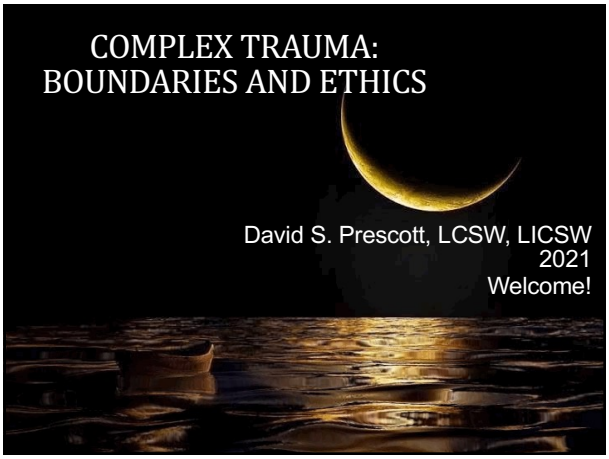
COMPLEX TRAUMA: BOUNDARIES AND ETHICS



David S. Prescott, LCSW, LICSW
2021
Welcome!

1

WELCOME!

2

LEARNING OBJECTIVES

1) Consider implications of trauma that are not explicitly addressed in the codes of ethics of professional organizations.

2) Distinguish between structural and interpersonal professional boundaries

3) Identify two critical elements of professional boundaries (i.e. balancing connection and protection)

4) Consider the cumulative effect of experiences not always considered to be traumatic, such as verbal abuse

5) Use processes for addressing ethical quandaries

3

FOCUS

- Introductory remarks
- What is complex trauma?
- What are ethics?
- What are the most common issues?
- Case examples from the field
- Boundaries
- Bonus material if there's time: Putting it all together in the workplace

4

PLEASE NOTE

- I'm including lots of extra slides!
- These are for your enjoyment and thought.
- They are a bonus and not the result of poor time management.
- If we can cover them, we will. ☺

5

INTRODUCTORY REMARKS

6

LET'S BE PATIENT

- We live in troubled times
- I am going to be very provocative
- I am going to be highly irreverent
- This is a training for professionals only
- I come in peace and believe in human dignity
- I mean no harm
- Please take everything I say in the spirit in which it is intended

7

LET'S BE HONEST

- Everyone is at a different place in their professional development
- This presentation is for all audiences
  - Format intended to be more conversational than didactic.

8

LET'S BE CLEAR

We do hard work

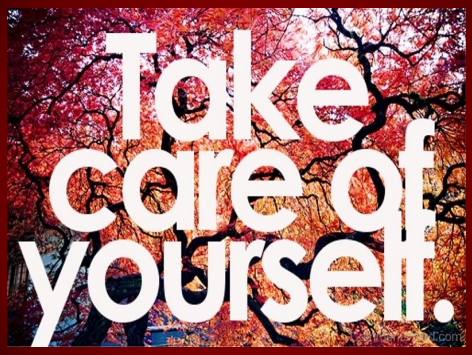
9

Question…

Do we choose this work?

Does this work choose us?

10



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ON THE EVOLUTION OF RESIDENTIAL TREATMENT

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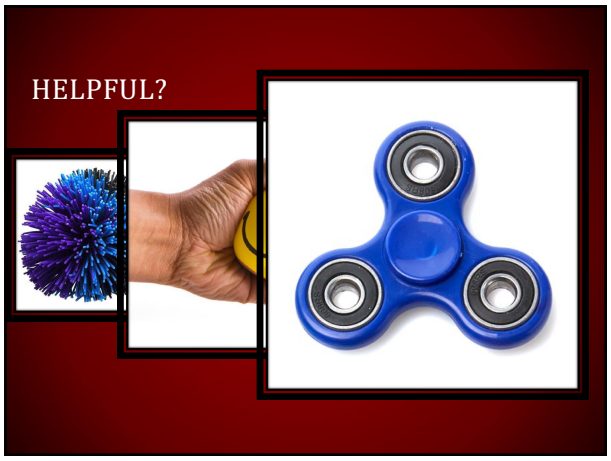
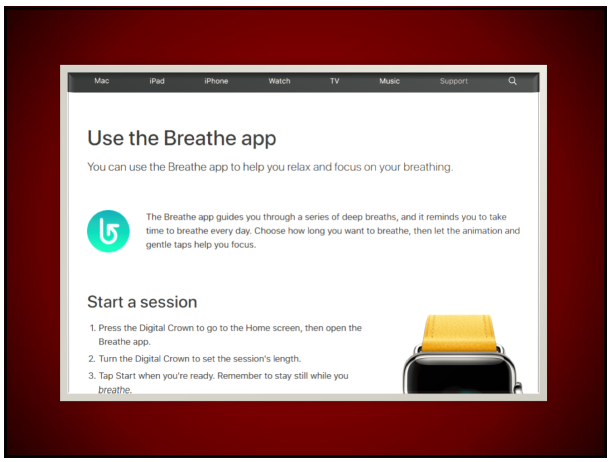
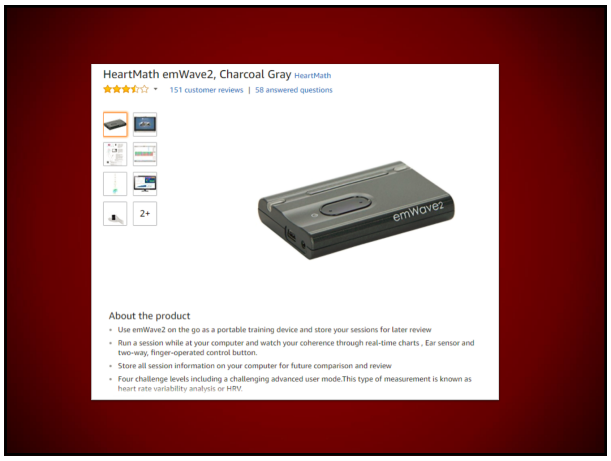

HELPFUL?

13


Mac
iPad
iPhone
Watch
TV
Music
Support
Use the Breathe app
You can use the Breathe app to help you relax and focus on your breathing.
The Breathe app guides you through a series of deep breaths, and it reminds you to take time to breathe every day. Choose how long you want to breathe, then let the animation and gentle taps help you focus.
Start a session
1. Press the Digital Crown to go to the Home screen, then open the Breathe app.
2. Turn the Digital Crown to set the session's length.
3. Tap Start when you're ready. Remember to stay still while you breathe.

14


HeartMath emWave2, Charcoal Gray
HeartMath
151 customer reviews | 58 answered questions
2+
emWave2
About the product
Use emWave2 on the go as a portable training device and store your sessions for later review
Run a session while at your computer and watch your coherence through real-time charts , Ear sensor and two-way, finger-operated control button.
Store all session information on your computer for future comparison and review
Four challenge levels including a challenging advanced user mode.This type of measurement is known as heart rate variability analysis or HRV.

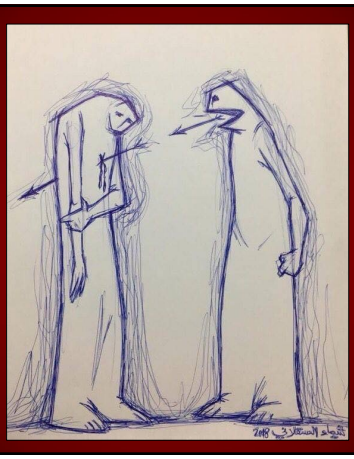
15

16

DON'T TRY TOO HARD

17

18



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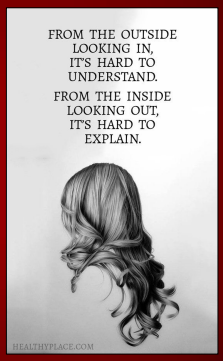
WHY
SO
COMPLICATED?



