Guidelines on Key Considerations for Working With Adults With PTSD and Traumatic Stress Disorders

WORKING GROUP PTSD/TRAUMA GUIDELINES

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Introduction

Overview

According to the U.S. Department of Health and Human Services (HHS), trauma results from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Exposure to trauma increases the risk and severity of substance use problems, mental health conditions (e.g., depression; anxiety; posttraumatic stress disorder (PTSD); dissociative, eating and sleeping problems; psychosomatic disorders; and disruptive behavior disorders), other risky behaviors (e.g., self-injury, suicidality, risky sexual encounters), and physical health problems (e.g., cardiovascular, gastrointestinal, metabolic, and immune disorders). Childhood trauma and trauma involving intentional infliction of harm are most likely to cause behavioral and chronic physical sequelae (Karatzias et al., 2022).

At the same time, since current definitions of trauma may not sufficiently account for culture, they may lack cultural relevance (Bryant-Davis, 2019; Bryant-Davis & Ocampo, 2006; Hinton & Good, 2015; Hinton & Lewis-Fernandez, 2012). This in itself is problematic as individuals from marginalized groups may be more vulnerable to certain types of trauma. In addition, individuals may experience trauma differently as identity may intersect with and be impacted by sociocultural context. New research suggests that many people experience historical or intergenerational trauma, often compounding the impact of recent trauma experiences (Kirmayer et al., 2014).

As a result, determining the impact of exposure to trauma on an individual or family involves assessment and evaluation of a complex set of issues. These professional practice guidelines aim to inform psychologists working with adults with traumatic stress disorders, including PTSD and other trauma-related symptoms. They also describe when psychologists may seek supervision and consultation, and/or make referrals to those with specialized training in specific issues or areas. These guidelines offer relevant guidance and highlight the knowledge base and scientific support informing professional practice in this critical area.

Purpose and Scope

The purpose of these guidelines is to provide psychologists with a scientifically supported framework for working with adults with trauma-related disorders. These guidelines consider how trauma, and its aftereffects, are compounded by other stressful factors and life events, including inequities related to race, ethnicity, sectarianism, gender, age, socioeconomic status, sexual identity, immigration, and disability. Consideration of such cultural and intersectional factors may add to treatment complexity (Bryant-Davis, 2019). As such, these guidelines address considerations and approaches that may include, but extend beyond, symptoms/diagnosis to understand and enhance adaptive biopsychosocial functioning, resilience, and quality of life.

While these guidelines were created to inform psychologists without specialized education and training in trauma, they also may be of interest to those with specialized training. They address both forensic and clinical practice, including assessment of traumatic stress disorders and interventions. The guidelines also inform psychologists of the knowledge base and scientific support for trauma practice, as well as relevant professional education and training in this area. In addition, the guidelines discuss population health issues that may either exacerbate trauma (e.g., racial disparities, immigration and refugee status, gender inequality, poverty) or mitigate the psychological impact of trauma where protective environmental factors exist (e.g., social support). The last section of the guidelines highlights the importance of attaining and maintaining competence in factors relevant to equity, diversity, inclusion, and trauma.

Documentation of Need

Although children and adults who experience psychological trauma may recover without experiencing chronic behavioral or physical health problems, at least 15% (and as many as 50%–75% who experience traumatic violence, abuse, or exploitation) develop PTSD or other trauma symptoms, and many (33+%) develop or have a significant increase in the severity of other behavioral or physical health disorders (Alisic et al., 2014; Atwoli et al., 2015; Bryant, 2019; McElroy et al., 2016; Pietrzak et al., 2011a, b, c; Santiago et al., 2013; Smith et al., 2019). Given the significant numbers of patients who have experienced trauma (Benjet et al., 2016; Kessler et al., 2017; McLaughlin et al., 2013), these professional practice guidelines seek to offer important insights and guidance in this area of professional practice.

These guidelines aim to expand on guidance provided in the APA's (2017b) Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults (under revision). This includes assessment and clinical decision-making, evidence-informed treatment interventions on an individualized, client-centered, and collaborative

basis, factors to establish and strengthen the therapeutic relationship, client engagement, and safety, professional boundaries, and fully comprehensive services. These guidelines aim to address key considerations in working with adults with traumatic stress disorders across a range of topics with scientific support, including clinical complexity and use of telepsychology. They also address the necessary legal rules and regulatory issues that may be present when working with trauma survivors.

Development of Guidelines

In July 2018, the American Psychological Association (APA) Council of Representatives referred, following discussion of potential directions and content, to the APA Board of Professional Affairs a motion to appoint a Working Group to develop professional practice guidelines on key considerations in working with adults with traumatic stress disorders. Members of this Working Group were selected for their diverse perspectives and backgrounds in several areas, including direct provision of clinical treatment or services in PTSD and trauma, research expertise in the treatment of PTSD and trauma, and familiarity with professional practice guideline development and APA policy on guidelines. Working Group members represented a variety of theoretical orientations (e.g., cognitive behavioral, family systems, humanistic, psychodynamic), geographic locations, patient populations, and practice settings. The Working Group developed these guidelines over several years, revising the document in response to feedback received and posting the guidelines for public comment in advance of their final review and adoption. No group or individual contributed financial support for this project, and no member or sponsoring organization will derive financial benefit from the review, approval, or implementation of these guidelines.

Consideration of Global Population Health Impacts From COVID-19

It is increasingly clear that the global pandemic has been experienced by many as a form of trauma as individuals confronted the acute illness and death of loved ones, often under isolation. Other impacts included moral injury (Serlin et al., 2019) associated with these losses; an increase in race-based discrimination and hate crimes; and sharp inequities in access to health care across population groups (Gold et al., 2020; Rossen et al., 2020; Moore et al., 2020; Nieuwsma et al., 2022).

Indeed, the COVID-19 pandemic has impacted health care on a global scale, magnifying inequities in access to quality health care that persisted before the pandemic. This pandemic highlighted the equity gap in outcomes for marginalized communities—specifically the Black, Indigenous, People of Color (BIPOC) community—as demonstrated by the disparate morbidity and mortality from COVID-19 in individuals from these communities compared with the majority White population (Gold et al., 2020; Rossen et al., 2020; Moore et al., 2020). Furthermore, obesity and associated comorbidities, which disproportionately affect racial or ethnic minorities, have played a part in driving severe cases of COVID-19 in marginalized communities (Garg et al., 2020). Communities of color have been disproportionately impacted by the COVID-19 pandemic, and researchers continue to study and report on the mental health implications of these pandemic-related disparities. (Saltzman et al., 2021).

Studies by Mayo Clinic (Garg et al., 2021) reported a major increase in the number of U.S. adults reporting symptoms of stress, anxiety, depression, and insomnia during the pandemic, compared with surveys before the pandemic. In these, some were found to have increased use of alcohol or drugs to address fears about the pandemic.

Health care and other professionals, including psychologists, have had to innovate and pivot during this time to meet increased demand for both physical and behavioral health services, and new resources were developed to guide these efforts (Figley et al., 2023). These Guidelines consider this important context, understanding that the long-term effects of these "syndemics" are not yet fully known.

Distinction Between Standards and Guidelines

The term Guidelines refers to statements that suggest or recommend specific professional behavior, endeavor, or conduct for psychologists (APA, 2015). Guidelines differ from Standards in that Standards are mandatory and may be accompanied by an enforcement mechanism. Guidelines are aspirational in intent. They are meant to promote a high level of professional practice by psychologists and to facilitate the continued systematic development of the profession. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional and clinical situation. They are not intended to take precedence over the professional judgments of psychologists that are based on the scientific and professional knowledge of the field. They are not intended to create a requirement for practice or to be used by third parties to limit coverage for reimbursement. Guidelines may be superseded by federal or state laws (APA, 2015).

APA distinguishes between Clinical Practice Guidelines and Professional Practice Guidelines, noting that the former provides specific recommendations about clinical interventions for certain disorders or conditions based on systematic reviews of scientific evidence, whereas the latter offer guidance on psychologists' roles, populations, or settings based on the scholarly literature and professional consensus. Although the phrases Professional Practice Guidelines and Clinical Practice Guidelines are often used interchangeably, APA draws a

distinction between the two and encourages consistent use of terminology within the Association (APA, 2015).

Compatibility

The following guidelines were written to be compatible with the Ethical Principles of Psychologists and Code of Conduct (APA, 2017a) and informed by APA guidelines and policies, including but not limited to Clinical Practice Guidelines for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults (APA, 2017b), Guidelines for Psychological Practice in Health Care Delivery Systems (APA, 2013c; under revision), Specialty Guidelines for Forensic Psychology (APA, 2013b; under revision), Guidelines for Psychological Assessment and Evaluation (APA, 2020), and Professional Practice Guidelines on Evidence-Based Psychological Practice in Health Care (APA, 2021a). These guidelines also are consistent with and informed by the APA's (2021b) resolution on the Role of Psychology and the American Psychological Association in Dismantling Systemic Racism Against People of Color in the U.S. APA's (2021c) Resolution on Advancing Health Equity in Psychology, and Psychology's Role in Advancing Population Health (APA, 2022a) among other frameworks relevant to Equity, Diversity, and Inclusion (APA, 2021d) and Human Rights (APA, 2021e).

Relationship to Other Documents on PTSD and Trauma

The APA (2017b) Clinical Practice Guideline for the Treatment of PTSD in Adults recommends interventions for the treatment of PTSD in adults based on a systematic review of the scientific evidence, a weighing of the benefits and harms of interventions, consideration of what is known about patient values and preferences, and consideration of the applicability of the evidence across demographic groups and settings. These Professional Practice Guidelines were commissioned as a companion document to this clinical practice guideline (and any updates to it) to address key considerations in working with adults with traumatic stress disorders, including the importance of the therapeutic relationship. There may be other APA policies that relate to PTSD and trauma, including proposed guidelines under development.

Potential Users and Stakeholders

The intended users of these guidelines include, but are not limited to, psychologists, other health and mental health professionals, consumers, families of consumers, students, educators and training programs, supervisors and trainers, policy makers, and members of the public. Those working with military service members, veterans, and their families may find these guidelines of interest, as will those working with vulnerable communities or in high-risk environments, including law enforcement and public safety, among others. APA presenters, conferees, divisions, state associations, professional networks, and researchers also may find these guidelines of interest. It is hoped that these guidelines will become an important resource for practitioners and members of the public unfamiliar with the nuances of professional practice in this area. The guidelines intend to strengthen professional practice, health care systems, and communities with respect to important aspects of trauma and working with trauma.

Key Terminology and Definitions

These are key terms that the reader may find helpful.

Trauma and Stress Disorders

According to the APA Dictionary of Psychology (APA, n.d.), a traumatic disorder is any disorder that results from physical or psychological trauma. Trauma- and stressor-related disorders involve exposure to a traumatic or stressful event. Two of the trauma-related disorders are acute stress disorder (ASD) and posttraumatic stress disorder (PTSD). (American Psychiatric Association, 2022).

Interpersonal Trauma

Interpersonal trauma includes intentional acts by other human beings that are sufficiently violent, exploitive, coercive, invasive, or devaluing to be life threatening or irreparably damaging to the health, bodily integrity, relationships, or home and community of one or more individuals. Sexual and physical assault, domestic and intimate partner violence, war, terrorism, historical and racial trauma, sexual exploitation, torture, kidnapping, and political and hate-based violence fall within this domain. Individuals may be impacted by interpersonal trauma through direct experience, witnessing such harm to someone else, or learning of such harm to a person upon whom the individual depends for security and protection (Forbes et al., 2014).

Non-Interpersonal Psychological Trauma

Non-interpersonal psychological trauma includes nonintentional accidents, illnesses, and natural disasters that are life threatening or cause irreparable damage to health, body integrity, relationships, or home and community.

Developmental Trauma

When interpersonal psychological trauma occurs in formative developmental periods of rapid growth of the brain and body (e.g., early childhood) or at developmental transitions (e.g., from adolescence to adulthood), it can disrupt the individual's psychosocial development and give rise to traumatic stress symptoms that extend broadly across the mental/emotional, physiological, neurobiological, behavioral, relational, and self/identity domains because of a disruption of normal devel-

opment in those domains (D'Andrea et al., 2012; Ford et al., 2018). Sexual, physical, and emotional child abuse; childhood witnessing of family and community violence and murder; and bullying are examples.

PTSD

PTSD is one of several potential sequelae of exposure to trauma and involves (a) unwanted and intrusive re-experiencing of memories of traumatic events (which often occur as emotional or physiological reactions to reminders of such events but also may occur as specific distressing memories, nightmares, or flashbacks); (b) maladaptive attempts to avoid trauma-related re-experiencing (which often are so automatic that the individual is not aware of the attempts) that interfere with psychological adjustment, relationships, health, and quality of life; (c) emotional distress or numbing and a loss of trust, hope, and self-confidence due to viewing the world as unsafe and oneself as powerless, unworthy, guilty, or ineffective; (d) a sense of having to always be on guard (hypervigilance) that leads to feeling tense, irritable, distracted, and unable to relax or sleep; and (e) in some but not all cases, dissociative symptoms of depersonalization or derealization (i.e., dissociative subtype).

Complex PTSD (CPTSD)

Another constellation of biopsychosocial symptoms that are sequelae primarily of developmental trauma (and potentially other forms of extreme interpersonal psychological trauma such as sexual exploitation, intimate partner violence, and torture) form a complex variant of PTSD: (a) emotion dysregulation (distinct from but potentially comorbid with unipolar and bipolar depression); (b) difficulty in establishing or sustaining primary relationships and friendships due to avoidance or enmeshment; and (c) a sense of self and identity as being irreparably damaged and unlovable. Complex Trauma, of course, may include but is not limited to the above-mentioned symptoms.

Trauma-Exacerbated Psychopathology

Persons experiencing numerous mental and behavioral health problems often have histories of trauma and experience subthreshold symptoms of PTSD or CPTSD (or the full disorders of PTSD or CPTSD that are identified as comorbidities) and exacerbate their identified mental or behavioral disorders, including affective, anxiety, eating, substance use, psychotic, psychosomatic, sexual, sleep, learning, developmental, attentional, oppositional-defiant, conduct, and personality disorders.

Trauma-Exacerbated Physical Health Problems

In persons who have medical illnesses and conditions, psychological trauma is associated with more severe physical symptoms, disability, and pain related to health problems including cardiovascular, pulmonary, dermatologic, metabolic, immunological, autoimmune, and neuroendocrine diseases, as well as cancer and asthma. These links are bidirectional.

Trauma-Informed Care (TIC)

TIC is an intervention and organizational approach that focuses on how trauma may affect an individual's life and their response to behavioral health services from prevention through treatment. There are many definitions of TIC and various models for incorporating it across organizations, but a "trauma-informed approach incorporates three key elements: (a) realizing the prevalence of trauma; (b) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (c) responding by putting this knowledge into practice" (SAMHSA, 2012, p. 4). TIC often refers to the setting whereas trauma-specific care refers to specific techniques.

Intersectionality

This term highlights how intersecting power relations influence social relations across diverse societies as well as individual experience in everyday life. As an analytic tool, intersectionality views issues of race, class, sexual orientation, and gender diversity, including but not limited to country or area of origin, ability, disability, neurodiversity, ethnicity, and age, among others, as interrelated and mutually shaping one another (APA, 2023). Intersectionality is a way of understanding and explaining complexity in the world, in people, and in human experiences (Krieger, 2021a).

Secondary Traumatic Stress

Secondary trauma describes the stress reaction induced in caregivers following exposure to clients' traumatic material. Specifically, Figley (1995) describes secondary traumatic stress as a class of "natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other (or client) and the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 7). Over time, it is suggested that the caregiver develops some of the symptoms of posttraumatic stress disorder (PTSD), mirroring client symptoms. Clinically, this stress reaction refers to secondary traumatic stress (Sprang et al., 2019). As an example, a nurse who witnesses or hears about a gruesome, traumatic injury may experience secondary traumatic stress if their experience with traumatic material generates PTSD-like symptoms.

Compassion Fatigue

Also known as compassion stress, this term originally was coined by Joinson (1992) in reference to burnout and nurses and has been referred to as a more user-friendly substitute to secondary traumatic stress (Figley, 1993). Compassion fatigue is described as an acute, affective phenomenon that engenders high levels of stress for caregivers and in which caregivers' symptoms parallels those of the original trauma

victim's (e.g., avoidance, hyperarousal, numbing, sleep disturbances; Figley, 1995). In most operationalizations, compassion fatigue is viewed as a multidimensional construct composed of two dimensions, burnout and secondary traumatic stress (e.g., Stamm 2012). While secondary traumatic stress is acute, burnout is a gradual process of emotional exhaustion (Figley, 1995).

Racial Trauma, or Race-Based Traumatic Stress (RBTS)

RBTS refers to the mental and emotional injury caused by encounters with racial bias and ethnic discrimination, racism, and hate crimes. Any individual that has experienced an emotionally painful, sudden, and uncontrollable racist encounter is at risk of suffering from a race-based traumatic stress injury. In the U.S., BIPOC are most vulnerable due to living under a system of white supremacy.

Experiences of race-based discrimination may have detrimental psychological impacts on individuals and their wider communities. In some individuals, prolonged incidents of racism may lead to symptoms like those experienced with PTSD. This may present as depression, anger, recurring thoughts, physical reactions (e.g. headaches, chest pains, insomnia), hypervigilance, low self-esteem, and mental distancing. Some or all of these symptoms may be present in someone with RBTS, and symptoms may look different across different cultural groups. Unlike PTSD, RBTS is not considered a mental health disorder. Rather, RBTS is a mental injury that may occur as the result of living within a racist system or experiencing events of racism. (Mental Health America, n.d.)

