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Posttraumatic Growth as an Intervention for Counselors Supporting Black American Clients

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This article explores the use of Posttraumatic Growth (PTG) as a method of facilitating psychological and emotional processing of race-based traumatic experiences when working with Black American clients. With a better understanding of the feasibility of PTG within the therapeutic environment, professional counselors can offer better support and outcomes for Black American clients seeking to reconcile race-based traumatic stress (RBTS) during this time of the Black Lives Matter Movement (BLMM). To facilitate this objective, a review of the PTG and RBTS literature will be explored along with clinical implications and recommendations that suggest methods of integrating the use of PTG with existing therapeutic modalities.

Keywords: Black Americans; Posttraumatic growth; race-based traumatic stress; Black Lives Matter Movement

The systemic racism, discrimination, and disenfranchisement of Black Americans are at the foreground of long-standing social injustices that adversely affect Black people in the United States, resulting in chronic psychological and emotional stress (Fisher et al., 2000). Although the Black Lives Matter Movement (BLMM) was formed to remedy the stress and upset many Black Americans have experienced, (Marino, 2015), there is a new level of awareness of how the traumatic history and civil unrest (Hardy, 2013) continues to adversely affect the level of functioning of Black Americans that have been traumatized (Carter, 2007; Carter & Sant-Barket, 2015). This diminished ability to function seems to be attributed to the daily awareness of social injustice, including the murders of unarmed Black men and women in the United States, along with a lack of understanding of how to process the augmented sense of racial salience that BLMM has exposed (Philippe & Houle, 2020).

The Black Lives Matter Movement (BLMM) continues to make progress toward its objectives, by creating opportunities to advocate for social change while confronting discrimination toward Black Americans (Fisher et al., 2000; Marino, 2015). However, there continues to be a lack of substantive, tangible remediation for the hundreds of years of racial trauma that has been seen in the United States (Franklin, 1999), amplifying the level of stress within Black communities due to systemic and structural racism. Carter (2007) has identified how systemic racism affects Black Americans when experiencing repeated race-based trauma, often resulting in psychological, emotional, and chronic mental health conditions, including anxiety, depression, low self-worth, and internalized racism (Nicolaidis et al., 2010; Williams & Williams-Morris, 2000). The difficulty with resolving and treating race-based trauma includes an inability many Black Americans have with processing stress, due to a lack of understanding of what comprises stress and how to differentiate stress from trauma within the context of race (Carter et al., 2020). This article will include an examination of race-based traumatic stress (RBTS) in the time of the Black Lives Matter Movement. An examination of posttraumatic growth (PTG) as an intervention for counselors supporting Black American clients considering cultural considerations for non-Black American counselors will be provided. Additionally, the term Black Americans will be used for racial and ethnic inclusivity (American Psychological

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Association, 2020) and in accordance with the standards of the United States Census Bureau (2020).

The Black Lives Matter Movement

The Black Lives Matter Movement (BLMM) developed following the fatal shooting deaths of Trayvon Martin in 2013 and Michael Brown in 2014 (Marino, 2015) with the objective of increasing social awareness, while adding political pressure to a system that has created disparity toward persons of color, especially to those who are Black (Evans et al., 2016). In addition to targeting sociopolitical biases, BLMM has exposed alarming numbers of incidents of civilian violence occurring on predominately Black Americans by law enforcement, along with incidents of White Americans who have misperceived threat (Isom Scott & Steven Andersen, 2020) also resulting in the murder of unarmed Black Americans (Marino, 2015). The system established to create and enforce laws has fostered a climate of racial mistrust between Black and White Americans, while exposing a resurgence of racist attitudes (Isom Scott & Steven Andersen, 2020), resulting in Black Americans experiencing disproportionate psychological stress and trauma due to the fear of harm while under constant threat (Fisher et al., 2000; Pieterse et al., 2013). Although supporters of BLMM have exposed the systemic failures that perpetuate the stress and trauma of Black Americans (Ra & Kim, 2019), there is a lack of attention to resolve the additional psychological harm experienced by Black Americans when their views are negated (Pieterse et al., 2013). Alternative viewpoints that defy and challenge BLMM, suggest that All Lives Matter (all people) and Blue Lives Matter (police) (Ra & Kim, 2019). These opinions shift the intention from a Black American perspective (Marino, 2015) and seems to imply and minimize the ideology of BLMM, with an effort to diminish its purpose of gaining visibility to Black American issues. As BLMM facilitates Black Americans to be more visible and heard in the spaces where injustices may persist, the overt rejection of BLMM further exacerbates and augments the injustices and trauma Black Americans encounter, fostering an additional sense of invisibility that has been present for hundreds of years (Franklin, 1999), thereby perpetuating intensified stress, and race-based traumatic stress (Carter et al., 2020).

Systemic and Structural Racism

Racism has been defined as the belief that one race has superiority over another (Evans et al., 2016) while discrimination is *acting* upon that belief (Carter, 2007). The perception of racial inferiority is a mindset that many racially traumatized Black Americans have internalized, resulting from occurrences of racial discrimination, and creates a foundation for economic disparity and social inequity from a control/helplessness paradigm (Steele, 2020). The internalized perception increases the division between those who have and those who have not. In other words, individuals who represent the economically stable, who have their basic needs more easily and readily met (White Americans) and have no significant visible insecurity, represent a control paradigm. In contrast, those individuals who are considered more economically fragile and dependent (Black Americans) upon the economically stable (White Americans), are rendered helpless and dependent (Nicolaidis et al., 2010). This power differential is at the crux of structural and systemic racism and increases the vulnerability that Black Americans have to encounter racial trauma (Carter, 2007; Matthews, 2020).

Because structural and systemic racism is progressive, chronic, and often psychologically and socially obscure, during times of crisis similar to the coronavirus (COVID-19) pandemic (World Health Organization, 2019), the obscurities become transparent. The consequences of the current health crisis are resulting in food shortages, economic insecurity, joblessness, minimal access to educational opportunities (Matthews, 2020), and access to basic resources. The failure to ensure access to the basic needs of Black Americans creates further dependency, resulting in a cyclic, systemic, structural failure. This pervasive problem often creates a gross mistrust between Black and White Americans, as well as within the Black American community, perpetuating cycles of crime, incarceration, addiction, and trauma (Isom Scott & Steven Andersen, 2020). The sense of divisiveness is not exclusive to the legal system, but also in the educational and social systems which purport to facilitate balance in the social structure.

Psychological and Social Implications of Structural and Systemic Racism

When comparing Black and White Americans, there is evidence to suggest that Black Americans experience diminished academic success attributed to unaddressed stress and trauma (Carter, 2007), lack significant academic support to achieve, have increased social isolation (Nicolaidis et al., 2010), and real and perceived feelings of discrimination (Fisher et al., 2000; Sellers et al., 2006). In academic settings, imposed race-based stress results in diminished academic achievement as a result of stereotype threat (Steele & Aronson, 1995). For individuals with low racial salience, or a detachment from one's racial identity (Carter & Johnson, 2019; Cokley, 2005; Whaley & McQueen, 2010), the likelihood of depression and anxiety increases, due to the tendency to self-isolate (Nicolaidis et al., 2010). To further examine the academic and social implications of RBTS, Carter et al. (2017) investigated individual racial salience and internalization as a factor in moderating stress with a racially diverse, adult community and student population. It was discovered that individuals with higher internalization of racial salience, had less stress than individuals with dissonance or conformity to social norms, suggesting that the barrier to RBTS for minorities is a positive internalized racial identity (Campbell et al., 2019; Carter et al., 2017; Steele, 2020; Whaley & McQueen, 2010).

For Black American students who face external stress and trauma in academic settings, there is added difficulty mitigating RBTS, especially when attending predominantly White schools (Campbell et al., 2019) and the pressure to achieve is salient. While many Black Americans possess the ability to meet the requirements to succeed academically, there are sizeable numbers who struggle (Osborne & Walker, 2006) due to systemic mistrust and an unwillingness to seek support to facilitate academic achievement (Nicolaidis et al., 2010). This mistrust with the psychological stress of daily life is exacerbated when academic pressure, along with a climate of discrimination and racism by peers, professors, or social support, exists. These risk factors decrease the likelihood that Black Americans will thrive socially, psychologically, occupationally, and academically, continuing a system of academic and educational failure (Campbell et al., 2019). This sense of failure, with a lack of supportive resources to moderate and resolve the pre-existing risk factors, develops an internalized sense of invisibility and uncertainty (Franklin, 1999). The result of this failure phenomena increases vulnerability to depression, anxiety, addiction, low self-worth, and social isolation (Nicolaidis et al., 2010) and increases the risk for race-based trauma when a racist or discriminatory event occurs, either faced or witnessed (Carter et al., 2020).

