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2108-1055 West Georgia St.
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www.psychologists.bc.ca
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CONTENT

Winter 2023

BC Psychologist

A Message From The Board President

Dr. Erika Horwitz

Dr. Erika Horwitz is a psychologist in private practice with 30 years of experience as a generalist with a specialization in eating disorders and anxiety. She is the former director of counselling services at Simon Fraser University (SFU), where she implemented several mindfulness-based programs (drop-in mindfulness meditation, DBT-based groups, among others). She is also a lecturer both at SFU and UBC in counselling psychology. Dr. Horwitz spearheaded a provincial initiative (HiFIVE) to eliminate stigma against mental illness that has been adapted at several universities nationally and internationally. She published the book Through the Maze of Motherhood: Empowered Mothers Speak. She is currently the vice-chair of the national Council of Professional Associations of Psychologists. Dr. Horwitz has an interest in systemic change and social issues that affect disadvantaged populations. She is a certified mindfulness-based reduction teacher and was certified to teach mindfulness by the Centre for Mindfulness at the University of Massachusetts Medical School.

Dear BCPA Colleagues,

It is with great delight that I write to you in this our fall 2023 issue of the *BC Psychologist*. I am beyond excited to be starting my tenure as president of the BCPA and to get going on making our association stronger. I come with many hopes and dreams for the BCPA that I hope to bring to fruition while I serve as president. The BCPA is YOUR association, and I am hoping to make that clearer in the months to come. In my work as president, I will be guided by the recommended best practices for a psychological association, which include: a) meeting the learning needs of the members; b) building a sense of community; c) promoting the profession; d) being a trusted source of information; and e) meeting our members' growth needs.

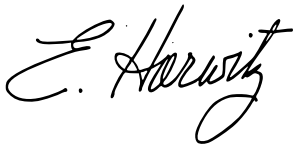
This past year, the Board and the staff have been working hard to rethink many processes and procedures to improve the flow of information between our members and the Board. For the past few months, I have been providing a presence in our forum and listserv with the purpose of communicating more consistently with members and improving this flow between members and the Board and staff. In addition, we have been thoughtful about the eBlast that goes out once a week via email to all our members. We are making a point of using the eBlast as an opportunity to inform our members of important projects or information about our association or what the Board is working on. My hope is that, over the next few months and years, our members will feel more integrated with the Board, the committees, and each other to create a strong sense of community and support.

This past fall, we offered the Ethics workshop, which we endeavoured to offer in a hybrid model to increase accessibility to all our members around the province. The workshop and the streaming of the live event were a success. We also very much enjoyed having many members attend in person and connect with one another while enjoying a nice lunch and treats. We plan to offer more of these hybrid workshops in the years to come. This workshop will be available to be viewed in our Thinkific platform until January 30th, 2024.

The BCPA continues to be committed to advancing the profession by funding and supporting the work of our Directors of Advocacy (DOA) who have been working beyond the call of duty to bring psychologists to primary care. In primary care, psychologists work in family medicine settings, offering access to patients in need of timely psychological services. The Directors of Advocacy are seeking to create these partnerships in primary care where the compensation for psychologists will be commensurate with our training, expertise, and current market rates. I have been attending meetings with our DOAs in support of this amazing and revolutionary project and feel excited about how a project like this is bringing more understanding about our profession and what we do to politicians and policy makers, because this will hopefully increase access to more members of the public and increase our visibility.

We recently added the BIPOC Resources to our website. This is a compilation of resources that was put together by our Diversity and Social Advocacy Committee (DASC). This resource includes 340 references that are about the experiences of BIPOC communities. The library includes online videos, books, articles, podcasts, websites, and more. This is an excellent example of some of the projects that the BCPA committees work on and contribute to our profession. This library is also an illustration of how the BCPA is committed to enhancing our members' knowledge and expertise on diversity and social issues. I invite you to take a look at it; it is truly amazing!

There is a lot more I could say or highlight, but in the interest of brevity, I will close by saying that I am really looking forward to making BCPA stronger and to interact with more of our members. Look for me on the forum, on the eBlast, and on our social media. For now, thank you for being part of our community!



Dr. Erika Horwitz
BCPA President

A Message From The Directors of Advocacy

Dr. Erika Penner & Dr. Lesley Lutes

The last year has been a busy one for your Directors of Advocacy, Drs. Erika Penner and Lesley Lutes. We have been working on a wide range of projects, all with the theme of increasing access to evidence-based psychological services.

One of our main projects has been the Primary Care Psychology program. In August of 2023, the Ministry of Health funded a feasibility and sustainability study for this program. The Directors of Advocacy, along with the Chair of the Advocacy Committee, Dr. Simon Elterman, were allotted six months to work closely with the Ministry of Health to plan both a pilot of the PCPsych program as well as an eventual province-wide roll-out. We expect to know in January 2024 whether the next step, the pilot, will be funded. If it is, we will be reaching out to the BCPA membership to share more details about this program, including the pay structure, training opportunities available, and job postings. If these new positions are created, it will represent a true shift in the way that the public accesses high quality psychological services as well as the manner in which psychology is funded through our public healthcare system.

Another area of focus has been the training of psychology residents. We recognize that the number of psychology doctoral students who graduate each year far exceeds the number of residency placements available in this province, leading to a 'brain drain' of our graduates to other residencies in North America. We are working to change this by actively meeting with relevant ministries to 1) alert them to the disparity between graduates and residency placements and 2) creatively devise new means of funding for residencies. This latter point is

crucial, given that virtually all residencies are funded by their individual sites (e.g., universities, health authorities) and, as such, their continued operation can be quickly compromised if funding priorities change.

