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- Beyond PTSD: Treating Survivors of Human Trafficking
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The Pennsylvania Psychologist

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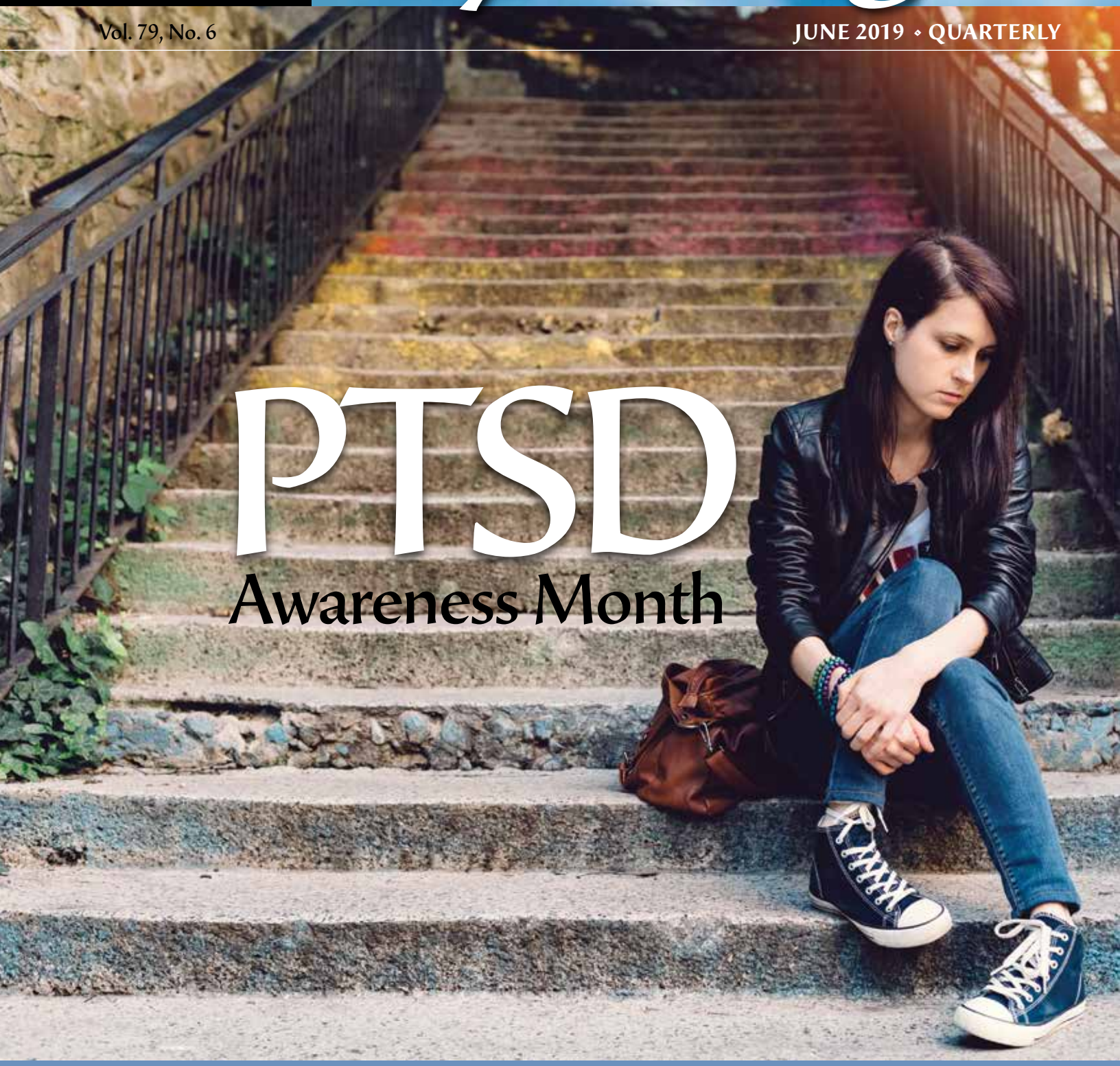

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June 2019 • **QUARTERLY**

REGULAR FEATURES

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SCHOOL PSYCHOLOGY SECTION

ACADEMICIAN'S CORNER

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ALSO INSIDE

Thank You!

Nicole P. Quinlan, PhD

I'm not sure where this year has gone. The June convention is upon us, we are finishing another full rotation around the sun, and I am about to pass the gavel into the very capable hands of Marie McGrath. There is no doubt that it has been a busy, productive, innovative year. Under the **wisdom** and direction of our energetic, innovative executive director, Ann Marie Frakes, and the guidance of Rachael Baturin, we made the leap to sell part of our office space that we were not using. Physical size does not always equal energy and strength, and by paring down our office space and selling a little less than half to our friendly neighbors (who were bursting at the seams!), we will increase our efficiency as well as our financial reserves. Our past leaders set us up well when we purchased the Stevenson Avenue address, and our current board and staff **courageously** took the next step. We remain at the same location, just a bit trimmer! We are also launching a new website, with the goal of making sure all we have to offer to our members and the public is easy to find and enjoyable to view. This too, has been something talked about for years, and no small undertaking.

This also seems like a good time to acknowledge and thank the amazing PPA staff who have worked closely with me this year – Ann Marie, Rachael, Judy, Erin, Sam, and Iva. It has been an honor to work with you as you execute PPA's mission and keep us strong and vibrant. I also want to express my appreciation to my executive committee, board of directors, and general assembly. Thanks especially to David Zehrung, who mentored me in my president-elect year; Brad Norford for being a faithful steward of our finances (and educating us all along the way); Jeanne Slattery for tirelessly documenting all that we do; Linda Knauss for her years of service as our American Psychological Association representative; and Tim Barksdale for being willing to step into a role on the executive committee as my appointee and bringing a fresh perspective with along with him. PPA is lucky to have volunteer leaders like you at the helm.

One of the most exciting advances for me this year has been the development and launching of a protocol to answer members' calls for PPA to act on social **justice** issues. This work, which was the project of Emerging Leader, Brittany Dancy Caro, is being unveiled at the Pittsburgh convention and can be found on our new website. I hope this encourages members to think about things that are meaningful to them and guides them in presenting their cause to PPA for consideration. We are also developing a way to recognize members who are community 'heroes' in big and small ways. Taking a page from APA's Citizen Psychologist initiative, we will be highlighting members who are making a difference in their communities above and beyond the difference we all make every work-day as psychologists.

I'd like to close out my final column with a focus on the things we do every day as psychologists—the **compassion** we show, and the skills and strength we share with our clients, our students, and each other. The work we do is hard (as is evidenced by the articles in this issue focused on PTSD), but it makes a difference each day. I think it is easy to recognize and acknowledge that when we see the 'big' wins—people who have turned the corner from debilitating symptoms and points of true crisis, or students who have 'found their calling' from our instruction and guidance. But every day that we share our training and ourselves with others, we make a difference. Every time we help someone find another way of thinking, or relating to others, or just being, we help change the trajectory of their lives in countless ways that have ripple effects for them and the people around them. As I said when I first took the podium a year ago, you are all a wonder. And I think it is fitting to close with the advice given to Wonder Woman by her mentor Antiope, and which was shared with me (and you all) by David Zehrung as he signed off last year, because I think none of us can hear this enough: "You are stronger than you believe. You have greater powers than you know."

Nicole P. Quinlan, Ph.D.

The Year in Review

Ann Marie Frakes, MPA

It is hard to believe that a year has passed by and technically I am now no longer the "new" executive director of PPA. Thank you to everyone for making this one of the best years of my professional life. I send a special thank you and congratulations to our outgoing president, Dr. Nicole Quinlan, our outgoing treasurer, Dr. Brad Norford, our outgoing APA representative, Dr. Linda Knauss, the PPA executive committee, the board of directors, the budget & finance committee, the entire general assembly, volunteers, members, and staff for helping to achieve great results for PPA this year. What a wonderful year it has been! We have accomplished so much as an organization. I am excited to share with you just a few noteworthy accomplishments of our 2018-2019 fiscal year.

