tatiana Tarasoff was murdered by a stalker, who had been consulting a psychologist at the Cowell Memorial Hospital, which was associated with the University of California at Berkeley. In the stalker's final session before breaking off therapy, he announced that he intended to kill Ms. Tarasoff. Although the psychologist alerted the police that the client should be hospitalized, the police released him after he promised to stay away from the young woman. The psychologist's supervisor ordered that the psychologist make no further attempts to detain the client, and nobody warned Ms. Tarasoff of the threats. The victim's parents sued the psychologist and the University.

The case, and a subsequent case in 2001, codified what had already been an ethical mandate for mental health professionals. For example, in the NASW Code of Ethics, Standard 1.07(c) allows disclosure of information when such disclosure "is necessary to prevent serious, foreseeable, and imminent harm to a client of others." (However, the Standard also instructs that only directly relevant information be disclosed.) In 1976, the *Tarasoff v. Regents* case was amended to add the duty to protect (GoodTherapy.com, 2015).

INFORMED CONSENT

Informed consent is a surprisingly recent ethical and legal requirement. Even after the mid-20th-century trials that showcased Nazi human experimentation, test subjects were often unaware that they were involved in experiments. This happened in spite of the publication of the Nuremberg Code in 1947, which mandated that "the voluntary consent of the human subject is absolutely essential" (National Institutes of Health, n.d.). Many people have heard of the Tuskegee syphilis study (the Tuskegee Study of Untreated Syphilis in the Negro Male; Tuskegee University, 2020), which continued until 1972, denying its African-American subjects treatment for syphilis even after use of penicillin became widespread (McVean, 2019; Nix, 2019). However, the Department of Energy was conducting radiation experiments on Americans into the 1980s (Resnick, 2020).

The term "informed consent" originated in a 1957 judge's ruling related to a surgeon who had not been forthcoming concerning the hazards of a surgical procedure that left a plaintiff paralyzed (Skloot, 2010).

Mainly in response to the Tuskegee study, Congress passed the National Research Act for the Protection of Human Subjects of Biomedical and Behavioral Research, which was signed into law in 1974 (Department of Health, Education, and Welfare, 1979). In 1976 a government-appointed commission met at the Belmont Conference Center near Washington, D.C., where they produced what became known as the Belmont Report (Kirsh, 2019).

The report referred back to the Nuremberg Code and addressed the problem of separating practice from research. The distinction had become blurred, with poorly defined "experimental" practices taking place. The commission concluded that:

> Research and practice may be carried out together when research is designed to evaluate the safety and efficacy of a therapy. This need not cause any confusion regarding whether or not the activity requires review; the general rule is that if there is any element of research in an activity, that activity should undergo review for the protection of human subjects. (Department of Health, Education, and Welfare, 1979)

The commission had decided that human research needed to follow three ethical principles:

- **Respect for persons**: This principle aligns with the ethical principle of autonomy, and the related principle of self-determination that is so important in social work ethics. But, as with other ethical principles, dilemmas arrive. The capacity for self-determination matures during an individual's life, and some individuals lose this capacity wholly or in part because of illness, mental disability, or circumstances that severely restrict liberty. Respect for the immature and the incapacitated may require protecting them as they mature or while they are incapacitated.

- **Beneficence**: In the report, the commission seems to conflate the ethical principle of non maleficence (do no harm) with the classification of beneficence. However, this conflation, which seems strange to contemporary professionals who work within lengthy ethical codes, serves to illustrate that even in the middle to late twentieth century the idea of carefully codifying ethical research and practice was fairly new. In any case, the report points out an ethical dilemma that would now be recognized as an attempt to balance beneficence with non maleficence:

  > Learning what will in fact benefit may require exposing persons to risk. The problem posed by these imperatives is to decide when it is justifiable to seek certain benefits despite the risks involved, and when the benefits should be foregone because of the risks.

  It is easy to see how such an ethical dilemma can arise during a public health crisis, for example, when the need for new vaccines and therapies might cause debates over possibly fast-tracking some medicines (Maschke & Gusmano, 2020).
- **Justice**: The report addresses problems that are always present, but that can become magnified during a health emergency:

  > It can be seen how conceptions of justice are relevant to research involving human subjects. For example, the selection of research subjects needs to be scrutinized in order to determine whether some classes (e.g., welfare patients, particular racial and ethnic minorities, or persons confined to institutions) are being systematically selected simply because of their easy availability, their compromised position, or their manipulability, rather than for reasons directly related to the problem being studied. Finally, whenever research supported by public funds leads to the development of therapeutic devices and procedures, justice demands both that these not provide advantages only to those who can afford them and that such research should not unduly involve persons from groups unlikely to be among the beneficiaries of subsequent applications of the research.

The Belmont Report remains an important basic document in human research, and is especially important as it relates to informed consent, which according to the report requires information, comprehension, and "voluntariness." However, informed consent is an important concept not just in research and experimentation but also in the provision of services. In the NASW Code of Ethics, informed consent falls within Standard 1, Social Workers' Ethical Responsibilities to Clients. Standard 1.01, Commitment to Clients, and Standard 1.02, Self-Determination, both figure in the concept of informed consent, and the first sentence under Standard 1.03(a), reads, "Social workers should provide services only in the context of a professional relationship based, when appropriate, on valid informed consent."

Informed consent services should only be provided when valid informed consent can be obtained. Therefore, clients must know the exceptions to self-determination before consenting to treatment or other services. Mental health professionals working in child welfare or forensic practice settings are faced with additional challenges. In their article about informed consent in court-ordered practice, Regehr and Antle (1997) state:

> Informed consent is a legal construct that is intended to ensure that individuals entering a process of investigation or treatment have adequate information to fully assess whether they wish to participate. This concept of informed consent is closely linked with the value of self-determination.

Generally, potential threats and factors to be considered in insuring the validity of informed consent are:

- Language and comprehension.
- Capacity for decision making.
- Limits of service refusal by involuntary clients (including court-mandated clients).
- Limitations and risks associated with electronic media services.
- Audio and video taping.

An informed consent has been called the "quintessential document" in the provision of mental health services (Bradshaw, Donohue, & Wilks, 2014). In addition to being one of the first documents to comprise a record, it is one of the best risk-management tools. Informed consent in today's healthcare milieu demands details not previously considered, including potential benefits and risks of engaging in treatment, the nuances of technology use, limitations on confidentiality, and mandated reporting.

Competence (or professional and ethical competence)

Another issue that relates to informed consent, **competence**, is mental health professionals' responsibility to represent themselves and to practice only within the boundaries of their education, experience, training, license or certification, and level of supervisory or consultant support. For example, poor practice, or the failure of a worker to provide services within accepted standards, was the second most common form of violation found in Strom-Gottfried's study of code violation allegations resulting in findings of ethical misconduct in social work practice (2000).

The study also revealed findings of incompetence in conjunction with other forms of unethical behavior in 21% of the cases. In these cases, reasons that a social worker was not competent to deliver services included:

- Personal impairments.
- Lack of adequate knowledge or preparation, or
- Lack of needed supervision.

Ingrao (2015) outlined five generally agreed-upon core competencies of social work practice:

- **Practicing with professionalism**: Every social worker is a representative of the profession, and for this reason all social workers should know the history of social work and commit themselves to the conduct and growth of the profession. They should advocate for access to social work services and constantly reflect on their work and ways to improve. They should be aware of professional roles and boundaries, make use of supervision and consultation, and keep learning. It is also important that social workers maintain a professional demeanor.
- **Practicing ethically**: Practicing in an ethical manner involves education in and an understanding of ethics and a willingness to tolerate the ambiguity encountered in ethical dilemmas. Social workers need to use ethical reasoning to come to principled decisions.
- **Using critical thinking and professional judgment**: Social workers need to use evidence-based knowledge and good sense, and they need to be able to communicate well.
- **Embracing diversity**: Social workers need to be aware of the effects of the surrounding culture on individuals, be it oppression and marginalization or privileging and empowering. They need also to be aware of their own biases and preconceptions.
- **Advancing human rights and socioeconomic justice**: Social workers must understand the inequities and work to improve social and economic justice.

Concerning the core concept of practicing with professionalism, it is important to note that professionalism, though it is in many ways intertwined with ethics, does not have exactly the same meaning. Ethical principles lay the foundation for ethical practice, but the principles in and of themselves mean nothing unless the professional honors them.

Professionalism is sometimes hard to define, but it is recognizable. To be a professional implies practicing one's lifework at a higher level. The relationships among social workers, clients, and society are based on trust. Clients and society trust that social workers will behave in the best interest of their clients at all times, and that they will stay abreast of the latest developments in their profession and in the technology that has become such an integral part of communication and documentation.

ETHICS IN CULTURAL COMPETENCE AND SOCIAL DIVERSITY

Cultural competence and social diversity in mental health practice recognizes that mental health professionals provide services that are sensitive to each client's culture. Demonstrating ethical cultural competence includes:

- Being knowledgeable about culture and its impact on human behavior.
- Recognizing and appreciating the strengths found in cultures.
- Considering the nature of social diversity and oppression.

According to the U.S. Department of Health and Human Services (2015), cultural competence, in general, is defined as:

> The ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths or religions in a manner that recognizes, affirms, and values the worth of individuals, families, tribes and communities, and protects and preserves the dignity of each.

Due to societal and cultural changes occurring in the 21st century, understanding cultural competence is an ongoing learning process and a vehicle to broaden knowledge and understanding about individuals and communities.

Mental health practitioners should understand five elements of cultural competence that include:

- Valuing diversity cross-culturally in behaviors, practices, policies, attitudes, and structures.
- Conducting cultural self-assessment to assess for personal and professional proficiency in cultural competence.
- Managing the dynamics of difference within natural, formal, or informal support and helping networks within clinical settings.
- Acquiring and integrating cultural knowledge by seeking out information and consultation and practice application.
- Adapting to diversity and cultural contexts that include policies, structures, values, and services.

Defining linguistic competence

According to the National Center for Cultural Competence (2020), linguistic competence is defined as:

> The capacity … to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing.

In positive culturally competent communication climates, trust is established and reaffirmed, allowing freedom to explore sensitive issues and express disagreements. Positive talk climates are:

- Descriptive.
- Oriented toward problems.
- Spontaneous.
- Empathic.
- Express equality.
- Provisional.

Richardson and Molinaro (1996) suggested that self-awareness be a prerequisite for multicultural competence. Self-awareness often develops from personal and professional socializations to divergent cultural experiences (Helms & Cook, 1999). When this self-awareness is integrated into clinical roles, mental health professionals are likely to develop complex perspectives on cultural influences on their roles.

Common errors in demonstrating cultural competence

Demonstrating ethical behavior in cultural competency can be somewhat confusing for mental health practitioners, depending on their regional, cultural, and linguistic orientation. However, common errors demonstrated by often well meaning professionals include:

- Unintentional racism.
- Miscommunication.
- Lack of personal awareness.
- Insensitivity to nonverbal cues.
- Lapse in discussion of racial/ethnic issues.
- Gender bias.
- Overemphasis of cultural explanations for psychological difficulties.
- Lapse in including appropriate questions within the context of acquiring background information.
- Inability to appropriately present questions that elicit valuable information or feedback.
- Non participation in multicultural activities that facilitate cultural awareness that would include interactions among people of similar and different racial identities.
- Little or no processing of cultural difference in supervision.
- Inability to identify multiple hypotheses and integrate this information in a culturally competent manner into a client's presenting problem.

A lack of cultural awareness can manifest as "microaggressions," which are a form of often unconscious racist behavior. Examples of microaggressions are complimenting a U.S.-born Asian American person's English or "over-identifying" by asserting that as a woman one understands the oppression suffered by African Americans. It is often assumed of African American women that they are "strong" (Williams, 2013). It is important to reflect on one's own assumptions and biases. Although microaggressions are common and may seem mild to those not on the receiving end, research shows that an accumulation of microaggressions can harm mental and physical health. When the microaggressions come from healthcare and service providers, they can erode trust in the system (Torino, 2017).

Recommendations to promote ethical cultural competence were developed by the Georgetown University National Center for Cultural Competence (2009). Mental health practitioners can use these recommendations to promote ethical practice in cultural competence through the following:

- Display materials that reflect cultures and ethnic backgrounds of clients within your practice.
- Printed materials in your reception area are of interest to and reflect cultures of people served.
- Treatment aids such as play therapy and games reflect cultures of people served.
- Attempt to learn and use key words in client's language.
- Attempt to determine familial colloquialisms that impact assessment and treatment.
- Use visual aids, gestures, and physical prompts when appropriate with clients who are limited in English proficiency.
- Utilize bilingual colleagues or trained and certified interpreters to assist you with assessment and treatment.
- Try to ensure that all written communication, including consent forms, are written in client's first language.
- Screen books before sharing them with clients.
- Recognize that clients have varying degrees for acculturation.

- Understand that meaning or value of medical treatment, health care, and health education varies in clients.
- Understand that beliefs and concepts of emotional well-being vary from culture to culture.
- Understand that mental health and emotional disability are culturally based and that responses to these conditions are influenced by culture as well.
- Recognize that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with physical/emotional disability or special health care needs.
- Understand that traditional approaches to disciplining children are influenced by culture.
- Understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self-help skills.
- Accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.
- Before providing in-home mental health services, seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by you.
- Acquire information during intake and/or assessment about natural helpers that may assist you, with informed consent, in providing services.

CONFLICTS OF INTEREST

One of the most difficult areas of responsibility to clients is conflict of interest. Workers need to avoid conflicts of interest that interfere with the exercise of:

- Professional discretion, and
- Impartial judgment.

The issue of informed consent should include both prescribing the need to inform clients of potential or actual conflicts and taking reasonable steps to resolve any conflict in a way that protects the client's needs and interests.

Dual or multiple relationships

Dual or multiple relationships occur when mental health professionals relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.

Dual or multiple relationships with current or former clients should be avoided whenever possible, and the exploitation of clients for personal, religious, political, or business interests should never occur.

Further, workers should not engage in dual or multiple relationships with clients or former clients where there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable, workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries.

Recognizing that there are many contexts within which mental health work is practiced, dual relationships are not always entirely banned by different professional association ethical codes. The word "should" in sections where dual or multiple roles are outlined within various codes of ethics implies that there is room for exceptions. However, what they are usually distinguishing is that dual relationships are not permitted *when there is risk of exploitation or harm*. Not banning all dual relationships puts the burden on each worker both of determining and, if needed, proving that the relationship was not harmful to the client.

Boundary violations

Conflicts of interest relate closely to other types of unprofessional behavior, such as "boundary violations," a term that more specifically identifies harmful dual relationships. Most mental health professionals can easily recognize and identify common boundary issues presented by their clients.

Likewise, most can identify examples of boundary violations around professional behavior – for example, sexual misconduct. While not exclusive to the clinical role, there are certain situations that are more challenging than others, especially for workers vulnerable to committing boundary violations.

Boundary issues involve circumstances in which there are actual or potential conflicts between workers' professional duties and their social, sexual, religious, or business relationships. These are some of the most challenging issues faced in the mental health profession and typically involve conflicts of interest that occur when a worker assumes a second role with one or more clients. Such conflicts of interest may involve relationships with:

- Current clients.
- Former clients.
- Colleagues.
- Supervisees and students.

With that in mind, the following would be examples of inappropriate boundary violations, and thus unethical, in that workers are involved in a dual relationship that is exploitative, manipulative, deceptive, or coercive in nature:

- Buying property from a disaster client at far below its market level.
- Falsely testifying to support fraudulent actions of clients.
- Imposing religious beliefs on a client.
- Suggesting that a hospice client make you executor of his/her will.
- Referring a client to your brother-in-law, the stockbroker.
- Friendship with the spouse of a client you are treating for marital issues.

Five conceptual categories with regard to boundary violations generally occur around five central themes:

1. **Intimate relationships**: These relationships include physical contact, sexual relations, and gestures such as gift giving, friendship, and affectionate communication.

   For example:
   Amanda didn't think much about a client's thank-you bouquet, until a week later, at their session, he confessed his strong romantic affection for her.

2. **Pursuit of personal benefit**: The various forms this may take include monetary gain and receiving goods and services or useful information.

   For example:
   Lawrence was surprised to learn that one of his colleagues was receiving stock tips from one of his clients, who ran a very successful brokerage firm.

3. **Emotional and dependency needs**: The continuum of boundary violations ranges from subtle to glaring and arises from social workers' need to satisfy their emotional needs.

   For example:
   Jeff thought of himself as a father figure to his clients, and encouraged them to contact him at any hour of the day, including during his vacations.

4. **Altruistically motivated gestures**: These arise out of a mental health practitioner's desire to be helpful.

   For example:
   Sandra felt compelled to give a newly sober client a small loan after the client cried that she didn't have enough money to feed her children. After Sandra gave her the cash, the client purchased alcohol and got drunk.

5. **Responses to unanticipated circumstances**: Unplanned situations over which the social worker has little or no control.

   For example:
   Jake was uncomfortable when his mother was admitted to the same mental health hospital where he was on staff.

Intimate relationships

As discussed earlier, boundary issues involving intimate relationships are the most common violations. Those involving sexual misconduct are clearly prohibited and will be further explored in this course.

While most professionals might agree that having other, non-sexual, relationships, such as a friendship with a current clinical client is inappropriate, the rules are not as clear regarding ex-clients and even less so for those clients in case management, community action, or other non-clinical relationships.

When a dual relationship results in personal benefit to the practitioner, it also undermines the trusting relationship. Some of the scenarios mentioned earlier (getting property below market value, becoming the executor of the client's will, and referring clients to a relative) are examples.

There are very respectful, sound, and appropriate reasons for encouraging clients to share what they know and to listen to their strengths. Benefiting from information the client has (e.g., stock tips and leads on jobs) is another matter. It is important to remember that this can apply both ways, i.e., the mental health professional needs to avoid offering assistance in areas outside his or her role.

According to Reid, 1999:

> Your usefulness to your patients lies in your clinical skills and separation of your professional role from other roles which would be better filled elsewhere in their lives. Do not suggest, recommend, or even inform the patient about such things as investments, and be cautious about giving direct advice on such topics as employment and relationships. There is a difference between eliciting thoughts and feelings to encourage good decision making and inappropriately influencing those decisions.

Another tricky area involves bartering arrangements, particularly involving the exchange of services. These should be considered carefully and, according to Reamer (2003), limited to the following circumstances when they are:

- An accepted practice among community professionals.
- Essential to service provision.
- Negotiated without coercion.
- Entered into at the client's initiative, and
- Done with the client's informed consent.

Again, the professional is in the unenviable position of determining whether an action presents the possibility of psychological harm to the client. Kissing on the cheek, for example, may be perfectly correct, and clearly non-sexual, in certain cultures and contexts, but may confuse or intimidate a client in other contexts.

Another area fraught with peril is when workers engage in behavior arising from their own emotional needs. Most mental health practitioners are more familiar with examples of intentional and even more egregious examples such as the practitioner who uses undue influence to "convert" the client or takes sides in a custody case in order to foster a relationship with one of the spouses.

Many times boundaries are crossed unintentionally, as when a practitioner becomes overly involved in a case with which she personally identifies. Or the worker may be experiencing life issues that make him or her more vulnerable to the attentions of a client.

Mental health professionals have a responsibility to maintain competence in both the professional and emotional arenas. Regardless of the circumstances, the worker's first responsibility is always to the client.

There are also times when the intent of the professional is truly to be helpful – for example, buying merchandise from a client whose business is struggling or inviting a divorce recovery group client to a community function in order to help her broaden her social network.

While some types of situations may not be considered unethical or illegal, the worker needs to carefully review his or her motivation and the potential consequences of each decision. Some helpful questions to ask are:

- Would I do this for all my clients?
- Am I doing this because I feel uncomfortable (e.g., saying no)?
- Am I feeling at a loss to help the client any other way and thus feeling "I must do something" to feel competent?
- How might the client interpret my gesture?
- Am I doing this just for the client's interest or also for my own interest?
- What are all the potential negative outcomes?

There will be occasions when you incidentally come into contact with a client, such as finding your client's daughter is on the same soccer team as your child. Some practitioners go out of their way to live in a different community so the chances are minimal that this could happen. Others see that as over managing a potential situation that is unlikely to lead to harm for the client or colleague (as in the case of supervisees).

The appropriateness of relationships with clients is often debated across the profession. The unique service settings and roles assumed by workers often contrast with the traditional clinical approach to human service. Applying strict rules around relationships can appear excessive and/or contradictory with sound mental health practice. A worker, for example, may work in a small, isolated community that would expect its community members to share in social customs such as family meals and weddings.

Ethical guidelines recommend giving students and supervisees guidelines to guarantee client protection instead of blanket advice to avoid dual relationships altogether (Boland-Prom & Anderson, 2005).

Freud and Krug (2002b) also feel that "overcorrecting a problem, as is a frequent tendency in our society, sometimes escalates the very transgressions against which the new rules are to protect us." While necessary and healthy debate continues, practitioners must, no matter what their scope of practice, seek guidance and input from a variety of sources to make good decisions around boundary issues.

There are some areas where clear rules about dual relationships are essential and include:

1. **Protection of the therapeutic process**: In the context of current clinical practice, "even minor boundary trespasses can create unwarranted expectations." Transference and countertransference issues are present and cannot be underestimated. According to Freud and Krug (2002b), "The mystique of the tightly boundaried, hierarchical therapeutic relationship heightens transference phenomena."

   For example:
   Mark, a mental health counselor, suspected that his therapeutic alliance with a depressed young woman had turned a corner when she reported feeling less hopeless and more energized. She gratefully acknowledged his assistance and stated that she was planning to return to college and become a therapist. Mark was careful to point out that it was his client's own work that facilitated her recovery.

2. **Client protection from exploitation**: A clinician may be tempted to meet personal sexual, financial, or social needs with persons who may be particularly vulnerable to exploitation. Ethical guidelines serve to protect clients from exploitation.

   For example:
   Jeff, a psychiatrist, received a referral for a patient who was severely depressed. Most of his patients were fairly wealthy and Jeff was impressed that his new patient had a good deal of money as well. As time went by, he insisted that the patient continue daily sessions, even though the man was clearly improving and no longer needed intense intervention.
3. **Protection from potential legal liability**: Workers are concerned about legal liability, and careful adherence to the boundary specifications may protect clinicians from malpractice suits.

   For example:
   Kim, a new clinical social worker, was interested in practicing "progressive" forms of therapy. One practice she'd adopted emphasized focusing on empowerment issues for survivors of incest. Kim demonstrated a lapse in judgment when she encouraged a vulnerable young client to confront a relative regarding retrieved sexual assault memories, even though the client herself was not sure the memory reflected an actual event.

Ultimately, it is the mental health professional's responsibility to establish appropriate and clear boundaries for clients; doing so often prevents issues from surfacing in the first place. The worker must not underestimate the importance of expectations; respecting the client means together creating a safe relationship where boundaries and expectations are unambiguous and openly discussed.

To further minimize possible harm to all parties – the client, the worker, the employer, etc. – the following risk management protocols to address boundary issues are suggested:

1. Be alert to potential or actual conflicts of interest.
2. Inform clients and colleagues about potential or actual conflicts of interest; explore reasonable remedies.
3. Consult colleagues and supervisors and relevant professional literature, regulations, policies, and ethical standards to identify pertinent boundary issues and constructive options.
4. Design a plan of action that addresses the boundary issues and protects the parties involved to the greatest extent possible.
5. Document all discussions, consultation, supervision, and other steps taken to address boundary issues.
6. Develop a strategy to monitor implementation of an action plan (with clients, colleagues, supervisors, and lawyers).

Sexual Relationships, Physical Contact, Sexual Harassment, and Derogatory Language

Ethical mental health practice limits sexual relationships with clients, former clients, and others close to the client; physical contact where there harassment; and the use of derogatory language in written and verbal communication to or about clients.

Sexual harassment

In1980 the EEOC (Equal Employment Opportunity Commission), the agency that enforces Title VII, first defined sexual harassment as a form of sex-based discrimination and issued guidelines interpreting the law. These guidelines define unlawful sexual harassment as:

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature, when:

- Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment.
- Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, or
- Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

In mental health practice, sexual harassment can take many forms, including offensive or derogatory comments, sexually oriented jokes, requests or demands for sexual favors, leering, visual displays depicting sexual imagery, innuendos, pinching, fondling, and impeding someone's egress. Workers should not sexually harass supervisees, students, trainees, or colleagues.

Sexual misconduct

Some states also have laws making sexual misconduct subject to lawsuits and even arrest. Practitioners need to be sure about the rules that apply to them and must be aware of how their behavior may be perceived by others. For example, Reid (1999) points out that in most situations consent will not be an effective defense against sexual misconduct allegations. The reasons Reid gives for a client's ability to consent being called into question are:

- The fiduciary trust between clinician and patient.
- Exploitation of transference feelings.
- The right of the patient to expect clinical needs to be the overriding priority.
- Exploitation of the patient's purported inability to resist the therapist's influence.
- The alleged "power differential" between any patient and his or her clinician.

Recorded history of sexual misconduct travels back to the 4th and 5th centuries B.C. and includes the Hippocratic Oath that states, "I will abstain from intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free."

In contrast, Sigmund Freud flagrantly demonstrated sexual misconduct when he excused such behavior by his male colleagues.

For example, Carl Jung, according to historians, became sexually involved with one of his patients by the name of Sabina Spielrein, a 19-year- old medical student. When corresponding with Freud, he stated, "the continued preservation of the relationship (with Sabina) could be rounded out only by sexual acts." As Jung became more desperate when the affair became known he was reassured by his colleague, Freud. Freud wrote to his friend not to blame himself and stated, "It was not your doing but hers" (McGuire, 1988).

Kenneth S. Pope has written extensively on sexual behavior between mental health professionals and their clients. He asserts that sexually abusive psychotherapists are well represented in the mental health profession. As a matter of fact, as Jung's letters to Freud make clear, there is nothing new about sexual contact between mental health practitioners and their clients.

Assalian and Ravart (2003) have identified two types of sexually offending professionals. They are described as **affective** or **predatory**. Affective offenders tend to have unresolved emotional problems and may engage in counter-transference, be depressed, or have substance abuse issues. They may have underlying and unresolved abandonment issues.

Predatory offenders tend to have personality disorders that include narcissistic, borderline, or psychopathic features. Predatory offenders have integrated their behaviors to use and exploit others in order to meet their needs.

Assalian and Ravart have identified seven subtypes within the affective and predatory types. They include:

- **Sadistic**: Offenders who enjoy using their power and authority to control and dominate the victim, receiving marked pleasure from being cruel and provoking suffering.
- **Exploitative**: Offenders who purposely use their power and authority to fulfill their needs, including the need to dominate and control.
- **Incidental**: Offenders who have impulsively behaved in a sexually inappropriate manner one time.
- **Narcissistic**: Offenders who demonstrate a need for attachment, admiration, approval, validation, love, and attention.
- **Angry**: Offenders who persistently sexually harass and offend against women.
- **Compensatory**: Offenders who offend to fulfill unmet needs for closeness, affection, and sexual relations.
- **Interpersonal**: Offenders who are motivated to establish a close, intimate and long-lasting relationship. The relationship appears to be authentic without clear signs of exploitation or abuse.

In a Swiss study, Moggi and colleagues (2000) sought to understand what risk factors might make some women more vulnerable to sexual exploitation by therapists. They found that the women who had experienced sexual exploitation had experienced more parental rejection as children than a control group of women who had been in therapy but who had not experienced the exploitation. They had also experienced more sexual violence.

Most offending therapists are male and most exploited clients are female (Capawana, 2016).

