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
* Identity/personality are often deformed by trauma: disorders of the self
* “I’m not the person I might have been”
  —incest survivor

Trauma, Self, and Spirituality

* Victims feel hurt, damaged, less than, not like others, not normal, contaminated
* Identify themselves as bad and as deserving of mistreatment/punishment, especially when abuse is by a caregiver/family member
* Internalize what happened to them—make it about them
* Loathe and blame themselves as a result
  * Shamed identity
  * Self-alienation and attack
Trauma, Others, and Spirituality

* Trauma impacts the ability to trust others
  * Others are dangerous rather than kind
  * Others are to be suspected and feared
  * Leads to a variety of interpersonal styles and an other-orientation and locus of control
    * Alienation/anger
    * Withdrawal/detachment
    * Superficial compliance
    * Pre-occupied and dependent
      * Paradoxical over-trust/attachment hunger/a search for the trustworthy or compensatory other
    * Ambivalent or disorganized attachment

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

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**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

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**Attachment/Relational Forms of Interpersonal Trauma**

- Occurs in attachment relationships with primary caregivers
  - 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
  - Impacts child’s development
Complex Trauma

- Attachment/relational/developmental trauma
- 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

- 1. 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

* 6. Somatization
   * a. Digestive system
   * b. Chronic pain
   * c. Cardiopulmonary symptoms
   * d. Conversion symptoms
   * e. Sexual symptoms
* 7. 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”
    * Resembles BPD
* 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 countertransference reactions/errors

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 treatment 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
* Role of trauma must be acknowledged
* Symptoms as adaptations

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
For trauma treatment: all this *and more*

“First, do no *more* harm”

- 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

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
  - safety planning
  - changing from a life of chaos/victimization
  - therapist stance
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.)

- Ongoing supportive neutrality with regard to suspected trauma history
  - encourage tolerance for “living with uncertainty”
  - therapy is not a hunt for missing memories and recovery of memories does not mean recovery
- Caution with regard to
  - disclosures/confrontations/breaking off relationships with major attachment figures
  - legal action
  - major life decisions
  - transference, countertransference, vicarious trauma, self-care
  - practicing in isolation

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 transferences, countertransferences, 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 the 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 a need to take care of or be 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.
Boundary Issues

* Responsibility of supervisors
  - To protect patient and the supervisee
  - To document supervision
* Response to a patient’s report of past or ongoing sexual relationship with previous therapist [The “Sitting Duck Syndrome” (Kluft)]/”Professional Incest” (Courtois)
  - Know state law—varies by jurisdiction
  - Consult state board, professional organizations, attorneys, insurance trust
* Patient welfare issues
  - be aware of ambivalent attachment
  - mistrust and boundary issues
* Therapist welfare issues
  - Impairment, CT, VT, & self-care

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
Safety and The Spectrum of Dangerousness

* An emphasis on safety must be maintained
  * must be explained
  * must be highlighted as a foundation/condition of treatment
* Safety must be collaboratively worked on
  * SAFETY PLANNING as a process
  * may be achieved slowly with starts, stops, relapses
  * is ultimately the responsibility of the client

The Suicidal Patient

* Reasonable duty to protect from danger to self
  * No standard of care for prediction of suicide, but does exist for adequate assessment of suicide risk
  * Recognition of the clinical need to support patient autonomy and the limitation of outpatient control
  * Inpatient duty to protect much more stringent
* Complex PTSD patients are at high risk, particularly with co-morbid depression, anxiety, and substance abuse
  * Long-term risk factors: severe hopelessness & depression, poor coping and self-regulatory skills, suicidal ideation and intent, history of previous attempts, family history, family injunctions/rules

Extension of Duty to Protect to Third Parties (Not Yet Formal)

* “Hot spot” in the field
* Therapists are being sued by families of alleged victims for damages to the family
  * Cases in litigation now
* Emphasizes the need for neutrality, careful documentation, not recommending “cut offs” from family unless there is clear evidence of contemporary danger
* Therapists are not private investigators or law enforcement officers
  * criminal prosecution or civil suits against alleged abusers will not succeed without independent corroborative evidence; client recollections may not be strong enough evidence to carry a case
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

The Evolving Standard of Care for Trauma Treatment

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

Science: The Evidence Base of Trauma Treatment

Foa et al. (2000)
- ISSTD Treatment Guidelines for DD’s
  - 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

### Evidence Base for Complex Trauma

- 12 published studies investigating
  - target symptoms
  - among adults
  - history of complex trauma in childhood required for enrollment
- 11 RCT's
  - investigated enhanced or phase-based treatment models
  - 1 head-to-head comparison of phase-based tx to exposure or skills focused tx
- 1 naturalistic study of volunteer therapists and patients with DID
  - investigated enhanced or phase-based treatment model published for the tx of DID

### Complex Trauma Findings

- Stabilization therapies associated with moderate to large effect sizes for
  - PTSD symptoms
  - Emotion regulation
  - Social/interpersonal
- Therapies with both stabilization/skills building and memory processing generally superior to those with only a stabilization component
- Individual therapies had larger effect sizes than group therapies
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
* Hierarchical
* 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
Evidence-Based Treatment Approaches for Complex PTSD

- Those for classic trauma: PE, CPT, EMDR, etc.
- EFTT (Pavio & Pascaule-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

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Psychological Trauma
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