Some of the other projects that we are focusing on include:

- replicating Ontario's referral service model to allow family doctors to refer to and communicate directly with private practice psychologists
- increasing access to psychological services for those using the First Nations Health Authority funding
- creating an infographic that helps non-psychologists understand the differences in training and expertise across mental health providers (e.g., psychologists vs. psychiatrists, counselors, social workers, etc.)
- coordinating with other provincial associations around Bill 36 (the new Health Professions and Occupations Act)
- working with the primary care networks to ensure that psychologists are represented on relevant committees

These are some of our main initiatives, with many other smaller projects on the go. That said, we want to hear from you! If you have concerns or know of happenings in your professional community that you'd like us to be aware of, please email admin@psychologists.bc.ca, and we'll get back to you. We want to get to know the psychologists in BC (there are only around 1400 of you!) and make sure that our work aligns with your priorities.

With gratitude,

Dr. Erika Penner, R Psych

Dr. Lesley Lutes, R Psych

Dr. Lesley Lutes

Dr. Lesley Lutes is a professor of psychology, director of clinical training, and director of the Center for Obesity and Well-being Research Excellence at the University of British Columbia - on the Okanagan Campus. Her are research is in behavioral medicine: developing innovative treatment approaches focused on improving mental and behavioral health in order to reduce chronic diseases (e.g., diabetes, heart disease) and improving quality of life. She has received over $7 million in grant funding to date, published over 70 peer reviewed papers, and completed over 100 national and international presentations. In addition to her research, she is currently the Co-Director of Public Advocacy for the BC Psychological Association. Since coming back to Canada in 2015, where she was born and raised, she has been passionate about helping change healthcare policy in BC, and integrating evidence-based models of care into primary care networks in order to improve the physical and mental health and well-being of individuals, improve physician wellness, and decrease healthcare costs.

Dr. Erika Penner

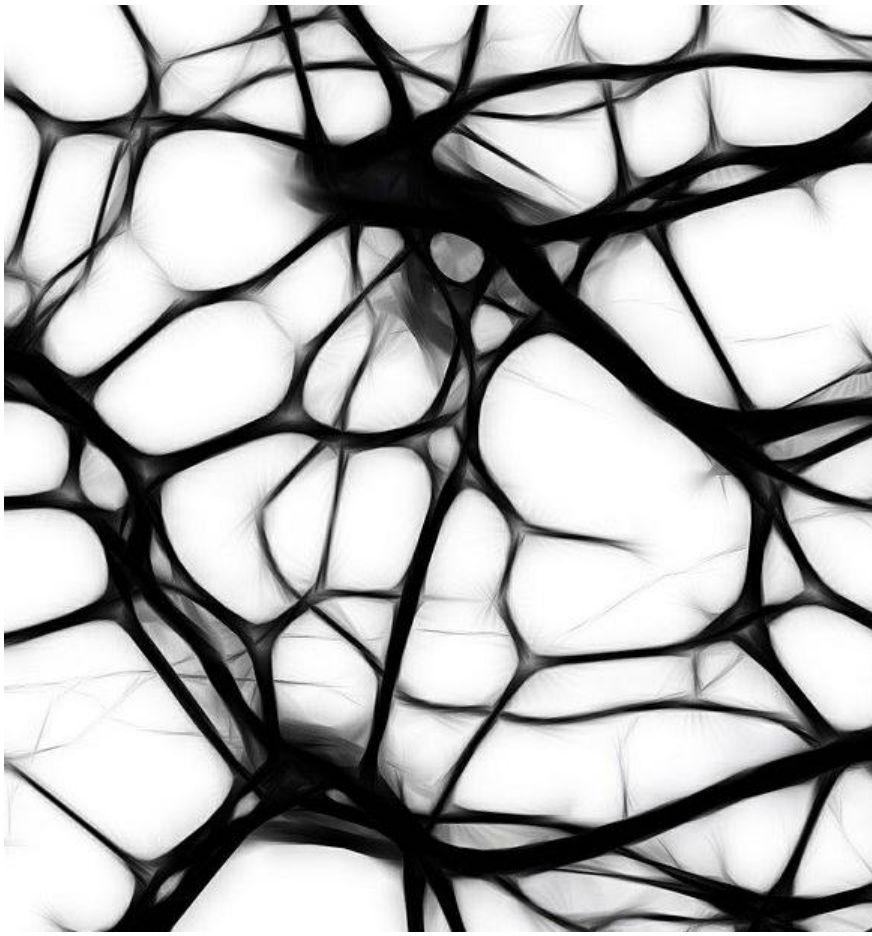
Dr. Erika Penner, R Psych, is a Registered Psychologist in BC and one of the directors of advocacy for the BC Psychological Association. She is a clinical instructor within the Department of Psychiatry and Faculty of Medicine at the University of BC, and a clinical associate (providing supervision to clinical psychology graduate students) at Simon Fraser University. She has temporarily stepped back from her role as the psychology lead for the Vancouver Coastal Health Region to focus on the Primary Care Psychology Proposal, a collaboration between BCPA and the Ministry of Health. She worked as a health psychologist within the Department of Medical Psychology at BC Children's Hospital for over a decade where she also conducted research in pediatric transplant as a clinical investigator with the BC Children's Research Institute.

Polyvagal Theory in Delivery of Trauma-Informed Care in Acute Medical Settings

By ***Arezu Moshrefzadeh,*** *Vancouver, BC &*
Ronald S. Manley, *Vancouver, BC*

Arezu Moshrefzadeh *is a Registered Clinical Counsellor with a background in health and mental health research. She sees clients in her private practice, facilitates workshops and offers consultation. She is passionate about using evidence-based learning to nurture individual growth and to contribute to collaborative community wellbeing.*

Dr. Ron Manley *is a registered psychologist who has worked for almost four decades in Vancouver, and is an associate faculty at the Vancouver campus of City University of Seattle. His interests include the integration of somatically-oriented psychotherapy with cognitive, attachment, and mindfulness approaches. He is also in private practice where he offers psychotherapy, consultation for therapists, and workshops/training. His current interests include human potential generally and the interface between psychotherapy and spirituality.*