Ravart and Assalian (2003) reference Sealy (2002) concerning the three severity levels of professional sexual misconduct:

1. **Sexual impropriety**: Violations such as inappropriate sexual remarks.
2. **Sexual transgressions**: Violations such as inappropriate touching.
3. **Sexual violations**: Violations that include sexual relationships.

In the same article, Ravart and Assalian report on a colorful categorical system developed by Irons and Schneider (1994, 1999) to describe mental health professionals who engage in sexual misconduct. This system – which offers another, simpler perspective on professionals who offend in this way – groups offenders into six types:

- **The Naïve Prince** (8% of Irons and Schneider's sample of 137): These individuals are new to the profession and develop a privileged relationship with one or more clients, blurring the boundaries. They are psychologically healthy and feel remorse for their sexual misconduct.
- **The Wounded Warrior** (22%): These individuals are generally psychologically healthy, but they are trying to escape professional demands, internal struggles, and unresolved childhood and adolescent issues with their sexual relationship. They feel remorse over the relationship.
- **The Self-Serving Martyr** (24%): These professionals are in mid- to late career, and have become isolated and resentful over sacrifices they have made and what they perceive as a lack of appreciation. The sexual misconduct is meant to relieve their suffering. These individuals are often dealing with addictive disorders. They may also have a personality disorder.
- **The False Lover** (19%): These individuals display creativity, intensity, and charm. They indulge in drama and lack impulse control. For these people sexual misconduct fills a need for excitement. They usually have a personality disorder, which is often their primary diagnosis, often with narcissistic, histrionic, and dependent features.
- **The Dark King** (12%): These professionals need to control and dominate and are driven by grandiosity. These people are often highly intelligent, but have a number of personality disorders.
- **The Wild Card** (15%): These people often have severe mental disorders and may even be suffering from dementia.

Anyone working in mental health practice has experienced different relationships with clients. Sometimes it is nearly impossible not to form respect and even affection for clients. However, practitioners must work diligently to avoid problems, i.e., either crossing the boundaries of the professional relationship or even appearing to do so.

In addition to other previously discussed actions designed to prevent harm to the client, workers can proactively address this issue by doing the following:

- Limiting practice to those populations that do not cause your own needs to surface.
- Seeking clinical supervision to effectively deal with personal feelings.
- Documenting surroundings and who was present during sessions and visits.
- Avoiding seeing the client at late hours or in locations that are atypical for routine practice.

Reporting sexual misconduct by a colleague is an ethical responsibility of mental health practitioners. Many states have laws that require licensed professionals to report such misconduct, as well as other ethical violations to their State Boards. It is the responsibility of every professional to protect clients by reporting a reasonable knowledge or suspicion of misconduct between the client and colleague.

Professional Boundaries Self-Assessment

Below are red flags that professional boundaries may be compromised. Some relate to you and some to clients.

As you honestly answer the following questions **Yes** or N**o**, reflect on the potential for harm to your client.

	Yes	No
Have you ever spent time with a client "off duty"?		
Have you ever kept a secret with a client?		
Have you ever adjusted your dress for a client?		
Has a client ever changed a style of dress for you?		
Have you ever received a gift from a client?		
Have you shared personal information with a client?		
Have you ever bent the rules for a client?		
Have you ever given a client a gift?		
Have you ever visited a client after case termination?		
Have you ever called a client when "off duty"?		
Have you ever felt sexually attracted to a client?		
Have you ever reported **only** the positive or **only** the negative aspects of a client?		
Have you ever felt that colleagues/ family members are jealous of your client relationship?		
Do you think you could ever become over-involved with a client?		
Have you ever felt possessive about a client?		

Clients who lack decision-making capacity

The practitioner's responsibility is to safeguard the rights and interests of clients who lack decision-making capacity. Persons who lack this capacity include intellectually delayed or impaired individuals, some older adults, and children under the age of 18. It is especially important to utilize consent forms at all times, and inform and document contact with family and other service providers. In addition, social work professionals should understand how these clients may become vulnerable to – and potentially harmed by – businesses, institutions, and family or other caregivers.

Social workers, for example, are obligated to serve within the best interests of children, and to help guide decision making; to ethically work toward children's well-being, therefore, social workers must focus on the potential for abuse. The welfare of all children must be of utmost concern to society: Their best interest is at the heart of decision making. Yet caring and ethical conduct also stresses the importance of promoting positive relationships – working toward the prevention of family disintegration. This can pose an ethical dilemma in some scenarios.

For example:

> *Parental rights are in the process of being terminated for two sibling clients. Ana, their mental health counselor, must consider how the two girls would adjust to their prospective adoptive placement: One of the children has a severe attachment disorder. Should the two children be placed together, or will placing them together prolong a prospective adoption? Should each sibling's placement be separately planned? Ana knows that sibling bonds may be stronger than parental attachments in families where the parental system is dysfunctional. So she must refer to sources outside of her immediate level of expertise as she considers her recommendations. One important source of information would be the Child Welfare League of America's (2016) standard for out-of-home care for neglected and abused children, which states that siblings should remain together. However, the standard also indicates that, in some cases, separation is indicated.*

Payment for services

With regard to payment for services, it is most helpful to refer to your particular professional association's financial arrangement ethical standards. Professional association ethical guidelines, in general, call for fair and reasonable fees for services, prohibition or no prohibition of solicitation of fees for services entitled and rendered through the workers' employer, and avoidance of bartering arrangements. Other guidelines include **no acceptance** or offering of kickbacks, rebates, bonuses, or other remuneration for referrals. Clear disclosure and explanation of financial arrangements, reasonable notice to clients for intention to seek payment collection, third-party payor fact disclosure, and no withholding of records because payment has not been received for past services, except otherwise provided by law, are also examples of ethical financial guidelines.

Interruption of services and termination

Mental health practitioners should demonstrate reasonable efforts for continuity of services when services must be interrupted or terminated. Interruptions may come from practitioner's or client's vacation or illness. There may be a loss of funding for the service. The typical reasons termination occurs is when the client and practitioner agree that the:

- Goals of treatment or service have been met.
- Client can no longer benefit from treatment/service.
- Client will be referred to another professional or service.

Other reasons include a client's failure to make adequate progress toward treatment goals or failure to comply with treatment recommendations, therapist retirement, discovery of a hitherto unrecognized conflict of interest, or client noncompliance or a client ceasing to communicate (Felton, 2015).

In the case of termination for nonpayment of agreed-upon fees, there are criteria to be met (Felton, 2015):

- The fee arrangements have been made clear to the client.
- The client poses no imminent danger to himself or herself or others.
- The consequences, including the clinical consequences, of nonpayment have been discussed with the client.

In any case, if the client is in crisis, termination should be delayed, and it is vitally important to avoid abandonment of a client, for both legal and ethical reasons.

Felton (2015) offers the following termination tips:

- Start preparing for termination and discuss termination with the client early on so that the process can be discussed during several sessions.
- If referring, offer at least three detailed referrals, and, if the client consents, assist in the transition.
- If possible, conduct the final session in person, and not electronically.
- Be certain that the client understands why and how therapy is being terminated.
- Document termination discussions.
- Send the client a personalized termination letter. Do not use a form letter.

When a referral is made, the referring clinician is obligated to determine the appropriateness of the referral, including the abilities of the receiving professional or agency, and should follow up on the client's progress wherever possible and permitted. Finally, mental health practitioners should continue to refer to their professional association's ethical code guidelines and state laws regarding a related issue: the disposition of client records upon termination, referral, or practice closure.

ETHICS IN PRACTICE SETTINGS

Administration

Mental health administrators should advocate within and outside their agencies for adequate resources, open and fair allocation procedures, and a work environment that is not only consistent with but encourages compliance with ethical standards of practice. Ethical standards of practice should be included with materials given to new workers and emphasized during staff hiring. And some form of ethics language should be included with a mission statement.

Billing

Practitioners need to establish and maintain accurate billing practices that clearly identify the provider of services. Many agencies, associations and boards include these expectations in their own values and codes of ethics, commonly under the category of stewardship.

Client transfer

Mental health practitioners should consider the needs and best interests of clients being served by other professionals or agencies before agreeing to provide services, and discuss with the client the appropriateness of consulting with the previous service provider. Informed consent is an important aspect of this issue, in that a practitioner must discuss all implications, including possible benefits and risks, of entering into a relationship with a new provider.

Client records

Maintaining records of service and storing them is not always easy. Aside from the potential negative legal fallout of not doing so, there are good reasons for keeping records including:

- Assisting both the practitioner and client in monitoring service progress and effectiveness.
- Ensuring continuity of care should the client transfer to another worker or service.
- Assisting clients in qualifying for benefits and other services.
- Ensuring continuity of care should the client return.

To facilitate the delivery and continuity of services, the practitioner, with respect to documentation and client records, must ensure that:

- Records are accurate and reflect the services provided.
- Documentation is sufficient and completed in a timely manner.
- Documentation reflects only information relevant to service delivery.
- Client privacy is maintained to the extent possible and appropriate.
- Records are stored for a sufficient period after termination.

Record keeping

State statutes, contracts with state agencies, accreditation bodies, and other relevant stakeholders prescribe the minimum number of years records should be kept. For example, HIPAA has a requirement of six years for electronic records. The NASW Insurance Trust actually strongly recommends retaining clinical records *indefinitely*.

Professionals who are primary custodians of client records should refer to additional legal requirements, such as those established by state licensing boards, regarding care for client records in the event they retire and/or close their business or practice.

THE ETHICAL IMPORTANCE OF DOCUMENTATION

Documenting according to ethical standards is relevant to all clinicians. With technological advances, digital documentation has become increasingly the norm; however, electronic health records and other forms of electronic communication pose their own ethical risks in documenting services.

For social workers, counselors, marriage and family therapists, and psychologists, documentation is equally important before, during, and after a clinical encounter. A common adage states: "If it isn't written, it didn't happen." Although documentation serves multiple essential purposes, it is fraught with risk and liability.

Practitioners usually know what is minimally required in documentation; however, what is least required may differ significantly from what is recommended or optimal. Optimal documentation includes information that is relevant to the clinical services being provided and that addresses legal, ethical, and administrative obligations. Agency practice and time demands often result in practitioners documenting only what is required. This practice may leave the agency and practitioner open to scrutiny and risk and, at the same time, shortchange the client's services.

Pope (2015) makes a poignant and powerful statement about the importance of documentation, going so far as to say that clinical records have "life-changing power."

> A record's facts, inferences, conclusions, gaps, inaccuracies, wording, and tone can affect whether a person keeps custody of a child, gets a security clearance, receives life-saving help in a crisis, or secures needed accommodations at work for a disability. When a record's security is breached, the content – diagnosis, medications, clinical history, and a patient's most sensitive and private information – may find its way to an array of people and organizations, perhaps exposing the patient to gossip, ridicule, identity theft, exposure of private information on social media, and worse. For example, after learning that an employee hates her job and boss, a company may "reorganize" so that the employee's position is no longer needed. If records of a clinical psychologist's own therapy leak out, it might damage the psychologist's alliance with his or her own therapist and could influence current and future patients' decisions to consult another therapist. A battered woman's husband may discover that she was seeing a therapist, despite his threat that he would kill everyone in their family if she did so.

Record keeping represents practitioners' values as well as those of the agencies in which they work. Thus, it is important for practitioners to abide by their profession's ethical and legal guidelines for documentation as well as practice.

How does the record represent agency or practitioners' values? The values of beneficence, nonmaleficence, autonomy (closely related to self- determination), and justice, as well as fidelity, are often cited as basic principles undergirding ethical decision-making standards of care in behavioral health. Common questions include:

- Do the records reflect those values?
- Is what is documented in the best interest of the client (beneficence)?
- Does the documentation do no harm (nonmaleficence)?
- Does it reflect fidelity (loyalty, integrity, truthfulness)?
- Do the records indicate protection of a client's self-determination (autonomy) and fairness, nondiscriminating language, and equal service (justice)?

Good record keeping entails more than the dreaded paperwork required by agency regulations, although required paperwork often serves the same purposes as good documentation in client records. Bodek (2010) offers seven purposes of documentation, all of which have ethical implications:

1. To document professional work.
2. To serve as the basis for continuity of care by the treating provider.
3. To serve as the basis for continuity of care for subsequent providers.
4. To manage the risk of malpractice complaints and assist in the defense of such complaints.
5. To comply with legal, regulatory, and agency requirements
6. To facilitate quality assurance.
7. To facilitate coordination of care among members of the treatment team.

Clinical, administrative, and legal domains of providing mental health services exist. All of them are related, overlapping, and affected by ethical documentation.

Administratively, records provide accountability on several levels: to the client, funding sources, the agency, regulatory bodies, and the profession. In an ideal world, records might also provide quality assurance. Usually, no one is observing services offered. Thus, records may provide an indirect window through which to observe and monitor the quality of service. Records also provide the means for securing resources; that is, documenting "billable" services works to substantiate reimbursement and can also justify the need for additional services.

Good documentation provides cumulative data that can be used to demonstrate gaps in service delivery or in the continuing education needs of staff. The data can be employed to evaluate program effectiveness and demonstrate successes. Accrediting and regulatory bodies rely almost exclusively on records to provide oversight and assessment of agency efficiency and quality. This aspect of documentation lends itself to a high risk of ethical violation as staff may be instructed or encouraged to "write for the reviewer," and the temptation to falsify or alter records is high. The unethical practice of backdating notes or embellishing data to secure funding or accreditation may be rationalized by thinking, "If we don't get the funding, we can't continue providing service."

Put simply, according to Mitchell (2007): Records should be understandable and accountable.

Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not specify what is required in a medical record, according to Groshong and Phillips (2015), the following must be included to meet behavioral health guidelines:

- Billing information and payment records.
- Formal evaluations.
- Collateral contacts, including release of information (ROI) for all.
- Records from other providers with ROI.
- Counseling session dates, with start and stop times.
- Modalities and frequency of treatment.
- Medications.
- Diagnoses.
- Functional status (activities of daily living [ADL], ability to work, interpersonal capacity).
- Medical/physical problems.
- Community contacts, including phone calls, emails, or texts.
- Treatment plan and goals.
- Symptoms and prognosis.
- Progress in each session.
- Disclosure forms and informed consents signed by the licensed professional and client.
- Presenting problem(s) or purpose of visit.
- Referrals to and results of formal consultations.
- Progress notes sufficient to support responsible clinical practice for the type of orientation/therapy used.

All digital medical records should be backed up regularly and kept in encrypted format, with frequent changes in passwords. Although there can be both a medical record and psychotherapy notes, information cannot be put into psychotherapy notes to avoid putting it into the medical record (Groshong & Phillips, 2015).

Obtaining informed consent is not a perfunctory and merely obligatory part of documentation. There are actually risks associated with it. Although it is a legal and ethical requirement in health care, true informed consent is difficult to obtain and substantiate. The level of understanding and decision-making capacity of the client can vary across time and situations. Although a client may give consent for disclosure of information, for example, that disclosure may inadvertently backfire, possibly causing the client harm. Clients may be harmed by released health information that is improperly disclosed by the third-party recipient or when the information is used against them in court proceedings. Even when properly released and disclosed, the information now made public may have residual effects for the client. In our digital world, informed consent should now include explanation for clients regarding the use of technology "to gather, manage and store protected health and other sensitive information" (Reamer, 2018a).

The Health Insurance Portability and Accountability Act regulations have affected how client records are organized and what may be included. Documentation is often considered synonymous with record keeping; however, documentation encompasses many aspects, formats, and types of record keeping. To distinguish among the various types of records, the following definitions are offered:

- **Mental health records**: These are patient records related to the evaluation or treatment of a mental disorder. These records include, but are not limited to, substance abuse (drugs and/or alcohol) records (Moline et al., 1998). Typically, behavioral health documentation is noted in a separate section of the electronic health record (EHR).
- **Patient medical records**: These are records maintained in any form or medium, by or in the custody of a healthcare provider, which relate to a patient's health history or diagnosis, or the treatment provided. Patient records do not include information given in confidence by a person other than another healthcare provider or the patient.
- **Psychotherapy notes**: Psychotherapy notes, according to HIPAA regulations, are notes recorded in any medium by a healthcare provider who is a mental health professional that (a) document or analyze the content of conversations that took place during a private counseling session or a group, joint, or family counseling session and (b) are separated from the rest of the client record. Psychotherapy notes (as compared to medical records) do not include medication prescription and monitoring; counseling session start and stop times; the modalities and frequencies of treatment furnished; results of clinical tests; or any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date (HIPAA Survival Guide, 2003). Several mental health provider associations have debated this ruling. The Health Insurance Portability and Accountability Act specifies that "psychotherapy notes are held to a higher standard of protection because they are not part of the medical record and never intended to be shared with anyone else" (Bodek, 2010). If it were true that psychotherapy notes were not intended to be shared, there certainly would be less cause for concern.

In addition to the client record, a HIPAA compliance folder for each client must be maintained. Furthermore, HIPAA specifies that psychotherapy notes are to be kept separate from the rest of the individual's medical record, including the HIPAA compliance folder (Bodek, 2010). This regulation sets up a baffling conundrum in that healthcare facilities usually maintain a single consolidated medical record for each client that includes all consultations, including behavioral health interventions. As a result, the therapist may maintain his or her own clinical or shadow notes, which may be considered "personal," but are nevertheless subject to the same legal scrutiny as the official record. Some states protect personal notes from legal discovery, yet keeping such notes does pose a risk. Mitchell (2007) describes a case in which a practitioner naïvely kept the second set of notes in a foreign language as protection. Of course those notes could be translated. Other practitioners may conclude that "what they don't know won't hurt me" and keep the personal notes a secret. If asked under oath if all records have been provided, however, the consequences of perjury and ethical misconduct may be worse than what was written in the notes.

The privacy rule (HIPAA)

In the late 20th century, the problem of employees losing health insurance between jobs and the danger of healthcare fraud led to the creation and passage of an important new law (HIPAA Journal, 2017). In 1996 the 104th Congress amended the Internal Revenue Code of 1986 and created Public Law 104-191, the Health Insurance Portability and Accountability Act. This Act established the first-ever national standards for the protection of certain health information, in an effort, not just to prevent fraud, but to protect client and patient privacy. These standards, developed by the Department of Health and Human Services, took effect April 14, 2003. The Privacy Rule standards address who can use, look at, and receive individuals' health information (Protected Health Information or PHI) by organizations (Covered Entities) subject to the rule. These organizations include:

- Most doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and other health care providers.
- Health insurance companies, HMO's, and most employer group health plans.
- Certain government programs that pay for health care, such as Medicare and Medicaid

Key provisions of the standards include:

- **Access to medical records**: Patients may ask to see and get a copy of their health records and have corrections added to their health information.
- **Notice of privacy practices**: Patients must be given a notice that tells them how a covered entity may use and share their health information and how they can exercise their rights.
- **Limits on use of personal medical information**: The privacy rule sets limits on how health plans and covered providers may use individually identifiable health information. Generally health information cannot be given to the patient's employer or shared for any other purpose unless the patient signs an authorization form.
- **Prohibition of marketing**: Pharmacies, health plans, and other covered entities must first obtain an individual's specific authorization before disclosing their patient information for marketing.
- **Stronger state laws**: As stated earlier, confidentiality protections are cumulative; any state law providing additional protections would continue to apply. However, should state law require a certain disclosure: such as reporting an infectious disease outbreak: the federal privacy regulations would not preempt the state law.
- **Confidential communications**: Patients have the right to expect covered entities to take reasonable steps to ensure communications with them are confidential. For example, a patient may want to be called on their work phone rather than home telephone.
- **Complaints**: Patients may file a formal complaint regarding privacy practices directly to the provider, health plan, or to the HHS Office for Civil Rights. Consumers can find out more information about filing a complaint at https://www.hhs.gov/hipaa/filing-a-complaint/index.html or by calling (800) 368-1019.

It is very important to know that professionals who work in the mental health field are responsible for following and enforcing the HIPAA Privacy Rule. There can be severe civil and criminal penalties if procedures are not followed, and depending on the situation, an individual employee may be held responsible for not protecting a client's privacy. For unknowing civil violations of the standards, the Office for Civil Rights (OCR) may impose monetary penalties of from $100 to $50,000 per violation, with an annual maximum of $25,000 per year for repeat violations. Penalties are higher for reasonable cause and willful neglect. PL 104-191 prescribed criminal penalties for certain actions such as knowingly obtaining protected health information in violation of the law. The Department of Justice handles criminal penalties, which are significantly higher than civil penalties, ranging from $50,000 and one year in prison up to $250,000 and 10 years in prison if the offenses are committed with the intent to sell, transfer, or use PHI for commercial advantage, personal gain, or malicious harm.

This rule ensures protections for clients by limiting the way covered entities can use personal medical information. The regulations protect medical records and other individually identifiable health information (identifiers), whether the information is transmitted in electronic, written, or verbal format. This then would include faxes, email, online databases, voicemail, and video recordings, as well as conversations among practitioners. Examples of identifiable health information include:

- Name or address – including city, state, and zip code.
- Social Security number.
- Dates related to birth, death, admission, discharge.
- Telephone and fax numbers.
- Email or URL addresses.
- Medical record numbers, account numbers, health plan beneficiary numbers.
- Vehicle identifiers such as drivers license numbers and license plate numbers.
- Full-face photographs distributed by the agency.
- Any other unique identifier, code, or characteristic used to identify clients that is protected under HIPAA.

In addition to reasonable safeguards, covered entities are required to develop and implement policies and procedures that limit the sharing of protected health information and to implement them as appropriate for their practices. The policies must limit who has access to protected health information and specify the conditions under which it can be accessed and designate someone to be responsible for ensuring that procedures are followed (Privacy Officer).

It may seem that the law serves only to place limits on the sharing of information. However, it does allow the sharing of protected health information as long the mental health worker takes reasonable precautions with the information. Some steps professionals can follow include:

- Ensure that protected health information is kept out of sight. This could mean keeping it in separate locked files, covering or turning over any material on your desk, or setting your computer to "go blank" after a minute or two in case you walk away.
- If you must discuss protected health information in a public area such as a waiting room, hospital hallway, or courtroom, make sure you speak quietly and others cannot overhear your conversation. If privacy cannot be assured, move to another area or schedule another time to discuss the information.
- Use email carefully. Make sure you send the information only to the appropriate people. Watch the "CC" lines to make sure your email is not copied to unauthorized parties. Use passwords and other security measures on computers.
- If you send a fax, don't leave the material unattended. Make sure that all of the pages go through and check the fax numbers carefully to make sure the information is sent to the correct person. You should also add a disclaimer stating that the information in your fax is confidential.
- Avoid using client names in hallways, elevators, restaurants, etc., unless absolutely necessary.
- Post signs and routine review standards to remind employees to protect client privacy.
- Secure documents in locked offices and file cabinets.

Note that there is another law, 42 CFR Part 2, which provides additional protections for clients receiving alcohol and drug treatment. Information is available at the Substance Abuse and Mental Health Services Agency (SAMHSA) website at https://www.samhsa.gov/about-us/who-we- are/laws-regulations/confidentiality-regulations-faqs

This law applies to any program that engages in substance abuse education, treatment, or prevention and is regulated by or receives assistance from the federal government (Kunkel, 2012).

Although the SAMHSA (2019) Web page on this subject provides detailed legal information, some salient points are as follows:

- A client or patient who has signed a consent form allowing disclosure to multiple parties can revoke the consent to one or more of those parties.
- A single consent form can allow information to be exchanged for different purposes, such as treatment and management, but the form must specify the type and amount of information that can be disclosed to each of the recipients and the information disclosed must be solely for the purpose at hand.
- In the case of an immediate threat to the health and safety of the individual or the public, steps must be taken

before information can be disclosed. These steps can include notification of medical personnel in the case of an emergency or notification of the police if a crime against program personnel or a crime on program property poses a threat to an individual. The information that can be disclosed is limited, however, to such facts as name, address, last known whereabouts, and status as a patient in the program.
- The restrictions on disclosure do not apply in the case of child abuse or neglect, except that "restrictions continue to apply to the original alcohol or drug abuse patient records maintained by the program including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect [42 CFR 2.12 (c)(6)]."
- In certain circumstances, the Court can order a disclosure.

Recently, Congress has attempted to override some of the confidentiality regulations in 42 CFR Part 2, with the introduction and reintroduction of the Overdose Prevention and Patient Safety Act. The purpose of this Act, which was proposed in reaction to the opioid crisis, is to bring confidentiality requirements for substance abuse records closer in line with those for other medical records (Walden, 2019). According to the American Society of Anesthesiologists (2019), this Act, if passed, would provide them with more information to help them to more safely treat patients.

In 2009, President Barack Obama signed into law the Health Information and Technology for Economic and Clinical Health (HITECH) Act, as part of the American Recovery and Reinvestment (ARRA) Act. The goal of HITECH was to improve health care through the use of updated information technologies (Witten, 2018). This Act provided financial incentives that led to the wider use of electronic health records. The purpose of greater and more efficient use of electronic records was:
- Empowerment of clients and patients.
- Better outcomes.
- Greater transparency and efficiency.
- Improvements in population health.
- Acquisition of data on health systems.

The HITECH Act also added strength to the HIPAA Privacy and Security Rules (HIPAA Journal, 2018), clearing up confusion about protecting health information. Some ways that HITECH strengthened HIPAA included making business associates of HIPAA-covered entities accountable for HIPAA violations, increasing the penalties for HIPAA violations, and enabling clients or patients to obtain their own health records. This Act also required that clients and patients be notified if their health information was exposed in a security breach.

Although the HITECH Act does not offer incentives to behavioral health professionals, it represents the future of healthcare privacy regulations, and some states are already expecting all providers to switch to electronic record keeping (Boyd, 2020).

SUPERVISION AND CONSULTATION

Mental health supervision and management generally include three primary aspects of the supervisory role:
1. Administration.
2. Support.
3. Education.

(Kadushin & Harkness, 2014)

While the supervisor of mental health work is forced to be increasingly involved in the administrative and political realm, supervision, coaching, mentoring, and consultation remain key roles. Mental health practitioners need to be keenly aware of the role of a supervisor, because he/she is responsible for both the actions and omissions of a supervisee. This is called "vicarious liability."

To provide competent supervision, supervisors – particularly those in clinical settings – should remember the following:
- They need to possess the necessary knowledge and skill and work only within their area of competence.
- They must set clear, appropriate, and culturally sensitive boundaries that would include confidentiality, sexual appropriateness, and respect for other sensitive boundaries outlined earlier in this training.
- They should not engage in dual or multiple relationships with supervisees when there is risk of exploitation or potential harm.
- They should fairly and respectfully evaluate supervisee performance.
- They should avoid accepting supervisees when there has been a prior or an existing relationship that might compromise the supervisor's objectivity.
- They should take measures to assure that the supervisee's work is professional.
- They should not provide therapy to current students or supervisees.

Supervisors should consult their particular professional association guidelines regarding supervision, human resource policy, and other applicable resources. Effective and ethical supervisory practices benefit, not only the supervisees and their clients, but the supervisor as well. Supervisors can manage their vicarious liability in several ways, though:
- Clearly defined policies and expectations.
- Awareness of high-risk areas.
- Provision of appropriate training and supervision.
- Understanding supervisee strengths and weaknesses as practitioners.
- Developing an adequate feedback system.
- Supervisors knowing their own responsibilities.

Education and training

Mental health practitioners who function as educators, field instructors, or trainers are obligated to provide instruction only within their areas of knowledge and competence, evaluate student performance fairly and respectfully, and take reasonable steps to ensure that clients are informed when services are provided by students. Mentioned in the previous subsection, professionals functioning as educators or field instructors must not engage in dual or multiple relationships and should set clear, appropriate, and culturally sensitive boundaries.

