Working with Trauma: Clinical, Legal, and Ethical Considerations

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Disclosures

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Agenda

I. Self-Assessment
II. Overview of Trauma
III. Working with Traumatized Children, Adolescents, and Families
IV. Working with Traumatized Adults
V. Working with Trauma in Integrated Care Settings
VI. Self-Care

Learning Objectives

1. Describe the added impact of trauma on several common clinical and ethical situations.
2. List three ways that history of trauma exposure could impact clinical work with children and adolescents.
3. List three ways that history of trauma exposure could impact clinical work with adults.
4. Identify common factors that increase risk of legal or disciplinary involvement when working with traumatized patients/clients.
5. Explain strategies for addressing and minimizing risk when working in integrated care settings.
6. Recognize the impact of vicarious traumatization and the importance of self-care.

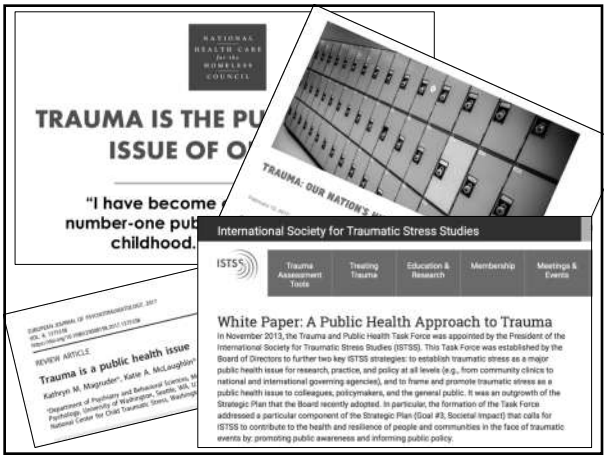
Professional Ethics

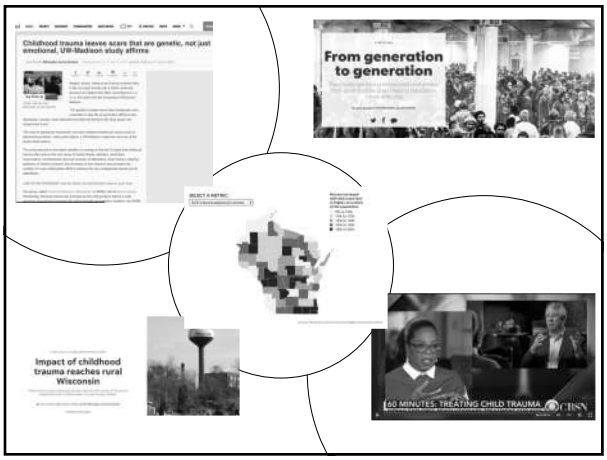
- Clinical & Counseling Psychologists (*APA Ethical Principles of Psychologists and Code of Conduct*)
- School Psychologists (*NASP Principles for Professional Ethics*)
- Counselors (*ACA Code of Ethics*)
- Clinical Social Workers (*CSWA Code of Ethics; NASW Code of Ethics*)
- Marriage & Family Therapists (*AAMFT Code of Ethics*)
- Substance Abuse Counselors (*NAADAC/NCC AP Code of Ethics*)
- Physicians (*AMA Code of Medical Ethics*)
- Nurses (*ANA Code of Ethics for Nurses*)

The ProQOL

Professional Quality of Life Scale
https://proqol.org/

Why Trauma? Why Now?





If 20 million people were infected by a virus that caused anxiety, impulsivity, aggression, sleep problems, depression, respiratory and heart problems, vulnerability to substance abuse, antisocial and criminal behavior, retardation and school failure, we would consider it an urgent public health crisis.

Yet, in the United States alone, there are more than 20 million abused, neglected, and traumatized children vulnerable to these problems. Our society has yet to recognize this epidemic, let alone develop an immunization strategy.

-Dr. Bruce Perry

https://www.npr.org/sections/health-shots/2018/11/09/666143092/should-childhood-trauma-be-treated-as-a-public-health-crisis

What is trauma?

- Exposure to one or more event(s) that involved death or threatened death, actual or threatened serious injury, or threatened sexual violation.
- In addition, these events were experienced in one or more of the following ways:
  - You experienced the event
  - You witnessed the event as it occurred to someone else
  - You learned about an event where a close relative or friend experienced an actual or threatened violent or accidental death
  - You experienced repeated exposure to distressing details of an event, such as a police officer repeatedly hearing details about child sexual abuse

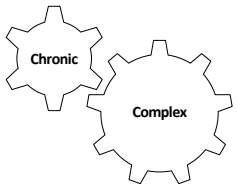
DSM-5 (2013)

"Events are never 'traumatic' just because they meet a threshold criterion."

~Arieh Shalev, M.D.

M. Blaustein Curriculum (used with permission): www.traumacenter.org

Classifying Trauma

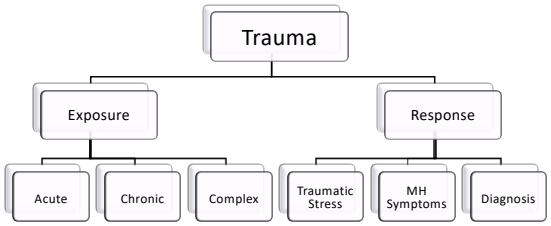


Acute
Single traumatic event that is limited in time

Chronic
Multiple traumatic events of longstanding trauma exposure

Complex
Exposure to chronic trauma, usually within the caregiving system, which can interfered with the child's ability to form a secure attachment and sense of safety and stability.

Understanding Trauma



Trauma Work and Risk


- "Trauma work requires additional care in the areas of navigating the minefield of client experience, maintaining self-awareness as the practitioner, and attending to ethical guidelines.
- Some of the risks inherent in trauma treatment include the risk of re-traumatization of the client and vicarious traumatization of the therapist.
- It is therefore imperative that the trauma therapist consciously adheres to ethical standards to protect client and practitioner from such psychological harms."

