

“Ethical Issues of Trauma-informed Care and Trauma-related Research”

Linnea Puckett

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Ethical Issues in Trauma-Informed Care and Trauma-Related Research

No matter what your personal life looks like, every human being must deal with trauma in one form or another. Sometimes it only affects people mildly, and most people can move on or past trauma in their lives. There are those, though, that because of the amount of trauma issued in their lives or throughout it, have a much harder time healing from it. In some cases, the severity of trauma can cause the onset of emotional, mental, physical, and learning disabilities, as well as developmental delays. Also, the younger the person experiences the trauma, the more likely it is to affect them as they get older. As a result of this, many people have been trying to find solutions to help them either get through their trauma (with the use of therapy) or to deal with those in their life that have been traumatized (as in many of the cases of adoptive/foster families or divided families). Most just want to help people heal from a past they are no longer in control of. That is where Trauma-informed care and Trauma-related research come in.

Trauma-informed care, according to Dr. L Elizabeth Lincoln is “practices that promote a culture of safety, empowerment, and healing”. This is usually directly or heavily influenced by trauma-related research, which is research that is focused on the trauma a person in their study has experienced and how it affects them. After doing trauma-related research, trauma-informed care is built on the findings. It is made up of strategies that are used to help people get through their trauma. Even though there are many positive parts to using this method of care, there are also some issues. In this paper, we will be covering the major ethical issues with Trauma-related research/Trauma-informed care, such as consent implications, the harm of labeling, and the

traumatization of individuals. We will then be covering the ethical solutions or frameworks that have solutions to these problems and also which ones would be the most effective to use.

Although most of the time, the consent for doing trauma-related research or performing trauma-informed care is readily given, there is the ethical issue of whether or not it is truly given by a volunteer or if the participant might be put in danger for being a part of the research. As the article *Ethical Issues in Trauma-Related Research: A Review*, it states “Studies involving interpersonal or political violence, especially those involving participants who live under coercive conditions, must minimize the possibility that individuals could be harmed or assaulted as a result of study participation, or that individuals could be coerced by abusers or abusive authorities to participate in research.” (E. Newman, E. Risch, N. Kassam, pg. 31).

There is also the problem of recruitment strategies for research, where a person can or will be approached right after a severely traumatic event in their life had just happened, and approached by more than one group of researchers who are looking to forward the fields of trauma. Although not necessarily a bad thing, this act could lead to a risk of further traumatizing the victims of trauma. The risks entail causing distress in the participants, even if trivial. For example, according to the article mentioned above, 48% of sexual assault survivors reported that the “trauma-focused portion of the physiological assessment was very distressing.” (E. Newman et.al, pg. 34). The types of distress were more about accessing painful feelings, the inconvenience of the research, elicited pain, confronting painful realities, and overall psychological distress.

Besides recruitment and possible involuntary inclusion, consent can also be a problem when the trauma is so severe that the consent cannot be considered valid. *Ethical Issues in Trauma-Related Research* states “Most experts agree that even severely trauma-exposed

adults(who are not suffering from other impairments that can affect consent such as head injury or acute psychosis) can completely consent to research... Nevertheless, it is possible that a minority of trauma survivors, struggling with trauma-related symptoms and adverse circumstances, might have impaired decision-making capacity.” (E. Newman et al. Pg, 38). Ultimately, the safety of the participant and the researcher must make sure the participant is ready and willing to participate in the research and receive treatment for their trauma.

With trauma-informed care and trauma-related research, there is also the possibility of harm in labeling trauma. Trauma doesn't just come from one variable under which we can label it. Everyone experiences trauma in different ways and at varying degrees. The stigma of labeling trauma often comes from an ableist mindset where people believe that labeling the trauma can help the treatment of it. As the article *Trauma and our identity sticky labels* state “Victims of trauma often develop views about themselves in the circumstance, which become rigidly fixed as labels. These labels become shorthand ways of explaining their experience and often can serve to lock them into ongoing suffering, rather than freeing them from it. Consider someone who comes to the clinic and says “I am a victim”. All of a sudden the label of their experience becomes part of their identity. Although it can be true that they were a victim, they have also been, and still are, so much more than that. When people use labels as identity statements, they can make their position more rigid, and lock in beliefs, meanings, and power positions that simply keep them stuck.”