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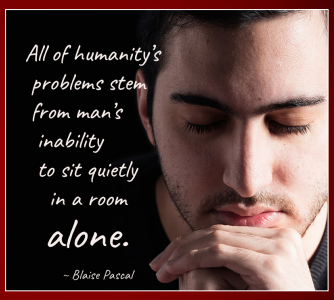
WHY?



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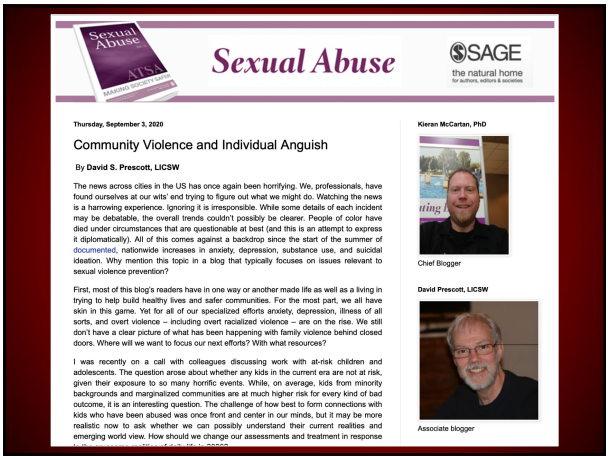
QUESTION

- *Between our pandemic and our community violence, is ANYONE not "at risk"?*

22



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MARSHALL, 2005

24

MARSHALL, 2005

- Warm
- Empathic
- Rewarding
- Directive

Problem:
Many people think they have these qualities, but don't

25

PARHAR, WORMITH, ET AL., 2008

- Meta-analysis of 129 studies
- *In general, mandated treatment was found to be ineffective … particularly when the treatment was located in custodial settings, whereas voluntary treatment produced significant treatment effect sizes regardless of setting.*

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WHAT NOT TO DO: CASE EXAMPLE

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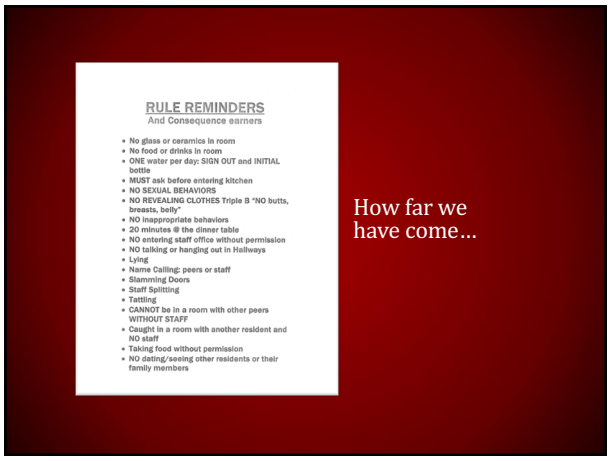
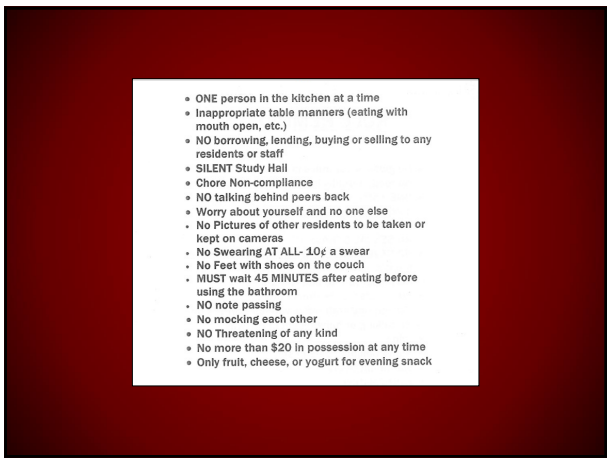

RULE REMINDERS
And Consequence earners
No glass or ceramics in room
No food or drinks in room
ONE water per day: SIGN OUT and INITIAL bottle
MUST ask before entering kitchen
NO SEXUAL BEHAVIORS
NO REVEALING CLOTHES Triple B "NO butts, breasts, belly"
NO inappropriate behaviors
20 minutes @ the dinner table
NO entering staff office without permission
NO talking or hanging out in Hallways
Lying
Name Calling: peers or staff
Slamming Doors
Staff Splitting
Tattling
CANNOT be in a room with other peers WITHOUT STAFF
Caught in a room with another resident and NO staff
Taking food without permission
NO dating/seeing other residents or their family members
How far we have come…

28


ONE person in the kitchen at a time
Inappropriate table manners (eating with mouth open, etc.)
NO borrowing, lending, buying or selling to any residents or staff
SILENT Study Hall
Chore Non-compliance
NO talking behind peers back
Worry about yourself and no one else
No Pictures of other residents to be taken or kept on cameras
No Swearing AT ALL- 10¢ a swear
No Feet with shoes on the couch
MUST wait 45 MINUTES after eating before using the bathroom
NO note passing
No mocking each other
NO Threatening of any kind
No more than $20 in possession at any time
Only fruit, cheese, or yogurt for evening snack

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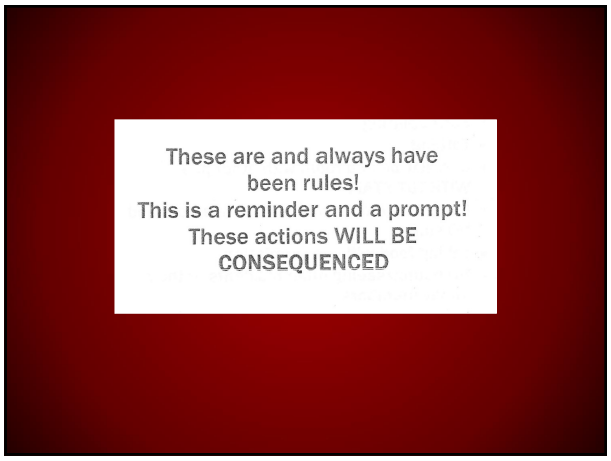
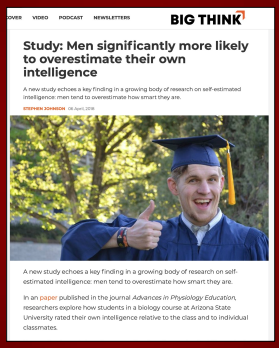

These are and always have been rules!
This is a reminder and a prompt!
These actions WILL BE CONSEQUENCED

30

SELF-ASSESSMENT BIAS

An Aggravating Factor

31



32

Walfish et al., 2012

- No differences in how clinicians rated their overall skill level and effectiveness levels between disciplines.
- On average, clinicians rated themselves at the 80th percentile
- Less than 4% considered themselves average
- No one rated themselves below average
- Only 8% rated themselves lower than the 75th percentile
- 25% rated their performance at the 90th% or higher compared to their peers

33

CONCLUSION:

WHAT WORKS?

***Who* works?**

34

OKAY, LET'S GO DEEPER!

35

WARNING!

- Again, this may be provocative
- We should come down on only one side:
  - Thoughtful, ethical practice

36

SAFETY

- Keep it simple!
  Everything should be made as simple as possible, but not simpler.
  – Albert Einstein
- Our work is hard enough
- Be careful out there!
  - (With apologies to Hill Street Blues…)

37

WHAT EXACTLY IS TRAUMA?

WHAT DOES IT MEAN TO BE TRAUMATIZED?

38

TRAUMA
Ford et al. (2012)

- Approximately **90%** of youth in juvenile detention facilities reported a history of exposure to at least one potentially traumatic event in two independent surveys of representative samples
  - E.g., being threatened with a weapon (**58%**), traumatic loss (**48%**), and physical assault (**35%**)

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TRAUMA

- Two complex trauma sub-groups:
  - **20%** some combination of sexual or physical abuse or family violence
  - **15%** emotional abuse and family violence (but not physical or sexual abuse)
- The resultant combined prevalence estimate of **35%** for complex trauma history is about three times higher than the **10-13%** estimates of polyvictimization from epidemiological study of children and adolescents

(FORD ET AL., 2012)

40

WHAT IS TRAUMA?