1. In July of 2018, we engaged McNees Winter Group as PPA's contract lobbyist. In less than 3 months, together, we hosted a very successful Advocacy Day at the capitol, which set the tone for a very ambitious legislative agenda, which included the passage of the Human Trafficking Safe Harbor Bill in June of 2018. This year's legislative agenda includes: SB67 Psychology Compact legislation and a resolution to study the shortage of mental health professionals, including psychologists and psychiatrists in the commonwealth.

2. In September of 2018, Dr. Tim Barksdale, our Public Interest Board Chairperson, made a compelling presentation and subsequent motion to the PPA Board of Directors to amend the PPA by-laws to include a Board of Directors position that focused on Diversity and Inclusion across the organization. This motion passed unanimously. A by-laws work group has been formed and their work will begin this summer.

3. In the fall of 2019, PPA staff started the hard work to update PPA's antiquated website. We are utilizing the services offered by our membership management software, *Your Membership* to design a modern, easy-to-navigate, mobile-friendly website. The new PPA website will be accessible via your cell phone or tablet and will also allow you to easily process electronic payments. In addition, new microsites for the ***Pennsylvania Psychological Foundation, PennPsyPAC*** and our public education site, ***Psychology Can Help*** are all coming soon. We will be showing our new website landing page to our members at PPA2019 during the Town Hall Meeting.

4. In December 2018, we partnered with other organizations in Pennsylvania for the first time to develop and produce educational programs for a wider audience. PPA and the Dauphin County Bar Association, led by Rachael Baturin, offered a 10-hour mediation training to attorneys, psychologists, and other professionals who were interested in serving as Parenting Coordinators. A six-hour School Shooter Seminar for school personnel, law enforcement and mental health professionals was conducted in partnership with WellSpan Philhaven and the Milton Hershey School. We look forward to developing more new programs to reach larger audiences this coming year.

5. In January, we updated PPA's sponsorship and exhibiting levels to include more benefits like social media posts, face-to-face interaction with our members, and more recognition on our website. We are happy to report that we have secured more sponsorship for PPA2019 than any other convention in the recent past.

   We are working hard to make our convention a revenue source not a just break-even endeavor. In addition, we have also updated on-line and print advertising levels for the first time in approximately 20 years.

Ann Marie Frakes

6. In January 2019, we transitioned to YM Careers for the PPA on-line career center. The marketing and ad sales are managed remotely, and we have higher revenue opportunities than ever before. Please check out our new career site: https://papsy.careerwebsite.com/ especially if you looking for a job or have a position to fill.

7. In March of 2019, we offered a new retirement benefit to PPA members. PPA members who are in private practice now have access to an affordable and easily managed 401(k) or Solo K retirement plan. In addition to being able to offer this benefit to our members, we are now able to provide a 401(k) plan to PPA staff. Membership and employee benefits like this will help us attract/retain members and staff. If you are interested in offering/having a 401(k) at your practice please reach out to our retirement professional, Steven Maher at spmaher@ehdadvisory.com or (717) 989-2935.

8. In March, PPA leased new computers for all staff and moved from a physical server in the office to cloud based storage. We are now all running Windows 10 on new Dell Latitude laptops. Everyone has updated security and access to IT support every day of the work week.

9. The first social of the Committee on Multiculturalism was held in September of 2013. The attendees were inspired by

Continued on page 5

Assisted Outpatient Treatment

Samuel Knapp, EdD, ABPP; Director of Professional Affairs
Rachael L. Baturin, MPH, JD; Director of Government, Legal, and Regulatory Affairs

Pennsylvania's Mental Health Procedures Act was amended in 2018 to allow for assisted outpatient treatment (AOT). AOT refers to a process whereby a court can order an individual with serious mental illness to receive outpatient mental health services, even if the individual objects to receiving those services.

Bills requiring AOT have been proposed in the Pennsylvania legislature for many years but received considerable opposition from consumer groups and organized psychiatry. The general thrust of these bills would allow courts to order outpatient treatment for patients with serious mental illnesses who have a history of non-cooperation with treatment. Although a provision for outpatient treatment already existed in Pennsylvania's Mental Health Procedures Act, the previous AOT bills would have greatly modified the standards for this commitment to include many seriously mentally ill persons who did not present an imminent threat to harm themselves or others.

Proponents of these bills noted that many of their family members with serious mental illnesses had poor quality lives because they were failing to get or continue with mental health treatments, even if those treatments had been effective in the past. Often their family members were homeless or ended up in county jails for minor offenses based on behaviors that were a manifestation of their mental illnesses. Opponents of these bills noted discomfort with anything that increased the coercion of mentally ill persons (which would make them more reluctant to get treatment voluntarily). They also noted that many outreach programs, if properly funded, had success in getting otherwise reluctant individuals into mental health treatment voluntarily. Finally, others were concerned about the illogic of mandating involuntary outpatient treatment for some individuals, while those seeking voluntary treatment were subject to long waiting lists.

The passage of HB 1233 in 2018 (Act 106) was a compromise between proponents and skeptics of mandated outpatient commitments. This compromise law only narrowly expanded the eligibility for involuntary treatment and allowed the administrators of county mental health programs to opt their counties out of these programs. Act 106 also ensured protections for the subject of the AOT and ensured that the AOT treatment plans would be specific enough to fulfill their intended goals. Act 106 changed nothing about the current standards or procedures for involuntary psychiatric hospitalizations.

Under the new law, individuals can be eligible for (or subject to) involuntary outpatient treatments if they "are unlikely to survive safely in the community without supervision; in the last 12 months had failed to adhere to treatment which was then a "significant factor in necessitating involuntarily hospital treatment" in the last 12 months; or in the last 48 months had failed to adhere to treatment which resulted in acts of serious physical harm to themselves or others. In addition, they are unlikely to voluntary participate in treatment due to their mental illness.


Dr. Samuel Knapp


Rachael L. Baturin

Any responsible person can file a petition for AOT. The petition must be accompanied by a statement from a psychiatrist or licensed clinical psychologist that they have evaluated the patient and believe that they need AOT. Or, the petitioner could write a statement that the subject of the petition has refused to be evaluated by a psychiatrist or licensed clinical psychologist. If the subject of the petition has refused an appointment with a psychiatrist or licensed clinical psychologist, a court may order an examination by a psychiatrist, licensed clinical psychologist, or other qualified mental health professional designated by the county administrator.

An AOT plan "means an individualized treatment plan developed by a qualified professional or treatment team that is ordered by a court for involuntary outpatient civil commitment of a person" (Section 107 (b)). The treatment plan must be based on the specific needs of the patient, enumerate the treating professionals, and document how, if at all, the patient was involved in the development of the plan. The plan may include case management services, medications, individual or group psychotherapy, treatment for the misuse of alcohol or other drugs, and other services. A "qualified mental health professional," defined as a mental health professional with graduate training, can develop the plan, although it must be approved by a psychiatrist or a "licensed clinical psychologist."[1]

A court hears all AOT petitions and the subject of the petition has a right to have an attorney present. A court can order the

Continued on page 11

1. Although the term "licensed clinical psychologist" does not appear in the Professional Psychologists Practice Act, it does appear in the regulations pursuant to the Mental Health Procedures Act. It refers to a licensed psychologist with a doctoral degree.

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Pennsylvania Psychology License Renewal Checklist

30 credits required

- 15 credits must be from live workshops
- 3 Ethics - The word "ethics" must be part of the title, or the certificate must state that the credits apply for ethics credits
- 2 credits - Child Abuse Recognition and Reporting - Act 31
- 1 credit - Suicide Prevention

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THE YEAR IN REVIEW

Continued from page 3

the many cultural dishes represented at the potluck buffer and suggested creating a recipe book. This April, ***Food for Thought: Multicultural Recipes from Members of the Pennsylvania Psychological Association*** was published. The cookbooks will be available for purchase at PPA2019 in Pittsburgh for $20.00 to support the funding of the Multicultural Student Award. If you are not able to attend convention, but would like to purchase a cookbook, please send an email to: annmarie@papsy.org to make arrangements for purchase.

