LEARNING OBJECTIVES

- As a result of this training, participants will learn about:
- Nuances of complex trauma
- Ethical considerations in addition to those found in the standards and ethics of professional organizations
- Considerations for professional boundaries and conduct.
AGENDA
• 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

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. 😊

LET’S BE HONEST
• Everyone is at a different place in their professional development
• This presentation is for all audiences
INTRODUCTORY REMARKS

PLEASE 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

LET'S BE CLEAR

We do hard work
Question...

Do we choose this work?  Does this work choose us?

ON THE EVOLUTION OF RESIDENTIAL TREATMENT
WHY SO COMPLICATED?

FROM THE OUTSIDE LOOKING IN, IT'S HARD TO UNDERSTAND.
FROM THE INSIDE LOOKING OUT, IT'S HARD TO EXPLAIN.

WHY?

All of humanity's problems stem from man's inability to sit quietly in a room alone.

- Blaise Pascal
QUESTION

• Between our pandemic and our community violence, are there ANY kids who are not at risk?
MARSHALL, 2005

- Warm
- Empathic
- Rewarding
- Directive

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

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.

WHAT NOT TO DO:
CASE EXAMPLE
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

CONCLUSION:
WHAT WORKS?

Who works?
OKAY, LET’S GO!

WARNING!
- This will be provocative
- We should come down on only one side:
  - Thoughtful, ethical practice

SAFETY
- Keep it simple!
- Our work is hard enough
- Be careful out there!
  - (With apologies to Hill Street Blues...)
WHAT IS 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%)

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)
WHAT IS TRAUMA?

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

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

– Jan Hindman
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.
KEY THEME
- Just notice
- See what happens next
  - Not just mindful...
  - Investigating each experience
  - Practice Making Choices based on what you notice

TRAUMA
- Relational issues
- Somatic challenges

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
CASE EXAMPLE

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

BENISH, IMEL, & WAMPOLD, 2008

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

SEPTEMBER 11

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

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
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

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

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
IMPORTANT

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

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

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?
A PIONEER IN OUR FIELD

Dear Parties:

Enclosed please find the Determination and Order (No. 09-39) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or service (7) days after mailing by certified mail, as per the provisions of §330, subdivision 6, paragraph (i) 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
Hodl Park Plaza
433 River Street - Fourth Floor
Troy, New York 12180

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(26) (mental unfitness); and
Seattle Times special report: Twisted ethics of an expert witness

By Kari Anderson and Shannon O'Neil

Earlier this year, a four-page document with a bland title, "Statement for Distress with Proposals," was filed in a civil matter pending on the King County Courthouse's 6th floor. Nearly everyone took notice. Most everyone had heard of it.

That document — filed by lawyers tangled up in the estate of Dr. Stuart Greenberg, a nationally renowned psychologist whose life ended in suicide — signaled the end of a tortious undertaking.

Greenberg had pressed such a basic force — a posture courting 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 toiled as an expert in forensic psychology, an insecure field with immense power. Pursuing to offer insight into the human condition, he evaluated more than 2,000

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 felony sexual assault (AFSA) for engaging in sexual penetration with the complainant "within one year of the termination of their therapeutic relationship," the defendant "acted in a manner which is not professionally recognized as ethical," thereby violating RSA 632-A:2, 1(b)(1).

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

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
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 integrity blunders become retraumatizing?

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

WHAT ARE ETHICS?

- Principles for behavior
WHAT ARE ETHICS?

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

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.
THE BIG THREE

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

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

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?
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?

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.

RESPONSIBILITY

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

VULNERABILITIES

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

WHAT ARE THE MOST COMMON ISSUES?

TRIVIA QUESTION

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

  - Coercive treatment
  - Misuse of assessments
### VAN HORNE ET AL. 2005

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<td>Communication</td>
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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

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.

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.
EXAMPLES

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.
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?
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?

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”
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.

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.
• 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
EXCITED UTTERANCE

• Doc, there’s something I gotta tell you...
• I killed a guy in a barfight...

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?
ETHNICITY

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

- What’s the dilemma? How to resolve?
POLYGRAPH FAILURE

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

• The case of "Angry Al"

RECORDS

• DJJ
• Records are confidential
• Outpatient providers can't access inpatient records

• What’s the dilemma? How to resolve?
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
Be very, very clear about your intentions
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

TWO KINDS OF BOUNDARIES...

Structural:
• Clarity and consistency of
  – Time
  – Place
  – Fees
  – The service itself

TWO KINDS OF BOUNDARIES...

• Interpersonal:
  – Physical contact
  – Gifts
  – Self-disclosure
  – etc.
CONSIDER...

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

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.
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

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
What happens in programs that have few or no complaints?

ENCOURAGEMENT

(THANKS TO JM WORLING)

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
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
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.

#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

DO NO HARM

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

PLEASE
DO NOT GO
BEYOND THIS POINT

REPUTATION
We will be known forever by the tracks we leave.
-American Indian Proverb
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?

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

DUAL RELATIONSHIPS
- With each other
  - Privacy
  - Outside relationships
  - Harassment
NON-COMPETE

• Stealing cases

• Privacy beyond confidentiality

• No hiring away

DISCLOSURE TO ADMINISTRATION

• Medical conditions
• Psychiatric conditions

  – For protection of self as well as clients

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
PROGRAM CULTURE

Getting there is harder than we think

READINESS TO CHANGE

• Internal factors
• External factors
  – Situation

• We are all more influenced by our situations than we think

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!
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.

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.

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.
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

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”

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
REGARDING CONSEQUENCES...

- Punishment in disguise?

- Getting to what’s real:
  - Does “acting out” get to consequences?
  - Or does it invite adults to understand?

REGARDING RESPONSE...

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

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
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.

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 keep listening”

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”
### 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"

### 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?

### 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
MANNERS

• 4 basic skills:
  - Please
  - Thank you
  - Excuse me
  - I'm sorry

• Addressing people respectfully:
  - "David" or "Mr. Prescott", but never "Prescott"

WORDS TO GIVE UP...

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

STAYING ON TRACK

• Please...
• who a...
• please...
• you have a choice...

• As soon as you ___, we can ___
TEAMWORK

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

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

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
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.

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

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
SELF-CARE & BURNOUT

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?

WHY DO WE KEEP DOING THIS WORK?

• Reduce the number of potential victims.
• On average, a poorly managed client will create many more victims than 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)
VICARIOUS TRAUMA

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

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

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.
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.

PREDICTORS & MEDIATORS OF SECONDARY TRAUMATIC STRESS EFFECTS

- Individual Factors
- Situational & Environmental Factors

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
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

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

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.
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:

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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.

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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.

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Thank you!

Be safe!

See you Soon!

WHAT MAKES A GOOD THERAPEUTIC CULTURE?

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

WHAT WE AREN’T
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

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

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
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