- PTSD
- Complex PTSD
- DESNOS
- Complex trauma
- Developmental Trauma Disorder

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WHAT IS TRAUMA?

Trauma is the desperate hope that the past was somehow different.

– Jan Hindman

43

WHAT IS TRAUMA?

APA:

- **Trauma** is an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives. Psychologists can help these individuals find constructive ways of managing their emotions.

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45

46

KEY THEME

- Just notice
- See what happens next
  - Not just mindful…
  - Investigating each experience
  - Practice Making Choices based on what you notice

47

48

The goal of (trauma) treatment is to help people live in the present, without feeling or behaving according to irrelevant demands belonging to the past.

– Bessel van der Kolk

49

CASE EXAMPLE

- EBT roll-out
- JCCO directed client into treatment
- Client reluctant to attend
- Harm

50

BENISH, IMEL, & WAMPOLD, 2008

- Treatment for PTSD is effective
- "Bona fide psychotherapies produce equivalent benefits for patients with PTSD"
- Much controversy

51

SEPTEMBER 11

- Critical Incident Stress Debriefing
- Some treatments cause harm
- Lilienfeld (2007)

52

ULTIMATELY

No intervention that takes power away from the survivor can possibly foster her recovery, no matter how much it appears to be in her immediate best interest.

— Judith Herman, M.D.

Reframe:
Interventions that empower survivors foster recovery.

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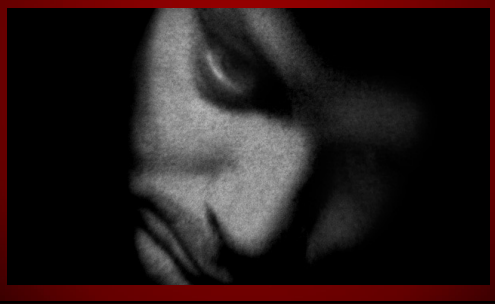
POST-TRAUMATIC STRESS DISORDER



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POST-TRAUMATIC STRESS DISORDER

- Traumatic event including
  - Actual or threat of death or serious injury
  - Threat to physical integrity
  - Response of intense fear, helplessness, horror
- Persistent re-experiencing of events
- Persistent avoidance of associated stimuli & numbing of responsiveness
- Persistent symptoms of increased arousal
- Duration > 1 month, significant disturbance in functioning

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POST-TRAUMATIC STRESS DISORDER

- Re-experiencing distress
  - Recollections, images, thoughts, perceptions
  - Dreams
  - Flashbacks, illusions, hallucinations
- Avoidance of related stimuli
  - Thoughts, feelings, conversations
  - Activities, places or people

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POST-TRAUMATIC STRESS DISORDER

- Numbing of general responsiveness
  - Inability to recall important aspects of event
  - Diminished interest/participation in activities
  - Detachment/estrangement from others
  - Restricted range of emotions (e.g., love)
  - Sense of foreshortened future
- Arousal symptoms
  - Insomnia, anger, hypervigilance, difficulty concentrating, exaggerated startle response

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POST-TRAUMATIC STRESS DISORDER

- Events
  - Military combat
  - Violent personal assault (physical, sexual, mugging)
  - Kidnapping, terrorism, torture, incarceration, disasters, auto accidents, terminal diagnosis)
  - Witnessing fatal accident, body parts
- Typically worse when event is of human design
- Typically worse when stressor is repeated, chronic

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WHAT IS TRAUMA-INFORMED CARE?

"A program, organization, or system that is trauma-informed:

1. *Realizes* the widespread prevalence and impact of trauma;
2. *Recognizes* the signs and symptoms of trauma;
3. *Responds* by integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist *re-traumatization*."

SAMHSA

https://www.samhsa.gov/nctic/trauma-interventions

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59

COMMON TRAUMA RESPONSES

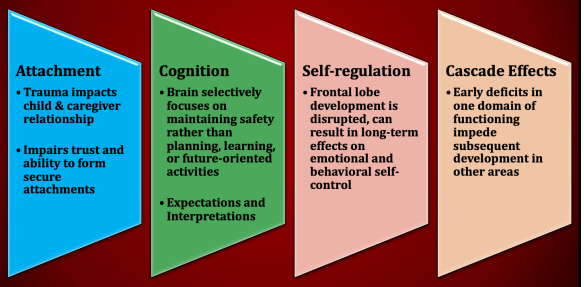
60

HOW DOES TRAUMA AND ADVERSITY AFFECT DEVELOPMENT?

And Risk Factors? And Good Lives Goals?

61

DEVELOPMENTAL EFFECTS OF CHILDHOOD ADVERSITY



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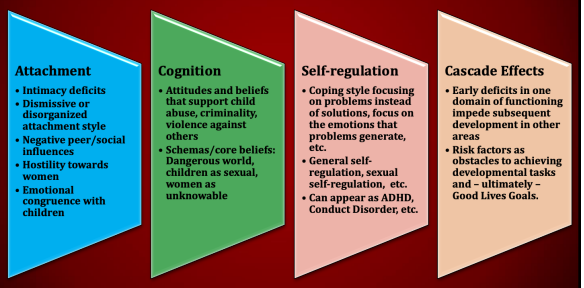
DEVELOPMENTAL EFFECTS OF CHILDHOOD ADVERSITY AND RISK



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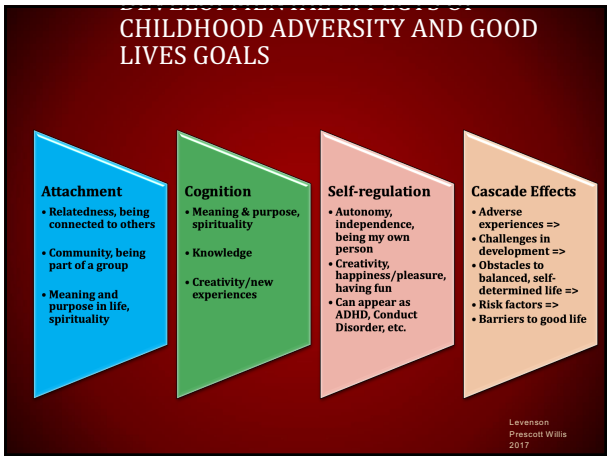

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THE IMPORTANCE OF NARRATIVE

65

CONSIDER …

Among the tasks of the mind is to reduce the difference between the prediction and the sensation

66

APPLICATION

"I went to the grocery store, and for the first time ever I knew what I wanted"

67

ANALYSIS

- Trauma interferes with decision-making
- Trauma interferes with prediction of sensations
- Trauma interferes with prediction of happiness
- Trauma interferes with the belief that predictions and decisions are possible
- Trauma focuses on surviving threats in the moment
- Move beyond teaching how to make lists
- Move beyond decision-making skills

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REFLECTION

1. *That's fantastic. There you were, able to focus on what you wanted and not on what others wanted from you.*
2. *Hey, that's great! In that moment, you were aware of the things that mattered most to you*
3. *Good for you. Staying focused on what matters to you in a busy place like a grocery store can be a real challenge.*

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69

APPLICATION

"I can't tell you what I'm thinking. It's too confusing. I'm not sure you'd get it. Look, never mind."

70

TRANSLATION

- "Other people have always told me what to do.
- I've had to hide to avoid being beaten
- Now you're asking me to express my thoughts freely; that's dangerous
- I've learned not to trust my thoughts and feelings
- Survival has meant focusing outside myself
- My capacities to observe my thoughts and feelings have atrophied.
- It's safer to shut down."