Stress and Trauma

Trauma and stress have now become frequent occurrences in our daily existence (Carter, 2007). However, for many Black Americans, there is a disproportionate rate of trauma due to incarceration, revictimization, isolation (Nicolaidis et al., 2010), stress, and fear (Townsend et al., 2020). Furthermore, the resulting shame of trauma within the Black community creates an innate sense of individualization with little ability to moderate or resolve the trauma with those who may have similar experiences and feelings (Townsend et al., 2020). Although there is a perception of internal strength and resilience to overcome stress and trauma within the Black community (Nicolaidis et al., 2010), there are other perspectives that argue that viewpoint and report higher levels of untreated depression, anxiety, and race-related trauma (Carter & Johnson, 2019; Hardy, 2013; Townsend et al., 2020; Williams & Williams-Morris, 2000). Aafjes-van Doorn et al. (2020) suggest that for clients who misperceive the severity of a stressful experience, autonomy is more beneficial than seeking treatment. However, for Black American clients, there may be a tendency to minimize the level of psychological distress experienced resulting in avoidance of treatment. For those who are aware of their struggle with race-based traumatic experiences, the distress may become problematic due to hypervigilance, systemic mistrust, isolation, and the need to survive when under additional stress and manifest as irritability, aggressiveness, resistance, or defensiveness. Within the framework of trauma, it may be better understood as depression, guardedness, or hypervigilance (Nicolaidis et al., 2010; Townsend

et al., 2020; Williams & Williams-Morris, 2000). Considering the relationship between Black American race-based trauma, a history of pervasive violence, systemic oppression, and its structural failure, there is a better way to understand racial trauma, its progression, and how untreated RBTS, results in internalization of the trauma with the shame of being unable to cope. With the subsequent disconnect from the community, the internalized trauma may be a factor in a diminished sense of self and identity, (Cokley, 2005; Cross, 1991; Townsend et al., 2020) struggles with psychosocial development (Gaffey et al., 2018), and creates further obstacles to seeking help.

Carter et al., (2017) have identified a correlation between racism, stress, and symptoms similar to trauma disorders and specified that the type of trauma many Black Americans continue to experience within the context of discrimination or racism, is better referred to as race-based trauma (Carter, 2007), due to the intensity and severity of the symptomology and the stress, which adversely affects daily functioning and coping. Race-based trauma (Carter et al., 2020) has been indicated as having similar symptomology of post-traumatic stress disorder, which includes primary and secondary trauma, that is trauma either experienced or witnessed. The behavioral, psychological, and emotional responses occurring within the context of race-based trauma is similar to post-traumatic stress disorder (PTSD), as clients may present as avoidant, mistrustful, with heightened reactions to stress, and intrusive memories of trauma either experienced (primary), witnessed (secondary), or have been made aware (tertiary). Additionally, a PTSD diagnosis identifies that the trauma can be actual/perceived or accidental/threatened. Although the expansion of the PTSD diagnosis is a more comprehensive and inclusive method of viewing PTSD, (witnessing violence, death, severe injury, or sexual violence), Carter (2017) suggests, it fails to include specific trauma related to race. It is arguable that in the time of BLMM and the racial upset that has been experienced by Black Americans, PTSD may be a consideration for diagnosis, although no race-specific specifiers are identified in the diagnostic criteria (American Psychiatric Association, 2013).

With an increased awareness of the long-term psychological and emotional impact of social injustice, disparity, and community violence that countless Black Americans have experienced, the role of counselors is integral to facilitate client's understanding of how to mitigate RBTS (Hardy, 2013; Williams & Williams-Morris, 2000). What we now understand about RBTS is that it offers context to better clarify diagnostic criteria for treatment planning as clients seek professional counselors to facilitate the process of creating purpose from a painful past (Carter, 2017; Evans, 2016; Tedeschi & Calhoun, 2004).

Race-Based Traumatic Stress

Race-based traumatic stress (Carter, 2007; Carter et al., 2020; Evans et al., 2016) occurs following a negative contact experience resulting in feelings of self-doubt, questioning, and uncertainty (Cross, 1991; VanDiver et al, 2000; Worrell, 2008). The contact experience may be attributed to microaggressions, physical assault, or overt discrimination either directly experienced or witnessed (Sue & Sue, 2007). As Carter et al. (2017) suggest, the experiences of Black Americans with RBTS are similar to individuals who experience PTSD, however, RBTS is contingent upon racial salience (Carter & Johnson, 2019; Cokley, 2005; Whaley & McQueen, 2010).

Cross's (1991) theory of nigrescence identifies a paradigm shift from a lack of awareness and salience of race, to a hyperfocused interest in all things that are Black (VanDiver, 2001; VanDiver et al., 2001). The BLMM is an example of both individual and group racial salience and awareness of Black identity as vital to survival (Carter & Johnson, 2019; Cokley, 2005; Whaley & McQueen, 2010). The need to survive, a result of this intensified level of awareness, heightens anxiety and hypervigilance (VanDiver et al., 2001), increasing a need to act and to react to protect the self and the reference group. This hypervigilance, a consequence of RBTS encountered during the contact experiences, has social and individual consequences, with the potential for destruction and retraumatization.

Posttraumatic Growth

Posttraumatic growth (PTG) was developed by Tedeschi and Calhoun (2004) as a method of facilitating change when trauma was present. As

defined by Little et al. (2011), PTG is the "positive psychological change experienced as a result of the struggle with highly challenging life circumstances." (p. 455). The changes include finding *inner strength and resilience, interpersonal effectiveness, gratitude for life, faith and spirituality, and identifying new opportunities* (Little et al., 2011; Tedeschi & Calhoun, 2004; Tedeschi et al., 1998). These concepts are the crux of Tedeschi & Calhoun's (2004) theory, which increases a clients' ability to create and explore life from a survival mindset with the goal of becoming transformed by the trauma. In psychoanalytic theory, sublimation offers an example of what PTG represents (Tedeschi et al., 1998). It is the ability to shift a mindset of victimization into empathy and purpose due to a traumatic experience, imparting a growth mindset (Meili et al., 2020).

There are theories similar to PTG, that facilitate personal growth, such as the Personal Growth Initiative (PGI). Weigold et al. (2018) stated the principles of PGI are "intentionality and transferability," (p. 482). The objective is similar to PTG as both theories promote a growth mindset (Meili et al., 2020) and a willingness to identify the salience to create change from experiences. However, PTG differs as it is trauma-specific with a focus on creating meaning in the process of change and is more appropriate to address race-based trauma as a treatment modality.

Black Americans and the Five Domains of PTG

The five domains of PTG include inner strength, interpersonal effectiveness, gratitude for living, faith and spirituality, and the ability to identify new opportunities for advocacy (Tedeschi & Calhoun, 2004). The ability to find *inner strength* while working through a tendency to isolate, attributed to the guilt and shame of experiencing trauma, is one of the five domains of PTG. Black Americans are able to find the inner strength within to tell their trauma narrative to others, increasing *interpersonal* effectiveness skills according to Jayawickreme et al., (2020) and "report higher levels of well-being than those who do not narrate their experiences," (p. 9). Additionally, McLean et al. (2020), reported that individuals who share their traumatic narratives with trusted individuals are perceived to be healthier, more likeable, and to have more desirable traits, which aligns with the research. The research supports PTG and provides evidence of positive interpersonal interactions occurring as a result of discussing trauma within trusted and supportive environments (Joseph & Linley, 2008).

Finding ways to increase positivism through *gratitude for living* and surviving race-based trauma is another aspect of PTG. The ability to gain an appreciation for both the struggle and the survival has been shown to be associated with strong *faith and spirituality*, which is an important aspect of PTG and the desire to find the purpose of the traumatic experience. Spirituality and integration of belief systems have been identified as a foundation for many clients who seek counseling to find meaning in their lives (Meili et al., 2020). For many Black Americans, there is a culture of religious and spiritual practices that allow for greater acceptance and understanding of race-based trauma toward forgiveness (Schultz et al., 2010). The ability to *identify new opportunities through* advocacy with organizations like BLMM allows reconciliation of the trauma through action and working through the trauma in a method that increases connection with other Black Americans who can relate to the experience (Carter, 2007). Furthermore, action in the form of creating possibilities to enact change for future generations increases the transmission of growth mindset and learning the purposefulness of the trauma for those who have survived and thrived (Meili et al., 2020).