10. On May 15, 2019, PPA successfully sold the office space known as Suite F to our across-the-hall neighbors. They were bursting at the seams and PPA had too much space. So, we built a demising wall and maintained enough space to comfortably house up to 6 staff and have plenty of meeting and storage space. Closing this transaction has significantly increased our operating and investments accounts, while at the same time lowered our monthly expenses of condo fees, real estate taxes and utilities by approximately 40%. During this process we were also able to clean and purge, to make the PPA office an even more comfortable and welcoming environment for volunteers and staff.

Thank you to everyone who made all this possible. YOU, the members, ARE PPA! It is my honor and privilege to continue serving as your Executive Director and I look forward to being part of PPA for many years to come. If you would like to share your PPA experiences and ideas with me, please do not hesitate to call or send me an e-mail. I will make every effort to meet with you in-person. I look forward to seeing many of you at PPA2019 in Pittsburgh! Thank you for all you do for PPA!

"Progress is not in enhancing what is, but in advancing toward what will be."
Khalil Gibran

Update on PSYPACT Legislation (Senate Bill 67) Introduced in Pennsylvania

Rachael L. Baturin, MPH, JD, Director of Governmental, Legal & Regulatory Affairs

This session Senator Judy Ward introduced Senate Bill 67. Senator Ward's legislation would permit Pennsylvania to adopt the Psychology Interjurisdictional Compact (PSYPACT) to increase public access to psychological services by allowing for tele-psychological practice across state lines as well as temporary in-person services.

Presently, there is an ongoing effort to establish a legal and ethical way for licensed psychologists to practice across state boundaries. Each state has its own licensing laws and rules which vary considerably, making it extremely difficult for a person to obtain a license to practice in several states. As such, the possibility of providing psychological services via telecommunication technologies (telepsychology) across jurisdictional boundaries is unattainable. Also, each state has varying time frames as it relates to permitting a psychologist to temporarily provide in-person, face-to-face services in their states.

To help address these issues, the Association of State and Provincial Psychology Boards (ASPPB), the alliance of psychology licensing boards in the U.S. and Canada, developed the PSYPACT, which would allow qualified licensed psychologists to practice using telecommunications technology and to practice temporary in-person, face-to-face services across state lines. The PSYPACT commission would be established to administer and enforce the PSYPACT, which is designed to achieve the following purposes:

Presently, there is an ongoing effort to establish a legal and ethical way for licensed psychologists to practice across state boundaries. Each state has its own licensing laws and rules which vary considerably, making it extremely difficult for a person to obtain a license to practice in several states.

- Increase public (patient/client) access to professional psychological services;
- Enhance the state's ability to protect client/patient health and safety;
- Promote cooperation between PSYPACT states in the area of licensure and regulation; and
- Exchange of information between PSYPACT states such as verification of licensure and disciplinary history.

The PSYPACT contains provisions concerning home state licensure; privilege to practice telepsychology; conditions of telepsychology practice in a receiving state; adverse actions; additional authorities invested in a state's psychology regulatory authority; a coordinated licensure information system; establishment of the commission, rulemaking; oversight; dispute resolution and enforcement; and the date of implementation of the PSYPACT.

PSYPACT has become operational as seven states have officially enacted the legislation. Oklahoma and Illinois have enacted PSYPACT legislation, but it does not become effective until November 1, 2019 and January 1, 2020, respectively. The nine states that have adopted PSYPACT legislation are Arizona, Nevada, Utah, Colorado, Nebraska, Missouri, Illinois, Georgia, and Oklahoma.

Next, the PSYPACT commission will be established and they will be responsible for the creation of bylaws and rules. Once those are finalized, the application process will open for the e-Passport and Interjurisdictional Practice Certificate (IPC).

The PSYPACT will benefit both psychologists and clients/patients. It will allow licensed psychologists to practice telepsychology and/or temporary in-person, face-to-face practice across state lines without needing to be licensed in other PSYPACT states. In addition, it will provide much-needed mental health care services to populations in geographically isolated areas, especially individuals living in rural parts of the country.

This bill is currently in the Senate Consumer Protection & Professional Licensure Committee and we are trying to get this legislation placed on the committee agenda for June. **Please reach out to your legislators and ask them to reach out to Senator Tomlinson, who is chair of this committee, and urge him to place this bill on the agenda for June and to vote this bill out of committee.** PPA has met with all members of this committee to educate them about this bill and how it will help psychologists and their patients. All committee members are supportive of this bill passing out of the committee. We just need your help to let the PA legislature know we want this bill passed out of committee in June.

If you have any questions about this legislation or would like more information on how you can help PPA advocate for this important piece of legislation, please feel free to contact Rachael Baturin at rachael@papsy.org.

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Towards a Basic Understanding of Posttraumatic Stress Disorder and its Treatment

Wayne Roffer, PsyD

In 2010, the U.S. Senate designated the 27th of June as PTSD Awareness Day, established to raise awareness and recognition of posttraumatic stress disorder (PTSD) and bring to attention the struggles of trauma survivors. In 2014 the U.S. Senate designated the entire month of June as PTSD Awareness Month. The 27th of June was selected to commemorate the birthdate of 2-tour Iraq veteran U.S. Army Staff Sgt. Joe Biel of the North Dakota National Guard, who committed suicide in April 2007 following his struggle with PTSD.

Posttraumatic stress has been documented for hundreds of years in a variety of mediums. Common reactions often associated with PTSD are described in Homer's Odyssey, as well as being depicted in Shakespeare's Othello. The condition eventually became synonymous with war and combat, and over time took on a variety of names such as Soldier's Heart (American Civil War), Shell Shock (WWI), and Battle Fatigue (WWII). The term PTSD, though, was not used until after the Vietnam War when it was introduced in the DSM-III.

Lifetime Prevalence

Sometimes referred to as the "invisible wound of war," PTSD is not specifically a combat or military related condition. Rather it can develop following a variety of potentially traumatic experiences, including sexual assault and rape, childhood abuse, serious accidents, and natural disasters. Rates of PTSD can vary greatly depending on the population being evaluated and the demographics within that population. Risk factors such as frequency of exposure to life threatening events, types of traumatic experiences, as well as protective factors such as availability of social support are a few elements influencing the variability of rates of PTSD between different groups. Generally speaking, nearly 90% of the U.S. adult population (aged 18 and older) has experienced a traumatic event consistent with DSM-5 Criterion A for PTSD (Kilpatrick, Resnick, Milanak, Miller, Keyes, & Friedman, 2013). Additionally, many of these individuals have experienced more than one such event. Despite this, the lifetime prevalence of PTSD among U.S. adults is approximately 9% (Kilpatrick et. al., 2013).

"Normal reaction to an abnormal event"

PTSD means "after a stressful situation, there is an anxious reaction." What we consider symptoms of a disorder typically start off as a normal stress response to an atypical (and often life threatening) event. Many individuals who encounter such traumatic events are going to display at least some of the symptoms associated with PTSD. Common reactions include sleep disturbance (including nightmares), changes in mood (anxiety, fear, depression, anger), hypervigilance, intrusive thoughts and memories, and physiological reactions to trauma reminders. For some, when encountering events so emotionally different and overwhelming to anything previously experienced, their mind and body goes into a state of imbalance. For most individuals, though, this is usually temporary as the brain eventually processes through all the cognitive and emotional information to make meaning of the event and integrate it into our understanding of our self and the world. Psychological and physical homeostasis is eventually achieved, and we return to healthy and adaptive functioning. However, if something interferes with this natural recovery process, the stress response may get stuck and remain activated, even in situations where no danger or threat exists. The normal stress reaction is now experienced beyond what would be expected and complications may then arise, such as physical health issues, relationship difficulties, drug and alcohol problems, and work/school/family difficulties.