Mailloux, 2014, p. 50

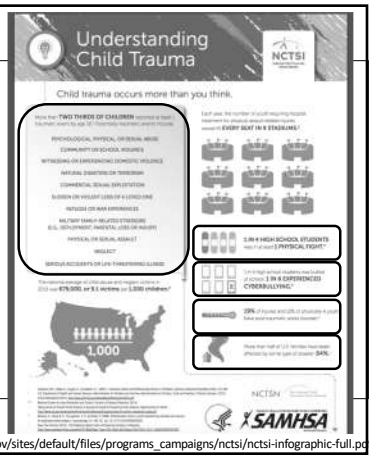
Trauma Work and Risk

- Client Factors
  - Re-traumatization
  - Ability to truly provide informed consent
  - Revisiting and processing of traumatic memories
- Clinician Factors
  - Competence
  - Complacency
  - Vicarious traumatization and burnout

Mailloux, 2014

Working with Traumatized Children, Adolescents, and Families

The Scope of Childhood Trauma



https://www.samhsa.gov/sites/default/files/programs_campaigns/nctsi/nctsi-infographic-full.pd

Situations that can be traumatic for kids:

- Witnessing or experiencing community violence
  - e.g., drive-by shooting, robbery, school fighting
- Witnessing police activity or seeing a loved one arrested or incarcerated
- Physical or sexual abuse
- Abandonment or neglect by caregiver
- Death or loss of a loved one
- Being bullied
- Life-threatening illness of a caregiver
- Witnessing domestic violence
- Car accidents or other serious accidents
- Life-threatening health situations or painful medical procedures
- Natural disasters
- Acts or threats of terrorism

NCTSN, 2012

Other Sources of Ongoing Stress

- Children frequently face other sources of ongoing stress that can challenge child welfare and mental health professionals' ability to intervene.
- Some of these sources of stress include:
  - Poverty
  - Discrimination
  - Separations from parent/siblings
  - Frequent moves
  - School problems
  - Traumatic grief and loss
  - Refugee or immigrant experiences

NCTSN, 2012

What is child traumatic stress?

- Child traumatic stress refers to the ***physical and emotional responses*** of a child to events that threaten the life or physical integrity of the child or of someone critically important to the child (such as a parent or sibling).
- Traumatic events overwhelm a child's capacity to cope and elicit feelings of terror, powerlessness, and out-of-control physiological arousal.

NCTSN, 2008

What is child traumatic stress?

The Impact of Childhood Trauma

The signs of traumatic stress may be different in each child. Young children may react differently than older children.

PRESCHOOL CHILDREN
- Fear being separated from their parent/caregiver
- Cry or scream a lot
- Eat poorly or lose weight
- Have nightmares

ELEMENTARY SCHOOL CHILDREN
- Become anxious or fearful
- Feel guilt or shame
- Have a hard time concentrating
- Have difficulty sleeping

MIDDLE AND HIGH SCHOOL CHILDREN
- Feel depressed or alone
- Develop eating disorders or self-harming behaviors
- Begin abusing alcohol or drugs
- Become involved in risky sexual behavior

Trauma can derail development.

NCTSN, 2012

Relational Development

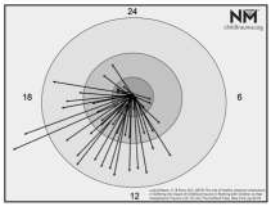
The Impact of Childhood Trauma

"The way we talk to our children becomes their inner voice."

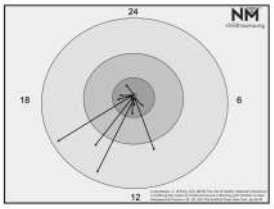
–Peggy O'Mara

Relational Poverty

Typical Child



Foster Child



Ludy-Dobson & Perry (2010)

The Impact of Childhood Trauma

IMPACT OF TRAUMA

The impact of child traumatic stress can last well beyond childhood. In fact, research has shown that child trauma survivors may experience:

- Learning problems, including lower grades and more suspensions and expulsions
- Increased use of health and mental health services
- Increased involvement with the child welfare and juvenile justice systems
- Long-term health problems (e.g., diabetes and heart disease)

TRAUMA is a risk factor for nearly all behavioral health and substance use disorders.

The Adverse Childhood Experiences Study

(Felitti et al., 1998)

The Adverse Childhood Experiences Study

(Felitti et al., 1998)

Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

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https://www.echotraining.org/

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TRAUMA is a risk factor for nearly all behavioral health and substance use disorders.

Common Diagnoses for Traumatized Youth

- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment Disorder
- Reactive Attachment Disorder
- Dissociative Disorders
- Attention-Deficit/ Hyperactivity Disorder (ADHD)
- Oppositional Defiant Disorder
- Bipolar Disorder
- Conduct Disorder

Many children with these diagnoses have a complex trauma history.

These diagnoses generally do not capture the full extent of the ***developmental*** impact of trauma.

"If child abuse and neglect were to disappear, the Diagnostic and Statistical Manual would shrink to the size of a pamphlet and the prisons would be empty in two generations."

-Dr. John Briere

Trauma's Varying Impact

"It is an ultimate irony that at the time when the human is most vulnerable to the effects of trauma – during infancy and childhood – adults generally presume the most resilience."

-Perry et al., 1995

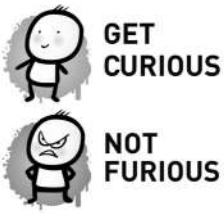
Variability in Responses to Trauma

- The impact of a potentially traumatic event depends on several factors, including:
  - The child's age and developmental stage
  - The child's perception of the danger faced
  - Whether the child was the victim or a witness
  - The child's relationship to the victim or perpetrator
  - The child's past experience with trauma
  - Public versus private nature of the trauma
  - The adversities the child faces following the trauma
  - The presence/availability of adults who can offer help and protection
  - Individual differences (e.g., child's coping style, temperament, cognitive functioning, etc.)

NCTSN, 2012

"Children's behavior almost always makes sense given an understanding of the context in which they develop…"

-Dr. Margaret Blaustein



Functions of Behavior

- Two primary functions of behavior:
  - To fulfill a need
  - To avoid danger or seek safety
- People who have experienced ongoing trauma in their families have generally had to cope with either or both:
  - Not enough attention/failure to meet basic needs (neglect)
  - To much danger (lack of safety)

M. Blaustein Curriculum (used with permission): www.traumacenter.org

What helps the traumatized individual survive?