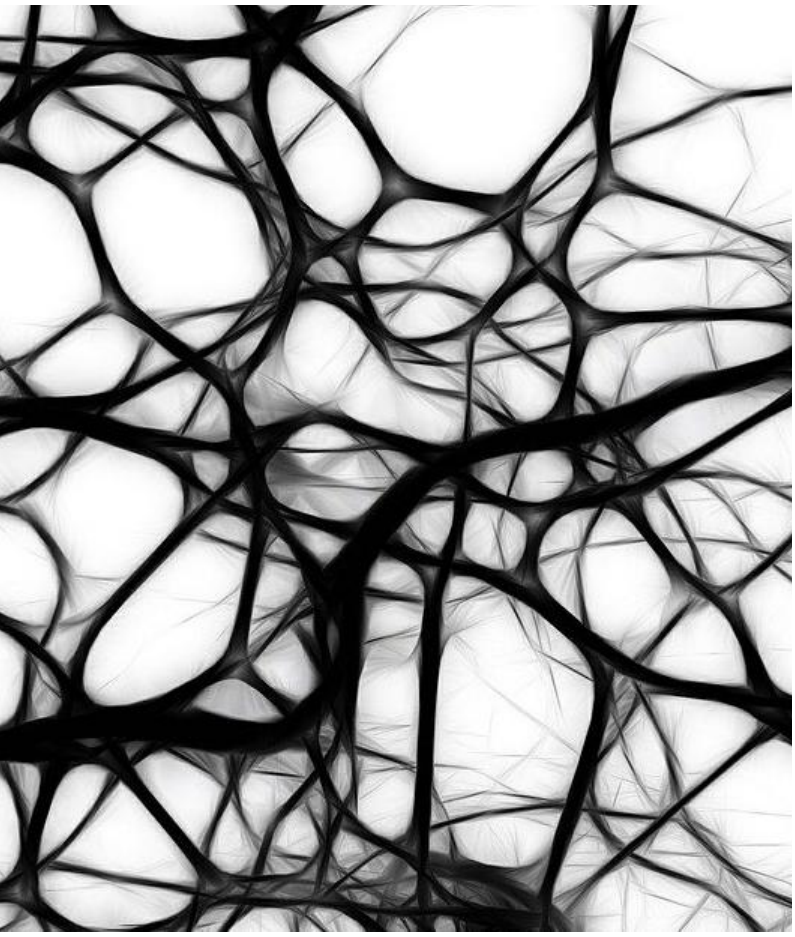
Statement of Disclosures

Both Ms. Moshrefzadeh and Dr. Manley do not have any conflicts of interest to report.

Abstract

Polyvagal theory has played a pivotal role in our understanding of the nervous system's response to threat and provides a framework for establishing safety in the healing alliance. Patients who are in medical and psychological distress

require a trauma-informed approach that is based on an understanding of the autonomic nervous system's hierarchical response to threat. This article outlines how practitioners can act as a source of safety for patients by assessing nervous system state, understanding the impact of this state on perceived safety, and using polyvagal principles to engage their patient's safety systems. We outline systemic harms that patients may face which impact their perception of threat in the medical environment, as well as the health care practitioner's potential to act as a calming resource to their patients.



Keywords: polyvagal theory, nervous system, autonomic state, patient safety, healthcare

Background

Threat During Acute Medical Events

Concerns around ill health are a source of stress and anxiety for most people, and the experience of needing treatment for an acute medical event has been shown to be particularly frightening, resulting in short and long-term adverse psychological and health outcomes (Chang, 2019), including the diagnosis of post-traumatic stress disorder (Starr et al., 2004 cited in Levine, 2010, p. 63). Moss et al. (2020), for example, found that almost all patients (98%) undergoing treatment for acute cardiovascular or respiratory illness perceived life threat, and 72% reported post-traumatic symptoms in relation to their hospital visit at follow-up. One report indicated "more than 52%" of patients treated for bone breaks developed PTSD (Starr et al., 2004 cited in Levine, 2010, p. 63). These findings are unsurprising when viewed through the lens of polyvagal theory given that an acute medical event can be life threatening or perceived as such and would activate the autonomic nervous system's (ANS) defense systems. Research conducted on hospitalized patients shows that this population exhibits prolonged states of hypervigilance, which not only impact them during their period of hospitalization but also leads to sustained negative effects following hospitalization (Chang, 2019).

Evidence supports that aspects of the medical environment also exacerbate a patient's anxiety and negatively impact their psychological state (Chang, 2019). Hospitals themselves are a real-life threat: data shows that medical errors and hospital acquired infections were a leading cause of death in the United States (Ulrich et al., 2004). Patients are exposed to numerous threats such as multidrug resistant infections as a result of poor air quality, construction/renovation activities and interpersonal contact (Ulrich et al., 2004). During the COVID-19 pandemic, many patients may have avoided emergency room visits due to fear of becoming ill. For some patients, the hospital environment has been found to lead to acute changes in mental status (Chang, 2019). The risks inherent in medical environments have led some researchers to hypothesize that the hospital environment itself may be a cause of patient harm and adverse outcomes (Chang, 2019). Structural limitations (for example, high noise levels), an inherent loss of autonomy, lack of control, unmet needs, reduced social interactions, and a perceived lack of self-competence all amplify the sense of danger

and threat in the medical environment (Lerwick, 2016; Porges, 2020). Anxiety and depression during medical treatment have been associated with impaired short-term recovery and increased vulnerability for readmission (Chang, 2019; DiMatteo et al., 2009). Patients with higher levels of anxiety have been found to have lower quality of life and longer stays in hospital (DiMatteo et al., 2000).

Polyvagal Theory in Healthcare

While polyvagal theory has been applied to trauma work in the therapeutic community, it appears to have received minimal attention to date in its application in the medical field, a field in which trauma is endemic. Most people can likely recount an experience of a healthcare visit or medical procedure that was anxiety provoking, and research supports that there is a clear correlation between healthcare, hospitalization, and anxiety (Lerwick, 2016). The anticipation of being in a medical environment alone causes fear and anxiety (Lerwick, 2016). Interaction with healthcare providers and medical environments can enhance anxiety and trauma, and even cause trauma directly (Chang, 2019; Lerwick, 2016) and there is clear evidence to support that medical environments elicit feelings of threat in patients (Chang, 2020).

