First, Do No More Harm: Ethics of Trauma Treatment

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Trauma

Trauma is an assault on the self and on self integrity/self-integration

Trauma, Self, and Spirituality

* Trauma involves the spirit and is *dispiriting* by its very nature
* Trauma involves a shattering of self definition, identity, life assumptions, spirituality, and meaning

Trauma, Self, and Spirituality

* The trauma of child abuse has been called "soul murder"

(Shengold)

* "I have a hole in my soul"

--incest survivor

Trauma, Self, and Spirituality

* Development is derailed by trauma
  * Regression
  * Acceleration
* Identity/personality are often deformed by trauma: disorders of the self
* "I'm not the person I might have been"

  --Incest survivor

Trauma Defined

"...the *unique individual experience*, associated with an event or enduring conditions, in which the individual's ability to integrate affective experience is overwhelmed or the individual experiences a threat to life or bodily integrity..."

(Pearlman & Saakvitne, 1990)

Types of Trauma

* I. Accident/Disaster/"Act of God"
  * Sudden, unexpected, one-time or time-limited
* II. Interpersonal
  * Sudden, unexpected, one-time or time-limited (more likely to be a stranger)
  * Anticipated, repeated, chronic (more likely to be known, related)
* III. Identity/ethnicity/gender
* IV. Community/group membership
* V. Complex/cumulative/continuous

Types of Trauma

* "Simple" single-incident trauma may not be easy to work with; often impersonal in causation
  * Can severely impact self, life trajectory, relationship with others
* Complex/compounded trauma likely even more difficult; often interpersonal in causation
  * developmental impact
* Comorbidity in both types

Dimensions of Interpersonal Trauma

- Relational
  - Disruptions in the sense of safety, security, loyalty, and trust in others
- Betrayal trauma
  - Betrayal of a role, relationship, responsibility
- Second or institutional injury/betrayal
  - Lack of response, notice, assistance and/or insensitivity from those who are supposed to help
  - Lack of response or collusion by institutions
  - Second injury *caused by* helpers or institutions

Attachment/Relational Forms of Interpersonal Trauma

- Occurs in attachment relationships with primary caregivers/significant others
  - insecurity of response and availability
  - mis-attunement, non-response
  - lack of caring and reflection of self-worth
  - caregiver as the source of *both* fear and comfort
- Includes DV and child abuse of all types
  - often "on top of" attachment insecurity
  - neglect, abandonment, non-protection, non-response, sexual and physical abuse and violence, verbal assault, antipathy, bullying

Complex Trauma

* Attachment/relational/developmental trauma &/or
* Other forms of chronic trauma:
  * Community & school violence
  * Combat trauma: warrior or civilian, POW
  * Political trauma: refugee status, displacement, political persecution, "ethnic cleansing"; forced displacement
  * Slavery/forced servitude and prostitution
  * Chronic illness w/ invasive treatment
  * Bullying
  * Sexual harassment
  * Other…

Complex Trauma

* Interpersonal and cumulative
* Involving all forms of traumatization
* Often begins In attachment relationships
  * Insecure and especially disorganized attachment
* Repeated/chronic
* Progressive
* Layered
* Revictimization
* Continuous and lifelong?

Symptom Categories and Diagnostic Criteria for Complex PTSD

* I. Alterations in regulation of affect and impulses
  * a. Affect regulation
  * b. Modulation of anger
  * c. Self-destructiveness
  * d. Suicidal preoccupation
  * e. Difficulty modulating sexual involvement
  * f. Excessive risk taking
* 2. Alterations in attention or consciousness
  * a. Amnesia
  * b. Transient dissociative episodes and depersonalization

Symptom Categories and Diagnostic Criteria for Complex PTSD/DESNOS

* 3. Alterations in self-perception
  * a. Ineffectiveness
  * b. Permanent damage
  * c. Guilt and responsibility
  * d. Shame
  * e. Nobody can understand
  * f. Minimizing
* 4. Alterations in relations with others
  * a. Inability to trust
  * b. Revictimization
  * c. Victimizing others
  * d. With perpetrator