Vicarious Trauma

Vicarious trauma refers to the secondary exposure to traumatic experiences shared by others. Early usage of the term referred to the exposure experienced by therapists/mental health professionals treating clients who have endured traumatic experiences. This type of vicarious trauma has also been referred to as secondary traumatic stress and compassion fatigue (Leung et al., 2022). More recently, the term has expanded to include exposure to violence and other life-threatening events via social media, particularly for members of marginalized and minoritized communities (e.g., police shootings of unarmed Black individuals; Bird et al., 2021; Bor et al., 2018; Cerdeña et al., 2021; Hartmann et al., 2019).

Vicarious Traumatic Stressors

This term refers to the indirect traumatic impacts of living with systemic racism and individual racist actions. Vicarious traumatic stressors may have an equally detrimental impact on BIPOC's mental health as direct traumatic stressors. For example, viewing videos of brutal police killings of Black people, such as the video associated with the murder of George Floyd, may cause traumatic stress reactions in the individuals who view them, especially in Black people. Of Latinx youth that immigrate to the U.S., two-thirds report experiencing one traumatic event, with the most common traumatic event reported during and post migration being witnessing a violent event or physical assault. Indigenous children may experience vicarious trauma by virtue of high rates of homicide, suicide, and unintentional injury in these communities. (Mental Health America, n.d.)

Selection of Evidence

Research and scholarly literature on these and related topics are extensive. As such, in accordance with APA policy on guidelines, the developers focused primarily on peer-reviewed publications and complemented these sources with books, chapters, and reports from authoritative sources. In surveying the professional literature, statistical reports, and other data, the developers reviewed and incorporated, as appropriate, relevant citations including (a) APA's (2017a) Ethical Principles of Psychologists and Code of Conduct; (b) legal and regulatory frameworks that generally apply to psychologists; (c) professional practice guidelines or other policies published or approved by APA; (d) scholarly literature relevant to select topics and competent practice in this area of professional activity; and (e) statistical reports and prevalence data from governmental, nonprofit, and other reliable sources, among others. The developers sought expertise from experts in equity, diversity, and inclusion (EDI) with an emphasis on racial trauma and included citations and references from this collaboration.

Status and Expiration Date

This document will expire as APA policy in 10 years following its adoption as Association policy by the APA Council of Representatives.

Ways of Knowing and Scientific Support for Trauma Practice

Overview

This Guideline strives to guide psychologists in evaluating both the quality of research evidence in scientific journals and what may be found in other publications and social media, underscoring the importance of collaborations between practitioners and scientists to advance the research base on trauma, including clinical and cultural innovations and discoveries, so that these may be integrated into clinical, social, and basic science research. The development of trauma practice began differently from other types of clinical treatment in that trauma practice was developed over the history of practice and added to different theories until finally developing its own theory and practice inclusive of additions when new events were studied. In the later developments, in addition to other techniques, trauma practice also provides safety, trust, empowerment, choice, and collaboration where possible (Walker, 2017).

GUIDELINE 1

Psychologists strive to collaborate across science and practice domains to develop familiarity with and contribute to the knowledge base, scientific support, and culturally responsive treatment options for trauma-informed care and the psychological assessment and treatment of traumatic stress disorders and their sequelae

Rationale

Research is rapidly evolving on the epidemiology, psychology, neurobiology, genetics and epigenetics, population health impact, and lifespan developmental psychopathology of traumatic stress, and the ethno-racial and sociocultural factors affecting pre- and posttraumatic stress reactions and their course (Kilpatrick et al., 2017). Scientific evidence indicates that most individuals experience at least one (and often several) traumatic stressors, with prevalence estimates reaching 80%–90% or more for children and adults in behavioral health treatment (Kilpatrick et al., 2017) . Maintaining an up-to-date knowledge of the major research findings in the traumatic stress field may enable this information to be incorporated together with clinical practice.

A trauma-informed approach strives to respect patients' preferences for varied forms of assessment and therapy and encourages scientists to develop procedures supporting patient choice, control, and empowerment (Campbell et al., 2019). Although research on assessment and treatment of disorders using a variety of evidence-based quantitative and qualitative methods usually informs clinical practice, the knowledge from clinical practice with trauma patients across the full range of traumatic stress disorders has better addressed the biopsychosocial symptoms (Sonis et al., 2017). Research evidence may assist when selecting appropriate assessment instruments and procedures, as well as trauma-specific treatment interventions and trauma-informed approaches to enhance interventions for other disorders. Relevant research also may help develop motivation for change and cultivate and maintain a collaborative therapeutic relationship, promote empathy, and enhance both treatment and provider credibility.

The integration of clinical with research experience is consistent with APA's policies on evidence-based practice in psychology (APA, 2006, 2021a; Silver & Levant, 2019; Stricker & Goldfried, 2019). Given that causal processes within psychology vary across people, (Bolger et al., 2019; Fowers et al., 2022; Van de Ven & Johnson, 2006) collaboration between researchers and clinicians about traumatic stress disorders, symptoms, and clinical interventions may enhance the effectiveness of trauma-focused treatments by integrating theoretical understanding of these disorders within evolutionary and biopsychosocial perspectives (Buss, 2020; Cosmides & Tooby, 2013; Gilbert, 1995; Pole, 2017). Collaborative research on relational or other common factors (Nahum et al., 2019; Norcross & Wampold, 2019a), such as therapist presence and responsiveness (Kramer & Stiles, 2015; Schneider, 2015; Wu & Levitt, 2020), may add crucial nuance to psychologists' appreciation of what works in traumatic stress assessment and treatment (Norcross & Wampold, 2019a).

There are increasing reports in social media, popular magazines, news sources, and the Internet, as well as self-help guides and phone applications, purporting to help people who have experienced trauma. Some are based on scientific evidence while others are not. Patients may seek psychologists' opinions on these resources. It may be helpful therefore for psychologists to gain familiarity with the scientific and clinical support for prominent mental health resources in the public domain.

Individuals who seek mental health services, especially those from Indigenous or marginalized cultures and groups, may have culturally specific beliefs, traditions, and experiences with healers that inform understanding of psychological trauma and recovery. These culturally based schemas, practices, and remedies may influence people's expectations of and willingness to engage with psychologists and other mental health professionals who practice within a Westernized cultural context. For psychology, adopting a multicultural lens and orientation, including cultural humility (APA, 2023) facilitates learning from patients of diverse cultural backgrounds and experiences, and aids in the integration of these insights into treatment. Moreover, this process may advance respect for patients' cultural frameworks (APA, 2022c).

Application

To provide trauma-informed care, psychologists strive to be knowledgeable about trauma-relevant research and practice innovations. This may include familiarity with the literature on psychosocial, neuroscience, psychophysiological, and sociocultural sequelae of psychological trauma, as well as empirically supported approaches to assessment and treatment. Practitioners also strive to be knowledgeable about rapidly expanding resources for the public on psychological trauma, recovery, and treatment and how these may come into consideration in trauma practice.

Psychologists may rely on numerous sources to stay current on the major developments in traumatic stress research, including peer-reviewed journals and professional books and presentations that characterize the impact of trauma on a wide range of biopsychosocial processes and disorders. Psychologists also may avail themselves of traumatic stress research published or presented on-line by professionally reputable sources to remain informed about the major research developments in the traumatic stress field that may affect their clinical practice, teaching, training, and research.

When evaluating the quality of publicly accessible information, psychologists consider the type and amount of research evidence and the extent to which the evidence answers the questions posed and supports the conclusions reached. Psychologists consider both efficacy (i.e., strength of evidence for a causal effect) and clinical utility (i.e., generalizability, feasibility, and cost-benefit analysis; APA, 2002). They appreciate the value of different study designs including but not limited to systematic reviews and meta-analyses, randomized controlled trials (RCTs), cohort studies, case control studies, case series, single-case experimental designs, process-outcome studies, effectiveness research, ethnographic research, clinical observation, qualitative research, and mixed-methods research (APA, 2006; Murad et al., 2016). Psychologists recognize that different designs, including descriptive and analytical, or observational and interventional studies, may address different questions (Dalenberg & Briere, 2017).

Psychologists strive to use a variety of professional and publicly accessible sources to stay current on research on traumatic stress assessment and treatment relevant to their clinical practice, teaching, training, and research. Psychologists aim to appraise reports and summaries of traumatic stress assessment and treatment research with caution based on including considerations of internal and external validity, methodology, transparency, equity, and ethics, balanced with an openness to consider new methods, findings, and approaches (Chefetz, 2019). In addition, practitioners seek continuing education to better assess and incorporate knowledge about new or emerging approaches, including but not limited to relational and somatic approaches with traumatized patients. Clinicians specializing in trauma treatment endeavor to expand their knowledge, seeking opportunities to collaborate with and otherwise inform the professional community to develop scholarly literature.

Clinicians may communicate and collaborate with researchers both formally (e.g., in peer-reviewed publications or professional meetings) and informally resulting in scientific research that is more grounded in clinical questions, insights, and innovations. Examples may include how clinicians respond when empirically based treatment is ineffective (Constantino et al., 2020) or when progress stalls for a specific patient (Nezu, 2020). Collaboration between clinicians and researchers also allows practitioners to incorporate the latest insights and innovations gained through research into clinical practice (Norcross & Lambert, 2019; Norcross & Wambold, 2019b).

Several examples exist of publicly accessible mental health resources with varying degrees of scientific support. For example, advertisements on social media for telehealth treatment may feature providers whose credentials and training are unknown. Publicly available mobile applications (apps) that purport to relieve mental health symptoms vary in the strength of the underlying knowledge base. Some individuals might benefit from using certain apps without other treatment, while other patients may be better helped when using apps in conjunction with psychotherapy. Patients may seek advice from their psychologist about purported remedies for traumatic stress that were touted online or in print and broadcast media. Psychologists therefore strive to become knowledgeable about popular or readily accessible resources, including websites, social media postings, podcasts, applications, and other media presentations, including the knowledge base upon which they are developed or maintained. They endeavor to evaluate the alignment of apps and other publicly accessible resources with established knowledge and evidence.

When selecting evidence-based interventions with clients impacted by trauma, psychologists strive to evaluate the usefulness of digital therapeutics, a subset of digital health, that are evidence based.

Education, Training, and Professional Development

Overview

The prevalence of trauma and evolving knowledge about it suggest a need for psychologists and mental health professionals to pursue education, training, and professional development across the career span on the impact of trauma on a range of clinical symptoms, mental health disorders, and other biopsychosocial consequences (Cook & Newman, 2017; Kendall-Tackett & Klest, 2013; Briere & Scott, 2015; Brand et al., 2019). This education and training may be foundational or of a specialized nature and offered in both graduate school and via professional development settings.

To stay informed and up-to-date, psychologists may benefit particularly from education that integrates foundational knowledge with new insights from psychological science and practice (Courtois & Gold, 2009; Gere et al., 2009; Turkus, 2013; Kumar et al., 2022; Cook & Newman, 2017). Psychologists also may maintain and enhance their education and training in the trauma field through ongoing consultation and supervision. Psychologists are mindful of education, training, and career span issues where they may need to address topics that may not have been available in graduate training or professional development. In this regard, psychologists strive to address where additional education, training, and professional development are needed as they relate to trauma. This may include, but is not limited to, becoming knowledgeable in trauma-informed care and treatment through additional education, training, consultation, and supervision.

GUIDELINE 2

Psychologists strive to engage in education and training based on current scientific knowledge and practice, including the biopsychosocial, sociocultural, and intersectional aspects of trauma, trauma-informed intervention, and recovery

Rationale

The scientific and clinical literature on traumatic stress and its assessment and treatment are constantly evolving (Cook et al., 2019). As such, securing new knowledge through appropriate and relevant education and experiential training are important across the career span of psychologists. Education and training that incorporate biopsychosocial, cultural, and intersectional aspects of trauma are available and may offer insights and knowledge on the skills and competencies necessary to address trauma across practice settings (Bryant-Davis, 2019; Courtois & Brown, 2019; Courtois & Gold, 2009; Henning & Brand, 2019).

Education and training in specialized clinical topics are also available for those who wish to specialize in more complex areas of trauma. These may include phase-oriented treatment (Dorahy & Van der Hart, 2015; Van der Hart et al., 2005), strategies related to affect regulation and dissociative states, interoceptive accuracy and proprioception (movement) (Ceunen et al., 2016), neuroception (Geller & Porges, 2014), and mentalizing (Mitchell & Steele, 2021).

Trauma-informed care (TIC) incorporates several key elements, including understanding the prevalence of trauma and how trauma affects individuals seeking services (SAMSHA, 2012). A TIC approach emphasizes the importance of working ethically on behalf of trauma survivors in various settings (Harris & Fallot, 2001b; APA, 2017a). This framework may be applied to general psychotherapy regardless of theoretical orientation. A trauma-informed approach may enhance treatment outcomes, maintain appropriate boundaries, and minimize harm for those who have experienced adverse effects (Henning & Brand, 2019; Lucio & Nelson, 2016).

Additional specialized education and training may offer in-depth knowledge on the range and complexities of various populations who may present with traumatic stress reactions. For example, specialized training may offer in-depth knowledge on the various techniques and approaches that deal directly with trauma symptoms themselves. Education and training in psychodynamic and relational therapies and approaches may be helpful (Barsness, 2018; Motta, 2020), as would education and training in exposure therapy, narrative exposure therapy (Foa et al., 2009), trauma-focused cognitive behavioral therapy, somatic approaches (Fisher, 2019; Payne et al., 2015), and cognitive processing therapy (Cloitre, 2009; Mendes et al., 2008; Cahill et al., 2009; Ehlers et al., 2010; Roberts et al., 2011; Hinton et al., 2012; Robjant & Fazel, 2010.)

Conceptualizing the impact of trauma within a cultural framework enhances knowledge and understanding of trauma and trauma practice. (Brown, 2008a). For example, marginalized groups may be at greater risk for trauma exposure and mental health issues such as PTSD and other trauma symptoms (Bailey et al., 2017; Buchanan & Wiklund, 2021; Mezzina et al., 2022; Saltzman et al., 2021;

Bernal & Sáez-Santiago, 2006; Matter et al., 2011). Risk factors that exacerbate traumatic stress include, but are not limited to, microaggressions, oppression, racism, and ethno-cultural violence (Brown, 2008a; Marsella et al., 1996). Additionally, members of marginalized groups may experience barriers to accessing culturally relevant trauma treatment. Education and training in cultural competence may shed light on the struggle that marginalized populations experience in accessing high-quality and culturally sensitive care (Henning & Brand, 2019).

Application

Across the career span, psychologists strive to seek out professional opportunities for learning through readings, attendance at workshops, classes, and conferences that address traumatic stress (Turkus, 2013). Supervision and consultation also may be helpful (Tosone et al., 2012; Pearlman & Saakvitne, 1995; Rasmussen, 2005) and can provide support for personal and professional growth (Berger & Quiros, 2014). Additionally, psychologists strive to consult with cultural brokers and nontraditional healers, as appropriate, who can provide insights on the cultural nuances related to trauma work (Brown, 2008a; Greenwald et al., 2008). Through education and training opportunities that offer knowledge on the biopsychosocial and cultural aspects of trauma, psychologists strive to develop a relevant lens to ensure scientifically grounded, evidence-based, and culturally responsive assessment and intervention strategies for trauma. Relevant domains of study may include, but are not limited to:

- epidemiology of trauma exposure, reactions, including but not limited to idioms of distress and comorbidity
- history of definitions and treatments for traumatic stress disorders
- recognizing traumatic stress reactions in practice
- trauma-informed assessment and diagnosis
- impact of culture and contextual variables on trauma exposure and reactions
- biopsychosocial domains
- trauma-informed case formulation and treatment planning
- theories of traumatic stress disorder treatment (including knowledge of Indigenous and nontraditional healing practices)
- relational variables in the treatment of traumatic stress disorders (i.e., interpersonal and system dynamics, therapeutic alliance)
- ethical and legal considerations

Psychologists strive to attain education and experiential training in trauma-specific interventions to enhance their ability to meet the needs of trauma survivors including, but not limited to, cognitions, behaviors, affect, autonomic and somatic responses, and treatments that target these responses (Henning & Brand, 2019; Porges & Dana, 2018).

With this education and training, psychologists may consider how symptoms and behaviors are related to traumatic experiences. They may learn and apply the trauma-informed principles of safety, collaboration, choice, and empowerment in their work (Harris & Fallot, 2001b; Henning & Brand, 2019; Knight, 2018.) Specifically, psychologists may seek to emphasize safety in their work to help clients regain a sense of control in their lives. Additionally, psychologists endeavor to emphasize strengths rather than deficits and consider the importance of the relationship in healing trauma (Hopper et al., 2010).

Employing a TIC lens may be useful when using various modalities. For example, relational approaches may help address consequences from betrayal, developmental, and interpersonal traumas. Mindfulness practices (e.g., mindfulness-based stress reduction), movement exercises (e.g., Feldenkrais, yoga or qigong, and manual therapies) may facilitate physiological calming in the body. Together, these interventions may facilitate improvement across domains. Psychologists strive to continually assess whether a need for specialized treatment may emerge that may go beyond using a TIC lens. For example, a client may experience triggers or flashbacks that need to be addressed with a trauma specific modality.