To understand patients' fear and anxiety, we must start with an understanding of the ANS. It has been well-established that the ANS is stimulated by exposure to threat and governs the survival responses of fight, flight, freeze, and feigned death (Levine, 2010; Porges, 2017; van der Kolk, 2015). The ANS is understood to have two main branches responsible for regulation: the sympathetic branch that prepares the body for action, and the parasympathetic branch which is responsible for conservation and restoration. The regulation of the relative responsivity of these branches of the ANS is controlled by the vagus nerve, which runs from the brain to the heart, gut, and other visceral organs (Porges, 2017). Previous literature regarding the ANS presupposed that there was a single branch of the vagus nerve originating in the brain (Porges, 2017). However, in 1994 Stephen Porges introduced polyvagal theory, which moved away from this univagal model. Porges (2006) stated

When our interactions with others fail to make us feel safe and secure, we 'drop down' the ladder and older structures responsible for survival take control.

that there are several pathways of the vagus nerve that were formed at distinct stages of human evolution. As each new pathway was formed, the older one was retained and continued to function as a survival response (Porges, 2006). As such, there is an autonomic "ladder" (Dana, 2018), a hierarchy of activation, from the newer pathways down to the older ones (Porges, 2011). When our interactions with others fail to make us feel safe and secure, we 'drop down' the ladder and older structures responsible for survival take control. In so doing, the body demonstrates an inherent wisdom in responding to threat and in not, at least initially, allowing our conscious decision-making cortical structures to be accessed.

Ventral Vagal Complex: Social Engagement System

The highest level on this hierarchy is the ventral vagal complex, which is a response of the parasympathetic branch of the ANS and which activates the social engagement system when engaged (Porges, 2006; van der Kolk, 2015). This allows for connection with others and is marked by a slower heart rate and deeper breathing (Levine, 2010; van der Kolk, 2015). This state is important for health, growth, and restoration (Porges, 2018). The body

and the brain work together in the ventral vagal state, and critical thinking, problem solving, and change are possible in this state (Dana, 2020). The social engagement system allows an individual to assess safety in facial expressions, tone of voice, and body language (Dana, 2020). It allows an individual to convey their state through facial expressions and variation in prosody of voice, and optimizes hearing to be within the frequency used for social communication (Porges, 2018).

Sympathetic System: Mobilization

When a threat of danger is perceived, the sympathetic nervous system circuitry is activated which is associated with the fight or flight response (Porges, 2006). This mobilization optimizes the body for the use of our limbs for evasion or fight (Levine, 2010; Porges, 2006). In this autonomic state, the heart rate increases, hearing becomes more attuned to sounds that signify danger, and breathing becomes shallower (Porges, 2018). This autonomic state is intended to be temporary and to focus bodily resources on fight or fleeing during moments of danger. While in this state, it is challenging to think critically, weigh options, and be empathetic (Sunseri, 2019).

Dorsal Vagal System: Immobilization

If the sympathetic nervous system response of fight or flight is not available or does not allow for a return to safety, the presence of life threat activates the dorsal vagal system (Porges, 2006). The dorsal vagal system is considered to be the most primitive part of the ANS, which activates strategies of tonic immobilization, more commonly referred to as shutdown or the "freeze" response (Levine, 2010; Schore, 2009). It is responsible for collapse, numbness, dissociation, and a feigned death response (Levine, 2010).

Neuroception

Polyvagal theory proposes that the evaluation of risk in the environment occurs continually and at a neural level below conscious awareness, in a process called neuroception (Dana, 2018; Porges, 2009, 2018). Porges (2009) stated that there are bidirectional neural pathways between the brain and the body that initiate processes that shift our physiological state, which in turn impact our perceptions. Neuroception impacts our physiological state (Porges, 2011), often instantaneously (Porges, 2018) and as a result, our behaviour. The mind then creates narratives and beliefs in an attempt to explain the autonomic state shift (Dana, 2018). As neuroception occurs without conscious awareness, we are often unaware of the reasons behind an autonomic state shift but are generally able to discern our body's subsequent reactions to it (Porges, 2018).

Coregulation

Porges (2011) stated that humans are a social species and that connection with others is a biological imperative, crucial for creating a shared sense of safety. Polyvagal theory asserts that human survival is dependent on the ability to regulate each other's nervous systems through bidirectional communication (Porges, 2011; Schore, 2009). A person that is in social engagement allows for the other to shift their autonomic state towards safety. When faced with a threat, the body first attempts to restore a sense of safety through coregulation (Porges, 2020), and if this fails, the sympathetic system is then activated to ready the body for fight or flight. Coregulation has a protective effect by reducing threat perception and deactivating the sympathetic nervous system, which allows a return to the social engagement system, thus increasing one's confidence in their ability to face challenges and ultimately reducing post-traumatic symptoms (Dana, 2018; Porges, 2020). The neurophysiological regulation of this process is thought to be through the vagal "brake", which allows more or less sympathetic arousal into the system depending upon environmental demands (Dana, 2018).

Coregulation requires that clinicians take time to recognize and tend to their own autonomic state and become grounded and regulated before attempting to be a resource for their patients. When practitioners are in social engagement or a ventral vagal autonomic state, coregulation requires them to be present, with the knowledge that if they remain in a calm state consistently, the patient will likely follow.