Symptom Categories and Diagnostic Criteria for Complex PTSD/DESNOS

- 5. Somatization
  - a. Digestive system
  - b. Chronic pain
  - c. Cardiopulmonary symptoms
  - d. Conversion symptoms
  - e. Sexual symptoms
- 6. Alterations in systems of meaning
  - a. Despair and hopelessness
  - b. Loss of previously sustaining beliefs

Challenges of Treating Trauma

- Spectrum of Posttraumatic and Dissociative Disorders
  - Classic PTSD
    - **New sub-type of dissociative PTSD in *DSM 5* most resembles complex PTSD**
  - Complex PTSD: not in *DSM IV or 5* except as an associated feature of PTSD, dissociative subtype
    - "PTSD plus or minus"
    - Resembles BPD in many dimensions
  - Dissociative disorders
  - Co-occurring conditions

Challenges of Treating (Complex) Trauma

- Relational deficits/attachment disturbances
- Emotion and life skill deficits
- Dissociation
- Somatic/medical problems
- Risk: depression, anxiety, dissociation, self-injury, suicidality, revictimization, memory disturbances
- Intense transferences that trigger equally intense countertransf reactions/errors

Ethics of Trauma Treatment

Ethics of Trauma Treatment

* Five areas to consider (there are many more)
  * 1. Competence and personal wellness of the therapist
  * 2. Willingness to treat and to learn
  * 3. Boundaries and their management
  * 4. Safety risk
  * 5. Evidence-based practice and the standard of care (evolving)

Ethics of Trauma Treatment

* Trauma tx presents unique challenges and risk
* Many clients have been mistreated and even re-abused when seeking mental health/medical care
* For many therapists, trauma not included in professional training
* Situation is now changing as more programs are including trauma in the curriculum
* Increased recognition of the ubiquity of trauma of all types and the connection between childhood trauma and later mental health concerns

The Trauma-Informed Care Movement

* Recognizes strong relationship between history of trauma and mental health and medical problems
* Trauma must be asked about, then returned to
* Role of trauma must be acknowledged
* Symptoms as adaptations
* Trauma symptoms must be treated

The Trauma-Informed Care Movement

* Clients must be treated with respect and not re-traumatized by helpers or institutions
* RICH Relationship
* THE CRITICAL IMPORTANCE OF COMPASSION
  * However, it may counter how the client feels about him or herself

Difference between Trauma-Informed Care and Trauma-Focused Treatment

Responsible and Ethical Practice Framework

“First, do no harm”

Definition of Risk Management

"Responsible clinical practice within the standard of care, which minimizes risk to patient and his/her significant others and to self as therapist"

Responsible and Ethical Practice Framework

- For psychotherapy in general:
  - Professional code of ethics, professional standards, and applicable state law
    - Appropriate licensure, liability insurance), hospital privileges
  - Professional business practices in keeping with the law (now HIPAA) and ethics/standards
    - Billing, record-keeping, confidentiality, staff
    - Emergencies and coverage

Framework (cont.)

- Collaborative relationships
  - Supervision and consultation
  - W/ prescribing psychiatrist
  - W/ all other treaters
- Ongoing training and continuing education
  - Have specialized training with specialized techniques and use tailored informed consent forms

Framework (cont.)

- Structure of psychotherapy:
  - Assessment before treatment
  - Full, informed consent/refusal
    - treatment frame communicated and agreed to
    - treatment plan communicated and agreed to
  - Comprehensive treatment and plan
    - ongoing monitoring and change of plan as necessary
    - with adjunctive work as necessary
  - Appropriate documentation
  - Planned, thoughtful termination
    - when treatment is at an untenable impasse or when contract is completed

Framework (cont.)

* For trauma treatment: all this ***and more***

"First, do no *more* harm"

Framework (cont.)

* For trauma treatment
  * Special knowledge/willingness to treat
    * Therapist must be open to trauma
      * does not dismiss or stigmatize
      * has training in treating these conditions
        * if not, refers or gets training
      * is not over-invested/over-fascinated
  * Comprehensive assessment
    * general *and* specialized
    * non-suggestive, non-suppressive
    * supportive neutrality
    * may extend over time as issues unfold

Framework (cont.)