- Assumption of danger
- Rapid mobilization in the face of perceived threat
- Self-protective stance
- Development of alternative strategies to meet developmental needs
  - e.g., self-injury, substance use, re-enactment)

M. Blaustein Curriculum (used with permission): www.traumacenter.org

Key Triggers for Traumatized Individuals

- Lack of power or control
- Unexpected change
- Feeling threatened or attacked
- Feeling vulnerable or frightened
- Feeling shame

M. Blaustein Curriculum (used with permission): www.traumacenter.org

Traumatic Assumptions

- I am not safe.
- People want to hurt me.
- The world is dangerous.
- If I am in danger, no one will help.
- I am not good enough/smart enough/worthy enough for people to care about me.
- It will never get better.

M. Blaustein Curriculum (used with permission): www.traumacenter.org

Case 1: Jessica

You are contacted by Ms. Jones, who was referred to you by her child's pediatrician. During the intake appointment, you learn that Ms. Jones is concerned about her 14-year-old daughter, Jessica, and her recent behavior at school and at home.

Before we go any further, what potential issues and questions might you have in mind?

Before we go any further, what potential issues and questions **should** you have in mind?

- How old is Jessica?
- Who has custody of Jessica?
- What types of behavior is Jessica engaging in?
- How long has this been going on?
- What might have changed in her life recently to trigger these issues?
- What other systems/providers are involved?

Before we go any further, what potential issues and questions **should** you have in mind?

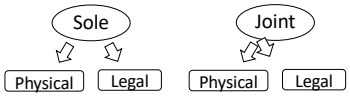
How old is Jessica?

- Age of consent in WI?
  - < 14: Parent must consent to outpatient MH treatment
  - ≥ 14: Parent AND minor must consent to outpatient MH treatment
- Depends on:
  - Type of treatment
  - Type of treatment setting
  - Parent-Child (Dis)Agreement
- Why does this matter?
  - Informed consent
  - HIPAA
  - Confidentiality
  - Records requests

Minor's Consent to Treatment

Before we go any further, what potential issues and questions **should** you have in mind?

Who has custody of Jessica?



- Require copies of:
  - Current custody orders
  - Notification of any changes to custody orders
  - Any protective/restraining orders
- If *joint legal custody*, seek consent from both parents.
  - Legally required? Not necessarily…
  - But, good risk management

Before we go any further, what potential issues and questions **should** you have in mind?

- What types of behavior is Jessica engaging in?
- How long has this been going on?

- Current level of risk?
- Suicidal or homicidal ideation?
- History of suicide attempts and/or self-injurious behavior?
- Symptoms escalating?
  - Intensity?
  - Frequency?

Before we go any further, what potential issues and questions **should** you have in mind?

What might have changed in her life recently to trigger these issues?

- Why now?
- Why might symptoms be manifesting in this way?
- Recent crises?
- Transitions?
- Displacements?
- Relationship ruptures? Perceived failures?

Before we go any further, what potential issues and questions **should** you have in mind?

What other systems/providers are involved?

- Education
  - Teachers
  - School administrators
- Medical
  - Pediatrician
  - Other Specialists
- Mental/Behavioral Health
  - Psychiatrist
  - Previous therapists/counselors
  - Case Managers
- Child Welfare System
- Legal/Juvenile Justice System
- Housing
- Church
- Mentoring/Coaching
- Childcare
- Others?

Case 1: Jessica

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Case 1: Jessica

More info:

- Parents are separated and currently have joint legal custody.
- Ms. Jones is seeking a TRO against Mr. Jones, based on domestic violence allegations.
- Jessica was recently suspended from school for smoking in the bathroom.
- Jessica does NOT want to be in therapy, but has been compliant thus far.

What issues and questions come to mind now?

- Clinical?
- Legal?
- Ethical?

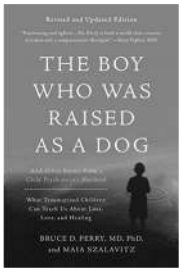
What issues and questions come to mind now?

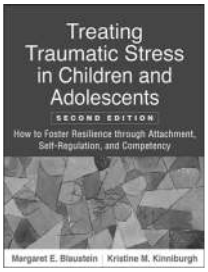
- Clinical?
  - Trauma exposure
  - Risky behavior
- Legal?
  - Confidentiality
  - Mandated reporting
  - Access to records
    - Parents
    - School
    - Medical providers
    - Courts
- Ethical?
  - Confidentiality
  - Clinician's personal risk threshold

Areas of Potential Ethical & Legal Challenges

- Informed Consent
  - Age of consent
  - Assent requirement
- Mandated reporting
  - Child maltreatment
  - Harm to self
  - Harm to others
- Legal Involvement
  - Child custody
  - School matters
  - Malpractice suits
- Confidentiality
  - How much to share with parents/guardians?
  - Who has access to records?
  - Risky decision-making
  - Self-harm/suicidality

Additional Resources



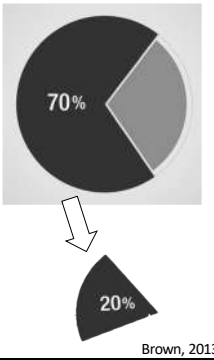


Working with Traumatized Adults

Godbold, 2018

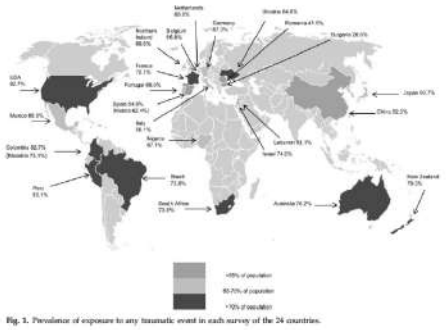
Scope of the Problem

- More than 70% of people in the general population have had at least one lifetime exposure to a traumatic event.
  - Only around 20% of these people are likely to develop PTSD (Briere & Scott, 2006).



Brown, 2013

Scope of the Problem



Benjet C, et al. The epidemiology of traumatic event exposure worldwide: Results from the World Mental Health Survey Consortium. *Psychological Medicine*. 2016; 46(2): 327—343.

- "Despite [this prevalence], most psychologists are poorly prepared to think about or address trauma in their clients' lives, frequently misinterpreting presentations of distress or behavioral dysfunction as evidence of other variables."