Ethical and Systemic Challenges

While the principles of polyvagal theory are applicable in all human relationships and therefore all patients, many patients belong to groups who have been and are subject to systemic harm or have had traumatic experiences and, as such, are more susceptible to feeling under threat in the medical environment. Using knowledge of the ANS to engage patients' safety systems becomes of even greater importance for these individuals and groups. It has been established that trauma is a compounding risk factor for lowering the threshold at which there will be autonomic arousal and perceived threat (Porges, 2020). Groups that experience more systemic harm and oppression have an increased risk of experiencing trauma, and many have experienced harm as a direct result of the healthcare system. Research has clearly shown that racialized communities are less likely to receive appropriate medical services, and that when they do, they experience a lower quality of care (Frakt, 2020; Mitchell et al., 2019; Ruíz, 2020). Black communities have long been subject to unethical treatment from the health system and their health outcomes are poor compared to white populations (Frakt, 2020). Medical research studies like the Tuskegee study revealed clear acceptance of blatant racism and led to a deep distrust of the health system (Frakt, 2020). Indigenous communities have also suffered medical experimentation and a long history of colonial and institutional trauma (Mitchell et al., 2019). Across the world, Indigenous peoples are disproportionately represented in the burden of mental and physical illness relative to settler populations (Mitchell et al., 2019). Medical gaslighting, defined as the marginalization and dismissal of illness by a healthcare practitioner, is a common experience for Indigenous patients (Ruíz, 2020). It is also commonly reported amongst women (Ruíz, 2020) and patients with a diagnosis of a mental illness (Hahn et al., 1996). Medical prejudice is also prevalent when viewed through the lens of gender inequity, with women disproportionately experiencing discriminatory practices and poorer health outcomes (Ruíz, 2020).

These more vulnerable sociocultural groups may have a lower threshold for detecting threat in the medical environment based on traumatic histories and continued unethical treatment within the health system and in society at large. As a result, their attitudes, behaviours, and worldview are more likely to be impacted by a dysregulated state when seeking medical care. Patients in an immobilized autonomic state are significantly more likely to be non-compliant with medical treatment recommendations and more likely to overestimate the severity of their circumstances (DiMatteo et al., 2000). They are more likely to be labelled as a 'difficult patient' (Hahn et al., 1996), and it is important for healthcare providers to understand not only the complex histories of trauma that their patients may carry, but the neurological underpinnings of their behaviour.

Considerations for Clinical Practice

Establishing Safety and Determining Autonomic State

While there has been much attention given to the partnership between healthcare providers and patients (Fuertes et al., 2015), and to psychologists being integrated into primary care settings, research has only just begun to consider this relationship through a neurophysiological lens (Thompson, 2018). Healthcare providers have little or no training to understand that a patient's capacity to engage with them is determined by their neurophysiological state. As a result, healthcare providers may, as Thompson (2018) termed it, exhibit 'polyvagal blindness'. By addressing polyvagal blindness, healthcare providers can assess a patient's autonomic state, empathize with their resulting behaviours, and send signals of safety. In doing so, they have the ability to activate a patient's social engagement system, which enables the patient to be engaged in collaboration and make informed decisions regarding their care (Porges, 2020; Thompson, 2018).

By determining the autonomic state of a patient, healthcare providers are able to gain insight into the patient's perception of threat and understand that the patient's perception and worldview will be determined by this state (Dana, 2018). Determining a patient's autonomic state requires centering the patient's voice so that symptoms and the resulting impacts can be observed and assessed. In doing so, the healthcare provider demonstrates to the patient that their needs are prioritized and begins to build trust (Thompson, 2018). Understanding the components of each state as outlined previously enables healthcare providers to determine what state their patient is in, and if unsure, the practitioner can look for the following signs:

- Signs of a patient being in ventral vagal may include sustained and appropriate eye contact, a range of facial expressions, calmness, hope, ability to focus, and capacity for self-reflection.
- Signs of a patient being in sympathetic activation may include shallow breathing, muscle tension, wide eyes, and rushed speech.
- Signs of a patient being in dorsal vagal may include dissociation, flat affect, monotone voice, slumped posture, sense of overwhelm, emotionally numb, and disconnected.

Downregulating Defence

According to Porges (2018), there are two pathways that can activate the neural mechanisms that downregulate autonomic arousal: passive and active. The passive pathway occurs outside of conscious awareness through the influence of neuroception. Safety signals and positive interactions with others in the immediate environment activate the neural pathways that enable the social engagement system. The active pathway involves undertaking conscious behaviours, such as controlled breathing exercises and specific movements and postures, with the intent to trigger the neural mechanisms that can shift autonomic state. Establishing safety through the passive pathway is generally more feasible than utilizing the active pathway within the scope of current medical practice.

By understanding the process of neuroception, healthcare providers can begin to engage their patient's social engagement system through conveying cues that signal safety. The following paragraphs briefly outline the cues of vocal prosody, active listening, safe touch, facial expressions, and reflecting observations of the patient as important signals of safety at a neurobiological level.

Vocal Prosody

Vocal prosody is the rhythm and intonation of speech, and it conveys information beyond the literal meaning of words being spoken. Levine et al. (2015) drew particular attention to the importance of vocal prosody since the nervous system continually detects and reacts to sound. While visual stimuli can be ignored through closing the eyes or turning the gaze away, it is not possible to turn off hearing and as a result the nervous system continually interprets the features of sound and voice (Levine et al., 2015). Awareness of the effects of vocal prosody on a patient's state can

help healthcare providers interact with patients in ways that better support coregulation and connection. A healthcare provider's tone and pitch can convey emotional states that alert the patient's neuroception to safety or danger. Vocalizations that are monotone, shrill or too deep alert the nervous system to potential threat (Dana, 2018). In contrast, a voice that displays a range of intonation and has rhythm conveys safety (Porges, 2017). Prosody is also a tool to communicate intent. It can be used to convey compassion and caring which have been shown to lower autonomic arousal (Dana, 2018). Curiosity, concern, playfulness, and care all come through the voice when there is a range in the tone and a sing-song quality to it (Sunseri, 2019).

Active Listening

Listening that is active, attentive, concerned, and empathetic has emerged as a crucial element in healing relationships between practitioners and patients, providing a contrast to the scientific model of viewing listening solely as an act of information gathering. Active and reflective listening allows healthcare practitioners to understand their patients, empathize with their suffering, and increases the healing potential of their work together (Jackson, 1992).

