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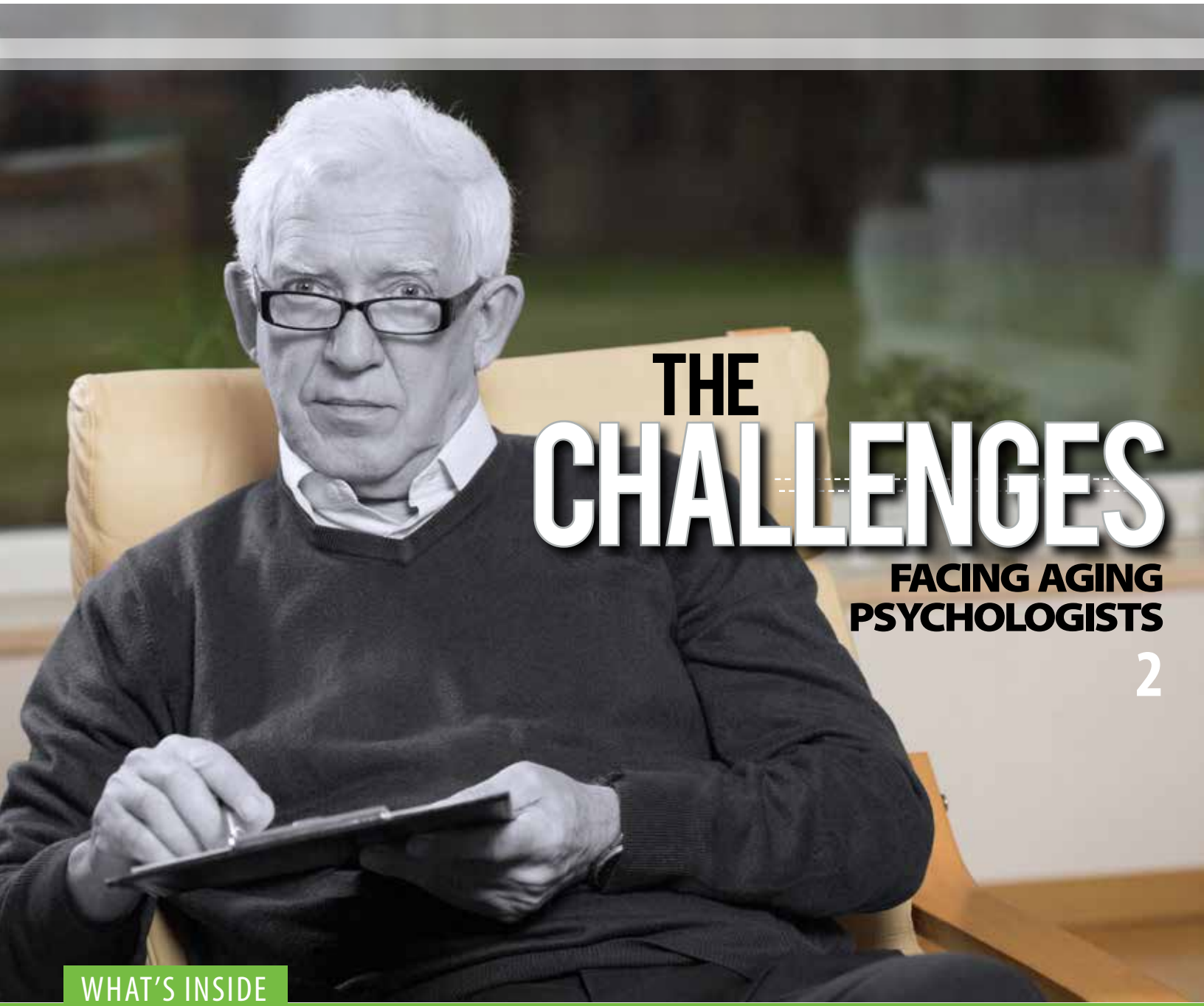

THE CHALLENGES FACING AGING PSYCHOLOGISTS

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PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION
5925 Stevenson Avenue, Suite H
Harrisburg, PA 17112
717-232-3817 • papsy.org

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Publications Committee Chairperson:
Jade Logan, PhD, ABPP
Copy Editor and Graphic Design:
Graphtech, Harrisburg

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The CHALLENGES FACING AGING PSYCHOLOGISTS

SAMUEL KNAPP, EdD, ABPP
RACHEL GINZBERG, PsyD
IRA ORCHIN, PhD

During PPA's fall CE week, the authors of this article led a webinar for aging psychologists. This workshop was motivated by our concern for our colleagues and informed by our own experiences as aging psychologists. We have known psychologists who retired, then decided that they retired too soon and returned to work. We have also known psychologists who kept working too long to the point where they were delivering substandard treatments. We have known psychologists who worked effectively well into their 80s, and psychologists who needed to retire in their 40s due to medical problems.

During this workshop, among other things, we asked participants to identify their concerns about being an aging psychologist. The participants identified many concerns, such as a lack of stamina, cognitive decline, challenges of dealing with technology, being out of touch with younger patients, loss of motivation, and the risk of declining in professional skills. A certain amount of stamina loss and cognitive decline is normative, but when does it decline sufficiently to the point that psychologists can no longer practice effectively? Other psychologists noted that they could accommodate their diminished stamina by being more selective in patients that they take on, while others noted that they have more perspective and experiences to draw upon when facing difficult patients.

Many psychologists emphasized the importance of wisdom and experience. As we age, we may feel more comfortable, present, and intuitive. Our depth of experience may increase our confidence in our interactions with our patients. Irving Yalom reported that he felt freer to be more self-disclosing and direct with his patients as he has aged. He also reported an increased gratitude in being able to do his work (Sandmaier, 2018).

However, we need to guard against overestimating our capabilities. Our investment in our professional identity, the wounding of diminishment, and the fear of our own mortality can lead us to deceive ourselves. Who are we if we are no longer practicing and from where will we derive our sense of meaning and usefulness? Other factors may interfere with our self-assessment: we may need the income or the gratification that we get from feeling special to our patients. We may depend on the relational intimacy with our patients, particularly if we have sustained significant losses in our own lives.

Psychologists approach retirement differently as well. Any decision to retire involves a combination of push and pull factors. Push factors are those that make working less attractive, such as the demands on one's time and the cognitive and emotional energy that working involves. Pull factors are those that make retirement more attractive, such as the option of spending more time with family or on interesting projects.

Experiencing fear and anxiety when contemplating slowing down, or retiring is to be expected. We encourage psychologists to face and discuss these uncertainties: they are growing pains and likely to accompany any major life transition. These emotions are neither signals that we should nor should not retire. Rather, we are experiencing emotions that require our attention. These

emotions may motivate us to reflect on what adaptations to our practice we should take and how we might create a smooth retirement plan that reflects a professional and dignified concern for ourselves and our patients.

Because we all have the capacity to deceive ourselves as to our ability level, we may need to ask ourselves additional questions: "How receptive are we to feedback?" "How willing are we to adopt compensatory strategies?" and "How proactive are we in planning our retirement?"

How open are we to feedback? The most effective psychologists solicit and use feedback from others including their patients and colleagues. This feedback/receptivity principle especially applies to older psychologists who are at a greater risk for physical illness and meaningful cognitive decline. Ideally, we will be embedded in a loving and protective community that will tell us how we are doing and warn us when they see early slips in our professional behavior. Two of us (RG and IO) participate in an elders' group where older psychologists engage with each other, consider how to maintain the quality of their practices, and plan together for their eventual retirement. One of the most meaningful aspects of our meetings is the feedback that we give each other on our thoughts and feelings about our practices and retirement plans. We have agreed to hold each other accountable in monitoring any decline, helping to ensure that we attend to any lapses and get any additional consultation, as necessary. Should any of us be hanging on beyond what is appropriate, we imagine gently pointing our colleague to the exit.

How willing are we to adopt compensatory strategies? A weekly schedule with more than 25 patients might have been reasonable for psychologists in their 30s (or 50s) but becomes less doable for older psychologists. To maintain an acceptable quality of service, older psychologists may need to cut back on the number of patients seen, allow more time between appointments, or become more selective in whom they are willing to accept as patients. Other older psychologists note that they must keep better records because their ability to recover details about their patients is gradually declining with age. Of course, people age at different rates. Some psychologists can keep a heavy schedule much longer than others. But this is not a competition. Every psychologist needs to consider what is reasonable for them given their health and competing demands.

Many psychologists emphasized the importance of wisdom and experience. As we age, we feel more comfortable, present, and intuitive. Our depth of experience may lead us to increased confidence in our interactions with our patients.