Recommendations for Counselors

Posttraumatic growth (PTG) offers clients a framework to find understanding and purpose when trauma has been experienced (Tedeschi & Calhoun, 2004). The literature indicates that regardless of the type of trauma experienced, PTG supports psychoemotional processing toward purpose, meaning, and supports the use of exploration and movement toward a growth mindset, positivism, and a sense of control and purpose in new relationships (Meili et al., 2020; Tedeschi & Calhoun, 2004). When working with Black American clients, who have

experienced RBTS, counselors must first seek to identify if race-based symptoms have been experienced and to understand the narrative associated with the trauma (Meili et al., 2020). Additionally, counselors should pace the sessions to allow sufficient time for clients to process the trauma with validation, empathy, and active listening (Day-Vines et al., 2007). With the understanding of the complexity of race-based trauma and the beneficence of PTG, the needs that Black Americans have to be visible and heard will occur. To identify the dimensionality of clients' psychological processes, having clients complete the short version of the Post Traumatic Growth Inventory (PTGI-SF) can offer both counselors and clients a basis for treatment planning (Tedesci & Calhoun, 1996; Veronese & Pepe, 2019). The PTGI-SF is a brief self-reporting instrument that allows clients to find how they are learning to work toward the five domains of PTG (relating, possibilities, strength, spirituality, and appreciation of life). By using both the client narrative and reliable clinical measures, a comprehensive assessment of how to plan and support the therapeutic process is ensured. Additional measures, such as the Personal Growth Inventory (PGI) and The Race-Based Traumatic Stress Symptom Scale (RTBSSS; Carter et al., 2013; Carter, & Sant-Barket, 2015), will provide counselors comprehensive clinical measures to monitor RBTS clients' symptoms, allowing for appropriate treatment planning that is collaborative and comprehensive.

Other recommendations include counselors being comfortable with allowing the introduction and integration of spiritual and faith-based dialogue to find deeper meaning in the ability to survive and to thrive. Spiritual change is one of the five dimensions of PTG and is an identified part of mindfulness, distress tolerance, and emotion regulation skills learned in Dialectical Behavioral Therapy (Prasko et al., 2015). A dialectical approach combined with PTG increases interpersonal effectiveness skills, while distress tolerance skills will control distress when recalling traumatic memories (Tedeschi et al., 1998).

Both Cognitive Behavioral Therapy (CBT) and DBT explore thoughts and may increase RBTS clients' ability to find ways to create meaning in their experiences (Prasko et al., 2015; Steele, 2020). Processing the relationship between thoughts, emotions, and action (Stockton et al., 2011), may support the desire for advocacy by joining groups that facilitate change, like BLMM. In turn, the act of doing good works may increase mood, while regulating the feeling of loss of control that race-based trauma imparts. For some clients, exploring and finding new pathways to direct frustration and upset may bring about a more purposeful way for clients to relate to others who have similar experiences while reconciling the emotional need to seek support.

For counselors who utilize innovative and creative modalities, CBT combined with PTG may support Black American clients with visualization tools to conceptualize how to envision their lives (Hays, 2009). With Cognitive Behavioral Therapy (CBT), the use of mind mapping, visual thought exploration, and life visioning using technology, or on poster board, can offer clients an opportunity to explore their thoughts in a non-threatening way, to distract from the intensity of traditional talk therapy. Little et al. (2011) discovered that when working with children and adolescents diagnosed with trauma or stress disorders, CBT interventions have proven useful within the school environment. With the use of Trauma-Focused CBT and Cognitive Behavioral Intervention for Trauma, these integrated treatment approaches proved effective within a similar PTG framework while considering diversity and culture.

To support the PTG process, it is essential for counselors to create a clinical environment that facilitates understanding and meaning of RBTS, while supporting the discovery of the level, depth, and complexity of the discrimination, disenfranchisement, and trauma experience (Triplett et al., 2012). This discovery should not solely be seen from a global or historical perspective, but must consider the individual and group orientation perspective (Campbell et al., 2019; Carter, et. al, 2017). Individual orientation focuses on the experience one individual has. However, the strength of a group allows for an understanding of an individual's experience *while* increasing empathy with the connection and alliance to other Black Americans' experiences. Using therapeutic groups may also afford RBTS clients to openly share and work through issues of guilt and isolation that may be associated with the shame of trauma (Campbell et al., 2019). With an increased

understanding of the complexities of what stress, trauma, and RBTS is and is not, Black Americans may actively seek help to support the process of resolving stress before trauma is internalized. While the idea of safe, emotional space is an understood concept within the field of professional counseling, the ability to increase that understanding to suit the specific needs of RBTS clients is integral when considering logistical space between counselor and clients (sitting too close can seem intrusive and threatening, while too far can seem distant). Sensory experiences that may seem non-threatening can easily become upsetting for RBTS clients exposed to environmental conditions that result in hypervigilance and distress, such as music, lighting, and décor. It is incumbent upon counselors to create a safe space to effectively process the psychological, social, and emotional traumatic contact experiences that contribute to the race-based trauma (Evans et al., 2016) and to accurately assess RBTS clients for discomfort during each session. By doing so, this reduces the barrier between counselor and clients while furthering the depth of the counseling relationship, allowing the supportive environment Black American clients need to mitigate the trauma that has been experienced (Hardy, 2013). The use of mindfulness, a non-judgmental stance, and unconditional positive regard (Thompson et al., 2011) further support clients' ability to approach topics that allow challenging dialogues to be broached and a change in mindset to occur (Tedeschi & Calhoun, 2004). Finally, in the process of supporting Black American clients who experience RBTS, it is integral for professional counselors to seek support and to acknowledge transference, countertransference, and vicarious traumatization when it occurs. The importance of self-care with consistent support and contact with peers, colleagues, mentors, and local associations may offer a significant benefit to cope with counselor overidentification with Black American clients diagnosed with RBTS.

Cultural Considerations for Non-Black American Counselors

For non-Black counselors, the safety of the therapeutic environment to process and understand the outlook clients have of their world (Hanna & Cardona, 2013; Tedeschi & Calhoun, 2004), of race, and of their own trauma can support effective joining in the therapeutic alliance. With appropriate use of self, RBTS (Carter, 2007) dialogue may foster the ability to work through the trauma narrative and find purpose in the pain of the experience that PTG facilitates. The use of validating, supportive statements that acknowledge and accept the client narrative, may facilitate the safety between client-counselor racial difference, thereby allowing the client to shift their outlook toward finding their own inner strength and visibility.

Counseling Standards

Counseling competencies and adhering to the ethical standard of care are at the foundation of clinical practice and increases the ability for non-Black counselors to align with their clients. The Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts, Singh, Nassar-McMillian, Butler, & McCullough, 2015) offer dimensionality and an integrated treatment approach, while furthering understanding of the barriers that exist when working with clients who are historically marginalized and oppressed. The MSJCC was endorsed by The American Counseling Association in 2015 and aligns with how to approach client diversity, which states that counselors "…recognize that culture affects the manner in which clients' problems are defined and experienced" (American Counseling Association, 2014, Section E.5.b.). In addition, the importance of recognizing and being aware of any real and perceived power differential may increase counselor "critical consciousness," (Ratts et al., 2015, p. 261). This consciousness offers an opportunity for professional growth as a substantive foundation to increase empathy and to better understand the complexity of Black American race-based trauma. To support professional development goals, ACA (2014) Section C.2.d., identifies the need for counselors to self-assess for treatment efficacy and to seek supervision to improve the standard of care.

Conclusion

This article examined the utility of PTG to support Black American clients to find purpose in the pain of race-based traumatic experiences. Through the lens of the Black Lives Matter Movement, there is an opportunity for Black American clients experiencing

RBTS to integrate social justice with purpose, offering recompense for the injustices that have been experienced and witnessed. For other Black American clients, forgiveness, faith, and spirituality offer relief and resolution toward this objective (Schultz et al., 2010). Having the ability and making the choice to surrender the hurt in exchange for peace may allow clients to feel a sense of control and to increase positivism, which allows for increased interpersonal connectivity (Schultz et al., 2010). The counselor's role in supporting their clients' ability to work through the depth of the trauma, utilizing PTG with complementary treatment modalities can facilitate understanding of clients' race-based trauma and will provide manageable steps and tangible assessment of progress in the process of healing and reconciling the trauma.

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COVID-19 Implications on Medication-Assisted Treatment Expansion in a Rural County Jail

Kelley McNichols

The opioid epidemic and the COVID-19 pandemic have presented extraordinary implications for vulnerable populations, such as justice-involved individuals presenting with opioid use disorders (OUD). Strategic interventions, specifically medication-assisted treatment expansion in criminal justice settings, are warranted to support the complex needs of justice-involved individuals with OUD during the COVID-19 pandemic. A case study will be provided about a rural county jail in Pennsylvania where COVID-19 has profoundly affected medication-assisted treatment expansion initiatives.