Mental health administrators and supervisors should also take reasonable steps to provide for the continuing education and personal development of their staff.

Commitment to employers

Several standards that address issues around loyalty and ethical responsibilities in one's capacity as an employee are formally or informally discussed in professional association ethical guidelines. Generally, mental health practitioners should do the following:
- Adhere to commitments made to employers.
- Work to improve employing agencies' policies, procedures, and effectiveness of service delivery.
- Take reasonable steps to educate employers about mental health workers' ethical obligations.
- Ensure that the employing organization's practices do not interfere with one's ability to practice consistent with one's mental health association professional ethical guidelines.
- Act to prevent and eliminate discrimination.
- Accept employment or refer others to only organizations that exercise fair personnel practices.

- Be diligent stewards of agency resources.

In general, mental health practitioners should support their agency's mission, vision, and values and also its policies and practices – in essence maintain loyalty to the organization or agency they are committed to. That is not to say one should disregard the profession's standards and ethical codes of conduct.

When an employer engages in unethical practices, whether knowingly or not, the worker still has an obligation to voice those concerns through proper channels and advocate for needed change, while conducting oneself in a manner that minimizes disruption. But what does the worker do when faced with an ethical dilemma in the workplace that is not easily solved?

Reamer's (2006) review of the NASW Code of Ethics discussed the challenge a social worker may have in deciding whether or not to continue honoring a commitment to the employer:

> This broaches the broader subject of civil disobedience, that is, determining when active violation of laws, policies, and regulations is justifiable on ethical grounds. Most social workers acknowledge that certain extraordinary circumstances require social disobedience.

Reamer believes that it is possible to provide clear guidelines about when it is acceptable to break one's commitment to an employer. He poses several questions that must be explored before taking action:

1. Is the cause a just one? Is the issue so unjust that civil disobedience is necessary?
2. Is civil disobedience the last resort?
3. Does the act of civil disobedience have a reasonable expectation of success?
4. Do the benefits likely to result clearly outweigh negative outcomes, such as intra-organizational discord and erosion of staff respect for authority?
5. If warranted, does civil disobedience entail the least disruption required to rectify the targeted injustice?

Labor-management disputes

Mental health practitioners are generally allowed to engage in organized action, including the formation and participation in labor unions, to improve services to clients and working conditions. When involved in a dispute, job action, or strike, workers should carefully weigh the possible impact on clients and be guided by their profession's ethical values and principals prior to taking action.

In 2013, Morgan and Polowy, attorneys for the National Association of Social Workers, wrote that:

> When social workers engage in union activities on their own behalf they are expected to do so in a professionally responsible manner so that work-stoppages may be avoided if possible and/or to provide the legally-required notice so that dispute resolution mechanisms may be employed to lessen the potential impact on clients or patients.

Professional competence

The following guidelines discuss professional competence in mental health practice:

- Accept responsibilities or employment only if competent or there is a plan to acquire necessary skills.
- Routinely review emerging changes, trends, and best practices in the mental health field, and seek ongoing training and educational opportunities.
- Use empirically validated knowledge to guide practice/ interventions.
- Disclose potential conflicts of interest.
- Do not provide services that create a conflict of interest that may impair work performance or clinical judgment.

In addition to education and experience, mental health practitioners need to be cognizant of their personal behavior and functioning and its effects on practice:

- Refrain from private conduct that interferes with one's ability to practice professionally.
- Do not allow personal problems (e.g., emotional, legal, substance abuse) to impact one's ability to practice professionally or jeopardize the best interests of clients.
- Seek appropriate professional assistance for personal problems or conflicts that may impair work performance or critical judgment.
- Take responsible actions when personal problems interfere with professional judgment and performance.

Burnout and compassion fatigue

An area receiving increasing attention is that of burnout and compassion fatigue. The consequences of burnout and compassion fatigue (or any other form of professional impairment) include the risk of malpractice action. Resulting from the effects of day-to-day annoyances, overburdened workloads, crises, and other stressors in the workplace, burnout and compassion fatigue can be serious and may be considered similar in many ways to acute stress and post-traumatic stress disorder.

Burnout

According to Maslach and Leiter (2016), burnout is "a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job." This syndrome is characterized by "overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment." Burnout occurs when gradual exposure to job strain leads to an erosion of idealism with little hope of resolving a situation. In other words, when mental health practitioners experience burnout:

- Their coping skills are weakened.
- They are emotionally and physically drained.
- They feel that what they do does not matter anymore.
- They feel a loss of control.
- They are overwhelmed.

Burnout manifests as "physical and emotional exhaustion," "cynicism and detachment," and "feelings of ineffectiveness and lack of accomplishment" (Carter, 2013). Within these overall symptoms are feelings of apathy and detachment, which are disastrous for anyone in a helping profession and for his or her clients.

According to the Mayo Clinic (2018), causes of job burnout include:

- **Lack of control**: Being left out of decision making that directly affects the individual's schedule or workload, for example.
- **Unclear job expectations**: Feeling unclear about what is expected or one's degree of authority.
- **Dysfunctional workplace dynamics**: Bullying and micromanagement or feeling undermined by colleagues.
- **Extremes of activity**: Encountering monotony or chaos.
- **Lack of social support**: Feeling isolated at work and at home.
- **Work-life imbalance**: Too much time spent working and not enough enjoying other aspects of life.

The Mayo Clinic puts working in a helping profession in a list of risk factors for job burnout. Other risk factors are:

- Identifying so strongly with work as to create a work-life imbalance.
- Having a high workload.

- Trying to be "everything to everyone."
- Feeling of having little or no control over the work.
- Monotony.

They recommend evaluating one's options by discussing specific concerns with one's supervisor and setting realistic goals, seeking support, being sure to get enough sleep, and practicing such activities as yoga or mindfulness.

Burnout and its attendant symptoms are relevant to the ethics of helping professions. According to Bray (2018), counselors who fail to realize that they are suffering from burnout are "playing with fire." When they are "detached from their work and not taking steps to address burnout (or missing its indicators) [they] are entering a danger zone rife with ethical pitfalls." Bray recounts the warnings of certified counselor Monica Band, who cautions that exhaustion can lead to indifference and cynicism, possibly leading to the blurring of practitioner-client boundaries, incompetent decision making, and an inability to build rapport. Bray reminds helping professionals that "the prevention of burnout – and the commitment to seek help if it occurs – is both a best practice and an ethical mandate."

Compassion fatigue

A newer definition of worker fatigue was introduced late in the last century by social researchers who studied workers who helped trauma survivors. This type of worker fatigue became known as compassion fatigue, or secondary traumatic stress (STS).

Burnout is gradually acquired over time and recovery can be somewhat gradual. Compassion fatigue surfaces rapidly and diminishes more quickly. Both conditions can share symptoms such as emotional exhaustion, sleep disturbance, or irritability. According to Cocker and Joss (2016), compassion fatigue is a kind of vicarious traumatization:

> Characterized by exhaustion, anger and irritability, negative coping behaviours including alcohol and drug abuse, reduced ability to feel sympathy and empathy, a diminished sense of enjoyment or satisfaction with work, increased absenteeism, and an impaired ability to make decisions and care for patients and/or clients.

Compassion fatigue shares many symptoms with posttraumatic stress disorder, and another name for compassion fatigue is secondary stress disorder (Administration for Children and Families, n.d.). Symptoms of compassion fatigue include:

- Feelings of isolation.
- Anxiety.
- Dissociation.
- Physical ailments.
- Sleep disturbances.

Among the cognitive symptoms are:

- Lowered concentration.
- Apathy.
- Rigid thinking.
- Perfectionism.
- Preoccupation with trauma.

Among the behavioral symptoms are hypervigilance and an elevated startle response. According to the Administration for Children and Families (n.d.), an impaired immune system can be a physical symptom of this condition.

According to Harr and colleagues (2014, citing Forster, 2009), a contributor to compassion fatigue is the "moral stress caused by the various ethical and value conflicts social workers often encounter in practice." Moral stress can result from situations such as being unable to provide adequate care because of a client's inadequate health insurance or the urge to skip reporting child abuse for fear of causing more harm than good or the urge to give money to a destitute client (Fried, 2016). These scenarios can place the practitioner in ethical and legal jeopardy, as the wrong choice can lead to conflicts with ethical codes, state laws, and other rules.

Dealing with burnout and compassion fatigue

A professional mental health practitioner can take steps to increase her or his ability to cope and achieve balance in life. Maintaining a healthy lifestyle balance and recognizing the signs of burnout and compassion fatigue are important. The responsible mental health clinician will take action, which can range from a vacation break to a change in schedule or job duties. Practitioners also need to be aware, not only of the signs and symptoms of burnout and compassion fatigue, but, more importantly, of the situations that may set the stage for their occurrence. Ongoing supervision is the mental health practitioner's best defense.

In addition to ongoing supervision, regular supportive contact with other practitioners to prevent isolation is recommended. Houston-Vega, Nuehring, and Daguio (1996) recommend the following measures to help prevent burnout or compassion fatigue:

- Listen to the concerns of colleagues, family, and friends.
- Conduct periodic self-assessments.
- Take needed "mental health days" and use stress-reduction techniques.
- Arrange for reassignment at work, take leave, and seek appropriate professional help as needed.

PRACTITIONER IMPAIRMENT

Ethics complaints and lawsuits may be the result of practitioner impairment. Impairment may involve failure to provide competent care or a violation of social work's ethical standards. Social workers who engage in egregious ethical misconduct, especially cases involving inappropriate dual relationships and incompetent practice, are often impaired in some manner (Reamer, 2015). According to Reamer, impairment may take the following forms:

- Impairment may take such forms as providing flawed or inferior services to a client, sexual involvement with a client, or failure to carry out one's duties as a result of an addiction to alcohol, drugs, gambling, sex, or mental illness.
- Research suggests that distress among human service professionals falls into two categories: environmental stress – which is a function of employment conditions such as stressful working conditions or inadequate professional training – or personal stress – caused by problems with one's marriage, relationships, emotional and physical health, legal difficulties, and finances.
- In recent years, strategies for dealing with impaired practitioners have become more prevalent. Some professional associations are examining the extent of impairment among colleagues to address the problem.
- Despite discussions of specific forms of impairment, such as alcoholism, there is little discussion of the general problem of impairment in social work literature.
- Research on impairment among professionals suggests that many struggling practitioners do not seek assistance, and colleagues who are concerned about them may be reluctant to share their concerns.
- Some impaired professionals may find it difficult to seek help because of an erroneous belief in their own competence and invulnerability. They believe that a therapist is not available or that therapy will not help. They often prefer to seek help from family members or friends, or they believe they should be capable of resolving problems on their own.
- Professionals may not seek assistance because they fear exposure and the disclosure of confidential information. They may be concerned about the amount of effort required, the cost, have a spouse or partner who is unwilling to participate in treatment, or they do not comprehend (or cannot admit) the seriousness of the problem.

ETHICS RELATING TO A PUBLIC HEALTH CRISIS

When a public health crisis such as the one surrounding the COVID-19 pandemic arises, social workers and other providers of services to already troubled populations can experience greater stress. The National Association of Social Workers (2020a) offers ethics-related suggestions for getting through an especially difficult time:

- In order to avoid burnout and compassion fatigue, self-care remains important.
- In keeping with NASW Standard 1.15, Interruption of Services, social workers need to have a plan in place to provide continuity of services. Social workers should be able to provide remote services if need be, and they should have an emergency backup person or system in place, and have communicated the plan or policy and acquired the necessary valid consents.
- Social workers need to communicate, although this can be challenging in a new and ever-changing situation. It is important to be aware of and coordinate with local, state, and federal resources. Social workers need to keep communications secure, to the extent possible, and avoid breaching privacy and confidentiality.
- In keeping with NASW Standard 1.04(d), Competence, social workers need to be competent in the technology to provide appropriate telehealth services, if necessary.
- In keeping with Standard 1.07, Privacy and Confidentiality, it is important to ensure the privacy and confidentiality of electronic communications in every way.
- In keeping with Standard, 1.03(e), Informed Consent, social workers need to discuss their policies involving the use of technology with their clients.
- When a crisis involves a communicable disease, special ethical issues arise around testing and reporting. Social workers need to understand the law as well as the ethical issues around confidentiality and the disclosure of information.
- In keeping with Standard 6.03, Public Emergencies, "Social workers should provide appropriate professional services in public emergencies to the greatest extent possible."

The NASW also instructs social workers to check with their licensing boards, their liability insurance providers, other regulatory bodies, and their employers for changes in policy and exceptions in the time of crisis.

A public health crisis can give rise to numerous stressful ethical dilemmas for individual professionals, their employing agencies, and all levels of government. Compromises may need to be made in standards of care (Leider, DeBruin, Reynolds, Koch, and Seaberg, 2017). Individuals may need to surrender privacy in the case of contact tracing or the tracking of movements through cell phone locations. An extremely distressing dilemma arises through the necessity for triage, in which choices need to be made concerning who will get available treatment when there is not enough to go around.

The COVID-19 crisis forced the Office for Civil Rights (2020), an arm of the U.S. Department of Health and Human Services, to issue guidance concerning the disclosure of confidential health information in certain circumstances. For example, the individual's HIPAA authorization is not needed when disclosure is necessary:

- To provide treatment.
- When the notification is required by state law.
- To notify public health authorities to prevent spread of disease.
- When first responders are at risk of infection.
- When first responders need the information for the sake of an individual or the public in the case of an imminent public health threat.
- In certain circumstances, when the information is requested by a correctional institution or law enforcement official having lawful custody of an inmate or other individual.

Social workers, who are ethically obliged to maintain clear boundaries may be forced, during a public health crisis, to communicate with clients using personal devices and accounts, or to work at odd hours, simply because of the massive need of the public. They may encounter clients who have no means of communicating electronically, which might require that the agency supply the means. According to Barsky (2020), these actions are not boundary violations, but they are boundary crossings that require risk-reduction strategies, such as informing clients that after a certain hour in the evening, they should call 911 instead of the social worker.

Although HIPAA regulations were eased during the COVID-19 crisis to allow the use of communication apps that were not HIPAA compliant, Barsky advised that social workers use HIPAA-compliant apps where possible and try to gain access to HIPAA-compliant apps for the long term.

Related personal and professional integrity issues

Mental health practitioners must also address issues related to personal and professional integrity. They are:

- Dishonesty, fraud, and deception.
- Misrepresentation.
- Solicitations.
- Failure to acknowledge credit.

Practitioners have an obligation to avoid actions that are dishonest, fraudulent, or deceptive. Such actions, or in some cases, lack of action, put the continued integrity of both the individual mental health worker and the profession at risk. Some examples include:

- Falsifying records, forging signatures, or documenting services not rendered.
- Embellishing one's education and experience history or qualifications (refer also to "Misrepresentation").
- Lying to a client or the client's family to "protect" them from unpleasant information.
- Not sharing legitimate options with a client because they violate the professional's beliefs.
- Misleading potential donors or current funders with false outcome data.

Misrepresentation occurs when mental health professionals present opinions, claims, and statements that are either false or lead the listener to believe facts that are not accurate. Three actions must be taken to ensure that clients and the public receive accurate information:

1. Clearly distinguish between private statements and actions and those representative of an organization, employer, etc.
2. Accurately present the official and authorized positions of the organization being represented or on whose behalf the professional is speaking.
3. Ensure accurate information about, and correct any inaccuracies regarding, professional qualifications/credentials, services offered, and outcomes/results.

Admonitions against client solicitation stem from a concern for clients whose situations may make them vulnerable to exploitation or undue influence. Such clients' circumstances create the potential for manipulation and coercion. Mental health practitioners should refrain from doing the following:

1. Engaging in uninvited solicitation, or
2. Soliciting testimonial endorsements from current clients or other potentially vulnerable persons.

Mental health practitioners also have an ethical responsibility to the contributions of others by acknowledging credit. They should:

1. Take responsibility and credit only for work they have actually performed and contributed to, and
2. Honestly acknowledge the work and/or contributions of others

Ethical responsibilities to colleagues

Licensed mental health practitioners should not only take responsibility for their own actions, but also take actions that ensure the safety and well-being of any clients served by others in the mental health profession. Thus, their responsibilities include:

- Duty to clients.
- Duty to colleagues, and
- Indirectly, duty to the mental health profession.

In addition, they demonstrate further ethical responsibility by:

- Respecting and fairly representing the qualifications, views, and obligations of colleagues.
- Respecting shared confidential information.
- Promoting interdisciplinary collaboration.
- Not taking advantage of disputes between colleague and employer or exploiting clients in disputes with colleagues.
- Seeking advice and counsel of colleagues who have demonstrated knowledge, expertise, and competence so as to benefit the interests of clients.
- Referring clients, without payment for such, to qualified professionals and transferring responsibilities in an orderly fashion.
- Consulting and assisting impaired and/or incompetent colleagues, and addressing impairments through proper channels when they are unable to practice effectively (e.g., reporting to professional associations or licensing and regulatory bodies).
- Discouraging unethical conduct of colleagues; being knowledgeable about established procedures and taking action as necessary through appropriate formal channels.
- Defending and assisting colleagues who are unjustly charged with unethical conduct.

Ethical responsibilities to the mental health profession

In general, national mental health professional associations discuss the responsibility to help maintain the integrity of their particular mental health focus as well as issues related to mental health work evaluation and research. Maintaining the integrity of the profession is a responsibility of every licensed mental health professional and requires the active participation of each person whether it be collaborating on the creation of new standards, continuing to challenge mediocrity or complacency, or taking advantage of educational opportunities. Mental health professionals should demonstrate the following integrity safeguards:

- Maintain and promote high standards of practice.
- Uphold and advance the values, ethics, knowledge, and mission of the profession through study, research, active discussion, and reasonable criticism.
- Contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the profession.
- Contribute to the knowledge base and share with colleagues knowledge related to practice, ethics, and research.
- Act to prevent unauthorized/unqualified practice of mental health work.

Evaluation, evidence-based practice, and research

In recent years, greater interest in "evidence-based practice" (EBP) has become a prominent theme in the social work profession due to the need for justification for payment of services, as well as the need for methods of best treatment practice in social work. The role of professional ethics and values is an important source of evidence in the process of making decisions about evidence-based practice.

Significant failures in making decisions occur when evidence is not used. These can include:

- Ineffective use of interventions.
- Interventions that do more harm than good.
- Continuing to use interventions instead of replacing them with better interventions.
- Failure to discontinue interventions that do more harm than good.

Evidence-based practice (EBP) is the integration of best research evidence with clinical expertise and patient/client values. The purpose of EBP is to promote effective practice and to enhance public health by applying empirically supported principles of assessment, case formulation, therapeutic relationship, and intervention (Mount Saint Mary's University, 2020). Evidence-based guidelines for best practice in the mental health profession should draw upon critical thinking, practice-related research, accountability, service to clients, informed consent, self-determination, and social justice as essential components of evidence-based practice.

Evidence-based practice in social work focuses on evidence-based research in which clinical knowledge and client values are important considerations. Evidence-based practice implements the current state of knowledge and best practice strategies: etiology, causation, prevention, and treatment of a wide range of conditions using state-of-the-art methods.

Evidence-based practice in social work utilizes the best available research evidence, along with professional wisdom and individual family values. The social worker should reflect on the following questions:

- Which treatment approaches and specific interventions are most effective?
- In what contexts and for whom?
- What are the indicators of effective social work practice using this method?
- How will results of treatment be measured?
- How can the assessment data be used to inform future work throughout the course of practice?

These questions illustrate the close connection between critical thinking and the application of evidence-based practice. Of course, all social work practice must be individualized for the client based on the client's specific needs and the most effective evidence-based methods to achieve his or her goals. All practice methods and techniques must be within the limits of the social worker's training and experience, as outlined in ethical standards for competency.

The mental health profession has become more organized around the need for monitoring and assessing the effectiveness of interventions, policy initiatives, and program implementation. Improved services and outcomes for clients and enhancements increase credibility. Licensed mental health professionals should:

- Respect the dignity and protect the welfare of research participants.
- Be aware of applicable laws and regulations and professional standards governing the conduct of research.
- Monitor and evaluate policies, program implementation, and practice interventions.
- Promote and facilitate evaluation and research.
- Critically examine and keep current with emerging mental health practice research.
- Obtain voluntary, written informed consent, which includes:
    - No implied or actual deprivation or penalty for refusal, or undue inducement to participate.
    - Regard for the participant's dignity, well-being, and privacy.
    - All information about the nature, extent, and duration of the participation and disclosure about the risks and benefits.
    - When the participant is incapable, provision of appropriate explanation to the participant, obtaining of permission to the degree he or she is able, and obtaining of written consent from the appropriate proxy.

- Never design or conduct evaluation or research that does not use informed consent procedures.
- Inform participants of the right to withdraw from evaluation and research.
- Ensure participants access to appropriate supportive services.
- Protect participants from unwarranted physical or mental distress, harm, danger, or deprivation.
- Discuss collected information only for professional purposes, with only those who have a professional concern for the information.
- Ensure anonymity and confidentiality of all participants and their data, and:
    - Inform participants of limits of confidentiality, measures taken, and when records will be destroyed.
    - Omit identifying information from reports unless disclosure is authorized.
    - When the possibility exists that others, including family members, may obtain access to confidential information, explain this possibility, along with the plan for protecting confidentiality as part of the procedure for obtaining informed consent.
- Respect each participant's freedom to decline participation in or to withdraw from a research study at any time.
- Report evaluation and research findings accurately.
- Be alert to and avoid conflicts of interest and dual relationships with participants.
- Educate self, students, and colleagues about responsible research practices.

More about informed consent

The issue of informed consent relates closely with one of the most important values of ethical mental health practice: self-determination. In order for informed consent to be valid, the following conditions must be met:

1. A person of legal age must give consent voluntarily.
2. The individual must be competent to refuse or to consent to treatment.
3. The client must be given thorough, accurate information about the service so she or he may weigh the benefits and risks of treatment.
4. Information must be given in a format that can be fully comprehended by the client based on age, cognitive ability, level of literacy, taking account of any disabilities, which must be accommodated.

One of the newest challenges for mental health practitioners is the issue of informed consent in e-therapy. Kanani & Regehr (2003) point out the following reasons:

1. Anonymity on the Internet makes it more difficult to determine the client's mental capacity or visual or auditory capacity to comprehend the terms of consent.
2. It may be more difficult to determine legal age.
3. Potential conditions such as suicidal behaviors and eating disorders may not be suitable for online therapy.
4. There is limited empirical research available, thus limiting both the practitioner and client's understanding of either the efficacy or the risks associated with e-therapy.
5. Internet identity issues place a greater burden on the practitioner to determine whether the client is legally and ethically able to consent.
6. The client and social worker may need training to be proficient in using the devices, including downloading documents and completing electronic signatures.
7. Technical problems with the device or the connection may interfere with the transmission or storage of documents.

Ethical responsibilities to the broader society

All mental health practitioners are shaped and impacted by such influences as their family, community, environment, and culture. Therefore, it is helpful for them to promote the general welfare of both their immediate clients and the present and long-term welfare of the society at large.

For example, the NASW points out that social workers should remain mindful of:

- Social welfare.
- Public participation.
- Public emergencies.
- Social and political action.

Ethical social mindfulness can be demonstrated when mental health practitioners work to promote involvement in social and political actions that:

- Ensure equal access to resources and opportunities.
- Advocate for improvements in social conditions.
- Promote equality for all people.
- Expand choice and opportunity to all people.
- Promote cultural and social diversity.
- Prevent and eliminate the domination, exploitation, and discrimination of any person, group, or class of people.

ETHICS FOR SPECIALIZED PRACTICE AREAS

Responsible mental health practice can be found in a variety of settings and address multiple issues. As the world changes, practitioners are increasingly challenged to broaden their knowledge and adopt practices that meet the unique needs of their service populations and settings.

Currently, most mental health associations provide additional guides or standards of practice that address areas including substance abuse, health care, marriage and family issues, couples' work, clinical social work, child welfare, palliative/end of life care, work with adolescents, and long-term care. They also publish standards that address issues such as technology, cultural competence, and genetics.

It is helpful to review a couple of relevant issues impacting mental health practice:

Genetics

Years ago, mental health practitioners could neither fathom the science of genetics nor predict its impact on the profession. Today genetics, or the study of genes and their effects on human growth and development, is looking increasingly promising as a solution to many of the health problems faced by humans.

Genetics enables science to diagnose certain conditions and offers hope of deeper understanding of diseases and conditions so that they may be prevented and/or treated. And as history has demonstrated, any innovation brings with it new challenges to what we consider right, fair, ethical, and legal.

All licensed mental health practitioners can take an active role in ensuring that their clients are protected against genetic discrimination in areas such as health and life insurance, employment, and adoption. And national mental health professional associations are beginning to address the need to integrate knowledge of genetics into mental health practice. Some of their objectives are to:

- Inform about genetics as an expanding field of mental health knowledge.
- Improve the quality of services provided to clients with genetic disorders.
- Provide a basis for the development of continuing education materials and programs in genetics.
- Ensure that services to clients with genetic disorders are guided by association code of ethics.
- Advocate for clients' right to self-determination, confidentiality, access to genetic services, and non-discrimination.

- Encourage mental health practitioners to participate in the formulation and refinement of public policy (at the state and federal levels) relevant to genetic research, services, and treatment of populations with genetically identified predispositions or conditions

In 2003, the National Association of Social Workers published the NASW Standards for Integrating Genetics into Social Work Practice. These standards were meant to educate and inform social workers, encourage them to participate in formulating and refining public policy, advocate for clients' life, and make sure that social workers provide services to clients with genetic disorders in a manner guided by the NASW Code of Ethics.

TECHNOLOGY

While there are many individuals who are hesitant to embrace new technology that can enhance best practice, one cannot ignore its many benefits. Currently, mental health professionals can use technology, particularly the Internet, to conduct research, provide e-therapy, advertise their services (when permitted), and communicate on a global scale with both clients and other professionals.

Email, though fraught with potential for security violations and miscommunication, has certainly increased the efficiency and speed with which people can communicate with one another. For example, a mental health researcher can conduct a search on the Internet to inquire about and then contact another professional in another region to investigate innovative approaches to service delivery.

Software applications (e.g., basic word processing, financial management systems, and documentation templates) assist practitioners with service planning, delivery, evaluation, and reporting. And wireless technology allows better utilization of their time away from the office. Cell phones have greatly increased accessibility as well.

National mental health associations, along with others, are continuing to develop and published guidelines to assist practitioners in the appropriate use of technology, including those who provide virtual therapy services. Technology and practice are generally defined as *any electronically mediated activity used in the conduct of competent and ethical delivery of services.*

For example, a copy of the standards as developed by several social work organizations can be found at https://www.socialworkers.org/includes/newIncludes/homepage/PRA-BRO-33617.TechStandards_FINAL_POSTING.pdf. Social workers shall:

- Act ethically, ensure professional competence, and uphold the values of the profession.
- Have access to and ensure their clients have access to technology and appropriate support systems.
- Select and develop culturally competent methods and ensure that they have the skills to work with persons considered vulnerable (e.g., persons with disabilities and persons for whom English is not their primary language).
- Increase their proficiency in using technology and tools that enhance practice.
- Abide by all regulations in all jurisdictions in which they practice.
- Represent themselves accurately and make attempts to confirm the identity of the client and the client's contact information.
- Protect client information in the electronic record.
- Provide services consistent with accepted standards of care, regardless of the medium used.
- Use available technology to both inform clients and mobilize individuals and communities so that they may advocate for their interests.
- Advocate for technologies that are culturally sensitive, community specific, and available for all who can benefit from them.
- For those in administrative practice, keep themselves informed about technology that can advance quality practice and operations, invest in systems, and establish policies that ensure security and privacy.
- Conduct a thorough assessment, including evaluation of the appropriateness of potential clients for e-therapy. This includes the need for the social worker to fully understand the dynamics involved and the risks and benefits for the client.
- Evaluate the validity and reliability of research collected through electronic means and ensure that the client is likewise informed. Continue to follow applicable standards and laws regarding supervision and consultation.
- Adhere to *NASW Standards for Continuing Professional Education* and applicable licensing laws regarding continuing education.