How proactive are we planning for our retirement? Are our finances in order? Do we have activities and relationships to keep us engaged when we retire? Have we addressed our feelings about the loss of our professional identities whether they include grief and/or celebration? How satisfied are we with how our careers went and how does that impact our readiness to let go?

Have we thought through the mechanics of retiring? Part of that process may mean writing a "professional will" which instructs our executors on how to handle our practices if we were to die or become disabled suddenly. Even if our retirement is more planned and uneventful, the professional will addresses the details involved in closing a practice. A sample professional will can be found at the PPA website (Resources> Legal and Ethical>Retirement). As one example of the tasks that need to be considered, psychologists will need to maintain a list of their current patients and how to reach them, ideally leave some brief information re how to best help them, and include information about managing records, their computer and online presence, and accounting.

Being intentional about letting go of our practice will not only serve our patients but enable us to gracefully let go and move on to the next chapter of our lives.

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EATING DURING A PANDEMIC: CHALLENGES for Those with EATING DISORDERS

DEA SILBERTRUST, PhD

The pandemic has affected the eating habits of many Americans. We eat out less, cook more, and indulge in more comfort foods resulting in jokes about the Pandemic 15. Last Spring, the sale of cooking implements soared and social media was flooded with the results of culinary experiments. Meanwhile, job loss and school closures led to a massive increase in hunger and food shortages. Food pantry lines snaked through parking lots as people waited hours to pick up one box of groceries.

Studies confirm the changes in eating habits around the world. In the U.S. there has been a general increase in food consumption, especially alcohol and sweets, and a decrease of fruits and vegetables (Andrade & Bin Zarah, 2021). This is more pronounced in those experiencing economic hardship, another example of COVID-19's unequal impact. According to a report by the United Nations World Food Program, the number of people worldwide experiencing acute food insecurity nearly doubled between 2019 and 2020.

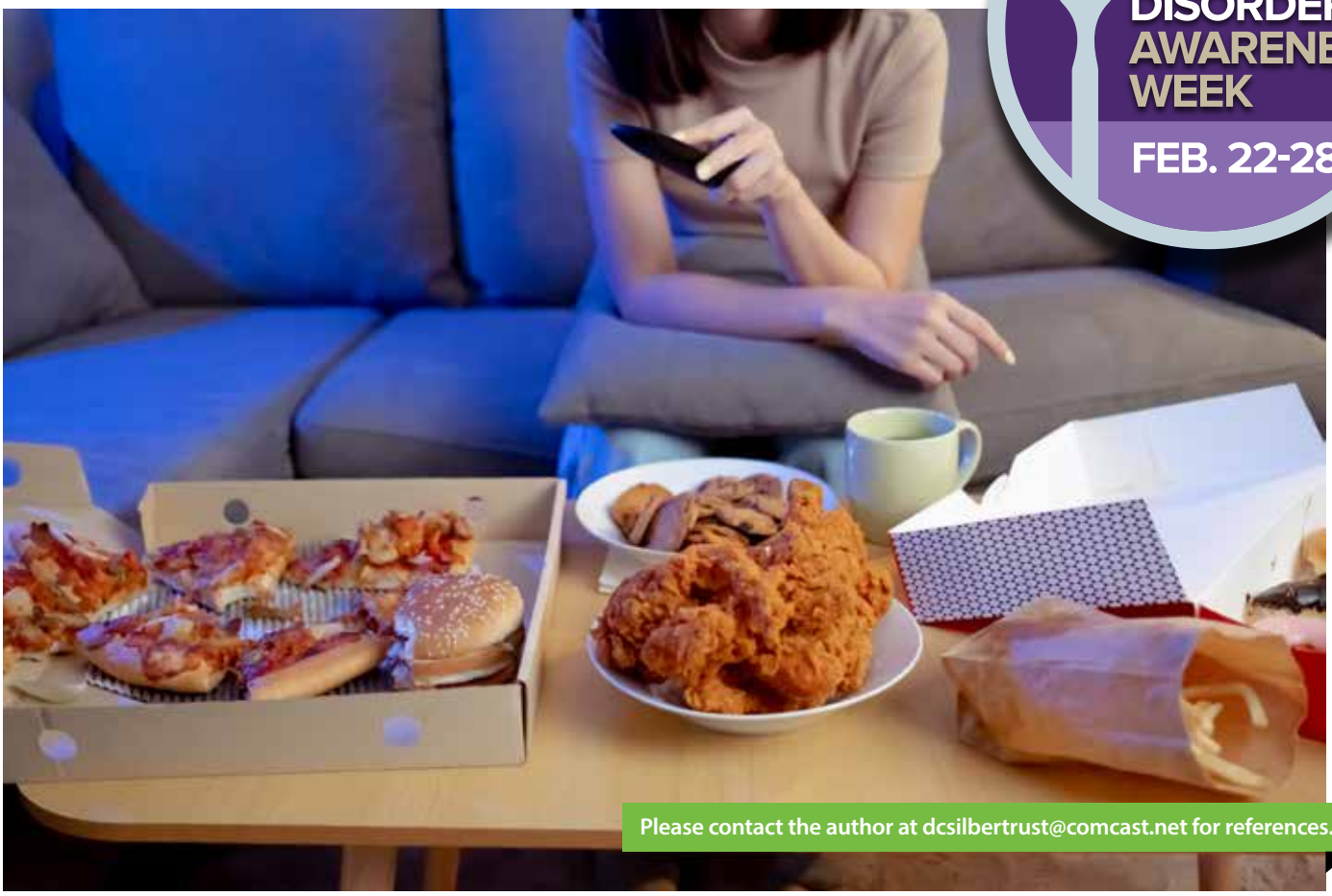
Occasionally using food as a source of comfort is common, and it is not surprising that this would increase during the multiple stresses wrought by the pandemic. However, when an individual's primary coping strategy involves eating, they develop maladaptive patterns that can become serious enough to warrant a diagnosis of an eating disorder. Approximately 9% of the U.S. population will meet the criteria for an eating disorder at some point during their life. The percentage is greatest for Binge Eating Disorder (BED), less for Bulimia Nervosa (BN), and even less for Anorexia Nervosa (AN), which has the highest mortality of any DSM-V mental disorder. A substantial group also fall into the diverse category called Other Specified Feeding or Eating Disorders (OSFED).

Occasionally using food as a source of comfort is common, and it is not surprising that this would increase during the multiple stresses wrought by the pandemic.

Studies from Australia, Europe and the U.S., show increased levels of binge eating and food restriction, especially among adolescents and young adults. This was true even among those with no history of eating disorder symptoms (Fladias et al., 2020; Phillipou et al., 2020). Those already diagnosed with eating disorders also show increases in purging and compensatory exercise (compared with the general population in which there is a decrease in exercise). Those with early trauma and/or an insecure attachment style are particularly vulnerable to a re-occurrence of or increase in symptoms (Castellini et al., 2020).

There are myriad paths for COVID-19 to affect those with eating disorders. In general, the impact can be seen in three ways: 1) increased risk; 2) decreased protective factors; and 3) barriers to treatment (Rodgers et al., 2020).

Here are just a few examples of ways in which recent changes brought by the pandemic can increase the risk of symptoms and decrease protective factors. Disruption of daily routines and increased social isolation may increase anxiety and loneliness, feelings that frequently underlie eating disorder behaviors. This also decreases the protection afforded by external structure and social interaction.



Please contact the author at dcsilbertrust@comcast.net for references.

Fears of contagion can increase both obsessive thinking and compulsive behaviors (OCD frequently co-occurs with eating disorders), including those related to obtaining food. Awareness that obesity increases risk of severe COVID-19 symptoms can increase weight and body preoccupation. This can have the paradoxical effect of making it more difficult to modify eating and exercise habits.

Furthermore, there are additional barriers to care, such as lack of reliable Wi-Fi or no privacy for virtual therapy. In addition, it is harder to monitor weight and easier to camouflage the body when seeing someone from the shoulders up. It is especially important that clients remain in contact with their PCPs and figure out ways to do weight checks if that is part of their treatment plan.

On the upside, the pandemic has forced therapists and treatment centers to find creative ways to use technology. This can include virtually accompanying clients to the grocery store, or talking a client through a meal (Huff, 2020). On-line groups have proliferated and can be an important part of recovery. Many eating disorder programs also provide virtual IOP and day programs.

> ***There are myriad paths for COVID-19 to affect those with eating disorders. In general, the impact can be seen in three ways: 1) increased risk; 2) decreased protective factors; 3) barriers to treatment***

Helping clients form better routines for meals and snacks is especially important during the pandemic, and some may also need help with food shopping and preparation. Sleep schedules and exercise habits impact food intake, so include them in your assessment and treatment plans.