Safe Touch

Touch has the potential to be a powerful healing tool with which to communicate and transform emotions. Touching an individual's arm, knee or shoulder, or simply moving closer to them, can activate the social engagement system (Dana, 2019). It is important to emphasize that the focus is on safe and non-sexualized touch - touch that is welcomed and done with informed and empowered consent. Touch is a contentious topic and discussion of the ethics of the use of touch in medical environments is beyond the scope of this paper. However, touch is included here as a consideration since medical intervention most often involves direct physical contact, and navigating the inclusion of gentle healing touch can be a tangible experience of support. Safe touch has been cited as one of the most powerful pathways to establishing a sense of wellbeing (Dana, 2019). Touch has been shown to convey somatic cues of safety, and the tactile connection to a safe other can assist patients to move out of a state of mobilization and towards social engagement.

Facial Expressions

Porges (2003) explained that there is a face-heart connection in which the ventral vagus pathway (which activates the social engagement system) is connected to the neural pathways that control the muscles in the face. Facial expressions continuously convey information and send signals of warning or welcome (Dana, 2020). Signals of safety that are conveyed by the face are a gentle soft gaze, genuine smile and allowing the face to have natural movement and expression (Dana, 2020; Porges, 2003). Having movement in the shoulders and tilting the head when listening conveys safe curiosity (Dana, 2020). While personal protective equipment that is often required in the medical environment, particularly during the COVID-19 pandemic, can be a barrier to expressing a calm state, facial expressions remain an accessible way to convey safety. Equipment such as face masks still allow for conveying gentle gaze and crinkles around the eyes which are important safety cues (Dana, 2018).

Reflecting Back Observations

When a healthcare provider is aware of the messages conveyed in body language and pays attention to physical manifestations of shifts in autonomic state, it can enhance a patient's sense

of safety (Levine, 2010). Thompson (2018) encouraged medical practitioners to refocus on the patient experience by noting when the patient's body language changes and using it as an opportunity to ask what they are experiencing. The body demonstrates the patient's autonomic state, and in attending to the shifts conveys safety to the ANS and builds the patient's trust in their care provider (Levine, 2010).

Conclusions and Lessons Learned

Healthcare providers are uniquely positioned to impact a patient's sense of safety at a time of vulnerability and immense need for care. Over the last two decades, health service delivery research and change has been focused on patient satisfaction, resulting in a shift towards a patient-centered approach (Zhao et al., 2016). This shift involves viewing the patient more holistically and considering their emotional, mental, spiritual, social, and financial needs in addition to their physical health needs (Zhao et al., 2016). It involves healthcare providers establishing a partnership with patients and working collaboratively with them in their healthcare decisions (Zhao et al., 2016). Early research regarding patient-centered care was quick to discover that for shared decision-making to be effective in practice, a strong partnership between the healthcare provider and patient was necessary (Fuertes et al., 2015). Establishing this alliance requires a sense of safety, as polyvagal theory indicates that the nervous system defense strategies interfere with interpersonal interactions, trust, and the ability to feel safe with another person (Porges, 2020). The critical thinking and problem-solving capabilities required for decision-making are only accessible when an individual has access to their ventral vagal/social engagement system (Dana, 2020). This system is the optimum neurophysiological state from which to make decisions and to engage in collaboration (Thompson, 2018). When patients feel safer and are able to maximally participate in their care, research has shown that there is then decreased pain, decreased drug use, increased sleep, improved adherence to medical instructions, better patient experience, decreased symptom burden and overall improved patient satisfaction (Fuertes et al., 2015; Ulrich et al., 2004).

Using polyvagal theory to understand the human response to threat, we can see that when patients experience a sense of threat and are unable to coregulate, their ANS will move towards mobilization. This state may be expressed as anxiety or irritability (Porges, 2020). When this does not provide safety or when the threat is life-threatening, the ANS will move towards an immobilized state which may be seen as depression, dissociation, a desire for social isolation, withdrawal, loss of purpose, and feelings of despair (Porges, 2020).

> ***Polyvagal theory stresses the need to center people at the heart of the healing work, a need that is too often left unattended.***

Understanding the effects of the ANS through the lens of polyvagal theory allows healthcare providers to understand their patients' responses that occur beneath the level of awareness. When practitioners have polyvagal awareness, they can translate patient behaviour to understand their neurophysiological state, and as a result can more fully understand and empathize with the patient's experience. When working from a polyvagal lens, healthcare providers are better equipped to act as a source of safety for their patients and as a result are better able to impact both the experiences and outcomes of their patients as they work towards healing. Polyvagal theory stresses the need to center people at the heart of the healing work, a need that is too often left unattended. This includes healthcare providers who themselves are aware of and coping with the effects of the increasing disconnection between practitioners and their patients. This is a place where polyvagal theory has immense potential for impact by focusing on the wellbeing of both people involved in the healthcare dyad. A grounding in the neurological underpinnings of the partnership between

> ***As healthcare providers increase their capacity to effectively engage the body's safety system, they provide their patients access to a neurological state that is optimized for health, growth, and restoration.***

patients and their healthcare providers enriches the collaboration between them and requires attending to the wellbeing of the provider so that they may be of best service to their patients. They must also have an acute awareness of systemic and societal harms that patients face which may put them at a higher risk of perceiving threat in the medical environment. As healthcare providers increase their capacity to effectively engage the body's safety system, they provide their patients access to a neurological state that is optimized for health, growth, and restoration.

Key Clinical Considerations

- Medical environments activate the body's ANS defense system, increasing fear and anxiety for patients.
- To engage their patients' safety system clinicians need to begin with an assessment and understanding of their ANS state.
- Through an awareness of the processes of neuroception, a subconscious constant scanning of the environment for threat, healthcare providers can convey cues that signal safety.
- Strategies for the clinician include attention to voice prosody, active listening, consideration of safe touch, facial expressivity, reflecting back observations, and acting as a calming resource to their patients.