-Dr. Laura S. Brown, 2013

Trauma Impact: Adulthood

- Trauma reactions may lead to:
  - Low self-esteem
  - High self-blame
  - Expectations of rejection and loss
  - Mood disturbances
    - e.g., depression, anxiety, anger, and aggression
  - Dissociation
  - Drug and alcohol use as a coping mechanism to [illegible] with stress
  - Other compulsive behaviors as coping mechan[illegible]
    - e.g., binging and purging, self-mutilation, risk[illegible]ual behavior
  - Increased risk of serious health problems
    - e.g., heart disease, obesity, alcoholism, liver disease, etc.

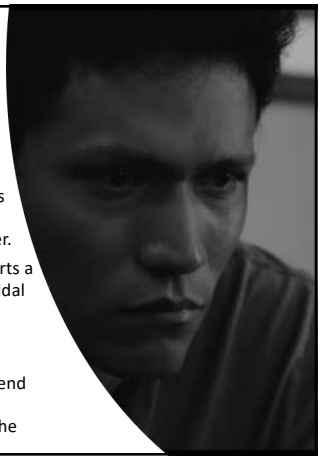
Collins et al., 2010

High-Risk Patients

- Serious personality disorders
  - e.g., borderline or narcissistic personality disorder
- Complex PTSD
- Dissociative Identity Disorders
- Recovered memories of abuse
- History of abuse as a child
- Present serious risk of harm to self or others
- Involved with lawsuits or legal disputes

Knapp et al., 2013

Case 2: Manny



- Manny is 23 years old and has contacted you because he needs help with his "anger problems," according to his probation officer.
- During initial screening, he reports a history of substance abuse, suicidal ideation, and past diagnoses of conduct disorder and bipolar disorder.
- He currently lives with his girlfriend and their infant son. She is threatening to throw him out if he doesn't deal with his issues.

Would you take this case?

What potential issues and questions might you have in mind?

What are some potential issues and questions you **should** have in mind?

- Is this court-ordered treatment?
- What is the nature of his involvement with the criminal justice system?
- What is his current level of risk?
- Does he have a history of violence?
- What might have happened in his life recently to trigger these issues?
- What other systems/providers are involved?

Areas of Potential Ethical Challenges

- Confidentiality
  - Who is client?
  - Who owns privilege?
  - With whom do you have authorization to communicate?
- Mandated reporting
  - Child maltreatment
  - Harm to self
  - Harm to others
- Legal Involvement
- Relationships
  - Boundaries
  - Multiple roles

Confidentiality

- Who is client?
  - Mandated vs. voluntary treatment
  - Clients vs collaterals
    - Case example
- Communicating with others
  - Family
  - Providers
  - Employers
  - Others?

Manny asks you if his girlfriend can attend some of the sessions so that you can help them work through some of their conflict.

What should you do?

Clarifications

- **Privacy**
  - Legal right
  - Applies to the person
- **Confidentiality**
  - Ethical obligation
  - Applies to the data/information
  - An extension of privacy
- **Privilege**
  - Privileged communication is information that is disclosed in the context of a specific relationship (e.g., psychotherapist-client) and cannot simply be demanded by a third party for legal purposes

Mandated Reporting of Child Maltreatment

- How might this come up in your work with Manny?
  - Manny as victim
  - Manny as perpetrator
  - Manny as witness/reporter
- Often feels like a no-win situation:
  - If reporting Manny as potential abuser…
    - If don't report → legal sanction
    - If do report → rupture, breach of confidentiality
  - If reporting Manny as victim or witness, against his wishes…
    - If don't report → legal sanction
    - If do report → rupture, re-traumatization, breach of confidentiality

Fears/Barriers to Reporting

- Violating confidentiality
- Report will cause more harm
- Agency may not investigate
- Accuracy of the allegation
- Client may discontinue seeking support
- Directly instructed **not to file** a report
- Reputation
- Cultural norms

Golomb, 2018 (used with permission)

How to Prepare

- Review federal and state law
- Review your applicable ethical codes
- Develop policies & procedures, checklists, decision trees, etc.
- Informed consent
- Seek consultation
- Build a support network
- Careful and thorough documentation

Decision-Making Considerations

- Setting/Context
  - e.g., clinic, school, private practice, hospital
- Clinical situation
  - e.g., assessment, therapy, consultation
- Your Role
  - Clinician, caregiver, teacher, student/supervisee, supervisor, administrator
- Relationship Factors
  - e.g., How long have you been working with client? What is the nature of your professional relationship?

Minimizing Risk After a Report is Made

- Preserving the therapeutic alliance
- Establishing safety
- Monitoring/balancing judgments about cultural practices/implications
- Educating clients about the role of DCS, supports and services they can provide, de-mystifying the process
- Involving clients in the reporting process, when possible and appropriate
- Obtain report about final case disposition, document report number
- Distribute the liability/risk across providers
- Ongoing monitoring of safety (for client and self)
- Practice self-care

Mandated Reporting in Wisconsin

- Mandated Reporters: Sec. 48.981
  - A mandated reporter, in the course of his or her professional duties, has reasonable cause to suspect that a child has been abused or neglected.
  - A mandated reporter, in the course of his or her professional duties, has reason to believe that a child has been threatened with abuse or neglect or that abuse or neglect will occur.
- Definitions: Wis. Stats. Ch. 48
  - Definitions of abuse, neglect, sexual abuse, emotional abuse, abandonment, etc.
  - Search by state at www.childwelfare.gov
- Sec. 48.981(4): Immunity
  - Any person or institution participating in good faith in making a report, conducting an investigation, ordering or taking photographs, or ordering or performing medical examinations of a child or an expectant mother pursuant to this section shall have immunity from any liability, civil or criminal, that results by reason of the action. For the purpose of any civil or criminal proceeding, the good faith of any person reporting under this section shall be presumed.
- Reporting in other states…(likely no immunity)

Mandated Reporting of Child Maltreatment

Manny disclosed that he was abused as a child by his stepfather, who still lives with his mother and his younger siblings in Chicago.

What should you do?

Manny reported that he became so angry at his girlfriend last week, when she wouldn't let him hold his son, that he yanked the baby out of her arms and stormed out of the house.

What should you do?

