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ETHICAL ISSUES AND DECISION-MAKING IN THE TREATMENT OF TRAUMA

Support

- The Thomas Scattergood Behavioral Health Foundation, Philadelphia, PA

University of Pennsylvania

- Department of Psychiatry, Mood & Anxiety Disorders Treatment Research Program
- Department of Medical Ethics & Health Policy

Overview

- Cases
- DSM-5 revisions
- Trauma & PTSD
- Ethical issues in trauma: diagnosis & treatment
- Strategies for confronting and resolving ethical dilemmas

Case #1

Jennifer is a 25 year old single white woman. Her mother had been an addict and prostitute, who prostituted Jennifer from the age of 9. She had a stillborn child at age 13. Jennifer reports having participated in prostitution because she wanted to protect her younger siblings from similar abuse.

She tells you early in treatment, "*I always tried to get my mother to talk about the abuse but she denied it, ignored it, or blamed me. It made me frustrated and angry. She is in the hospital now and really ill. I want to confront her again now that I am an adult and she may die*."

http://www.pandys.org/articles/confrontingyourabuser.html

Case #2

Jose, a 33 year old Hispanic male, is a veteran of the Iraqi and Afghanistan wars and has been seeing you for treatment with Prolonged Exposure. Consistent with treatment procedures, the sessions have intensified with repeated retelling of the bombing that killed four of his friends. One of the friends was thrown on top of Jose and bled to death in his arms. Jose reports increased nightmares and intrusive flashbacks and wants to terminate therapy. He claims that talking about the trauma has only made it worse.

Case #3

Stephanie, 48 year old widowed accountant, has just begun to talk about her husband's murder (during a household robbery) and how scared, vulnerable, and alone she feels. She tearfully describes the loss of his physical and emotional support---- "*He would be comforting me now if this had happened to anyone else*." At the end of session, she wipes her tears away with a tissue and asks you for a hug.

Case #4

Tara is a 30 year old African American female who just began treatment with you after being stabbed during a mugging a few blocks from her home. She currently meets criteria for Acute Stress Disorder but with a history of childhood emotional and physical abuse you are worried she may develop PTSD. The only mental health insurance she has is through her job EAP program which allows 4 sessions of therapy.

Trauma & PTSD

- The convergence of ethics, values and treatment is no more apparent than in the area of trauma and PTSD.
- Trauma may occur as a result of war, violent crime, abuse, social unrest, or repeated exposure
- Professionals struggle with the balance between:
  -truth versus reality
  -objective data versus subjective experience
  -confidentiality versus righting legal wrongs
- Need for self-awareness and self-care

Trauma & PTSD

- 61% of men & 51% of women report experiencing at least one traumatic event but…..only about 25% develop PTSD.
- >10% of men and 6% of women report 4+ types of trauma during their lifetimes
- Lifetime prevalence for PTSD is 7-8%
  - ~11-20% of Iraq/Afghanistan war Veterans
  - ~10% of Gulf War Veterans
- Women 2x as likely to develop PTSD as men
- 90% of individuals with serious mental illness have been exposed to trauma and most experience multiple events: 40-80% report some type of victimization, 35-50% report childhood abuse
- The annual cost of PTSD in US is ~ $42.3 billion

DSM-5

Anxiety Disorder Revisions

- Anxiety Disorders
- OCD & Related Disorders
- Trauma & Stressor Related Disorders

Trauma & Stressor Related Disorders

- PTSD (adults & kids)
- Acute Stress Disorder
- Adjustment Disorders
- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder

DSM-5

Adjustment Disorder

- Re-conceptualized as a wide array of stress-response syndromes occurring after exposure to a distressing (traumatic or non-traumatic) event

Acute Stress Disorder

- Must specify whether experienced directly, witnessed, or experienced indirectly
- Subjective reaction to trauma--eliminated
- Any 9 of 14 symptoms in categories: intrusion, negative mood, dissociation, avoidance, and arousal.

DSM-5: PTSD

- PTSD trigger: exposure to actual or threatened death, serious injury, or sexual violation.
- Result from one or more of the following:

  -direct experience of traumatic event;

  -witness traumatic event in person;

  -learns that traumatic event occurred to a close family member or close friend (actual or threatened death is either violent or accidental);

  -experiences first-hand repeated or extreme exposure to aversive details of the traumatic event.

- Causes clinically significant distress or impairment in social interactions, capacity to work, or function. Not physiological result of another medical condition, medication, drugs, or alcohol.

DSM-5: PTSD

Revisions

- Clearer definition of trauma (sexual assault, recurring exposure) with no language about reaction to trauma
- 4 symptom clusters:
  re-experiencing, avoidance,
  negative cognitions and mood (blame, estrangement),
  arousal (aggressive, reckless, sleep-"flight & fight")
- Eliminate acute, chronic features
- Subtypes: PTSD preschool (<6 years)
  PTSD dissociative (feeling detached or world is unreal)

Ethical Issues In Trauma

- Is PTSD a social or medical disorder?
- Accurate diagnosis/assessment
- Focus of treatment and risk for suicide
- Helpful and harmful treatments
- Therapist expertise
- Abuse disclosure and confronting abuser
- Trauma “chasing”

Ethical Issues In Trauma: Diagnosis

- How do we measure symptoms in PTSD?