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Clinician's Corner

This is a place to share your opinion with readers on scenarios faced in our work with clients. Questions will be posed in each issue of the BC Psychologist, and readers can submit responses. Select responses will be published in the following issue. Readers can also submit their own question to be posed in later issues.

The three questions that you can submit responses to are given below:

1. *How do you handle the situation if you are providing couple counselling and one member drops out and the other wants to continue?*

2. *How much do you personally disclose about yourself, e.g., that you are married or divorced, that you have children or not, if your parent has died, etc.?*

3. *What do you say if client threatens to report you to the college? How do you respond?*

Submission details:

- Responses are limited to 500 words. Responses may be edited for clarity.
- Questions should follow the theme related to practice with clients.
- Please allow the editors time to review your responses. If your response is selected for publication, you will be contacted by the Lead Editor.

If you are interested in participating, please scan the QR code or go to the following link: https://www.surveymonkey.com/r/BCPAclinicianscorner

Responding to the Needs of Refugee Clients: Challenges and New Directions for Psychologists

By ***Tanya (Tatjana) Elez, PhD, R Psych & Sumin Na, PhD, R Psych***

Tanya (Tatjana) Elez *is a psychologist in private practice in New Westminster, BC. She taught at the University of Winnipeg, Adler University and University of British Columbia. Tanya immigrated from the Former Yugoslavia during the nineties war and has been engaged with refugee and immigrant communities throughout her career. She is a member of the BCPA's Diversity and Social Advocacy Committee.*

Sumin Na, *is a psychologist in private practice in Vancouver, BC. Having immigrated from South Korea as a child, she is passionate about working with immigrants, refugees and other historically marginalized populations. She is a member of the BCPA's Diversity and Social Advocacy Committee.*

We are privileged to live and work in a country that welcomes immigrants and refugees every year. Since 1980, Canada has offered a safe home to over a million refugees from all over the world (UNHCR, 2023). Even though escaping the dangers of political violence and moving to a safe country may be the most important first step in refugee adaptation, settlement is not an easy process for many. This process involves a never-ending negotiation between "here and there, between past and present, between homeland and hostland, and between self and others" (Bhatia & Ram, 2009, pp. 141-142). In this process, a person must embrace their painful history, establish a sense of continuity, and resist the harmful effects of political violence and oppression that is frequently experienced both at home and in the new country. Individualistic, linear, and one-directional conceptualizations of mental health and acculturation, which many psychologists are accustomed to, may not sufficiently capture this process.

Extant psychological literature frequently conceptualizes the refugee experience as a series of steps. These include pre-migration, characterized by political violence; migration, characterized by a period of uncertainty; and post-migration, characterized by various settlement-related challenges (Beiser & Hou, 2016; Mock, M., 1998; Stewart & Nowosad, 2020). Even though the refugee trajectory may not always be so linear, challenges have been documented at each step.

Prevalence studies consistently demonstrate that refugees are about 10 times more likely to be diagnosed with posttraumatic stress disorder (PTSD) and/or depression compared to the general population. These studies indicate that

PTSD and depression linked to pre-migration experiences of political violence appear to persist many years after displacement (Blackmore et al., 2020; Charuvastra & Cloitre, 2008; Fazel et al., 2005; Nickerson et al., 2011; Steel et al, 2009). Prevalence findings in children, who comprise 51% of the refugee population, are even more alarming. With 23% prevalence for PTSD, 14% prevalence for depression, 16% prevalence for anxiety disorders, and 9% prevalence for ADHD, these findings suggest that high numbers of refugee children may be at risk for educational disadvantages, poor social integration, and an overall negative impact on their life course (Blackmore et al., 2020b).

In addition to experiences of political violence, the literature describes stressors related to exile and resettlement to be significant sources of mental health struggles for the refugees. These include racism, underemployment, unemployment, lack of recognition of academic credentials, and constraining bureaucratic practices. Social dislocation and separation from family, friends, and community seem to be the most salient factors negatively affecting both mental health and settlement in a new country (Beiser, 1999; Elliot & Gray, 2001; Griswold & al., 2021; Liddell et al., 2022; Simich, 2008).

Considering most psychologists' individualistic training that emphasizes diagnosis while minimizing the larger context, it is important to point out the risk involved in focusing on pathology at the expense of the immense resilience of the refugee population. In addition, we know very little about psychological variables or other factors that may contribute to successful refugee settlement. Some literature sources highlight the importance of so-

cial determinants of mental health, such as social support and community connections in the new country (Beiser, 1999; Elliot & Gray, 2001; Keyes & Kane, 2004; Schweitzer et al., 2007; Simich, 2008; Thomas et al., 2011). When considering these findings, the literature demonstrates a need for increased psychological engagement and also highlights ways in which psychologists' approach must be modified in order to adequately respond to this population.

Despite the critical need for mental health and psychosocial support for refugees (Blackmore et al., 2020; Hynie, 2018), individual and systemic barriers lead to disparities in the use of mental health services. Researchers have explored barriers experienced by refugees in accessing mental health services, such as stigma towards mental illness, language, and financial barriers (Byrow, et al., 2020). However, few studies have examined the perspectives of mental health care providers that affect their willingness or reluctance to provide services to refugee clients.

In a study of psychotherapists in Germany, therapists who were more relationally oriented reported greater readiness to work with refugees (Schlechter, et al., 2020). Moreover, prior experience working with refugees, but not years of clinical experience, was associated with readiness to work with refugees. Therapist factors, such as interest in political events and openness to experience, were also positively associated with readiness. On the contrary, therapist's self-doubt, as in perceived inability to manage unanticipated situations and difficulties working with challenging clients, was negatively associated with readiness to work with refugees. However, the authors also note that high self-doubt has been associated with better therapeutic alliance and may be associated with cultural humility (Schlechter et al., 2020).