Keywords: opioid use disorder, COVID-19, medication-assisted treatment, vulnerable populations, criminal justice

The opioid epidemic has long plagued the United States. From 1999 through 2018, an estimated 750,000 Americans died as a result of a fatal drug overdose (Center for Disease Control, 2020). In 2018, the Center for Disease Control (CDC, 2020) reported a total of 67,367 drug-related overdose deaths identifying the presence of opioids, primarily fentanyl, in 46,802, or 69.5%, of all decedents. While Americans continue to combat the opioid epidemic, a new threat has emerged further complicating the situation. This new threat is the coronavirus (COVID-19) which is caused by severe acute respiratory syndrome coronavirus 2, or SARS-CoV-2 (CDC, 2020). As of August 18, 2020, the CDC (2020) confirmed a total of 169,870 COVID-19 deaths in the U.S. Having lost almost one million people combined, the U.S. is now faced with the dual threat of the opioid epidemic and the COVID-19 pandemic. As such, this case study will explore the implications of the identified dual threat as it relates to a medication-assisted treatment expansion initiative within a rural county jail in Pennsylvania.

Pennsylvania's Dual Threat

There is no doubt that the dual threat of the opioid epidemic and the COVID-19 pandemic have profound implications for our communities as well as some of our most vulnerable populations. For instance, in 2018, the Commonwealth of Pennsylvania lost 4,491 individuals due to drug-related overdose deaths (OverdoseFreePA, 2018). Of the 4,491 drug-related overdose deaths, opioids were present in 82% of the decedents with fentanyl being the most frequently identified substance in decedents followed by heroin and then cocaine (Drug Enforcement Administration, 2019). Moreover, as of August 18, 2020, Pennsylvania confirmed 122,050 cases of COVID-19 and 7,499 COVID-19 related deaths (Pennsylvania State Department of Health, 2020). Within the last two years in Pennsylvania alone, the dual threat has resulted in a staggering loss of approximately 12,000 lives.

Rural communities face distinct challenges during the opioid epidemic and the COVID-19 pandemic. The CDC recognizes "long standing systemic health and social inequalities" are especially unique in rural areas (2020, para. 1). This is not only true in regard to implications of the COVID-19 pandemic, but also true in regard to the drug-related overdose death rates. The CDC (2017) also acknowledged that rural overdose death rates are trending higher compared to urban areas.

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Armstrong County, located in a rural southwestern part of Pennsylvania, has encountered the aforementioned threats, challenges, and related implications. To date, Armstrong County has confirmed 245 cases of COVID-19 resulting in nine deaths (Pennsylvania Department of Health, 2020) and 20 reported drug overdose deaths in 2019. As such, the county has experienced 45% more drug-related overdose deaths than deaths from COVID-19. Consistent with the findings of drug-related overdose drug categories in the U.S. and Pennsylvania, fentanyl, heroin, and cocaine were the most frequently identified substances in 90% of the decedents in Armstrong County (OverdoseFreePA, 2020). There is mounting concern that COVID-19 implications will have long-term consequences for communities and vulnerable individuals, especially for individuals with "developing or existing mental health and substance use disorders experiencing relapses and other negative outcomes…" (Inter-Agency Standing Committee, 2020, p. 3).

Vulnerable Populations

Justice-involved individuals and pregnant women presenting with opioid use disorders (OUD) are among some of our most vulnerable populations. Treating vulnerable populations that present with opioid use disorders during the COVID-19 pandemic is an exceptional challenge. Due to drastic shifts in service delivery, it is expected that individuals with mental health conditions, especially those with opioid use disorders (OUD), will experience exacerbated mental health symptoms due to increased feelings of isolation and reduced, or disrupted, access to treatment (IASC, 2020; Pineo & Schwartz, 2020). Subsequently, there is fear that this will lead to a spike in drug-related overdose deaths. It is critical that the counseling profession is prepared to implement effective, evidence-based treatment interventions to vulnerable populations in hopes of reducing recidivism and drug-related overdose deaths in the midst of the current public health crises.

Justice-Involved Individuals with OUD

The rates of opioid overdose deaths and incarceration have more than quadrupled in recent decades (Bone et al., 2018). As you can surmise, justice-involved individuals that present with OUD are an especially vulnerable population for a number of reasons. First, opioid drug use can compromise an individual's health, subsequently increasing the risk of contracting COVID-19. Individuals with OUD are at higher risk of illness from COVID-19 due to the effects that opioids have on the respiratory system and pulmonary health (NIDA, 2020). Second, individuals with OUD are also at increased risk of overdose if they have COVID-19 (OverdoseFreePA, 2020). Third, justice-involved individuals with OUD have an increased likelihood of having close contact with others who might also be at risk of infection. Lastly, the risk of overdose death following a period of incarceration is 12.7 times greater for those experiencing prisoner reentry compared to the general population (Bone et al., 2018). Undoubtedly, COVID-19 has elevated the already extraordinary risks for this vulnerable population warranting a more strategic response from counseling professionals.

Pregnant Justice-Involved Women with OUD

Another vulnerable population at acute risk of the dual threat is justice-involved pregnant women presenting with OUD. Between 1980 and 2014, the number of women incarcerated in the United States increased by more than 700% and research shows that approximately 5% of women in jails are pregnant upon intake (Peeler et al., 2019). Thus, routine screening and evidence-based treatment interventions are imperative for successful treatment outcomes (Peeler et al. 2019; Robinson & Strugar-Fritsch, 2020; Winkelman et al., 2020). Additionally, justice-involved women have higher rates of mental illness and trauma coupled with higher overdose death rates compared to their male counterparts (Peeler et al, 2019; Pineo & Schwartz, 2020). However, Winkelman et al. (2020, p. 2) postulated:

> Pregnant women with OUD referred by criminal justice agencies received evidence-based treatment at lower rates than women referred through other sources. Improving access to medications for OUD for pregnant women referred by criminal justice agencies could provide public health benefits to mothers, infants, and communities (p. 2).

Thus, appropriate screening and treatment are of the utmost importance when working with this vulnerable

population.

Pregnant justice-involved women with OUD have unique health needs of which the counseling profession must become familiar with in order to offer effective, evidence-based treatment interventions. The American Society of Addiction Medicine (ASAM, 2020) reported:

> Pregnant people have changes in their bodies that may increase their risk of some infections. Pregnant people have had a higher risk of severe illness when infected with viruses from the same family as COVID-19 and other viral respiratory infections, such as Influenza (p. 1).

Evidenced-based treatment options, such as medication-assisted treatments (MAT) are available options that will help mitigate health risks for pregnant justice-involved women presenting with OUD. Although naltrexone is not recommended for the treatment of pregnant people with OUD, methadone and buprenorphine have not only been found to be well accepted by mothers and infants, it has been found to be effective and supported by meta-analysis of randomized trials (Peeler et al., 2019). Of utmost importance, pregnant women presenting with OUD that participate in opioid agonist therapy (e.g., methadone or buprenorphine) experienced a 70% reduction in overdose related deaths (Wright, 2020).

In order to care for pregnant women with OUD, ASAM (2020) recommends providing education and resources on COVID-19 along with tips to stay healthy, engage in self-care, as well as cope with stress and anxiety. Counseling services should also be made readily available. MAT can prevent withdrawal symptoms and related complications, reduce the risk of relapse and overdose, and has been associated with increase adherence to addiction treatment as well as prenatal care (Peeler et al., 2019). However, there appears to be minimal literature addressing the specific needs of justice-involved pregnant women presenting with OUD on MAT during the COVID-19 public health crisis.

Offender Re-Entry

"Over 12 million people enter the criminal justice system each year and 95% of these individuals are released back into the community" (Moore, 2020, p. 93). The phenomenon of offender reentry is fraught with numerous challenges, especially for individuals that present with OUD. In fact, between 58% and 68% of incarcerated individuals present with substance use disorders (SUD) and have disproportionate rates of poor health outcomes (Moore, 2020, Mace et al., 2020). Medication-assisted treatment interventions have been proven to reduce cravings, overdose deaths, illicit use, and infectious disease while improving treatment retention and decreasing criminal behavior (Mace et al., 2020; Moore, 2020; Waller, 2020). Justice-involved individuals that participate in MAT experience a 61% decrease in overdose deaths upon reentry and 82.4% continued participating in MAT post-release (Waller, 2020).

In addition to the live saving benefits of MAT, naloxone (e.g., narcan) is a non-addictive overdose reversal medication used for the treatment of an opioid emergency or suspected opioid overdose. The CDC (2020) recommended that inmates experiencing reentry be released with naloxone; however, distribution of naloxone was yet another challenge in light of the COVID-19 pandemic. COVID-19 impacted the continuity of care for reentry experiences. Access to treatment and related resources was sparse. Access to Narcan was significantly limited to vulnerable populations experiencing reentry.