Psychologists also may wish to consider other resources such as clinical practice and professional practice guidelines that may highlight aspects of trauma practice or recommended interventions and treatments (Hamblen et al., 2019). Psychologists strive to determine when to offer general trauma-informed care and when to refer patients for more specialized treatment.

Education and training may help psychologists better understand the social, historical, cultural, political, and spiritual context of trauma and the intersectionality of identity and trauma (Brown, 2008a; Cook et al., 2019). Having this intersectional framework may foster a holistic understanding of patients and supports more accurate assessment and appropriate treatment (Buchanan & Wiklund, 2021; Heberle et al., 2020; McCauley et al., 2019; Brown, 2008a). Individuals may experience trauma differently based on their sociocultural context. Some patients may present physical symptoms instead of or as psychological distress. For example, some Cambodian refugees presented with idiopathic blindness upon their arrival in the US. Other groups also may present with conversion symptoms that manifest physically but do not have a physical cause. These symptoms may be difficult to differentiate from physical illnesses and may benefit from careful consultation with other experts, including those who may have expertise in physical therapy, ethno-cultural violence, oppression, racism, and microaggressions.

Psychologists also strive to gain insight into the cultural and sociopolitical factors that may exacerbate trauma. For example, the chronic stress of racism may exacerbate symptoms of PTSD, especially in African American populations. This is especially seen in negative health outcomes in these

and other racially diverse populations. For example, given cultural barriers and stigma, immigrants and refugees may face barriers to accessing mental health services. Culturally informed education and training may shed light on barriers to accessing treatment and could help psychologists create novel approaches to engaging diverse populations in mental health services. In addition, psychologists strive to attain and integrate best practices related to collaborating and coordinating with other professionals including cultural experts. Finally, psychologists endeavor to collaborate within primary care settings to address cultural barriers to mental and behavioral health services.

GUIDELINE 3

Psychologists endeavor to seek consultation and supervision on trauma-related concerns as needed and when appropriate including for secondary victimization and vicarious trauma.

Rationale

There are unique challenges related to the assessment and treatment of adults with traumatic stress disorders, where consultation and supervision may provide useful insights. Consultation may help highlight the identification of traumatic stress reactions and their impact during treatment. Supervision, for its part, may build skills and expertise when working in new areas. Consultation with legal and regulatory agencies may be more frequent when working with trauma survivors. Given the complexity of working with adults with traumatic stress disorders, consultation and supervision may enhance and strengthen work in this area and may be considered forms of continuing education.

Secondary victimization or vicarious trauma may surface for providers when working with populations that have experienced trauma, including experiencing similar symptoms as the patient after hearing accounts of trauma and violence (Figley, 1993; Pearlman & Mac Ian, 1995; McCann & Pearlman, 1990; Courtois & Gold, 2009). These issues may contribute to burnout and the availability of providers of mental and behavioral health services across the career span. At the same time, professionals in this field may experience posttraumatic growth (Groleau et al., 2013; Wheeler & McElvaney, 2018) and compassion satisfaction (Craig & Sprang, 2010). Such benefits may be fostered through trauma-informed clinical consultation and supervision. These and other steps may mitigate impacts on personal and professional identity, relationships, and worldview (Whitt-Woosley & Sprang, 2018; Sprang, 2018; Sprang et al., 2019; Figley, 1993, 2002; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995).

Application

Psychologists may strengthen their skillset through consultation and supervision. This may reinforce psychological knowledge, evidence-based practices, and methods, as well as increased fidelity, competence, and sensitivity to the backgrounds, preferences, and needs of the patient. For example, consultation or supervision may be helpful if and as trauma surfaces in treatment. Psychologists may access resources for consultation and supervision through colleagues and professional networks, including APA Divisions and State Psychological, Territorial, and Provincial Associations (SPTAs).

Additionally, psychologists may attain greater self-awareness including increased attention to personal health, wellbeing, and self-care (Courtois & Gold, 2009; Turkus, 2013; Carello & Butler, 2015). In addition to consultation and supervision, ongoing self-reflection and personal therapy may allow psychologists to access support and address any vicarious trauma reactions, countertransference, or other personal issues that might emerge in working with clients (Rothschild & Rand, 2006; Turkus, 2013).

Working with trauma survivors may trigger distress among psychologists, a phenomenon that has been described as "vicarious trauma" or "secondary traumatic stress" (Pearlman & Mac Ian, 1995; Dunkley & Whelan, 2006; Sprang et al., 2019; Wheeler & McElvaney, 2018). Psychologists strive to obtain education and training on risk factors for vicarious trauma, as well as interventions that may help assist in its prevention. Psychologists strive to understand how vicarious trauma can emerge across the career span and how organizations and professional relationships can provide support for psychologists in this regard.

In encountering vicarious trauma, psychologists may experience burnout, feel overwhelmed, withdraw, and experience a reduction in their ability to practice self-care (Etherington, 2009; Shannon et al., 2014). Psychologists may need to appreciate that at times fidelity and competence may be at odds with patients' preferences and needs, which may render context responsiveness an important element of evidence-based practice. At the same time, psychologists may benefit from positive impacts of their work that can counter the negative effects of working with trauma if they are attuned to those aspects of their work (Arnold et al., 2005; Silveira & Boyer, 2015). For example, developing skills to tolerate ambiguity, emotional intensity, and holding the reality of both good and evil may be useful (Danylchuk, 2015). Psychologists also may strive for more frequent breaks or limit the number of trauma survivors seen on a particular day. Psychologists may monitor vicarious trauma across the career span and avail themselves of supervision and peer consultation groups and support networks. Exploration through education, training, consultation, and supervision also may be beneficial (Hernández et al., 2007; Engstrom et al., 2008; Hernández et al., 2010; Wheeler & McElvaney, 2018).

Legal and Regulatory

Overview

In considering assessment and working with adults with traumatic stress disorders, psychologists may benefit from attaining and maintaining knowledge of the legal and regulatory framework associated with an individuals' legal status and considerations specific to trauma, and consulting with legal and other experts on local, state, and federal laws and regulations, and pertinent case law. These guidelines aim to highlight key issues in understanding and navigating these complex legal and regulatory frameworks when working with patients needing trauma-informed care. In addition, we have developed guidelines for psychologists providing clinical forensic psychology practice that has different requirements than clinical psychotherapy but commonly required by trauma survivors.

GUIDELINE 4

Psychologists strive to be knowledgeable of federal and state legal and regulatory frameworks, policies, and procedures that may be relevant to or have implications for working with adults with traumatic stress disorders. This includes scope of practice for licensure, mandated reporting of trauma to children, older adults, persons with disabilities, or other vulnerabilities, and duty to warn or duty to protect those who may pose a risk of harm to themselves or others.

Rationale

Myriad legal and regulatory frameworks and other rules, policies, and procedures may be relevant to trauma practice. Developing and maintaining working knowledge of these laws, rules, and systems may be important, as they can have added consequences in psychological practice with adults with trauma stress disorders. Areas for learning and review may include ethical standards, administrative requirements, court referrals and policies, and legal authorities that may relate to assessment and treatment (Health Insurance Portability and Accountability Act, 1996; APA, 2017a, 2013b; Shapiro & Walker, 2019).

In some cases, trauma assessment and treatment may elevate a patient's legal risk or exposure. For example, assessment may uncover possible child abuse that would need to be reported to authorities under mandatory reporting requirements. Others may pose barriers and limitations given a patient's legal status or court involvement. For example, the patient may be incarcerated and not easily available for a full evaluation or assessment. Knowledge of these issues and impacts may inform the timing and nature of initial and ongoing trauma assessment and treatment. In addition, communications on these issues in the informed consent process and throughout treatment may be helpful and important.

Within federal and state legal and regulatory frameworks, there may be rules and regulations or administrative procedures that govern, guide, and inform the assessment and treatment of adults with traumatic stress disorders. For example, these may apply in cases where individuals with employment-related or military service-connected injuries seek health care and trauma-specific treatment, compensation, and/or damages. There may be other rules and regulations that pertain to the recovery of damages and treatment options for addressing traumatic events, including traumatic brain injuries (TBIs) from military service. In addition, federal and state programs may govern workplace injury and disability. Understanding how these programs and frameworks intersect with psychology practice may serve to inform and optimize working with adults with traumatic stress disorders.

A state licensing board generally establishes rules and regulations to ensure the integrity and competence of licensed psychologists and investigates complaints on professional conduct. State boards may issue rules and regulations governing how psychologists perform their duties in a particular jurisdiction and the conditions under which they practice. Familiarity and compliance with laws, rules, and regulations as they relate to licensure and scope of practice is important to optimize psychological testing, assessment, and treatment of adults with traumatic stress disorders, including providing for the appropriate protection and release of patient records.

Mandated reporting refers to the legal requirement whereby psychologists and other human services personnel (e.g., social workers, nurses) report suspected or known cases of abuse or neglect of a child, dependent adult, or an older person. Health care providers in particular have an important ethical and legal role in identifying and reporting abuse in children and other vulnerable populations to their appropriate state agencies (Thomas & Reeves, 2023). Depending upon the jurisdiction, those who fail to report such cases may be subject to legal and professional sanctions. Jurisdictions

vary in terms of the laws, rules, regulations, policies, and procedures associated with mandated reporting of abuse to vulnerable people. As such, familiarity with these requirements, and striving to remain updated, may inform decision-making and actions. In addition, heightened awareness of families and family systems, where multiple forms of abuse may occur, or its impact felt, may be important (Child Welfare Information Gateway, 2023).

State law may require mandatory reporting of those individuals at risk or presenting harmful behavior to themselves or others. As such, attaining and maintaining knowledge on the relevant laws and regulations as they relate to psychology practice with adults with traumatic stress disorders is important. This area and the cases that may emerge bring a level of complexity such that consultation with legal counsel and experienced colleagues may be helpful. These cases often involve crisis intervention, involuntary and voluntary commitments and hospitalization, and the involvement of law enforcement, social workers, courts, and others. Understanding these dynamics, potential outcomes and urgency, and the requirements of professionals informs optimal trauma practice. (Edwards, 2010; Johnson et al., 2018).

Jurisdictions may have laws, rules, and regulations about duty to warn others if a patient reports a credible threat or intention to harm an identifiable third party. In some jurisdictions, professionals, including psychologists, may have a duty to protect a third party where they may have to use their clinical judgment regarding an effective intervention. In other areas, they may have a duty to warn the intended victim or target. These rules may be embedded in case law or statute and may change over time. State laws and the Ethics Code may be instructive in this regard.

Application

Through state boards of psychology and state psychological association resources, in print and online, psychologists may access, attain, and maintain knowledge of relevant legal and regulatory issues and frameworks. In addition, professional liability insurers also may have resources available on their websites. Legal and regulatory insights also may be gleaned through professional associations and continuing education opportunities. For example, some jurisdictions spotlight new rules and regulations during required continuing education for licensure renewal.

To learn and maintain knowledge in these areas, psychologists also may want to consult with legal counsel licensed in the state(s) where they are licensed, or with other experts, to better understand the parameters for and implications of screening, assessment, and treatment of trauma. Psychologists are particularly mindful of gaining up-to-date understanding of the rules and regulations impacting U.S. military veterans, service members and their families, or those referred by the courts or other institutions. Psychologists seek to understand the implications for intake in trauma cases, including informed consent and record keeping, as well as potential regular reporting requirements. Reporting requirements also may apply to individuals who have sustained traumatic injuries in the U.S. Coast Guard, Merchant Marine, and other contexts, including athletics. Psychologists are mindful that all patients referred by the courts may be covered by similar protocols, including reporting requirements and health privacy laws that may need to be understood and applied.

Psychologists strive to be aware of their responsibilities in monitoring their own competence in working with adults with traumatic stress disorders, professional ethics, and scope of practice. Under some licensing laws and test publisher copyright agreements, psychologists may be limited in the release of psychological testing and interview protocols, including disclosure of trauma treatment patient records, to those not trained in their interpretation unless and until there is a court order signed by a judge. In these situations, psychologists may be required to provide a rationale for the security, protection, or disclosure of patient records. In complying with court orders, psychologists are mindful of the need to communicate with patients on these and other related legal developments to ensure transparency and trust.

Psychologists are encouraged to obtain and maintain knowledge of policies and procedures associated with mandatory reporting of abuse. Psychologists strive to understand the definitions and standards relevant to reporting requirements and protocols. Depending upon the jurisdiction, mandated reports may be made to law enforcement or designated child protection agencies. States may have penalties for failing to report. In some jurisdictions, psychologists may issue a report of abuse by telephone whereas in others, psychologists may use electronic means and devices. Psychologists endeavor to understand how abuse is defined and described in the law, rules, and regulations. For example, in some jurisdictions, child protective services may consider child abuse to be occurring when a suspected abuser remains in the home; in other states, this may not be the case. The conditions that may require abuse reporting can vary state-by-state, where past abuse may or may not be a criterion for reporting. When practicing across state lines using telehealth or other electronic means, psychologists strive to familiarize themselves with laws and regulations governing these issues in the relevant jurisdictions.

Psychologists working with adults with traumatic stress disorders are mindful that they are often providing services to patients to whom the traumatizing experience has already taken place. Psychological practice aims to help patients with trauma's aftermath, including avoidance of re-exposure to harm and danger, and recovery from the physical and psychological harm experienced. Psychologists

are mindful that vulnerable patient populations may be at higher risk for exposure, including abuse, and comply with timely reporting of abuse (Jackson et al., 2015).

Psychologists strive to understand these laws and mandates and have a risk assessment plan for determining whether the person poses a danger to themselves or others. Psychologists may need to consult with attorneys, mental health professionals, or members of law enforcement. Whether the matter is ultimately reported or not, psychologists should maintain a record of the incident. The psychologist may want to seek additional resources, including consulting with their professional liability insurer or legal counsel. Some states may mandate that parents be notified of a minor's suicidal threats.

When or if psychologists suspect that a patient may pose a risk of harm to themselves or others, they may need to act quickly. Also, psychologists may have additional responsibilities relevant to cases of involuntary hospitalization. For example, psychologists may be asked to perform an evaluation or appear in a court proceeding regarding the issue or commitment.

Psychologists strive to determine what constitutes a patient posing a credible threat to an identifiable third party by using validated risk assessment tools. In some jurisdictions, the duty to warn is highly specific, including warning the third party and/or contacting law enforcement, while in others the duty to protect may allow for clinical interventions and judgment. For example, psychologists may increase the number of therapy sessions, provide ways for reaching psychologists in an emergency, have patients undergo medication evaluation, and/or discuss voluntary hospitalization.

In addition to court decisions in recent years that have found that psychologists have a duty to protect, there are questions as to what duties may arise in broader areas such as working with clients who are HIV-positive. For example, a psychologist may be treating someone who is HIV-positive and learns in a session that the patient is having unprotected sex. Psychologists should be aware of relevant state laws in such situations. Consultation with colleagues and attorneys then may be appropriate on issues stemming from these and other treatment scenarios (APA Services, Inc., 2005; American Bar Association, 2019). Along with a recognition of the laws and procedures that apply in these matters, psychologists are mindful of the exceptions to confidentiality and disclosure as detailed in the APA's Ethical Principles of Psychologists and Code of Conduct (2017a), which allows for exceptions to confidentiality when there is a clear intention to harm self or others.

GUIDELINE 5

Psychologists strive to become knowledgeable about the various types of legal proceedings with which trauma survivors may become involved including the laws and regulations around serving as a forensic expert as well as the implications of treatment approaches with patients who are justice-involved or engaged in other legal proceedings.

Rationale

Forensic and legal affairs often impact clinical practice with adults with traumatic stress disorders. As such, determinations on the legal standing or status of a patient may be particularly important and relevant. This may include looking through a variety of lenses and gaining insights in a number of legal and forensic areas, including but not limited to family law (e.g., marriage dissolution, paternity and child custody, child protection, guardianship, protective orders against domestic violence, termination of parental rights and adoptions, and juvenile matters), civil law (e.g., negligence, fraud, medical malpractice, marriage dissolution, bankruptcy, defamation, breach of contract, and personal injury), and criminal law (e.g., murder, assault and battery, theft, driving under the influence of alcohol or drugs (DUI), and possession). The justice-involvement of an individual (e.g., as suspect, felon, offender, or parolee), and potential role in a legal matter (e.g., alleged perpetrator, victim, survivor, defendant or plaintiff, or witness), also may be important to ascertain. Understanding the justice-status of the individual and where they fall within the justice continuum (pretrial, trial, sentencing, incarceration, release, parole status, etc.) is key as all these may have relevance to and implications for the psychological assessment and treatment process.

Litigation may provide further important context for PTSD and trauma assessment, evaluation, and treatment. For example, individuals may be court-ordered to undergo psychological assessment or psychotherapy whereas others may be referred by health care providers. Some may seek consultation, testing and assessment, and treatment at the suggestion of their attorneys. Having a solid understanding of the context for services, including referral, and status of any legal proceedings may offer psychologists insights into the potential implications of testing, assessment, and treatment.

In addition, the presence of third-party payers and court orders, referrals, judgments, and other determinations, including personal injury awards, may carry a host of implications for the provision of services, billing, and payment. In this regard, psychologists may provide important support to help patients make informed choices about services and treatment, act on administrative details including paperwork and filing deadlines, and engage in other decision making.

There may be important issues to consider in working with adults with traumatic stress disorders who are justice-involved or otherwise engaged in legal proceedings. Understanding

the justice system, how courts work, and the status of individuals involved in these cases and proceedings are important issues relevant to professional practice (Bureau of Justice Statistics, 2021). For example, the influence of the legal and regulatory process, including case types and prevalence of legal issues, may add to case complexity relevant to individuals who present for psychological assessment or treatment for trauma.