Not only in labeling their trauma but labeling their behaviors as results of trauma can also be troubling. A student who is labeled to be manipulative, defiant, oppositional, hyperactive, etc,

can experience prejudice from teachers and peers. Teachers will blame their behaviors on their trauma and either sympathize with the student and never challenge behavior, or become more strict because they don't trust the student. They could also completely ignore them. As Ron states in his blog about trauma-informed care " If we label incorrectly, we will treat them incorrectly. This is might also be why so many survivors appear to "sabotage" their success. It isn't a real desire to ruin their life. They need sensitive professionals and parents who understand how to deal with the root, trauma issues." When working with individuals that have suffered trauma without giving them a label can also have its implications, in that without knowing what they are dealing with, a caretaker will face difficulties in finding ways to treat trauma. Ultimately, this could lead to second-hand traumatization of the caretaker.

Second-hand traumatization is where the severity of the trauma from a person begins to traumatize the person taking care of them or the other people in their lives. Some examples of this would be developing anxiety and depression after having a family member injure themselves or commit suicide due to a trauma they have experienced, or developing an emotional disturbance disorder while working with someone who has attachment issues or emotional disabilities because of traumatic experiences. My family has been dealt a bad hand in this part of trauma-informed care, as some of my family members now suffer from second-hand trauma due to having siblings that were severely traumatized by their biological parents before being adopted. My mom was dealt the most brutal of it as she had to quickly become trauma-informed to raise us kids, and in the process, had to deal with the second-hand trauma to continue raising us. In an interview with my mom Nicole Puckett, I asked her about her experience. "I think secondary trauma is inevitable when living with kids with trauma because you have to put their

needs before your needs. Also, you feel helpless when you don't know how to help them," she stated. (This is not word for word phrasing, but a summarization of what she said). When asked if she thinks she handed secondary trauma to the best of her ability, Nicole answered "Yes and no, I wasn't informed of what secondary trauma was, so I wasn't aware that I would have to deal with it. I have found that it is important to take care of your trauma before you can treat other people's trauma. Think of it like when you are on an airplane and they tell you to put on the oxygen mask first before attending to your child, if you don't take care of your own needs first, then you can't attend to the needs of your children." But secondary trauma doesn't just affect parents, but other caretakers as well.

Hospital caretakers, non-profit organizers, asylum caretakers, refugee providers, and anyone who professionally works with people that may have experienced severe traumatic life experiences. In the article *Second-Hand Emotion? Exploring the Contagion and Impact of Trauma and Distress in the Asylum Law Context*, it states "the need to negotiate the personal, emotional consequences of the persecution stories of 'others' affects all professionals working in the asylum arena, even though it may not always be directly acknowledged or reflected upon." (Helen Baillot, Sharon Cowan and Vanessa E. Munro, pg. 519). This is known as the "Hot potato effect" (Dr. Scuro, interview). No matter what professional motto or training is put into place, a professional cannot stop being human, and it is only human to react to trauma.

Philosophers in ethics offer solutions to these three issues faced by the patients and caretakers. Utilitarianists have two variant solutions. According to the article *Utilitarian and deontological ethics in medicine*, act utilitarianism "deals with decisions undertaken for each

case analyzing the benefits and harms promoting overall better consequences. Every action/decision arrived for each patient is confronted with the measurement of the balance of the benefits and harms, without examining the past experience or evidence.” and rule utilitarianism “no prediction or calculation of benefits or harms is performed. These decisions are guided by preformed rules based on evidence...” (Jharna Mandal, Dinoop Korol Ponnambath, Subhash Chandra Parija). Act Utilitarianism in trauma-informed care or trauma-related research is considered an “enormous wastage of time and energy in decision-making and are prone to bias.” (Jharna Mandal, et. al). Because the patient’s past is not considered in decisions so the patient suffers more. With Rule Utilitarianism “morally right decision is an action complying moral codes/rules leading to better consequences.[1] Although these concepts look appealing patients feel constrained when clinicians make the decisions, affecting the fundamental ethical principles.” (Jharna Mandal, et. al). The ultimate decision comes from the overall evidence of what works best for the patient and the patient’s family. Under these two forms, secondary trauma is less likely to occur, therefore it is no longer an issue.

Deontologists, on the other hand, are more concerned about duty where the morality of an action depends on the nature of the action. Their decision is based on individual cases instead of societal outcomes. So in regards to this, a deontologist might perceive that if the patient is in more danger by participating in or consenting to trauma-informed care/trauma-related research, then they might not accept the patient into their program. Also if the patient is affected negatively by labeling, the deontologist might not diagnose the patient or opt to not inform the patient of their diagnosis. Lastly, if the caretaker is faced with secondary trauma, then a deontologist might suggest emotional distress to be an acceptable reason for a caretaker to quit or

take a break from work. If it is at home, then a deontologist would suggest counseling, or even taking days off by allowing others to take care of the patient or child. Allowing their caretaker to heal so that they can, in turn, take care of their patient.