"Abuse"

(WI Stat. Sec. 48.02; 48.981)

- 'Abuse' means any of the following:
  - Physical injury inflicted on a child by other than accidental means
  - When used in referring to an unborn child, serious physical harm inflicted on the unborn child and the risk of serious physical harm to the child when born caused by a habitual lack of self-control of the expectant mother of the unborn child in the use of alcoholic beverages, controlled substances, or controlled substance analogs, exhibited to a severe degree
  - Manufacturing methamphetamine in violation of § 961.41(1)(e) under any of the following circumstances:
    - With a child physically present during the manufacture
    - In a child's home, on the premises of a child's home, or in a motor vehicle located on the premises of a child's home
    - Under any circumstances in which a reasonable person should have known that the manufacture would be seen, smelled, or heard by a child
- 'Physical injury' includes, but is not limited to, lacerations, fractured bones, burns, internal injuries, severe or frequent bruising, or great bodily harm.

Tarasoff /Duty to Warn/Duty to Protect

- Wisconsin courts have upheld *Tarasoff* and affirmed that clinicians have a duty:
  - To warn others of threats of harm by the patient
    - This extends to whatever other steps are reasonably necessary under the circumstances (e.g., contacting police, recommending or requiring hospitalization, notifying a friend/family member who can help ensure safety).
  - The victim does NOT have to be foreseeable.
    - You have a duty to warn even if the actual victim(s) was not specified and was a more general statement
  - Act in a manner that is consistent with the seriousness of the threat in deciding how, and to whom, to report the threat.

https://dsps.wi.gov/Pages/BoardsCouncils/Psychology/PositionStatements.aspx

Tarasoff /Duty to Warn/Duty to Protect

- Questions to consider before breaching confidentiality:
  - Sincerity, capability, imminence, gravity of the threat
  - Does this person have a genuine intent to inflict harm?
  - Does the person have the ability and opportunity to carry out the threat?
  - Is there some sense of immediacy to the threat?
  - Is there a serious risk of harm?
- What would a reasonable practitioner do under similar circumstances?

https://dsps.wi.gov/Pages/BoardsCouncils/Psychology/PositionStatements.aspx

Duty to Protect?

"We want to be loved so bad, we're willing to die for it."

Suicide Risk Factors

1. Direct verbal warning
2. Plan
3. Past attempts
4. Indirect statements and behavioral signs
5. Depression
6. Hopelessness
7. Intoxication
8. Marital separation
9. Clinical syndromes
10. Sex
11. Age
12. Race
13. Religion
14. Living alone
15. Bereavement
16. Unemployment
17. Health status
18. Impulsivity
19. Rigid thinking
20. Stressful events
21. Release from hospitalization
22. Lack of a sense of belonging

Pope & Vasquez, 2013

Suicide Risk Assessment

1. **Do not avoid the discussion**
   - Explore the issue sensitively, directly, and frankly.
   - It is a **myth** that raising the topic of suicide with a patient may increase the likelihood that the patient will act on the idea.
2. **Get specifics**
   - Replace whatever is vague, abstract, or general with information that is as precise and specific as possible.
     - Is there a specific setting, date, time of day?
     - Does the intent include a plan?
     - Is there a specific method? Is that method likely to be lethal?
     - Does patient have access to the means or already have the means?
     - Does the plan include physically injuring or killing another person?
     - Could the chosen method potentially endanger others?

Pope & Vasquez, 2013

Suicide Risk Assessment

3. **Protective factors**
   - What factors or resources does the patient have that may be sources of resilience or serve as buffers against suicide?
   - What does the patient care about or feel connected to?
   - Is there a person or pet whom the patient loves and for whom the patient has important responsibilities?
   - Are there causes or projects to which the patient is devoted?
   - Is the patient a member of a group or organization in which he/she can become more active and make a more meaningful contribution?
   - Is the patient willing to commit to treatment?
4. **Ethical and legal responsibilities**
5. **Cultural, religious, and other personal values**
6. **Documentation**
7. **Continuing competence**

Pope & Vasquez, 2013

Suicide Risk Management

1. Evaluation and assessment
2. Documentation
3. Information on previous treatment
4. Consultation on present clinical circumstances
5. Sensitivity to medical issues
6. Knowledge of community resources
7. Consideration of the effect on self and others
8. Awareness of diversity and multicultural considerations
9. Special populations (e.g., veterans, older adults, children)
10. Preventative preparation

Bongar & Sullivan, 2013

Assessing Nonsuicidal Self-Injury (NSSI)

- Most common among adolescents
  - avg. age of onset is 12-14 years
- Most common forms:
  - Skin cutting
  - Burning
  - Banging/hitting body parts
- Most self-injurers have used more than one method

Assessment and Treatment:

- Understand the motivations
  - Affect regulation
  - Self-punishment
  - Ending episodes of dissociation
- Ensure good rapport
- Assess thoroughly
- Consider the level of care
- Treat carefully
- Distinguish between NSSI and suicide attempt
- Attend to heightened risk for suicidal behaviors
- Avoid misconceptions

Klonsky, 2013

Legal Involvement

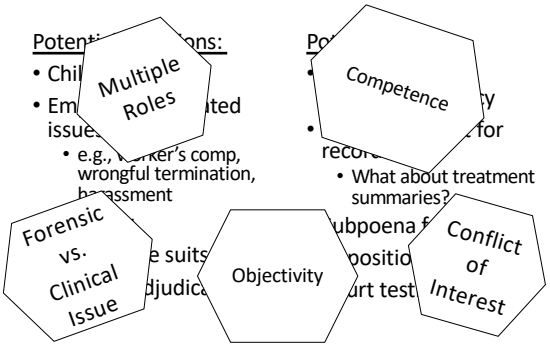
Potential Situations:

- Child custody
- Employment-related issues
  - e.g., worker's comp, wrongful termination, harassment
- Disability
- Malpractice suits
- Criminal adjudication

Potential Roles:

- Letter of Support/Advocacy
- Written request for records
  - What about treatment summaries?
- Subpoena for records
- Deposition testimony
- Court testimony

Ethical Issues in Legal Involvement



Legal Involvement

Manny has asked you to write a letter to his probation officer and judge advocating for him and confirming that he is "cured" of his anger issues.
What should you do?

Manny and his girlfriend have spit up and are now in a bitter custody battle. You receive a subpoena for his records from his ex-girlfriend's attorney.
What should you do?