Examples of different types of legal proceedings trauma survivors may be involved with include:

Criminal Proceedings

Criminal cases may require individuals to comply with and otherwise meet a series of deadlines and complex requirements. For example, individuals may be required to appear, file paperwork, and otherwise comply with court requirements that may create additional stress to an individual with trauma. If a patient is unwilling or unable to follow these requirements, a psychologist may assist them to understand the consequences. Psychologists also may be helpful in clarifying the roles and responsibilities of prosecutors, defense attorneys, and members of the judiciary or courts, including where patients may appropriately seek advice and counsel on their criminal case or status. In this way, psychologists may educate and guide individuals during justice involvement. Forensic psychologists also may provide assessments and other expert witness testimony, including mental health status and competency. Correctional psychologists may provide additional services to those traumatized individuals who may be in detention or incarcerated. Psychologists are especially mindful of professional boundaries, refer matters to legal counsel, and strive to refrain from giving legal advice.

Civil Proceedings

Civil proceedings may take place concurrently with, or separately and distinct from, criminal proceedings. Psychologists may be helpful to their patients in clarifying the roles and responsibilities of both plaintiff and defense attorneys and members of the judiciary or courts, including where patients may appropriately seek advice and counsel on their civil case or status. When working with trauma, psychologists may help individuals who are injured take appropriate steps to recover funds for damages to health or property. Civil litigation of any kind may pose high stakes including ones where psychologists may play important roles in providing support to those who have been traumatized. Of course, psychologists take steps to ensure that these roles serve to clarify, but do not substitute for, consultation with legal counsel.

Family Law Proceedings

Family law proceedings can be exceedingly complex, multistep, and challenging to individuals experiencing trauma. Psychologists in this context may play myriad but distinct roles, including providing psychological services, forensic evaluation, and consultation. Psychologists also may be asked by the parties to offer expert testimony. For example, psychologists may be referred by the courts to perform evaluations for child custody (APA, 2022b) or child protection (APA, 2013a). Psychologists may be engaged as parenting coordinators (APA, 2012) with high-conflict families with child involvement, or as court-ordered therapists. Psychologists may support patients as they go through these family law proceedings. This may be particularly relevant and important when intimate partner violence/domestic violence (Walker, 2017) is present. Psychologists may become involved as a supportive resource or forensic evaluator in guardianship and conservatorship matters or in cases involving disability determinations (APA, 2022b).

Juvenile Proceedings

The juvenile court system may be distinguished from the adult criminal court system as children may not be treated, with some exceptions, the same as adults. Juvenile cases may have their own set of rules and requirements. Children and adolescents who live in homes where there is abuse may become involved in juvenile court where their parents may be court-ordered into taking certain actions. Young children referred for evaluation for abuse allegations may require special interview techniques to avoid suggestive questioning that may increase errors in their reports. Juveniles in some states may have the right to representation by an attorney of their own, separate from their parents. Psychologists may be positioned to assist patients in understanding these complex rules and requirements. Psychologists may play other roles relevant to professional practice with children and youth (Shapiro & Walker, 2019).

The APA Ethical Principles of Psychologists and Code of Conduct (APA, 2017a) and other relevant guidelines may identify and clarify best practices in record keeping and records information management, including appropriate steps to take for informed consent and records retention, as these may be subpoenaed and/or subject to release in legal proceedings or the public domain. Having a system whereby records are established, maintained, and accessible is an essential component of professional practice. That adults with trauma may find themselves justice- or court-involved highlights the relevance and importance of appropriate record keeping and records information management.

Strong awareness of the implications of multiple roles in professional practice, especially as this relates to clinical and forensic roles, is particularly important in working with adults with PTSD and other traumatic stress disorders. Role conflicts are particularly problematic in the forensic context and may require additional steps to ensure against dual roles and harm. In addition, it may be important to consider the laws, rules, and authorities governing disclosure of clinical material and how disclosing clinical material may vary in clinical and forensic practice. Some states may prohibit working in both clinical and forensic roles in the same case.

Some treatment approaches may interfere with the patient's ability to pursue legal remedies to recover damages. This may include, but is not limited to, use of hypnosis or exposure therapy that may impact the accuracy of the patient's memory of the trauma. Treatment where the goal is to correct the patient's memory of the trauma so it may become less frightening may distort the memory of the actual event or the damage the trauma caused the patient.

At times, a court may order interventions that may not be sufficiently evidence-based or -informed. In these cases, it is important for psychologists to call attention to these concerns and, as needed, identify potential options that align with psychological knowledge and evidence-based practice. Patients themselves may request interventions that may not be evidence-based; further consultation may be helpful in clarifying what may or may not be appropriate.

Application

Depending upon the issues that present themselves, psychologists may need to become familiar with specialized areas within forensic practice. One such area pertains to the evaluation of young children in regard to allegations of sexual abuse. In these cases, it may be important for psychologists to be aware that too many evaluations, poor formatting of questions, and use of certain props have been found to impact the child's memory and recall. This knowledge may inform the way these evaluations are conducted.

Psychologists are mindful that criminal and civil codes may change over time and have implications for the legal questions asked. As such, it may be important to consult with legal counsel to become familiar with these updates and how they may impact data collection and reports.

In some jurisdictions and under federal law, psychologists may be considered part of the legal team. In criminal cases, this may have implications for privacy and confidentiality, as attorney-client privilege may be broader than psychologist-client privilege. In these same cases, under the U.S. Constitution, defendants are considered innocent until otherwise proven guilty and enjoy due process protections including those against self-incrimination. Psychologists strive to be mindful of these important protections and how their reports and testimony may impact due process rights, and steps to be taken in consultation with an attorney to avoid harm or improper disclosure.

Psychologists, along with other professionals, may assume important roles as expert witnesses. Expert testimony is an opinion stated during a trial or deposition by an expert witness on a subject relevant to a civil or criminal court proceeding. Expert witnesses serve as objective parties in the process. Expert witnesses often hold extensive experience or knowledge in a specific field or discipline and educate the court. Expert witness testimony offers a professional option to issues under review or in dispute in a court proceeding.

There are important distinctions between factual and opinion testimony. For example, testimony about diagnosis or a specific treatment plan is usually considered opinion while testimony about dates of service or types of treatment may be considered factual and may not require expert designation by the court. Rules of evidence often specify what information can and cannot be presented in a court case.

A treating psychologist who is asked to testify about their patient's diagnosis, prognosis, and recommendations strives to consult with the patient's lawyer before going to court, and this consultation may be included in billing for services. Preparation for court proceedings may include having a full understanding of the potential questions that may be asked on direct examination and what to expect during cross-examination by another attorney. Attorneys may not regularly prepare psychotherapists to testify and may not distinguish between treating and forensic experts, so it may be helpful for the psychologist to educate the attorney about the differences. For example, a treating expert may educate the court on how a patient's perception of trauma has impacted their life over time whereas a forensic expert may inform the court, through assessments made in response to referral question(s) or in testimony, of how the specific trauma impacted the client at a particular point in time. As an example, in a contested custody case a treating expert may speak to what has been learned through psychotherapy while a forensic expert may use and report on data obtained through the evaluation process.

Psychologists in both areas strive to become familiar with the functioning of the court and the expectations of those who appear before the court. Psychologists aim to anticipate what the court expects and how to manage court appearances and rescheduling (which may arise, for example, at the last minute). Each court will have its own protocols. Basic matters like how to dress, arrival time, where to sit while waiting to be called or heard, use of or prohibitions on cell phones, and files to bring or documents needed are among the considerations that psychologists may want to be aware of.

Further, psychologists may want to clarify the nature of testimony that they are being asked to provide and what may or may not be admissible. Adequate preparation in advance of court proceedings, particularly in complex or contentious cases, may help clarify issues and promote avoidance of harm. In such cases, it may be advisable to consult one's own attorney.

There is a distinction between psychologists who may treat mental and behavioral health issues by providing assessment, counseling, and psychotherapy, and those who may serve in forensic roles and the expectations of each. For example, a treating psychologist may help patients address symptoms and recover from trauma. This psychologist will collaborate with the patient on establishing treatment goals and interventions that intend to help the patient meet those goals. The psychologist may testify and offer opinions on a patient's diagnosis and prognosis as

well as treatment goals over time. By contrast, a psychologist who has been hired as a forensic expert may conduct a psychological assessment and testify to inform "triers of fact" (the judge and/or jury) about PTSD and other psychological impacts from trauma.

Additionally, clinical forensic psychologist experts may testify on how a traumatic event impacted a particular client using clinical assessment tools, such as standard or structured clinical interviews, cognitive, affective and behavioral measures, and specific standardized trauma tests. The same experts may need to adapt these tools, as appropriate, in cases including but not limited to those outside standardization norms. If conflicts arise between the APA's code of conduct (APA, 2017a) and court orders, psychologists may need to consult with legal counsel and the judge. However, ex-parte discussions are almost never permitted without attorneys present even in cases of consultation with the court.

GUIDELINE 6

Forensic Psychologists may choose to assist other professionals in the legal system to help answer legal questions about trauma survivors for which psychology has the knowledge.

Rationale

Forensic psychology is a specialty area informed by the APA's code of conduct (APA, 2017a) and APA guidelines, policies, and procedures relevant to this area of psychology practice. Some rules of evidence vary by jurisdiction and may change over time in different jurisdictions such that consultation with retaining attorneys may be helpful. In court-ordered referrals, forensic psychologists may have the option of refusing a case when they determine they do not have the requisite expertise or competence. There may be procedural guidelines to assist a forensic expert in performing an evaluation about the impact of trauma on an individual's mental health. These guidelines may include the types of data that may need to be examined, other witnesses whose reports may be helpful, and the types of clinical interviews that avoid bias in the evaluation. Understanding how data may be used to assist the judge or triers of fact may be factored into what types of interview techniques and psychological tests are needed.

Expert testimony may be an opinion stated during a trial or deposition by a treating therapist or forensic expert on a subject relevant to a civil or criminal court proceeding. Expert witnesses may serve as objective parties in the process. Expert witnesses usually have extensive experience or knowledge in a specific field or discipline and educate the court and/or the jury. Expert witness testimony offers a professional opinion on issues under review or in dispute in a court proceeding.

There are important distinctions between factual and opinion testimony. Testimony about diagnosis or a specific treatment plan is usually considered opinion while testimony about dates of service or types of treatment may be considered factual and may not require expert designation by the court. Rules of evidence often specify what information may and may not be presented in a court case.

Application

Specialty guidelines for forensic psychology (APA, 2013b) may be a helpful resource in providing guidance to psychologists working in forensic roles. The guidelines apply to psychologists who may provide expertise to judicial, administrative, and educational systems including, but not limited to, examining or treating persons relevant to legal, contractual, administrative, and other proceedings; offering expert opinions about psychological issues in the form of amicus briefs or testimony to judicial, legislative, or administrative bodies; acting in an adjudicative capacity; serving as a trial consultant or otherwise offering expertise to attorneys, courts, or other decisionmakers; conducting research relevant to litigation; or involvement in educational activities of a forensic nature. The APA code of conduct (APA, 2017a) offers a set of principles and standards relevant to psychological practice and applicable to working in forensic and related areas.

Psychologists may play a wide variety of roles in helping the patient cope with the impacts of trauma, or the stress and complexity of civil proceedings and justice involvement. As such, psychologists strive to become knowledgeable in the relevant systems and processes and how trauma may impact or present other barriers to the patient. For example, psychologists may be asked to consult with or obtain information from a patient's attorney. They may be asked questions about subpoenas or asked to provide support to patients who need to testify in court or be deposed. Psychologists may help patients navigate other issues, including how to comply with court orders and the potential penalties of noncompliance.

Trauma Assessment

Overview

Trauma assessment involves consideration of the patient's past and current potentially traumatic experiences (i.e., trauma history) and PTSD and complex PTSD symptoms (i.e., traumatic stress reactions such as intrusive re-experiencing, avoidance of reminders, hyperarousal, dissociation, emotion dysregulation and numbing, detachment from relationships, negative self-perceptions). (Frueh et al., 2012). In addition, assessing the impact of traumatic stress reactions on biopsychosocial functioning (Spinazzola & Briere, 2020) is important, including difficulties in adaptive capacities or development that involve alterations in emotion regulation, information processing, biological self-regulation, and relational engagement (Ford, 2020). Trauma assessment includes looking at how traumatic stress reactions may contribute to or exacerbate comorbid mental health symptoms for patients who meet diagnostic criteria for disorders other than PTSD, as well as those who meet criteria for PTSD/CPTSD.

Research has suggested that over 50% of those people seeking psychological assistance have been exposed to one or more traumatic stressors in their lifetime (Kessler et al., 1995; Wittchen et al., 2009). Some may not remember (or understand the importance of) a traumatic stressor unless specifically asked about such events during assessment and ongoing treatment. Other patients may not be ready to disclose information on traumatic events until a trusting relationship is established. Memory of traumatic incidents, and intensity and frequency of traumatic stress symptomatology, may change over time. Trauma assessment thus should be conducted not only in the initial intake but also throughout therapy using a variety of evidence-supported approaches and methods.

Content Areas for Trauma Assessment

Trauma assessment allows for gathering reliable and valid information, including but not limited to the following (Frueh et al., 2012; Spinazzola & Briere, 2020):

- Past and current exposure to potentially traumatic stressors
- Current and prior history of traumatic stress symptoms that may impact or have implications for health, well-being, and functioning
- Ebb and flow of traumatic stress symptoms across time, developmental periods, and life circumstances
- Interaction of traumatic stress symptoms with other psychological, medical, and/or life problems
- Impact of prevention or treatment intervention on changes in personal risk of further exposure to traumatic events and/or recovery from traumatic stress symptoms
- Impact of sociocultural factors on the nature and impact of traumatic experiences and of traumatic stress reactions

Dissociation is an important component for many who experience severe trauma and psychologists may be able to identify, assess, and treat it. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2022) defines a dissociative subtype of the PTSD diagnosis (Choi et al., 2017; Dorahy & Van der Hart, 2015; Harricharan et al., 2017). Normal and pathological dissociative signs linked with trauma can vary; they are rarely diagnosed quickly (Loewenstein, 2018). People may shut down (Arieli & Ataria, 2018) when faced with inescapable life-threats where active flight or fight defenses are futile, as in childhood (Liotti, 2004; van Dijke et al., 2015). In contrast to active defenses (hyperarousal), passive states (tonic or flaccid immobility) may form a basis for depersonalization, derealization, and other dissociative types (Frewen & Lanius, 2006; Schauer & Elbert, 2010) by disrupting the functional balance and integration of brain networks (Lebois et al., 2021; Scalabrini et al., 2020). Patient experiences vary. For example, dissociative symptoms may be more common among those whose trauma histories began early in childhood, were repeated, and involved betrayal or interpersonal abuse (Zaleski et al., 2016). PTSD patients who differ on dissociative symptoms also may differ on emotional avoidance, interoceptive or body awareness (Brewer et al., 2021), personal space, and other concerns (Cavicchioli et al., 2021; Rabellino et al., 2020). Some highly hypnotizable people may mentally distance themselves from unbearable situations in ways that others cannot (Dell, 2019). Patients with a history of repeated traumas that evoked diverse defensive responses may present with physical comorbidities and more complex issues. Since dissociative or conversion symptoms may be less responsive to talk therapy (Gupta, 2013; Verhaeghe et al., 2007), these symptoms clearly sway recommendations for treatment. Accordingly, asking about and listening for signs of dissociation may be critical when assessing patients reporting histories of trauma.

GUIDELINE 7

Psychologists strive to use multiple sources of data where appropriate, including culturally informed sources, when assessing trauma history, traumatic stress symptoms, and their impact on physical and mental health and psychosocial functioning during initial and ongoing psychological assessment.

Rationale

Individuals may have experienced one or more traumatic events before, as well as while, a psychologist evaluates them. Some also may have experienced historical, intergenerational or community trauma. As such, it is important to ask directly about such experiences and how the patient feels they have been impacted by them. Helping patients define what might constitute a traumatic event may assist patients in understanding the importance of discussing potentially traumatic experiences and symptoms that are trauma related. At times, traumatic stress symptoms may lead to impairment in biopsychosocial functioning in any of several domains (e.g., family and peer relationships, school and work, quality of life, and health).

Traumatic stress symptoms also may co-occur with and contribute to or exacerbate the symptoms of other psychological problems and psychiatric disorders and should be addressed in treatment whether they rise to a level warranting a diagnosis of PTSD/CPTSD or not.

Traumatic stress symptoms are not static and, therefore, may become evident and of clinical concern during the initial assessment or subsequently during the course of psychotherapy. Clinically significant traumatic stress symptoms may surface following asymptomatic periods. Since memories or reminders of traumatic events may be more impactful in patients' lives at different times, consideration of traumatic experiences and traumatic stress reactions is important throughout the course of psychotherapy (Frueh et al., 2012). In addition, the existence, severity, and impairment related to traumatic stress symptoms should be assessed over time in the patient's past and current life, including both when traumatic events were or were not occurring or imminent.