71

REFLECTION

1. *Describing your experience is really hard.*
2. *It's really hard to talk about these things when you don't know if I'll really get it.*
3. *There's a bigger piece of all of this that I may not be seeing.*
4. *If you were to really talk about these things, you'd need to know that others will understand and respect you.*

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72

CULTURAL TRAUMA

"What's it like to be working with a white guy like me?"

- Activation of cultural trauma can happen at the epigenetic level
- We forget how much power we have over clients

73

POSSIBLE REFLECTIONS

- *You might be wondering if someone like me – who comes from outside your culture – can understand you and you have every right to be suspicious about all of this.*
- *With everything going on for you, including having to talk with a counselor who's not from your same culture(s), it's probably better if you don't completely trust me.*
- *At some point, if you'd be willing to talk with me about our cultural differences, I would be honored to listen and respond as best I can.*

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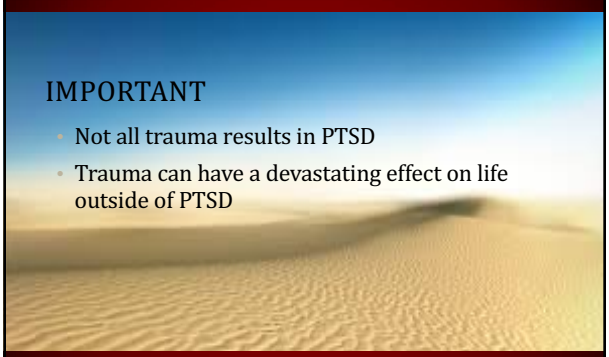
IMPORTANT

- Not all trauma results in PTSD
- Trauma can have a devastating effect on life outside of PTSD



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TAKE-HOME SKILLS

- Distinguish between trauma treatment and trauma-informed care
- Think about trauma physically as well as emotionally, executively, etc.
- Establish a plan of self-care

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BAD BOUNDARIES, BAD OUTCOMES

77

TRIVIA QUESTIONS

- What is the number one crime committed by treatment providers?

If you thought that was easy…

- What is the second most common crime committed by therapists?

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MPRnews Sections Members More

Minnesota sex offender program guard accused of sex with patient

Mankato, Minn. · Feb 9, 2019 Issues

A security guard at the Minnesota Sex Offender Treatment Program in St. Peter is accused of having a sexual relationship with a patient.

Claudia Kogo, 57, of Mankato, was charged Friday in Nicollet County District Court with felony counts of criminal sexual conduct, the Mankato Free Press reported.

Authorities say a patient who was committed as a sexually dangerous person reported that he had sex with Kogo more than two dozen times in late 2017. The patient said the relationship started with flirting and progressed to sex.

Prosecutors allege that Kogo told a state investigator she kissed and groped the patient but denied having sex with him. A St. Peter police detective who listened to recordings of phone calls between Kogo and the patient said many of the calls included conversations about their sexual activities, according to court documents.

Kogo no longer works at the facility, a Minnesota Department of Human Services spokesman said. A phone number for Kogo could not be found.

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A PIONEER IN OUR FIELD

Dear Parties:

Enclosed please find the Determination and Order (No. 00-30) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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Based on the evidence in this case the Hearing Committee concludes that the conduct resulting in the Oregon Board's disciplinary action against Respondent would constitute misconduct under the laws of New York State, pursuant to:

1. New York Education Law §6530(2) (practicing the profession fraudulently);
2. New York Education Law §6530(16) (failure to comply with federal, state, or local laws, rules, or regulations governing the practice of medicine);
3. New York Education Law §6530(20) (moral unfitness); and
4. New York Education Law §6530(21) (willfully making or filing a false report).

3

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Seattle Times special report: Twisted ethics of an expert witness

Stuart Greenberg was at the top of his profession: a renowned forensic psychologist who in court could determine which parent got custody of a child, or whether a jury believed a claim of sexual assault. Trouble is, he built his career on hypocrisy and lies, and as a result, he destroyed lives, including his own.

By Ken Armstrong and Maureen O'Hagan
Seattle Times staff reporters

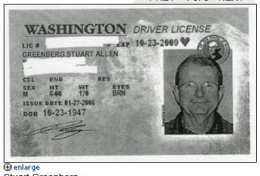
Earlier this year, a four-page document with a bland title, "Stipulation for Dismissal with Prejudice," was filed in a civil matter percolating on the King County Courthouse's ninth floor. Hardly anyone took notice. Most everyone had moved on.

But that document — filed by lawyers tangled up in the estate of Stuart Greenberg, a nationally renowned psychologist whose life ended in scandal — signaled the end of a tortuous undertaking.

Greenberg had proved such a toxic force — a poison coursing through the state's court system — that it took more than three years for lawyers and judges to sift through his victims and account for the damage done.

For a quarter century Greenberg testified as an expert in forensic psychology, an inscrutable field with immense power. Purporting to offer insight into the human condition, he evaluated more than 2,000

PREV 1 of 5 NEXT



enlarge
Stuart Greenberg

The reporting for this story

To uncover the secrets Stuart Greenberg had buried, The Seattle Times got court files unsealed in the superior courts of King and Thurston counties. Through a motion filed by the state Attorney General's Office, the newspaper also got an order lifted that barred public inspection of Greenberg's disciplinary history. Reporters obtained other documents — for example, Greenberg's emails at the University of Washington — through public-records requests, and

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2013: NEW HAMPSHIRE

For the purposes of this appeal, the following facts are undisputed. At the time of the alleged crimes, the defendant was a licensed psychologist, who provided therapy to the complainant in 2007. Less than a year after the therapy ended, the two became sexually involved. In April 2010, the defendant was charged with thirty counts of aggravated felonious sexual assault (AFSA) for engaging in sexual penetration with the complainant between February 1, 2008, and December 9, 2008. The indictments alleged that by engaging in sexual penetration with the complainant "within one year of the termination of their therapeutic relationship," the defendant "act[ed] in a manner which is not professionally recognized as ethical," thereby violating RSA 632-A:2, I(g)(1).

In December 2010, the defendant moved to dismiss the indictments, arguing, inter alia, that RSA 632-A:2, I(g)(1) violated his state and federal rights to substantive due process because it "criminalizes the private sexual conduct

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2013: FLORIDA

Arcadian | Page 8 www.sunnewspapers.net The Sun / Thursday, May 30, 2013

FCCC employee arrested on sex charge

By SUSAN E. HOFFMAN
Arcadian Editor

DESOTO COUNTY — The DeSoto County Sheriff's Office reported on Wednesday that an employee of the Florida Civil Commitment Center was arrested for allegedly engaging in sexual activity with a resident.

According to the sheriff's arrest report, Leanne Paynter, 42, of Sebring, was charged with sexual misconduct and is being held without bond in the DeSoto County Jail. FCCC is a facility for treatment of convicted sexual predators who have served time for their crimes but have been determined too dangerous to release.

According to the report, an employee at FCCC called DCSO regarding a video allegedly showing Paynter, a clinician at FCCC, engaged in inappropriate sexual activity with a 42-year-old male resident. The video reportedly shows the resident and then Paynter entering her office, a room divided into cubicles, and going to the floor behind a partition. The report said the video shows Paynter's head moving up and down consistent with the act of intercourse.

PAYNTER

Similar behavior was allegedly discovered on video on four instances in April and May between Paynter and the same resident.

When confronted, Paynter first said no one was in her office with her, then later said he had come in to remove trash, according to the report.

When asked if the activity was consensual, the resident told investigators that "nothing was forced."

A warrant was issued on May 19 and Paynter was then arrested at FCCC, after submitting her resignation.