One final point. BIPOC are less likely to be questioned about their eating habits, and to have problems minimized by health providers. Also, despite these being considered women's disorders, men make up about 25% of the those diagnosed with eating disorders. Include questions about exercise and eating during intakes of all new clients, not just those you suspect of having an eating disorder.

RESOURCES FOR PROFESSIONALS AND GENERAL PUBLIC:

1. www.nationaleatingdisorders.org – NEDA is the largest non-profit dedicated to eating disorders with lots of general information, referral help and a helpline.
2. www.feast-ed.org – F.E.A.S.T. is a family-oriented site with parent guides and forums, including information on the impact of COVID.
3. www.anad.org – ANAD is the oldest organization that provides advocacy and support for those struggling with eating disorders. Helpline available.

ETHICALLY CHALLENGING DILEMMAS: EATING DISORDERS and Treatment Options

MELINDA PARISI CUMMINGS, PhD, CEDS-S, *mcummings@holyfamily.edu*
AMANDA JERVIS, BA, *ajervis@holyfamily.edu*
MORGAN FISHER, MS, *morganfisher2000@holyfamily.edu*
TAYLOR KLIEBHAN, BA, *tkliebhan@holyfamily.edu*
JASMIN ROLLING, MHS, *jrolling@holyfamily.edu*
Graduate Counseling Psychology, Holy Family University

Eating disorders are among the deadliest of psychiatric disorders, with mortality due to both medical complications and suicide (Thornton et al., 2016; Zhao & Encinosa, 2011). At the same time, they are inherently treatment resistant illnesses, due in part to the intense distress patients experience when facing change (Abbate-Daga et al., 2013). Given this reality, including the very real possibility of death, clinicians who treat those with eating disorders frequently need to make ethically challenging decisions—choices that have serious implications for a patient's physical and mental health.

The right to enter treatment voluntarily (and, by extension, to refuse treatment) is protected in most jurisdictions and is central to the practice of informed consent in healthcare. At the same time, there is a clear duty to protect the welfare of vulnerable patients, especially when there is imminent risk of harm (Matusek & Wright, 2010). These concepts are reflected in the ethics codes of most mental health disciplines, such as principles A (Beneficence and Nonmaleficence) and E (Respect for People's Rights and Dignity) of the American Psychological Association's code of ethics (American Psychological Association, 2017). These principles often conflict in the treatment of eating disorders, as treatment interventions aimed at reducing the potential for harm (such as hospitalization, imposed weight gain, tube feedings, or monitoring of meals or bathroom visits) frequently conflict with patients' wishes and are experienced as coercive; enforcing them thus poses a threat to patients' autonomy (Long, 2014). Resolving this conflict poses a crucial but very difficult ethical challenge.

Literature dealing with the rejection of life-saving treatment, while spare, shares common themes centering on the concepts of capacity, competence, the role of family, suffering, burden, and benefit. When the individual is at risk for dying, the conflict between respecting autonomy or initiating treatment against the patient's will takes on additional complexity, and the stakes are high (MacDonald, 2002). While in some cases those with anorexia nervosa have been granted the right to refuse treatment and the right to die, with consensus from family members and ethics committees (Giordano, 2010; Tan & Hope, 2008; Tan et al., 2003; Goldner et al., 1997), overall, the literature supports implementing compulsory treatment when patients lack capacity to agree to treatment and when that treatment might be lifesaving (Westmoreland et al., 2017).

Enacting compulsory treatment is logistically difficult and is itself ethically challenging. To compel adults into treatment, they must be legally judged to be incompetent based, for example, on impaired cognitive ability or lack of insight regarding the severity of their illness (Bohon & McCurdy, 2014; Goldner et al., 1997; Griffiths & Russell, 1998); furthermore, legal procedures are jurisdiction specific. While the need to protect a patient from harm may override the patient's right to autonomy, a scenario that is not unique to the treatment of eating disorders, this is a potentially damaging choice that should not be made casually (Bohon & McCurdy, 2014; Westmoreland et al., 2017). Alternatives to compulsory treatment include collaborating with patients to reduce the need for involuntary treatment or utilizing a harm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reduction approach (Bohon & McCurdy, 2014; Russell et al., 2019).

Harm reduction (or harm minimization) approaches call for a paradigm shift within the field and place greater emphasis on improving overall quality of life than weight restoration and other symptom resolution (though not precluding further recovery; Russell et al., 2019). To reduce harm, treatment teams are advised to monitor and maintain various markers of medical stability, such as body temperature, hydration status, and electrolyte balance; address dental, bone, and reproductive health; and treat trauma and comorbid disorders while managing self-harm and suicidality (Russell et al., 2019). Russell et al. (2019) further urges clinicians to facilitate weight restoration to the extent possible but to also accept "with good grace and encouragement what can be achieved and what cannot," (p. 394) and attempt to maintain long-term engagement. Allowing more autonomy where possible can result in greater treatment compliance, suggesting that a harm reduction approach could be helpful in situations involving life-saving treatment rejection (Bohon & McCurdy, 2014).

Apart from discussions of life-saving treatment, there is a dearth of literature on dealing with more common treatment-rejection scenarios, such as a decompensating patient's unwillingness to enter a higher level of care or refusal of interventions aimed at treating the disorder or decreasing the risk of harm. While imminent risk of death may not be present (at least, not yet), treatment refusal may prolong the course of a physically and psychosocially devastating illness and may eventually result in life-threatening consequences. Clinicians are therefore frequently faced with dilemmas for which there is insufficient guidance in the literature and are forced to look to other sources of direction or grapple with these issues on their own.

In recognition of this need, we began an exploratory study to identify treatment refusal situations for which clinicians seek support, the issues they find especially difficult, and the factors they consider and processes they use when making decisions. As a first step, we conducted focus groups with treatment providers who have had substantial experience working with patients with eating disorders. Participants were licensed mental health or medical professionals or registered dieticians with at least one year of full-time experience working exclusively with patients who have eating disorders (or the equivalent), though in most cases they had considerably more experience. Focus group participants were asked to discuss areas of concern they may have when working with patients who have eating disorders. These dialogues highlighted several common themes for which little guidance is available. A major area of discussion involved questioning the steps that should be taken if a patient needs a higher level of care but refuses to do so, and whether it is

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THE ROLE OF PSYCHOLOGISTS in Juvenile Transfer Proceedings

MELISSA JOHN, MS, JD, *Carlow University*[1]

The United States Supreme Court has decided over the last several years that children who commit crimes must not be treated the same as adults who commit crimes. In *Roper v. Simmons* (2005), the Supreme Court ruled that death sentences for children were not constitutional, noting that children lack maturity, are particularly vulnerable to peer pressure, and exhibit personality traits that are of a "transitory" nature (*Roper v. Simmons,* 2005, p. 570). In 2010, the Supreme Court held life-without-parole (LWOP) sentences for children guilty of crimes other than homicide unconstitutional and referenced the "underdeveloped" nature of children's brains and character (*Graham v. Florida,* 2010; Juvenile Sentencing Project, n.d.). In 2012, the Court examined the constitutionality of mandatory LWOP sentences for children guilty of homicide (*Miller v. Alabama*, 2012). The Court ruled that LWOP sentences were no longer mandatory and that each case should be considered individually, noting the child's age as a factor, and recognizing the mitigating impact of youth (*Miller v. Alabama*, 2012). The Court revisited LWOP sentences for children in 2016, noting such a sentence should be preserved only for those children that "exhibit(s) such irretrievable depravity that rehabilitation is impossible" (Juvenile Sentencing Project, n.d.; *Montgomery v. Louisiana*, 2016).

In reaching these conclusions, the US Supreme Court relied on studies in psychology, sociology, and neuroscience. The American Psychological Association (APA) filed amicus briefs in the *Roper* (2005), *Graham* (2010) and *Miller* (2012) cases (Brief for the Petitioner, *Graham v. Florida*, 560 U.S. 48 [2010] [No. 08-7412, 08-7621]; Brief for Petitioner, *Miller v. Alabama*, 567 U.S. 460 [2012] [No. 10-9646, 10-9647]; Brief for Respondent, *Roper v. Simmons*, 125 S.Ct. 1183, 543 U.S. 551 [2005] [No. 03-633]). Justice Kennedy, writing for the court in *Graham v. Florida* (2010), cited to the APA amicus brief when stating "developments in psychology and brain science continue to show fundamental differences between juvenile and adult minds" (p. 67).

This US Supreme Court trend however has been limited mainly to the sentencing of juveniles already tried as adults. This raises the question: how do we decide that a juvenile should be tried and sentenced as an adult in the first place? Psychologists will play a role in guiding society and the courts toward fair treatment of children charged with criminal conduct and must be prepared to answer this question.