Virtual or e-therapy

Depending on their mental health focus and where they practice, many mental health practitioners offer online therapy services through real-time chats, email, videoconferencing, telephone conferencing, and instant messaging. The benefits touted by supporters of online therapy, as described by Kanani & Regehr (2003), include the ability to:

- Serve millions of people who would otherwise not participate (e.g., people with certain conditions such as agoraphobia, persons living in remote locations, or those concerned about the stigma of counseling).
- Decrease inhibitions clients may have about fully disclosing relevant information.
- Increase the thoughtfulness and clarity of communication as an unintended by-product of written communication.
- Produce a permanent record that can be easily referred to, forwarded to clients or colleagues for review and consultation purposes.
- Substantially reduce overhead costs, thus reducing costs for the consumer.
- As discussed earlier in this training, one of the major areas still under debate as a result of this new technology is that of jurisdiction. For example:
    - When the client lives in a different state, how can violations of licensing laws be avoided? And which state's laws would be applicable?
    - Is the origin or location of counseling in the client's community or the therapist's? Or is it somewhere in cyberspace?
    - And what defines location if a busy executive is involved in an online session while flying from Tucson to Bangkok?

This is clearly an ambiguous area that will undoubtedly continue to be discussed.

Kanani & Regehr (2003) have summarized some of the other concerns regarding the use of e-therapy:

- E-therapy does not allow practitioners to observe and interpret facial expressions and body language.
- The Internet poses serious risk to security and thus to confidentiality.
- Inappropriate counseling may occur due to therapist ignorance about location-specific factors related to the client (e.g., living conditions, culture).
- Clients cannot be sure as to the credentials, experience, or even identity of the person they are trusting to provide services.
- Clients may not have any legal recourse for malpractice, given unresolved questions about jurisdiction and standards of care.

Limiting risk in the practice of E-therapy

Matthew Robb (2004) recommends the following for those practicing e-therapy:

1. **Full disclosure**: This relates to informed consent and the need to fully disclose the possible benefits and risks of distance counseling, including informing the client that this is a new area of practice, which has not had the benefit of long-term study.
2. **Comprehensive assessment**: Provide clients with detailed and complete assessment tools and encourage full disclosure by client.
3. **Confidentiality and disclosure of safeguards**: Take all precautions to safeguard the confidentiality of information and avoid misdirected emails, eavesdropping, hacking, etc. Alert the client to these potential risks as well.
4. **Emergency contact**: Obtain information for an emergency contact and together develop a clear emergency plan.
5. **Consult your association's code of ethics**: Review standards regarding informed consent, confidentiality, conflict of interest, misrepresentation, etc.
6. **Consult state licensing provisions**: Research both the statutory regulations of your board and those in the client's home state.
7. **Consult a malpractice/risk management attorney**: Consider asking a legal specialist to review website materials to determine compliance with standards of care and potential malpractice issues.
8. **Provide communication tips**: If communicating solely by text-based messaging, provide client with clear tips regarding communication.

Texting has become more common in clinical practice. In spite of the imminent risk to client privacy and breach of confidentiality, some clients, especially adolescents, prefer this mode of communication. Practitioners using texting as a form of communication should have a clear policy outlining when texting will be used or is acceptable (NASW, 2017). Informed consent should also address and cover this risk. Should texts be included in the health record? The short answer is "Yes." Whether to include the exact text or a summary of text discussion is at the discretion of the provider, but there should be some record of text communication. Texts, much like email, need to reflect the values, ethics, and mission of the practitioner's profession (NASW, ASWB, CSWE, & CSWA, 2017; Reamer, 2018b; Sidell, 2015). Current guidelines for the use of technology are discipline-specific, and clinicians wishing to use technology in their practices should ensure that they are following their profession's ethical and legal standards.

When practitioners decide to engage in texting with clients, their policies should be provided to clients during the first session, and they should obtain informed consent.

Therapeutic contact via texting is now being advertised. Although texting may be a comfortable means of communication for some clients, this means of engagement with clients can raise ethical and legal issues. Although companies providing therapeutic conversations have not been presenting their services as actual therapy, it is unclear that clients understand that this is the case. According to Groshong and Aronson (2019), texting might work as a way of beginning the therapeutic process, which could then move on to therapy conducted through videoconferencing or in person.

Legal problems with this form of client engagement might result from privacy and security concerns, and specifically with HIPAA compliance. Furthermore, the commercial nature of the texting being advertised could lead to ethical problems.

Using email with clients poses other challenges that need to be addressed with clients. Although convenient for a number of purposes, including completing necessary paperwork before sessions, scheduling, or answering simple questions without playing "phone tag," email carries inherent confidentiality and boundary risks. The need for informed consent, with its attendant implications and risks, must be taken into consideration. The added protection of an encryption program, as well as the use of a password or code words or an electronic signature system that verifies clients' identities, could also be considered (Sidell, 2015). Both texting and emailing clients can pose ethical dilemmas and place practitioners at potential risk for favoritism, conflicts of interest, and boundary confusion (NASW, ASWB, CSWE, & CSWA, 2017). Furthermore, it is never possible to ensure that the intended person is receiving an electronic communication. Again, referring to professional guidelines for technology, along with ethical and legal standards, is key to effective and appropriate documentation.

The National Association of Social Workers (2020b) presents a list of eight ethical considerations when starting a telehealth practice:

1. In keeping with Standard 1.04(a), Competence, in the NASW Code of Ethics, "Social workers should provide services only within the bounds of their education, training, license, certification, consultation received, supervised experience, or relevant professional experience." In the context of telehealth, this means that social workers must receive adequate training and be competent in the work. In accordance with Standard 1.04(d), social workers need to understand the communication challenges of this type of work and be able to implement strategies to address the challenges.
2. In accordance with Standard 1.02, Self-Determination, social workers need to be aware of client preferences and capabilities. In accordance with Standard 1.03,(f)(g), Informed Consent, social workers must be aware of clients' ability to understand and use such services. Also, Standard 1.05(d), Cultural Awareness and Social Diversity, requires that social workers understand issues such as culture, economic status, mental or physical abilities, and language issues that might influence the effectiveness of such services for clients.
3. In accordance with Standard 1.04(e), Competence, social workers need to be sure that they are appropriately licensed and adequately insured when providing telehealth services.
4. In accordance with Standard 1.07(m), Privacy and Confidentiality, social workers need to select a secure and HIPAA-compliant platform.
5. In accordance with Standard 1.13, Payment for Services, and 3.05, Billing, social workers need to pay attention to payment and billing requirements. Standard 1.07(m), Confidentiality, must also be addressed when third-party billers such as insurance companies, Medicare, or Medicaid are involved.
6. Social workers need to implement technology standards, policy, and procedures, in accordance with Standards involving informed consent, privacy and confidentiality, and conflicts of interest.
7. Because technology can be disrupted, social workers need to develop an emergency backup plant.
8. When necessary, social workers will need to seek consultation from technical experts, attorneys, or professional colleagues with relevant expertise and experience.

SOCIAL WORK IN THE DIGITAL AGE

In 2015, the American Academy of Social Work and Social Welfare, in conjunction with thirteen universities across the country, developed *Practice Innovation through Technology in the Digital Age: A Grand Challenge for Social Work Working Paper Number 12.*

The Grand Challenges were:

> Designed to focus a world of thought and action on the most compelling and critical social issues of our day. Each grand challenge is a broad but discrete concept where social work

> expertise and leadership can be brought to bear on bold new ideas, scientific exploration, and surprising innovations. (Coffey, 2016)

The Grand Challenges for Social Work include the following:

1. Ensure healthy development of all youth.`
2. Close the health gap.
3. Stop family violence.
4. Eradicate social isolation.
5. End homelessness.
6. Promote smart decarceration.
7. Reduce extreme economic inequality.
8. Build financial capability of all.
9. Harness technology for social good.
10. Create social responses to a changing environment.
11. Achieve equal opportunity and justice.
12. Advance long and productive lives.

Working Paper Number 12 addresses harnessing technology for social good. According to Berzin, Singer, and Chan (2015):

> Information and Communication Technology (ICT) is transformational in its power to connect, create access to, and embolden new opportunities to rethink social work practice. … As the world becomes increasingly reliant on technology, a grand challenge for social work is to harness technological advancements and leverage digital advances for social good. Meeting this challenge would result in more accurate, timelier targeted services. Social service recipients would benefit from improved assessment, intervention, and real-time feedback. Social services would be available to people who traditionally have been excluded because of geography, transportation, and scheduling barriers. Enhanced by innovative integration of ICT, social work would have a broader reach to the benefit of society as a whole.

Berzin and colleagues have identified three facts that make the challenge of integrating technology and social work practice a compelling priority for the profession and the general public, including important statistics.

First, these authors point out that “the professional reach of social workers is unparalleled in human services delivery,” and that the number of social workers providing services is higher than the numbers of all other mental health professionals combined.

In 2016, there were more than 680,000 social workers employed in the United States (Torpey, 2018). By contrast, there were about 140,000 mental health counselors (U.S. Bureau of Labor Statistics, 2017). According to the Bureau of Labor Statistics, there were approximately 59,000 marriage and family therapists in 2019, and there were fewer than 182,000 psychologists and 25,630 psychiatrists as of 2018 (U.S. Bureau of Labor Statistics, 2019a,b; 2020b). As of May 2019, there were about 296,000 educational, guidance, and career counselors and advisors (U.S. Bureau of Labor Statistics, 2020a).

It is worth noting that the above statistics represent a shortage in mental health professionals in the United States, especially in rural areas, some urban areas, and community mental health centers that may be charged with treating people with serious mental illness (Weiner, 2018), as well as children and youth (Centers for Disease Control and Prevention, 2020).

Taking the above into account, “harnessing ICT for social good” (Berzin et al., 2015) can have a great positive impact. According to the Census Bureau, in 2015 78% of U.S. households had a desktop or laptop computer, 75% had a handheld device such as a smartphone, and 77% had a broadband Internet subscription (Ryan & Lewis, 2017). Use of ICT can “connect populations previously marginalized by geography, disability, and economics” (Berzin et al., 2015). In addition:

> Wireless technologies … are removing the economic barriers faced by those previously unable to connect to the Internet or receive online services or support. Such technologies also provide access across rural and urban areas and among populations previously cut off from wired infrastructure.

The second fact that Berzin and colleagues point out is that, because what literature there is on the integration of practice and technology comes mostly from psychologists and counselors, a gap exists between social workers’ expertise in direct practice and the growing understanding of “how and when to best integrate technology and practice.”

Third, drawing on the work of scholars in the field, Berzin and colleagues explain that social workers face a number of limitations when trying to integrate technology into practice:

- Limited education and training are barriers to social workers’ ability to effectively incorporate ICT (Mishna, Bogo, & Sawyer, 2015).
- Social workers may not understand ICT’s use because their exposure to innovative applications of ICT in therapeutic work has been limited (Freddolino & Blaschke, 2008; Langlois, 2011).
- Evidence of the effectiveness of ICT’s use is limited (Chan & Holosko, 2015), probably because few social work interventions use the technology and little empirical evidence exists concerning the role played by ICT in the interventions.
- Financial resources for adopting and testing ICT in the field are limited.

Berzin and colleagues go on to outline the benefits of using ICT. For example, integrating services using technology can provide flexibility and on-demand services, less encumbered by geography, office hours, and even cost. Clients in rural areas and people with limited mobility or other disabilities can profit from the use of ICT in social work practice. Clients may still see a social worker in person but have their contacts augmented through technology.

Another benefit is relief from the rigid structures and timeframes of traditional services:

> For example, clients often wait three weeks for an intake appointment, wait another three weeks to be assigned a therapist, and then have weekly appointments dictated by either treatment manual or agency protocols. Interactive computer-, web-, or app-based programs enable the consumer to get the services they need at their pace and when they want them.

Although the use of technology can help to fulfill the ethical requirement of beneficence and the goal of social justice by potentially making clients’ lives better and helping people to overcome geographical and physical barriers, it does raise ethical issues as well. For this reason, the National Association of Social Workers, Association of Social Work Boards, Council on Social Work Education, and Clinical Social Work Association partnered to develop technology standards to guide social workers. The organizations formed a task force that met for almost two years, prepared a draft, and accepted comments from individual social workers, academicians, and groups. The result was NASW, ASWB, CSWE, & CSWA Standards for Technology in Social Work Practice (2017). This document incorporates the new world of technology into the traditional world of social work ethics and law.

DECISION-MAKING MODEL

As we have seen it is not uncommon for mental health professionals to grapple with conflicts involving personal values and beliefs, ethical duties, employment practices, and the law. Sometimes they may be faced with a choice between taking action that supports an ethical standard but violates the law, or vice versa.

While national mental health associations’ ethical standards usually provide excellent frameworks to guide practice and assist with the resolution of ethical dilemmas, it is naïve to assume they all hold the answers to all the questions faced by licensed mental health practitioners.

While both necessary and useful, some experts, such as Freud and Krug (2002a), argue that for ethical decision-making alone, codes of ethics are insufficient. In effect, they state that codes of ethics are frequently used as a risk management tool, offering guidelines for practice that may not be compatible with other goals set forth by a particular mental health focus. In addition, unique and unexpected ways ethical issues may emerge in clinical practice work against attempts to apply codes of ethics.

For those reasons, Freud and Krug (2002a) propose that "ethical judgments are best made in small groups where members bring different perspectives and intuitions to the process while agreeing on basic humanistic values." Still, codes of ethics are invaluable tools for guiding mental health practitioners toward ethical practice. Thus the authors recommend that, in general, codes of ethics be used to help guide professionals in decision making and include:

1. **Increased attention to our moral intuitions and emotions**: Rational, ethical decision making should be supplemented by a person's emotions and intuition, as shaped by culture and profession. In an effort to maintain a rational, detached, and professional approach to service, mental health practitioners may ignore warning signals and gut instincts relevant to the reason for a decision.
2. **Institutionalized opportunities for dialogue and ethical concerns**: It is important to have safe, nonjudgmental group forums for open and regular discussion of ethical issues.
3. **Open acknowledgment and respect for moral diversity within a shared body of basic values**: The decision-making process works best when consulting with a diverse group of individuals who share basic values but differ in perspectives and intuitions.

Mental health practitioners also need to consider basic protocols and steps to take to increase their ability to make sound ethical decisions. While not all ethical dilemmas have a corresponding definitive solution, professionals can take reasonable steps to arrive at the best possible decision through an ethical decision-making model that would:

1. Identify the problem or conflicts between the ethical and legal expectations and requirements, including the values and duties that may conflict.
2. Understand and apply the state and national professional association code of ethics.
3. Identify the individuals, groups, and organizations that are likely to be affected by the decision.
4. Tentatively identify all possible courses of action and the participants involved in each, along with possible benefits and risks for each.
5. Thoroughly examine the reasons in favor of and opposed to each possible course of action, considering relevant:
    a. Ethical theories.
    b. Codes of ethics.
    c. Constitutional provisions, statutes, regulations, court decisions, and executive orders.
    d. Personal values (including religious, cultural, and ethnic values).
6. Consult with colleagues and appropriate experts.
7. Make and implement the decision and document the decision-making process.
8. Monitor and evaluate the decision.

Applying the model

We can use this model to critically examine the last scenario, that of David and his dilemma regarding placement of a child.

> *David, a licensed marriage and family therapist, believes a child's right to permanency would be better served by placement with an affluent, Caucasian, Christian family versus a middle class family of the same race as the child. He believes they are a very nice couple who have been waiting far too long for a child to adopt.*

David's obligation is to the best interests of the child, so it is clear to whom he is committed. **Therefore, the length of time one couple has spent waiting to adopt a child should not be a consideration. Finding the best family for the child is the primary consideration.**

In addition, standards regarding competence and social diversity require David to be knowledgeable about the child's culture and the importance it will play in the child's life. He also needs to consider the overall strengths offered by both families as well as any potential barriers to placement. One family has unlimited resources, while the other family has enough resources to afford a lifestyle typical of most families in the community.

The person most affected by the decision will be the child. The prospective adoptive families will be impacted as well. To a lesser degree, so will the two adoption agencies. For example, they will wonder if one family may become disenchanted by the wait for an adoptive child and choose to go to another provider. There may be macro-level issues involved as well, given the debate at the national level concerning interracial adoptions. Again, these should not be a consideration, because the primary responsibility is to find the best family for the child, not to find a child for a family. David will ultimately keep this in mind when he makes his recommendation to the Court.

Conclusion

Ethical dilemmas are varied, common, and complex. Ethical decision making can be difficult as well as time-consuming, while sometimes mental health practitioners are still left with a little ambivalence and uncertainty following their decision. Typically, there will be more than one person involved with the ethical decision-making process. It is always important to keep in mind that the power of supervision and consultation regarding any mental health practice ethical dilemma cannot be overstated.

Information

This information is not intended to provide all of the details of the HIPAA Privacy Rule or of any other laws or guidelines. This presentation also does not constitute legal advice. If there is any discrepancy between the provisions of the HIPAA Privacy Rule, other laws or regulations, and the material in this presentation, the terms of the laws, rules, professional guidelines, and regulations will govern in all cases.

This information is not intended to describe all of the national mental health associations' guidelines, but to ensure that learners are guided by their particular association's code of ethics and state licensing regulations in order to make the most appropriate ethical decisions.

Any case examples used within this course do not reflect actual individuals.

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PROFESSIONAL ETHICS AND LAW

Final Examination Questions

Select the best answer for each question and complete your test online at **EliteLearning.com/Book**

56. “Guiding beliefs and principles that influence your work behaviour” that are “usually an extension of your personal values” (Birmingham Community Healthcare) are:
    a. Ethics.
    b. The law.
    c. Professional values.
    d. Assumptions and norms.

57. All of the following are types of laws that may affect practice EXCEPT:
    a. Probationary.
    b. Executive Orders.
    c. Statutory.
    d. Regulatory.

58. In the United States, which ethical system forms the basis of all codes of ethics in the health professions today?
    a. Consequentialism.
    b. Deontology.
    c. Virtue ethics.
    d. Principlism.

59. With regard to law and ethics:
    a. Ethical principles are legal principles.
    b. Legal principles are a codification of ethical principles.
    c. Legal principles always take precedence over ethical principles.
    d. Adherence to ethical principles may sometimes challenge legal principles.

60. Ethical dilemmas can occur when:
    a. Two ethical standards or rules conflict.
    b. An ethical standard conflicts with the profit motive.
    c. Ethical standards conflict with an individual’s preferences.
    d. A social worker is physically attracted to a client.

61. Confidentiality of records falls under the classification of:
    a. Statutory law.
    b. Regulatory law.
    c. Court-made law.
    d. Common law.

62. Most healthcare issues that become legal issues are dealt with as:
    a. Criminal issues.
    b. Statutory issues.
    c. Constitutional issues.
    d. Civil issues

63. Who owns confidentiality and privilege?
    a. The social worker.
    b. The social worker’s supervisor.
    c. The client.
    d. The agency.

64. State oversight boards
    a. Serve an advisory function.
    b. Regulate practice through statutes.
    c. Promote research.
    d. Advocate for the state in the case of job actions by practitioners.

65. In a 2000 review of ethics complaints filed with the NASW, ______ of the cases resulted in hearings, and of those, ______ concluded that violations had occurred.
    a. 48%, 62%.
    b. 15%, 37%.
    c. 8%, 76%.
    d. 0.9%, 22%.

66. The fallacious principle of specific ignorance states that:
    a. Ignorance of the law is no excuse.
    b. It is sometimes best to keep clients in the dark about certain options.
    c. What you do is not illegal as long as you are unaware of the law prohibiting the action.
    d. An action is ethical if you know that other practitioners have behaved in the same way.

67. The fallacious principle of literalization states that:
    a. If we cannot find a specific mention of a particular incident anywhere in legal, ethical, or professional standards, it must be ethical.
    b. If we do not document a particular incident, it can be considered literally not to have happened, according to legal standards.
    c. Providing literal facts concerning a particular incident fulfills an ethical requirement.
    d. Providing concrete facts to a client is always preferable to discussing abstractions.

68. The saying “First, do no harm” applies to the ethical principle of:
    a. Beneficence.
    b. Nonmaleficence
    c. Justice.
    d. Fidelity.

69. For an organization or profession, core values describe
    a. Precise directions for behavior.
    b. A supplement for a code of ethics.
    c. An alternative for a code of ethics.
    d. The foundation for behavior

70. Ethical professional practice can include all of the following EXCEPT:
    a. Helping people in need.
    b. Challenging social injustice.
    c. Recognizing the central importance of human relationships.
    d. Advocating for technologies that are culturally sensitive, community specific, and available for all who can benefit from them.

71. Promoting client well-being is an example of:
    a. An enforceable principle.
    b. A suggested principle.
    c. An aspirational principle.
    d. An unspoken principle.

72. In 1984, Kitchener identified all of the following as moral principles that are essential ethics guidelines EXCEPT:
    a. Integrity.
    b. Beneficence.
    c. Autonomy.
    d. Justice.

73. The case of Tarasoff v. Regents of the University of California established:
    a. The right to physician-assisted suicide.
    b. Mental health professionals’ duty to warn potential victims.
    c. The need for informed consent.
    d. Aspirational principles in mental health care.

74. Informed consent has been:
    a. A carefully followed policy since the publication of the Nuremberg Code.
    b. A long-held idea that is now being questioned.
    c. An ancient idea dating back to Hippocrates.
    d. A recent ethical and legal requirement.

75. The Tuskegee syphilis study ended in:
    a. 1937.
    b. 1952.
    c. 1967.
    d. 1972.

76. Factors to be considered in insuring the validity of informed consent include:
    a. The presence of a mental health disorder diagnosis.
    b. Language and comprehension.
    c. Oppositional language in a client’s living will.
    d. Obstinance from a client’s next of kin.

77. Advancing human rights and socioeconomic justice is:
    a. Admirable behavior but outside the competency of a social worker.
    b. Fine but should not get in the way of professional demeanor.
    c. A core competency of social work practice.
    d. An enforceable social principle for social workers.

78. All of the following are examples of microaggressions EXCEPT:
    a. Asserting that as a white male with a disability one understands the oppression suffered by persons of color.
    b. Complimenting a U.S.-born Asian American person’s English.
    c. Assuming an elderly client has a living will.
    d. Labeling a black woman as “strong.”

79. Demonstrating ethical cultural competence includes:
    a. Being knowledgeable about music and its impact on human behavior.
    b. Considering the nature of social diversity and oppression.
    c. Recognizing and appreciating the strengths found in select individuals.
    d. Participating in the practices and customs of at least two racial and ethnic groups.

80. Microaggressions are a form of:
    a. Intentional or unintentional racism.
    b. Mild physical abuse.
    c. Nonparticipation in multicultural activities.
    d. Insensitivity to nonverbal cues.

Course Code: SWUS04PE

Chapter 5: Suicide Risk in Adults: Assessment and Intervention, 2nd Edition

3 Contact Hours

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Upon successful completion of this course, continuing education hours will be awarded as follows:
- **Social Workers and Psychologists: 3 Hours**
- **Professional Counselors: 3 Hours**

Faculty

Author:

Edward A. Selby, PhD, is an associate professor and the director of clinical training in the clinical psychology PhD program at Rutgers University in New Brunswick, New Jersey. Dr. Selby's extensive research and clinical experience has sought to improve our understanding and treatment of suicidal behavior, personality disorders, and eating disorders. He has written 108 peer-reviewed scientific articles and book chapters, and he was named a "Rising Star" by the Association for Psychological Science in 2015. Much of his work is aimed at understanding the emotional experiences related to suicidal behavior and self injury, as well as the factors among different psychiatric disorders that increase risk for suicidal behavior, including eating disorders and personality disorders. Dr. Selby's research has been funded by the National Institute of Mental Health, the Brain and Behavior Research Foundation, Janssen Pharmaceutica, and the Association for Behavioral and Cognitive Therapies. Dr. Selby is a licensed practitioner and has been trained extensively in major treatments for suicidal behavior and crisis intervention, including cognitive behavior therapy and mindfulness-based interventions. More information about Dr. Selby's research program can be found on the Emotion and Psychopathology Laboratory at Rutgers website: www.edwardaselby.com.

Edward A. Selby has no significant financial or other conflicts of interest pertaining to this course.

How to receive credit

- Read the entire course online or in print.
- Depending on your state requirements you will be asked to complete:
  - A mandatory test (a passing score of 75 percent is required). Test questions link content to learning objectives as a method to enhance individualized learning and material retention.
- Provide required personal information and payment information.
- Complete the mandatory Course Evaluation.
- Print your Certificate of Completion.

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Learning objectives

After completing this course, the learner will be able to:
- Define terms related to suicide and suicidal behavior.
- Identify specific risk factors and warning signs in adult patients that increase their risk for suicidal behavior.
- Describe effective and efficient assessment of adults who may be at risk for suicide.
- Explain approaches to intervention and safety planning to manage individuals exhibiting suicidal ideation and other risk factors for suicide.
- Recognize essential components of decision making and documentation with respect to suicide assessment and intervention.

Course overview

Suicide is a tragic public health consideration that affects all Americans; it is a significant public-health problem that is the 10th-leading cause of death in the United States, claiming more than 38,000 lives annually – almost double the number of homicides – and nearly one million lives annually across the globe. In youth and young adults aged 10 to 25 years, suicide is the third-leading cause of death, accounting for 14.2 deaths per 100,000 in 2018, an increase of 35% relative to 1999 (Centers for Disease Control and Prevention [CDC], 2020). It is a leading cause of death on college campuses (Cramer et al., 2020). An untold number of other nonfatal attempts and self-harming behaviors escape surveillance, but all have impact on families, peers, and communities. Even when suicide attempts are survived, these nonfatal attempts increase risk for suicide even further. An estimated 6.7% of nonfatal suicide attempters go on to die by suicide in the years following their attempt (Parra-Uribe et al., 2017), and this is likely a conservative estimate. Therefore, preventing suicide and suicidal behaviors wherever possible is a public-health imperative (David-Ferdon, Crosby, Caine, Hindman, Reed, & Iskander, 2016). Finally, evidence is growing of a substantial trend of increasing suicide rates in the United States since the year 2000 (Hedegaar & Curtin, 2018), with rates among adults and youth approximately 30% higher in 2018 than they were in 2000 (Miron et al., 2019). Even more concerning, the Coronavirus (COVID19) pandemic of 2020 has increased public health concern for continued increases in suicidal behavior (Reger, Stanley, & Joiner, 2020).

Given the prevalence and increasing trends of suicidal behavior in the United States, it is more important than ever for clinicians, medical staff, educators, community service providers, and even families to be well-versed on the topic of suicide and the best ways to assess and treat those at risk for suicidal behavior. Indeed, most clinicians will treat suicidal individuals in some capacity during their careers, and even more will interact with suicidal individuals unknowingly, due to still-insufficient knowledge about key risk factors and assessment strategies (Franklin et al., 2016). This is problematic because many Americans assume that mental health professionals have substantial training in this clinical domain; this assumption likely influences help-seeking behaviors and/or beliefs about the wellbeing of those seeking help.