COVID-19 Implications on MAT Expansion in a Rural County Jail Case Study

Armstrong, Indiana, Clarion Drug and Alcohol Commission is committed to combating the opioid epidemic and was awarded the Pennsylvania Commission on Crime and Delinquency (PCCD) State Opioid Response Grant (#31632) (Anderson, 2019-2020) that would further support this work in Armstrong County jail. The grant provided the drug and alcohol commission with an exceptional opportunity to fight the opioid epidemic by expanding access to medications for opioid use disorders (MOUD), specifically buprenorphine, in the criminal justice setting. The implementation of the grant's MAT expansion in the jail unequivocally aligned with ASAM's (2020) new and major updates which reported that all Federal Drug Administration (FDA) medications, most notably buprenorphine, methadone,

and naltrexone, should be available to all patients (Robinson & Strugar-Fritsch, 2020).

The drug and alcohol commission and the county jail were well suited for this grant opportunity given the fact that they had already made significant strides in decreasing overdose death rates. From 2016 through 2018 Armstrong County experienced a 46% decrease in overdose deaths (OverdoseFreePA, 2020). Offering FDA approved MAT options, such as methadone and naltrexone (e.g., vivitrol) in addition to naloxone to justice-involved individuals, played a significant role in the reduced number of overdose deaths. Incorporating buprenorphine seemed to be a natural next step in the process by enhancing available MAT options to save more lives.

Implementation of MAT in the criminal justice system has been known to reduce cravings, overdose deaths, illicit drug use, infectious disease, and criminal behavior (Waller, 2020). With surmounting support for MAT as an evidence-based practice the drug and alcohol commission partnered with the criminal justice system working together closely to offer substantial treatment options for justice-involved individuals presenting with OUD and other substance use disorders. In addition to offering FDA approved MAT options, other available treatment included, but was not limited to, licensed drug and alcohol outpatient treatment activities (e.g., assessment, individual, and group counseling), drug and alcohol case management, recovery supports, as well as re-entry services such as overdose prevention training and distribution of naloxone for inmates upon reentry into the community (Anderson, 2019-2020; K. Anderson, personal communication, October 2020).

With a pre-existing framework of treatment interventions to targeting the jail's most vulnerable populations already in place, the immediate goal of the Armstrong County jail-based MAT expansion program was to deliver buprenorphine treatment in the jail to justice-involved individuals presenting with OUD. Individuals are required to have a valid buprenorphine prescription, as confirmed by the Pennsylvania Prescription Drug Monitoring Program (PDMP), in order to qualify for the program. Qualifying individuals were also required to participate in the Intensive Supervision and Treatment Program (IST) (Anderson, 2019-2020), which is an alternative to traditional sentencing for offenders whose substance use disorder appeared to contribute to their arrest or conviction of a crime.

Justice-involved individuals entering the jail that were deemed eligible for the MAT expansion program would be able to sustain their MAT regimen, avoid withdrawal, and would be able to engage in a wide array of treatment options within the jail. Ultimately, the long-term goal of the MAT expansion program was to decrease recidivism and overdose death rates (Anderson, 2019-2010).

Program Implementation

The program was implemented on January 13, 2020, directly preceding the declared state of emergency in response to the COVID-19 pandemic. As of March 11, 2020, a total of 27 inmates entered the jail with a valid PDMP prescription for Buprenorphine. Three of the 27 inmates, or 11%, participated in the MAT expansion program. One reason for the initial limited participation in the program was that inmates either opted not to participate in IST or were not eligible for IST. In order to reach more justice-involved individuals presenting with OUD program modifications were made eliminating the IST requirement (D. Salsgiver, personal communication, March 11, 2020).

The program eligibility modification went into effect in April coinciding with the ever-increasing cases of COVID-19. As a direct result of COVID-19, the daily jail census decreased from 170 to approximately 100 (D. Salsgiver, personal communication, April 14, 2020). Nonviolent offenders received early release and new admits were minimal. In order to adhere to Center for Disease Control (CDC, 2020) guidelines, treatment programming in the jail came to an abrupt halt while concerned stakeholders redefined what operating procedures for essential service would look like inside the walls of the institution.

As of May 20, 2020, there were a total of 10 justice-involved individuals that presented with OUD and entered into the MAT expansion program. Of the 10 individuals that entered the program, five were males and five were females. Three out of the five females, or 60%, were pregnant people with OUD. All

individuals had received MAT within the community prior to incarceration and were willing and able to comply with the MAT expansion program. Compliance seemed to be linked to the individual's motivation to avoid withdrawal symptoms and sustain recovery efforts (D. Salsgiver, May 20, 2020).

As a direct result of COVID-19 implications, access to the jail and client care was disrupted. Regulations established well before the pandemic were quickly called into question. During unprecedented times, unprecedented changes to regulations were needed to decrease disruptions to care. As such, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Drug Enforcement Administration (DEA), and the American Society of Addiction Medicine (ASAM), agencies that address clinical practice and prescribing guidelines for the treatment of substance use disorders, made extraordinary changes to regulatory standards. Of utmost importance was the expansion of telemedicine and OUD prescribing guidelines that increased access to treatment services during this unprecedented time (Pineo & Schwartz, 2020; Robinson & Strugar-Fritsch, 2020).

Understanding that providers may not be able to obtain written patient consent for disclosure of substance use disorder records, especially for the incarcerated, drug and alcohol confidentiality guidelines were revised with major changes. The Coronavirus Aid, Relief, and Economic Security (CARES) Act was passed by Congress prompting SAMHSA (2020) to address implications of COVID-19 on the treatment of substance use disorders by revising the Code of Federal Regulations, Title 42, Part 2 (42 CFR Part 2), regulations which are designed to protect patient records created by federally assisted programs for the treatment of substance use disorders, by modifying several major sections of the code. The revised code declared prohibitions on the use and disclosure of patient identifying information would not apply in the event of a medical emergency. Subsequently, COVID-19 public health emergency response opened new opportunities to vulnerable populations for treatment alternatives, such as telehealth. As such, telemedicine was swiftly implemented within the jail.

Conclusion

As the dual threat of the opioid epidemic and the COVID-19 pandemic continue to evolve, the world appears to be adjusting to some semblance of a new normal. Restrictions have been lifted allowing the MAT expansion program to become more robust. Currently, the daily jail census is raising at approximately 150 inmates. The number of justice-involved individuals involved in the MAT expansion program has increased exponentially from 10 to 62 in three months (D. Salsgiver, personal communication, August 12, 2020). Essential services, such as drug and alcohol treatment, are being offered via telehealth platforms until face-to-face counseling can resume safely.

In conclusion, the dual threat of the opioid epidemic and COVID-19 pandemic is complex. Justice-involved individuals with opioid use disorder are at increased risk of COVID-19, recidivism, relapse, and fatal drug overdose deaths. Vulnerable populations are more disconnected now than ever before calling on the counseling profession to adapt, provide access to education, prevention, and evidence-based treatment interventions. Expansion efforts and regulatory guidelines have started to shift in hopes of addressing identified barriers to treatment. More needs to be done to better address and understand the needs of vulnerable populations during the COVID-19 pandemic. Specific attention must be given to justice-involved women that are pregnant and present with OUD and related MAT interventions. Soon, treatment efforts will resume but they will be forever changed. Support is here, waiting for the threat to quiet so that the voices of recovery can be heard reaching further than ever before.

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Becoming an Animal-Assisted Therapist in Counseling: Practical, Ethical, and Clinical Implications

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A therapy dog can light up the counseling room and enhance the therapeutic process for clients and counselors alike. However, animal-assisted therapy requires counselors to invest both time and money into their practice. Counselors must address practical, legal, and ethical questions prior to taking on the responsibility of a therapy dog. Counselors must also learn new clinical techniques and develop a new set of competencies. This article will help clinicians consider the advantages and disadvantages of becoming an animal-assisted counselor.

Keywords: animal-assisted therapy in counseling, private practice, therapy dogs

Animal-assisted therapy in counseling (AATC) is a branch of counseling growing in popularity, but it is nowhere near infancy. Humans have documented the healing power of animals from as early as the 9th century (Serpell, 2010). In one widely cited study in 1970, Ethel Wolf, a Philadelphia psychologist, surveyed psychotherapists in the United States and reported that 48% of institutions utilized animals in their work (Arkow, 2015; Morrison, 2007; Cusack, 1988). Today, we have seen an increase in the use of many animals in the therapeutic environment including cats, horses, birds, pigs, llamas, alpacas, rabbits, rats, and guinea pigs, although dogs are the most prevalent (Pet Partners, 2021). Dogs are especially popular because of the ease of training and their wide acceptance in public spaces. The idea of having a dog to assist in counseling sounds exciting, but there are many factors to consider before pursuing this type of work. In this article, we will explore practical facets of becoming an animal-assisted therapist, legal and ethical questions to ask yourself, and share a few of our favorite clinical interventions. First, let us define what a therapy animal is and look at other similar types of support animals.