Since its inclusion in the DSM-III, PTSD had been considered a disorder of anxiety. However, with the release of DSM-5 (American Psychiatric Association, 2013), PTSD was moved into a new classification/category called Trauma and Stressor-Related Disorders. The change reflects an understanding that individuals with PTSD experience a wide range of emotional responses besides just anxiety, including depression and anger.

Identification

Since its inclusion in the DSM-III, PTSD had been considered a disorder of anxiety. However, with the release of DSM-5 (American Psychiatric Association, 2013), PTSD was moved into a new classification/category called Trauma and Stressor-Related Disorders. The change reflects an understanding that individuals with PTSD experience a wide range of emotional responses besides just anxiety, including depression and anger. A second reason for the new category centers around the argument that the hallmark feature of PTSD is a "watershed experience" – an event so profound as to change the trajectory

of one's life (Friedman, 2013). While the DSM-5 trauma workgroup considered removing Criterion A altogether, it was the significance of the event that led them to leave Criterion A alone, and to create the new category for behavioral conditions stemming from such experiences.

Other changes to PTSD between DSM-IV and DSM-5 was the removal of Criterion A2 (fear, horror, helplessness), though this was really just moved into a new cluster entitled Negative Changes in Cognition and Mood. The overall number of symptoms also increased from 17 to 20, and the number of clusters from 3 to 4. To make a diagnosis of PTSD, individuals must meet a Criterion A traumatic event, as well as experience one symptom from Cluster B (re-experiencing such as flashbacks or intrusive memories); one symptom from Cluster C (avoidance such as avoiding places that represent or are similar to their traumatic experience); two symptoms from Cluster D (negative changes in cognition and mood such as blaming oneself or feeling angry); and two symptoms from Cluster E (hyperarousal, such as difficulty falling asleep or constantly being on guard), as well as meet the duration (Cluster F) and significant distress (Cluster G) requirements (American Psychiatric Association, 2013). With the current diagnostic criteria, over 636,000 clinical presentations of PTSD exist (Galatzer-Levy & Bryant, 2013).

Recovery is Possible

The primary treatments for individuals struggling with PTSD are medication and psychotherapy. Medications are often utilized to help manage or control the symptoms of PTSD, while psychotherapy is often utilized to target the underlying unresolved traumatic experience(s) contributing to those symptoms.

Two notable clinical practices guidelines have been published within the last 10 years to assist providers in selecting the most appropriate treatments for PTSD. The Department of Veterans Affairs / Department of Defense (VA/DOD) introduced their guideline in 2010, later revised in 2017. The American Psychological Association followed (APA), adopting their clinical practice guidelines in 2017. As the labels used to represent the different recommendations are not the same between the two guidelines, I will be using the terms Tier 1 and Tier 2 to standardize the recommendations and make it easier for readers to compare and contrast the recommendations.

VA/DOD Tier 1 (recommended) treatments consist of manualized, trauma-focused psychotherapies such as Cognitive Processing Therapy (CPT), Prolonged Exposure Therapy (PE), and Eye-Movement Desensitization and Reprocessing (EMDR), as well as Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure. Individualized, trauma-focused psychotherapies are recommended over pharmacotherapy, though pharmacologic treatment remains a Tier 1 treatment if individualized, trauma-focused psychotherapy is not available or preferred by the individual. Tier 2 (suggested) treatments include Stress Inoculation Training (SIT), Present-Centered Therapy (PCT), and Interpersonal Psychotherapy (IPT).

The APA practice guidelines also list CPT and PE, as well as CBT, as a Tier 1 (strongly recommended) treatment. Tier 2 (conditionally recommended) treatments include EMDR, BEP, NET, and pharmacotherapy.

The discrepancy in treatment recommendations between these guidelines may be due to the population used in the research from which the guidelines are based. There may also exist treatment differences and it is therefore recommended that providers follow the guidelines most associated with the population with whom they are working.

To further assist those seeking treatment, several (free) smartphone applications have been developed to support patients and providers in their work. The Defense Health Agency (formerly the Center for Telehealth and Technology) and the VA offer a wide range of mobile health applications, such as PTSD Coach, CPT Coach, PE Coach, Mindfulness Coach, CBT-I Coach, LifeArmor, and Virtual Hope Box. The National Center for PTSD has also established the PTSD Consultation Program to help providers working with trauma survivors with treatment decisions and referrals (www.ptsd.va.gov/professional/consult/index.asp)

Future for Trauma Recovery

In addition to the aforementioned practice guidelines, a number of complementary practices have been demonstrated to show promise in at least augmenting treatment. Mindfulness Based Cognitive Therapy, Yoga, and Virtual Reality have shown some added benefit in alleviating some of the symptoms of PTSD. While not enough empirical support exists to warrant their inclusion as stand-alone treatments, there is some evidence to suggest their inclusion in an individual's treatment plan can enhance trauma recovery when used in conjunction with trauma-focused psychotherapy.

Trauma recovery is a change in one's lifestyle. Providers should encourage those still struggling with post-trauma difficulties to make changes in their life that will promote healing. Through education, shared decision-making, evidence-based practice, and encouragement, recovery is possible.

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Beyond PTSD: Treating Survivors of Human Trafficking

Shari Kim, PhD


Shari Kim, PhD

On the surface, it might appear that treating a survivor of human trafficking would be just like treating any other case of complex trauma. Trafficking, however, goes much deeper than the traumatic events. People who have been trafficked have undergone a systematic disassembly of their basic instincts, defenses, and thought patterns. Once they are recovered from the trafficking ring, we cannot even access the posttraumatic stress disorder (PTSD) before combatting what has often been years of brainwashing and perpetuation of trauma bonds.

Trauma bonding

Trauma bonding, also known as Stockholm Syndrome, involves a seemingly misplaced connection to a captor. The term was coined after a bank robbery and hostage situation inside a Stockholm bank. The hostages began to feel bonds with their captors and even wanted to protect them. There are several ways in which traffickers can (and do) facilitate this process in their victims (Reid, Haskell, Dillahunt-Aspillaga, & Thor, 2013):

- Alternating attacks and positive or neutral interactions: It may seem odd that attacks can facilitate trauma bonds, but it makes perfect sense when you think of the power and control wheel used in the domestic violence world. The relationship starts out positive, and the person being trafficked gets caught in a cycle of waiting for the kindness to return.
- Creation of an Anxious-Ambivalent Style: Here we harken back to Bowlby and Ainsworth. The unpredictability of the trafficker fosters an Anxious-Ambivalent attachment style which draws the person being trafficked in closer to the trafficker.
- Misinterpretation of terror as love: On the surface, this idea seems rather foreign. When we dig a bit deeper, however, it is not so odd. Terror, like the early stages of romance, causes bursts of adrenaline and butterflies in the stomach. To a person who has not had much experience in healthy relationships, these physical sensations feel similar to infatuation.
- Hostage negotiations may cause victims to feel undervalued by rescuers: In hostage negotiations, those being trafficked often feel that the negotiators do not care about them. They believe law enforcement views them as bargaining chips and not people. That view is contrasted with how they believe the traffickers see them, which, while not much better, at least makes them feel they are seen as human beings.
- Fueled by cognitive dissonance between opposing views of the abuser: Those being trafficked are put in a confusing position. They are being forced to do things with which they are uncomfortable and being treated poorly, but sometimes they feel the trafficker loves them. They are forced to rationalize doing things that make them feel ashamed, so they rationalize that they love the traffickers and do those things to make the traffickers happy.

Traffickers purposely engage in behavior that facilitates trauma bonds, so that their victims do not want to leave and want to please them. Trauma bonds are also the reason that people being trafficked often do not want to leave the trafficker when someone comes to recover them.