When mental health professionals serve clients with suicidal ideation or behavior, they will often collaborate with members of a multidisciplinary team of professionals from education, mental health, social, and medical services in a variety of inpatient, outpatient and long-term care residential facilities. For clinicians, social workers, educators, and medical professionals to be effective in providing services to clients facing these issues, they must develop competencies of knowledge in the above areas of mental and physical/behavioral health. In addition, they must be competent in clinical skills to deliver the highest quality of care for the welfare of their client. This course will provide information and research on these areas of knowledge to enhance social-work competency in assisting clients with life-threatening suicidal ideation and behavior.

The purpose of this course is to assist clinicians in understanding factors that contribute to suicidal behavior, conducting comprehensive suicide risk assessments, and engaging patients in brief, empirically-supported interventions to reduce risk of death. This course meets an increasing demand of many mental health professionals seeking information about working with suicidal clients and conducting empirically- supported suicide risk assessments. This intermediate-level course is designed for social workers, mental health counselors, marriage and family therapists, educators, community-based program administrators, providers, and psychologists. The course will cover major risk factors, demographics and warning signs for suicidal behavior, as well as provide guidance on clinical risk assessment and options for intervention. Although the information presented here is useful to many mental health providers, no continuing education course can provide all the information that may be required in working with each individual who comes for help. It is therefore important that mental health providers consult knowledgeable colleagues, review the most recent articles and books on the topic of suicide, read and understand the risk- management practices of their agency, and maintain awareness of applicable local and state laws concerning the management and referral of suicidal persons. References and resources for those interested in pursuing further education on this topic are provided at the end of the course.

CLARIFICATION OF TERMS

Confusion and ambiguities surround the terms used to describe suicidal phenomena. For example, in the United States, the term *non-suicidal self-injury* (NSSI) refers to self-harming behaviors (e.g., cutting, burning, or picking at skin) that do not have a fatal outcome and were not done with suicidal intent. *Suicide gesture* usually means that a client is engaged in sublethal self-harming behavior, but with a motivation that was not intended as life-ending. However, some use the term to denote any suicide attempt that did not have a fatal outcome. Gesture also has the connotation that the suicide attempt was less serious than one in which a method with a higher lethal probability was used. However, suicide gestures should be taken very seriously, and clinicians should focus on lethality and intent of any suicide-related behavior (Frey et al., 2020).

The term *commit suicide* is one that advocacy and other groups challenge because the word commit usually connotes engaging in a crime. (Suicide once was considered a crime.) The favored terms are to complete suicide or die by suicide, and this course holds to that convention (Massachusetts Coalition for Suicide Prevention, 2016).

Table 1 lists terms describing suicidal behavior as currently defined (Glenn et al., 2020). These terms were selected to help clarify various issues of concern to mental health providers, coroners, and researchers. Each of these acts, with the exception of suicide and suicidal thoughts, can be further clarified as being with injuries, without injuries, or with fatal outcome.

The *intent* to kill oneself is a foundational aspect of defining an act as suicide-related. For example, if a person were to die as a consequence of an *instrumental suicide-related behavior*, as defined in Table 1 (e.g., a knife wound self-inflicted for the purpose of mood regulation rather than death), the death would be classified as accidental rather than suicide because the intent to die is missing. The goal of developing a uniform nomenclature is to increase the ability of mental health providers, researchers, epidemiologists, and policy makers to better communicate with each other and to better research and intervene with at-risk populations.

According to the Navy and Marine Public Health Center (n.d.):

> The knowledge and use of appropriate terminology when dealing with issues related to suicide helps to reduce stigma associated with help seeking. Appropriate use of terminology by the healthcare team and those referring individuals for care promotes and facilitates appropriate and timely care of at-risk individuals and those affected by suicide and demonstrates respect and sensitivity to the experiences of those affected by suicide.

Table 1: Nomenclature Describing Suicidal Behavior

Suicide	Death from injury, poisoning, or suffocation where there is evidence that the injury was self-inflicted and that the deceased intended to kill him- or herself.
Suicide attempt with injuries	An action resulting in nonfatal injury, poisoning, or suffocation where there is evidence that the injury was self-inflicted and that the person intended at some level (more than zero) to kill him- or herself.
Suicide attempt	A potentially self-injurious behavior with a nonfatal outcome for which there is evidence that the person intended at some level (nonzero) to kill him- or herself. A suicide attempt may or may not result in injuries.
Suicidal act	A potentially self-injurious behavior for which there is evidence that the person intended at some level (nonzero) to kill him- or herself. A suicidal act may result in death (completed suicide), injury, or no injury.

Table 1: Nomenclature Describing Suicidal Behavior	
Instrumental suicide-related behavior	Potentially self-injurious behavior for which there is evidence that (a) the person did not intend to kill him- or herself and (b) the person wished to use the appearance of intending to kill him- or herself to attain some other end (e.g., to seek help, to punish others, to receive attention).
Suicide-related behavior	Potentially self-injurious behavior for which there is evidence either that (a) the person intended at some level (nonzero) to kill him- or herself, or (b) the person wished to use the appearance of intending to kill him- or herself to attain some other end. Suicide-related behavior comprises suicidal acts and instrumental suicide-related behavior.
Suicide plan	A proposed method of carrying out a course of action that will lead to a potentially self-injurious outcome.
Suicide threat	Any interpersonal action, verbal or nonverbal, stopping short of a directly self- harmful act that a reasonable person would interpret as communicating or suggesting that a suicidal act or other suicide-related behavior might occur in the near future.
Suicidal ideation	Any self-reported thoughts of suicide (i.e., passive ideation) or engaging in suicide-related behavior (i.e., active ideation).
Non-suicidal self-injury	Self-inflicted injury that is engaged in without suicidal intent.
Note. Based on terms defined in Glenn et al. (2020) and Frey et al. (2020).	

IDENTIFYING CLIENTS AT RISK: IT'S NOT SUICIDE PREDICTION

In a classic study attempting to identify which clients would complete suicide within 5 years based on known risk factors, Pokorny (1992) concluded "that we do not possess any item of information or combination of items that permit us to identify to a useful degree the particular persons who will commit suicide, in spite of the fact that we do have scores of items available, each of which is significantly related to suicide" (p. 127). Unfortunately, though the situation today is better, we still have a long way to go (Large et al., 2017). A recent examination of the predictive power of self-injurious thoughts and behaviors in the prediction of suicidal ideation and behavior came to a similar conclusion. "When considered in the context of the extremely low prevalence of suicidal thoughts and behaviors and the clinical demands that call for very short prediction timeframes, prior self-injurious thoughts and behaviors may not improve prediction much beyond chance levels" (Ribeiro et al., 2016, p. 234). Because of the challenges of predicting suicide outcomes, the provider's primary task instead is to identify those persons most at risk for suicide, and then to appropriately respond to that immediate risk with proper assessment and treatment (Chu et al., 2015). It is important to remember that the notion of assessing risk should not be confused with actually predicting suicide. It also should be remembered that risk assessment, although imperfect, likely saves lives and should be done rigorously.

Warning signs of elevated suicide risk

The following are general warning signs for potential suicidal behavior (National Institute of Mental Health [NIMH], 2018):

- Talking about wanting to die.
- Looking for a way to kill oneself.
- Talking about feeling hopeless or having no purpose.
- Talking about feeling trapped or being in unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious, agitated or reckless.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

In addition to these general behaviors, additional clinical warning signs are defined and arranged in the mnemonic acronym "IS PATH WARM?" (See Table 2). It is also important to note that, whereas depression and/or depressed mood are psychiatric problems associated with risk for suicide, they are not warning signs for suicide. So, for example, while a diagnosis of major depressive disorder may increase an individual's risk for suicide, the diagnosis alone does not indicate that the individual may be suicidal. However, a number of the warning signs, such as hopelessness, withdrawal, and mood changes, are, in fact, symptoms of a depressive episode; therefore, noting changes in associated symptoms is necessary in providing ongoing care and supervision of those who are at heightened risk for suicide. Further information will be provided in subsequent sections to assist clinicians in differentiating general risk factors and warning signs from the most important factors in the upcoming suicide risk assessment section.

Table 2: Warning Signs for Suicide: IS PATH WARM?

Warning Sign	Description
Ideation	Threats or talk of wish to hurt or kill self.
Substance abuse	Increasing alcohol or drug use.
Purposelessness	Expressing no reasons for living.
Anxiety	Agitation, restlessness, unable to sleep.
Trapped	Feeling that there is no way out.
Hopelessness	Self lacks value, others do not care, future is unchanging.
Withdrawal	From friends, family members; sleeping all the time; anhedonia.
Anger	Uncontrolled and excessive expressions of anger.
Recklessness	Acting recklessly; high-risk behaviors.
Mood changes	Dramatic shifts from typical mood state: ask to get more information.

Note. Adapted from "Know the Warning Signs," by the American Association of Suicidology, n.d. Retrieved from http://www.suicidology.org/resources/warning-signs

Predisposing factors

Although there are numerous risk factors for suicide, these are often presented without much context as to when the risk factor might occur or what kind of relationship they may have to an episode of suicidal behavior. By breaking down risk factors into specific types, clinicians, educators, and families can better understand the ways in which a specific factor might be connected to suicidal behavior, and how long before the suicidal behavior such a risk factor may occur. Risk factors for suicidal behavior can be divided into three types in terms of timing in relation to suicidal behavior: distal risk factors, proximal risk factors, and potentiating factors.

Distal factors

Distal risk factors are separated further in time from suicidal behavior, potentially having occurred months, years, or even decades before suicidal behavior. Distal factors are important because they create a statistical potential for suicidal ideation and behaviors; they set the stage for later problems with suicide, so to speak.

Proximal factors

Proximal factors refer to those risk factors that arise in close temporal proximity to acute suicidal behavior, meaning they are often viewed by others, family, or society as "triggering" events that spur acute (recent) suicidal behavior. Indeed, proximal factors can increase individual motivations for suicide, and proximal risk factors can also determine the timing of suicidal behavior by translating the statistical potential of distal risk factors into action (Franklin et al., 2016). Precipitating stressors or crises have substantial predictive value with respect to suicide attempts. Stressful life events have been found to have occurred for most individuals on the day they attempted suicide (Shen, Cunha, & Williams, 2016) or died by suicide (Howarth et al., 2020).

Potentiating factors

Potentiating factors represent a particularly powerful proximal risk factor, and typically involve the availability of lethal means (e.g., owning a gun, access to pills), recent or ongoing major stressors, illness, and so forth. Potentiating factors might be thought of as "triggers" for suicidal behavior, and often align with the warning signs for imminent suicidal behavior as previously discussed. Clinicians should be aware, however, that many patients will not be able to identify potentiating factors for their suicidal behavior.

Distal factors

Biological risk factors

Biological risk factors for suicide can be both distal and proximal. Genetic factors, for example, are a distal risk factor arising at birth, and have been linked to suicide outcomes in large population-based studies (Erlangsen, Appradurai, Wang, Turecki, Mors, Werge, et al., 2018). However, it is important to note that the effects of any one genetic polymorphism on suicidal behavior are relatively small and no clear genetic combination has been found to have large effects in predicting suicidal behavior. Other biological distal factors can include abnormalities in neurotransmitter physiology, hormonal factors, and neurophysiological abnormalities (Turecki & Brent, 2016). Important proximal biological risk factors include suffering from physical illness, chronic pain, cancer, and/or a disability as near-term stressors that could precipitate a suicide crisis (Ferro, Rhodes, Kimber, Duncan, Boyle, et al., 2017; Henson, Brock, Charnock, et al., 2019; Lund, Nadorff, Winer, & Seader, 2016; Racine, 2018). Although biological risk factors likely play a role in the suicidal ideation and behavior of some patients, meta-analytic research has found that many biological links to suicidal behavior are relatively small (Chang et al., 2016), so while it is important to consider biological risk factors, suicide risk assessment and intervention should primarily focus on proximal biological risk factors (e.g., chronic pain or illness) as well as behavioral and psychosocial risk factors. Biological sex (i.e., for cis-gendered men versus women) is another important factor to consider, with men being more likely to die by suicide but with women attempting suicide far more often than men (Siegel & Rothman, 2016).

Psychiatric diagnoses

As has been previously discussed, aside from past suicide attempts, psychopathology is the most important predictor of suicide and is strongly associated with other forms of suicidal behavior. The vast majority (90 to 95%) of individuals who die by suicide have some diagnosable disorder at the time of death (Choi, Lee, & Han, 2020); it is likely that the fraction who did not were experiencing subclinical levels of psychopathology. Although most mental illnesses increase risk for death by suicide (APA, 2013), there are several disorders that are associated with particularly high risk. These include schizophrenia (approximately 13-fold increase in risk; Cassidy, Yang, Kapczinski, & Passos, 2018), anorexia nervosa (up to a 31-fold increase in risk; Selby & Coniglio, 2020), bipolar disorder (approximately 17- fold increase in risk; Olfson et al., 2016), major depressive disorder (approximately 20-fold increase in risk; Olfson et al., 2016), impulse- control disorders such as opioid use (approximately 14-fold increase in risk; Maruti et al., 2017), and personality disorders, especially borderline personality disorder (up to a 45-fold increase in risk; Soloff & Chiappetta, 2019). Retrospective interviews with informants, commonly referred to as psychological autopsies, have frequently been used to investigate the association between psychopathology and suicide and have consistently shown that roughly 90% of individuals who die by suicide had an identifiable psychiatric disorder before death (Perlis et al., 2016).

Prior suicide attempts

Approximately half of individuals who die by suicide do so after a single attempt (Franklin et al., 2016), which means that about 50% of individuals will die on their first attempt. A recent study on risk factors for death by suicide concluded that prior attempts and suicidal ideation were the best predictors of completed suicide (Ribeiro et al., 2016). However, it should be noted that prior attempts and suicidal ideation were relatively weak predictors, as they only increased risk for later death by suicide two-fold. Some research suggests that people who make multiple attempts (i.e., two or more) are at greater risk for further suicide attempts and completion than people who have made only one attempt (Defayette, Adams, Whitmyre, Williams, & Esposito-Smythers, 2020). Additionally, research suggests that, among attempters, the greatest risk for a subsequent attempt is in the 6 months to 2 years following the attempt (Franklin et al., 2016). Clearly, clinicians should take note of any history of prior attempts, as well as the timing of the behavior, in order to better assess risk status.

Substance use

The connection between heavy substance use and suicidal behavior has long been a subject of investigation, with questions arising as to whether the substance drives the individual toward suicidal behavior, or whether the substance is used as a way of coping with the suicidal behavior (Chesin, Interian, Kline, Hill, et al., 2019). Recent meta-analytic studies have identified substance use as a major predictor of suicidal behavior, with the odds of suicide increasing seven-fold among substance users relative to those refraining from substance use (Conner, Bridge, Davidson, Pilcher, & Brent, 2019). For example, alcohol use increases the proximal risk for suicidal behavior because of its ability to increase psychological distress and aggressiveness, push suicidal ideation into action through suicide-specific alcohol expectancies, and limit cognition, which in turn impairs the creation and implementation of alternative coping strategies (Borges, Bagge, Cherpitel, Conner, et al., 2017). Because of the clear link between a variety of substance use disorders and suicide, any acute changes in substance use behavior should be examined in connection to potential increases in suicide risk.

Nonsuicidal self injury

Although by definition non-suicidal self-injury (NSSI) is engaged in without suicidal intent, a host of recent research demonstrates that NSSI is associated with risk for future suicidal behavior (Cipriano, Cella, & Cotrufo, 2017; Selby et al., 2019), and is as strong a predictor of future suicide attempts as are previous suicide attempts themselves (Kiekens et al., 2018). In most cases, NSSI functions as a behavioral coping mechanism through which highly emotional vulnerable individuals use the pain and vividness of the NSSI behavior to distract themselves from these distressing emotions (Selby et al., 2019). However, NSSI behavior should be addressed in clinical settings as an essential way to reduce future risk of suicidal behavior.

Proximal factors

Economic factors

Economic uncertainty has been linked to an immediate increase in suicide risk for those affected (Vandoros, Avendano, & Kawachi, 2019), although economic factors alone are unlikely to be the sole cause of suicidal behavior. Findings include acute adverse financial market conditions as a risk for proximal increases in suicidal behavior (Agrrawal, Waggle, & Sandweiss, 2017). Individuals reporting chronic income and full-time employment problems have also been found to have higher risk (Griffith, 2017). Rates across various socioeconomic statuses tend to fluctuate over time, but suicide rates are generally higher in more economically deprived communities (Iemmi, Bantjes, Coast, Channer, Leone, et al., 2016).

Health disparities and illness

Health disparities are preventable differences in the incidence, prevalence, mortality and disease burden that are closely linked with social, economic, and environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their race or ethnicity; religion; socioeconomic status; sexual orientation; gender, gender expression, or gender identity; age; mental health; cognitive, sensory or physical disability; geographic location; or other characteristics historically linked to discrimination or exclusion (Barnett, Gonzalez, Miranda, Chavira, & Lau, 2018; Oberg, Colianni, & King- Schult, 2016). Young women with a history of an abortion are also indicated to be at higher risk for suicide (Miranda-Mendizzbal et al., 2019), which may be connected to poor access to healthcare and broader support networks.

Family dysfunction

A history of dysfunction in the family of origin is another distal potentiating factor. Family histories of violence, abuse (physical and sexual), neglect, and parental separations are associated with increased suicide risk, as well as a variety of self-harming behaviors (Clements-Nolle, Lensch, Yang, Martin, Peek, & Yang, 2020). Additionally, it appears that suicide tends to run in families, and it has been estimated that social environment and genetic factors play about an equal role in determining who engages in suicidal behaviors (Lin & Tsai, 2016). Other family dysfunction factors linked to suicidal behavior include parental separation or divorce, presence of psychiatric diagnoses in other family members, domestic violence, and displacement (e.g., temporary living situations vs. stable ones; Clements-Nolle et al., 2020; Marshall, Semovski, & Stewart, 2020; Miranda-Mendizzbal et al., 2019).

Romantic relationships and divorce

Difficulties in romantic relationships can be a contributing or even a potentiating factor for suicidal behavior. Dating violence in young women, for example, has been connected to suicide risk (Miranda-Mendizzbal et al., 2019). Non-married and especially divorced status are predictive of suicide among men and, to a lesser degree, women (Kyung-Sook, SangSoo, Sangjin, & Young-Jeon, 2018). As will be seen in subsequent discussion of theoretical models of suicide, romantic relationships represent one of the most important interpersonal relationships an individual can have, and problems in this area can substantially weaken interpersonal connections that buffer against suicide risk.

Domestic violence

Women experiencing turbulent relationships are also at increased risk for suicide, especially when the relationship is characterized by domestic violence and in cases where the partner is exhibiting addiction, coercion, physical assault, jealousy, infidelity, or threatening divorce (Rahmani, Salmasi, Rahmani, Bird, Asghari, et al., 2019). Patients indicating the presence of domestic violence in their home should be carefully screened for suicide risk in addition to addressing personal safety concerns.

Potentiating factors

Suicidal ideation

Suicidal ideation is an important risk factor in the detection of potential suicidal behavior and involves increased thoughts about and potential desires for death, active thoughts about harming oneself or taking one's life, consideration of potential suicide methods and/or plans, and contemplation about planning for one's death (Klonsky, May, & Saffer, 2016). The more intense and frequent suicidal ideation becomes on a daily basis, the greater the need for clinical concern. However, although suicidal ideation is present in the majority of cases of suicidal behavior, suicidal ideation is a non-specific risk factor for suicide, and it is not predictive of imminent suicide risk. Indeed, to date, no studies have found that asking someone about current suicidal ideation is predictive of a suicide attempt in the very near future (Franklin et al., 2016). Accordingly, presence of suicidal ideation should also indicate the need for further suicide risk assessment, however, suicidal ideation in the absence of other risk factors is unlikely to indicate imminent suicide risk. Nonetheless, safety precautions in the presence of suicidal ideation should always be taken.

Suicide plans and preparations

Common behaviors under the umbrella of suicide plans include giving away possessions, writing notes, acquiring weapons or other items that will facilitate a suicidal act. A patient acknowledging the presence of suicidal planning and preparing is known to be one of the strongest risk factors for suicidal behavior (Marie et al., 2020) and should be taken very seriously, as will be discussed in the upcoming section on suicide risk assessment.

Access to lethal means

Access to means to enable a suicide attempt is a particularly troubling risk factor for suicide, especially among men (Miranda-Mendizzbal et al., 2019). In the United States, more than 50% of deaths by suicide involve utilizing a firearm (Khazem & Anestis, 2016). Indeed, the presence of a gun in the home is one of the strongest predictors differentiating those who died by suicide from other suicidal individuals who attempt but survive suicide (Knopov, Sherman, Raifman, Larson, & Siegel, 2019; Santaella-Tenorio, Cerdá, Villaveces, & Galea, 2016). Firearms simply are a very lethal suicide attempt method. This lethality is aided by the quickness and extent of physical trauma that firearms can deliver. All suicide assessments should include questions about the availability of firearms (Khazem & Anestis, 2016). Contrary to interviewers' concerns, patients are likely to adhere to advice about gun removal, and legislation that reduces access to guns is related to lower suicide rates (Houtsma et al., 2018; Anestis et al., 2015). If the patient does have firearms at home, the assessing clinician should advise him or her to remove the ability to access the guns.

High-risk populations

In addition to the prior risk factors, there are certain populations who are known to be at increased risk for death by suicide, including: sexual and gender minority populations, older adults (65 and older), veterans, and individuals in jail or recently released.

Sexual and gender minority populations

Individuals who identify as sexual minorities (e.g., individuals identifying as lesbian, gay, bisexual, transgender, queer, intersex, asexual or those questioning their orientation; LGBTQIA) face a number of unique challenges and stressors, and these stressors have often translated into elevated rates of suicidal behavior for both adults (Chang, Fehling, & Selby, 2020) and adolescents (Chang, Kellerman, Feinstein, Selby, & Goldbach, 2020). Youth and young adult suicide rates can reach as high as 20% among LGBTQIA groups and as high as 41% in transgender groups (Turban, Beckwith, Reisner, et al., 2019), making assessment and intervention for suicide concerns essential for these high-risk individuals.

Senior populations

Suicide is a significant problem among older adults. Suicide rates are particularly high among older men; according to the Suicide Prevention Resource Center (SPRC), men 65 and older have the highest rate of any group in the country (SPRC, 2018b; Sheava, Hitching, & Dunn, 2019). Suicide attempts by older adults are much more likely to result in death than attempts by younger persons. Reasons for this may be that: older adults plan more carefully and use more deadly methods; older adults are less likely to be discovered and rescued; or the physical frailty of older adults means they are less likely to recover from an attempt. Risk factors for this population include depression and other mental health problems; substance use problems (including prescription medications); physical illness, disability, and pain; and social isolation. Protective factors include care for mental and physical health problems, social connectedness, and skills in coping with and adapting to change.

Military populations

Veterans of the wars in Iraq and Afghanistan have a 41 to 61% higher risk of suicide than the general U.S. population (Wood et al., 2020). While risk increases for many reasons, post-traumatic stress disorder (PTSD) has emerged as one of the strongest predictors, but not every veteran develops PTSD or becomes suicidal. Suicide is influenced by multiple factors, including biological factors, such as sex; socioeconomic factors, such as employment status; and other factors, such as access to firearms. These factors can confer increased risk of suicidal behaviors and suicide. The veteran population in general tends to be more affected by these factors or has more access to these risk factors (i.e., firearms), thereby increasing their risk.

Incarcerated populations

Rates of suicide in jails are greater than in the overall population (46 vs. 13 per 100,000), but research findings suggest the suicide rate is even higher in the year following release (Noonan, Rohloff, & Ginder, 2015). Legal problems and incarceration can also affect a number of other psychosocial risk factors, which makes suicide risk assessment for patients with these concerns paramount (Gould, McGeorge, & Slade, 2018).

THEORIES OF SUICIDAL BEHAVIOR

Theories about why people die by suicide have been considered for centuries, with historical conceptualizations of suicide often being unfairly harsh, judgmental, or derogatory toward the afflicted individual. Today, the act of attempting or dying by suicide itself can be viewed as a medical problem and one of the leading preventable causes of death. As such, people exhibiting suicidal concerns should be treated with empathy, compassion, and respect. Nonetheless, many researchers, clinicians, and families still desire to understand what factors may lead an individual to engage in, and in many tragic cases, die from suicidal behavior.

Theories of suicide are often a function of the lens through which the theory writer views behavior more broadly. For sociologists, the function of suicide may point to broader dysfunction in society. For biological and medically-oriented approaches, suicide may be viewed as either a function of genetic risk or neurophysiological dysfunction (Miller & Prinstein, 2019). For psychologists, suicidal behavior may be viewed as a behavioral reaction to difficult emotional and interpersonal stressors. In any regard, suicidal behavior remains one of the more debated topics at the crossroads of public health, philosophy, and bioethics (Malhi, 2019). Common to all theories of suicide, however, is the premise that the person experiencing the suicidal crisis desires to die, and hopefully, in better understanding what causes this desire, healthcare providers can improve suicide prevention and recovery efforts. This next section briefly reviews some key historical and modern theories of suicide.

Durkheim's Sociological Theory of Suicide

French sociologist Emile Durkheim was one of the first to publish a historic account of suicide in 1897, and although multiple models have been advanced since then, Durkheim's approach is still used to understand aspects of suicide today. Unique in his time, Durkheim reported on occurrences of suicide across groups of individuals. Some of his findings remain true to this day (e.g., suicide rates are higher among men than women, and suicide rates are higher among soldiers than civilians). Perhaps his greatest contribution to the field was his definition of four types of suicides (listed below), derived from the imbalance between social integration and moral regulation (Durkheim, 2005):

- **Egoistic suicide**: Refers to a suicide resulting from a sense of detachment from society, a lack of belongingness or integration with a community. Apathy and meaninglessness may result.
- **Altruistic suicide**: Occurs when an individual is overwhelmed by society's goals and beliefs and finds the achievement of these goals to be more important than his or her own individual life, such as suicide bombers and other soldiers in war. Thus, in an altruistic society, individuals would have no need for suicide, except in cases where it is expected that the individual kill themself on behalf of society.
- **Anomic suicide**: Results from moral deregulation and lack of social restraint. The individual does not appear to understand how he fits into society. He is unaware of the limits to desire and is constantly left feeling disappointed.
- **Fatalistic suicide**: Is the opposite of anomic suicide and occurs when individuals feel societally oppressed, as if their futures are hopelessly directed for them. In these cases, the individual believes it is better to die than to continue to live within that society.

Joiner's Interpersonal Theory of Suicide

Perhaps the most empirically examined and comprehensive model to date is Dr. Thomas Joiner's Interpersonal Theory of Suicide (IPTS; Joiner, 2005; Van Orden et al., 2010; Ma, Batterham, Calear, & Han, 2016). To date, literally hundreds of studies have been published testing and exploring the theory (Chu et al., 2017), providing an evidence base that rivals the best models across all of psychological science. Based on ample empirical support, Joiner's theory postulates that for an individual to die by suicide, the individual must first develop the desire to die, and second, the individual must have developed the capacity to enact lethal self harm. The desire to die (suicidal ideation) arises through two key constructs: perceived *burdensomeness* and *failed belongingness*.