In Pennsylvania, children charged with specific crimes may be tried as adults in criminal court. In these statutorily defined instances, children are either automatically charged as adults or are first charged as juveniles and then transferred

1. Ms. John was the co-winner of the 2020 Patricia M. Bricklin Award for the best work product by a psychology student in Pennsylvania.

to adult criminal court. Both instances afford the opportunity for a transfer hearing – colloquially called "Act 33" hearings in Pennsylvania (Act of Nov. 17, 1995, Spec. Sess. 1, P.L. 1127, No. 33; Pennsylvania Juvenile Act, 2012).

In transfer proceedings, the court weighs certain factors enumerated by the legislature in reaching a decision. Licensed psychologists as expert witnesses guide the court in considering factors like mental capacity, maturity, amenability to treatment, and risk (Pennsylvania Juvenile Act, 2012). Jurisdictional procedures differ and competencies of legal professionals and courts vary, so some amount of inconsistency is expected in transfer proceedings (Kruh & Brodsky, 1997). Unfortunately, a significant amount of inconsistency may also arise due to the psychologist. As Justice Kennedy remarked in *Roper v. Simmons* (2005), "it is difficult even for expert psychologists to differentiate between the juvenile offender whose crime reflects unfortunate yet transient immaturity, and the rare juvenile offender whose crime reflects irreparable corruption" (p. 573). Exacerbating this challenge for psychologists, there is a dearth of research exploring these ethical and practical issues.

The APA Code of Conduct offers some guidance. Psychologists without foundations in child development, forensic assessment instruments, and the criminal justice system should properly consider the "boundaries of their competence" before accepting such a role (APA, 2017, General Principles). Psychologists should also be aware of how different life experiences may inform their practice. A disproportionate number of individuals charged with crimes are minorities and/or are economically disadvantaged, and in transfer proceedings, the clients are always children. The ethical principles of Justice and Respect also compel the psychologist to consider their role within the larger system (APA, 2017). For example, the likelihood of transfer to adult court is significantly greater for Black children as compared to White children and Black juvenile defendants are more likely to receive jail sentences than their White counterparts (Howell & Hutto, 2012).

Risk and amenability are often the most salient factors to the presiding court (Kruh and Brodsky, 1997). However, it is not practice to operationalize these ideas (risk, treatment, and amenability) within the profession. Between professions (law and psychology), the concepts likely diverge even further. There is no agreed upon way to properly assess risk and amenability (Kruh and Brodsky, 1997). Further, there is a lack of research on whether the tools used are properly normed and validated for this use. And psychologists must interpret assessment results aware that situational, personal, and cultural differences could impact the psychologist's judgment and "reduce the accuracy of their interpretations" (APA, 2017, Section 9.06; Specialty Guidelines for Forensic Psychology, 2011, Guideline 10.02).

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Risk, likely to be a factor of youth and positively impacted by normal development and maturational processes, is often linked to diagnosis. However, psychologists should consider if they are in the best position to diagnosis the child. Psychologists should be wary before using specific labels and terminology that may be misinterpreted by the court (Specialty Guidelines for Forensic Psychology, 2011, Guideline 10.01). For example, studies show that judges respond negatively to children described as psychopathic (Edens & Fernandez, 2003; Jones & Cauffman, 2008).

When it comes to amenability, Kruh and Brodsky (1997) warn that "(t)he blanket statement that juvenile treatment efforts are ineffective seems unwarranted" (p. 155). It is difficult, at best, to offer an opinion about the likelihood of an individual's future behaviors without a clear understanding of treatments available and the conditions under which those treatments may be implemented. Are psychologists to consider only the treatment resources available in the jurisdiction at issue? Only the services the child's family can afford?

Lastly, what is 'treatment' in this legal context? Is it traditional psychotherapeutic interventions only? Is the goal of treatment risk reduction or mental health symptom reduction, or is this the same thing (King, 2018)? Do we consider educational, vocational, and community/social service

interventions (King, 2018)? The ethical principles of Justice and Respect must guide the psychologist to think outside the confines of the criminal justice system and creatively explore any factor that may impact a child's future (APA, 2017).

Maybe 'the ethos of the court…reinforces a reliance on unstructured professional judgment" (Mulvey & Iselin, 2008). But, the ethos of our profession requires we adhere to our ethical principles, code of conduct, and scientific rigor (APA, 2017, Standard 2.04). If the profession has not even reached a consensus about what the constructs at issue mean, the term 'science' begins to fade. Combine that with a lack of valid and reliable assessment techniques, and a general absence of thorough evaluative procedures, and 'science' disappears.

The role of the psychologist in transfer proceedings is fraught with ethical considerations to explore and there is a paucity of guidance for some of the more nuanced issues. The APA's Ethical Principles of Psychologists and Code of Conduct (2017) and the Specialty Guidelines for Forensic Psychology (2011) offer a beginning. However, real development demands that psychologists work together, prepared to be critical of past practices in considering the underlying psychological constructs within the psycho-legal framework discussed. The Specialty Guidelines for Forensic Psychology (2011) are scheduled to expire on August 3, 2021. The best next step is a cadre of psychologists — from neuropsychology, child psychology, school/educational psychology, social psychology — collaborating during 2021 to share knowledge and ideas in support of a single goal: that juvenile justice professionals no longer make decisions about risk and amenability on intuition and make it the rule, rather than the exception, "to consider a consistent set of carefully assessed, empirically verified data" with cultural awareness (Mulvey & Iselin, 2008, p. 38). With this, psychology will demonstrate its' commitment to the community and prepare to assist courts making such life changing decisions more systematically, more consistently and, hopefully, more justly.

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Psychologist Involvement in NATIONAL SECURITY SETTINGS: PUBLIC and PSYCHOLOGIST OPINIONS

ALICE THORNEWILL, JD, PhD, *Drexel University*[1]

Psychologist involvement in matters of national security and interrogation practices garnered increased attention following the September 11th terrorist attacks. Due to concern regarding potentially problematic practices in this domain, the American Psychological Association (APA) commissioned an independent review to evaluate APA's potential involvement with "enhanced interrogation" procedures. "Enhanced interrogation" refers to the systematic interrogation practices sanctioned by the Bush Administration (Halpern, Halpern & Doherty, 2008) that included "hooding or blindfolding, exposure to loud music and temperature extremes, slapping, starvation, wall standing, and other stress positions and, in some cases, water boarding" (Gross, 2010, p. 128).

The results of the independent review concluded that APA officials worked with the Department of Defense (DoD) to maintain an ethics policy that was broad enough in scope to allow for psychologist involvement in enhanced interrogation practices (Hoffman et al., 2015). Moreover, the independent review concluded that APA's primary motive in doing so was "to align APA and curry favor with DOD" despite having "knowledge that there likely had been abusive interrogation techniques used and that there remained a substantial risk, that without strict constraints, such abusive interrogation techniques would continue" (Hoffman et al., 2015, p. 9). The release of the independent review led to substantial discussion within APA and the broader public regarding the appropriate roles of psychologists in national security settings, especially given the ethical concerns at issue (Thornewill, Heilbrun, & DeMatteo, 2019).

Several ethical dilemmas in this domain are worth considering. First, psychologists involved in national security interrogations may be expected to fill conflicting roles as safety officers and effectiveness consultants. In the role of a safety officer, a psychologist is present to ensure the safety of a detainee and prevent any "behavioral drift" on the part of the interrogator that could lead to inappropriate interrogation tactics (Hoffman et al., 2015, p. 293). A psychologist in the role of effectiveness consultant acts as the "partner of the interrogator in trying to engage in interrogation techniques that will be effective in getting the detainee to be cooperative and to tell the truth about what he knows" (Hoffman et al., 2015, p. 294). According to the independent review, this dual role is problematic and requires the psychologist to rely on subjective judgment in a situation where he or she may feel pressure to appease the interrogator (Hoffman et al., 2015).

Second, unlike detainees interrogated within the U.S., detainees involved in national security interrogations are not afforded basic legal protections, including the right to counsel, the right to a fair trial, and the right against self-incrimination (Olson, Soldz, & Davis, 2008).

Third, military psychologists often face ethical dilemmas when an "obligations to individual patients compete with obligations to the Department of Defense

1. Dr. Thornewill was the co-winner of the 2020 Bricklin Award for the best work product by a psychology graduate student in Pennsylvania.

or federal regulations" (Kennedy and Johnson, 2009, p. 22). The APA Ethics Code principle of Beneficence and Non-Maleficence encourages psychologists to strive to benefit those with whom they work and take care to do no harm (APA, 2010). Some suggest this "do no harm" principle is not sufficiently nuanced, given that some "psychologists employed by government agencies may feel compelled to limit the freedom or overlook the best interests of one person to promote or safeguard the best interests of a larger group, or even society at large" (Kennedy & Johnson, 2009, p. 27).