In a study in Alberta, service providers who work with immigrants and refugees highlighted insufficient public structures and systemic barriers that affect their ability to provide services to this population (Salami, et al., 2019). For instance, they reported a lack of cultural brokers (i.e., people who mediate between individuals of different cultures and often act as advocates for the person from the non-dominant culture) who understood their role in therapy sessions, which includes the ability to develop rapport with clients and effectively interpret terminology related to mental health. Immigrant service providers also reported that this responsibility often fell on a family member, especially a child, which can interfere with the therapy process and may have repercussions on the family member. Moreover, participants perceived that refugee clients may fear negative consequences for having mental health concerns, such as depor-

> ***Psychologists are challenged to work beyond their familiar individualistic model to provide support and engage in advocacy in a broader context. Fortunately, psychologists are uniquely positioned and have the potential to support refugee clients in these various domains. In addition to strong clinical skills, psychologists already possess a number of competencies that may augment their work with these clients.***

tation and access to resources, which impair their ability to engage in treatment (Salami et al., 2019).

Psychologists in B.C. likely experience similar challenges and structural barriers that contribute to difficulties or reluctance to provide mental health services to refugee populations. These may include: lack of clinical experience with refugee clients, unavailability of supervision, self-doubt, difficulty accessing an interpreter or cultural broker trained to work in mental health settings, inability to find appropriate funding, and the need to work with clients who have mistrust towards mental healthcare professionals and those who may have a different understanding of mental health.

The barriers that lead to disparities in mental health among refugees are multidimensional and include individual, interpersonal, institutional, and structural factors. Psychosocial interventions that integrate the social determinants of mental health, including adequate housing, income, and social support, appear particularly important when working with refugees (Hynie, 2018). Thus, psychologists are challenged to work beyond their familiar individualistic model to provide support and engage in advocacy in a broader context. Fortunately, psychologists are uniquely positioned and have the potential to support refugee clients in these various domains. In addition to strong clinical skills, psychologists already possess a number of competencies that may augment their work with these clients.

At a time of increased political conflict and forcibly displaced individuals, enhancing psychologists' engagement is crucial in supporting refugee populations. In order to offer adequate services, psychologists need to develop and practice a broad range of competencies. Below we have outlined some of the competencies that psychologists already have that can contribute to better engagement with refugee populations. This is just the beginning and there is much to learn. In addition to broadening psychologists' scope of practice, working collaboratively with refugees and community organizations will be critical in building on our role as psychologists.

Table 1

Psychological Competencies that Can Improve Engagement with Refugee Clients

Research	**Community based research** • Needs assessment of refugee population • Needs assessment of community agencies' staff/service providers **Integrating research for advocacy** • Application for funding for research or additional resources • Using current data to highlight service/mental health disparities among refugees and among psychologist and community • Using research evidence to advocate for policy changes • Identifying gaps in services from community data • Collaboratively publishing research findings
Program Evaluation	• Use quantitative and qualitative data to examine current strengths and limitations of community programing
Supervision and Training	• Supervising and training psychologists, service providers, and community members to support refugee populations • Supervision of psychology, social work, and counselling students interested in working with refugee populations • Improving group work, collaboration, and coalition development • Support development and growth of multi-lingual clinicians
Consultation	• Ethics and ethical concerns in community organizations and in work with clients (e.g., documentation, boundaries, reflective practice) • Understanding the complexities of dynamic systems, including ecological framework • Organizational development • Evidence-based interventions • Assessment • Sociocultural and multicultural issues • Assisting others in developing a learning community on different topics (e.g., social justice, culturally-based interventions, language, and interpretation) • Supporting community leadership and capacity building
Education and Prevention	• Information dissemination (e.g., publishing articles, creating educational materials, public speaking) to raise public awareness • Workshops presented in collaboration with community

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Psychology Month 2024

Building Bridges: *Cultivating Care, and Connection*

Like every year, BCPA is gearing up for a month of Free Online Public Talks from February 1 to 29, 2024. This year, our focus is on "Building: Bridges, Cultivating Care, and Connection".

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Stay tuned as we unveil the schedule and speakers soon!

Obituary for **Dr. Brian Ferris**

FEBRUARY 21, 1944 - JUNE 28, 2023

By **Hillary Verheyen**

We are sorry to share the very sad news that our Dr. Brian Ferris passed away from cancer on June 28 of 2023 after being a psychologist and member of the British Colombia Psychological Association (BCPA) for over 45 years. Brian had the honour of serving as both a board member for the BCPA and editor of the BCPA's journal, *BC Psychologist,* in the mid-1990s.

Cameron Brian Ferris was born February 21, 1944, in North Bay, Ontario. Brian attended public schools in Sault Ste. Marie, Ontario, before going to college at Lake Superior State University, where he received his B.A. in Psychology in 1970. In 1975, he received his PhD in Psychology from the University of Texas in Austin. After completing his doctorate, Brian moved to British Columbia where he became a registered clinical psychologist and joined the BCPA.

Brian dedicated his life to helping others improve their lives and mental health. From 1975 until 2021, he was in private practice counselling clients individually. Throughout his career, he remained up to date in his field by exploring, mastering, and practicing different therapy methods.

His favourite was intensive short-term dynamic psychotherapy (ISTDP), as he found this method offered true emotional healing.

Additionally, Brian founded the Youngs-Ferris International Vocational Testing Service in Burnaby, BC, where he was a vocational counselor and diagnostician where he matched clients with their ideal career from 1975 until he sold the business in 1993.

In his private life, Brian was a funny and fun-loving person who loved travel and adventure. A lifelong super-fan of the Seattle Seahawks, Brian had an encyclopedic knowledge of the team and never missed a game.

Brian is survived by his loving wife, Carol Ferris, and four children: Pat Dawson (Sault Ste. Marie, ON), Teresa Ferris (North Vancouver, BC), Hillary Verheyen (Vista, CA), and Ray Laponder (Nanaimo, BC) as well as six wonderful grandchildren of whom he was very proud. If you wish to express your condolences, the family would love to read your shared memory of Brian at his memorial website: https://everloved.com/life-of/brian-ferris/ or you may contact his wife, Carol, at c.hardington53@gmail.com.

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