With Ethics of Care, the important factor is to be humane about the person you are caring for. They asked the question if the action they are doing is the most humane thing they can do for their patient. Ethics of care Principlism “claims that the four principles of respect for autonomy, nonmaleficence, beneficence, and justice are part of a common morality” shared by “all morally serious persons” (p 3),¹⁴ whatever the underlying philosophical or religious commitments of those persons. Practical moral decision-making involves a process of specification of the principles’ implications in the particular situation in view and balancing the relative importance of the principles if they conflict. (p 1-25).” (Beauchamp TL, Childress JF). On the other hand ethics of care autonomy and contractual state “understanding the relationship as a contract, advocates of this model seek to place professional and patient on an equal footing, spell out the legitimate expectations that each can have of the other, and empower the patient to play an active part in decision making about (his)her treatment.” (N.G. Messer pg. 277).

Lastly in his ethical study of otherness and the ethics of responsibility Emmanuel Levinas provides us with an answer to these issues as well. Levinas talks specifically of how one might consider someone to be other because of their not normal circumstances. In the article *Violence in the Vulnerable Face of the Other*, they state it as “...a responsibility for the other. This responsibility consists in the first place in taking care not to violate or destroy (“kill”) the other in his/her otherness, which is to say not to reduce the other to his/her countenance, but instead to

recognize, respect, and do justice to him/her in their otherness.” (Roger Burggraeve, pg. 32).

With this understanding, we must make sure that when we are doing trauma-related research or offering trauma-informed care, we do not belittle their differences by labeling them, challenge their differences in our studies, or offer to heal their differences in our informed consent. Most importantly, if we are to face secondary trauma, we must recognize that we cannot blame it on the patient and we should also isolate our traumatic feelings from their traumatic feelings. Since they are different.

In my opinion, the most ethically permissible solution to the three problems laid out in this paper would probably be by Autonomy Ethics of Care. Since it places patients on equal footing, but also it takes the patient’s past into account when making decisions. Ultimately the informed consent will not be a power move by the doctor, but the respected decision of the patient, there would only be a diagnosis that is given to the patient, but no labeling, and when a caretaker suffers secondary trauma, they treat it in the best way possible without placing blame on the patient. On the other hand, the most ethically probable solution would be Act Utilitarianism, since ultimately the decisions are made without considering the effect it might have on the patient who has a traumatic past. For example, if a patient suffers from PTSD from a past experience, and therefore does not think it can participate in a study, the doctors will balance the pros and cons of the situation without considering that their PTSD comes from this past experience and ultimately decide to go ahead with the study anyways. Which will lead to greater trauma for their patient. Also, it is prone to bias. This means that based on an opinion already set by the doctor, the patient might be put in more harm than being in the process of healing.

If I were to rank the solutions based on my understanding and principles of what I consider the most ethically permissible to the most probable. I would say that besides the solution mentioned above, I think that Principlism could also be considered an ethically permissible solution, as it takes in most of the important factors of decision making, based on the four principles, and makes decisions while balancing these principles. Also Rule Utilitarianism, as long as the patient is included in the decision making, is considered ethically permissible. For it uses the evidence from the patient's past as well as evidence shown in the present to make the ultimate decision with the patient included.

On the other hand, deontology, as well as the ethics of otherness and responsibility have a few issues that might come up in their offered solutions and they may be more probable choices to make. In deontology, the rejection of certain people based on their past might cause more problems than solutions for that patient that is hoping to get into the study. Also if a patient is unaware of their diagnosis, then they are unaware of how they can attend to their needs outside of doctor help, making patients incapable of tending to their own needs and healing on their own. In Ethics of otherness and responsibility, there could be the issue of being unable to isolate one's trauma from your patients, as most likely the trauma you are facing is triggered by the trauma of your patients. Also as mentioned above, without a proper diagnosis, a patient becomes solely dependent on a doctor or caretaker for their care. Lastly, If we do not offer healing through our studies, or we do not offer to help situations that the person is in that might be causing the trauma because we don't want to affect their otherness or differences then we are not offering much change for those who are seeking change. Ultimately it would be more harmful to them to be set in complete professionalism if one cannot offer compassion as well.

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