Managing Relationships

- Informed Consent
- Boundaries
  - Be clear about the rules and expectations
  - Immediately address boundary crossings and unacceptable conduct
- Avoid multiple relationships
- Repair ruptures
- Termination
- Consultation
- Documentation

Younggren, 2013

Would you take this case?

Let's get to know Manny a little better…

http://www.rememberingtrauma.org/

Would you take this case?

What do trauma survivors need?

- To feel safe
- To feel in control
- To express their emotions
- To know what comes next

OVC, 2001

How can these needs manifest in ways that are challenging?

- **To feel safe**
  - Unrealistic demands
  - Mistrust/suspicion
  - Unrecognized triggers
  - Fear of opening up
- **To feel in control**
  - Boundary crossing
  - Increasing demands
  - Interpersonal intrusion into personal life/privacy
- **To express their emotions**
  - Transference
  - Re-enactment
  - Displaced rage
- **To know what comes next**
  - Feelings of betrayal
  - Ruptures
  - Sabotage

Complex Trauma Treatment

- Common treatment sequence:
  - Pre-treatment assessment
  - Early stage of safety, education, stabilization, skill-building, and development of the treatment alliance
  - Middle stage of trauma processing
    - Often destabilizing and requires the skills learned in the previous stage
    - Various forms of trauma processing are used in this stage (e.g., exposure, cognitive restructuring, EMDR, etc.)
  - Late stage of self and relational development and life choice
    - May experience a bit of existential crisis associated with new sense of self
- How might there be increased risk in this approach?

Courtois, n.d.

Other Trauma Treatments

- CBT
- Trauma-Focused CBT
- Exposure therapies
- Cognitive Processing Therapy
- EMDR
- Parts Work for Dissociation
- Stress inoculation training
- Medication

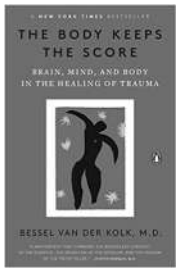
- How might there be increased risk with these approaches?

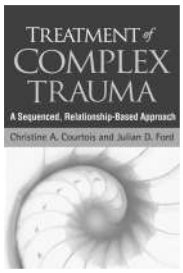
General Strategies to Manage Your Risk

- Set clear rules at the beginning of treatment
- Maintain control of therapy
- Immediately address patient boundary crossings and unacceptable conduct
- Do not fear termination
- Do not accept patient misbehavior and threats
- Document all patient misconduct and your termination plans
- Consult, consult, consult

Younggren, 2013

Additional Resources





Working with Trauma in Integrated Care Settings

General Integrated Care Challenges

- The need for mental and behavioral health professionals (BHPs) integrated into primary care clinics and medical settings is growing at unprecedented rates
  - The demand is far outweighing the supply
- The training of mental health clinicians has been slow to adapt to a changing market and systems
  - As a result, new clinicians are often unaware and unprepared for the differences in culture, modes of operation, and policies that seem to conflict with their training.
- Changing nature and pace of behavioral health care delivery formats
- Evolving or inadvertent multiple roles and conflicts

Beacham & Van Sickle, 2018

Case 3: Leah

Leah is 27 years old and recently gave birth to her first child. Her pregnancy had been unremarkable, but she experienced some unexpected complications during childbirth due to what appears to have been a dissociative episode during labor. Much to the shock of her husband and the medical team, she became extremely hostile and thrashed around such that she had to be sedated and an emergency C-section was ordered.

Case 3: Leah

- Leah is 27 years old and just gave birth to her first child.
- Her pregnancy had been unremarkable, but she experienced some unexpected complications during childbirth due to what appears to have been a dissociative episode during labor.
- Much to the shock of her husband and the medical team, she became extremely hostile, kicking the doctor and nurses such that she had to be sedated and an emergency C-section was ordered.
- Her medical team is worried about her risk for postpartum psychopathology and want you to evaluate her before a decision is made regarding whether she can be discharged.

What potential issues and questions might you have in mind?

What are some potential issues and questions you **should** have in mind?

- What is the specific referral question? Scope of the evaluation?
- What will informed consent need to look like?
- What risk factors are present and what is her current level of risk?
- Does she have a history of dissociation? Trauma?
- What might have happened during labor to trigger these issues?
- How much information needs to be shared with the medical team?

Areas of Potential Ethical Challenges

- Informed consent in a fast-paced environment
- Maintaining confidentiality with multidisciplinary teams and EHRs
- Providing specialty supervision to high-risk patients
- Beneficence versus harm from multidisciplinary perspectives
- Feeling pulled in many directions
  - Loyalty to the treatment team
  - Maintaining good professional relationships
  - Pressure to disclose more than necessary
  - Protecting patient's privacy
  - Sharing difficult news with the patient
  - Multiple roles (e.g., therapist and evaluator)

Ashton & Sullivan, 2018

Case 3: Leah

- During her meeting with you, Leah discloses that she was sexually abused by an older male relative as a child and that all of the intimate medical exams throughout her pregnancy were difficult, but she was able to mentally prepare and get through them alright.
- However, she indicated that something happened in the delivery room and she had a flashback while the doctor was examining her and does not remember anything after that, until she woke up after the C-section.
- Leah reported that she has never told her husband or her family about the abuse, as her abuser has since passed away and, given her cultural context, she can't bear the shame that would be inflicted by her family were she to now dishonor him.
- She begs you not to include this information in her medical records and to convince her doctors that she is fine to go home.

Informed Consent

- Passive vs. Active consent
- Necessary clarifications (both verbally and in writing):
  - Nature of the referral
  - Your role
  - Purpose of the visit
  - What types of recommendations may be made
  - Who will have access to the information and how that information will be communicated (e.g., in a report)
  - How records will be kept and who has access to these records
  - Limits of confidentiality
- Important to not gloss over these issues in the interest of being efficient in a fast-paced medical environment

Ashton & Sullivan, 2018

Confidentiality & Documentation

- It's important to be clear about how records will be kept and who will have access to them.
- The rise of EHRs have made records more accessible and searchable
  - Pros: eases care coordination and communication across disciplines
    Cons: frequent misunderstandings about who will be accessing records
- Some ways to deal with these concerns:
  - Audit system that records who access records and when
  - Firewall that keeps MH notes separate from rest of chart.
  - Warnings that are triggered when someone tries to access a MH note without authorization (Note: HIPAA prohibits this).
  - Always assume the patient will be reading your notes and write them accordingly
    - Use behavioral terms and quotes
    - Avoid subjective or judgmental comments
  - Minimize the inclusion of unnecessary or irrelevant sensitive information