- Comprehensive treatment
  - with attention to available ***evolving*** standards and science
  - *stage-oriented, progressive, carefully paced*
  - ***not*** *oriented to memory retrieval and/or only to trauma processing*
  - with ongoing attention to skill-building, self-management, functioning, attunement
- Initial and ongoing attention to safety
  - changing from a life of chaos/victimization
  - therapist stance and security, concern for safety

Framework (cont.)

- Ongoing attention to treatment alliance
  - active vs. passive stance
  - reliability and consistency; attunement
  - collaboration, relational approach
  - awareness of relational instability, mistrust
- Boundary management with particular attention to transference and countertransference
  - **boundaries, boundaries, boundaries … with a certain degree of flexibility**
  - "treatment traps"
  - transference enactments
  - countertransference and vicarious traumatization
  - beware abandonment of patient

Framework (cont.)

- Continuing education
  - Training
    - assessment and treatment of posttraumatic and dissociative disorders
    - nature of traumatic memory
    - Specialized techniques
    - general training (non-trauma-oriented)
      - maintain breadth of knowledge in mental health field
  - Literature on posttraumatic and dissociative disorders, existing practice guidelines, memory research (see bibliography)
  - Supervision and consultation
    - peer support: do not practice in isolation

The Importance of Relationship

- Competence to treat and wellness of therapist
- Relational healing for interpersonal trauma
  - A sacred obligation
- Interpersonal neurobiology
  - Right brain to right brain attunement
    - implicit memory and knowledge
  - Development of new neuronal pathways
    - "neurons that fire together wire together"
  - "Earned secure" attachment

The Importance of Relationship

- Therapist must maintain empathy and attunement
  - When ruptures occur (as they always will), opportunity for communication and problem-solving leading to repair
    - therapist owns mistakes
    - therapist shares feelings in the moment (with discretion)
    - therapist is not blaming
  - Therapist must not make self the "all-knowing authority on high"

Boundary Issues

- Potential for boundary violations (vs. crossings) common with this population (indiscretions, transgressions, and abuse)
  - Playing out of attachment style and issues
  - Playing out the roles of the Karpman triangle, plus
    - victim, victimizer, rescuer, passive bystander
    - potential for sado-masochistic relationship to develop
  - Roles shift rapidly, especially with dissociative clients

Boundary Issues

* Therapist must be aware of transference, countertransference issues and carefully monitor the relationship
* Therapeutic errors and lapses will occur and how they are handled can either be disastrous or can be restorative to the patient and the relationship
  * knowing about them can help the therapist get out of them more rapidly and manage them with less anxiety (Chu, 1988)

Boundary Issues

* Safety of the therapeutic relationship is essential to the work
* Responsibility of therapist to
  * Maintain vigilance and the integrity of frame
  * Be thoughtful as to setting boundaries/limits
    * re: availability, personal disclosure, touch, fees, gifts, tolerance for acting out behavior, social contact, etc.
  * On average, start with tighter boundaries
  * Avoid dual roles wherever possible
  * Be prepared to hold to boundaries/limits but also to have some flexibility
  * Complete personal therapy as necessary
  * Engage in ongoing consultation/supervision, peer support

Boundary Issues

- Rescuing-revictimization "syndrome"
  - "vicarious indulgence" as a treatment trap, especially for novice therapists and those with need to caretake or are enticed by the client
  - may give client permission to overstep boundaries, ask for and expect too much
  - may then lead to resentment/rage on the part of the therapist and abrupt, hostile termination for which the client is blamed
  - may relate to malpractice suits, in some cases (see BPD literature)
- Progression of boundary violations: the "slippery slope" e.g., from excessive disclosure to client as confidante, excessive touch to sexual comforting and contact

Safety and The Spectrum of Dangerousness

- A portion of this population is at high risk for:
  - Self-injurious behaviors
    - self-mutilation
    - risk-taking/revictimization
    - unsafe sexual activity
    - substance abuse
    - eating disorders
    - avoidance of medical care
  - Harm from others
    - domestic violence and other revictimization
  - Suicidality (approximately 10% successful in BPD population)
  - Homicidality
  - Other risk to third parties
    - Minor children --abuse, neglect, inability to parent, suicide
    - Family -- disclosures/confrontations, cutoffs, legal action