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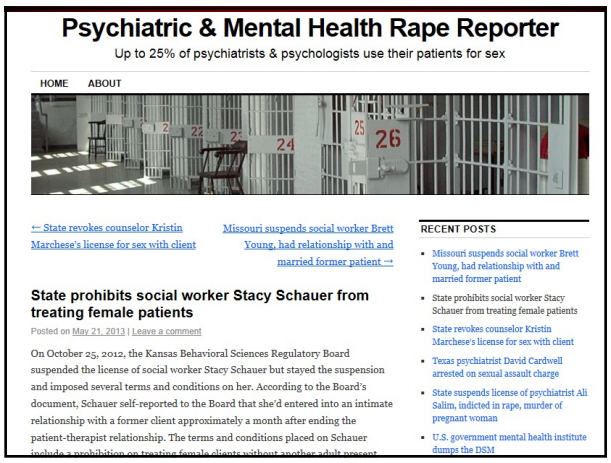

Psychiatric & Mental Health Rape Reporter

Up to 25% of psychiatrists & psychologists use their patients for sex

HOME ABOUT

← State revokes counselor Kristin Marchese's license for sex with client

Missouri suspends social worker Brett Young, had relationship with and married former patient →

State prohibits social worker Stacy Schauer from treating female patients

Posted on May 21, 2013 | Leave a comment

On October 25, 2012, the Kansas Behavioral Sciences Regulatory Board suspended the license of social worker Stacy Schauer but stayed the suspension and imposed several terms and conditions on her. According to the Board's document, Schauer self-reported to the Board that she'd entered into an intimate relationship with a former client approximately a month after ending the patient-therapist relationship. The terms and conditions placed on Schauer include a prohibition on treating female clients without another adult present

RECENT POSTS

- Missouri suspends social worker Brett Young, had relationship with and married former patient
- State prohibits social worker Stacy Schauer from treating female patients
- State revokes counselor Kristin Marchese's license for sex with client
- Texas psychiatrist David Cardwell arrested on sexual assault charge
- State suspends license of psychiatrist Ali Salim, indicted in rape, murder of pregnant woman
- U.S. government mental health institute dumps the DSM

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FRANCOISE BOURZAT

Mad in America

EDITORIAL DRUGS EDUCATION VETERANS FAMILY MIA GLOBAL GET INVOLVED ABOUT

Ending The Silence Around Psychedelic Therapy Abuse

By Will Hall, MA, DipIPW - September 25, 2021

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Psilocybin helps with depression, anxiety, and addiction. It also helps with grief.

My client Joan was bereft. Her son David had died 10 years prior to cancer when he was 14. She had not been able to truly move on with her creativity and return to any real joy for life. She felt constantly in the throes of depression and heart heaviness. During her mushroom experience, she felt David's Presence, a soul floating near her, calm and serene. She felt her own serenity, her own calmness, her joy of life. When she shared with me afterwards, her main comment was; " I am alive and he wants me to be in my life again. He is ok." The heaviness lifted, she reported feeling 80 % less depressed. She said this was truly miraculous.

~Francoise Bourzat, psilocybin guide

One of our depression volunteers had a child who died shortly after he was born. Almost 10 years later, the pain, guilt and grief were still present. In her first psilocybin session, she experienced being back with her son as he was taking his last breathe, but this time rather than feeling helpless and fearful, she breathed his last breath with him, and with that, let him go. She felt at peace with his

When my 17 year old son died in a car crash modern psychiatry and psychology had nothing to offer me that worked for my grief. Nonordinary states of consciousness were my road back to mental health. They helped me to come to a deeper understanding of life, death, the meaning of relationship, and love. I have encountered my son in medicine journeys and now have a continuing relationship with him. I know not everyone will encounter their loved one but I was lucky enough to have seen him and talked with him. He wants me to live my life to the fullest and to know he is fine. He tells me I will be with him again when I have finished what I came here to experience. These journeys into non-ordinary states of consciousness have saved my life.

~Sam's Dad

Another volunteer had lost his young daughter decades before he joined our cancer/psilocybin study. He thought he had healed from the grief of her passing but in his psilocybin session he had an experience that brought him back to that time and he relived her death and his grief. During the session he sobbed and sobbed and felt he finally

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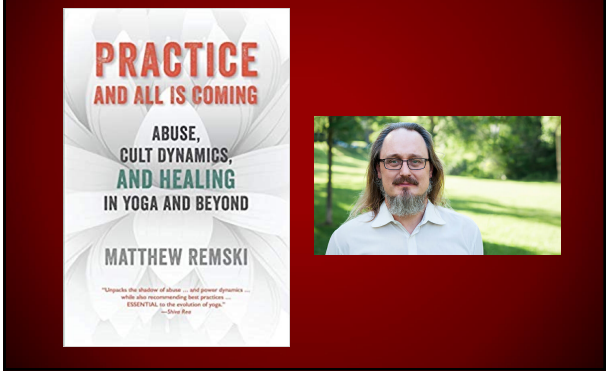

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The New York Times

The 'King' of Shambhala Buddhism Is Undone by Abuse Report

A photo of Sakyong Mipham Rinpoche, the leader of Shambhala International, sits on a throne reserved for him inside the group's New York center, but he has taken leave amid charges of sexual abuse. Gabriella Angotti-Jones/The New York Times

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HTTPS://WWW.YOUTUBE.COM/WATCH?V=FXL-CBPEGRA

91

CONSIDER…

- *Unless we are truly supporting autonomy in our attempts to help people, we may not be helping them.*
- "Am I supporting autonomy and if so, how?" can be an excellent first step in resolving issues.

92

MAJOR CONSIDERATIONS IN TRAUMA

1. Distinguishing facts from appearances
2. Objective reality/findings and client experience
3. Questions about our role and who the client is:
   - Autonomy support versus righting wrongs/fixing things
   - Seeking disclosures of trauma based on therapist beliefs

93

ETHICS OR BOUNDARIES?

- The case of the trauma therapist who…
- bought emotional support equipment…
- to bring his dog onto airplanes

- How does integrity factor into our work?
- How might our our integrity blunders become retraumatizing?

94

MAJOR PROBLEM

- Ethical and boundary problems happen to people who think they're at no risk.
- Being a little anxious about boundaries and ethics can be a good thing.
  - Good people can do bad things
- For managers, our ethics should include providing an excellent workplace as well as outstanding treatment

95

WHAT ARE ETHICS?

96

97

WHAT ARE ETHICS?

- Principles for behavior.
- The moral correctness of conduct
- Ethical codes protect the client and guide the professional

98

ETHICAL PRACTICE

- We have a duty to ourselves, our clients, and our fellow citizens to maintain ethical practice at all times.
- Breaches of professional ethics always lead to harm.

99

THE BIG THREE

- Beneficence
  - Kindness, wellbeing, mercy, etc.
- Autonomy
  - Client right to self-determination
- Nonmaleficence
  - Avoiding harm or unacceptable risk of harm

100

WHY SHOULD WE CARE ABOUT THIS?

- Threat to safety of clients, staff, and public
- Known high-risk context for escape
- Venue for contraband and drug traffic
- Contaminates the treatment environment
- Illegal, unethical, and policy violation
- Disaster for employee, family, and facility or organization

101

RELATIONSHIPS & BOUNDARIES

- Do you look forward to seeing a particular client when you come to work?
- Have you done anything with a client you would not want your supervisor or your family to know about?
- Would you be reluctant to have a coworker observe your behavior for a whole day?
- Do you talk about personal matters with clients?
- Do you believe you can ask a client to do personal favors for you?
- Have you ever received personal advice from a client?

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RELATIONSHIPS & BOUNDARIES

- Have you said anything that you wouldn't want recorded?
- Do you have thoughts or fantasies of touching a particular client?
- Do you have the right to touch a client wherever and whenever you want?
- Do you have a feeling of not being able to wait to share good/bad news with a client?
- Do you think clients are not allowed to say no to you, no matter what you ask?
- Have you ever allowed clients to talk about past sexual experiences or sexual fantasies, or tell sexual jokes in your presence outside of treatment?