Perceived burdensomeness is the individual's belief that not only is he or she flawed in some capacity but that his or her existence burdens friends and family. While the suicidal individual believes this calculation to be correct, it is a potentially fatal misconception. Perceived burdensomeness occurs when a person believes his death is worth more than his life to others (Teismann, Forkmann, Rath, Glaesmer, & Margraf, 2016).

Failed belongingness is the sense that the individual is alienated from his or her significant others. When this feeling is combined with perceived burdensomeness, Joiner's theory suggests that all ties to life are cut off and the desire for death becomes seen as an option. Thwarted belongingness results when the basic human need of connection to others (Hom, Chu, Schneider, Lim, Hirsch, Gutierrez, & Joiner, 2017), is not met.

When an individual experiences the desire to die, as a function of impaired belonging and perceived burdensomeness, that does not necessarily mean that individual engages in suicidal behavior. For suicidal behavior, the individual must exhibit acquired capability.

According to the IPTS, the *acquired capability* for suicide is believed to be one of three proximal, jointly necessary, and jointly sufficient causes that must be present before a person will die by suicide; the other two factors are *perceived burdensomeness* and *low (or thwarted) belongingness*. Acquired capability for suicide is a construct made up of both pain tolerance and fearlessness about death. Specifically, according to the IPTS, humans have been evolutionarily designed to fear dying, and thus, in order to overcome this fear and make a lethal suicide attempt, a person must become accustomed to the fear and pain involved in dying. The theory further posits that the capability for suicide is developed over time with repeated exposure to pain (e.g., childhood abuse, injuries) and provocative events (e.g., being in combat, shooting a gun, bungee jumping). The acquired capability for suicide is believed to be elevated primarily through behaviors and physical experiences and has been found to be in part genetically determined (Rimkevicience, Hawgood, O'Gorman, & De Leo, 2017). Notably, Chu and colleagues (2017) found evidence for the distinctiveness of the acquired capability for suicide from suicidal ideation. In other words, one may have acquired the capability for suicide, but have no suicidal desire. Conversely, one may have suicidal desire, but lack the capability to die by suicide. However, having elevated acquired capability in conjunction with perceived burdensomeness and low belongingness is believed to put an individual at risk for death by suicide.

Thus, according to Joiner's model, suicide attempts and deaths will only arise when an individual experiences all three essential risk factors simultaneously: thwarted belongingness, perceived burdensomeness, and acquired capability for suicidal behavior. Overall, the Interpersonal Theory of Suicide has done much to advance the understanding of suicide and has garnered an impressive level of empirical support. However, the nature of science is to strive for the most accurate and predictive level of understanding possible, and additional advances building on the interpersonal theory continue to be made.

Three Step Theory (3st; Klonsky & May, 2015)

Although Joiner's Interpersonal Theory has made substantial improvements in our understanding of suicidal behavior, the truth is that suicidal behavior is a complex phenomenon and is influenced by a larger number of interacting variables than even the brightest human mind can integrate. This has led to more modern research approaches utilizing complexity science and machine learning in attempts to understand the interplay between more variables than are humanly comprehensible (Ribeiro et al., 2019).

As these efforts continue, however, one major theoretical breakthrough in the field has been to narrow down the issue of suicide into one essential component: the transition from suicidal ideation into suicidal action. This issue is best exemplified by a recent "ideation-to-action" model proposed by Klonsky and May (2015), referred to as the *Three-Step Theory (*3ST). The issue of ideation-to-action in suicidal behavior starts with the understanding that there are a substantial number of individuals who experience suicidal ideation, and yet only a small fraction of those individuals ever goes on to attempt suicide, and even fewer die by suicide. Ideation-to-action models attempt to understand this transition and what factors spur an individual to move from suicide contemplation into suicidal planning, preparation, and behavior.

The first step in the 3ST (Step 1) posits that the individual first experiences a combination of psychological pain and hopelessness that leads to the development of suicidal ideation. This may be a function of various variables, including but not exclusive to those factors outlined in the interpersonal theory of suicide. In this step pain can be derived from a variety of sources, but the feeling of hopelessness is necessary because it creates the perception that this pain will not fade. Step 2 in the 3ST then posits that suicidal ideation escalates as psychological pain intensifies and overwhelms feelings of interpersonal connection. In this case, interpersonal connectedness is viewed as one of the final safeguards against the desire for death, and if those bonds are overcome, risk for suicide becomes more severe. Finally, Step 3 in the 3ST suggests that suicidal ideation can only be acted upon when an individual develops an acquired capability for suicidal behavior (from the interpersonal theory or suicide). It is only at this stage that suicidal behavior can occur.

The 3ST has made substantial contributions to the theoretical basis of suicide and helps build an understanding of the process that patients may experience in the development of suicidal ideation (initial desire to die) and eventually into enacting suicidal behavior. Ongoing research continues to provide support for the 3ST model as well (Klonsky, Saffer, & Bryan, 2018).

Overall, major progress continues to be made in enhancing our understanding of the causes of suicidal behavior; the better we can understand these causes, the better we can improve our suicide risk assessment and intervention efforts. The next section details suicide risk assessment, including ways in which these assessments have been enhanced by integrating the above-outlined theories of suicidal behavior.

SUICIDE RISK ASSESSMENT TOOLS

Psychological Questionnaires and Interviews

The Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011) is a questionnaire used for suicide assessment that can also be conducted in an interview format. It is available in 114 country-specific languages. Mental health training is not required to administer the C-SSRS. Three versions of the C-SSRS are available for use in clinical practice. The Lifetime/Recent version is used to gather lifetime history of suicidality as well as any recent suicidal ideation and/or behavior. The Since Last Visit version assesses suicidality since the patient's last visit. The Screener version of the C-SSRS is a truncated form of the full version. Various professionals can administer this scale, including physicians, nurses, psychologists, social workers, peer counselors, coordinators, research assistants, high school students, teachers, and clergy.

The C-SSRS supports suicide risk assessment through a series of simple, plain-language questions. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support the person needs. Users of the C-SSRS tool ask people:

- Whether and when they have thought about suicide (ideation);
- Which actions they have taken to prepare for suicide, and when; and
- whether and when they attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition.

Whichever clinical assessment measure is utilized, it is important to make sure the requirements of the measure fit the needs of the setting with regard to length of administration, required background of the clinical assessor, and the intervention/documentation requirements of the setting/agency. Furthermore, any clinical assessment can be further informed by the suicide risk assessment modalities that will be discussed further along in this section.

For clinicians wanting to obtain a thorough assessment of both NSSI and suicidal behavior, it is recommended that the **Self-Injurious Thoughts and Behaviors Interview** (SITBI; Nock et al., 2007; Fox et al., 2020) be used. The SITBI is a well-validated, structured clinical interview consisting of five modules that assess self-injury, suicidal ideation and plans, and suicidal behavior. A major focus of the interview is about the form, frequency, and severity of self-injury, as well as the frequency and intensity of urges about self-injury. Participants respond to open-ended questions about the frequency, methods, and severity of self-injury, and then they rate the various functions of self-injury as it applies to their behavior using a Likert scale ranging from 0 (never) to 4 (frequently). Options for the functions of self-injury include escaping aversive feelings, generating feelings, communication with others, or to avoid activities or others. Participants also rate the extent to which they feel pain during self-injury, and to what extent their family, friends, or peers may have contributed to self-injurious behavior. Finally, participants also rate the likelihood that they will engage in self-injury in the future.

The SITBI interview also assesses the dangerousness of self-injurious behaviors and if previous medical attention was required for the behavior. The SITBI also consists of segments about the frequency, intensity, and duration of suicidal ideation in the past week through the past year, occurrence of suicidal plans and gestures, and detailed information about previous suicide attempts. Each of the five modules begins with an initial screening question, and if that initial question is endorsed, then the full module is included in the interview. This allows for skipping sections that are not relevant to an interviewee, thus reducing the total length of the interview. A particular advantage of the SITBI is that it includes a thorough assessment of suicidal ideation and behavior in addition to self-injury, a feature that is particularly useful given the high association between self-injury and suicidal behavior (Fox et al., 2020). The SITBI interview is freely available from the developer's website (see the Resources section of this course) and comes in longer and shorter versions depending on assessment needs. With some time, preparation, and training, the interview can be integrated into a wide variety of clinical settings.

Virtual Suicide Risk Assessment Measures. With regard to suicide-specific online measures, the field of virtual suicide assessment has boomed over the last few years. New improvements have been made with real-time monitoring of suicide risk (Kleiman, Turner, Fedor, Beale, Huffman, & Nock, 2017) and integrating virtual suicide monitoring into general hospital settings and emergency departments (Kroll, Stanghellini, DesRoches, et al., 2020). Numerous suicide risk assessment and safety planning apps have been studied, including: Virtual Hope Box (Bush, Smolenski, Denneson, et al., 2017), Stay Alive (Bakker, Kazantis, Rickwood, & Rickard, 2016), Suicide Safety Plan (de la Torre, Castillo, Arambarri, et al., 2017), and many others (Castillo-Sanchez, Camargo-Henriquez, Munoz-Sanchez, et al., 2019). However, despite such drastic progress in this area, there remains yet to be a clear, gold-standard online or virtual suicide risk assessment program or protocol. Therefore, while these emerging options continue to be studied, it is recommended to supplement any virtual or online methods with more traditional clinical assessment protocols.

INITIATING A SPECIFIC-SUICIDE INQUIRY

Now that we have covered some basic information and options regarding clinical assessment and suicide risk assessment modalities, we will focus our attention on the suicide risk assessment process more specifically. It is common for clinicians who are new to assessing suicide risk to have some hesitation or anxiety about asking about suicidal behavior; suicidal thoughts and behavior can be upsetting and worrisome to learn about for any clinician, educator, or family member. However, it's also important to recognize that being unwilling to inquire about suicidal behavior can be exceedingly dangerous and, in some cases, tragic. Therefore, if there is any concern for suicide risk, any reticence or anxiety on the part of the clinician must be overcome to ensure safety. Fortunately, any anxiety associated with conducting a suicide risk assessment will be reduced over time, and the more a clinician can respond to the at-risk individual with a calm demeanor and empathy, the more readily an intervention plan can be enacted.

When conducting a suicide-specific inquiry, clinicians should use explicit language when asking patients about suicidal thoughts, for example: "Have you had thoughts about killing yourself?" (Chu et al., 2015). Blunt language may help elucidate the seriousness of the patient debate. Another advantage of the direct question is that the phrase "killing yourself" is not ambiguous; what is being asked is quite clear. Some clinicians may feel anxious about this and feel an impulse or desire to use more gentle language, but this impulse can result in reduced accuracy of assessment, so clinicians must withstand this impulse.

The following general questions should be answered in the course of a suicide risk assessment:

- What are the suicide-relevant thoughts?
- Are they active or passive?
- When did they begin?
- How frequent are they?
- How persistent are they?
- Are they obsessive?
- Can you control them?
- Are there command hallucinations (i.e., with an external voice encouraging suicidal behavior)?

One of the most common reports by patients is referred to as *passive suicidal ideation*. Passive suicidal ideation refers to desires for death in the absence of an active will to harm oneself, and even though this may be a less severe form of suicidal ideation, it should still be taken very seriously (Liu, Bettis, & Burke, 2020). *Active ideation*, on the other hand, refers to clear thoughts and/or desires to harm or kill oneself. The presence of a suicide plan further increases the risk for suicide beyond ideation. How well the plan is thought out, its consideration of avoiding detection, and the lethality of the planned method all converge in the assignment of the risk level for suicide. A patient may not know that their planned method of suicide is not a great risk for imminent death (e.g., overdosing on three extra Zoloft); however, it is the patient's perception of risk for death that should be ascertained.

The patient's level of ambivalence also should be assessed. Even up until the moment of death, many patients who die by suicide appeared to have debated the question of continuing to live or not (Bergmans, Gordon, & Eynan, 2017.) Less risk would be indicated by there being a greater number and ranking for reasons to live. The tension between the "living-or-dying" internal debate can create great anxiety, which in turn can confer greater risk for acting on suicidal thoughts (Bergmans et al., 2017; Deuter, Procter, & Evans, 2019). Hopelessness, as conveyed by patients' belief that their situation cannot improve, should also be assessed at this juncture. Hopelessness has been shown to be a significant predictor of suicide risk (Ribeiro, Huang, Fox, & Franklin, 2018), though it is not necessarily an indicator of near-term suicide danger because, for many patients, hopelessness can exist for some period of time before suicidal action is taken (Qiu, Klonsky, & Klein, 2017).

Now that the basic foundations of clinical and suicide risk assessment have been laid, two potential suicide risk assessment framework options will be discussed in detail. Two independent frameworks are presented so that clinicians and educators can select the framework that best fits the unique needs of their practice or educational setting. Both frameworks have established empirical evidence in improving suicide detection and intervention outcomes, and differences between the frameworks tend to be more stylistic, with each framework sharing some key strategies. Presented in no particular order of preference are:

- Framework #1 – **Five-Step Evaluation and Triage (**SAFE-T; Fowler et al., 2017); and
- Framework #2 – **Joiner's Assessment Model** (Joiner et al., 1999; Chu et al., 2015).

Determining the level of intervention

Regardless of which suicide risk assessment approach is utilized, it is always necessary for an interviewing clinician to establish the suicide risk level of an individual *AND* select the appropriate level of intervention necessary to keep the high-risk individual safe. While some completing this training may not have definitive clinical duties and responsibilities that require them to intervene with a patient, it is nonetheless important and potentially lifesaving to follow the same procedures outlined with regard to assigning risk level and appropriate level of intervention.

Depending on the specific situation, determinations need to be made about the client's ability to manage the situation. For example, it is often necessary for the therapist to take control when suicidality is related to certain risk factors such as high-risk psychiatric disorders (e.g., schizophrenia), prominent feelings of pain and a wish to escape, or risk that is acute. When the specific situation is related to a client's personality disorder that presents with chronic suicidality and prominent feelings of anger, Jacobs and colleagues recommended giving the client more control and responsibility in managing the situation (Jacobs et al., 1999).

Although clients with personality disorders may exhibit a clear predominating set of features, it also should be remembered that they can shift toward greater risk and always need to be fully evaluated. In such cases, the clinician should be ready to take more responsibility than was previously appropriate. If suicide risk is deemed high in these clients, the clinician needs to ensure that the individual is in an appropriately safe and secure environment. It is vital that the clinician organize reassessment within 24 hours. The clinician should make sure that contingency plans are in place for rapid reassessment if distress or symptoms escalate.

Clinicians need to assess a client's competence to enter into a treatment process when suicidal danger is acute. The client should be able to explain the risks and benefits for each treatment course considered. Given the extreme constriction that often is evident with suicidal clients, seeing alternatives may be quite a challenge for them. For example, clients experiencing a recent relationship break-up may be experiencing high levels of stress and suicidal ideation and may believe that the only solution left is suicide. They may have convinced themselves that they are "unlovable" and will never find love again because their partner has left them. If a client's competence to consent to treatment is impaired or if the clinician judges that the client is at imminent risk for suicide, involuntary treatment (usually hospitalization) should be sought.

SUICIDE ASSESSMENT FRAMEWORK OPTION #1: FIVE-STEP EVALUATION AND TRIAGE (SAFE-T)

Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) was developed in collaboration with the Suicide Prevention Resource Center (SPRC) and Screening for Mental Health (SAMHSA, 2017). The screening tool is the product of Screening for Mental Health, Inc. (SMH) and Suicide Prevention Resource Center in 2009 but remains one of the two screening tools recommended by SAMHSA in 2017.

Almost 3% of adults are assumed to experience thoughts of suicide at any specific time. The assumption is that the incidence of suicidal thoughts is much higher among adolescents. Five steps have been denoted key components of any suicide risk assessment (Kazim, 2017):

1. **Assessment of risk factors**: Risk factors include various life events and circumstances, such as illness. The strongest predictor of suicide is the presence of a previous suicide attempt. Individual risk factors for suicide include major physical illness, chronic pain, and the presence of traumatic brain injury. Mental health disorders are also included in this category. This section should also include a family history of suicide and abuse, the patient's psychiatric state of mind, the presence of drugs, and other confounders, such as insomnia.
2. **Suicide inquiry**: This suicide-specific inquiry should include specific questions about suicidal thoughts/ideation, suicidal plans, suicidal intent, and access to means. In general, patients will not spontaneously report suicidal ideation, but it has been shown that up to 70% of patients will report their intentions to attempt suicide to their friends and family members. To get patients to open up when asking about suicidal ideation, it is important that the clinician avoid asking leading questions (Kazim, 2017). An example of a wrong question to ask is, "You are not thinking about committing suicide, are you?" The correct question to pose is, "Have you ever tried to kill yourself or thought about suicide?" If this inquiry reveals no indications of any suicidal ideation, questioning may stop at that time. However, if the clinician is highly suspicious that the patient may have suicidal thoughts, but initially denies any suicidal thoughts, he or she may keep asking questions as many times as necessary until the incongruence is resolved. The clinician must ask questions until any discrepancies between the assessment and the patient's responses are addressed.
3. **Determine intensity**: In cases where the patient is having suicidal thoughts, the clinician should ask specific questions about the intensity and frequency of the suicidal thoughts as well as the degree to which the patient is prepared. Does the patient have a suicide plan? If a specific plan is described, the clinician should document that and document whether the patient has self-injurious or lethal plans. Additionally, the clinician should inquire about the method of suicide rehearsals, such as loading a gun, walking on a bridge to assess the height, or tying a noose. Whenever possible, the clinician should confirm findings with a family member or a close friend because patients are more likely to inform close relations of suicidal ideation than they are to tell a healthcare provider.
4. **Assessment of protective factors**: The clinician should inquire about existing protective factors against suicidal thoughts, such as strong family ties and friendships or the presence of a significant other. Additionally, religious belief, faith, and a sense of belonging can be used as protective factors. It is best to explore the patient's reasons to die versus reasons to live. The presence of protective factors can help dampen the suicide risk in people with low or moderate

suicide risks. Ideally, protective factors can be strengthened and used as part of safety planning in patients with low to moderate suicide risks.

5. **Clinical judgment**: The provider should use the above information to form and make a clinical decision on the risk of suicide. Clinical decision making is complex given the medical comorbidities, mental health diagnoses, and the contextual and environmental factors affecting patients with suicidal risk. This decision-making process also includes appropriate documentation of risk and intervention.

Assessment of risk level is based on clinical judgment after completing steps 1 through 3.

High risk level:

- **Risk and/or protective factors:** Psychiatric disorders with severe symptoms, or acute precipitating event.
- **Suicidality**: Potentially lethal suicide attempt or persistent ideation with strong intent or rehearsal.
- **Possible interventions**: Admission generally indicated unless a significant change reduces risk; suicide precautions necessary.

Moderate risk level:

- **Risk and/or protective factors**: Multiple risk factors, few protective factors.
- **Suicidality**: Suicidal ideation with plan, but no intent or behavior.
- **Possible interventions**: Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers.

Low risk level:

- **Risk and/or protective factors**: Modifiable risk factors, strong protective factors.
- **Suicidality**: Thoughts of death but no plan, intent, or behavior
- **Possible interventions**: Outpatient referral, symptom reduction, give emergency/crisis numbers.

The documentation of the above-four components in their entirety within the medical record (Kazim, 2017).

SUICIDE ASSESSMENT FRAMEWORK OPTION #2: JOINER ASSESSMENT MODEL

Joiner and colleagues (1999) originally developed a suicide risk assessment decision-tree interview based on the interpersonal theory of suicide, which was also recently updated by Chu and colleagues (2015). The Joiner assessment model is comprehensive and organized into four risk categories (low, moderate, severe, extreme). However, these categories are flexible, and individuals can be classified in between categories (e.g., low-moderate, moderate-severe). As with all risk assessments, Joiner and colleagues note "suicide risk categories guide clinical decision making and allow clinicians to titrate the level of clinical action insofar that efficiency and efficacy are maximized" (Chu et al., 2015, p. 1187).

The first step involves conducting the suicide risk assessment. Joiner and colleagues provide a template for a semi-structured interview to use (see the article by Chu and colleagues in the Resources section of this course). Box 1 is a sample semi-structured interview for clinicians to conduct when assessing suicide risk. The Joiner system requires the assignment of a risk category that then guides the clinician's intervention. After risk is assessed, clinicians can use the suicide decision-tree to determine risk level (see Figure 1 and Table 3). For example, a person who has not attempted suicide multiple times experiencing suicidal ideation with limited intensity and duration, with no intent, would be assigned a low-risk category; a person who has attempted death by suicide multiple times with strong intent and who has made preparations for suicidal behavior would be assigned to the extreme-risk category. Joiner and colleagues also offer clinicians possible actions to take depending on the client's risk category and explain how to appropriately document these actions (see Box 2). Some of the actions listed in Box 2 are explained in greater detail later in the course.

Box 1: Suicide Risk Assessment Interview

Assess ideation and desire:

1. Have you been having thoughts of suicide or killing yourself? Have you been having thoughts of wanting to be dead? Please tell me about them.
   a. How often are you having these thoughts?
   b. How long do they last?
   (If the client answers "no" to question 1, ask: Have you ever had thoughts about suicide or wanting to be dead?)
2. Tell me about previous suicide attempts. How many times have you hurt yourself with some desire to die? How did you do it (by what means)? What were the results?

Now assess resolved plans and preparation:

3. On a scale of 0 to 10, rate the strength of your intention to kill yourself right now (or tomorrow, or next week), with 0 being no intention at all and 10 being definite intention. What was the strength of your intention last week? What do you imagine your intention will be in the near future?
4. Do you have any plan(s) for how you would kill yourself? What are they?
   (If client answers "no" to question 4, ask: Have you ever made a plan to kill yourself? What was it? Have you researched methods of killing yourself?)
   (If there is no current or past planning, proceed to question 9.)
5. Have you made preparations for a suicide attempt (e.g., buying pills, rope, gun)? Have you written a suicide note?
6. Do you have the pills, rope, gun?
7. When and where do you think you will implement your plan? Will there be an opportunity to implement your plan? When?
8. Are you afraid to die? (Scale of 0 to 10, with 0 = not at all afraid; 10 = very afraid) Are you confident that you could attempt suicide?

Box 1: Suicide Risk Assessment Interview

Now assess perceived burdensomeness and belongingness:

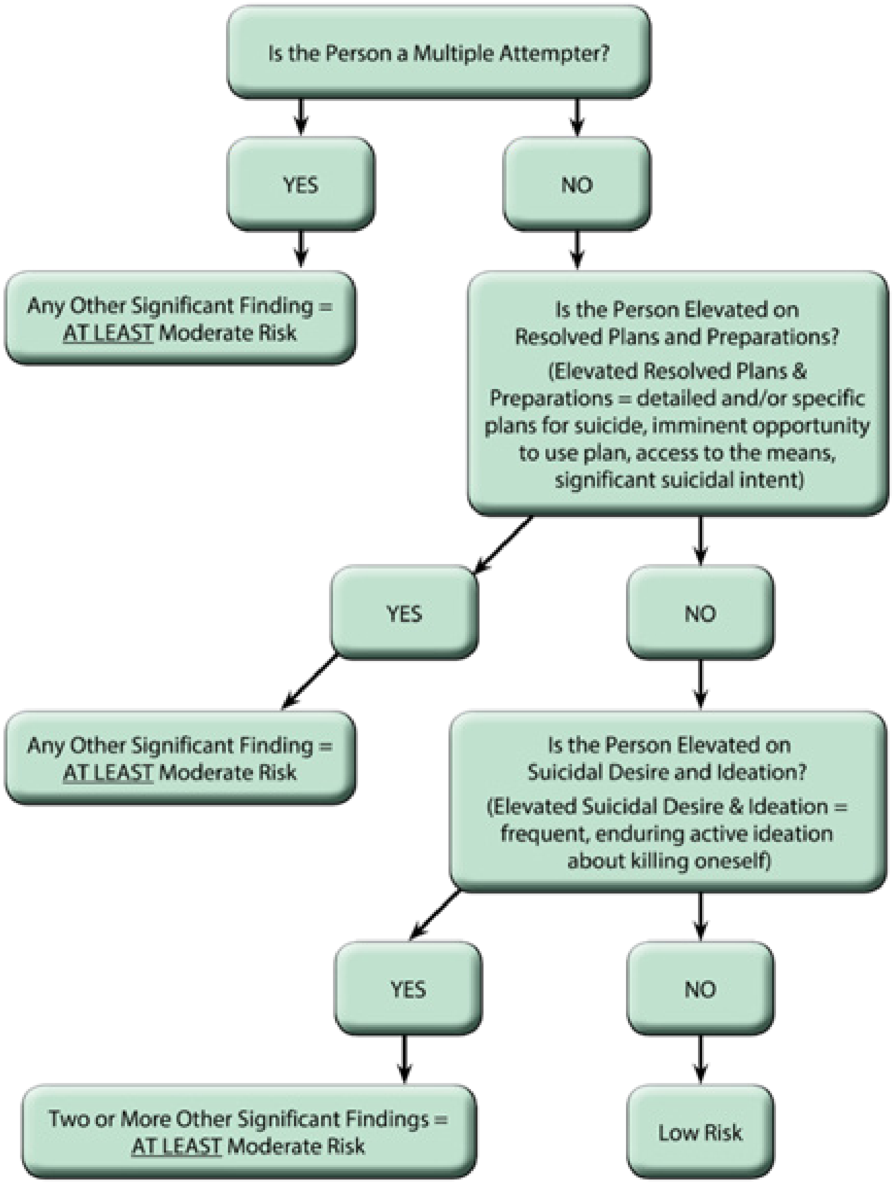
9. People sometimes think things like: 'My friends or family would be better off without me.' Do you ever have thoughts like that?
10. Are you connected to others? Does anyone live with you?
11. When you feel badly, is there someone you can call? Who are they? Is there anyone you feel close to?
12. How hopeless do you feel? Is there more you can say about it?

Now assess important factors (other significant findings):

13. Have you ever harmed yourself by cutting, burning, or causing other injury without the intention of dying (NSSI)?
14. Is there something stressful happening or currently going on? Has there been something stressful recently?
15. What do you do when you feel bad? People sometimes do impulsive things to help themselves feel better like self-harming, drinking alcohol, binge eating, having sex, or destroying things. What do you do to try to feel better?
16. Interviewer should assess for the presence of psychopathology.
17. Interviewer should assess for agitation, social withdrawal, rage, insomnia, guilt, nightmares, impulsivity, and marked irritability.

Note. Adapted from "Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update," by C. Chu, K. M. Klein, J. M. Buchman-Schmitt, M. A. Hom, C. R. Hagan, & T. E. Joiner, 2015. *Journal of Clinical Psychology, 71*(12), pp. 1186-1200.

Figure 1: Suicide Assessment Decision Tree



Note: Adapted from "Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update," by C. Chu, K. M. Klein, J. M. Buchman-Schmitt, M. A. Horn, C. R. Hagan, and T. E. Joiner, 2015, *Journal of Clinical Psychology, 71*(12), pp. 1186-1200.

Table 3: Risk Categories

Risk Rating	Description
Low	• No symptoms of suicidal ideation. • Non-multiple attempter with ideation that is limited in intensity and duration; no/mild plans or preparations for an attempt; and no/few risk factors. • Multiple attempter with no other risk factors.
Moderate	• Non-multiple attempter with moderate-severe suicidal desire/ideation, no/mild plans and preparations for an attempt, and two or more risk factors. • Non-multiple attempter with moderate-severe plans and preparations. • Multiple attempter plus one other risk factor.
Severe	• Non-multiple attempter plus moderate-severe plans and preparations for an attempt, and one or more risk factors. • Multiple attempter plus two or more risk factors.
Extreme	• Non-multiple attempter plus severe plans and preparations for an attempt and two or more risk factors. • Multiple attempter plus severe plans and preparations for an attempt.