What is Animal-Assisted Therapy?

In 1962, a child psychologist by the name of Dr. Boris Levinson noticed that his clients were more likely to open up when his beloved dog, Jingles, was in the room. He began to write about the interventions with Jingles and went so far as to call Jingles his "co-therapist" (Morrison, 2007, p. 52). Levinson was the first trained clinician to write about animal-assisted therapy, and later became known as "the father of AAT" (Ernst, 2014, p. 28).

A therapy animal is trained to assist a mental health professional and is intentionally incorporated into a client's treatment plan (Chandler, 2012). The introduction of a dog into the treatment plan provides both the counselor and the client a new set of techniques to work with (Chandler, 2012). Animals can be just as beneficial to the counselor's well-being as they can be to the client's growth and healing (Morrison, 2007). However, therapy animals are primarily present to enhance the therapeutic relationship and help the client make the most of therapy (Chandler, 2012).

Animal-assisted interventions (AAI) have a broader scope in comparison to the more narrowly defined animal-assisted therapy in counseling (AATC). Pet Partners is the largest organization for certifying animals and their human handlers. They define AAI as "goal oriented and structured interventions that intentionally incorporate animals in health, education and human service for the purpose of therapeutic gains and improved health and wellness" (Pet Partners, 2021). AATC can be thought of as a subset or specialty field. As counselors, our work incorporates "specially trained and evaluated animals as therapeutic agents into the counseling process, whereby professional counselors use the human-animal bond as part of the treatment process" (Stewart et al., 2016, p. 2). The differences may sound

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unnecessarily nuanced, but the fact is that other human-animal teams cannot do what we do. The presence of a counselor to facilitate the client-animal interaction creates a special opportunity for growth and healing. Because animal-assisted interventions may be conducted by a paraprofessional, such as a volunteer in a hospital, or by a professional in another capacity outside of mental health, we carefully distinguish the specialty of AATC. Physiotherapists, for example, have found animal-assisted activities useful for the health and rehabilitation of elderly patients (Berry et al., 2012). An AATC provider is always a trained mental health provider, and is typically a professional counselor, clinical social worker, or licensed psychologist (Stewart et al., 2016).

Types of Support Animals

Support animal is the catch-all term the authors are using to indicate any animal that has a specific supportive role for their human handler. These include emotional support animals, service animals, and therapy animals. Despite their similarities, each type of support animal has a unique role with specific legal implications. These terms should not be used interchangeably.

Schoenfeld-Tacher and colleagues (2017) delineated some of the characteristics and requirements of an emotional support animal (ESA). An ESA can be part of any animal species. They are prescribed or recommended by qualified professionals, including medical doctors and licensed professional counselors (Schoenfeld-Tacher et al, 2017). The special animal in this role is protected by the Fair Housing Act, where an ESA is described as an animal that accommodates a person who has some form of a psychological disability. Although an ESA is not necessarily trained to complete a specific task, neither is it considered a pet. ESAs accomplish their goal by providing companionship and comfort to one specific individual. When evaluating a client for an ESA, there are two questions that must be answered (U.S. Department of Housing and Urban Development, 2020). The first question determines the existence of a disability for the person requesting the ESA, and the second considers whether or not the disability causes a need that an ESA can alleviate. Qualifying individuals are permitted to be accompanied by an ESA in their home, even if the housing facility has a no-pet policy. Emotional support animals may be part of a treatment plan as a supplement to between-the-sessions homework, but they do not work directly in the therapy room or with the mental health professional. As of December 2, 2020, federal law was revised to state that emotional support animals no longer have access to specific public spaces in which they were formerly permitted. The revised regulation is the Air Carrier Access Act, which now states that airlines are only required to permit service animals onboard the aircraft. Emotional support animals are distinguished as different from service animals, and are no longer protected under this law. Therefore, as of this publication, people with an ESA are only protected by the Fair Housing Act.

Service animals are similar to but distinct from emotional support animals. Service animals, typically dogs, are protected by the Americans with Disabilities Act and are trained to perform specific functions for a person with a disability (Schoenfeld-Tacher et al., 2017). An example of this is a guide-dog trained to assist a visually impaired person. People have the right to access all public spaces with their service animal. Service animals work independently with their individual handler and do not involve a counselor or clinical treatment plan. In addition to this, the definition of a service animal has been expanded to encompass any animal performing tasks for those suffering from psychiatric disabilities. An example of this is an animal trained to calm an individual who has just suffered an anxiety attack (Schoenfeld-Tacher et al., 2017).

Therapy animals are dogs, cats, or other animals that are trained to work alongside a professional or paraprofessional to provide comfort to a large number of people (Reisen, 2019). While they may be exceedingly smart and friendly animals, they need a qualified, well-trained human to facilitate the comforting and healing interactions that occur between animal and client. This is distinct from ESAs and service animals because therapy animal interventions are written into treatment plans and program guides. There is intentionality in the work of therapy animals and their professional handlers. Therapy animals have the fewest legal protections among the various support animals. There are no specific laws in Pennsylvania that pertain to therapy animals beyond the Health Care Facilities Act discussed later in this article. They are not permitted in public spaces the way service animals are and do not even have limited permissions like ESAs. Counselors planning to bring a therapy animal into their practice are encouraged to discuss this with the property owner in advance and include the therapy animal as a necessary addition in their lease.

Therapy animals, emotional support animals, and service animals provide comfort, guidance, and/or assistance to an individual. It is paramount for counselors to understand both the similarities and differences among these support animals, especially when deciding to incorporate animal-assisted therapy into their counseling practice.

Core Competencies

To better understand animal-assisted therapy in counseling, it is not only helpful to know the core competencies established by the American Counseling Association, but it is also an ethical mandate to develop these competencies. These competencies are required for a counselor to maximize the effectiveness of partnering with animals during sessions. While many counselors enjoy the benefits of having a pet in the office, it is necessary to develop these competencies to authentically and ethically practice AATC. The full competencies, which can be accessed through the American Counseling Association's website for free (Stewart et al., 2016), are summarized as follows:

1. Formal animal-assisted therapy training: Education, supervision, and assessment are necessary to prepare yourself for this specialized field.
2. Knowledge of the animal: It is important to understand the animal's personality and have a working knowledge of their breed and species.
3. Knowledge and demonstration of ethics: This covers risk management and ensuring both animal and client safety.
4. Proficiency of rudimentary counseling skills: A command of basic counseling skills is required before becoming an animal-assisted therapist.
5. Intention: AATC interventions are intentionally incorporated into counseling relationships.
6. Specialized skill set: Animal-assisted therapy is a specialized skill set that should be attained thoughtfully and ethically.
7. Animal advocacy: The advocacy of animal welfare and rights. This includes the counselor taking responsibility for the care and well-being of their animal.
8. Professional development: Continuing to pursue training and growth in this field is essential. As a relatively new field, techniques and training are changing constantly and it is important to stay up to date.
9. Professional values: This is the pursuit and implementation of values necessary in this field. Some examples include open-mindedness, flexibility, and passion.

These nine competencies indicate the lengthy process of becoming an animal-assisted therapist. It is a process that requires patience, training, and a developed relationship between the counselor and the animal. As counselors, it is an ethical requirement to gain competence in a new area of practice. There are several aspects to consider before committing to an animal and the training required; the first to consider is the practicality of this endeavor.

Practical Issues

This article has defined animal-assisted therapy in counseling, explored the types of support animals relevant to the conversation, and addressed the ethical mandate of developing core competencies in the specialty. Building on this foundation, we now turn to the practical components of becoming an animal-assisted therapist. Practical issues include: selecting an AATC training program, selecting an animal co-therapist, training and communicating with the animal, preparing for the animal's eventual retirement, and protecting your practice from liability.

Selecting an AATC Training Program

If a counselor has the time and finances to invest in an animal co-therapist, it is time to consider AATC training. There are several programs and curricula to choose from. Usually, a certification program combines online coursework with practical fieldwork. Some, such as the Animal Behavior Institute at AnimalEdu.com, specialize in preparing counselors for animal-assisted therapy. Others, such as PetPartners.org, focus on assessing animals for appropriate client interaction in specific settings such as nursing homes and hospitals.

Currently, there are only a few research-supported AAT certifications focused on counseling. Dr. Risë Van Fleet, co-founder and director of the International Institute for Animal Assisted Play Therapy, offers training and certification for mental health professionals interested in incorporating animals into their practice (International Institute for Animal Assisted Play Therapy, n.d.). A similar organization is the Animal Assisted Therapy Programs of Colorado. They offer online and in-person educational training.