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Brainwashing

The other mountain to climb before PTSD can be addressed is brainwashing. Imagine trying to help clients process trauma when they do not feel they have experienced anything traumatic. Brainwashing can take the form of programming, in which the victim dissociates, carries out a task for the trafficker, then returns to normal life with no memory of what has occurred. You might remember seeing programming in *The Manchurian Candidate*. It can also be a form of convincing a person to go along with the trafficker's commands without argument. There are several components that facilitate brainwashing, and traffickers may use all or only some of them to carry out the task. Most of them involve ways to alter the victim's consciousness, so that they will not be able to think clearly and be more susceptible to suggestion. Some ways to accomplish that are:

- Torture, including Food Deprivation
- Administration of Drugs
- Classical Conditioning
- Gaslighting and Isolation: Gaslighting is a form of psychological abuse that involves making the people being abused question their own perceptions of reality. For example, they might tell victims that something they

believe to be true never happened. When combined with isolation, the victims have no one to validate their reality.

- In-Group/Out-Group: This concept dates back to the work of Gordon Allport, in which people view those belonging to their group (e.g., ethnic group, gang, political party) as "good." The stronger their identification with that group, the more they look at those outside that group as "bad." In trafficking, people not being trafficked are the out-group. When people stop being trafficked, they will themselves be part of the out-group. A common statement from people being trafficked is that they "don't want the square life," which refers to the life involving a legal job and a stable household. This idea of avoiding "square life" is a reference to not wanting to join the out-group.

How Brainwashing and Trauma Bonding Interfere with Treatment

Most people who have been trafficked either view the situation as voluntary or feel they are to blame for what happened; they usually do not identify themselves as trafficking victims. Also, trafficking survivors often believe that their traffickers are omniscient, will find out that they have told someone what happened, and will come and harm them. When we add into the mix the negative self-image that trafficking survivors (and most trauma survivors) have, we also start to struggle with a population that does not believe they deserve to get better. The most frustrating and heartbreaking way in which these things interfere with treatment, however, is that they often return to their traffickers.

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Treating the PTSD

Once we have fostered a safe and supportive therapeutic environment, we can overcome brainwashing and trauma bonds through consistency, patience, empathy, and respect. If we as clinicians rush that process, we can be certain that they will leave treatment. Once we have developed trust and safety, we can move into treatment of PTSD. The National Center for PTSD only recommends three treatments for PTSD. That is not to say that others are ineffective, but rather they only feel there is sufficient evidence to support the following treatments for anyone struggling with PTSD:

- Eye Movement Desensitization and Reprocessing (EMDR): EMDR causes the brain to reprocess the trauma through the hippocampus (as it would any other memory) by alternating stimulation of the left and right hemispheres of the brain. The stimulation is completed through moving the eyes left and right, or the stimulation can be tactile or auditory. The traumatic memory then gets filed like any other memory. While it will not be a good memory, it will cease to be a constant disruption to the client's daily activities.
- Cognitive Processing Therapy (CPT): This treatment combats negative cognitions that the individual holds relating to the trauma (e.g., "I am a bad person," "No one can be trusted"). It can be accomplished through group or individual therapy.
- Prolonged Exposure Therapy (PE): PE has two components. The first component involves the client reading the trauma narrative into a voice recorder and playing it back repeatedly. The concept is that the exposure to the narrative leads to desensitization to the story. The other component requires the client to engage in graduated exposure (similar to the treatment for phobias) to trauma triggers to desensitize those triggers.

Working with trafficking survivors can be rewarding and also frustrating. It is imperative, though, that anyone working with this population is well-versed in treatment of complex trauma.

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ASSISTED OUTPATIENT TREATMENT

Continued from page 4

initial AOT for up to 90 days and can renew the AOT for up to 180 days.

Administrators of county MH/MR programs can determine annually if their county will offer assisted outpatient treatment. Analysis by the House and Senate Appropriations Committee determined that this additional program will cost the state government no money. They cited statistics from New York State which found that the average patient on AOT cost almost $50,000 a year. However, having a patient on AOT greatly reduced emergency room visits, incarcerations and in-patient hospitalizations thus more than off-setting the costs incurred by the AOT program itself.

Act 106 was introduced as HB 1233 by Rep. Thomas Murt (R-Montgomery County).

A Curious Intersection of Ethics, Self-awareness and Self-care

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A Narrative:

Recently, on the PPA list serv, a female member of PPA described an uncomfortable experience, and requested suggestions of how to handle the situation. It involved a threat from the father of an adult client; she acknowledged recognizing some clinical implications and then, she specifically asked for any practical steps anyone would recommend to protect herself or for suggestions about issues she may not have considered. She also referenced "a threatened feeling I am having."

Initial responses were swift, plentiful and helpful. They included reassurance, some minimizing the real threat, some interpretations of the threat, suggestions about what you can say and to whom, discussions about contacting her malpractice carrier, and eventually an acknowledgement of the emotional impact of this experience and a separate suggestion to 'talk this over with a trusted colleague.' I'm not sure if it was one of these last two remarks or my last 16+ years of teaching physicians to 'validate' their patients' emotional experiences that stirred in me the thought of responding with a slightly different direction to this thread. In addition to hoping I would validate the original writer's experience; I was also reminded of a time I felt threatened. In addition, I thought that there is a high probability that others who may be reading her original post have had a similar experience of being threatened and a similar emotional reaction. I described my own experience of being threatened, and I then invited others to share their stories. Within a day, two more stories were shared and then a whole other thread emerged with stories and, most notably to me, explicit appreciations for all those who preceded them in sharing experiences which in many cases have been the first time these stories were told, especially in such a public / professional forum.

In addition to noticing a 'first joiner' phenomena - it took a day for two people to accept my invitation to share a personal experience before there was a flood of appreciative postings - there are additional subtle learnings worth identifying. Further, I think about all the psychologists who read this thread, have felt threatened, but did not feel free to share it publicly on the list. I would encourage them to write down a description of the experience, including all the emotions they experienced, what they did or did not do, and who they told or did not tell, and why! Read what you have written and then decide if you would like to share it with others.

Our Human Doing vs. Our Human Being:

There is a tendency that many of us humans have to solve or fix problems as soon as we possibly can. It is especially gratifying when we listen to someone else's problem and the solution we suggest is effective. One of the challenges in this type of scenario is that in our enthusiasm to provide a solution, we may skip over a better understanding of the emotional impact of a significant experience. I refer to this tendency to fix as the 'human doing' part of all of us. This contrasts to a 'human being' part of us which is able to be present, in the moment and is more sensitive to an emotional state. In this situation, one clue that there might be an important emotional impact of an experience is the word 'threat.' Offering a fix or 'solution before the impact is identified is like putting the cart before the horse. Validation is the affirmation of an emotional experience, and it is sometimes accompanied by the sharing of a similar experience which resulted in a similar emotion. This sharing is a way to say, "I have an idea of what it feels like because I had a similar experience." Acknowledging the presence of an emotion is the first step in recognizing an experience we have had that may impact us ("You have to be it to see it"). Naming the emotion is a next step that is essential in taming its impact ("You have to name it to tame it."). It is also the segue to the next point we too easily gloss over.

A Hidden Self-Care Need:

Unless and until an emotional experience is named and validated, we will very likely ignore the impact of that experience. We don't see what we do not attend to. Being threatened in any way, physically, professionally or symbolically is a game changer. We cannot put that genie back in the bottle. We become a different person. However, if we focus more on what actions we should take or on its implications for our work with our patients, we are not likely to process the impact of emotions like the immediate fear, or the denial of fear ("I'm not going to let anyone change what I do!"), tenseness, hyper-vigilance, caution, or self-protection.

Is it possible that we understand patients who have safety challenges better after we have our own safety challenge? How do any of our own emotionally loaded experiences impact our vulnerability and therefore our availability to our patients? What does it take to check in with ourselves and/or trusted

colleagues to be sufficiently self-aware? Imagine what we might experience if we took a few minutes to do some mindful breathing before and after every patient session.

The Possibility of Impairment:

We cannot be both sufficiently vigilant to the possibility of a threat and be available for intimate conversations and relationships. When we do not feel safe, we retreat into a protective mode with defenses up and our attention marshaled to focus on possibilities of threats. It is the biologically determined fight or flight response.