Safety and The Spectrum of Dangerousness

- In general, the client is not going to get better when s/he is in ongoing danger of being hurt or revictimized, when constantly self-harming or considering suicide/homicide, or when otherwise a danger to others
- Treatment must therefore be organized around safety
- What safety means to the clinician is often not the same as what it means to the client

The Evolving Standard of Care for Trauma Treatment

- Psychotherapy *and* psychopharmacology in majority of cases
- Stage-oriented for the entire PTSD-DD spectrum; three stages, plus pre-assessment:
  - **Early**: safety, stabilization and functioning, skill-building: decrease symptoms, increase coping; therapeutic alliance
  - **Middle:** trauma information and emotional processing
  - **Late**: self and relational development
- Different trajectories
  - according to patient's psychological make-up, tolerance and capacity, and resources

Science: The Evidence Base of Trauma Treatment

- Ever growing for classic PTSD
  - specific treatments:
    - CBT (prolonged exposure)
    - CPT & other cognitive protocols
    - EMDR
    - Psychopharmacology
    - Others?
  - applicable to complex trauma?
    - research generally excludes these patients
    - research easier to conduct on CBT approaches and specific posttraumatic symptoms

The Evolving Standard of Care for Trauma Treatment

- Foa et al. (2000)
- *Journal of Clinical Psychiatry* Expert Consensus Guidelines (2000)
- ISTSS Guidelines (2000, 2009)
- ApA Treatment Guidelines for PTSD/ASD (2004)
- ISSTD Treatment Guidelines for DD's
  - Adults (1994; 1997; 2005, 2011)
  - Children (2000)
- Institute of Medicine, CREST
- Delayed memory issues
  - Courtois (1999); Mollon (2004): overviews

Science: The Evidence Base of Complex Trauma Treatment

- Growing for complex trauma
  - critical role of the therapeutic relationship (the original evidence-based strategy)
    - relational healing for relational injury
    - interpersonal neurobiology
  - hybrid models of treatment
    - **DBT (Linehan)--BPD, affect dysregulation and skills**
    - **TARGET (Ford), STAIR (Cloitre)**
    - Seeking Safety (Najavits) and ATRIUM (Miller & Guidry)--substance abuse

Recommended Treatments for Complex PTSD

(ISTSS Complex Trauma Task Force Survey Results, *JTS*, 2011)

- **Sequenced** or phased in most cases
  - Some clients require processing the trauma "out of order" (Shapiro)
- Three stages, plus pre-treatment assessment and contracting
- Establish **safety** as the foundation on which treatment is built
- Initially, build skills for emotion regulation, life stabilization, and relationships ; build on strengths and resilience

Sequenced Model of Treatment

* Spiral rather than linear
* Hierarchal
* Educational
* Learning and relapse-based
* Recursive
* Oriented towards approaching and processing trauma rather than avoiding it
* Geared to the emotional "window of tolerance" and expanding emotional tolerance to achieve processing and regulation

Recommended Treatments for Complex PTSD

(ISTSS Complex Trauma Task Force Survey Results, *JTS*, 2011)

* "First line" approaches:
  * Emotional regulation
  * Narration of trauma memory
  * Cognitive re-structuring
  * Anxiety and stress management
  * Interpersonal approach
  * Education
* "Second line" approaches:
  * Meditation/mindfulness/building self-acceptance, self-awareness & self-compassion

Evidence-Based Treatment Approaches for Complex PTSD

- Those for classic trauma: PE, CPT, EMDR, etc.
- EFTT (Pavio & Pascuale-Leone)
  - Emotionally focused & experiential
  - Narrative
- STAIR (Cloitre)
- TARGET (Ford)
  - Freedom Steps
- SEEKING SAFETY (concurrent addiction tx) (Najavits)
- DID (preliminary data) (Brand)
- EFT for couples (Johnson)