Study Aims

Thornewill et al. (2019) evaluated the opinions of psychologists and the public regarding psychologists' roles in national security interrogations following the release of the independent review. Given the profession's commitment to empirical evaluation, this study sheds light on the broader perceptions of the independent review's conclusions and provides helpful data in considering future directions for psychologists working in these settings.

A survey of psychologists (N = 1,146) and of the general public (N = 522) evaluated the perceptions of the general public and psychologists regarding (1) the appropriate role of psychologists in national security interrogations, (2) the appropriate role of psychologists in other non-treatment-focused settings, and (3) the extent to which psychologists should engage in professional activities that may cause harm to those involved (Thornewill et al., 2019).

Results

Regarding involvement in national security interrogations, both psychologists and the public somewhat approved of psychologists: providing consultation while not present, interrogating criminal and terrorist suspects within the U.S., using expertise to prevent behavioral drift, and using clinical judgment to elicit information. Both psychologists and the public expressed mixed feelings about psychologists using social science to make interrogations more effective, and both groups opposed psychologist

involvement in activities that could result in harm. Notably the public appeared more accepting than psychologists of psychologists' involvement in national security settings.

Regarding psychologist involvement in non-treatment-focused settings, both psychologists and the public expressed approval for psychologists' involvement in: teaching, consulting, conducting risk assessments, assisting with personnel selection, and assessing individuals who are involuntarily committed (with no significant differences between the groups) (Thornewill et al., 2019).

Finally, psychologists expressed strong opposition to psychologist involvement in national security related activities that may cause harm, while the general public expressed mixed opinions regarding psychologist involvement in such activities. For a full breakdown of study results, see Thornewill et al., 2019.

Discussion

This study revealed a disparity between psychologists' perspectives and the perspectives of the population served by the profession. Indeed, the general public appears to be more supportive of psychologists' involvement in national security settings, including involvement in the exact activities the independent review identified as problematic. The public's opinions could be related to views about national security generally, especially given the heightened emotions around such concerns. However, this discrepancy is worth exploring further. It appears that psychologists strongly support adherence to the "do no harm" principle, especially as it realtes to working in national security settings. Future research could examine the role of external circumstances (i.e., level of current terrorist threat) on opinions in this domain. Overall, the results from this study are worth considering as the profession moves forward with decision-making and policy development regarding the role of psychologists in national security settings.

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OUTCOMES WITH MEDICAL MARIJUANA on Mental Health Conditions

SAMUEL KNAPP, EdD, ABPP, *Director of Professional Affairs*[1]

Many patients are or will be using marijuana recreationally or self-medicating themselves for medical conditions. In addition, according to Pennsylvania's Act 16 of 2016 (Medical Marijuana Act) or as approved by the Medical Marijuana Advisory Board, approved physicians may prescribe medical marijuana for a variety of conditions including anxiety, autism, post-traumatic stress disorder, severe, chronic, or intractable pain of neuropathic origin, and Tourette's syndrome. In addition, it may be used for opioid use disorder if conventional therapeutic interventions are contraindicated, ineffective, or as an adjunctive therapy for primary therapeutic interventions (Pennsylvania Department of Health, 2020). Because many patients will be seeking medical marijuana for their problems, it is useful to know the outcome data with medical marijuana for conditions treated by psychologists.

Medical Uses of and Outcomes with Marijuana

The strength of the evidence on the effectiveness of marijuana-based treatments on the medical conditions listed in Pennsylvania's Medical Marijuana Act varies considerably. The FDA has approved THC-based medications for the treatment of nausea for patients undergoing chemotherapy for cancer, to simulate appetite in patients experiencing wasting syndrome secondary to AIDS, and to control some forms of epilepsy. Other applications for cannabis-based treatments have been approved in other countries or are currently undergoing clinical trials in the United States, even if the FDA has not yet approved them. However, the evidence for the effectiveness of marijuana with other conditions listed in Pennsylvania's Medical Marijuana Law is less robust.

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Outcome with Autism

Autism spectrum disorders can involve a wide range of behaviors including a lack of social responsiveness, repetitive behaviors, and sometimes agitation such as tantrums, violence, and self-injury, such as head banging. Behavioral interventions often, but not always, help children control their socially disruptive behaviors. Non-randomized studies found that cannabis treatment reduced behavioral disruptions in about 60% of children with autism, and side effects such as sleep disturbance or lack of appetite were rare (Aran et al., 2019; Duval, 2019; Mostafavi & Gaitanis, 2020; Schleider et al., 2019). However, these short-term studies cannot assess for the long-term impact of cannabis use on children, which is a special concern because previous studies have found that regular use of cannabis by adolescents may alter their brain development and put them at risk for a psychotic episode. According to the policy statement of the American Academy of Pediatrics, physicians should not prescribe medical marijuana for children except "for children with life limiting or severely debilitating conditions and for whom current therapies are inadequate" (Ammerman et al., 2015, p. 586). Even then, physicians should monitor the treatment and discourage parents from using "home remedies" of cannabis that may contain impurities with unwanted side effects.

Outcome with PTSD

In addition to anecdotal reports, several studies suggest that marijuana can reduce many of the symptoms associated with PTSD, although these studies had many methodological shortcomings such as uncontrolled designs, non-representative samples, or small sample sizes. But the evidence is not altogether favorable. Veterans with PTSD who have a history of heavy marijuana use tend to have

1. This is an excerpt from a longer home study on medical marijuana available from PPA.

poorer outcomes when given traditional treatments for PTSD. Experts remain divided on whether to recommend cannabis for PTSD (Cannabis, 2016), although all recognize that any treatment does run the risk of some negative consequences and that more research is needed (Steenkamp et al., 2015; Walsh et al., 2017).

At this point, evidence suggests that: (1) some patients with PTSD may find meaningful symptom reduction from using marijuana; (2) some patients with PTSD could reduce symptoms much better if they took traditional medications with a proven track record for reducing symptoms; (3) marijuana use can harm some patients, especially those who have a history of substance abuse; and (4) marijuana may be indicated for the treatment of PTSD if traditional treatments have failed to provide sufficient symptom relief, and the patient has no history of substance abuse.

Outcome with Anxiety

Anxiety disorders are widely prevalent in the United States, approved treatments are not always effective, and anxiety disorders are one of the most common medical reasons that people use marijuana or its extracts (Kosiba et al., 2019). Although many studies have been conducted on the use of cannabis for anxiety, the data is not sufficiently strong or compelling to recommend cannabis as a front-line treatment for anxiety.

Most cannabis users report that marijuana reduces their anxiety (Kosiba et al., 2019; Turna et al., 2019), but some of these studies were retrospective self-reports of users on surveys, and many respondents might not have had an anxiety disorder. Nonetheless, some studies with patients with anxiety disorders have found positive benefits. For example, two studies found that CBD reduced social anxiety (Calapai, 2019) and reviews by Skelley et al. (2020) and van Amerigen et al. (2019) reported benefits for many persons with anxiety disorders who took cannabis as part of their treatment. However, sample sizes were small, often the studies lacked control groups, the outcome measures and doses administered were not standardized, the

mode of the administration of the drug varied, and the length of treatment varied. Although the reported negative effects from these studies was rare (Bahji et al., 2020), researchers have raised concerned in that cannabis use disorder (CUD) is associated with high anxiety and the treatment may inadvertently lead some patients to develop a CUD. Furthermore, some evidence suggests that cannabis can induce panic disorders in some patients (van Amerigen et al., 2019). Cannabis extracts have a promise to be effective for the treatment of anxiety, but the data is not sufficient to recommend them as a front-line intervention.

The data on the effectiveness of marijuana on chronic pain is mixed. Studies with neuropathic pain (from disorders of the peripheral or central nervous system) have found conflicting results.

Outcome with Chronic Pain Management

Chronic pain is the most common reason that patients take marijuana or its extracts for medical purposes (Kosiba et al., 2019; Lankenau et al., 2018). Chronic pain is difficult to treat and often patients suffer for long periods of time and have limitations on their activities of daily living.

The data on the effectiveness of marijuana on chronic pain is mixed. Studies with neuropathic pain (from disorders of the peripheral or central nervous system) have found conflicting results with Maharajan et al. (2020) concluding that it was effective whereas Sharon and Brill (2019) reported that the benefits were small or nonexistent. Studies have not found benefit for cancer related pain (Boland et al., 2020), although some oncologists report individual cases of effectiveness of marijuana for cancer-related pain (Sharon & Brill, 2019). The outcome studies with pain associated with multiple sclerosis-related pain and visceral pain have too many methodological problems to conclude that they would benefit for patients with those conditions (Campbell et al., 2019). The claim is sometimes made that those who use marijuana for pain management will substitute marijuana for opioids, benzodiazepines, or other medications (Boehnke et al., 2019). However, these studies suffered from methodological limitations (Le Foll, 2020).