All good therapy depends on a therapeutic relationship with the patient. As soon as any threat is introduced into this work, the closeness of the relationship is compromised. Whether we acknowledge it or not, our innate unconscious reaction to threats is self-protection and backing away, even just a little, from the closeness we previously enjoyed. It is also possible that a recent threat may trigger responses from previously experienced and unprocessed threats. It is crucial that we assess our own personal situation and seriously consider if we need to ethically modify our working practices. Do we need a professional consultation? Should we work fewer hours or schedule more or longer breaks in between patients? Should we avoid taking certain types of patients?

Our single most effective tool is our ability to form therapeutic relationships with our patients or our clients. Functioning at our best requires a regular maintenance schedule. A key part of maintenance is self-awareness and self-care. We fool ourselves if we think we can do this alone.

Classifieds

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The Role of the Psychologist in Building Trauma-Informed, Resiliency-Focused Communities

Kirby Wycoff, PsyD, MPH, NCSP
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For many, when they hear the word "trauma" they often think of a single incident traumatic event associated with extreme situations and extreme responses. Most people, however, do not consider the role of chronic traumatic stressors like living in an unsafe community, witnessing violence, living in poverty or experiencing oppression and marginalization. Whether a single incident event that involves actual or threatened death, ongoing childhood adversity like maltreatment, or a lifetime of exposure to racial discrimination, these experiences are often accompanied by feelings of intense fear and helplessness. They overwhelm individuals' physiological systems and regulatory capacity, resulting in a lack of internal resources to respond and cope (Ghosh Ippen, 2018). When the stressful stimuli continue to occur, and the dangerous event does not go away, the physiological arousal and corresponding cascade of responses persist in the human body. This leads to an increase in allostatic load, or wear and tear on the body which can ultimately result in chronic illness (Sapolsky, 2003; 2004; 2019).

Adverse Childhood Experiences

In a landmark public health study in the late 1990s, researchers discovered that the more exposures that a child had to adversities like neglect, sexual trauma, domestic violence, parental addiction and incarceration and more, the higher the chance for adverse health outcomes across the lifespan (Felitti et al., 1998). Aside higher risks for social-emotional distress, those with increased exposure to traumatic stressors also experience higher rates of obesity, heart disease, chronic lung disease, liver and digestive problems, diabetes, asthma and shortened lifespan (Pretty et al, 2013; Danese et al., 2009; Anda et al., 2006; Williamson et al, 2002). Across the country, almost half of all children in most states have experienced at least one ACE (Merrick et al., 2018) and almost half of the young people in Pennsylvania (45%) have experienced at least one ACE – 25% of those have experienced 1 ACE, 10% have experienced 2 ACES and 10% have experienced 3 to 8 ACEs (Sacks & Murphy, 2018).

Adverse Community Environments

Ongoing stressors like witnessing community violence, living in unsafe neighborhoods, living in foster care, experiencing bullying and experiencing racism can also serve as traumatic stress experiences. The results from the Philadelphia Urban ACEs study indicated that 40.5% of Philadelphians reported witnessing violence, 34.5% experienced discrimination and, 27.3% experienced an adverse neighborhood event. More than half of Black adults in Philadelphia (52%) regularly saw violence compared to one in four White adults (25.9%) and almost half of Black adults experienced racialized discrimination (49.5%) compared to significantly less White adults (15.8%) (Cronholm et al., 2015; Wade et al., 2016; Pachter et al., 2017).

The increased experiences of racial discrimination among persons of color is consistent with other literature indicating racism, not race, is the risk factor involved. Racial mistreatment can lead to clinically significant anxiety, stress, and trauma symptoms and may result in symptoms consistent with Race-Based Traumatic Stress (Williams, Printz & DeLapp 2018; Williams, Kanter & Ching, 2018; Carter, 2007).

Trauma-Informed, Resiliency-Focused Systems

Trauma-informed systems are those that understand the impact of chronic, traumatic stress and respond accordingly. "Programs and agencies within such a system infuse and sustain trauma awareness, knowledge and skills into their organizational cultures, practices and policies" (National Child Traumatic Stress Network, 2016, p. 1). Visualizing a stone dropping in a pond and the corresponding "ripple effect" highlights the importance of sharing trauma-informed perspectives across systems (Ghosh Ippen, 2018). Equally important is understanding resilience and the need to counterbalance positive and negative experiences in a child's life. We can help buffer against stressors with responsive relationships, skilled caregiving, safe schools and communities, food and housing security, equitable policies, and bolster individuals' skills for managing stress, solving problems, regulating emotions and more (Center on the Developing Child at Harvard University, 2015). It is critically important that growth mindset to this work when talking about the impact of ACEs. As Mike O'Bryan (Director of Youth and Young Adult Initiatives at the Village of Arts and Humanities and Lindy Fellow, Drexel University) notes, many impacted may say "that's not traumatic, that is just the way I was raised" and we cannot pathologize or leave individuals feeling stereotyped or damaged as a result of their life experiences (Mabaso, 2015).

The "Building Community Resilience" collaborative at the George Washington University School of Public Health,

highlights the role of inequitable community conditions, systemic racism, lack of power and access to resources as intimately related to traumatic stress (Ellis & Dietz, 2017). The BRC model is a process model that highlights the role of shared understanding, state of readiness, and cross-sector partnerships (Ellis & Dietz, 2017). The "Pair of ACEs" - Adverse Childhood Experiences and Adverse Community Events – helps us conceptualize adversity across family and community systems (Ellis & Dietz, 2017). When we understand the relationship between these various interconnected factors, we can better imagine where psychologists might position themselves to impact change.

Community Coalitions in Pennsylvania

Across the state, there are community coalitions that are involved in building the capacity of the Commonwealth to become a trauma-informed state. In their interviews on "Working Toward a Trauma-Informed City," thought leaders Sandy Bloom, MD (Dornsife School Public Health at Drexel University) and Mike O'Bryan discuss the importance of addressing structural inequities through and authentic community engagement in building trauma-informed communities (Bloom & O'Bryan, 2016). One example of a community-level effort in the is the Chester County ACEs coalition (CCACE). While not the first in the region, the CCACEs mission is to increase the county's knowledge of ACEs, to build resiliency and foster hope across sectors. CCACE does this work with many others, like the Trauma-Informed Education Coalition (TIEC) whose longstanding mission has been to ensure a trauma-informed education system for all Pennsylvanian students. The TIEC and NAACP of Pennsylvania, under the leadership of Dr. Joan Duvall-Flynn, have been instrumental in bringing key legislation on "Trauma-Informed Schools" to the Commonwealth. CCACE acknowledges and extends the work of TIEC and others, including the Pottstown Trauma Informed Community Connection in Montgomery County, Philadelphia ACEs Project, Lancaster County ACEs, and Resilience Connection, Lehigh Valley ACEs Connection, and more. The ACEs Connection "Mapping the Movement" tool can be used to find a coalition or community group near you.

Chelsea Melrath is the Chester County ACEs Coalition Coordinator and a Health and Social Services Program Coordinator at Home of the Sparrow. The Home of the Sparrow is a non-profit agency providing housing and supportive services to women who are experiencing housing instability. Over time, the organization recognized that there was more to supporting women in the program than just addressing housing needs. As the organization expanded their understanding of the role of trauma and toxic stress on health and wellness, there was a realization that they needed to improve their systems and practices to become more trauma informed. A trauma-informed organizational model that included partnerships with psychologists, social workers, health providers, child-focused agencies, social services agencies, schools, and others were the keys to improving outcomes.

In a landmark public health study in the late 1990s, researchers discovered that the more exposures that a child had to adversities like neglect, sexual trauma, domestic violence, parental addiction and incarceration and more, the higher the chance for adverse health outcomes across the lifespan (Felitti et al., 1998).

The CCACE was created in 2017, initially as a way to build a resource network of clinicians who could provide treatment for traumatic stress. As more and more organizations became interested in ACEs the CCACE expanded to provide education and outreach across sectors. In addition to educational opportunities, and film screenings (using *Paper Tigers* and *Resilience: The Biology of Stress and the Science of Hope* by KPJR Films) the CCACE serves as a hub for a growing network of trauma-informed organizations, to create a trauma-responsible community. ACEs Coalition member Tiffany Cooke, MD, MBA says of her work with the coalition and the significance of educating health care providers on the impact of trauma "It is imperative that providers screen for specific risks that can prevent children from growing into their full potential and productivity which benefits us all."