Application

Psychologists strive to obtain a complete assessment of each patient's trauma history, traumatic stress symptoms, and the impact of those symptoms on psychosocial functioning and health, based on a combination of intake screening and collecting social history in an initial evaluation and in ongoing treatment sessions. Psychologists are mindful that self-reporting may bring limitations relevant to accuracy and completeness due to potential subjective and socioculturally based biases and gaps in or constraints on awareness and memory, especially for trauma survivors (Frueh et al., 2012). Trauma assessment may be accomplished through a combination of validated questionnaires and semi-structured clinical interviewing, as well as through other relevant external documentation (e.g., medical, educational, legal, or social services records). A sensitive and thorough trauma assessment is done with careful attention to the patient's level of internal distress. While often not an easy area for patients to discuss, the assessment may be a source of relief and reassurance for many trauma survivors who have not had an opportunity to disclose troubling memories or symptoms in a supportive context and relationship. As such, conducting trauma assessment may enhance the therapeutic relationship by increasing patients' sense of trust and rapport.

When conducting initial and/or ongoing assessments, psychologists strive to inquire about events or experiences in the patient's history that may have been psychologically traumatic and related traumatic stress symptoms that currently are causing or contributing to problems in psychosocial functioning and quality of life. Psychologists endeavor to use empirically supported approaches to the assessment of both trauma history and traumatic stress symptoms (Frueh et al., 2012; Spinazzola & Briere, 2020), while also considering their intersection with patients' developmental status, family, interpersonal, and sociocultural context, and identity characteristics (e.g., race, ethnicity, age, sexual orientation, gender identity, spirituality, socioeconomic status, disabilities, language, nationality, immigration status). Psychologists also may inquire about a patient's family history such as having close relatives who experienced the holocaust or other community or historical racism where appropriate.

Psychologists strive to identify trauma symptoms using empirically supported measures as a guide when evaluating patients' difficulties and on an ongoing periodic basis during treatment (Frueh et al., 2012). When treating disorders other than traumatic stress disorders, psychologists attempt to identify traumatic stress symptoms that co-occur with and contribute to or intensify the symptoms of the other disorders, to identify the need for treatment that addresses the traumatic stress aspects of the symptoms.

During assessment, psychologists may find that traumatic stress symptoms occur in patients who are diagnosed with mood, anxiety, dissociative, psychotic, addictive, disruptive behavior, or other psychiatric disorders (Ford et al., 2021; Gradus et al., 2022). When psychiatric disorders other than PTSD are the focus of assessment or treatment, psychologists strive to identify past or current traumatic experiences that may be contributing to the identified disorders and to assess whether traumatic stress symptoms should be addressed in addition to the focal disorders' symptoms. For example,

with a patient for whom depression and substance use problems are the prominent symptoms, assessment of trauma history and traumatic stress symptoms such as avoidant or hyperarousal reactions or reminders of traumatic experiences may provide an otherwise overlooked opportunity to address the trauma-related aspects of the more evident symptoms in treatment. Another example may be to consider the patient's current setting, such as military service or correctional institution that may exacerbate traumatic stress symptoms. Psychologists are also mindful that serious health conditions, like cancer, diabetes, heart disease, and long COVID, may coexist with and exacerbate trauma responses. Assessment may shed light on these and other co-occurrences.

GUIDELINE 8

In conducting trauma assessment, psychologists strive to practice with cultural competence and sensitivity, including use of appropriate and behaviorally specific terms, language, and cultural idioms, while carefully monitoring patients' internal distress, and providing therapeutic support throughout the process.

Rationale

Traumatic experiences and trauma-related symptoms may occur in cultural contexts that involve a wide range of colloquial definitions or understandings of what constitutes a "traumatic experience" and "traumatic stress reactions" for different communities and populations. Traumatic stress reactions may present as complex biopsychosocial symptoms and/or effects that are not meaningfully explained through Western culture, language, and science (Hinton & Lewis-Fernandez, 2010). Cultural idioms such as attaque de nervios (or spirit possession), for example, may be more representative of how patients from some cultures experience traumatic experiences and trauma-related symptoms than definitions in the DSM-5 or the World Health Organization's International Classification of Diseases, 11th Revision (ICD-11; World Health Organization, 2019; van Duijl et al., 2010). Understanding cultural idioms and their meanings, therefore, is of high importance in trauma assessment.

Application

Psychologists strive to educate themselves regarding cultural terms and expressions that may be relevant and useful to trauma assessment in specific communities and populations and/or to consult with cultural brokers and other professionals as needed. For example, some cultures interpret illness and traumatic events as a test or rite of passage, a message or sign, or even punishment. Cultural differences may present barriers to help-seeking and access to supportive resources outside the cultural community. Culture may add nuance and complexity to the assessment process and impact trust building and communications. Psychologists are mindful of these and other examples and include methods and approaches within the assessment context to gain new insights into these areas and meanings when conducting trauma assessment and consult with cultural experts and brokers to better understand their implications for this assessment.

Psychologists strive to understand the cultural/contextual factors involved in trauma assessment, including the choice of approach and tools (e.g., questionnaires, interview guides) with the increasingly diverse populations that psychologists serve. (APA, 2020; Bolger et al., 2019) Additional steps, including use of interpreters during the testing process, also may be needed and psychologists are encouraged to plan carefully for and consult on these and other issues relevant to culture in trauma assessment.

Experts suggest that PTSD has been observed in Southeast Asian, South American, Middle Eastern, and Native American survivors (Osterman & de Jong, 2007; Wilson & Tang, 2007). Accordingly, psychologists strive to be aware that observation of PTSD may not be the only or best conceptual tool for assessing posttraumatic distress among non-Western individuals (Akerele et al., 2021; Palgi et al., 2021). Psychologists are mindful that trauma-related symptoms in individuals from other cultures may not fit neatly into the DSM-5 or ICD-11 criteria for PTSD and CPTSD. Trauma-related symptoms may include, but are not limited to, somatic and psychological symptoms and beliefs about the nature and source of trauma. Psychologists strive to understand the impact that religious and spiritual beliefs may have on how a survivor experiences trauma and how it may be considered. For example, in societies where attitudes toward karma and the glorification of war veterans are predominant, it may be more difficult for war veterans and their family members to come forward and disclose traumatic experiences and trauma-related symptoms (Brown, 2008a.)

In conducting trauma assessment, psychologists monitor for avoidance and emotional numbing symptoms that characterize PTSD as well as the dysregulation of emotions, consciousness (i.e., dissociation), relationships, bodily functions, and sense of self that constitute complex traumatic stress disorders (Ford, 2020). With careful titration of the intensity of assessment inquiry, clinical discussion, and therapeutic support during and after sessions, trauma assessment may be done with no more than manageable distress and so foster a sense of safety and empowerment for the patient. Psychologists are mindful of the importance of creating an environment where patients feel safe to participate in trauma assessment. For example, psychologists carefully pace and sequence trauma-related assessment questions and discussion, using

language that supports patient decision making and disclosure. Psychologists are mindful to communicate nonjudgmental acceptance, genuine interest, and empathic validation of the patient's perspective and goals, and to maintain a supportive therapeutic relationship in which the patient may openly disclose and productively reflect on traumatic experiences and trauma-related symptoms.

Psychologists strive to learn how patients experience trauma in the context of the intersection of their culture, identity, and life experiences, with the traumatic events and trauma-related symptoms they have experienced. They also aim to learn how their patients understand the nature and cause of symptoms that are of concern to them and may be trauma related. Psychologists endeavor to learn the meaning of cultural idioms that their patients use to describe and explain traumatic events and related symptoms, and factor these into assessment and treatment. In conducting trauma assessment, psychologists also strive to identify and manage their own personal biases and assumptions and seek consultation as needed.

GUIDELINE 9

Psychologists strive to incorporate information from trauma assessment into the development and updating of the treatment plan to provide interventions designed to ameliorate each patient's specific trauma-related symptoms and their impact on the patient's mental and physical health and psychosocial functioning.

Rationale

Trauma assessment provides a context for therapeutic treatment that is sensitive to the adversities that each patient has experienced and that addresses the trauma-related symptoms in the context of the patient's intersectional identities, beliefs, and values. As such, the initial treatment plan should incorporate the patient's trauma history and clinically significant trauma-related symptoms (or exacerbations of other symptoms) in the psychosocial formulation that will guide the treatment. Then, throughout treatment, it is important to continue to assess trauma history and trauma-related symptoms to modify the treatment plan accordingly and provide therapeutic interventions developed to address the full range of traumatic stress symptoms experienced by children (Ford & Courtois, 2013; Landolt et al., 2017) and adults (Ford & Courtois, 2020; Schnyder & Cloitre, 2015).

Application

Psychologists strive to use the results of both initial and ongoing trauma assessment to select empirically supported therapeutic interventions for traumatic stress symptoms and formulate treatment plans that address each patient's unique type and combination of traumatic experiences and traumatic stress symptoms. Psychologists consider sociocultural context, personal identity characteristics, and culture and systems of beliefs and values identified in the overall psychosocial and trauma assessment when deciding which trauma-focused treatments and cultural adaptions of those treatments best match each patient's needs and preferences. As treatment progresses, psychologists adjust the type and approach provided for trauma-related symptoms based upon new information from their ongoing trauma assessment.

Interventions

Overview

Interventions for psychologists working with trauma survivors usually involve psychotherapy that is provided in-person or via telehealth (Morland et al., 2017). Psychopharmacology or other biological interventions (e.g., neurofeedback) also may be used, optimally in conjunction with psychotherapy.

A framework for the treatment of trauma survivors includes: (a) safety (Porges, 2011); (b) respect for each individual, their identity, culture, resources and relationships, life history and circumstances, and strengths; (c) fostering and sustaining a collaborative therapeutic relationship; (d) providing evidence-based treatment that is trauma-focused or trauma-informed; and (e) ensuring that treatment is provided with expertise based upon general and trauma-specific professional training and qualifications, and ongoing supervision and consultation when needed (Courtois et al., 2020).

GUIDELINE 10

Psychologists strive to adhere to the principles of trauma-informed care.

Rationale

Trauma-informed care (TIC) has been defined as involving 4 "Rs" (Butler et al., 2011; SAMHSA, 2014). First, psychologists who provide trauma-informed care realize that the results of clinical research demonstrate that most children and adolescents (Ford et al., 2011; Vibhakar et al., 2019), adults (Gradus et al., 2015; Green et al., 2010; Zhang et al., 2020), and older adults (Rhee et al., 2019) with behavioral health disorders have experienced psychological trauma in their lives, often multiple events or prolonged experiences of traumatic adversity that began in childhood (Ford & Courtois, 2020). Second, trauma-informed care includes careful screening and assessment to recognize and integrate each patient's unique trauma history and trauma-related symptoms into the planning and delivery of treatment (see Guideline 9 above for Trauma Assessment). Third, trauma-informed providers respond with compassion for the suffering that trauma has caused, respect for the patient's strength and resilience in coping with trauma, and therapeutic assistance designed to enhance the patient's safety, empowerment, benevolent life experiences, and support system. Finally, trauma-informed care involves collaboration with the patient to prevent further revictimization, including identifying and taking steps to proactively change or discontinue involvement in risky circumstances, relationships, and behavior patterns. Trauma-informed care also involves intentional awareness and action by the treatment provider to proactively address the impact of secondary traumatic stress, vicarious trauma, and compassion fatigue on their well-being, and ability to provide effective and trauma-informed treatment (Sprang et al., 2019).

Application

Psychologists aim to be knowledgeable about the wide range of potentially traumatic experiences and trauma-related symptoms that may occur in the lives of their patients. They seek to sensitively inquire about trauma history and both acute and chronic traumatic stress reactions in conducting psychosocial screening and assessment (see Guideline 9 above for Trauma Assessment), to recognize the signs and symptoms of traumatic stress reactions in patients and their families, including but not limited to the symptoms of posttraumatic stress disorder (PTSD). Psychologists aim to provide psychotherapy that integrates this knowledge of trauma history and trauma-related symptoms into their therapeutic practices with all patients, including those whose diagnoses and treatment involve disorders other than PTSD as well as patients diagnosed with PTSD. Psychologists also carefully consider potential risks and sources of harm in each patient's current life going forward to collaboratively codevelop steps to prevent retraumatization with each patient. Psychologists strive to consider whether each patient might benefit from intensive trauma-focused therapy and to be sufficiently knowledgeable about what such treatment involves, providing patients for whom it may be beneficial with psychoeducation about it. Psychologists strive to provide trauma-informed psychoeducation that reduces stigma and enhances trauma survivors' resilience and ability to recover from trauma. (Ford, 2020).

When family members (e.g., parents of a child patient) or adjunctive professionals (e.g., interpreters) are included in therapy sessions in which traumatic events or their impact on the client are discussed, psychologists aim

to sensitively debrief those individuals during or after the session to assist them in coping with any secondary traumatic stress reactions they may experience.

Psychologists also strive to advance the integration of trauma-informed care principles into organizational policies and procedures in support of care provision at every level of the organizations or programs in which they work or with which they are associated.

When treating a patient with a known or likely history of trauma, psychologists may consider how the patient's history might lead to a misperception of the therapist's actions. They strive to monitor both their own behavior and patient engagement in the therapeutic dialogue to identify and repair actual or potential breaches in the therapeutic relationship that may impede patient progress in trauma-focused therapy (Eubanks, 2018; Howard et al., 2022). Psychologists also endeavor to communicate to patients that they may choose to stop trauma-focused treatment or change to another approach at any point if they experience adverse reactions that cannot be mitigated with the help of the provider.

GUIDELINE 11

When providing trauma-focused psychotherapy, psychologists strive to facilitate therapeutic trauma memory processing, effective coping with trauma-reminders in daily life, and emotion regulation to support psychosocial functioning and prevent crises.

Rationale

Trauma-related symptoms may involve hypo- and hyperarousal emotions, including but not limited to PTSD (e.g., dissociative hypoarousal). Psychotherapy may involve both intentional (i.e., trauma-focused therapy, e.g., trauma memory processing) or inadvertent (e.g., therapeutic discussion of trauma history or current triggers) challenges that may lead to either (or both) hypoarousal and hyperarousal.

Trauma-focused psychotherapy involves interventions designed to counteract severe hyperarousal (e.g., emotion processing, behavioral activation, cognitive reappraisal) and also to enhance patients' ability to modulate both intense hyperarousal (e.g., relaxation and mindfulness techniques, affect regulation, reflective processing and mentalizing; accessing or developing secure internal attachment working models) and hypoarousal (e.g., somatic and emotion-focused interventions for numbing and dissociative symptoms) (Ford & Courtois, 2013, 2020; Landolt et al., 2017; Schnyder & Cloitre, 2015). Some evidence-based trauma-focused psychotherapy models engage patients in therapeutic processing of trauma-related memories both imaginally and in vivo (Ford, 2018) and trauma-related behavior problems (Briere, 2019).

Application

Psychologists who conduct trauma-focused psychotherapy strive to obtain and maintain education and training relevant to conducting evidence-informed approaches to trauma memory processing (Schnyder & Cloitre, 2015; Ford, 2018; Landolt et al., 2017) and trauma-focused therapy that does not require memory processing (Ford, 2017; Ford & Courtois, 2013; 2020). Psychologists aim to be knowledgeable of the many ways in which trauma memory processing may be accomplished in trauma-focused psychotherapy (Ford, 2018), and that this permits flexible individualization based on clinician judgment and expertise, and patient preferences and response to interventions (Hanley et al., 2019; Schiller et al., 2010). Psychologists strive to understand that trauma memory processing may offer a mechanism for patients to approach safely and intentionally rather than avoid, to make meaning self-reflectively of traumatic experiences, and to reconsolidate trauma memories as organized and meaningful parts of their autobiographical memories and life narrative (Ford, 2018; Hyland et al., 2022). Psychologists also understand that trauma memory processing may provide trauma survivors with opportunities to gain a sense of empowerment by formulating personal statements or testimonies based on core values and affirmation of their worth as a person (Harvey, 1996; Litz et al., 2009; Nixon et al., 2021).

Psychologists strive to deliver trauma-focused psychotherapy with evidence-based and psychologically supported interventions in a way that provides patients with choices about the nature, sequencing, timing, intensity, and format of intervention, while also maintaining the integrity and structure of evidence-based intervention protocols and practices. When a trauma-focused intervention has preset requirements about its delivery (i.e., one that cannot be modified without violating the intervention's core processes or mechanisms), psychologists endeavor to review these requirements and the rationale for them with the patient in advance. Psychologists aim to assist patients in pacing, pausing, or stopping their participation in trauma-focused therapy interventions at any point if they experience adverse reactions that cannot be mitigated with the help of the provider. When patients decline to receive a therapeutic intervention (or decide to stop at any point in its conduct), psychologists endeavor to suggest alternatives that either they can provide or via referral to another qualified professional, or from resources of the patient's choice (such as Indigenous healers, peer mentors, or social or faith-based services).

When providing trauma-focused psychotherapy, psychologists strive to consider the full range of traumatic stress reactions, including but not limited to PTSD and its symptoms, especially when a patient has experienced multiple or prolonged

interpersonal traumatic stressors (e.g., abuse, violence) (Ford & Courtois, 2013, 2020). Psychologists are mindful to ask about injuries, physical symptoms, and social/relational issues that may connect to histories of trauma and strive to develop interventions or assist the patient in gaining access to health care or other services that may mitigate the distress or impairment caused by these problems (Choi et al., 2018; Ko et al., 2008).

When conducting trauma-focused psychotherapy, psychologists strive to monitor and assist patients in staying within a window of emotional and physiological activation that is tolerable and does not exacerbate symptoms. Psychologists may find it helpful to consider each patient's traumatic experiences that have elicited extreme states of arousal, and in the context of the patient's historical and current difficulties in modulating states of both hypoarousal and hyperarousal. Psychologists conducting trauma-focused therapy aim to monitor potential safety risks on an ongoing basis, with heightened vigilance when patients with trauma histories experience current events or contexts that may evoke or exacerbate trauma-related symptoms. Psychologists may intervene to restore or enhance patient present-orientation, relational security, and self-awareness to assist trauma survivors to recognize early warning signs and trauma-related triggers and help them develop grounding, self-awareness, and executive function skills to enhance their ability to recover from these states (Fisher, 2020; Ogden, 2020; Rothschild, 2021).