  -With ¼ of trauma victims having PTSD, need careful assessment
  -Interview: SCID, ADIS, PTSD interview
  -Self-report: Impact of Events Scale, Post-traumatic Diagnostic Scale, PTSD checklist

- Distinguishing Acute Stress Disorder from PTSD.
- What role do values play in diagnosis?
- Is PTSD pathological?
- Does it warrant permanent disability?

Ethical Issues In Trauma: Treatment

- Treatment “disease-focused” or “patient-focused”?
- Focus of treatment: trauma, depression, drugs?
- Risk for Suicide
- Risk for re-traumatization
- Boundary issues
- Countertransference & vicarious traumatization
- Are our therapy techniques harmful or helpful?
- Consent for “difficult” treatments (e.g., PE)

Treatment

“disease-focused” or “patient-focused”?

The ethical principles of beneficience and non-maleficience can be restated in this population as “*do good and do no more harm*”.

Do the symptoms of PTSD constitute a “disorder” or do they represent an ineffective response to severe stress?

Does this distinction matter in regard to treatment?

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Focus of treatment

Trauma associated with high co-morbidity

- ~50% of people with PTSD also have depression
- Nearly 75% of trauma victims have some type of drug/alcohol problem (60-80% of veterans)
- 10-20% of chronic pain patients have PTSD and among PTSD patients 60-80% report chronic pain
- Sleep is a significant problem in ~50% of patients

What is the “problem” that needs treatment?

In focusing on one issue, how do the other issues get addressed? How do they impact on treatment?

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Risk for Suicide

- Anxiety disorders are highly under-recognized and under-treated in suicidal people.
- Traumas ---physical violence, mental/sexual abuse, bullying, victimization, --- are all significant risk factors for suicide.
- PTSD is strongly associated with suicidal behaviors, and more so than other anxiety disorders.
- In PTSD, co-morbid major depression significantly increases suicide risk.
- Childhood trauma (esp. sexual/physical abuse) is a significant risk factor for suicidal behavior.
- CBT is highly effective for treating suicidal behavior but ONLY if suicide is the focus of treatment

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Re-traumatization

Role of trauma in predicting PTSD

- Strongest predictor of who will develop PTSD following a trauma is whether individual has had previous trauma exposure

PTSD followed by additional trauma

- Reading about trauma in newspaper
- Violence/restraint during hospitalization
- Perceived/real loss of control
- Retelling of trauma in treatment
- Insensitive or unaware clinicians (touch, voice, etc.)

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Boundary issues

Boundary violations as a part of trauma

- Loss of control in relationships
- Confusion between love and abuse
- Privacy

Boundary issues in treatment

- Risk for over-involvement - “savior”
- Misperception of touch
- Confidentiality and trust
- Personal space boundaries
- Inappropriate patient behaviors

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Countertransference

- Significant levels of countertransference risk problems.
- Over-response: need to “rescue” patient
  Under-response: anger, detach, or blame patient when overwhelmed
- Risk for vicarious traumatization-
  therapist traumatized by stories from multiple patients
- Issues are so prevalent requires:
  continuous self-reflection
  collegial support
  ongoing supervision

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Help or harm?

Psychological debriefing

- Designed to reduce psychological morbidity after trauma.
- psychological debriefing not only is ineffective, it can exacerbate trauma.

EMDR

- Effective treatment but some studies suggest EMDR < PE (or other CBT).

PE

- Strong consistent evidence to support effectiveness of PE in treating PTSD.

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Consent

- Need to maintain/foster autonomy in trauma patients especially since they have experienced severe loss of control over their lives and bodies. To do otherwise would be a violation of autonomy.
- Consent in regard to:
  - -when they want to explore the past abuse
  - -at what speed they wish to explore the abuse
  - -the risks and benefits of exploring the memories
  - -any and all treatments that will be used

Ethical Issues

Disclosure and confrontation

- Disclosure of abuse to family, confrontation, taking action against the abuser, maintaining/severing contact with the abuser, and restitution are all issues about which there is no concrete answer.
- Remain supportive but address risks/benefits

Trauma “chasing”

- Seeking personal satisfaction
- Risk for increasing symptoms
- Assume ASD = PTSD

Ethical decision-making

- Patient Self-determination
- Fairness and justice
- Do good, do no harm
- Rights of individual vs. rights of society
- Impaired relationships
- Involvement of family

How do I know any decision I make is right?

What if others don't hold my same values?