103

ROBIN'S RULE

When you're getting ready in the morning, check yourself out in the mirror.

If you say to yourself…

"Hey, you look pretty good."

…Go change.

104

RESPONSIBILITY

Generally speaking

- Our client is:
  - The clients themselves
  - Their families
  - The programs
  - The community

105

SAWYER & PRESCOTT, 2010

- *The therapist has an ethical responsibility to the client, a legal responsibility to the court, and a moral/ethical responsibility to the community*

106

107

VULNERABILITIES

- It is easy to minimize vulnerability when:
  - Clients are ambivalent about treatment
  - Their crimes are severe
  - They have exploited the vulnerabilities of others

108

SMITH & FITZPATRICK, 1995

- Three principles underlying therapist-client relationships:
  - Abstention: refraining from self-seeking and personal gratification
  - Neutrality: Focusing on the client's therapeutic agenda
  - Therapists strive for client independence and autonomy

109

WHAT ARE THE MOST COMMON ISSUES?

110

TRIVIA QUESTION

- What are the two most common ethical complaints in our field?

- Coercive treatment
- Misuse of assessments

111

VAN HORNE ET AL. 2005

August 1983 - January 2005

Sexual/Dual Relationship with patient	842	30.49%
Unprofessional/unethical/negligent prac	823	29.80%
Conviction of crimes	252	9.12%
Fraudulent acts	173	6.26%
Improper/inadequate record keeping	148	5.36%
Breach of confidentiality	124	4.49%
Inadequate or improper supervision	121	4.38%
Failure to comply with CE requirements	121	4.38%
Impairment	108	3.91%
Fraud in application for license	50	1.81%

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APA, 1992, ON ETHICAL QUANDARIES

Category	n	%
Confidentiality	128	18
Blurred, dual, or conflictual relationships	116	17
Payment sources, plans, settings, and methods	97	14
Academic settings, teaching dilemmas, and concerns about training	57	8
Forensic psychology	35	5
Research	29	4
Conduct of colleagues	29	4
Sexual issues	28	4
Assessment	25	4
Questionable or harmful interventions	20	3

113

APA, CONT.

Competence	20	3
Ethics (and related) codes and committees	17	2
School psychology	15	2
Publishing	14	2
Helping the financially stricken	13	2
Supervision	13	2
Advertising and (mis)representation	13	2
Industrial-organizational psychology	9	1
Medical issues	5	1
Termination	5	1

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STEPS IN ETHICAL DECISION-MAKING

Pope & Vasquez

1. State the dilemma, question, or concern as clearly as possible
2. Anticipate who will be affected by the decision
3. Figure out who, if anyone, is the client
4. Assess whether our areas of competence – and missing knowledge, skills, experience, or expertise – are a good fit for this situation

115

STEPS IN ETHICAL DECISION-MAKING

5. Review relevant formal ethical standards
6. Review relevant legal standards
7. Review relevant research and theory
8. Consider whether personal feelings, biases, or self-interest might affect our ethical judgment.
9. Consider whether social, cultural, religious, or similar factors affect the situation and the search for the best response.

116

STEPS IN ETHICAL DECISION-MAKING

10. Consider consultation
11. Develop alternative courses of action
12. Think through the alternative courses of action
13. Try to adopt the perspective of each person who will be affected.
14. Decide what to do, review or reconsider it, and take action.
15 Document the process and assess the results.

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TELETHERAPY 2021

- Your client is in a state where you are not licensed to practice
- Your client expresses suicidal intent

119

120

TO DISCLOSE OR NOT TO DISCLOSE?

- Client doesn't know if she should confront the male family member who abused her.
- Resolving ambivalence versus providing advice.

121

122

TO DISCLOSE OR NOT TO DISCLOSE?

- Youth in treatment discloses molesting his mother while she sleeps.
- What are the limits of confidentiality?
- What are obligations to disclose?

123

124

CONFIDENTIALITY

- 12-year-old: What we talk about is confidential, right?
- Clinician: Yes, and…
- 12-year-old: Good, 'coz my dad's been taking pictures of me with no clothes on, only necklaces. What should I do?
- What's the ethical dilemma?

125

Key aspects of informed consent

126

INFORMED CONSENT – CIVIL COMMITMENT

- 1) A client signs consent to treatment but he spells his name backwards
- 2) The same client then signs his name upside down

- 3) A client signs informed consent and adds "Signed under duress and threat of returning to prison"

127

INFORMED CONSENT

- A college professor teaching a course on trauma breaks students out into small groups and has them disclose traumatic events in their past.
- On the surface, it's a voluntary activity, but the course is for a grade
- Then the students take turns role playing a counselor and client to discuss these traumas.

128

Key aspects of informed consent

129

CHILD SEXUAL ABUSE IMAGERY

- A client in treatment discloses having viewed child sexual abuse imagery. He is not subject to court orders or supervision conditions.

130

131

THREAT

- 14-year-old
- Privacy is everything
- Conversations with guardian happen only in his presence
- Threatens to kill his 3–year-old sister
- What's the ethical dilemma

132

DISCLOSURE

133

EXCITED UTTERANCE

- Doc, there's something I gotta tell you…
- I killed a guy in a barfight…

134

135

THOSE PESKY DISCLOSURES

- I was 13
- At a party
- I saw an 18 year old shoot dope
- He died
- They took him out to the woods and buried him

- What's the ethical dilemma? How to resolve?

136

137

ETHNICITY

- Civil commitment
- Allegations of institutional racism
- Led to the unfortunate nickname…
- *Prescott Hair Initiative*

- What's the dilemma? How to resolve?

138

GET READY, HERE IT COMES…

139

POLYGRAPH FAILURE

- Polygraph w/o parental consent
- Moving forward
- Moving back
- What do we need to know?

- The case of "Angry Al"

140

141

RECORDS

- DJJ
- Records are confidential
- Outpatient providers can't access inpatient records
- What's the dilemma? How to resolve?

142

ADDITIONAL CONSIDERATIONS
(THANKS TO POPE AND VASQUEZ)

- Being ethical is an ongoing process
- Being ethical is a verb, not a state or trait
- Formal codes don't take the place of thoughtful approaches
- Legal standards should not be confused with ethical responsibilities
- The overwhelming majority of professionals are conscientious and caring
- Many of us are better at spotting ethical issues in others than in ourselves

143

WHAT ARE BOUNDARIES?

144

WHAT ARE BOUNDARIES?

- Protected and connected
  - Both are required for the safety of all

145

PROTECTED AND CONNECTED

146

147

Be very, very clear about your intentions

148

EMAIL IS DISCOVERABLE

- You only think they need probable cause…
- DOC investigation turns up ties to others employed elsewhere
- Administrator affair with supervisee
- Leaked emails regarding Harvard cheating
- "confidential" incident report leaked to home addresses
- ATSA listserv restrictions
- Spilled cup of coffee

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TWO KINDS OF BOUNDARIES…

Structural:

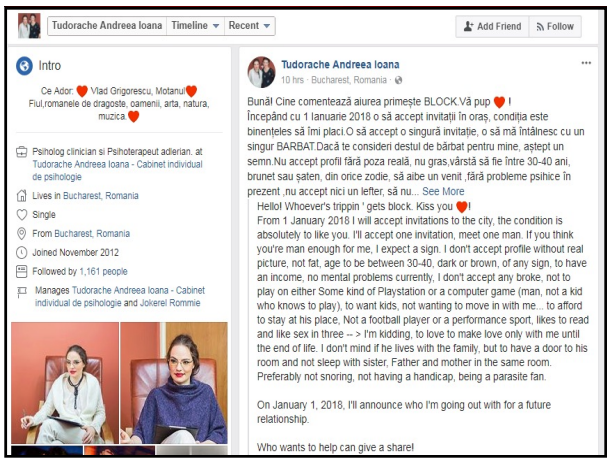
- Clarity and consistency of
  - Time
  - Place
  - Fees
  - The service itself

150

TWO KINDS OF BOUNDARIES…

- Interpersonal:
  - Physical contact
  - Gifts
  - Self-disclosure
  - etc.