When conducting trauma-focused therapy, psychologists also strive to monitor and address self-harm, behavior that endangers self or others, victimizing relationships or circumstances, and extreme forms of self-dysregulation (e.g., impulsivity, aggressiveness) (Dyer et al., 2009; Hyland et al., 2022). Psychologists aim to assist patients in anticipating early warning signs of crises or dysregulation that involve reminders of traumatic events and to develop strategies for avoiding, distracting from, or otherwise managing these cues. A comprehensive safety plan may be developed in collaboration between therapist and patient. Psychologists may seek specialized training or supervision before initiating trauma-focused interventions with patients, or may refer out for specialized care, when treating patients experiencing severe recurrent trauma-related crises.

Psychologists conducting trauma-focused psychotherapy strive to consider primum non nocere (first, do no harm) in accordance with the APA Ethical Principles of Psychologists and Code of Conduct. Psychologists are especially mindful that multiple relationships may harm patients and may replicate previous abusive or exploitative relationships. Psychologists also strive to recognize that the blurring of personal and professional boundaries, coercive therapeutic actions or requirements, or other actions may trigger trauma-related distress. Psychologists aim to reflect on and seek consultation or supervision when concerned about actions on their own part that might lead to actual or perceived boundary violations, coercion, or exploitation, including countertransference and secondary traumatic stress reactions. (Courtois, 2020; Courtois et al., 2020).

GUIDELINE 12

Psychologists strive to understand the relevance and use of psychopharmacology and other biological agents for trauma-related symptoms and disorders.

Rationale

The use of psychopharmacological and other biological interventions together with psychotherapy has become an important addition to psychology practice (Greenway et al., 2020). Specialized training has been developed for those psychologists who seek prescribing privileges. In the context of trauma-informed care and trauma-focused therapy, psychopharmacology may be helpful to provide symptom relief and assist in trauma memory processing (Hoskins et al., 2021a, 2021b). Biologic agents may be selected to target symptoms that are causing distress and impairment, including symptoms of comorbid disorders (e.g., anxiety, dysphoria, mood instability, impulsiveness, psychosis) when these overlap with or exacerbate trauma-related symptoms. In addition, patient preferences may play an important role in the decision to provide psychopharmacological or biological interventions in the treatment of trauma-related symptoms (Zoellner et al., 2019).

Treatment with other body-focused interventions, such as exercise, manual or movement therapies (Cristobal, 2018; Leitan & Murray, 2014; Price & Hooven, 2018), neurofeedback (Fisher et al., 2016; Gerge, 2020; van der Kolk et al., 2016), acupuncture, transcranial magnetic stimulation (rTMS) (Bisson et al., 2020), and tai chi and qigong (Osypiuk et al., 2018) or yoga (Francis & Beemer, 2019; Sullivan et al., 2018) may be useful, in addition to or as adjuncts to trauma-focused therapy (Smith & Ford, 2020; Tedesco et al., 2021; Varker et al., 2021).

Application

Psychologists strive to become familiar with psychopharmacological and biological treatment approaches and the relevant evidence base to be knowledgeable of (a) the empirically supported pharmacological or biological interventions or agents for trauma-related symptoms; (b) the specific symptoms each may treat; (c) the rationale for its use and potential options; (d) how and why it can be discontinued; (e) the benefits and risks; (f) duration of use; (g) contraindications and drug interactions; (h) risks associated with sudden discontinuation; (i) the labs

and physicals needed for monitoring therapeutic levels; (j) the psychologist's role and the importance of the therapeutic relationship in its provision; (k) questions or concerns patients may have; (l) uses as a supportive measure in psychotherapy; and (m) medication/procedure adherence and compliance issues. Collaborating with prescribers may be helpful in understanding the impact medication may have on the therapeutic process. For example, the use of benzodiazepines may interfere with some interventions such as exposure-based treatments.

GUIDELINE 13

Psychologists strive to integrate principles of trauma-informed care when telehealth platforms are used as a mode of service delivery.

Rationale

Telepsychology may be helpful in areas facing a shortage of skilled providers (Morland et al., 2017). This is particularly seen in natural or other disasters (Morland et al., 2017), including the COVID-19 pandemic (Hellstern et al., 2023). Additionally, rural communities facing a shortage of mental health providers, especially with expertise in the treatment of PTSD and trauma, may find additional benefit from the expanded use of telepsychology to meet the demand for services (Gonzalez & Brossart, 2015). Access to culturally competent providers also may be enhanced using telepsychology.

While issues related to privacy, security, and confidentiality are relevant to the practice of telepsychology generally (APA, 2024; American Telemedicine Association, 2014; Turvey et al., 2013), trauma-informed or trauma-focused telepsychology may be preferable for patients because receiving care in the privacy of their own homes may increase safety, reduce barriers related to stigma and fear of the negative impact of others knowing they are in therapy, and provide an alternative for those who avoid driving or using public transportation due to trauma-related symptoms (Morland et al., 2017; Kuhn et al., 2010). In addition, if perpetrators of interpersonal trauma also live locally or many community members experience a shared trauma (e.g., mass disaster or violence), telepsychology may facilitate engagement in treatment by increasing privacy and offering access to providers outside of the immediate community (Gamble et al., 2015; Simpson & Reid, 2014).

However, there may be barriers to telepsychology related to adequate space, privacy, and sound protection. Furthermore, patients may face challenges related to skillful communication with others in their household about boundaries to minimize interruptions and receiving assistance with household responsibilities, like care for others in the home while in session. In addition, telecommunication technologies may pose threats to security and transmission of information that may carry greater weight given the possible sensitive nature of in-session conversations about trauma (APA, 2024).

Some patients may experience discomfort with telecommunication and using unfamiliar technological platforms may exacerbate distress already present and lead to undue confusion and anxiety (Murphy & Pomerantz, 2016). Distress may be exacerbated by technical difficulties and patients may experience guardedness and suspiciousness in using this type of platform that could impact progress (Simpson & Reid, 2014; Backhaus et al., 2012). Although telepsychology may allow for the development of a strong therapeutic alliance even in the face of ongoing exposure to trauma (Wagner et al., 2012), differences in engagement have been noted. For example, telepsychology visits have been observed to have less small talk and socialization (Bulik, 2008), which for some patients may be an important part of developing rapport and establishing a sense of safety and comfort before launching into more sensitive trauma-related material. In addition, social and nonverbal cues may be difficult to assess over telepsychology (Romani and Schieltz, 2017) both for the clinician and the patient, which can interfere with therapeutic attunement, social connection, and a deepening of the therapeutic relationship, aspects of treatment that are particularly relevant in work with trauma survivors. Finally, telepsychology may create therapist-client relational boundary issues not relevant to face-to-face encounters (Drum & Littleton, 2014) that may require additional sensitivity (Herman, 1998) and additional conversations.

In addition to psychotherapy via telehealth, mobile apps may provide self-help, education, and support for trauma survivors. While apps are not intended to replace needed professional services in most cases, they may help address a variety of issues associated with barriers to care (Morland et al., 2017). In addition, apps may be downloaded at minimal or no cost and used in vivo when they are needed (Owen et al., 2018). Some trauma-specific apps are designed to be used independently or as an adjunct or extender of traditional care (Owen et al., 2018); these apps may be more focused on providing psychoeducation, support, and guidance relevant to living with PTSD. These types of apps also may support individuals who do not yet have sufficient motivation to talk with a psychologist (Morland et al., 2017) or for whom psychological providers may not be readily available. Other trauma-related apps are treatment companion apps that may be intended to be integrated into existing treatment and used with the assistance of a health care provider. There are also a variety of apps that are not necessarily trauma-specific yet may assist with challenges common to people who have experienced psychological trauma.

Application

Psychologists conducting trauma-informed or trauma-focused psychotherapy strive to identify issues of accessibility and privacy in order to inform decisions on the use of telepsychology. Psychologists seek to remain sensitive to trauma survivors' concerns around telepsychology and to modify approaches as needed. Psychologists also make efforts to determine the type of telecommunication technology best suited for each patient, including but not limited to online and mobile apps, as guided by the scientific literature (Norwood et al., 2018). For example, software that aids in closed captioning may be helpful for patients with hearing impairments or when video quality is not optimal.

When conducting trauma-focused therapy via telehealth, psychologists strive to inquire sensitively about patients' concerns regarding privacy and confidentiality related to limitations of the security of the internet platform/server, access to the psychologist or other sources of help in the event of experiencing trauma-related distress or impairment during or outside of therapy sessions, and any other potential fear or anticipated problem of concern to the patient related to addressing trauma memories and trauma-related symptoms by telehealth. Psychologists strive to collaboratively develop a safety plan and/or therapeutic contract (Courtois et al., 2020) at the outset of treatment that specifically addresses potential trauma-related risks or problems associated with conducting the treatment by telehealth, and to revisit and reinforce the plan/contract periodically over time.

Psychologists are mindful that medical trauma (or trauma perpetrated by a provider or authority figure) may lead patients to be unwilling or unable to attend in-person appointments (Morland et al., 2017). Psychologists strive to provide telehealth services to those for whom medical conditions or trauma, or betrayal trauma by health care providers, result in them being unwilling or unable to meet in person. Psychologists also strive to understand that veterans and military service members, in particular, may find that driving to appointments may activate memories of deployment and trauma-related symptoms, and to provide these patients with trauma-informed telepsychology.

Psychologists strive to familiarize themselves with mobile apps for trauma-informed or trauma-focused psychoeducation and treatment, and relevant research, and to use this information to make decisions about recommending their use or integrating them into clinical care.

Psychologists seek education, training, and professional development opportunities on ways to use telehealth and mobile apps safely and effectively when providing trauma-informed or trauma-focused treatment.

Equity and Historical/Intergenerational Trauma

While access and equity issues and dynamics are raised throughout this guidelines document, this section focuses on select areas of timely importance as trauma practice evolves. One of the most important emerging areas is the impact of historical and intergenerational trauma on both the individual and their community's health and mental health. Among the highlighted issues include racial trauma, sexual harassment of women, immigration status, health disparities and identities/intersectionality, and equity issues relevant to the global pandemic and its aftermath. While highlighting these issues and topics is intended to increase awareness and understanding of the impact of trauma, on marginalized populations and communities, it is important to note that coverage of these topics is not meant to be exhaustive. Rather, the aim is to support efforts by psychologists to seek further training and education in these areas and to remain abreast of new topics, issues, and developments as they relate to and surface in trauma practice. Indeed, while there are many more topics that pertain to equity and trauma to consider, these areas afford an opportunity to examine issues that are representative of challenges and opportunities in trauma practice.

Exposure to trauma and its sequelae is not distributed randomly or equitably. Data suggests multiple ways in which social and economic marginalization may increase risk for exposure to traumas and their potential sequelae. Furthermore, unequal access to resources and power disparities may make it more difficult for some to access quality care, therefore deepening these disparities (Magruder et al., 2017). Further, many communities carry with them historical and intergenerational memories of earlier trauma compounding their current experiences (Bryant-Davis, 2019; Comas-Díaz, 2007; Felsen, 2020). Therefore, it is important to understand the social determinants and the context of trauma.

Research suggests that individuals from low-income and marginalized communities may face negative health outcomes, and that the social determinants of health, including neighborhood and physical environment, may not be sufficiently factored into evaluation, diagnosis, or health care provision (Romano et al., 2021). Factoring these insights into working with adults with traumatic stress disorders may be beneficial as psychologists strive to advance health, well-being, and recovery in these individuals and patient populations.

The context, then, in which trauma occurs, as well as survivor's identities and group memberships, not only influences trauma exposure but also survivors' experiences of, responses to, and recovery from traumatic stress (Brown, 2008b; Bryant-Davis, 2019; Comas-Díaz et al., 2019). In addition, a multitude of adverse mental and physical health effects are associated with "minority stress" and can increase vulnerability to the effects of trauma (Kendall-Tackett & Klest, 2013). Negative institutional or systemic

responses to trauma (e.g., disbelief, victim blaming, minimization, minimal or nonexistent consequences for perpetrators) may also disproportionately impact those in marginalized communities and further exacerbate trauma sequelae (Brown, 2008a). Heightened exposure to discrimination, harassment, and structural inequality may act as a form of traumatic stress and impact recovery. For example, survivors may feel targeted by perpetrators due to some aspect of identity, or experience discrimination as part of their trauma (e.g., racialized sexual harassment and sexualized racial harassment, homophobic or transphobic remarks made during physical or sexual abuse). Access to effective social support in the aftermath of trauma also may be limited.

GUIDELINE 14

Psychologists strive to address the physical and emotional harm and impacts associated with barriers to timely, quality health care and include cultural considerations that may optimize compliance with health care directives and protocols to avoid exacerbating health disparities and create conditions for further trauma

Rationale

Research suggests that in addition to physical or sexual abuse, psychological trauma also may impact both short- and long-term physical health and health outcomes. The U.S. health care system is only beginning to grasp the role trauma plays in chronic disease, how inequities compound these issues, and the importance of promoting healing versus symptomatic control. (APA, 2022a). Psychology has much to contribute to this research, knowledge development, and understanding, including what insights may be shared from professional practice and outcomes measurement.

There is growing appreciation that culture may impact patient compliance with medical directives, treatment planning, and adherence to medication as prescribed. Understanding these impacts, including ways that providers may provide safe spaces for discussion and remove barriers to care would be beneficial in advancing the health and wellbeing of trauma patients.

Racism at every level permeates the landscape of education in the United States, from housing and policies that determine where children are zoned to attend school in prekindergarten through postsecondary and lifelong learning, to the detriment of the academic achievement, self-concept, persistence, and success of students of color (Baumgartner & Johnson-Bailey, 2010; Burt et al., 2018; Sosina & Weathers, 2019; Voight et al., 2015; Wong et al., 2003). Traumatic incidents in educational and school settings, including but not limited to bullying, bigotry, bias, and discrimination, are known to occur frequently in settings where other difficult social conditions also exist, such as deep poverty (Davis & Williams, 2020), high levels of alcohol and substance use, and high rates of juvenile delinquency and family justice-involvement. Lack of access to trauma-related treatment and services may combine to deepen these social conditions.

Psychologists strive to actively engage in antiracist efforts to address the causes and effects of all levels of racism in the education system. Advocacy for changes to policies and procedures that contribute to racist practices and outcomes, engagement in antiracist practice through an intersectional lens, development of preventive and intervention efforts to promote racial justice, and promotion of racial justice through scholarly research, education and training, practice, and advocacy may be among the important steps in understanding structural and systemic racism and mitigating the conditions that drive trauma. Moreover, because racism may be in criminal justice, employment, housing, health care, and education, support for efforts and programs to address these issues may create more effective strategies for addressing health disparities and trauma (APA, 2021b).

Understanding that COVID-19 arose in a sociocultural context and involves a range of mental as well as physical symptoms (Dedoncker et al., 2021; Leung et al., 2022) suggests this may be a new type of trauma (infection and economic fears, grief, and lockdown stresses) (Kira et al., 2021a, 2021b) that entails biopsychosocial processes (Kop, 2021). Broadening the conception of PTSD as the single, primary construct for trauma-related disorders (DiMauro et al., 2014) may result in expanding what experts consider trauma-related issues.

As the pandemic wore on, a new "long COVID" diagnosis emerged (Barker et al., 2022; Byrne, 2022). The protracted symptoms of this emerging disorder are thought primarily to affect women and those with childhood or other prior chronic trauma histories (Poyraz et al., 2021; Yuan et al., 2021); these symptoms resemble medically unexplained, functional somatic, and postviral or postinfection syndromes or disorders such as chronic fatigue, fibromyalgia, and chronic pain (Afari et al., 2014; Barker et al., 2022; Calabria et al., 2022). A detailed neurological examination of 12 individuals diagnosed with long COVID reported signs of immune dysregulation or exhaustion as well as autonomic issues (Mina et al., 2023). These prolonged symptoms are reminiscent of historic issues such as irritable heart (Mackenzie, 1920) or railway spine (Harrington, 2003), as well as psychosomatic or functional somatic disorders (Calsius, 2020; Dedoncker et al., 2021; Salamanna et al., 2021; Slavich & Irwin, 2014) that arise when infection or physical injury is experienced in conjunction with intense fear causing trauma reactions.

Application

Psychologists are mindful of the harm and impacts of health inequities, including access to timely, quality care, and may screen and assess accordingly. In working with adults with traumatic stress disorders, understanding risk factors and impacts may result in better outcomes, including lifestyle changes that minimize risk of further disease. At the same time, psychologists are aware that these and other interventions may be limited by economic and social barriers, including but not limited to food insecurity, affordable transportation, housing and shelter issues, age, ability, and employment status.

Psychologists strive to appreciate the health equity issues that diverse populations have experienced during and after the recent pandemic. Psychologists may appreciate that among the most vulnerable are older adults, people of color, those with disabilities, and those with low incomes. Barriers to timely, quality care may mean that these individuals may not recover at the same rate as others and may need enhanced support and services.

Psychologists are mindful that their actions with individual patients, patient populations, and communities may be more impactful as they connect with other providers and systems leaders on these issues. Psychologists may want to consider their role in advocacy and the importance of taking a population approach to address health disparities, trauma, and barriers to timely and quality care. (APA, 2022a).