On behalf of their work with the coalition, Kirby Wycoff, Psy.D., MPH., NCSP and Nadine Bean, Ph.D., LCSW have presented to multiple groups of health professionals including physicians, nursing professionals, and practice managers across health care settings throughout the county. Dr. Bean (Professor of Social Work at West Chester University) notes of this outreach effort, "Health care professionals seem to be hungry for the information on ACEs, toxic stress, and building resilience. They also want to advance to the next level beyond screening and learn evidence-based interventions for mitigating the impact of trauma on health and building resilience. We are prepared and pleased to offer this information so that these professionals can add to their trauma-informed toolbox and improve health outcomes across the lifespan."

Public Health Framework and the Role of the Psychologist

A public health framework offers a useful approach for translating ACEs research into action steps to build trauma-informed capacities at a local level. Clinical providers, including psychologists, typically focus on treating those who are already experiencing symptoms of illness or distress (downstream), while public health focuses on preventing individuals from becoming unwell in the first place (upstream). Multi-generational approaches that focus on both parents and

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THE ROLE OF THE PSYCHOLOGIST IN BUILDING TRAUMA-INFORMED, RESILIENCY-FOCUSED COMMUNITIES

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children and look at the entire family system, while integrating community psychology principles can be helpful - particularly in considering where in the intervention cycle we can be most useful (Murphy et al., 2016; Dingfelder 2011; Hepworth, 2004.) The APA initiated a set of formal guidelines, consistent with the United States Department of Health and Human Services' focus on health promotion and prevention, to help guide psychologists in thinking about prevention activities (APA, 2014). As our communities continue to experience trauma and stress at ever increasing rates, psychologists are well poised to share their expertise, engage with others and serve as key players in building trauma-informed communities.

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Reflections on Surviving and Thriving in Academia: Viva la Revolucion!

Shannon Len Deets, PhD


Shannon Deets, PhD

As you read this, I imagine I am sitting peacefully by a campfire with no looming deadlines and blissfully counting stars. However, as I write this I am in a much different state. It is right now, the end of April. In academia, the end of April means:

- Finalizing registration for classes next fall with students who were waitlisted, revising their entire schedule, had financial holds, decided to change their major, or any other variety of reasons.
- Comfort students who just realized they are in fact not going to pass statistics and will have to retake the class.
- Celebrate with students accepted into graduate school or employment positions.
- Celebratory dinners for our students inducted into honor societies.
- Multiple conferences to which to escort excited presenting students.
- Senior night for the department.
- Increased grading due to final projects and papers.

I am sure I have forgotten at least six things and those do not even include the lists I have in my role of a mother, a sister, a friend, among others. Nevertheless, understand, I LOVE ALL of this! I thoroughly enjoy all of my roles and sought out most by my own free will! However, I wonder is the pace of academia healthy for us as a society? Fifteen weeks of frenetic energy and stress, 3 weeks of recovery over winter break, 15 weeks of frenetic energy that is somehow more intense than the fall semester, delirious amounts of celebration and graduation events all seemingly packed into one week, 3 months of recovery and steadily building guilt over the amount of work you were going to "get to" but haven't yet- I see you August!

I have kept this schedule in some form from kindergarten to my current career teaching psychology. I found that over the years I have developed my own coping strategies to deal with this cycle. I actively meditate as a means of finding stillness in the escalating movement of time from August to May. I foster forgiveness for myself to acknowledge when meditating might be good for me but I'm just going to bed instead. I reaffirm my resilience each time I make it to the "finish line." I use humor when I mess up and clearly, things are just not in my control. I look forward to upcoming plans of dancing, creating art, and general relaxation. I have learned all of these coping skills as a result of this experience, and for that I am grateful.

However, what would my life look like if I had not accepted this seemingly frantic schedule as normal? What if I had not been a counseling psychologist who was continually reminded of the importance of self-care and often told of the ethical implications of burnout, as a component of my graduate training? I remember my undergraduate experience and the sleepless nights, caffeine headaches, and chronic self-doubt. Clearly, I was not feeling gratitude for the experience at that time! I was miserable and persisting despite the chaos of academia, not because of it. I see this in my students even now. I have made sure to incorporate self-care assignments into my course work to encourage students to learn good habits during their undergraduate experience. In addition, I was asked to visit a health professions introductory course each Friday of the semester to teach meditation. Various other professors who have incorporated some kind of self-care into their classes.

But I still find myself coming back to my original question: why are we doing this? It is clear there is an enormous amount of stress inherent in the way in which we educate our students. We would not place such an emphasis on teaching them meditation, if we did not recognize the struggle they experience. The amount of articles showing up on my newsfeed that discuss stress in academia make it very clear, it's not just the students suffering! Instead of trying to cover over the problem by teaching coping skills, why don't we remove the stress itself and restructure how we function in higher education?

I believe there are many reasons why we choose to bandage the wounded along the way and keep moving. First, consider all the moving components of academia from housing, academics, financial aid, campus jobs, and even part-time off campus jobs in some college towns, are deeply interconnected through this academic schedule. There are likely just too many moving parts to make drastic changes. Second, humans have short memories. I am sure that by now, June, I have forgotten all about the April madness that academia brings. Instead, I am thinking only of my time off and I might even start to justify to myself that really it is not so bad, after all in the summer I get time to myself. However, I will not quietly step aside simply because something is hard to do, complex, or easily forgotten. Instead, I want to rally other like-minded people to start the discussion about what we can actually do to make academia the rewarding pursuit of knowledge and truth that it is meant to be, instead of something to simply get through. Instead of coping, we should be creating new possibilities. Instead of surviving, we should be thriving!

It's a Small World!

Jeanne M. Slattery, PhD, Linda K. Knauss, PhD

This discussion is part of a regular series examining clinical dilemmas from an ethical perspective. In addition to the two of us, the respondents to this vignette included Drs. Lavanya Devdas, Claudia Haferkamp, Sam Knapp, Brett Schur, Max Shmidheiser, and Ed Zuckerman. Rather than immediately reading our responses, consider reviewing and carefully working through the vignette first.

> Dr. Furst met a new client for an initial session. Mei appeared very depressed and anxious (although she did not label her feelings as such), and has some suicidal ideation. Mei is also being seen by a psychiatrist, who has prescribed an antipsychotic.
>
> After Mei left, Dr. Furst realized that he is also seeing Mei's adult son, who will be moving far enough away that they are currently planning a transfer to another psychologist. He had seen her son relatively briefly for work-related issues, but it was clear that Mei and her son have a "complicated" relationship. Dr. Furst is not fluent in Mandarin, Mei's preferred language, but he does have more Mandarin and understanding of Chinese culture than other psychologists in driving distance.

Identify the Options

Under normal conditions, one might choose to continue seeing Mei's son and refer Mei elsewhere (prioritizing continuity of care), but this isn't a normal scenario. Whether or not Dr. Furst, Mei, and her son live in a small town or a large city, they are facing a "small community" problem, as there appear to be no Mandarin-speaking therapists within reasonable driving distance. In considering this scenario, we saw several options: (a) increase the size of the available "community" by recommending teletherapy for one client; (b) choosing to work with one client and refer the other client elsewhere; or (c) work with both clients, with or without their knowledge.

Multiple Relationships

Standard 3.05 of the Ethics Code observes, "Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical" (APA, 2017, p. 6). Could we reasonably expect to work with both parties without causing impairment or risking harm? Without knowing more, we probably cannot answer this question. On the other hand, we should not necessarily conclude that such a relationship would be problematic. In fact, Dr. Devdas observed that, in Chinese culture, family is often perceived as a unit. As a result, it might be problematic and culturally-insensitive to choose to work with one party over the other. Would that be the case for this particular family?