When seeking a reputable training program, counselors should look for several items to be covered in the course. It is not enough to simply learn the techniques of animal-assisted therapy in counseling. An AATC training curriculum should also include:

- The human-animal bond, which creates a theoretical framework for conceptualizing the healing process that animals bring to counseling,
- The ethical implications of incorporating an animal into the therapeutic setting,
- Specific clinical techniques of animal-assisted therapy,

- Guidance on incorporating this modality into your theoretical orientation,
- And practical instruction on the nuts and bolts of opening an AATC program or practice.

Most counseling programs will not include animal-science or animal-training in the curriculum. Counselors should expect to undertake further study outside of counseling-specific courses to learn about the behavior and care of the animal species they choose for this work.

Since this is a growing field in counseling, more research and development are needed to enhance AATC training programs. One notable exception is the abundance of research that has already been published to support the use of horses in a variety of therapeutic settings, including mental health and addiction counseling (Wilkie, 2016). Canine-assisted counseling and similar studies would do well to follow their lead, since we already know a great deal about the efficacy of horse-related counseling and therapy interventions (Earles, 2015).

Selecting an Animal Co-therapist

When specializing in AATC, it is imperative to find the right dog (or other animals). Not every dog is equally suited for the job. The dog should be young enough to fully train but old enough to pass the necessary tests. The recommended age for any dog in AATC training is one year, regardless of the type of setting. By the time the dog enters AATC training, he or she should have already been trained in basic commands. Looking into the specific breed, sex, size, age, and temperament patterns in a dog is also a significant part of the search (Ernst, 2014). It is necessary to remain conscious of the population the dog will be serving. For instance, if a counselor were implementing AATC in a nursing home environment, he or she would not want a dog that is young, hyperactive, and playful (Ernst, 2014). Whereas a counselor specializing in play therapy with a younger population may prefer a more energetic dog.

A dog is a significant commitment of time and resources for counselors who seek to add AATC to their practice. Dogs must be cared for daily, both in the workplace and in the home. The counselor must consider the cost of food, veterinary services, and training. The average cost of owning a dog is more than $15,000 over the animal's lifetime (Reisen, 2017). It is the counselor's financial responsibility to care for the dog.

Dog's Nonverbal Communication Patterns

Beyond the physical and financial needs of the dog, the counselor and dog must develop a close emotional relationship. Essentially, the counselor has to know the dog and be able to sense if it is having a bad day or is uncomfortable. The development of this bond comes from a counselor's thorough understanding and awareness of their dog's nonverbal communication patterns. A counselor should be able to recognize the physical symptoms a dog displays while under stress (Chandler, 2005). Common visible signs of a dog in distress include but are not limited to: shaking or trembling, panting and salivating, dilated pupils, excessive blinking, shedding, vocalizing, inappropriate urination, turning away, attempts to leave, ignoring commands. Even though these are common visible signs, each dog responds differently to stress. Learning the unique way in which a dog responds to stressful situations will aid in further enhancing the counselor and dog's trusted relationship. In addition to this, it is equally as important to view a situation through an environmental context (Chandler, 2005). For instance, a dog pants when he or she is thirsty and in need of water. In this case, the dog is dehydrated. In another scenario, the dog could be panting out of fear because another dog is acting as a threat to their safety (Chandler, 2005). The characteristics of a dog's body language will change depending on what the dog is feeling and their environmental context. For instance, a dog expressing fearful body language signs, such as a tail tucked between their legs and body trembling, could quickly change to aggressive behavior if suddenly feeling threatened (Chandler, 2005). Ultimately, knowing stressors and postures, and recognizing the overall demeanor of a dog is critical for everyone's safety, including the dog's. Dogs have their own personalities and feelings and it is up to the counselors to read those feelings and act on them appropriately.

Retirement

While counselors are typically aware of the need to plan for their own retirement, they may be surprised to learn that their therapy dog needs a retirement plan too. After all, the dog will eventually become too old to work. The dog's retirement will have an impact on the clients' experiences in therapy. Ng and Fine (2019) comment on the importance of understanding each aspect of a therapy animal's retirement. Sample questions to consider include:

- How will you feel about your co-therapist retiring, while you continue to practice?
- How will your co-therapist respond to no longer fulfilling this role?
- How will you facilitate the conversation of your co-therapist's retirement with the clients they are serving?

As dogs grow older, they show less interest in interacting with strangers and become easily distressed in challenging situations (Ng & Fine, 2019). Consistent documentation of the animal co-therapist's behavior

helps the counselor note any changes in their interactions with clients. These notes will help the counselor make an informed decision about the animal's retirement as they near their middle age. Keep in mind that it was not the animal's choice to take on the role of co-therapist and the welfare of the animal must always remain a top priority. Ensuring the comfort and security of the dog in its older age is the responsibility of the counselor.

Liability Insurance

Before launching an AATC practice, the counselor must consider liability insurance. Even when all possible steps are taken to ensure the safety of the client and animal, incidents do occur. For this reason, a counselor should maintain some form of liability insurance to protect themselves, the dog, and the practice. Some certification programs provide comprehensive general liability insurance for their volunteers. This may be sufficient if the counselor plans to limit their animal-assisted activities to visiting schools and hospitals. However, many counselors choose to bring their animal into the counseling office. In this case, it is best to purchase one's own insurance policy separate from the program coverage.

Becoming an animal-assisted therapist can be a fruitful and fulfilling venture if done correctly. Ensuring that it is a practical and attainable goal is the first step for a counselor to take on this journey. Although the practicality of dog ownership and training is important, there are other considerations to take into account.

Legal Implications

Common to growing fields, the laws and regulations pertaining to this field are sparse. Section 803, Regulation 211.17 of The Health Care Facilities Act, under the Pennsylvania State Law, addresses the standards for Pet Therapy (Pennsylvania Code, n.d.). The six standards are as follows:

1. Animals are not permitted in the kitchen or other food service areas, dining rooms when meals are being served, utility rooms, and rooms of residents who do not want animals in their rooms.
2. Careful selection of types of animals shall be made so they are not harmful or annoying to residents.
3. The number and types of pets shall be restricted according to the layout of the building, and the type of residents, staff, and animals.
4. Pets shall be carefully selected to meet the needs of the residents involved in the pet therapy program.
5. The facility shall have written procedures established which will address the physical and health needs of the animals. Rabies shots shall be given to animals who are potential victims of the disease. Care of the pets may not be imposed on anyone who does not wish to be involved.
6. Pets and places where they reside shall be kept clean and sanitary.

Although there is limited legislation, a counselor must consider the legal implications of having an animal in the workplace. The counselor has the responsibility of ensuring the safety of both the client and the animal during sessions. Since this field is rapidly changing, it is advisable to stay up to date on any regulation or legislation pertaining to AATC. It is also advisable to ensure the therapy animal's training comes from a credible source and is up to date with current practices. The counselor is liable for the behavior of the animal and should ensure that the animal has adequate training to function in an AATC role. The authors consulted not only with an American Kennel Club (AKC) trainer, but also with a canine veterinarian to ensure the suitability of our therapy dog for this type of work.

Clinical Techniques

Before a new client enters a session with a dog, counselors should formalize a screening process, typically conducted over phone or video. Ask prospective clients if they would be interested in receiving AATC services. Despite their feelings toward dogs in particular, some clients may simply prefer traditional counseling. However, if the answer is yes, the counselor should then disclose the breed of the dog and inquire about allergies or medical conditions. The counselor should also explore whether there are any fears or prior negative experiences with dogs (Morrison, 2007). The main goal of the interview is to ensure the ethical treatment of both the client and the dog, but there is clinical value in spending a little extra time on this conversation. Clients are typically interested in the animal's story and often share their own pets' names and breeds. This is the first opportunity to establish rapport. A rich conversation about the nature of AATC during the screening call can make the first clinical session more comfortable for the client.

Remember that animal-assisted interventions are a set of techniques meant to be incorporated into each client's therapeutic experience, rather than a theoretical orientation unto itself. Many AATC interventions will be a creative version of the techniques counselors already use in their clinical work. Animal-assisted rapport-building, walk-and-talk therapy, and

mindfulness are a few techniques that adapt easily to this modality. These interventions are monitored and planned by a counselor and intentionally incorporate the animal into the working relationship with the client to strengthen rapport and trust, and to enhance the therapeutic process overall (Walsh, 2009). A specific objective and treatment plan are implemented through direct interaction with the animal. The animal acts as a helping agent and co-therapist to the counselor (Montolio & Sancho-Pelluz, 2020). There are several ways to accomplish this. In the same way that all treatment plans are tailored to the individual, techniques utilizing the therapy animal in sessions can be slightly modified or new ones can be created from scratch. Here are some examples of techniques that are commonly used with therapy dogs.