Outcome with Tourette's Syndrome

Anecdotal reports of the effectiveness of marijuana for Tourette syndrome have been around for more than 20 years. Retrospective self-reports of marijuana users with Tourette's syndrome have reported benefits including a reduction in the severity of tics, improved mood, and better sleep (Abi-Jaoude et all, 2017; Thaler et al., 2019). The sample sizes were small, and all datum were retrospective and based on self-report.

Summary

The evidence supporting medical marijuana has not kept pace with the popular enthusiasm for it. Unfortunately, the internet is replete with false or misleading information that exaggerates the effectiveness of marijuana in treating health conditions. One review found that only 10% of websites contained accurate information on the medical benefits of marijuana (Boatwright & Sperry, 2020). When approached by patients concerning the option of using medical marijuana, psychologists must consider many clinical and contextual factors, including the outcome data reviewed in this article.

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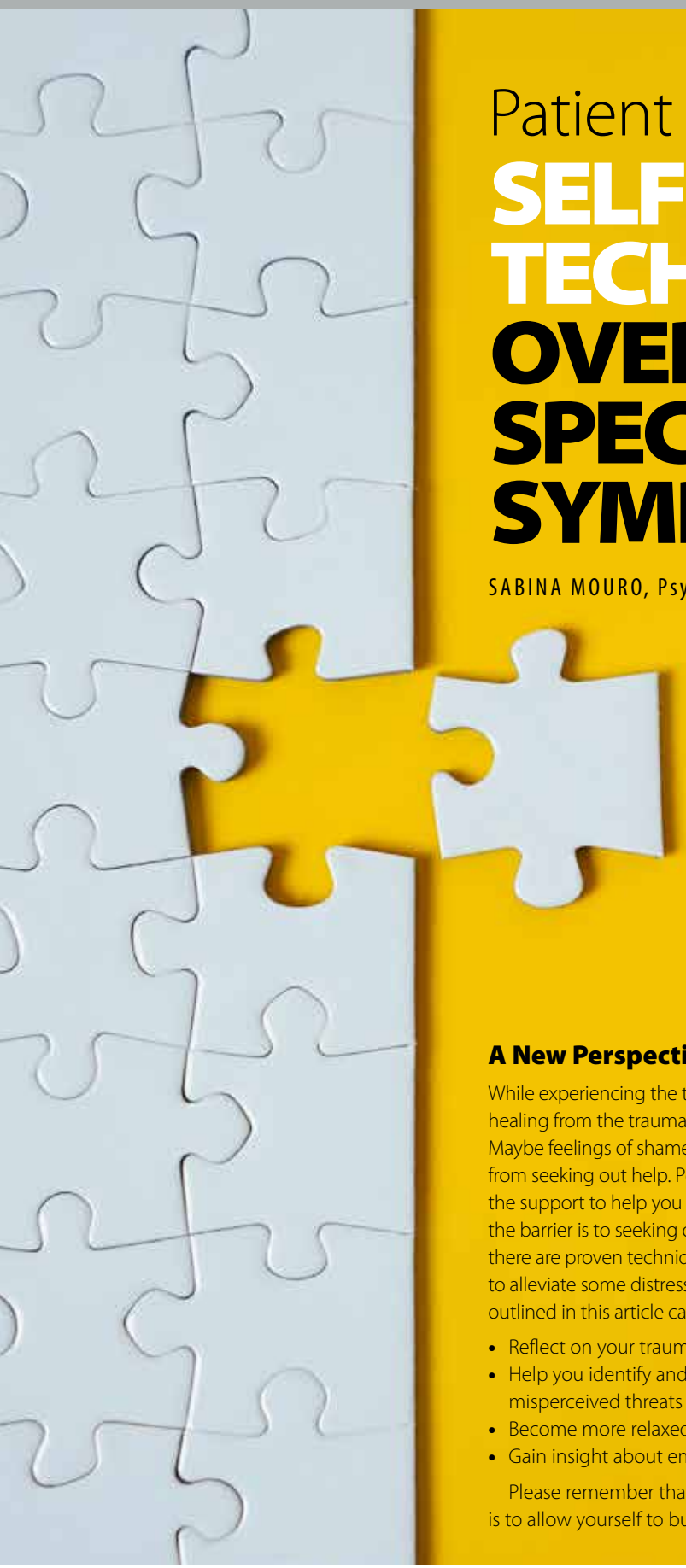

Patient Handout

SELF-HELP TECHNIQUES: OVERCOMING SPECIFIC PTSD SYMPTOMS

SABINA MOURO, PsyD

Editors' Note: Readers may use this article as a patient handout or modify it according to their preferences.

Disclaimer: Although many people will experience a traumatic event in their lifetime, a small portion of individuals develop PTSD due to certain factors prior to the trauma, during the trauma, and after the trauma. The type of treatment for PTSD varies for each individual. Everyone's experience after a traumatic event is different and these self-help techniques may not be helpful to all. Please chose and discuss these techniques with your psychologist. Additional tools, techniques, and education about trauma and PTSD can be found in *Healing PTSD: A CBT Workbook for Taking Back Your Life (Mauro, 2020).*

A New Perspective

While experiencing the trauma was painful, healing from the trauma can seem far away. Maybe feelings of shame have prevented you from seeking out help. Perhaps you do not have the support to help you get through. Whatever the barrier is to seeking out professional help, there are proven techniques that you can use to alleviate some distress. The four techniques outlined in this article can be used to:

- Reflect on your trauma
- Help you identify and recognize misperceived threats
- Become more relaxed in your environment
- Gain insight about emotional awareness

Please remember that the goal of this article is to allow yourself to build a new, clearer, and healthier perspective on events that cannot be changed not to "cure" you from PTSD. This article will require you to do some self-reflection and self-awareness.

Start off self-reflection and awareness by taking a second to recognize that you have survived a tragedy, a horrific event, a life-changing experience. Although the worst is over and is a fact from your past, the lingering negative effects of the trauma have you feeling like you are "stuck," "trapped," or continuously being reminded of what happened to you. This feeling is one of the common reactions after a traumatic event.

The psychological and emotional effects of trauma typically present itself in the form of Posttraumatic Stress Disorder (PTSD), a diagnosis that is given to a survivor that has

difficulty adapting and moving forward after the traumatic event. PTSD consists of specific clusters of symptoms that can be summarized in the following ways:

- Intrusive thoughts/memories: involuntary thoughts about the trauma, "re-living" the trauma, nightmares
- Avoidance: avoiding anything that is a reminder of the traumatic event
- Trauma related mood and thoughts: this primarily includes a distorted perception of yourself, others and the world as a result of your trauma; emotional numbness, distrust, etc.
- Change in arousal activity: body is more alert and on guard; person may engage in self-destructive behavior

*Exposure is also a cluster of symptoms in which the individual has experienced trauma directly (e.g., experienced it) or indirectly (e.g. witnessed it).

The four techniques noted below target a specific cluster of symptoms. This does not mean that these are the only techniques available. Some techniques may work well for certain symptoms while other techniques may not alleviate symptoms. This is not to discourage you but to encourage you to recognize that it may take more than one technique and more than one try to become in control of your PTSD.

Targeting Intrusive Symptoms:

Intrusive thoughts and memories and nightmares are involuntary and unwanted. They contain the most intimate details of the trauma often feeling "so real" as if it is currently happening. When these intrusive thoughts and memories occur, they become too painful to process because you feel defeated.

Technique:

Although you cannot change what happened, you have the power and control to change the meaning of these intrusive reminders. Here is one strategy to try:

- Change the details of your traumatic event to "I survived"
    - o How does this change the meaning of the memory?
    - o How does this change the meaning of what happened?

The goal of this self-help technique is to help you recognize that the meaning you give to your thoughts and memories can be very powerful. By giving a new perspective to the meaning of your unwanted thoughts and unpleasant memories, you start to regain control of yourself.

Targeting Avoidance Symptoms

Avoidance is actually a powerful weapon that trauma survivors have learned to use to prevent getting further hurt. Avoidance may serve its purpose temporarily but there are more powerful tools that can help you in the long-term.