151



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CONSIDER…

- Attempting to "save" clients
- Expectations of trust
- Physical touch
- Personal space and related boundaries
- Role of client feedback

153

WHAT'S WHAT?

- Boundary crossings: non-pejorative. Departures from commonly accepted practice. May or may not benefit the client.
- Boundary violation: Departure from accepted practice that places the client or therapeutic process at risk.

154

BEFORE WE TALK ABOUT ANYTHING ELSE

- How to manage ethical and boundary violations:
  - Culture: No secrets (repeat X3)
  - All staff make clear to others there are no secrets anywhere (repeat X3)
  - This is for the safety of clients and the program alike
  - Make every attempt to involve the other person

155

156

EXAMPLES

- I'm not sure this is such a good idea. Let's both go talk to the director.
- We both know that this can't stay secret. Would you like to speak with the director before I do, or should we both go together?
- We can't be in this situation alone. It would be bad for the kids, the program, and us. We need to talk to the director

157

What happens in programs that have few or no complaints?

158

ENCOURAGEMENT

(THANKS TO JIM WORLING)

159

OUR WORK ENVIRONMENTS

- Expect hard work and professional development (deliberate practice)
  - ("when do I start?")
- Everyone is responsible for their own morale
  - Step up to the plate
- Part of drawing a paycheck is showing up to work…
  - Ready, willing able
  - Rested

160

161

DOCUMENT
Everything

162

AN OUNCE OF PREVENTION

- Documentation
  - Why document?
    - Contractual obligations
    - If we were all hit by a bus…
    - Protection of all parties
  - If it's not on paper it doesn't exist

163

WHAT MAKES THE PROFESSIONAL?

- Dress Code
- Showing up – timeliness
- Follow-through
- Open Mind
- Presentation of self – manners, etc.
- Life-long commitment – who you have been to this young person and their family can never change.

164

#1: TEAM SPIRIT

- Everyone is depending on you
- Be on time, do what you say you'll do
- Be helpful
- Give more than you get

165

DO NO HARM

- No sex
- NEVER say bad things about clients or their families
- No scared straight
- Be strength-driven, not symptom-driven

166

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DUAL RELATIONSHIPS

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DUAL RELATIONSHIPS

- Probation officer as co-facilitator
  - Observes group
  - Equal responsibility for treatment?
  - Represents court
  - Carries out orders of the court
  - Therapist can then be seen as agent of the court
  - Affects therapeutic alliance (?)
  - Increased client vulnerability due to wanting to look good?

170

DUAL RELATIONSHIPS

- With kids
- With families
- Self-Disclosure
- Whose needs are we meeting?

171

DUAL RELATIONSHIPS

- With each other
  - Privacy
  - Outside relationships
  - Harassment

172

NON-COMPETE

- Stealing cases
- Privacy beyond confidentiality
- No hiring away

173

DISCLOSURE TO ADMINISTRATION

- Medical conditions
- Psychiatric conditions
  - For protection of self as well as clients

174

CONCLUSION

- Offer choices, explore choices, clarify choices within all contexts
- Be the person who offers choices when all other choices have been taken away.
  - Multiple choice where possible
  - Not "do it or go to prison"
- Be very clear about assessment limitations

175

PROGRAM CULTURE

Getting there is harder than we think

176

READINESS TO CHANGE

- Internal factors
- External factors
  - Situation
- We are all more influenced by our situations than we think

177

RELATIONSHIPS

- Alliances and cliques can destroy good programs, but…
- The appearance of alliances and cliques can be even more harmful
- *A lot of bad things happen when people just don't pick up the phone. Just pick up the phone!*

178

BASIC PSYCHOLOGY

- People form theories about themselves and others based on very little information
- These are called schemas
- The less information you have, the more likely you are to draw conclusions on schemas
- Example: *Mr. X is a supervisor. Supervisors don't understand people at the front lines. Mr. X is therefore not trustworthy.*

179

BASIC PSYCHOLOGY

- Confirmation bias happens we have beliefs. It is easy to disregard evidence that our beliefs are wrong.
- *Supervisors X and Y are friendly. We are not as friendly with each other. Therefore, when they agree on something, it's because those two are friends and I'm stuck with their decision.*

180

THE ANTIDOTE

- Programs should expect all staff to put the clients and the program ahead of momentary personal consideration. Obviously, one's long-term self-care is also important.
- Your client is the clients, their families, and the program itself.

181

COLLABORATION

- Treatment driven by the client's needs
- Staff trained in therapeutic engagement
  - e.g., welcoming, inviting
- focusing the client on us so he's not focused on others… engagement is vital.
- Supervisor is apparent
  - Chain of command, not cult of personality
- Doing no harm is an explicit value

182

COLLABORATION (CONTINUED)

- Rejection of micro-aggression is an explicit value in all domains
- The ongoing 2nd chance (students re-engaged rather than punished)
- Rejection of lectures (talking to a client when they're not ready to listen)
- Teaching accountability rather than "holding them accountable"

183

COLLABORATION (CONTINUED)

- Jargon discouraged
- Clients participate in risk management strategies
  - Joint commitment to success
- Consider "emotional bank accounts": all responses consider long-term needs
- Overnight staff in residential programs can be given special training in engagement

184

REGARDING CONSEQUENCES...

- Punishment in disguise?
- Getting to what's real:
  - Does "acting out" get to consequences?
  - Or does it invite adults to understand?

185

REGARDING RESPONSE...

- Guided by values, not the moment
- Considers long-term development
- Involves teaching

186

WHAT IT TAKES

- Courage
- Willingness to give up lip service to non-coercive treatment
- Willingness to engage with all elements of a person's life

187

BASIC ASSUMPTIONS

- Everyone does better when they are listened to
  - Listening can prevent bad behavior
- Everyone needs to tell their story
- Everyone needs to experience competence
- The more we talk about ourselves, the less our work is about *them*.

188

EXCELLENT STAFF *(...from another program)*

- Dwain
  - *"Just keep singing Sesame Street"*
  - *"Just remember: These guys have nothing"*
- Shawn
  - *"Just keep to the routines"*
- Ray
  - *"Just keep talking to them"*
  - *"Just remember where they're from"*
- Kurt
  - *"Just keeping listening"*

189

EXCELLENT STAFF *(…from another program)*

- Keep routines going
- Know their clients
- Can spot trouble before it happens
- Set limits early
  - *"We're all going to set limits sooner or later, so we might as well do it now"*

190

WHAT IT MEANS

- Annoying behavior means *"I'm getting upset and need help"*
- Disruptive behavior means *"listen to me"*
- Dangerous behavior means *"I'm losing control"*
- Possibly lethal behavior means *"Stop me"*

191

BUILDING PATIENCE

- Try to imagine a 15 minute video of the worst 15 minutes of their life
  - Do you think you *can* imagine it?
  - Do you want to watch it?
  - If you did, what would you learn?
  - If you did, how might it change your view of them?

192

SO WHO ARE WE?

- We're not the judge or jury
- We're not the Warden
- We're not the ones who are going to change these kids...
- We're the ones setting up the environment where these guys can change

193

MANNERS

- 4 basic skills:
  - Please
  - Thank you
  - Excuse me
  - I'm sorry
- Addressing people respectfully:
  - "*David*" or "*Mr. Prescott*", but never "*Prescott*"

194

WORDS TO GIVE UP...

- Why
- It sounds like...
- How does that make you feel...
- You people...

195

STAYING ON TRACK

- Please…
- whoa…
- please…
- you have a choice…
- As soon as you ___, we can ___

196

TEAMWORK

- Supporting patients starts with supporting each other
  - If you don't think you can talk about it somewhere, that's a real problem!