Note: Note. Adapted from "Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update," by C. Chu, K. M. Klein, J. M. Buchman-Schmitt, M. A. Horn, C. R. Hagan, and T. E. Joiner, 2015, *Journal of Clinical Psychology, 71*(12), pp. 1186-1200.

Box 2: Taking Action and Documenting

Rate Risk (also use decision tree)

Risk is: low ☐ low-moderate ☐ moderate ☐ moderate-severe ☐ severe ☐ extreme ☐

Take Action All the following actions can be taken by assessor:

Low End of Risk Scale:

- Regular monitoring.
- Provide client with emergency numbers (1-800-273-TALK and local numbers).
- Provide client information about adjunctive treatment.
- Encourage client to seek support from friends and family.
- Tell the client: "If you begin to experience suicidal feelings and for any reason cannot get help, go to the closest emergency department or call 911."
- Document.

Low to Middle of Risk Scale (take previous actions and also …)

- Mid-week phone check-in scheduled for: ____.
- Means safety/restriction interventions (ask about removing guns, pills, ropes from the home or restricting access in other ways).
- Complete safety plan form with client.
- Complete a crisis card with client.
- Consult supervisor within 24 hours.

Above Middle of Risk Scale (take all previous actions and also …)

- Frequent phone check-ins.
- Arrange for client not to be alone (monitored by family member or friend).
- Consult supervisor before client leaves.

Severe or Extreme Risk

- Voluntary or involuntary hospitalization.

Consult if: unsure of risk level or actions taken, moderate to severe risk level or above, notable increase in symptoms.

Suggested Documentation

"Suicide risk was assessed according to Joiner et al. (1999) and determined to be [low/moderate/severe/ extreme] due to … [e.g., ideation, plans, preparations, etc.]. Action taken: [e.g., safety plan, emergency numbers, consulted with supervisor, etc.]. Risk will continue to be monitored."

Note. Adapted from "Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update," by C. Chu, K. M. Klein, J. M. Buchman-Schmitt, M. A. Horn, C. R. Hagan, and T. E. Joiner, 2015, *Journal of Clinical Psychology, 71*(12), pp. 1186-1200; and "Scientizing and Routinizing the Assessment of Suicidality in Outpatient Practice," by T. E. Joiner, Jr., R. L. Walker, M. D. Rudd, and D. A. Jobes, 1999, *Professional Psychology: Research and Practice, 30*(5), pp. 1-7.

The presence or absence of a history of multiple prior attempts is an important variable in the Joiner system and is emphasized with a separate categorization of risk. In a classic study, Rudd, Joiner, and Rajab (1996) explored the relationship among suicide ideators, single attempters, and multiple attempters across several categories, and they determined that "multiple attempters presented a more severe clinical picture and, accordingly, elevated suicide risk compared to [single] attempters and ideators" (p. 541).

Further, according to the Joiner risk assessment model, attempt status (i.e., whether the individual has attempted once [single attempter] or more than once [multiple attempter]) should be considered along with several risk factors in order to determine an individual's risk category. Risk factors from Joiner's model of suicidal behavior, the Interpersonal Theory of Suicidal Behavior (IPTS; Joiner, 2005; Van Orden, et al., 2010) include:

- Capability for suicide (e.g., non-suicidal self-injury, fearlessness about death).
- Thwarted belongingness.

- Perceived burdensomeness.
- Hopelessness.
- Family history of suicidal behavior.
- Recent stressful life events.
- Impulsivity, and
- Presence of acute indicators of risk (agitation, social withdrawal, sleep disturbance, severe affective states, weight loss).

Once a decision about acquired capability has been made, the decision-tree interview should be conducted. Resolved plans or preparations that are clear and with high intent, combined with any other significant findings, result in at least moderate risk. Even without resolved plans or preparation, elevation of suicidal desire or ideation combined with two or more other significant findings result in at least moderate risk. Perhaps the most compelling aspect to this assessment approach is that every element is backed up by ample empirical data for the resulting clinical decisions (Chu et al., 2015; 2017).

Joiner and colleagues also offer clinicians possible intervention actions to take depending on the patient's risk category and explain how to appropriately document these actions (see Box 2). Notably, safety intervention can take a variety of forms from provision of crisis hotline numbers, to generation of helpful activities to cope with suicidal ideation, to higher levels of care and/or hospitalization. Intervention activities will be discussed in further detail later on in the course. Finally, the final step in suicide risk assessment in the Joiner model is, after assigning risk level and developing an intervention plan, appropriate documentation. Examples of documentation of the assessment and intervention level can be found in Box 2.

The Joiner model is illustrated in the following case examples. First example:

Samantha is a 20-year-old white female who presented for therapy after the break-up of a long-term relationship. During intake, she noted that she wanted help for her "serious abandonment issues" and stated that she often "jumped from one relationship to another." Samantha noted that she "can't be alone" and that she has suffered from these problems over the past 5 years. She had no prior treatment history but meets criteria for borderline personality disorder. Samantha had no history of engaging in self-injurious behaviors and denied current and past suicidal ideation.

According to the Joiner model, Samantha would be considered to be at low risk because she has no past or current suicidal symptoms. In this case, the Joiner model would recommend taking the following actions:

- Tell the client something along the lines of:
  > *"In the event that you begin to develop suicidal feelings, here's what I want you to do: First, use the strategies for self-control that we will discuss, including seeking social support. Then, if suicidal feelings remain, call [the emergency call person]. If, for whatever reason, you are unable to access help, or if you feel like things just won't wait, call 911 or go to the emergency department."*
- Give additional emergency numbers, including 1-800-273-TALK.
- Consider creating a safety plan (see Intervention section).
- Continue to monitor risk in subsequent sessions.
- Document activities in progress notes.

Second Example:

Megan is a 37-year-old white female who presented for treatment of depression. She reported that she had been depressed her entire life. As a teenager, Megan abused alcohol and drugs, including amphetamines, marijuana, and LSD, and received inpatient substance use treatment at the age of 18. Shortly thereafter, Megan joined Alcoholics Anonymous and has not used alcohol or drugs since that time. Megan has attempted suicide twice, once by overdose and once by carbon monoxide poisoning, and cut herself in several locations while in substance use treatment. Megan was diagnosed with persistent depressive disorder and borderline personality disorder. She scored in the severe range on the Beck Depression Inventory (31) and reported frequent suicidal ideation but denied suicidal intent. Megan also reported difficulties in her romantic relationship and indicated that she had no close friends. In addition, she reported that she had been unable to maintain employment as a result of difficulty communicating with others.

According to the Joiner model, Megan would be considered to be at severe risk because she is a multiple attempter and has current suicidal ideation and at least two additional risk factors (depression, borderline personality disorder, relationship difficulties, thwarted belongingness, employment difficulties).

In this case, the Joiner model would recommend taking the following actions:

- Consult with colleague or supervisor before client leaves.
- Consider emergency mental health options with colleague/supervisor (and offer to client).
- Create a safety plan.
- Give emergency numbers including **1-800-273-TALK**.
- Schedule mid-session phone check-ins.
- Attempt to limit access to lethal means (ask about guns, pills, etc.) and document if client refuses.
- If client leaves, arrange for client to be accompanied/monitored at all times until next appointment.
- If hospitalization is not warranted, get client's permission to elicit help/support from family members.
- For minor clients, notify parents/guardians.
- Continue to monitor risk in subsequent sessions.
- Document activities in progress notes.

INTERVENTION - CLINICAL REFERRAL

For many professionals, the primary intervention for a patient at elevated suicide risk is referral to additional healthcare. While some professionals may have the ability to work with a suicidal patient utilizing the following clinical interventions, other professionals may not have the ability to directly intervene and will instead have to refer a patient for a higher level of care. Such referring clinicians can include educators, medical or dental professionals, physical and occupational therapists, religious and legal professionals, and it is important to emphasize that intervention via referral in these settings is just as important as direct clinical intervention done by mental healthcare workers. This is because the vast majority of suicidal patients are seen and interact in settings outside that of clinical mental health, and unless these individuals are pointed in the direction of direct intervention many will go on to engage in suicidal behavior without realizing help is available. Thus, someone working in a professional setting involving clinical referral, as opposed to direct care, should take the following steps for referral:

1. Gather suicide risk information. It's okay to ask a patient about suicidal ideation or plans, doing so will not cause any harm (Bender et al., 2019), and asking can help a potentially suicidal patient open up about what they've been experiencing.
2. Using the suicide risk assessment in this course, a referring professional can get a sense of how elevated an individual's risk is. While a referring clinician may not be responsible for making suicide risk decisions, they can occasionally have the potential to identify high risk cases. In the case of a high-risk patient expressing very intense suicidal ideation, suicide plans, and suicide intent, the professional should consider directing the individual to the hospital for further evaluation, or in extreme cases reaching out to local police for assistance in escorting the individual for further intervention. The referring clinician should not attempt to physically restrain or transport an agitated or potentially hostile suicidal individual, and even if the individual leaves, a professional can simply

report their concern about the individual to the police, who will conduct a wellness check. While such actions may seem intimidating to many professionals, it's perfectly acceptable to feel nervous or worried in the process, and it is crucially important to get the high-risk individual help. The alternative of doing or saying nothing, even if no intervention is required in a given profession, is the potential loss of life to death by suicide. While high-risk intervention is intense, it's also the most extreme scenario and likely to occur rarely in most professional settings.

3. In the case of a non-high-risk case of a suicidal individual needing referral, a professional should have ready the contact information for local mental health evaluation centers, psychiatric hospitals, behavioral health centers, and in more extreme circumstances the local hospital emergency department. In referring a patient for mental health services, it's helpful to normalize the experience of suicidal ideation and reduce potential concerns about stigma a patient may have. For example, you can say, "It's very common for people in your situation to experience thoughts about hurting or killing yourself, but people can help with this. You don't have to suffer all alone." In addition to providing local treatment information, individuals should also be provided with the phone numbers for any local crisis hotline as well as the national Suicide Crisis Hotline **1-800-273-TALK (8255)**. Individuals can also provide website information such as that of the suicide prevention resource council (http://www.sprc.org) or others provided in the Resource Section of the course. Finally, it may be beneficial for the professional to check back with the individual at a subsequent meeting to see if they've followed through with obtaining mental health services but attempting to push or pressure the patient may be counterproductive. Your role as a referring professional is simply to ensure the individual has access to the suicide intervention treatment information needed and to continuing being a source of support to the individual.

The collaborative approach

A widely used intervention developed by Jobes (2000; 2017) is the Collaborative Assessment and Management of Suicidality (CAMS) approach. CAMS is a "phenomenological" approach, meaning it places an emphasis on what appears to the senses. Jobes was influenced by the work of Shneidman (1999; 2001), who opened the first suicide prevention center in Los Angeles in the 1960s and founded the American Association of Suicidology in 1968. Shneidman developed a theory about suicide that he termed psychache, and many of the areas assessed in the CAMS approach are corollaries to this theory. Shneidman is well known for his development of neologisms (such as "suicidology" and "psychological autopsy"). The following quote from Shneidman underscores his influence on Jobes:

> Our best route to understanding suicide is not through the study of the structure of the brain, nor the study of social statistics, nor the study of mental diseases, but directly through the study of human emotions described in plain English, in the words of the suicidal person (Cited by Jobes & Mann, 1999, p. 97).

The CAMS approach veers away from approaches to intervention that focus on signs and symptoms of depression, and instead devotes more attention to suicidal thoughts, the meaning of the suicidal crisis for the individual, and the client's views of how suicide represents a solution. CAMS practitioners are interested in psychopathology, but they focus on the "owner of these symptoms" – the suicidal person – and the meaning these problems have for this person. CAMS practitioners also take an explicitly collaborative approach: "When any client acknowledges some degree of current suicidality, the clinician and client proceed to literally and figuratively sit side-by-side to conduct collaboratively an assessment of the client's suicidality" (Jobes, 2000, p. 13).

In the CAMS approach, the client and the therapist independently complete a Suicide Status Form, which ranks the following experiences on a 5-point Likert Scale (Jobes, 2000):

- Psychological pain.
- External pressures.
- Agitation (emotional upsetness).
- Hopelessness.
- Self-regard.
- Overall risk for suicide.

An item termed *Reasons for Living/Reasons for Dying* (RL/RD) also is included: On two sets of five blank lines, the client is asked to list separately the reasons for living and dying in order of importance (Jobes & Mann, 1999).

In their evaluation of the RL/RD data from clients, Jobes and colleagues (2004) were able to develop consistent categories that could help clinicians identify areas of client concern. Furthermore, responses to the RL/RD provide a window into the client's internal debate about suicide and thus offer a marker for the client's motivation toward or away from suicide. Ambivalence is clearly an important hallmark of the suicidal mind, and this simple test is a useful way to approach the subject. The test can have intervention value, "particularly for the cognitively constricted client who is not consciously considering a broader perspective or the full implications of suicide" (Jobes & Mann, 1999, p. 102).

The elements considered important in the CAMS therapy approach involve collaborative treatment planning by therapist and client and clinical alliance in treatment.

> The treatment of an acutely suicidal person is quite simple: It consists, almost by definition, of decreasing or mollifying his level of perturbation. In short, we defuse the situation (like getting the gun), we create activity of support and care around the person, and we make the person's temporarily unbearable life just enough better so that he or she can stop to think and reconsider. The way to decrease lethality is by dramatically decreasing the felt perturbation (Shneidman, 1999, p. 87).

Safety planning intervention

Originally developed for the U.S. Department of Veterans Affairs, the safety planning intervention (Stanley & Brown, 2008; 2012; 2018) is a brief intervention designed to assist suicidal individuals if a suicidal crisis emerges. It differs dramatically from traditional "no-suicide" contracts in that the safety plan provides information and instruction for suicidal individuals about what to do during a crisis. Conversely, "no-suicide" contracts only state what not to do and have no evidence supporting their use in reducing someone's suicide risk (Bryan et al., 2017). Safety plans should typically be conducted following a comprehensive suicide risk assessment, utilizing data focused on warning signs, triggers, and protective factors. During the intervention it is recommended that the clinician and patient should sit side by side. All responses should be written in the patient's own words and be clearly legible. In fact, it is often helpful to have the patients fill out a safety plan template in their own writing. The brief instructions of what to do during a crisis can then be adapted to a format that can be carried at all times. The patient may store the written safety plan in a wallet or purse or keep a photo of the completed safety plan on his or her cellphone. This is particularly helpful for adolescents and young adults, who have their cell phones with them at most times.

Stanley and Brown's brief safety planning intervention, estimated to take 20 to 45 minutes, also provides patients with a prioritized and specific set of coping strategies and sources of support that can be used should suicidal thoughts reemerge. The intent of the safety plan is to help individuals lower their imminent risk for suicidal behavior by consulting a predetermined set of potential coping strategies and a list of individuals or agencies they may contact (Stanley & Brown, 2012).

Five steps of safety planning

There are five basic steps of the intervention, and these steps should be engaged in sequentially until the suicidal crisis is averted. Table 5 provides an overview of each step for a quick reference.

1. **Recognition of warning signs**: The first step is to help the patient recognize signs that indicate a suicidal crisis is impending. These warning signs could include "personal situations, thoughts, images, thinking styles, moods, or behaviors" (Stanley & Brown, 2012, p. 258). For example, a patient may identify problematic situations such as arguments with a partner, thoughts such as, "I can't take it anymore," images of overdosing, depressed or agitated mood, and/or behaviors like drinking more than usual or refraining from social activities. A good review and history of prior crises can help generate a list of thoughts, feelings, behaviors, or images that may trigger suicidal behaviors. This step could essentially be renamed: "When do I need to pull out my safety plan?" This step also includes discarding any unused medications, securing firearms, and identifying other potential methods for suicide and reducing access.
2. **Employing internal coping strategies**: As noted, "In this step, patients are asked to identify what they can do, without the assistance of another person, should they become suicidal again" (Stanley & Brown, 2012, p. 259). Examples of these strategies include taking a shower, going for a jog or walk, doing a puzzle, partaking in a hobby, playing an instrument, listening to feel-good music or watching a feel-good television program, or playing with a pet. Typically, activities are more helpful if they require attention, are soothing, involve physical activity, foster belongingness, and/or have worked in the past. Clinicians can work with their patient to pick a few activities that seem most helpful and list them in the order the patient would likely try them. Step two identifies internal coping strategies that may have been effective previously in reducing thoughts of depression, loneliness, or suicide. This is the first of the brief lifesaving steps an individual can take when in crisis. As with all of the steps in the safety planning intervention, it is important to help elucidate as many options as possible. Further, clinicians should help patients consider what barriers may exist that would interfere with attempting any of the items on the safety plan or reduce the likelihood of its success. Options should be varied enough that at least one option is available in any situation. For example, going for a walk may be effective during the day or on the weekend, but it may not be the safest approach if a crisis emerges at 2:00 a.m. Realistic alternatives should be available for all situations.
3. **Utilizing social contacts as a means of distraction from suicidal thoughts**: The next step involves patients identifying people or places where socialization is likely to happen. The idea is that if internal strategies were not successful at alleviating the suicidal crisis, the patient should next try distraction from the suicidal thoughts through socializing. Stanley and Brown (2012) list examples of social contacts such as spiritual centers, coffee shops, Alcoholics Anonymous meetings, and workout classes. Step three is built upon the finding that most suicidal crises are short-lived; identifying distractions can be helpful in getting a suicidal individual through a crisis (Stanley & Brown, 2012). Further, an underlying theme in the National Strategy for Suicide Prevention (U.S. Department of Health & Human Services, 2012) is that connection with others is perhaps the greatest protective factor. Strategies for this step can include entering distracting situations or engaging with individuals with whom the patient can spend time, even if the topic of the suicidal crisis is not a part of the conversation. The goal is simply to put the suicidal individual in the presence of others, with the hope that a sense of connection will trigger lifesaving cognitions.
4. **Contacting family members or friends who may help to resolve the crisis**: If the previous three steps have been unsuccessful in reducing the crisis, then patients should reach out to others and let them know that they are in a crisis and need help and support. If possible, the patient should share the safety plan with the individuals named in this step. Step four takes step three further by including people the patient could talk to when feeling down, depressed, or suicidal. There should be as many people as possible on the patient's list. One concern is that if a patient consistently approaches the same friend when feeling suicidal, that friend may eventually become overwhelmed and start to withdraw. This withdrawal may lead patients to a greater sense of isolation and hopelessness, two feelings suicidal individuals should avoid during a crisis. Additionally, individuals listed in Step 4 should be upbeat and able to help foster a sense of hope. Individuals who are being added to the list should be made aware of their role in the patient's safety plan, and if they feel unable to be of help during a time of crisis, the patient should seek alternatives.
5. **Contacting mental health professionals or agencies**: In this step, the clinician and patient work together to create and prioritize a list of professionals or other services that could be helpful to the patient when he or she is in distress. This list could include the patient's current treatment provider (if he or she has one), contact information for local 24-hour emergency treatment facilities in the area, and local or national services, such as the National Suicide Prevention Lifeline (1-800-273-TALK [8255]) and the Crisis Text Line (741-741), professional agencies and resources that are available to the suicidal individual at any hour of the day. This section may also include local emergency departments, or 911.

After the clinician and patient have developed plans for steps 1 through 5 and reviewed access to lethal means, the clinician should review the entire plan with the patient in order to assess the patient's feelings about it and his or her willingness to use it. The clinician can explore any hesitancy about using the plan and engage in techniques (e.g., role play, problem solving) to help increase the patient's willingness. Once the patient has agreed to use the plan, he or she should be given a copy of it and there should be a discussion of where the plan will be kept and how the patient will have easy access to it. For instance, the patient may wish to take a picture of the plan on his or her phone, make multiple copies of the plan and put them in places where they are accessible, or make a small copy of the plan that could fit in a wallet or billfold. Further, the clinician should also keep a copy of the plan for his or her records. A template for the safety plan is available at suicidepreventionlifeline.org, and is listed below and in the resource section of this course:

> https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf

It is also worth reiterating that the once-popular "no-suicide contracts" (patients' written commitment to maintain their safety and to not make a suicide attempt) are no longer considered an appropriate intervention for suicidal patients. Not only is there is no empirical evidence supporting their use, but studies that have investigated no suicide contracts have found them less effective than other safety planning interventions (Bryan, Mintz, Clemans, Leeson, et al., 2017).

Table 4: Safety Planning Intervention

Step 1. Warning Signs that a Crisis May Develop:

- What are the thoughts, feelings, images, behaviors, and/or situations that precede suicidal thoughts or behavior?
- "When do I need to access my safety plan?"

Step 2. Internal Coping Strategies:

- "What can I do to take my mind off my problems without having to contact others?" (e.g., relaxation, listening to music, and going for a walk)

Step 3. People and Social Situations that Provide Distraction:

- "Who can I hang out with when I am feeling down, depressed, or suicidal?"
  - Write down names and phone numbers for all possible contacts.
- "Where can I go to hang out that will prevent me from being alone when I am feeling down, depressed, or suicidal?"
  - Write down names of places.

Step 4. People Who can be Accessed in a Time of Crisis:

- Write down names and phone numbers for people who the client can contact when feeling down, depressed, or suicidal.
  - This should include upbeat and positive individuals who can provide a sense of hopefulness.

Step 5. Professionals or Agencies that can be Contacted During a Crisis:

- Write down the names and phone numbers for all contacts.
  - Therapist/Clinician (Include any pager numbers or after-hours numbers).
  - Local crisis centers/urgent care centers.
  - National Suicide Prevention Lifeline (1-800-273-TALK/1-800-273-8255.
  - Local emergency department (Write down address).
  - 911.

Note: Adapted from Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version, by B. Stanley and G. K. Brown, 2008, New York, NY: New York Suicide Prevention Center, Department of Psychiatry: Columbia University & New York State Psychiatric Institute; and "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk," by B. Stanley and G. K. Brown, 2012, *Cognitive and Behavioral Practice, 19*(2), pp. 256-264.

Crisis cards

Crisis cards are another form of intervention available to clinicians when patients are determined to be at a moderate level of risk or lower. They must, however, provide more than just emergency numbers. Like safety planning intervention, crisis cards highlight mood regulation techniques, pleasant activities, and emergency numbers in the event that other techniques fail to reduce suicidal symptoms. Using this technique, clinicians assist patients to match protective behaviors with feelings, thoughts, or nonprotective behaviors that might activate a suicidal crisis. For example, agitation may be met with relaxation and/or exercise. Loneliness may be addressed with behavioral activation with an interpersonal focus, such as calling a friend. Each suicidal crisis trigger is then written on a card with an identified protective symptom-matching technique to be used when the trigger occurs. Thorough assessment aids in the creation of symptom-matching hierarchies (Pauwels et al., 2017). Patients can keep these cards handy to consult as needed, and in recent years digital crisis coping card smartphone apps have been created (Bush et al., 2017; Pauwels et al., 2017). Box 3 outlines the steps for creating a crisis card.

Box 3: Steps for Creating a Crisis Card

1. **Explain the rationale to the client**: I'd like us to come up with some steps you can take if you become upset or start thinking about suicide. It can be hard to think clearly when you are having this kind of crisis, so I'd like us to write the steps on this index card (or keep them as a note in your smart phone), and you can pull out these steps when you realize you are thinking about suicide.
2. **Brainstorm with the client things that make him or her feel better**: Clinicians can ask: What have you found helps you when you feel badly? How have you taken the edge off intense feelings? How do you distract yourself from suicidal thoughts? What helps you feel even a little better?

   Helpful activities are ones that have worked in the past or require at least one of the following:
   - Attention (e.g., working on a puzzle requires attention; watching television does not require attention).
   - Physical activity.
   - Increased belongingness (e.g., calling a friend, going to a place with people, such as a restaurant or mall).

   See Appendix A and Resources for other ideas on pleasant events for adults.
3. **List the helpful activities on the card in a step format**. Example:

   When I'm upset and thinking about suicide, I'll take the following steps:
   - Step 1: [pleasurable activity or therapy skill].
   - Step 2: [pleasurable activity or therapy skill].
   - Step 3: [pleasurable activity or therapy skill].
   - Step 4: Repeat all of the above.
   - Step 5: If the thoughts continue, get specific, and I find myself preparing to do something, I'll call (insert number of emergency call person) or 1-800-273-TALK.
   - Step 6: If I still feel suicidal and don't feel like I can control my behavior, I'll call 911 or go to the emergency department.

Cognitive behavioral therapy

Cognitive and behavioral therapies (CBT) usually are short-term treatments (i.e., often between six and 20 sessions) that focus on teaching patients specific skills. CBT is different from many other therapeutic approaches because it focuses on how a person's cognitions (i.e., thoughts), emotions, and behaviors are connected and affect one another. Behavior therapists and cognitive-behavior therapists usually focus more on the current situation and its solution, rather than the past. They concentrate on a person's views and beliefs about their life, not on personality traits. CBT trials with suicidal adults typically find encouraging results and several models share key features, some of which are described below (e.g., Asarnow et al., 2017; Bryan, 2019; Lee, Bryan, & Rudd, 2020; Singer, O'Brien, & LeCloux, 2017). The central premise of cognitive theory is that the meaning people assign to environmental stimuli significantly shapes subsequent affect, and affect is in turn associated with their behavioral responses (Asarnow et al., 2017). Several empirically-based suicide cognitive constructs are identified through assessment, including hopelessness, heightened impulsivity, information-processing biases, problem-solving deficits, and dysfunctional attitudes.

Behavioral approaches vary; however, they focus mostly on how some thoughts or behaviors may accidentally be "rewarded" within one's environment, contributing to an increase in the frequency of these thoughts and behaviors. Behavior therapies can be applied to a wide range of psychological symptoms to adults, adolescents, and children. Although behavioral therapies are different from disorder to disorder, a common thread is that behavioral therapists encourage patients to try new behaviors and not to allow negative "rewards" to dictate the ways in which they act. Once cognitive constructs are identified, a comprehensive behavioral chain analysis is conducted to specify antecedents and consequences of suicidal thoughts and behaviors. CBT includes several strategies to reduce suicide risk including behavioral activation, emotion regulation, cognitive restructuring, enhancing problem-solving skills, and improving interpersonal effectiveness (Bryan et al., 2019). In the case of suicide crises, clinicians using a CBT approach can also incorporate Safety Planning procedures or Crisis Cards into their treatment approach.

Mood graphing can also be a useful strategy. Having patients record their mood at several points throughout the day can provide patients and clinicians with information for their ongoing assessment and about the outcomes of various interventions. Finally, some clinicians have used a hope kit to facilitate reasons for living when patients are feeling suicidal (Denneson et al., 2019). To make a hope kit, patients fill a small box with items that lead to positive feelings, instill hope, and take the edge off a suicidal crisis. Examples of items in the hope kit include pictures of the patient with loved ones, awards from school, and cards or letters from important people. Patients are instructed to place the hope kit in a prominent area, such as in the case of adolescents, a desk in their bedroom. Simply viewing the hope kit on a regular basis may help prevent a crisis once the adolescent realizes it contains concrete evidence of reasons for living. Recent research advances have pioneered the use of digital hope kits through the use of smartphone apps (Bush et al., 2015).

In addition to more general CBT approaches to suicide, some suicide-specific CBT protocols have been created, such as *CBT for Suicide Prevention* (CBT-SP; Bryan, 2019). CBT-SP can be used with adults and adolescents and includes:

- Cognitive restructuring strategies, such as identifying and evaluating automatic thoughts from cognitive therapy.
- EEmotion-regulation strategies, such as action urges and choices, emotions thermometer, index cue cards, mindfulness, opposite action and distress tolerance skills from DBT (discussed below.
- Other CBT strategies, such as behavioral activation and problem-solving strategies.