Ethical decision-making

Formal model for decision-making offers:

- A process for dealing with moral uncertainties
- Introduces a degree of rationality and rigor into our moral deliberations

Organizing Principles of Ethics

- Autonomy: right to noninterference, self-determination
  (confidentiality, treatment options, records)
- Beneficence: mercy, kindness, charity to others
  (competent, identify/report abuse & neglect,
  community service)
- Nonmaleficence: avoid harm or risk of harm
  (know limits, keep current, refer, consult)

Organizing Principles of Ethics

- Justice: benefits, risks, costs distributed fairly (treat fairly, non-prejudicial care, emergency care)
- Fidelity: faithfulness to duties or obligations (honest, trustworthy, overbilling, waiver of co-payment)
- Empathy: experience the experience of others

Ethical decision-making

Ethical Principles inform decisions

(e.g. informed consent)

- Ends -based
- Rule-based or Kantian principle
- Justice or fairness-based (Aristotle)
- Care-based principle (i.e., Golden Rule)
- Virtue-based

Ethical decision-making

Most dilemmas are not *right vs. wrong* but *right vs. right* dilemmas.

- It is right to respect autonomy,
  it is right to prevent harm

- It is right to uphold confidentiality,
  it is right to protect the welfare of others

How Good People Make Tough Choices
Rushworth M. Kidder, 1995

Ethical decision-making

Dilemmas often represent competing moral paradigms

- Truth vs. Loyalty
  duty to paying parents vs. duty to minor patient
- Individual vs. Community
  patient needs vs. family needs
- Short-term vs. Long-term goals
  work demands vs. family demands
- Justice vs. Mercy
  respect for autonomy vs. respect for others

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Ethical decision-making

Models to guide us in making decisions

- Standards-based
- Principle-based
- Virtues-based
- Moral Reasoning model
- Practice-based

Ethical decision-making: Models

I. Standards-based model

Based on the assumption that rules, laws, & policies provide the best basis for determining action.

- Determine primary dilemma
- Spell out ethical standards for response
- Determine if there is a reason to deviate
- Decide on course of action

Ethical decision-making: Models

Case Examples

- confront abuser
- stop treatment
- touch
- premorbid PTSD

When would following the rules be the best choice?

What difficulties might arise if we followed rules/policies for all ethical dilemmas?

Ethical decision-making: Models

II. Principles-based model

Clarify

- Determine dilemma
- Key ethical principles and values involved

Evaluate

- Any ethical principle violated?
- Facts vs. beliefs, theories, opinions
- Consider credibility of sources
- Weigh benefits, burdens and risks

Ethical decision-making: Models

II. Principles-based model (cont'd)

Decide

- Evaluate alternatives & determine consequences
- Prioritize ethical principles/values

Consider worst case scenario & Apply principles

- Implement
- Maximize benefits & minimize costs & risks

Monitor and modify

Ethical decision-making: Models

Case Examples

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How does this approach improve upon the Standards Based Model?

In what situations does this model not help?

Ethical decision-making: Models

III. Virtues-based model

Dispositions and habits allow us to act to the highest potential of our character and on behalf of our values.

Virtue ethics asks of any action:

What kind of person will I become if I do this?
Is this action consistent with my acting at my best?

Use virtues in considering options

Make decision

Ethical decision-making: Models

Case Examples

- confront abuser
- stop treatment
- touch
- premorbid PTSD

How does reliance on virtues improve our decision-making?

Where does it fall short?

Ethical decision-making: Models

IV. Moral reasoning-based model (Jones, 1991)

- Recognize the moral issue
- Make a judgment
- Establish intent
  - individual & situational variables
  - factors of opportunity & significant others
- Moral intensity (effect of decision on others):
  - concentration of effect (individual or group)
  - probability of effect (likelihood of harm)
  - proximity (closeness to the issue)
  - social consensus (agreement with society)
  - temporal immediacy (closeness in time)
  - magnitude of consequence (impact)
- Act

Ethical decision-making: Models

Case Examples

- confront abuser
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- premorbid PTSD

How does moral reasoning help us better understand the situation?

In what ways is it not helpful?

Ethical decision-making

Application of an integrated model

Steps

1. Recognize there is a dilemma
2. Determine the actor(s)
3. Gather the relevant facts
4. Test for right-versus-wrong issues
5. Test for right-versus-right paradigms

Ethical decision-making

Steps

6. Determine resolution principles involved
   - Ends-based
   - Rule-based or Kantian principle
   - Justice or fairness-based
   - Care-based principle
   - Virtue-based
7. Investigate possibilities for action: “trilemma”
8. Consult
9. Weigh benefits & burdens

Ethical decision-making

Steps

10. Consider additional dilemmas
11. Make the decision
12. Formulate a justification for the decision
    - List reasons & arguments
    - Recognize shortcomings
    - Anticipate objections
    - Recognize limitations in perspective
13. Document
14. Review and reflect on decision

Summary

- DSM-5 revisions
- Trauma & PTSD
- Ethical issues in trauma: diagnosis & treatment
- Strategies for confronting &resolving ethical dilemmas

What issues do you need to be aware of?
What is your model for ethical decision-making?