Walk & Talk Therapy

Therapy sessions do not have to be limited to an office and a pair of chairs. Holding sessions while taking a therapy dog on a walk allows for a less formal treatment setting. It also allows for natural pauses and silences during the session (Fine, 2019). Providing a client with a more relaxed environment may help them feel more comfortable through the session and may encourage them to be more open. In addition to this, being surrounded by nature adds to the element of relaxation and stimulates conversation (Fine, 2019). By taking the dog on a walk, the counselor is also setting an example of responsibility for the client (Fine, 2019). The client is learning the importance of patience and understanding when the dog stops to relieve its bowels or when the dog suddenly changes the direction of the walk to investigate a squirrel.

Mindfulness

In some instances, sessions can become stressful and cause clients to become detached. Asking questions and provoking simple observations about the dog is a useful way of grounding a client (Atherton et al., 2016). Questions such as, "How does his fur feel?" can be enough to pull a client back into the here-and-now moment. This can be accomplished by engaging multiple senses. Along with touch, the counselor can introduce questions about the color of the dog's fur, the sound the dog makes when he or she is sleeping, or how the dog smells (Atherton et al., 2016).

Letter-Writing

This activity uses the dog's perspective. The enthusiasm, unconditional love, and nonjudgmental qualities that dogs show for clients are integral to their participation in therapy. With these traits in mind, clients can write letters from the dog's perspective to explore their own qualities and strengths. They can also write letters to the dog about tough topics that are hard to share with other people.

Letter-writing is a common tool among several counseling orientations. In narrative therapy, for example, letter-writing is a therapeutic tool in which the client can re-author aspects of their own life, including their own beliefs and patterns (Hoffman & Kress, 2008). An essential characteristic of a letter is that it is tangible. Clients can return to this letter whenever they are in need of some extra support and encouragement (Hoffman & Kress, 2008). Animal-assisted letter-writing helps the client highlight their positive qualities and strengths by seeing themselves through a loving dog's eyes. It is another resource the client can use during moments of negative self-talk and self-doubt, even after they leave the counseling room.

Modeling Self-Care

Taking care of a dog requires commitment and responsibility but the dogs are also helping the counselor and client take care of themselves. Dogs model self-care with purity and spontaneity. When they want to sleep, they sleep. When they are thirsty or hungry, they look for food and water. When they need to be taken outside, they whine or stand by the door. Dogs remind us to make sure our essential needs are being met. It can be easy for humans, in general, to forget about themselves while consumed with the daily demands of work, family, and life. Dogs not only model self-care, but also foster conversations about this topic in the therapeutic setting.

These are just a few examples of how to incorporate a therapy dog into sessions. There are many other creative techniques that can be used. A counselor may even be able to create new techniques and activities if it means supporting their client's growth. Regardless of the technique being used, one of the primary goals of an animal-assisted intervention is for the animal to provide healing "in the form of present-moment experiences that are nonjudgmental, enabling AAT recipients to better express their emotions" (Ernst, 2014, p. 32).

Conclusion

The benefits of animal-assisted therapy greatly outweigh the obstacles, in the authors' opinion. However, this is a personal and professional decision that is unique to each counselor. Our therapy dog, Benji, lights up the counseling room with his playfulness and gentle demeanor. He makes clients feel more at ease, enhances the therapeutic process, and reminds us to take care of ourselves throughout the day. On the other hand, this commitment required an investment of time and money. We had to carefully prepare for the practicality

of selecting and training our dog, the ethical questions (and related procedures) that would ensure client safety and humane treatment of the animal, and the legal facets of having an animal in the office. Beyond these practical, legal, and ethical preparations, there was also the challenge of learning new techniques and activities. Writing an animal-assisted treatment plan is different from writing a traditional treatment plan, and animal-assisted rapport-building is much noisier than a typical first session with a client. It took time to adjust to these changes.

In the same way that AATC is not right for every client, neither is it a good fit for every counselor. Although this growing field changes frequently and presents its own obstacles, many clients and counselors have found it to be a rewarding experience. In conclusion, it is our hope that this article assists in exploring the advantages and disadvantages of your personal journey into animal-assisted therapy in counseling.

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JPCA Test to Earn CE Credit

Note: Earn 2.0 Free Continuing Education Credits by reading selected articles in this issue. Read the articles identified below and answer 8 of the 10 questions correctly to earn 2 CE credit.

Race-Based Traumatic Stress in the time of the Black Lives Matter Movement: Examining Posttraumatic Growth as an Intervention for Counselors Supporting Black American Clients (pp. 4-14)

1. Cultural competency when working with Black American clients can be achieved:
- ☐ a. Through the use of counselor self-assessment for treatment efficacy.
- ☐ b. By recognizing any real or perceived power differential within the therapeutic relationship .
- ☐ c. By recognizing that culture affects the manner in which clients' problems are defined and experienced.
- ☐ d. Understanding counseling competencies and adhering to the ACA ethical standard of care.
- ☐ e. All of the above.

2. It is suggested that a barrier to race-based traumatic stress (RBTS) is:
- ☐ a. Participation in the Black Lives Matter Movement.
- ☐ b. Diminished academic achievement.
- ☐ c. A positive, internalized racial identity.
- ☐ d. Counselor likeness.
- ☐ e. None of the above.

3. The five changes of Posttraumatic growth (PTG) are:
- ☐ a. Inner strength and resilience, interpersonal effectiveness, gratitude for life, faith and spirituality, and a growth mindset.
- ☐ b. Inner strength and resilience, interpersonal effectiveness, gratitude for life, faith and spirituality, and identifying new opportunities.
- ☐ c. Inner strength and resilience, mindfulness, interpersonal effectiveness, distress tolerance.
- ☐ d. Inner strength, resilience, religion, intentionality and transferability.

4. The Black Lives Matter movement was developed:
- ☐ a. To refute the All Lives Matter movement.
- ☐ b. To increase social awareness.
- ☐ c. To add systemic political pressure.
- ☐ d. A, B, and C
- ☐ d. B and C

COVID-19 Implications on Medication-Assisted Treatment Expansion in a Rural County Jail (pp. 15-21)

5. For persons experiencing reentry into the community, they are approximately_____ times more at likely to have a fatal overdose compared to the general population.
- ☐ a. 20
- ☐ b. 11
- ☐ c. 13
- ☐ d. 40

6. _____ is not recommended for pregnant women that present with opioid use disorders.
- ☐ a. Naltrexone
- ☐ b. Buprenorphine
- ☐ c. Methadone
- ☐ d. Naloxone

7. Justice-involved individuals that participate in medication-assisted treatment:
- ☐ a. Have reduced recidivism rates .
- ☐ b. Are more likely to continue on MAT upon reentry.
- ☐ c. Have decreased overdose deaths upon reentry.
- ☐ d. All of the above.

Becoming an Animal-Assisted Therapist in Counseling: Practical, Ethical, and Clinical Implications (pp. 22-30)

8. Animal-assisted counselors incorporate specially trained animals as _____ in the counseling process and use the _____ as part of the treatment process.
- ☐ a. Tools; outcomes
- ☐ b. Therapeutic agents; animal responses
- ☐ c. Therapeutic agents; human-animal bond
- ☐ d. Partners; behaviors

9. Professionals in Pennsylvania who utilize a therapy animal in their facility are affected by which of the following laws?
- ☐ a. Air Carrier Access Act
- ☐ b. Federal Fair Housing Act
- ☐ c. Americans with Disabilities Act
- ☐ d. The Health Care Facilities Act

10. The American Counseling Association has recommended 9 core competencies for animal-assisted therapy in counseling. Which of these is NOT a core AAT competency?

☐ a. Formal animal-assisted therapy training
☐ b. Knowledge and demonstration of ethics
☐ c. Proficiency of rudimentary counseling skills
☐ d. Proficiency of animal science or animal behavioral analysis

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☐ I certify that I have completed this test without receiving any help choosing the answers.

Feedback

Please rate the following items according to the following scale:

5 – Superior 4 – Above Average 3- Average 2 – Below Average 1 – Poor

	Superior	Above Average	Average	Below Average	Poor
The authors were knowledgeable on the subject matter	☐5	☐4	☐3	☐2	☐1
The material that I received was beneficial	☐5	☐4	☐3	☐2	☐1
The content was relevant to my practice	☐5	☐4	☐3	☐2	☐1
This journal edition met my expectations as a mental health professional	☐5	☐4	☐3	☐2	☐1
How would you rate the overall quality of the test?	☐5	☐4	☐3	☐2	☐1

Comments/Suggestions?

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