Thus, although CBT-SP contains many elements of traditional CBT, it also focuses on some key issues involved in suicidal behavior that might not be addressed outside the context of suicidal behavior, especially with regard to emotion-regulation skills. In the case of adolescents and young adults, suicidal crises occur within an environment that may include problematic relationships, abuse, family dysfunction or poor school performance, CBT-SP includes family interventions if needed.

Dialectical behavior therapy

Dialectic behavior therapy (DBT; Linehan, 1993) is one of the most commonly used psychotherapeutic techniques for recurrent suicidal behavior. DBT is based on concepts from cognitive behavioral therapy, and it has been used mostly in patients with borderline personality disorder, but increasing evidence suggests it may be useful to people with a variety of different diagnoses (DeCou, Comtois, & Landes, 2019). Furthermore, DBT is one of the few treatments for suicidal individuals with solid data supporting its use in both adults and adolescents (DeCou et al., 2019; McCauley et al., 2018; Rathus, Berk, Miller, & Halpert, 2020).

The roots of dialectical behavior therapy (DBT) lie in Marsha Linehan's work with chronically suicidal adult patients. She originally attempted to use cognitive behavioral strategies with these individuals, only to discover that those approaches simply did not work well. The population with which she was working felt misunderstood and invalidated. Cognitive behavioral therapy's exclusive focus on change often pushed individuals into feeling emotionally overwhelmed, and they would frequently shut down. Conversely, focusing on acceptance also had its limitations. Individuals would feel extreme hopelessness or even rage at the clinician for failing to appreciate their emotional suffering and for treating it as inconsequential. As a result, Linehan (1993) developed DBT as a model that would balance and synthesize the opposing tensions between acceptance and change, good and bad, positive and negative. An important dialectical idea is that each position contains within it its own opposition. As Miller, Rathus, and Linehan (2007) describe it, "dialectic refers to change by persuasion and by making use of the oppositions inherent in the therapeutic relationship, rather than by formal impersonal logic" (p. 39). The therapy involves balancing problem solving and validation.

Dialectic behavior therapy promotes the belief in one's own ability to succeed, the ability to emotionally self-regulate, and interpersonal effectiveness. It has repeatedly been shown to reduce the recurrence of suicidal behaviors in affected patients when compared to standard treatment for both adults (DeCou et al., 2019) and adolescents (McCauley, Berk, Asarnow, Adrian, Cohen, et al., 2018). The DBT perspective emphasizes the role of emotional dysregulation and impulsivity in suicide. DBT therapists would respond to the patient by first assessing the patient's suicide intent. As in other therapies, if intent was high, the therapist would engage the patient in revisiting her commitment to refrain from life-threatening behaviors and review plans for safety. If the patient is safe to proceed with therapy, the DBT therapist might explore whether and how her suicidal ideation is an expression of her distress. The DBT therapist might use an intervention method called "extending," wherein they take the patient extremely seriously, possibly more seriously than the patient, and might wonder aloud about hospitalization with the expectation that the patient would back away from expressing suicidality in order to get a more desirable response, such as the therapist understanding her distress. This would allow the therapist to take the dialectic stance of validating the patient's experience while engaging her in problem solving and developing a plan for using previously-taught skills.

DBT involves a pretreatment stage and four additional stages, each with its own intervention targets. The pre-treatment phase aims to forge a mutual commitment to eliminate suicidal behavior and entails an intensive approach with weekly individual therapy and skills- training groups. Stage one focuses on: (a) decreasing behaviors that are life-threatening, interfere with therapy, and diminish quality of life, and (b) increasing behavioral skills. Stage two addresses decreasing post-traumatic stress. Stage three aims at increasing respect for self and achieving individual goals. Finally, stage four focuses on resolving a sense of incompleteness and finding freedom and joy. DBT skills are divided into several modules, including core mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance, and walking the middle path. DBT therapists meet weekly with other DBT providers in consultative groups to help one another maintain a validating and "dialectic" stance toward their patients. The dialectic stance involves balancing validation strategies with change interventions.

CLINICAL DECISION-MAKING CONCERNS AND DOCUMENTATION

When mental health providers are dealing with individuals who are suicidal, it is imperative that they be aware of the legal implications related to the seriousness of suicidal thoughts. There are times when clients will need to be protected from themselves through hospitalization. At times, hospitalization even may be involuntary. It is critical that clinicians be aware of the need for professional documentation of their decision-making process when dealing with clients who are at risk for suicide. The following section reviews various issues related to commitment and documentation issues.

Commitment criteria and imminent risk

Experiencing elevated intent to act on a suicide plan is perhaps the primary cause for concern in suicide crisis evaluations of high-risk individuals (Jordan & Samuelson, 2016). An important clinician concern is deciding when to hospitalize a suicidal patient. This is especially the case when a patient reports elevated "intent" to act on suicidal thoughts or plans (Jordan et al., 2019). In this situation, the clinician has an ethical responsibility to ensure the patient's safety (Obergi, 2017). Therefore, it is good practice to know and understand the applicable state statutes where one practices regarding options and obligations concerning involuntary treatment. Most states offer an option of pursuing involuntary commitment if a patient is endangering him- or herself or a third party as a result of psychiatric illness. See the Resources section for a link where practitioners may access their state's statutes.

Once clinicians have a good working knowledge of the state laws that govern involuntary commitment, they still are faced with the difficult decision of when to recommend this step for patients who are seriously at risk for engaging in self-harm. Unfortunately, there is no concrete, universally accepted definition of "imminent risk" for suicide. Suicide risk likely varies from minute to minute, hour to hour, day to day (Kleiman et al., 2017). This makes any prediction about imminent suicide, in Simon's words, "illusory." Moreover, time attenuates the accuracy of suicide assessments that are "here-and-now" judgments. Therefore, according to Simon, suicide assessment must be a process, not an event (Sommers-Flanagan & Shaw, 2017). Outpatient settings are not an appropriate level of care for patients who express a clear imminent intent and acknowledge possession of means to kill themselves. If such patients are unwilling to voluntarily admit themselves to an inpatient setting, they do meet the criteria for commitment to a secure inpatient hospital setting.

Standards of care

Clinicians need to be thorough in their assessment of each client on a case-by-case basis. It is only after a careful and comprehensive assessment that a clinician is able to determine each client's risk factor. Although it is possible that different risk elements can be considered in arriving at a legal standard of care for suicidal clients, the clinician needs to be guided, first and foremost, by clinical standards – i.e., What is in the best interest of this client given his or her needs and the available alternatives? (Obegi, 2017). Clinicians always are responsible for doing what is reasonably possible to enhance client safety and care (Chu et al., 2015), and the areas of client self-harm and suicidality are especially important for clinicians to address through risk assessment and risk management (Crowe, 2018). When documentation is guided by clinical standards and a clinician "thinks out loud" in terms of considering the pros and cons of each of the disposition alternatives, sound risk management is achieved for the clinician should a client attempt or complete suicide. Crowe (2018) advises:

> Documentation of suicide risk should state more than, "Patient denied suicidal ideation at this time." It is also important to document the safety plan that is created with the patient and/or in consultation with colleagues/supervisors in addition to the typical information included in the patient documentation form. Increased face-to-face and phone contact is recommended during times that the patient is experiencing, or signaling, suicidal ideation in order to continue to assess whether the patient needs additional care at a hospital. Following up with the patient is crucial in the prevention process.

Suicide is the most common cause of legal action against mental health care professionals (Jacobson, 2017). Documentation is the cornerstone of the defense of a potential suicide case. Good care combined with good documentation is the surest way to avoid being sued for malpractice. From the perspective of attorneys who review suicide-related matters for prospective plaintiffs on a weekly basis, the quality of documentation can determine whether a malpractice attorney accepts or declines a suicide case (Stanley et al., 2019). When assessing suicidal clients, consulting with knowledgeable colleagues not only helps the client, but also adds to the clinician's risk management strategy. Documenting that this consultation occurred, as well as the issues considered, is a wise risk-management strategy (Obegi, 2017).

Clinical example of documentation

The following is a fictional documentation summary of a suicide danger assessment.

> *Richard Moore is a 48-year-old Caucasian man who was seen for an assessment of suicidal danger. The client was referred by his individual psychotherapist, Liz McGinley, LCSW, who is employed at the local community mental health center. Ms. McGinley's working diagnoses for this client have been major depression, recurrent, without psychotic features; alcohol abuse; personality disorder, NOS (not otherwise specified). The client has had about 1 month of sobriety according to his therapist and also started on an antidepressant medication approximately 1 month ago.*
>
> *When asked why he was referred to this emergency assessment, he replied, "Well, I have been having some suicidal thoughts." Upon further questioning, he said, "Last night, I got out my gun, loaded it, and put it to my head a few times. I really wanted to pull the trigger, but, Doc, I just did not have the courage to do it. And, you know, I don't think I will do anything like that again." Of special interest, Mr. Moore indicates that at one-point last night when he*

> *had been holding the gun to his head, he went outside and fired the pistol into the ground. It was a way of "practicing, I guess," he said about this preparation behavior.*
>
> *In terms of precipitating events, Mr. Moore indicated that 3 days ago his wife left him. He explained that there had been long-standing tension in the marriage due to his alcohol abuse. The marital distress continued after he stopped drinking alcohol. With respect to prior attempts and suicidal behavior over the last 2 months, Mr. Moore stated that he threatened to kill himself about 3 weeks ago when his wife expressed her wish to leave him. He described getting the same handgun and holding it to his head, as he had done last night. Mrs. Moore agreed to return to Mr. Moore, and that ended the client's crisis at that time.*
>
> *Mr. Moore reported that he had attempted suicide twice; both times were by drug overdose about 4 and 5 years ago. He was having marital problems at that time also.*
>
> *The client does not have much of a support system at this time. He has an adult daughter, but she lives in another state and is not available to him; she tends to side with the mother in the couple's disputes. He reports having no friends.*
>
> *A mental status examination was completed. The client's mood and affect are both depressed and anxious and have grown much worse the last 3 days. He is not sleeping well (has got about 3 hours of sleep per night over the last week) and has a greatly diminished appetite. He is oriented to person, place, and time and evidences no memory problems. He has a recent history of alcohol abuse; he and his therapist believe this problem is now in remission. His similarities and proverb interpretations were concrete, suggesting some thought constriction. He reports feeling hopeless. [Note: A mental status exam has obvious clinical value but is also a risk management tool when evaluating suicidal clients (Berman, Jobes, & Silverman, 2006).]*
>
> *He admits to current suicidal ideation and intent at this time. He says he could not commit to his safety and rated the strength of his intention to kill himself an 8 on a scale of 0 to 10.*
>
> *Mr. Moore appears to be at high risk for suicide given his current crisis, lack of support, and history of multiple attempts. He seems to have recently moved down the pathway to preparation for suicide. He has access to lethal means.*
>
> *Mr. Moore indicates that he does not want to be hospitalized due to his fear of the consequences of absence from work. Although inpatient hospitalization would disrupt his work schedule, his danger to self outweighs this concern. The next lower level of care, partial hospitalization, would have the advantage of allowing him to stay at home in the evening, but would still disrupt his work schedule and would also appear to be inadequate in providing the protection he needs at this time. Continuing outpatient therapy, or even increasing his outpatient contact to daily, might help circumvent his work concerns. This, too, would obviously be less than the structured intervention he now seems to require.*
>
> *The recommendation of inpatient treatment was not welcomed by Mr. Moore. It was explained that this assessor was prepared to contact the authorities if Mr. Moore declined to be evaluated at the hospital. Mr. Moore indicated that he would rather "choose" going to the hospital over having the courts or police involved. The results and recommendations of this evaluation were shared with both the referring therapist and this evaluator's supervisor; both were in agreement. The client was escorted under constant observation to the hospital assessment center. A copy of this note was provided to staff there.*

This note covers the risk factors and recent and past suicide behaviors, summarizes a mental status examination, and provides a risk/benefit consideration of the various courses of action. The note provides a "thinking out loud" approach to the reasons for the clinical decision.

Joiner and colleagues suggest the following documentation if using their risk assessment:

> Suicide risk was assessed according to standard protocols (Chu et al., 2015) and determined to be [low/moderate/severe/extreme] due to … [e.g., ideation, plans, preparations, etc.]. Action taken: [e.g., safety plan, emergency numbers, consulted with supervisor, etc.]. Risk will continue to be monitored (Chu et al., 2015, p. 1200).

Conclusion

One of the most serious mental health issues that clinicians face in their work is dealing with individuals who are expressing suicidal intent. It is the clinician's responsibility to complete a thorough assessment of the risk factors expressed by all clients as they describe their thoughts, emotions, and behaviors. As the clinician collects this information, he or she is faced with the daunting task of determining the imminent risk for the client to attempt and perhaps complete a suicidal act. This course has provided information to assist clinicians to complete an assessment that will lead to better outcomes for clients. A thorough assessment that leads to a well-conceived intervention plan is the goal for both client and therapist. Of course, the clinician must also provide adequate documentation that a thoughtful and professional process has been followed in completing the assessment and intervention plan.

APPENDIX - IDEAS FOR PLEASANT EVENTS

- Soaking in a bathtub.
- Planning or organizing something.
- Reflecting on personal improvements.
- Buying things for myself.
- Playing a musical instrument.
- Using cologne, perfume, or aftershave.
- Doing housework, laundry, cleaning.
- Seeing or smelling a flower or plant.
- Writing letters, cards, or notes.
- Attending family gatherings.
- Reading a "How to" book or article.
- Playing in a musical group.
- Sleeping soundly at night.
- Playing baseball or softball.
- Seeing beautiful scenery.
- Discussing my hobby or special interest.
- Going somewhere beautiful.
- Speaking a foreign language.
- Meeting someone new.
- Looking at the stars or moon.
- Solving a puzzle or crossword.
- Knitting, crocheting, or embroidery.
- Playing pool or billiards.
- Reminiscing, talking about old times.
- Talking about philosophy or religion.
- Doing a project in my own way.
- Watching the sky, clouds, or a storm.
- Finishing a project or task.
- Going to lectures or hearing speakers.
- Playing checkers or chess.
- Reading cartoons or comic books.
- Discussing children/grandchildren.
- Building or watching a fire.
- Doing "odd jobs" around the house.
- Going to an amusement park, circus, zoo.
- Boating (canoeing, motor-boating, sailing).
- Researching something of interest.
- Canning, freezing, making preserves.
- Doing things with children.
- Getting a change of scenery.
- Putting on makeup or fixing my hair.

• Wearing clean clothes. • Planning for the next holiday. • Thinking up or arranging a song or music. • Planning a vacation. • Lighting scented candles. • Reading stories, novels, poems, or plays. • Preparing a new or special food. • Making food, crafts, or gifts to sell or give away. • Throwing away items no longer used or needed. • Donating time, money, or property to charity. • Watching the waves on the ocean.	• Listening to children play. • Complimenting or praising someone. • Playing lawn sports (badminton, croquet, etc.). • Wearing expensive or formal clothes. • Gardening, landscaping, or doing yard work. • Going to a health club, sauna bath, or spa. • Snowmobiling or dune-buggy riding. • Talking about politics or public affairs. • Attending a play, concert, opera, or ballet. • Cooking meals to freeze for future use.	• Being with parents. • Throwing a party or gathering. • Going to yard sales or auctions. • Hearing a good sermon. • Learning to do something new. • Being in a sporty or expensive car. • Having coffee, tea, coke, etc., with friends. • Listening to the sounds of nature. • Protesting social or political issues. • Being in the country. • Thinking about good things in my future.	• Doing artwork or making sculptures. • Eating good or healthy meals. • Expressing my love to someone. • Working with others as a team. • Buying something for family. • Gathering natural objects (rocks, driftwood). • Feeling the presence of God. • Going to a barber or beautician. • Playing soccer, hockey, or lacrosse. • Seeing something good happen to someone.
• Shaving. • Hiking. • Dancing. • Laughing. • Meditating. • Swimming. • Doodling. • Traveling. • Bicycling. • Sewing. • Acting.	• Golfing. • Bowling. • Camping. • Collecting. • Spontaneity. • Fishing. • Writing • Reading. • Cycling. • Budgeting. • Praying.	• Shopping. • Relaxing. • Eating. • Drawing. • Driving. • Cheering. • Designing. • Surfing. • Coaching. • Smiling.	• Climbing. • Typing. • Skiing. • Painting. • Creating. • Planting. • Performing. • Stretching. • Talking. • Kicking.
• Taking a shower. • Painting a room. • Taking a nap. • Walking a pet. • Brushing your hair. • Playing cards. • Taking a walk. • Playing basketball. • Sleeping late. • Repairing things. • Seeing old friends.	• Looking at maps. • Taking photos. • Making lists. • Snow skiing. • Being with family. • Sitting outside. • Playing with pets. • Practicing yoga. • Singing in a group. • Visiting others. • Playing tennis.	• Being in the city. • Making snacks. • Looking at photos. • Birdwatching. • Playing football. • Volunteering. • Walking barefoot. • Being with friends. • Doing a good job. • Daydreaming.	• Giving gifts. • Helping someone. • Beachcombing. • Playing ping pong. • Horseback riding. • Hearing jokes. • Writing in a diary. • Adopting pets. • Riding on a train. • Being with others.
Note: Adapted from http://www.dbtselfhelp.com/html/er_handout_8.html			

Resources

Assessment

- **Risk Assessment Protocol**
  Chu, C., Klein, K. M., Buchman-Schmitt, J. M., Hom, M. A., Hagan, C. R., & Joiner, T. E. (2015). Routinized assessment of suicide risk in clinical practice: An empirically informed update. *Journal of Clinical Psychology, 71*(12), 1186-1200.
- **Beck Scale for Suicide Ideation (BSS)**
  http://www.pearsonclinical.com/psychology/products/100000157/beck-scale-for-suicide-ideation-bss.html
- **Safety Plan Template**
  Barbara Stanley and Gregory K. Brown
  https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf
- **Self-Injurious Thoughts and Behaviors Interview**
  (Nock et al., 2007)
  http://nocklab.fas.harvard.edu/tasks
  This is a clinical interview recommended in the assessment of self-injury behaviors. It is freely available from the developer's website. To download the interview, go to the developer's (Dr. Matthew Nock) website above. The long or short form of the SITBI interview can also be downloaded.
- **Suicide Assessment in Incarceration Settings**
  Gould, C., McGeorge, T., & Slade, K. (2018). Suicide screening tools for use in incarcerated offenders: a systematic review. *Archives of Suicide Research, 22*(3), 345-364.
- **DBT Self Help: Life Skills for Emotional Health**
  http://www.dbtselfhelp.com/html/er_handout_8.html

Organizations

- **American Association of Suicidology (AAS)**
  http://www.suicidology.org
  Founded by Edwin S. Shneidman in 1968, the goal of the AAS is to understand and prevent suicide by encouraging, developing, and disseminating scholarly work in suicidology and the development and application of strategies that reduce the incidence and prevalence of suicidal behaviors. The AAS offers training in suicidology and recognizing and responding to suicide risk.
- **American Foundation for Suicide Prevention (AFSP)**
  http://www.afsp.org
  The AFSP supports and disseminates research into the causes of suicide, offers a community to suicide survivors and those contemplating suicide, and advocates for prevention and care.
- **Military Suicide Research Consortium (MSRC)**
  https://msrc.fsu.edu
  The MSRC was founded in 2010 as a joint project by the Department of Defense, Veterans Affairs Medical Center - Denver, and Florida State University with the goal of enhancing military- and veteran-relevant suicide research, prevention, and intervention projects. MSRC regularly

publishes groundbreaking new research, assessment and intervention protocols, and calls for grants funding new projects.

- **National Suicide Prevention Lifeline**
  http://www.suicidepreventionlifeline.org
  The National Suicide Prevention Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week. The lifeline has engaged in a variety of initiatives to improve crisis services and advance suicide prevention.
- **Society for the Prevention of Teen Suicide**
  http://www.sptsusa.org
  The mission of the Society for the Prevention of Teen Suicide is to reduce the number of youth suicides and attempted suicides by encouraging overall public awareness through the development and promotion of educational training programs for teens, parents, and educators.
- **Suicide Prevention Resource Center (SPRC)**
  http://www.sprc.org
  The SPRC is a federally supported resource center devoted to advancing the National Strategy for Suicide Prevention. They provide technical assistance, training, and materials to increase the knowledge and expertise of suicide prevention practitioners and other professionals serving people at risk for suicide. They also promote collaboration among a variety of organizations that play a role in developing the field of suicide prevention.
- **The Jed Foundation**
  http://www.jedfoundation.org
  The Jed Foundation was founded in 2000 by Donna and Phil Satow after they lost their son Jed to suicide. The foundation's goal is to promote emotional health and prevent suicide among college and university students.
- **The Trevor Project**
  http://www.thetrevorproject.org
  The Trevor Project provides crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, and questioning youth and young adults.

Other Online Resources

- **Center for Elderly Suicide Prevention**
  http://www.ioaging.org/services/all-inclusive-health-care/psychological-services/center-for-elderly-suicide-prevention
- **The Crisis Text Line**
  http://www.crisistextline.org
- **Question, Persuade, Refer (QPR) – Suicide Risk Prevention Training**
  https://www.qprinstitute.com
- **Suicide.org – Suicide Prevention, Awareness, and Support**
  http://www.suicide.org
- **Suicide Prevention Resource Center – Suicide Prevention Toolkit for Rural Primary Care**
  http://www.sprc.org/for-providers/primary-care-tool-kit

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SUICIDE RISK IN ADULTS: ASSESSMENT AND INTERVENTION, 2ND EDITION

Final Examination Questions

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81. Since the year 2000, the suicide rate among both youth and adults has risen approximately ______ percent.
    a. Five.
    b. Ten.
    c. Thirty.
    d. Ninety.

82. What term(s) should a clinician use to characterize the fatal outcome of a suicidal act?
    a. Committed suicide.
    b. Completed suicide or died by suicide.
    c. Chose to kill him- or herself.
    d. Successful suicide or suicided.

83. For a self-inflicted behavior to be considered suicide related, the person must have:
    a. Received no injuries from the attempt.
    b. Been legally competent at the time of the act.
    c. Been injured to some measurable degree during the attempt.
    d. Intended at some level (nonzero) to kill him- or herself by the act.

84. Which of the following is a conclusion from Pokorny’s study that attempted to predict which clients would complete suicide within 5 years?
    a. It is possible to predict which persons will most likely complete suicide by evaluating certain known risk factors.
    b. By observing several personality characteristics, one can accurately identify which clients will ultimately complete suicide.
    c. There is no item of information or combination of items to permit the identification of those persons who will commit suicide.
    d. Identifying which persons will ultimately complete suicide may be difficult; however, it is possible by observing the person’s demeanor and speech tendencies.

85. One warning sign for suicide found in the mnemonic acronym “IS PATH WARM” is:
    a. Sadness or depression.
    b. Reckless behavior.
    c. A history of child sexual abuse.
    d. Insomnia or interrupted sleep.

86. Which of the following statements is true about sex differences in suicidal behavior?
    a. Women die by suicide more frequently than men.
    b. Men attempt suicide more than women.
    c. Men and women die by suicide at equal rates.
    d. Men die by suicide more frequently than women.

87. The percentage of suicide victims who have a diagnosable disorder is:
    a. 60% to 65%.
    b. 70% to 75%.
    c. 80% to 85%.
    d. 90% to 95%.

88. The most common means of suicide in the United States, used in more than half of the cases, is:
    a. A knife.
    b. A bridge.
    c. A firearm.
    d. Asphyxiation.

89. Suicide attempts by older adults are much more likely to result in death than among younger persons because:
    a. They live away from family support.
    b. Older adults plan more carefully and use more deadly methods.
    c. They live in residential facilities.
    d. They own more guns than younger adults.

90. Perceived burdensomeness, failed belongingness, and acquired capability are the key factors in which theoretical model of suicide?
    a. Biopsychosocial.
    b. Interpersonal.
    c. Psychache.
    d. Organic suicide.

91. The Three-Steep Theory (3ST) of Suicide proposes that which of the following individual experiences are necessary for suicidal behavior to occur:
    a. Psychache, burdensomeness, frustration.
    b. Belongingness, burdensomeness, aimlessness.
    c. Anomie, fatalism, altruism.
    d. Hopelessness, interpersonal disconnection, acquired capability.

92. The Joiner model of suicide assessment:
    a. Guides clinicians toward interventions through understanding risk factors and the use of rating scales.
    b. Is useful only at the beginning of treatment, before a relationship with the client is established.
    c. Focuses on ways a clinician can gather sensitive client data through interviewing.
    d. Minimizes the significance of previous and multiple attempts in assessing current risk.

93. According to the Joiner assessment model, a person who is a non-multiple attempter experiencing suicidal ideation with limited intensity and duration, but who has no intent, would be assigned to which of the following risk categories according to the Joiner model?
    a. Low.
    b. Moderate.
    c. Severe.
    d. Extreme.

94. Which of the following is the most important factor in determining whether hospitalization for high suicide risk is necessary?
    a. Elevated intent to act on a suicide plan.
    b. Intense suicidal ideation.
    c. Complete disconnection from family.
    d. Giving away personal possessions.

95. In assessing for "imminent risk" for suicide, Simon suggests that clinicians:
    a. Focus on suicidal ideation.
    b. Recognize suicide assessment as a process, not an event.
    c. Focus on suicide attempts in the past 8 weeks when assessing risk.
    d. Follow their intuitive clinical judgment.

96. Which of the following interventions is primary for a patient with a suicide plan but who does not currently meet criteria for hospitalization?
    a. Supportive counseling.
    b. Dialectical behavior therapy.
    c. Lethal means reduction/restriction.
    d. Pharmacotherapy.

97. The CAMS approach to suicide intervention suggests that clinicians working with suicidal clients need to establish a relationship with the client that is:
    a. Causal.
    b. Cathartic.
    c. Collaborative.
    d. Continual.

98. A tool that provides insight into the client's internal debate about suicide and has intervention value for the cognitively constricted suicidal client is the:
    a. Suicide Status Examination.
    b. Desperation Index.
    c. Jacobs Suicide Protocol.
    d. Reasons for living/reasons for dying (RL/RD).

99. Step 2 of Stanley & Brown's (2012) safety planning, employing internal coping strategies, is when the patient:
    a. Calls his or her friend before calling 911.
    b. Recognizes that he or she has become suicidal.
    c. Engages in soothing physical activities that require attention and have worked in the past.
    d. Brings him or herself directly to the emergency department to address suicidal thoughts and feelings.

100. One strategy that may be used with a suicidal individual is a crisis coping card. Once the need to utilize the card is recognized by the individual, during intense suicidal ideation he or she should at the last:
    a. Try out internal coping strategies that might reduce the crisis.
    b. Call emergency crisis numbers to gain assistance in resolving the crisis.
    c. Find friends, family, or places that could serve as sources of distraction.
    d. call a friend for support.

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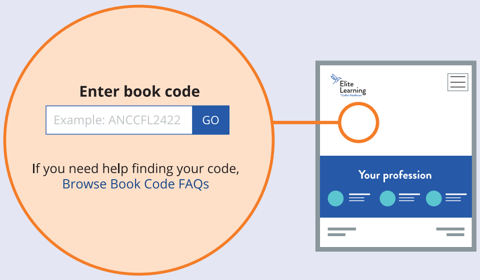

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