Psychologists may need to intervene when trauma survivors experience difficulty with medication adherence, treatment plan compliance, or following other steps and directives from health providers. While there are many reasons for this, culture may be a contributing factor to these challenges as are trauma symptoms that may be triggered in these processes. Understanding these cultural and trauma-related dynamics is essential to advancing health access, equity, and quality care (Ford et al., 2015).

Data suggests that racial/ethnic minorities are more likely to acquire, have complications from, and die from COVID-19 (Krieger, 2021b). This higher risk may be attributed to several factors, including the disproportionate share of people of color in "essential" jobs—as discussed above—and the higher rate of chronic health conditions in these populations, which are complex in origin but are powerfully shaped by social, economic, environmental, and behavioral factors. Psychologists strive to understand these dynamics and integrate them into treatment planning and care delivery.

Among these considerations may be structural factors and everyday experiences rooted in racism and discrimination. Mask wearing, for example, may have become common place and acceptable in many areas during COVID-19, whereas in high-crime areas this public health practice may have been interpreted as a means to shield identity and potential criminal conduct. Psychologists strive to understand these equity issues, and otherwise integrate sociocultural realities into treatment planning and care delivery (APA, 2022a).

Psychologists seek to understand systemic and structural barriers that may give rise to school environments that promote trauma and health disparities. Psychologists are mindful that professional roles may determine this interface with the schools. For example, school psychologists may work with the administration as well as with identified children and adolescents and their families. Clinical psychologists may provide services to individuals, families, and groups external to the school settings. In all cases, psychologists attempt to integrate their knowledge of structural racism into their assessment and treatment plans, including reducing barriers as much as possible. For example, school psychologists may engage in preventive activities, such as programming and other outreach, that serve to address bullying and other traumatic behavior. Other psychologists may engage in program development and evaluation relevant to social media impacts, alcohol and substance use, and bullying. Psychologists at college and university counseling centers may be able to assist Jewish students who are exposed to traumatic antisemitism.

Psychologists may assist patients with aspects of many long-term and chronic disorders such as trauma-related cultural, emotional, psychosocial, relational, and somatic issues; this broader definition of "trauma-related" recognizes bidirectional and strongly comorbid relationships between emotional and physical disorders (Jiang et al., 2019; Momen et al., 2020; Scott et al., 2016; Taquet et al., 2021), and points to a need to expand the types of approaches used in treating this wider range of relevant issues (Hayes et al., 2020; Kuhfuß et al., 2021; van Bavel et al., 2020).

GUIDELINE 15

Psychologists strive to understand the influence of racial, ethnic, and cultural factors on trauma and recovery, including the role of racist incidents and systemic oppression as forms of traumatic stress (e.g., race-based trauma, collective or historical trauma, etc.), and strive to respond and intervene in ways that do not contribute to systemically racist forms of oppression, discrimination, and cultural insensitivity.

Rationale

Psychologists try to recognize the various traumatizing influences of systemic oppression in all its forms, and the many ways consequences of marginalization hurt people who, as members of a cer-

tain group, face the unsafe and disempowering unfairness of discrimination.

The overarching context in which trauma occurs, as well as survivor's race, ethnicity, cultural identities, and group memberships, not only influence exposure to trauma and other stressors, like discrimination and violence, but also survivors' experiences of, responses to, and recovery from traumatic stress. Trauma survivors hold multiple identities simultaneously that may influence conceptualizations of trauma, coping, therapeutic interventions, and the recovery process (Brown, 2008a). Intersectionality refers to the way in which members of multiple marginalized groups experience not only their identity, but also systemic forms of discrimination and oppression, in ways that are qualitatively different than the experience of trauma survivors from dominant race and cultural groups (Crenshaw, 2005). These cultural aspects of identity include but are not limited to age, developmental and acquired disability status, religion, race, ethnicity, socioeconomic status, sexual orientation, national origin and language, and gender identity (Hays, 1996, 2008).

Overt forms of racism may involve verbal or physical attacks, threats to livelihood, social avoidance, harassment, discrimination, and/or exclusion (Brondolo et al., 2009; Bryant-Davis & Ocampo, 2005) and may have significant detrimental psychological impacts (Hemming & Evans, 2018). The impact of covert acts of racism, such as microaggressions, are also extremely negative. Microaggressions are the result of stereotypes and implicit biases held by others that may be intentional or unintentional (Blume et al., 2012; Sue et al., 2007). In addition to the immediate distress that microaggressions may cause, the cumulative effects of these experiences is extremely harmful (Nadal et al., 2014; Rivera et al., 2010; Sue, 2010; Sue et al., 2008) and has been described as death by a thousand papercuts (Nadal et al., 2011).

In sum, the impact of both overt and covert racism, including multigenerational racial trauma, is profound. Racism, which presents at the interpersonal, group, and systemic levels, may have detrimental impacts as highlighted in the nation and worldwide. Most recently, these detrimental effects have been illuminated by the disproportionate rates of COVID-19 among BIPOC that are attributable to social disparities (Gold et al., 2020; Moore et al., 2020; Romano et al., 2020; Rossen et al., 2020), and protests on police brutality against Black lives. Despite the impact of trauma, the impact of overt and covert racism has received insufficient attention to date in terms of assessment and treatment in clinical settings (Bryant-Davis & Ocampo, 2006). Further research is needed to advance our understanding of the potential trauma of racism and the most effective ways to help people recover from its effects. The guidelines that follow are rooted in currently available information and intended to serve as a framework as the field evolves.

Bryant-Davis (2019) describes the profound influence of racism, sexism, heterosexism, and classism on the trauma recovery process, and highlights forms of oppression that have been relatively under-attended to, including religious intolerance and able-bodyism. Collectively, the multitude of adverse mental and physical health effects and increased risk of stress exposures associated with minoritized group membership are termed "minority stress" (Meyer, 2003). Negative institutional or systemic responses to trauma survivors (e.g., disbelief, victim-blaming, minimization, minimal or nonexistent consequences for perpetrators) also may disproportionately affect those in minoritized communities and further exacerbate trauma sequelae. Moreover, survivors may feel targeted by perpetrators due to some aspect of identity, or even experience discrimination as part of their trauma (e.g., racialized sexual harassment and sexualized racial harassment, homophobic or transphobic remarks made during physical or sexual abuse).

Cultural differences between client and therapist also may affect the therapeutic relationship and process, thereby influencing outcomes. Dynamics related to differences in power and privilege also may be particularly salient if the therapist is the same race as the trauma perpetrator, or the same race as someone who responded harmfully when trauma was disclosed.

Race-based trauma is a term that has emerged to reflect the emotional, psychological, and physical reactions to experiences of harassment and discrimination that cause extreme distress and pain and may lead to a negative impact on individuals and communities. (Carter, 2007; Bryant-Davis & Ocampo, 2005; Karumanchery, 2003; Evans et al., 2016, Sanchez-Hucles, 2005). Race-based trauma may be distinguished from other traumas in that the person is not targeted randomly, but rather due to their race, a central part of identity that is beyond an individual's control. The incidences also occur within the contexts of biases, stereotypes, and stigma aimed at one's racial group that can further exacerbate their impact (Craig-Henderson & Sloan, 2003).

Another form of trauma potentially relevant to BIPOC is collective trauma. Due to shared identity characteristic/group membership, trauma that occurs to an individual or subset of individuals within a group may be experienced as a collective trauma. Thus, collective trauma often involves a shared feeling of being subjected to horrendous events that leave negative marks on a group's consciousness, even in the absence of fear (Gorman-Smith & Tolan, 1998). It may be felt by individuals, groups, and both within and across generations. For instance, the American Psychological Association's (2018) 12th annual Stress in America TM Survey found that Generation Z was overwhelmed by fears that have accumulated over centuries. These transgenerational impacts are often referred to as "historical trauma," a type of trauma that may lead to a distrust of systems and perpetuate stigma and fear in accessing health and mental health services (Kirmayer et al., 2014).

Research suggests that when there is a lack of racial, ethnic, and cultural understanding by the mental health community, current and historical patterns of pathologizing behaviors that are culturally normative often exist. Additionally, traditional healing practices and culturally relevant treatment options have often been in large part ignored by health care providers and systems. These forms of invalidation have further distanced communities from help-seeking, understandably creating fears and concerns of stigmatizing and overly pathologizing responses and of their entire personhood not being considered in therapy, thereby not receiving the support that they need or being taken seriously.

Given the prevalence of race-based trauma and health disparities, including barriers to access and quality care, the need to identify new and innovative ways is particularly timely and pressing. One of the more promising approaches to reducing disparities in health care settings is termed "patient navigation" (Phillips et al., 2018). Cultural navigators and cultural brokers may become involved in bridging, linking, and navigating between and among racial, ethnic, cultural, and other intersectional groups to promote change.

Application

Psychologists are mindful to ask about racial identity and intersectionality in a comprehensive, multidimensional, and explicit way, rather than making assumptions about group membership. The survivor's current familial, interpersonal, sociocultural, and political contexts, as well as those in which the trauma occurred, also may be assessed. The ways in which these contexts and identities have influenced the survivors' experience of and recovery from trauma also may inform evaluation. Psychologists strive to approach these conversations with sensitivity and curiosity, openly acknowledging any areas of unfamiliarity and striving to educate themselves regarding the racial and cultural backgrounds of their clients, including historical trauma and losses. Psychologists strive to maintain awareness of gaps in their knowledge, skills, and competence that may interfere with the therapeutic process and seek additional consultation when needed.

In addition to developing competency in assessing nuances of culture, identity, and sociopolitical context as they relate to trauma exposure, response, and recovery, psychologists strive to learn about the complexities of each individual client's racial and cultural background and identities. These efforts may involve the review of relevant books and articles, seeking out workshops and other forms of continuing education, working with interpreters, and consulting with cultural brokers and other professionals with expertise in working with specific cultural identities and communities. While such learning may be an important foundation, psychologists strive to clarify the extent to which various cultural beliefs, traditions, and practices may apply to a given client to refrain from being guided by biases and assumptions. In addition, the Cultural Formulation Interview and its Supplementary Modules to the Core Cultural Formulation Interview (American Psychiatric Association, 2013a), while not specific to trauma, may be a useful resource in exploring the influences of various aspects of identity as well as racial and cultural beliefs about trauma, coping and help-seeking.

Within a framework of cultural humility (Harvey & Tammala-Nara, 2007), psychologists strive to explore their own racial identity and maintain awareness of their forms of privilege. They may actively monitor their biases as well as the extent to which they may be unintentionally replicating some of the systemic or institutional dynamics, oppressions, and/or betrayals that contributed to the survivor's traumatic experiences (e.g., not believing a survivor, negative judgments about trauma responses). This active, ongoing assessment informs needed changes to the therapeutic process and/or treatment plan, as well as interpersonal repairs. Psychologists also may invite and remain open to survivors' feedback about gaps in understanding related to identity and unhelpful patient-provider dynamics. Honest discussions about differences between psychologists and clients in terms of cultural identities and privilege may be thoughtfully considered and integrated when needed. Naming dynamics that could impact the recovery process (e.g., therapist is the same race as the perpetrator of trauma and/or someone who negatively reacted to trauma disclosure) may be especially important (Bryant-Davis & Ocampo, 2004).

In general, psychologists strive to uphold an ethnopolitical approach that recognizes the important impact of oppression, racism, and political repression (Comas-Díaz, 2000). Thus, as part of their standard intake process, psychologists seek to ask questions related to the potential impact of systemic racism, collective trauma, and historical trauma for all clients, not just those who present with these stressors or who identify as members of a particular racial or ethnic group. Because many BIPOC may have become habituated to experiences of racism, given their ongoing nature, the connections between these experiences and mental health distress may not be immediately obvious. Therefore, using behavioral descriptors to share examples of systemic racism and oppression, race-based, historical, and collective trauma may be important, as is ongoing assessment throughout the therapeutic process. Seeking relevant training and education in effective ways of acknowledging race-based trauma also may be helpful for the practitioner (Bryant-Davis & Ocampo, 2006; Carter, 2007; Carter & Sant-Barket, 2015; Sue & Sue, 2003).

Given the risk of "secondary victimization" in response to disclosure or instances of racism and/or oppression, psychologists strive to respond with validation, competence, and compassion (Bryant-Davis & Ocampo, 2005), all under the umbrella of an "antiracist stance" (Bryant-Davis & Ocampo, 2006). While provision of practical

resources may be warranted (e.g., legal counsel to consider options regarding discrimination in the workplace), such resources do not help process the trauma or develop strategies for coping with ongoing racism (Bryant-Davis & Ocampo, 2004). Thus, specific treatment of race-based trauma may involve the following themes: acknowledge what happened; allow the act of disclosure; determine current level of safety; grief and mourn the losses associated with the racist incident or incidences; address shame, self-blame, internalized racism, and anger as part of the recovery process and be encouraged to express it in healthy ways; learn to cope and manage the distress; and be involved in resistance strategies that may involve social activism (Bryant-Davis & Ocampo, 2006; Hardy, 2013).

Psychologists seek to learn about various culturally normative practices for different groups, including traditional healing from books, documentaries, social media, and other resources recommended by those who are culturally knowledgeable, competent, and aware. Psychologists also may want to consult with others within a particular cultural community. For example, psychologists may find sensitivity groups addressing cultural issues helpful and informing about different cultural aspects and practices.

Psychologists strive to identify and collaborate with patient navigators and cultural brokers to assist in responding in culturally competent ways in health care settings. Psychologists may work collaboratively with the cultural brokers or patient navigators, mindful that positive patient outcomes are optimized when the cultural broker or navigator and clinician work as a team (Singh et al., 1999). Psychologists also may consult with cultural brokers or patient navigators to consider racial and culturally centered interventions or other traditional healing practices that align with the patient's cultural values and methods of healing. Psychologists strive to identify and provide opportunities to train communities that may lack mental health providers, or communities where the primary sources of support may be nonmental health professionals, to help increase access to mental health support and equip communities to intervene with basic helping skills and knowledge of resources and referrals.

GUIDELINE 16

Psychologists strive to learn about the unique dynamics involved in sexual harassment especially in certain workplace settings, including the military, law enforcement, and other male-dominated occupations, and how such trauma interacts with the broader context of societal messages, including other forms of interpersonal violence, sexism, and racism, both current and historical, that may contribute to survivors' sexual harassment experiences and associated traumatic distress.

Rationale

Trauma reactions may occur when an individual is exposed to gender-based, interpersonal violence with similar stressors and are most commonly experienced by women from men. They include domestic and intimate partner violence, child and elder abuse in families, rape and sexual assaults, sexual exploitation, and sex trafficking and sexual harassment. In most known cases, the victims are usually girls or women and the perpetrators are usually men who abuse the power and control that comes with their gender status. With the current focus on "me too" legal cases, where noted popular culture figures in positions of authority have been exposed as sexual predators, taking advantage over those whom they had power, the psychological impact of the trauma has been in the news. Others in similar, nonpublicized cases have sought treatment for their trauma reactions from mental health professionals. Many of the treatment models available deal with these different traumas through similar trauma specific interventions. Therefore, even though we chose to focus on guidelines to assist professional psychologists who may be called upon to treat those who have experienced sexual harassment, we believe that similar suggestions also may apply to those experiencing these other forms of gender-based violence where there is an abuse of power to control the victim.

Unwanted sexual attention, pressure, gestures, and remarks about a person's body or sexual activities are all examples of experiences that may constitute sexual harassment. Although sexual harassment may affect people of all gender identities, research to date has focused on women as victim/survivors. Meta-analytic work suggests that approximately 58% of women report experiencing harassing behaviors at work and 24% categorize these experiences as sexual harassment (Ilies et al., 2006). Although sexual harassment may occur in all workplaces, some professions are more likely to overlook or accept such harassment as a part of the culture, especially for job advancement. Misconceptions about the types of workplace settings in which sexual harassment occurs my also affect institutional and societal responsiveness and perceptions of credibility.

Importantly, research shows that sexual harassment in the workplace exists across disciplines. A 2018 report by the U.S. National Academies of Science, Engineering, and Medicine (Johnson et al., 2018) identified sexual harassment as an enduring problem in scientific fields, and especially in medicine (Dzau & Johnson, 2018).

Despite recent movements like #MeToo that have helped increase public awareness of the scope, severity, and negative impact of sexual

harassment, misconceptions about sexual harassment may persist and create barriers for receiving care. For example, some may view sexual harassment as "less traumatic" than other forms of sexual trauma even though sexual harassment may have profoundly negative physical, psychological, and professional effects (Fnais et al., 2014). In fact, high costs for targets and witnesses (e.g., posttraumatic stress, depression, negative health effects) as well as organizations (e.g., poor work performance, absenteeism, resignation) (Sims et al., 2005) is well documented.

Certain workplace settings may create pressures that make experiencing sexual harassment particularly detrimental and present unique and challenging issues for treatment and recovery. This is especially true in occupations where there is a strict hierarchy that governs conduct. In the military context, for example, 38 U.S. Code § 1720D (United States Veterans Health Administration, 1992) defines military sexual trauma (MST) as "physical assault of a sexual nature, battery of a sexual nature, or sexual harassment that occurred while the veteran was serving on active duty, active duty for training, or inactive duty training" to emphasize that a spectrum of unwanted sexual experiences may be experienced as traumatic (Fisher & Kinsey, 2018). Due to very real negative threats of career consequences (which in the military could also involve threats of more dangerous duty assignments), servicemembers may feel pressured to comply with and/or tolerate unwanted sexual activities (Bell & Reardon, 2012). In addition to explicit threats of negative consequences related to reporting (e.g., interference with career advancement, continued harassment, and discrimination), which is not unlike other workplace settings, military cultural values related to group cohesion and self-sacrifice also may interfere with disclosure and induce feelings of shame, self-blame, and stigma (Bell & Reardon, 2012). The prospect of needing to continue living and working with perpetrators also may add to these pressures.