Ashton & Sullivan, 2018

Working with Multidisciplinary Teams

- BHPs have a responsibility to keep discussion about the patient relevant to the primary question.
- Consider what level of detail is needed in both written documentation and when consulting with other professionals.
- Information that is not pertinent to decision-making is not necessary to share with the entire team
  - despite the potential for psychological voyeurism, which is not uncommon in medical settings
- Balance ethical obligations to cooperate with other professionals and protect the client's confidential information
  - Be mindful of multidisciplinary power dynamics that may unduly influence judgment and compromise the patient's dignity

Ashton & Sullivan, 2018

Working with Multidisciplinary Teams

- Resist the temptation to go beyond the scope of one's competence or role
  - e.g., don't provide opinions for which you do not have sufficient basis
- Become familiar with the similarities and differences between the various disciplines' ethics codes to help guide conversations and policy-making
  - Consult interprofessional competence literature
- Consult with hospital's legal team or ethics committee when ethical conflicts arise

Ashton & Sullivan, 2018

Trauma-Informed Care

1. Realize the widespread prevalence of trauma
2. Recognize the signs and symptoms of trauma in clients, families, staff, and others
3. Respond by integrating knowledge into policies, procedures, and practices
4. Actively resist retraumatization of clients, families, staff, and others

SAMHSA, 2014

We can do better…
Integration and Trauma-*Competence*

- Build meaningful partnerships that create mutuality among children, families, caregivers, and professionals at an individual and organizational level
- Address the intersections of trauma with culture, history, race, gender, location, and language, acknowledge the compounding impact of structural inequity, and be responsive to the unique needs of diverse communities.

SAMHSA

We can do better…
Integration and Trauma-*Competence*

- How are we making it harder on individuals and families when we, as systems or disciplines, don't talk to each other?
- What would an integrated, trauma-competent system of care look like in your community?
- How can we build on each system's strengths to build a more comprehensive, coordinated approach?
  - e.g., Risk-Need-Responsivity (RNR) Model

Essential Elements of a Trauma-Informed…
Healthcare System

1. Creating a trauma-informed office.
2. Involving and engaging family in program development, implementation, and evaluation.
3. Promoting child and family resilience, enhancing protective factors, and addressing parent/caregiver trauma.
4. Enhancing staff resilience and addressing secondary traumatic stress.
5. Assessing trauma-related somatic and mental health issues.
6. Providing coordinated, integrated care across child- and family-service systems.

National Child Traumatic Stress Network (NCTSN)

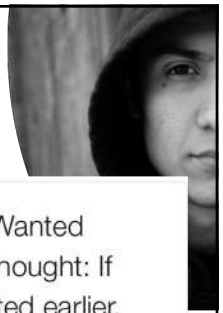
When providers "get" it…

How we ask about trauma matters…

- What gets missed in medical and behavioral health settings?
- *"I suggest we replace the word "screening" with the word "listening." Screening is something you give **to** someone while listening is something you do **with** someone." -Dr. Claudia M. Gold*

- Narrative medicine – Dr. Rita Charon
  - *"If somebody is in my office talking about chest pain, I think, Does this sound like heart trouble, stomach trouble, or muscle trouble?, while also using my narratological brain. What is she telling me? Why is she telling me this now? What is the beginning of this story? Where is it going? Even the metaphors she's using. And then alongside that is the affective or emotional stream. What is she really worried about? If she lets on, in a little dependent clause, that her father died of a heart attack when he was her age, well then, I have to hear that."*
    - -(Dr. Charon, as quoted in an article by Alexander C. Kafka)

How we ask about trauma matters…



> When I see the Ten Most Wanted Lists… I always have this thought: If we'd made them feel wanted earlier, they wouldn't be wanted now.
>
> **Eddie Cantor**

How we ask about trauma matters…

- "Sure, we can ask our clients for feedback about what's helping and what isn't; most therapists do. However, asking only helps if clients are forthcoming with their answers. And many clients withhold critical feedback, especially when therapy is unhelpful.
- In a recent survey, Columbia University's Matt Blanchard and Barry Farber asked 547 clients about their honesty in therapy. Seventy percent reported whitewashing feedback to their therapists, commonly by "pretending to find therapy effective" and "not admitting to wanting to end therapy." And if patients aren't telling us the truth, how can we know whether they are likely to deteriorate?
- Many clients are more willing to report worsening symptoms to a computer—even if they know that their therapist will see the results—than disappoint their therapist face-to-face.
- We therapists need to always remain aware that there is much we can't see in the fog"—and be open to tools that might compensate for our limited vision."

- Tony Rousmaniere, 2017

That we ask about trauma matters…

- "To not ask about the elephant in the room (trauma) leaves the client at great risk of being trampled by it."

Mailloux, 2014

When we ask about trauma matters…

- It has been estimated that each year, over one million children in the U.S. are misdiagnosed with a mental illness that could be better explained by trauma.

Discrepancy in diagnosis and treatment of post-traumatic stress disorder (PTSD): Treatment for the wrong reason

Ellen C. Meltzer, MD MSc[1], Tali Averbuch, MPP[1], Jeffrey H. Samet, MD MA MPH[1,5], Richard Saitz, MD MPH[1,3,4], Khelda Jabbar, MD[5], Christine Lloyd-Travaglini, MPH[1], and Jane M. Liebschutz, MD MPH[1,5]

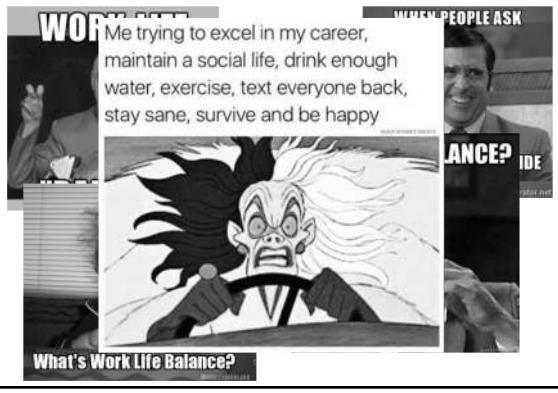
[1]Clinical Addiction Research and Education (CARE) Unit, Section of General Internal Medicine, Department of Medicine, Boston Medical Center and Boston University School of Medicine,

Leahy (2018); Siegfried et al. (2016); Meltzer et al. (2013)

More Resources for Trauma-Informed Integrated Care

- https://www.nctsn.org/trauma-informed-care/trauma-informed-systems/healthcare/nctsn-resources
- https://www.nctsn.org/audiences/healthcare-providers
- https://www.integration.samhsa.gov/clinical-practice/trauma-informed
- https://www.chcs.org/project/advancing-trauma-informed-care/

Self-Care



"While all types of therapeutic work are difficult as per the quest to help people help themselves, perhaps none is more challenging than trauma work."