Because PTSD is a fear based diagnosis, trauma survivors develop distorted perception of the world. They start to view people, places, and/or objects that are reminders of the trauma as dangerous, harmful, unsafe, and even life threatening. As such, avoidance becomes a way to protect themselves from anything that can put them in danger. It is exhausting for the trauma survivor to view the world as a misperceived threat. So how can trauma survivors learn not to avoid? Here is one strategy that you can try yourself:

Technique:

- Start to recognize and differentiate an actual threat (e.g. hurricane, lack of oxygen, venomous snake) from a misperceived threat (e.g. anything that is associated with your trauma such as smells, locations, certain people)
    - o Identify and label your trauma triggers as "misperceived threats" (e.g. "my trauma trigger is a misperceived threat") in order to help the body and brain recognize that you do not need to react with survival instincts and that the body can remain calm

The goal of this self-help technique is to help you understand that trauma survivors continuously scan their environment for any signs of danger in order to avoid being hurt again. The world right now may feel very dangerous for a trauma survivor because of their misperceived threats. Once you start to identify and label trauma triggers as that, your brain starts to rewire differently, often learning that your life is not constantly in danger.

Targeting Trauma Related Mood and Thoughts

Most likely trauma survivors have developed maladaptive thoughts and beliefs about themselves, the world, what happened to them, and how they dealt with the trauma. That is because trauma survivors tend to believe bad things about themselves and the world after bad things happen. Common changes in thought include phrases such as "It's my fault," "no one can be trusted," "everywhere I go is unsafe."

Trauma survivors learn to suppress all their emotions in order to protect themselves from more harm. Common phrases to explain their suppressed emotions include "I'm fine" "I've moved on," and "I don't need to talk about my trauma." Emotions are in fact part of survival as emotions serve as a cue for the body to respond in a given situation. If the individual is not experiencing effective emotions, information in the environment is misinterpreted often leading to inappropriate responses to the situation.

Technique:

- Write down trauma-related emotional responses (e.g., "I don't want to talk about my trauma")
- Next to these responses right down the emotion you are suppressing (e.g., Fear: "I feel nervous because I don't want to talk about my trauma; Sadness: "I feel sad because talking about my trauma is a reminder of what happened to me.")

The goal of this exercise is to help you recognize that when you bring emotions into your awareness, you are more cognizant of the emotion, you do not have to fear the emotion, and you are capable of self-regulating your emotions (e.g., appropriate response to the situation).

Targeting Arousal Activity

Although the trauma is not happening, the body may continue to experience chronic stress. Because untreated PTSD leaves the body in constant stress mode, the body is unable to recognize that the actual threat (in this case the trauma) is no longer present, hence making the trauma survivor feel frequently alert and on guard.

Technique

When you find yourself feeling more alert or on guard, try the following:

- Scan your environment for positive cues to help you assess that you are safe and okay. For example:
  - What are the facial reactions of people around you? Laughing? Screaming? Crying? Smiling?
  - What is the body language of others around you? Sitting down? Running? Hiding?
  - Are there any specific signals indicating danger? Do you hear sirens? Are smoke detectors going off?

The goal of this technique is to help you recognize that your hyperarousal is a result of the chronic stress. When your body is in hyperarousal state it becomes difficult for a trauma survivor to recognize that they are safe. By looking for positive cues in your environment, you can better assess and help the body calm down.

Empowerment: Ready for Change

If any of these approaches help or even seem to help, you may benefit from a specific treatment approach referred to as cognitive behavioral therapy, a type of treatment process that has proven to alleviate PTSD symptoms. If you did not like any of these strategies, that is okay too, because everyone heals differently. Take control of the present moment.

You have to remember that when it comes to overcoming these symptoms you have to be kind to yourself. It takes more than one try to be successful. It takes more than one specific technique to heal. It takes more than one day to recover. You also have to remember that just because one specific technique was not powerful enough to conquer a symptom does not mean that a different technique will not help you overcome these battles. The trauma happened in the past and in the present you take control.

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LARRY V. PACOE, PhD

(APRIL 24, 1938 – FEBRUARY 2, 2021)

Larry Pacoe, age 82, of the Squirrel Hill section of Pittsburgh, formerly of Forest Hills Borough, on Tuesday, February 2, 2021. Cherished husband of 60 years to Mary (Stern) Pacoe; proud father of Gregory and Beth Pacoe (Fred Rapone); beloved Pop-Pop of Domenick, Maxwell, and Preston; and brother of the late Howard V. "Bud" Pacoe, Jr. Larry also is survived by many nieces and nephews, cousins, friends, colleagues, students, proteges, and, of course, his grand-puppies Brody, Coco, Bear, and Tank, who will all miss the "weak link" at the dinner table. Born April 24, 1938 in Butler, Pennsylvania, he was the son of the late Howard V. and Jean (Dumbaugh) Pacoe. While a senior at Butler High School, Larry happened to be in the audience for its 1955 spelling bee. One wonders what words and in what voice contestant Mary Stern spelled them, but Larry was L-O-V-E-S-T-R-U-C-K with her and soon thereafter the two (BHS Class of '56) would be forever and hopelessly in love with one another. Larry graduated from the University of Pittsburgh in 1960; he and Mary were wed a week later; and the couple honeymooned in Forbes Field, cheering on the Pirates during that championship season. Larry continued his studies, obtaining his master's and doctoral degrees in psychology from Duquesne University. For the next six decades, he dedicated himself to the cause of mental health, whether in private practice, scholarship, or teaching. Larry trained and mentored countless students and residents as a faculty member at the University of Pittsburgh, its School of Medicine, and the Western Psychiatric Institute and Clinic. Among his many professional achievements, Larry was particularly proud of his skill as a Cognitive Behavioral Therapist, spending 40 years of his career learning, implementing, and teaching this mode of therapy. All was not work, however. He and Mary shared a love of traveling and the arts. He appreciated a well-prepared meal, the works of Sophia Loren, the Pittsburgh landscapes of Robert Schmalzried, and fine scotch (which he always shared). And, while a steady Pirates, Steelers, and Penguins fan, he reserved his deepest sports passions for his beloved Pitt Panthers. Larry and Mary relished the time spent with their circle of dear friends and he was a wonderful and engaging conversationalist. Most of all, Larry treasured being with his family. At home, poolside, aboard his boat, around the fireplace of the Hidden Valley house, or at his grandsons' ballgames. These were the best times. Memories yet remain to be created, but Larry's absence from these moments will not go unnoticed. American humorist and Yiddish lexicographer Leo Rosten defined the term "mensch" as follows: "someone to admire and emulate, someone of noble character. The key to being 'a real mensch' is nothing less than character, rectitude, dignity, a sense of what is right, responsible, decorous." Larry was such a person; "a real mensch". According to his wishes, he will be cremated, without visitation or religious ceremony.

LOUIS D. POLONI, PhD

(FEBRUARY 18, 1956 – JANUARY 28, 2021)

Louis D. Poloni, Ph.D. of Fairview township, passed away on January 28th at the age of 64.

He was preceded in death by his wife, Christine Murphey Poloni. He is survived by his son, Nathan Poloni of Snohomish, WA and his son's partner, Alexis Morales. He also leaves behind his partner, Kathy Luft of Mechanicsburg, PA. He is survived by three sisters, Aloma Schlegel and Louise Falcinelli, both of Pen Argyl, PA and Lori Sheetz of Naples, FL.

He was a graduate of the former Pius X High School in Roseto, Penn State University, Roosevelt University, and he received his doctorate in clinical health psychology from the University of Health Sciences at Chicago Medical School.

For 33 years he owned and operated Poloni and Associates, a counseling practice in York.

He enjoyed spending time at his beach house and mentoring undergraduate psychology students for Penn State's College of Liberal Arts Student-Mentor Program. He had a passion for antique glass, and for making his beloved peanut brittle and limoncello, although not necessarily in that order..

PRACTICE TIP 5:
Address Payment Issues Clearly in Your Informed Consent Agreement

Consider this situation,

A psychologist received a subpoena to testify on behalf of a patient who had also signed a release permitting the psychologist to testify. When asked if she could be compensated for her time, the patient's attorney insisted that she would be compensated. Later that week she received a check for $15 to cover witness fees.

When she approached her patient about the paltry compensation, the patient was indignant, "How can I pay you anything?" he shouted. "I just had to pay my attorney $10,000!"

So, it looks like this psychologist will be spending time in court, possibly losing hundreds of dollars of income, in exchange for $15. Was there any option that the psychologists could have taken to avoid such a problem?

The way to avoid this problem would have been for the psychologist to include a statement in her informed consent agreement that she may charge their patients for uncompensated time including but not limited to writing reports, attending meetings, appearing in court, and travel time at the request of the patient. Services will be billed at the rate of $XX per quarter hour increment or any fraction thereof. This broad wording covers more than court appearances.