Societal misconceptions regarding the negative impact of sexual harassment may fuel barriers to disclosure and lead survivors to minimize and question the legitimacy of their own experiences. Making sense of these experiences may be further complicated by their potential insidiousness and the survivors' relationship to the perpetrator. Sexism, gender role socialization and expectations, messages regarding the kinds of interpersonal behaviors that are deemed "acceptable," attitudes that blame victims, and systems that do not fully hold perpetrators accountable for their actions (Lonsway et al., 2008) also may affect societal responses to survivors and their recovery.

Even in the #MeToo era, in which many survivors have felt more empowered to come forward to share their experiences of sexual victimization, reactions of skepticism, disbelief, and minimization abound. Perpetrators themselves often deny their actions to deflect attention away from themselves; in addition, they may attack the survivor's credibility and assume the victim role while turning the true victim into an alleged offender (Harsey et al., 2017). Such reactions may prompt confusion, self-doubt, self-blame, and shame in survivors (Fitzgerald, 2017).

When sexual harassment occurs, targets and witnesses may presume the organization is not concerned with their welfare, which may lead to negative assumptions about organizational norms regarding fairness and justice (Hitlan et al., 2006; Lamertz, 2002) as well as feelings of institutional betrayal (Freyd, 2018; Smith & Freyd, 2014) that may exacerbate the negative sequelae of sexual harassment. Freyd has named this "institutional betrayal" and has studied the effects that may come from this behavior as a trauma.

Systemic issues like unclear policies and reporting structures, poor or nonexistent investigation of reported cases, little to no support or protection for targets of harassment, requirements that formal complaints or lawsuits be filed for follow-through to occur, whistleblower retaliation and punishment, and minimal and/or inconsistent consequences for perpetrators (Choo et al., 2019) may further invalidate the experiences of survivors, reinforce notions that these experiences of sexual harassment are not worthy of reporting, and suggest that seeking help may do more harm than good.

Despite the increased attention to sexual harassment in recent years, a 2018 APA survey found that only 32% of working Americans report that their employers have taken new steps to prevent and address sexual harassment since the recent increased media and public attention to the problem began in the fall of 2017 (APA, 2018; Winerman, 2018). Importantly, this APA survey suggests that organizational efforts to address sexual harassment do increase the likelihood of reporting: 78% of employees at companies where new efforts had been made said they were more likely to report sexual harassment because of these efforts, whereas only 35% of employees at companies who had made no new efforts said they were likely to report sexual harassment.

Application

When a psychologist is treating someone who has experienced unwanted sexual attention, they strive to also inquire about other forms of gender violence that may exacerbate the patient's reaction to the harassment, given the historical and intergenerational trauma context for their cultural group. It is common for a patient who reports sexual harassment to also have experienced other forms of racial and gender bias. This is especially important when the individual fears loss of a job or other status should the sexual harassment be reported.

Given the potential misconceptions surrounding the definition of sexual harassment and its relative impact, psychologists seek feedback on unwanted sexual experiences in behaviorally descriptive ways, ideally

using well-validated assessment measures and offering examples when needed. Psychologists also counteract harmful societal messages by aspiring to stay mindful of their own biases that may influence how they conceptualize unwanted sexual experiences, and instead assess the details and contexts of these experiences as comprehensively as possible to fully understand the survivor's perspective and their impact.

By striving to maintain an awareness of populations that may be particularly vulnerable to sexual harassment (e.g., women of color, workers who are physically isolated and/or paid low wages, immigrants, etc.), psychologists aim to sensitively ask about these experiences even when they may not be expressed initially as a presenting concern. By understanding the unique dynamics that may increase vulnerability of exposure to sexual harassment and exacerbate its impact in certain populations, psychologists also strive to normalize risk factors and the unfortunate frequency of these experiences. The above Guideline 15 on racial trauma may also be helpful to psychologists working with women of color who have also experienced other forms of gender violence, as the research suggests women may experience more than one form of abuse.

Psychologists try to offer psychoeducation regarding the difference between "compliance" and "consent," and work with clients to identify the unique aspects of the settings in which harassment occurred that may have contributed to its impact. Helping survivors contextualize their own actions within the overarching setting and values of the workplace in which these experiences occur is crucial to mitigating self-blame and negative self-directed beliefs that may arise out of perceptions that compliance is a form of consent. This contextualization may be particularly helpful with women who work in male-dominated or nontraditional fields such as finance, engineering, transportation, or the building and construction trades, among others.

Psychologists aim to help clients identify harmful societal messages that they may have internalized regarding their experiences of sexual harassment in an effort to empower them to treat their own experiences of sexual harassment, and subsequent ways of coping, as legitimate and valid. Psychologists also strive to help patients gain insight into ways in which they may feel disappointed or betrayed by larger institutions and systems that they hold accountable for aspects of their experiences. This may include helping the patient understand that in many cases their feelings are valid and actionable under the law.

Psychologists strive to help clients explore whether structural and systemic inequities in organizations may have interfered with disclosure, contributed to negative reactions to disclosure, led to perceived insensitivity and insufficient action in response to reports, and/or otherwise added to distress, so that these themes may be integrated into treatment and made a focus of recovery, as needed. Familiarity with the rules and regulations of the U.S. Equal Employment Opportunity Commission (EEOC) that companies and their employees follow may be of assistance to psychologists in understanding these complexities. For example, in cases where the EEOC dismisses the initial complaint, the agency may issue what is called a "right to sue" letter that will permit the victim/survivor to file a lawsuit in civil court for a financial remedy.

Other legal issues that often accompany reports of sexual harassment may exacerbate the stressors for victim and survivors while trying to protect them. Psychologists may be able to assist victims and survivors in managing these legal issues. For example, depositions of a victim by the opposing counsel may be extremely stressful.

GUIDELINE 17

Psychologists strive to understand both the strengths of people who have imMigrated to the U.S. as well as the trauma they have experienced in coming here, to better understand how to rebuild resilience in overcoming trauma.

Rationale

Although over 100 million people have fled their countries of origin to seek a better life or escape from war or poverty, only recently has psychology recognized the trauma of such migration and refugee status for some (APA, 2013d). The U.S. Census Bureau Report in 2010 found that 13% of the population was foreign-born with 18.1 million being naturalized citizens, 11 million more being "authorized," and 11 million more being undocumented noncitizens. Psychologists serve many of these people in a variety of settings, including schools, clinics, community health care centers, jails and prisons, and hospitals. In addition to psychotherapy, psychologists are also asked to provide evaluations and expert witness testimony in different types of immigration cases including political asylum, hardship, competency, and those under the Violence Against Women Act (VAWA, 1994; Acosta & De La Cruz, 2011).

Important differences exist in the experiences and how they are dealt with between immigrants seeking a better life in the United States and refugees fleeing from war or poverty. The former often have time to make plans to leave behind homes and families while the latter rarely have the time or resources to do so, leaving them vulnerable to the difficulties of relocation. However, given the political controversy surrounding immigrants in the United States during recent times, all those who have migrated here face mental health challenges exacerbated by language barriers, hostility from some U.S. citizens, and lack of access

to health care, especially to those who are undocumented. During the past 50 years many immigrants have been people of color from places such as Africa, Asia, Latin America, and the Caribbean (APA, 2013d). Recent refugees from Latin America and the Caribbean rarely speak English, have faced undue delays at the borders, and are often separated from their children (Dreby, 2015; Hampton et al., 2021). Others, who have overstayed their visas or are trying to gain lawful status, fear deportation or removal that would separate them from their families. Many have young children or are ready to begin families in the United States but have difficulty finding good jobs that pay decent wages even if they have been educated in their countries of origin (Churchill & Sabia, 2019). Some, if deported, would leave U.S. citizens in dire straits (Churchill & Sabia, 2019).

Some adult children of parents who did not obtain legal status are under enormous stress, especially those who did not know their status growing up until they arrived at school (Hampton et al., 2021). Many immigrants face racial profiling, discrimination, exposure to gangs, immigrant raids, dangerous workplaces, and threats of deportation to countries where they do not know anyone (APA, 2013d). Some refugees came to the United States alone, leaving families behind. Many faced traumatic experiences in their journey to the United States, including exploitation, sexual abuse, racial profiling, lack of shelter, hunger, and other hardships, only to be arrested and face removal. Some women refugees are lured to a better life through "mail-order" marriages to men that turn out to be abusers, sex traffickers, and/or human traffickers.

Psychologists have noted that immigrants and refugees tend to share some strengths that may be used during provision of services or while fulfilling requests for psychological evaluation and testimony in the courts. Research has found that, in general, immigrants and refugees are often highly motivated to learn English and are diligent workers when they have the opportunity to be so (Hampton et al., 2021). Most immigrants and refugees want to improve themselves and provide a better life for their children, who often outperform others on a wide variety of psychological and behavioral outcomes than those who have been left behind in their countries of origin. New immigrants' optimism, greater family cohesion, and positive religious and community supports have contributed to their resiliency.

Uncertainty about the laws that impact the status of those who have come to another country from their countries of origin may exacerbate healing from trauma. Having a full understanding of immigration laws and how they are implemented or enforced may assist mental health professionals in addressing their clients' extreme anxiety and fear associated with the immigration system.

For immigrants and refugees, migratory trauma may occur before, during, and after their journey and arrival in the United States, resulting in PTSD or other trauma symptoms (APA, 2013d). They also may have other disorders that began before or during their journey, such as anxiety, depression, trauma, and a variety of health conditions. Poor nutrition and other problems related to poverty and inability to complete one's education also may be present in some, but not all, situations. (APA, 2013d).

Feelings of persecution and distrust of institutions, fear, and betrayal may be related to prior traumatic experiences or current anxiety about family separation and disruption. Separating current interpersonal difficulties from past experiences is important. It may be traumatic for some who are unable to acculturate because they have compromised identification with their country of origin and their new country (APA, 2013d).

Immigrants and refugees often do not have sufficient command of the English language and may struggle to communicate effectively with psychologists. Words that sound the same may communicate different things if not properly translated. Often, they will use a friend, child, or family member to translate for them, and that may limit what they are willing to report. The use of a certified translator may provide psychologists with more relevant and reliable data collection.

Psychologists try to help immigrant and refugee families that have experienced distress to find positive strength as an important part of trauma treatment. Understanding one's strength can help clients heal from prior trauma and also become more resilient in the face of future uncertainty of trauma. This is especially true for those whose immigration status remains uncertain. Many refugees who have immigrated without members of their family spend more emotional energy on their loved ones back home instead of on themselves. These complexities are often known to cultural brokers who are willing to provide consultation to mental health professionals on these issues.

Immigrants' and refugee's well-being and acculturation is often dependent on their ability to access key indicators for adjustment in their host community and country. These are often influenced by popular culture and include: access to education, housing, and health care, as well as to opportunities for social interaction between and within groups. The integration framework (Ager & Strang, 2008) and indicators of integration framework (Ndofor-Tah et al., 2019) identify key domains for successful adjustment in the host country and community. Politics and media influence how imMigrants and refugees are depicted and that, in turn, influences host citizens' attitudes toward them.

In order to have a full understanding of an imMigrant's or refugee's experience, it is important to understand the history of the country, background, and any socioethnic and religious conflicts that they left. This would also include the country of origin's discriminatory practices, access to resources, and cultural practices of an

individual or family. This information assists psychologists in developing a trauma-informed approach.

Application

Psychologists strive to understand the immigration journey to better assess its impact on a patient's emotions and outlook. Psychologists strive to provide a safe space for exploring these matters, including information on an immigrant's legal status and/or standing in the immigration system. Offering services in native languages where possible, and use of translation services—even though they may be limited by regional differences in dialect or meaning—may be helpful in communicating with patients.

Psychologists may interface with new and longstanding refugees and immigrants in different ways and roles. For example, immigrants and refugees seeking to remain in the United States may ask a psychologist to document the hardship it might cause their U.S. families if they are removed. For those who have fled abuse in their countries of origin, they may request an evaluation documenting the psychological effects from abuse. Psychologists are mindful of the high stakes and sensitive nature of these evaluations, including the need to attend to specific filing deadlines and other procedures.

In other cases, immigrants and refugees may benefit from psychotherapy to help address depression, anxiety, and other health impacts stemming from fears about their immigration status or difficulties caused by their journey to the United States. Psychologists also may work with adults who arrived in this country as children who may experience fear and anxiety by virtue of their immigration status or trauma experienced on the journey to the United States.

Psychologists strive to understand the issues faced by immigrants and refugees both before and after arriving in the United States. Even after an individual's immigration status is resolved, there may be underlying trauma that continues to cause psychological distress. Understanding the possibilities of different layers of trauma may help psychologists develop successful treatment plans. In some cases, psychologists may find cases of survivor's guilt over those family members left behind. Often these issues may push individuals to engage in activities that cause continued anxiety and stress. In other cases, psychologists sometimes find immigrants and refugees who neglect their own health to send money to their families. Travel back and forth to their home countries, often presenting divided loyalties to their lives in both places, can strain a patient's ability to achieve their goals in either place. Indeed, psychotherapy may assist patients in recognizing the impact of these and other external situational factors.

Those who have grown up witnessing the horrors of war and other forms of brutality may have a well-earned distrust of government and its ability to protect citizens from violence. This experience may have repercussions for how they relate to authority figures. Cultural ways of responding to such atrocities may be different for those surviving in different countries, making it necessary for psychologists to listen to their patients' reports. For example, although people in many Latin American countries have experienced trauma from civil wars, some, like people in El Salvador, may have had more police brutality than perhaps those in Nicaragua. In Colombia, people may have been traumatized by the drug cartel wars against the government. In Venezuela, the extreme poverty and fighting against the dictatorship has caused trauma. Those in Syria may have experienced more violence from the government than in other countries, especially if they have attempted to flee. Despite these differences, all refugees and immigrants may benefit from trauma-specific treatment.

It may be helpful for psychologists to learn the words used in different cultures to describe traumatic experiences. In some cultures, there are no words, while in others there may be multiple words, each with their own meaning. Assessment instruments may need to be modified for meaning in a particular culture and questions should be translated into the person's language. It is often helpful to have a second translator review the translated instrument and translate it back to English as a way to verify that the translation conveys the proper meaning. While it may be useful to administer such tools to help assess impact from trauma, psychologists seek to be cautious when reporting results, including calling attention to the lack of similar people in the original standardization samples. It is helpful to understand the person's culture when asking certain questions that might be improper for people to answer in their community. For example, when asking questions about sexual relationships in Latin cultures, some research has found a reluctance to respond (Walker, 2017). In other cultures, there may be different meanings ascribed to words used routinely in the U.S. to describe abuse and maltreatment. Consultation may be most helpful in these situations.

Rebuilding resiliency and approaches to wellness may include more focus on the individual person than is considered appropriate in their culture. Research has shown that Asian cultures often emphasize the well-being of the family as primary rather than the individual (Nisbett and Miyamoto, 2005). However, younger generations may not see these issues the same as older generations. Yet, helping patients heal their trauma and develop more resilience may be the most important factor for them, including if they aim to help those that remain in their country of origin. In cases where that is not the goal, a positive attitude towards their own wellness can redevelop patients' resilience, which is often lost during their difficult journeys. Understanding the nuances of someone's cultural identification while following trauma treatment plans may be helpful in restoring such resiliency.

An example of the need to rebuild resiliency lies with the families of the children who have been separated and kept in cages at the border or in other institutions without contact with their families. There are thousands of children whose families' whereabouts are unknown and who will need trauma-specific treatment to help them deal with these experiences. Psychologists may wish to offer such treatment once the opportunity is available to assist them.

Influencing long-term and systemic changes in changing perceptions of imMigrants and refugees may require moving beyond individual interventions to macrointerventions. These may include involvement in advocacy, research, education of the public through politics and media, and serving as an expert in court cases. In addition, psychologists may seek involvement in influencing migration and integration policies. International collaboration among psychologists in different countries may provide an opportunity to explore and learn from colleagues about best practices.

Using a trauma informed approach allows for increased sensitivity by psychologists when considering all aspects of an individual or organizational intervention and processes when working with imMigrants and refugees. Increased research of ways that imMigrants and refugees contribute to the economy and disseminating this research widely could potentially decrease negative perceptions of these groups.

Conclusion

These guidelines seek to assist psychologists in their work with patients who have experienced past or current traumatic stress from historical, intergenerational, and community-based situations. The risk of retraumatization is sufficient to suggest that some training be sought before working with such patients. Education and training are available through continuing education and formal education. The guidelines have suggested ways of knowing about trauma given the large amount of information that appears in the general public as well as in psychological literature. There are legal and regulatory rules often associated with assessment and treatment of individuals with traumatic stress and the guidelines seek to assist psychologists in being aware of such directives. Assessment of traumatic stress may be more difficult in other areas of psychological disorders given the possible retraumatization. Newer adjuncts to psychotherapy have been found to be useful with some patients, guidelines for which have been discussed here. Finally, special areas where trauma responses may be more likely to occur are discussed as examples of the many different situations that elicit psychological responses, including the impact of health disparities, racial trauma, sexual harassment, and immigration and refugee status.

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