Science: The Evidence Base of Trauma Treatment

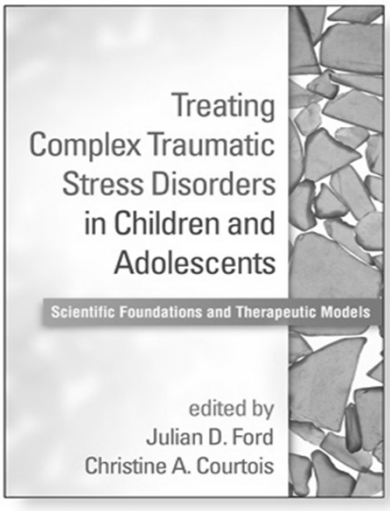
- *Will some techniques hurt more than help?*
- **A major ethical concern**
  - Potential for retraumatization must be monitored
  - Treatment must be tailored to individual
  - Therapist must monitor client's response
  - Must apply most effective but safe strategy
    - Must give informed consent/refusal

Summary

* Ethics and risk management are integral to responsible clinical practice of the traumatized
* Important to devote time and energy to practice issues
  * Stay current re: ethical and legal issues
  * Stay current re: evolving standards of care and science
    * Sequence treatment
    * Emphasize relational development, safety and boundary management
* Knowledge, structure, and support allay anxiety & improve care

Resources

* http://kspope.com/ethcodes/index.php
* http://kspope.com/taboo.php
* Bennett, B. E., Bricklin, P. M., Harris, E., Knapp, S., VandeCreek, L., & Youngren, J. N. (2006) *Assessing and managing risk in psychological practice: An individualized approach.* Rockville, MD: The Trust.
* Pope, K. S., & Vasquez, M. J. T. (2005). *How to survive and thrive as a therapist: Information, ideas, and resources for psychologists in practice*. Washington, DC: American Psychological Association.
* Pope, K. S., Sonne, J. L., & Greene, B. (2006) *What therapists don't talk about and why: Understanding taboos that hurt us and our clients.* Washington, DC: American Psychological Association.



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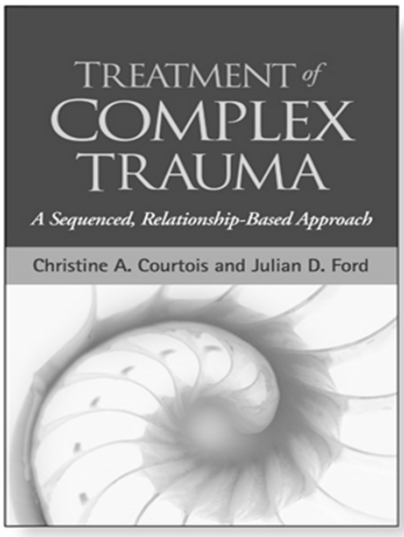

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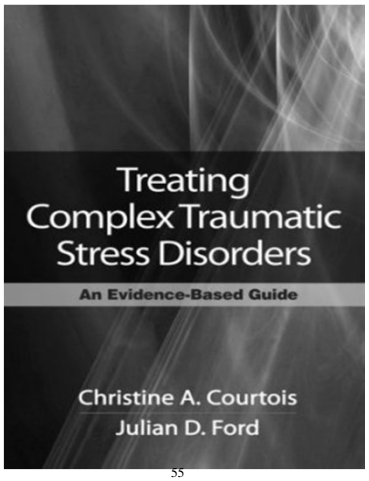

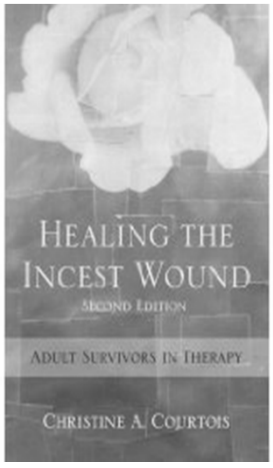

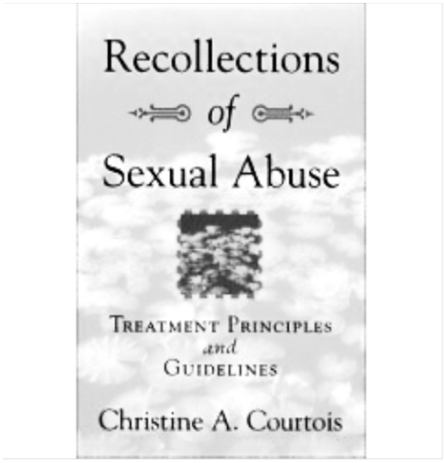

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