197

WHEN YOU COME TO WORK…

- Prepare
  - Use drive time; set things up the night before
- Bring your manners with you: It's Showtime!
- Expect resistance ("bring me the puck")
- Roll with resistance

198

WHEN YOU COME TO WORK...

- Be ready to listen
- "Be the change you want to see"
- Approach, Smile, Greet
  - (not "stalk, attack, kill)
- Tell the truth

199

WHEN YOU GET CAUGHT UP...

- If it feels wrong, it probably is wrong
- If you have any doubts, then there's no doubt
- Team approach!
  - Bring in a supervisor, another staff, etc.

200

GOOD ATTITUDES

- I am not the same as my work
- I'm not alone in this
- My attitude will dictate a lot of what happens at work
- Everyone's sexuality is different
- No one has all the answers, but I have places to go to get them

201

GOOD ATTITUDES

- The work day is only one small piece of the real work we do.
  - It's about contributing to reducing the harm of sexual abuse
  - In the end, whether a patient gave us a hard time today is much less of a concern

202

SELF-CARE & BURNOUT

203

WHY DO WE KEEP DOING THIS WORK?

- There is no denying that working with persons with sexual behavior problems is challenging.
- Some of our clients will be really good at "pushing our buttons".
- How do we offset our natural tendencies to be empathic and helpful with our natural tendencies to be angry and upset at what our clients have done?

204

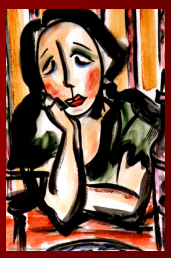
WHY DO WE KEEP DOING THIS WORK?

- Reduce the number of potential victims.
- On average, a poorly managed client will create many more victims that a well managed client
- Clients have the right to receive appropriate treatment and care
- For clients to have a quality of life as close as possible to that of others without disabilities
  - Lifestyle balance
  - Self-determinism (to the extent safely possible)

205

VICARIOUS TRAUMA

- Vicarious trauma
- Compassion fatigue
- Co-victimization
- Secondary survivor
- Emotional contagion
- Cost of caring



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VICARIOUS TRAUMA

- High Risk Professionals:
- Interview and counsel trauma victims
- Working with families and victims
- Working with person who have abused
  - counselors, health/hospital staff, emergency workers, child protection, corrections, law enforcement, volunteers

207

VICARIOUS TRAUMA

- A human phenomenon:
- …if a person holds the capacity for empathy, he or she will experience distress when hearing about dreadful things that have happened to others.

208

VICARIOUS TRAUMA

- Vicarious trauma challenges core beliefs individuals hold about self relationships, the nature of the world they live in, and their overall system of meanings and values.
- VT is a normal human consequence of exposure to traumatic material second-hand.

209

PREDICTORS & MEDIATORS OF SECONDARY TRAUMATIC STRESS EFFECTS

- Individual Factors
- Situational & Environmental Factors

210

INDIVIDUAL FACTORS

- Personal History
  - Personal experiences of trauma, loss, victimization
- Personality & Defensive Style
- Coping Style
  - Coping mechanisms
- Current Life Context
  - private life situation
- Training & Professional History
- Personal Therapy

211

SITUATIONAL FACTORS

- Workload
- Nature of the work
- Nature of the clientele
- Cumulative exposure to trauma material
- Relationship with co-workers
- Social and cultural context
- Supervision

212

MITIGATION FACTORS

- How good are you taking care of yourself?
  - Self-care in the workplace
  - Self-care in your personal life
- Holistic approach
  - Maintaining a balanced lifestyle is central to effective self-care

213

MITIGATION FACTORS

- The more balanced we are across this full range of personal care, the more we are able to cope with the stresses and demands that we will face.
- Create opportunity for renewal, simple pleasures, and enjoyment.

214

KINDERGARTEN

- Most of what I really need to know about how to live, and what to do, and how to be, I learned in Kindergarten. Wisdom was not at the top of the graduate school mountain, but there in the sandbox at nursery school. These are the things I learned:

215

KINDERGARTEN

- Share everything.
- Play fair.
- Don't hit people.
- Put things back where you found them.
- Clean up your own mess.
- Don't take things that aren't yours.
- Say sorry when you hurt somebody.

216

KINDERGARTEN

- Wash your hands before you eat.
- Flush.
- Warm cookies and cold milk are good for you.
- Live a balanced life.
- Take a nap every afternoon.
- When you go out into the world, watch for traffic, hold hands, and stick together.

217

Thank you!

~•~

Be safe!

~•~

See you Soon!

218

WHAT MAKES A GOOD THERAPEUTIC CULTURE?

219

CULTURE

- Treatment programs
- Not babysitting
- Keeping clients busy
- Keeping clients engaged with us
- Smartphones for work only

220

WHAT WE DO

221

WHAT WE AREN'T

222

TEAMWORK

- Work ethic
- Be invested in the outcome more than the income
- About kids and for kids
- Don't leave people hanging
- 4:1 rule
- Open to feedback
- Quality Improvement is the norm

223

EVERYONE'S INVOLVED!

- Sharing of information across the chain of communication
- No "cult of personality"
- Leadership by example
- Team decision-making wherever possible
- Mutual respect: All people

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REMEMBER

- *I never knew anyone who got into trouble for maintaining the highest standards of ethical behavior.*
  - Lloyd Sinclair
- *If you don't want it in the newspapers… DON'T DO IT!*
  - Jimmy Buffett

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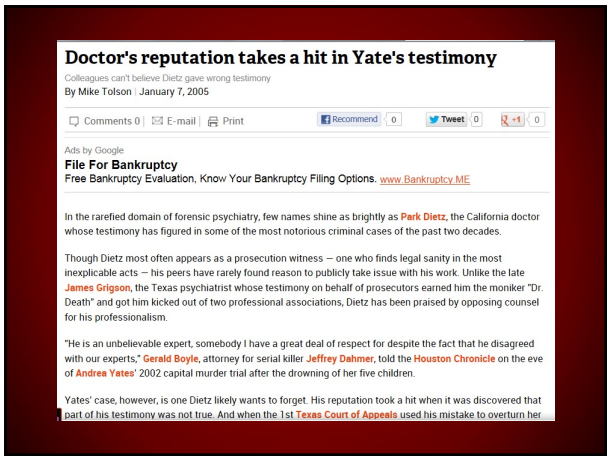

Doctor's reputation takes a hit in Yate's testimony

Colleagues can't believe Dietz gave wrong testimony

By Mike Tolson | January 7, 2005

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In the rarefied domain of forensic psychiatry, few names shine as brightly as **Park Dietz**, the California doctor whose testimony has figured in some of the most notorious criminal cases of the past two decades.

Though Dietz most often appears as a prosecution witness — one who finds legal sanity in the most inexplicable acts — his peers have rarely found reason to publicly take issue with his work. Unlike the late **James Grigson**, the Texas psychiatrist whose testimony on behalf of prosecutors earned him the moniker "Dr. Death" and got him kicked out of two professional associations, Dietz has been praised by opposing counsel for his professionalism.

"He is an unbelievable expert, somebody I have a great deal of respect for despite the fact that he disagreed with our experts," **Gerald Boyle**, attorney for serial killer **Jeffrey Dahmer**, told the **Houston Chronicle** on the eve of **Andrea Yates'** 2002 capital murder trial after the drowning of her five children.

Yates' case, however, is one Dietz likely wants to forget. His reputation took a hit when it was discovered that part of his testimony was not true. And when the 1st **Texas Court of Appeals** used his mistake to overturn her

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CONCLUSION

- Offer choices, explore choices, clarify choices within all contexts
- Be the person who offers choices when all other choices have been taken away.
  - Multiple choice where possible
  - Not "do it or go to prison"
- Be very clear about assessment limitations

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