-Sharon Mailloux

Why It Matters

Like everyone else, you may have to contend with trauma or crises in your personal life.

But, your job ***guarantees*** that you will have to deal with trauma in other people's lives.

Williams & Sommer, 2002

Why It Matters

- Neglecting self-care significantly increases certain risks:
  - Burnout
  - Vicarious trauma
  - Errors in judgment (e.g., blurred boundaries)
- *Professional Quality of Life Scale (ProQOL)*
  - https://proqol.org/
  - How did you do?
  - Are you surprised by your score?

Indicators of Distress

- Emotional Indicators
  - Sadness
  - Prolonged grief
  - Anxiety
  - Depression
- Physical Indicators
  - Headaches
  - Stomachaches
  - Lethargy
  - Constipation
- Personal Indicators
  - Self-isolation
  - Cynicism
  - Mood swings
  - Irritability with family/partner
- Workplace Indicators
  - Avoidance of certain individuals
  - Missed meetings
  - Tardiness
  - Lack of motivation

Strategies to Address Vicarious Trauma

- Awareness and acceptance
- Limit exposure where possible
- Attend and expand areas of empathy
- Attend to and explore reenactments
- Limit availability
- Maintain professional connection
- Seek support from others
- Create balance in your life
- Address and prevent VT on an organizational and personal level

Blaustein, 2010; Saakvitne, Gamble, Pearlman, & Lev: Risking Connection

Self-Care Strategies

- Professional Self-Care
  - Continuing education
  - Seek client feedback
  - Consultation and supervision
  - Networking
  - Stress management strategies
  - Refocus on the rewards
  - Set (and follow) boundaries
  - Limiting the amount of exposure to traumatic material (temporarily or permanently)
- Personal Self-Care
  - Healthy personal habits
  - Attention to relationships
  - Recreational activities
  - Personal therapy
  - Foster creativity and growth
  - Relaxation and centeredness
  - Self-exploration and awareness

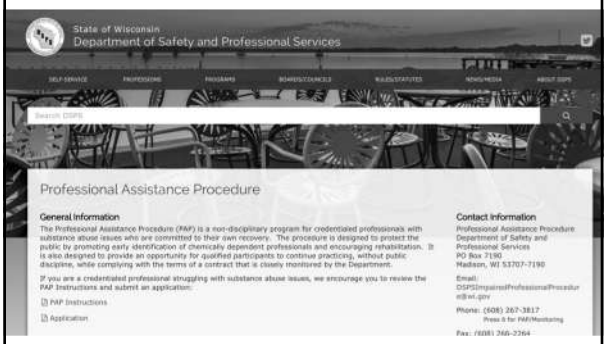
Norcross & Guy, 2013

Why Self-Care is a Legal and Ethical Obligation

- Competence
- Impairment
- Vulnerability
- Judgment

Reporting Impaired Colleagues in Wisconsin

- Physician's Duty to Report Act (2009)
  - Physicians must report colleagues who engage in a pattern of unprofessional conduct; engage in acts creating an immediate or continuing danger to patients or the public; may be medically incompetent; or may be mentally or physically unable to safely practice medicine. Failure to report such physicians may lead to discipline by the MEB.
- Psychologists: no law yet
- Social Workers, Counselors, and Marriage & Family Therapists:
  - Required to report any adverse action taken against a licensed colleague within 30 days (Wisc. Admin. Code Sec. MPSW 20)



https://dsps.wi.gov/Pages/SelfService/ProfessionalAssistanceProcedure.aspx

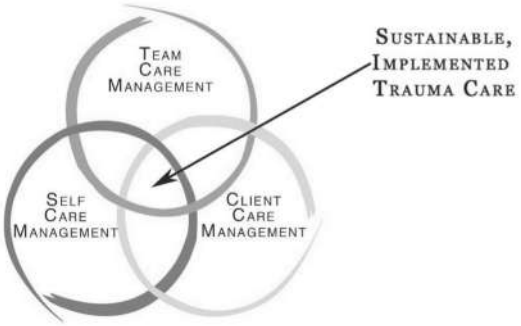
What happens when we make assumptions?

Trauma-Informed Interactions

- Without judgment, what was my reaction (physical, emotional, mental) and how did I then respond?
- Did the behavior offend against my personal values?
- Did it offend against my learned social values?
- Was it triggering my trauma?
- Was I witnessing a trauma response in the other person?
- Am I able to find compassion for myself and the other person?
- Did I respond by punishing, shaming, shunning or badgering?

Godbold, 2018

Traumatized Systems

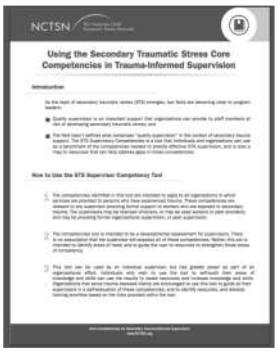


Prevention at the Organizational Level

- Primary
  - Sources of stress in work setting should be identified and minimized
    - e.g., being isolated, inexperienced, overworked, lacking support or supervision, unclear role definition
- Secondary
  - Early detection of individuals at high risk of developing stress-related problems and those with early signs of problems
- Tertiary
  - For individuals who have already developed stress-related conditions, strategies are needed that:
    - Minimize the effects of the problem
    - Prevent further deterioration or complications
    - Strive to restore the individual to the highest possible level of functioning

Phelps et al. (2009)

Trauma-Informed Supervision


NCTSN

Using the Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision

https://www.nctsn.org/resources/using-secondary-traumatic-stress-core-competencies-trauma-informed-supervision

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- https://www.integration.samhsa.gov/
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