Evaluate the Options

There is no easy answer to this dilemma. Rather than prioritizing ethical concerns over clinical ones, we wanted to consider both simultaneously. What is an ethical and clinically-appropriate response to this dilemma?

All of us believe that our response would depend on our assessment of individual, familial, and cultural issues. What individual dynamics do Mei and her son bring to the table? Are their clinical goals consistent with working with both of them together? How do

ethnicity and culture impact their behavior (see Clauss-Ehlers, Chiriboga, Hunter, Roysircar, & Tummala-Narra, 2019)? Perhaps Mei is grieving her son's "loss" because he is moving away, while her more acculturated son is attempting to create emotional distance by moving. Compared to Euro-Americans, Asian Americans are more likely to have turmoil in family relationships identified as a precipitant for a suicide attempt (Chu et al., 2017). Would working together address their clinical goals and help them feel supported – or would it raise issues of shame and attempts to "save face"? As it can be very difficult for some Chinese individuals to disclose mental health problems, could we be refusing therapy to an emotionally-vulnerable woman who might be unwilling to request treatment again? Because Mei's son is terminating soon and had been seen briefly for work-related issues—in contrast to his mother who has more severe issues – unless there is some overriding reason, it would be reasonable to continue working with Mei.

Is Dr. Furst's specific knowledge of this family's culture an important consideration with this family? It may have been the reason that both mother and son requested treatment from him. The importance of cultural competence and the apparently limited options for treatment caused us to explore more creative options than we might have otherwise done, including seeing both parties simultaneously under some circumstances. However, many psychologists in this situation would terminate with one client noting a "conflict of interest" (Knapp, 2016). Even if the psychologist did not identify the reason for the referral, the referred client would sometimes figure it out. Dr. Schur described a similar multiple relationship in his practice, where it was clearer that the two parties could not be seen simultaneously or together without a very likely negative outcome. Because there were other options available, he felt more comfortable referring one party. However, that party probably did not pursue treatment with another provider, something he continues to rue.

As Dr. Shmidheiser observed, with the advent of teletherapy, Dr. Furst's options may be much broader than they would have been in the past. Perhaps Mei would accept and appreciate a referral for teletherapy, where she would not be seen entering a psychologist's office. On the other hand, she might be an inappropriate candidate for teletherapy depending on her level of depression, anxiety, and suicidality, particularly if she was also paranoid. She might be uncomfortable with this referral if she believes information is not private on the internet, and if she is uncomfortable with technology or does not have the requisite technology available.

Confidentiality and Informed Consent

If we determined we could work with both parties at the same time, should we let them know we were doing so? If they were to find out and we did not let them know, they may feel betrayed. Individual, familial, and cultural differences might again play into this decision. Dr. Schur referred to Principle B of the Ethics Code: "Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work" (APA, 2017, p. 3). Would such an undisclosed multiple relationship encourage or undermine trust? How would disclosing and discussing the multiple relationship foster trust?

Several of us considered how and why we might discuss these issues with Mei and her son, considering general beneficence, nonmaleficence, and fidelity. Without a release of information, however, such discussions would become more difficult. On the other hand, both parties might already know – which could explain why they had both requested treatment from the same psychologist! Perhaps rigidly maintaining confidentiality with this family and refusing to consider whether seeing both clients was possible would cause more problems rather than it prevented. Concerns about confidentiality could be handled by asking both Mei and her son to sign a release to talk to the other.

Dr. Slattery suggested that those psychologists working within a small community – with gays and lesbians in a rural area, for example – might consider including statements in their informed consent materials about how such multiple relationships would be resolved (e.g., confidentiality across clients, attempts to schedule appointments to prevent accidental interactions among known friends or colleagues, consultations as needed if objectivity became more difficult). This might have been helpful in the case of Mei and her son – if Dr. Furst had frequently worked with this community before seeing Mei's son. If this was an unusual, chance situation, however, it would be more difficult to anticipate and resolve in this manner.

Conclusions

Some situations do not have easy answers, but the process of thinking through them and then documenting our thinking is what is important, as it can be very easy to overlook options or pitfalls given our own blind spots. In prioritizing clinical concerns in this situation, because Mei's son is terminating with Dr. Furst due to moving away, it seems unnecessary to make a referral for Mei. As we generally conclude, "Consult, consult, consult!" Good supervisors or peer consultation groups both hold us accountable and remind us that we have other options available.

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Would you like to be involved in future discussions of vignettes? Let us know by e-mailing jslattery176@gmail.com

CE Questions for This Issue

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Learning objectives: The articles in this issue will enable readers to (a) assess and explain current issues in professional psychology and (b) describe and act on new developments in Pennsylvania that affect the provision of psychological servicess.

Legal Column

1. The passage of HB 1233 in 2018 (Act 106) was a compromise between proponents and skeptics of mandated outpatient treatments.
   True
   False

2. An AOT plan may include all of the following EXCEPT:
   a. Medications
   b. Management Services
   c. Treatment for the misuse of alcohol or other drugs
   d. All of the above may be included

Baturin

3. The PsyPACT is designed to achieve all of the following purposes EXCEPT:
   a. Enhance the state's ability to protect client/patient health and safety
   b. Exchange information between Compact states such as verification of licensure and disciplinary history
   c. Increase revenue for psychologists
   d. Increase public (patient/client) access to professional psychological services

4. New Jersey and New York are two of the seven states that have offically enacted PsyPACT legislation.
   True
   False

Roffer

5. Which of the following is not considered a Tier 1 (recommended/strongly recommended) or Tier 2 (suggested/conditionally recommended) treatment for PTSD based on current clinical practice guidelines (VA/DOD or APA):
   a. Prolonged Exposure Therapy
   b. Virtual Reality
   c. Cognitive Processing Therapy
   d. Eye-Movement Desensitization and Reprocessing

6. Which of the following reaction(s) constitute the new Criterion D for PTSD (per DSM-5)?:
   a. Persistent angry or irritable mood
   b. Self-blame
   c. Hypervigilance
   d. Efforts to avoid external reminders associated with the traumatic event
   e. A and B
   f. All the above

Kim

7. Trauma bonds and brainwashing interfere with treatment of trafficking survivors because
   a. The client often fears the trafficker is omniscient
   b. Clients will ask the trafficker to be part of the treatment
   c. The trafficker often will threaten the therapist
   d. The client will always avoid treatment

8. Which of the following is NOT a component of brainwashing?
   a. Torture
   b. Administration of drugs
   c. Gaslighting
   d. Giving victims gifts

Wycoff & Melrath

9. Allostatic load refers to increased wear and tear on the body and brain, often associated with exposure to chronic stress:
   True
   False

10. Resilience focused practices include:
    a. Increasing responsive relationships
    b. Improving the skill of caregiving
    c. Ensuring access to safe schools
    d. All the above

Slattery & Knauss

11. Multiple relationships:
    a. Are always unethical
    b. Are always ethical
    c. Are ethical with some cultural groups
    d. Are ethical is reasonable believed to be without expected impairment, exploitation or harm

12. The reasons to continue to see Mai, despite a possible conflict of interest, include:
    a. Dr. Furst's greater understanding of Chinese culture and his facility with Mandarin
    b. Mei's greater psychological fragility and her son's expected termination from treatment soon
    c. There are other ways of handling confidentiality well
    d. All the above

Continuing Education Answer Sheet

***The Pennsylvania Psychologist*, June 2019**

Please circle the letter corresponding to the correct answer for each question.

1.	T	F	**4.**	T	F	**7.**	a	b	c	d	**10.**	a	b	c	d
2.	a	b	c	d	**5.**	a	b	c	d	**8.**	a	b	c	d	**11.**	a	b	c	d
3.	a	b	c	d	**6.**	a	b	c	d	e	f	**9.**	T	F	**12.**	a	b	c	d

Satisfaction Rating

Overall, I found this issue of the Pennsylvania Psychologist:

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

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Pennsylvania Child Abuse Recognition and Reporting—3 CE Version
Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

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