> ***"Don't overly pursue things like cancelled fees, charges for phone calls, and incidental paperwork."***

Of course, psychologists can always waive charges if they so choose and most psychologists would not nickel and dime patients for very brief non-covered services. One experienced psychologist wrote, "Don't overly pursue things like cancelled fees, charges for phone calls, and incidental paperwork. It doesn't endear you to your patients and it really isn't worth it in terms of effort or finances." Nonetheless, this language protects psychologists in case a patient makes an extraordinary demand on their time and allows the psychologists to charge the patient for the non-covered services delivered. It also keeps some patients from making clinically questionable demands on their time.

The informed consent document should also include information about missed or canceled sessions, the importance of paying on time, that the psychologist has the option of going to small claims court to pursue unpaid debts, and other office policies regarding payment.

Much discomfort can be avoided by refusing to allow patients to hold a large balance. For patients who are requesting a service that requires much time (such as a comprehensive assessment), psychologists can require payment up front.

PRACTICE TIP 6:
Be Prepared for Difficult Situations

Most days of a psychologist are routine. In the average day 5 or 6 patients may come in for psychotherapy, stay for 45 to 60 minutes, say thank you, pay their bills, and leave. But unexpected and difficult situations can come up quickly.

- Patients may report serious and persistent suicidal thoughts.
- Patients may become disruptive or threatening.
- The patient who seemed only quirky at first now appears to have a major personality disorder comorbid with other disorders.
- The child-rearing incident that the father reported appears so severe that you must consider a report of suspected child abuse.

Assaults on outpatient psychologists are very rare, but it is prudent to be prepared for that eventuality.

It pays to be prepared and to have a protocol ready when difficult situations arise. For example, one psychotherapist has a suicide folder in her desk. It contains, among other things, a brief suicide risk inventory and a checklist when evaluating suicidal patients. Several years ago, she had a suicidal patient and, although the intervention went well, she reflected on what she could have done to have been better prepared for future suicidal patients. Thus, she created her suicidal folder.

The types of difficult events will vary according to the nature of one's practice. A psychologist working with children can expect a different set of disruptive events than one who works primarily with older adults. Of course, no one can predict all the unusual events that one may experience as a psychologist. Nonetheless, as much as possible, anticipate disruptive events and have an immediate response prepared.

Assaults on outpatient psychologists are very rare, but it is prudent to be prepared for that eventuality. Many psychologists position their desks close to the door if it is necessary to exit immediately. Most female psychologists I know who are in independent practice will not have a first session with a male patient in any otherwise empty office suite in case that patient becomes aggressive or disruptive.

PRACTICE TIP 7:
Develop and Maintain Professional Connections

Psychologists tend to do better work when they are involved with a community of other professionals. This could take many forms such as participating in a consultation group, attending in-person CE programs where participants interact with each other, working in a group practice, belonging in PPA or another professional association (and perhaps serving on a committee), or sharing an office suite with other health care professionals. Also, professional contacts are sometimes made through collaboration on a case.

These contacts help keep us up-to-date on developments in the field, allow an opportunity to talk about difficult cases, and provide others who can monitor our well-being and allow us to recover from the emotional wounds that are an inevitable part of the work that we do. The benefits of seemingly small conversations add up tremendously over time. Colleagues share reactions to workshops that they have attended, podcasts that they have listened to, or books that they have read.

In addition, friends watch out for each. Good friends feel empowered to tell you when you are ready to step on a cow pie.[1] The problem is that when one is under emotional stress and one's competence is beginning to degrade, then one's personal "competence monitor" may become degraded as well.

When confronted with a particularly difficult case, psychologists can reach out to specialists. PPA staff is available to discuss legal or ethical problems that may arise. Some professional liability carriers, such as the Trust, offer consultative services as well. Dr. Eric Harris, a longtime consultant with the Trust, noted that isolated psychologists were the ones most likely to get into legal difficulty. "Outliers make outlaws," he said.

One of the benefits of nurturing professional contacts is that we can give to others as well. By being of assistance to other health care professionals we can further our goals of improving public health. They can consult with us on their difficult cases and we can keep an eye out for their emotional well-being.

Being in an independent practice does not necessarily mean that one is in an isolated practice.

1. One reviewer suggested replaced the phrase "cow pie" with a phrase that it less "earthy." But it accurately reflected the sentiment that I wished to convey and pays homage to my rural heritage, so I decided to keep it.

PRACTICE TIP 8:
Pay Attention to Details

Make your workspace as friendly as possible. Have comfortable furniture for you and your patients. Some psychologists have small refrigerators in their offices or microwaves.

You will be spending a lot of time in your office and having comfortable furniture for patients conveys that you care about them. Having a nice-looking office conveys a sense of organization and professionalism that helps install faith in the patient, even before you have started to speak together. Disheveled waiting rooms or dirty bathrooms can turn patients off.

Try to make your office decor congruent with your goals of psychotherapy. One psychologist who works largely with veterans, has a small American flag on her desk. Another psychologist who works with adolescents has pictures of his two dogs on his desk. He reported that even the most resistant adolescent will ask about the dogs and share their own dog-related stories.

Ethically Challenging Dilemmas: Eating Disorders and Treatment Options *continued from page 7*

appropriate to continue seeing the patient should this occur. A second important theme was that treatment rejection may not solely result from patients' ambivalence or resistance but often reflects practical or systemic barriers they have experienced, adding another layer of complexity to decision-making. To better understand how providers manage treatment rejection and learn how to better support them in these situations, we are presently interviewing clinicians individually (remotely). Criteria for interview participation echo those for the initial focus groups. Based on insights gained from focus groups, we have developed an interview protocol that examines in depth clinicians' experiences treating patients who have eating disorders and who refused treatment. They are asked about the difficulty they have experienced as the provider, the course of action they took and why, resources or guidance they considered or would have liked to have, and anything they might have done differently, upon reflection.

If you work with eating disorders, meet eligibility criteria, and are interested in participating, please contact us – we would very much like to talk to you about your experiences. It is our hope that the results of this study will help us to identify initial clinical guidance and recommendations as well as suggestions for further research. For more information, please contact Melinda Parisi Cummings at mcummings@holyfamily.edu.

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The Pennsylvania
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Home Study CE Courses

Act 74 CE programs

Essential Competencies when Working with Suicidal Patients—1 CE
Four Ways to Enhance Your Suicide Assessments (Webinar)—1 CE
Talking about Suicide: The Patient's Experience and the Therapist's Experience (Webinar)—1 CE
The Assessment, Management, and Treatment of Suicidal Patients: 2020—3 CE
The Essentials of Managing Suicidal Patients: 2020—1 CE
The Essentials of Screening and Assessing for Suicide among Adolescents—1 CE
The Essentials of Screening and Assessing for Suicide among Adults—1 CE
The Essentials of Screening and Assessing for Suicide among Older Adults—1 CE
The Essentials of Treating Suicidal Patients—1 CE

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version
Pennsylvania Child Abuse Recognition and Reporting—3 CE Version
Pennsylvania Child Abuse Recognition and Reporting (Webinar)—2 CE

General

Ethical Issues with COVID-19 (Webinar)—1 CE*
Ethical Responses when Dealing with Prejudiced Patients (Webinar)—1 CE*
Ethics and Self-Reflection—3 CE*
Foundations of Ethical Practice: Update 2019—3 CE*
Integrating Diversity in Training, Supervision, and Practice (Podcast)—1 CE
Interdisciplinary Collaboration in Assessing Capacity in the Elderly (Webinar)—1 CE
Introduction to Working with Chronic Health Conditions—3 CE
Legal and Ethical Issues with High Conflict Families—3 CE*
Mental Health Access in Pennsylvania: Examining Capacity (Webinar)—1 CE
Record Keeping for Psychologists in Pennsylvania—3 CE*
Telepsychology Q&A (Webinar)—1 CE
Why the World is on Fire: Historical and Ongoing Oppression of Black African American People in the United States (Webinar)—1.5 CE

This program qualifies for contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.

Act 74 CE Programs qualify for the suicide requirement mandated by the Pennsylvania State Board of Psychology.

Act 31 CE Programs have been approved by the Department of Public Welfare and the Pennsylvania Department of State to meet the Act 31 requirements.

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Calendar

SAVE THE DATES

JUNE 17 – 19, 2021
PPA2021
Virtual Convention

SEPTEMBER 23 – 25, 2021
PPA Fall Conference MAX
Lancaster Marriott at Penn Square
Lancaster, PA
Hybrid Event (In-Person and Virtual)

FRIDAY, OCTOBER 8, 2021
PPA Fall Conference MINI
Normandy Farm
Blue Bell, PA
Hybrid Event (In-Person and Virtual)

During this renewal period only, the limit on the number of home study and distance learning continuing education hours has been lifted. For this renewal period, psychologists can receive all of the continuing education through home studies or distant learning programs. If you have more than 30 continuing education credits for this renewal period, you may carry over up to 10 credits of continuing education into the next renewal period.