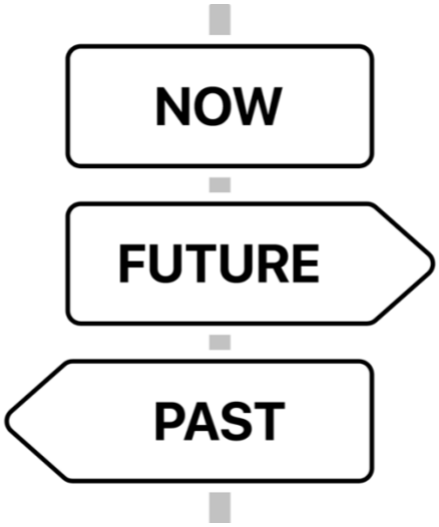
The mental health field and insidious trauma: General and Ethics videos+



Gwendolyn “Gwen” Downing (she/her), LPC
Version: May 04, 2025

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Opening

Acknowledging lived experience, with all the differing degrees, as we proceed, we keep that in mind.

Trainer and contact:

Gwendolyn “Gwen” Downing (she/her), LPC Gwen@ConnectAll.online www.ConnectAll.online

General training description:

This video identifies and explores: the definition of insidious trauma; some of its possible impacts; points of how the field has been, is, and might be, part of the problem - and has been, is, and might be, part of the solution and healing; and ideas to develop/expand a personal plan to address insidious trauma in your work.

Ethics training description:

(The General is a required pre-requisite) This video identifies and explores: ethics foundations; ethical considerations for insidious trauma in the mental health field; an overview of the steps of an ethical decision-making model; and ideas to develop/expand a plan to address insidious trauma ethical considerations in your work.

Information, disclaimers, and disclosure:

- The original and best, versions and purposes of training materials was live interactive training, never intended for this type of video.
- Purpose of videos: personal and group usage
- Video handout/workbook has information not covered nor indicated in videos.
- Videos and any associated handouts/materials are provided for informational purposes only.
- Inclusion does not indicate endorsement of any information, nor any sources.
    - As recognized information is what it is, and may be constantly evolving.
- I am the originator and Director of the Connect All initiative, which has 501c3 fiscal sponsorship by We, the World.

Norms and Expectations:

Safe, and thus brave, space

Trainer: Trying to model; Self-care; Respect of others, any sharing; Fluid structure; I might, probably will, fail – how do we keep learning and in relationship when I do; Work with you as a community

Group: Self-care; Respect of others, any sharing; Be present and engaged as possible; Learn in what way works for you; Be part of community

Self-Care:

- Since a focus on insidious trauma, some of the material we cover may create responses in our bodies, behaviors, thoughts, and emotions.
- Even if it wasn't about trauma, we all have internal and external factors, creating responses in our bodies, behaviors, thoughts, and emotions*. *There are situations, such as with alexithymia, where individuals truly aren't going to have, experience, identify emotions the same as others do.
- Whatever works for you
- Mindful moments: 30 seconds. Whatever works for you. May help with processing/retention of information and self-care.
- Apps and approaches section pp 6-9 and Appendix B
- Help lines/links, apps, approaches PDF – Connect All

Supplemental resources:

And ethics YouTube video: "A brief intro to ethics and ethical decision making"

Apps and approaches

Apps:

NOTE: Some things to consider when using hotlines or mental health/wellness apps/online services.

- How do they protect my privacy? Are there steps I can take to protect my privacy?
- Are they ethical in their practices?
- What is the benefit/cost/risk of using them?

PTSD Coach (https://mobile.va.gov/app/ptsd-coach): By the Veterans Administration, is for anyone experiencing Post Traumatic Stress, or wanting to know more to help someone else.

WYSA stress: Depression & anxiety therapy chatbot app (has free option).

Moving forward (https://www.veterantraining.va.gov/movingforward/): By the Veterans Administration, is for anyone coping with stressful problems.

Woebot - Your Self-Care Expert (https://woebothealth.com/): Helps with an array; everyday stresses and challenges, symptoms of depression and addiction.

Mindfulness: Headspace, Insight Timer, Mindfulness Coach, 10% Happier

Other: ACT coach, Virtual Hope Box, CALMapp

Techniques:

NOTE: Not all techniques work for everyone. And if one works one time, it might not work another time; and vice versa, it might not work then work later.

Mental – Physical – Soothing Grounding, Healthline: 30 Grounding Techniques to Quiet Distressing Thoughts (https://www.healthline.com/health/grounding-techniques)

A few examples:

Mental: Pick a category (e.g., state capitals, teams, movies, bodies of water) and list as many as you can; or list them alphabetically or by some system (e.g., largest to smallest, oldest to newest). Do math exercises. Go through anchoring facts (e.g., my name is, today is).

Physical: Touch something. Breathing exercise. Physical activity. Use your 5 senses.

Soothing: Think of face/voice/thing/place that soothes you. Talk yourself kindly through it. List positive things.

5-4-3-2-1 practice- In your mind, out loud, or written:

- 5 things I can see
- 4 things I can touch
- 3 things I can hear
- 2 things I can smell
- 1 thing I can taste

SOS Technique, developed by Julian Ford:

- Slow down - Slow down or stop; as needed, connect to body and let mind clear.
- Orient - Pay attention to where you are, what you are doing, who you are with, what's important.
- Self-check: How stressed or calm you are in the moment *and* how in control or dysregulated you are.

Breathing techniques: There are so many options, here's two examples.

- *Box breathing:* Exhale to a count of four. Hold your lungs empty for a four-count. Inhale to a count of four. Hold the air in your lungs for a count of four. Exhale and begin the pattern anew.
- *Mindful breathing*: Example, breathe in and out to a phrase, e.g. "I breathe in calm, I breathe out tension."; "Breathing in, I know I am breathing in. Breathing out, I know I am breathing out". Video**:** Mindful Breathing Exercise from Every Mind Matters – YouTube

Example other approaches:

- **Thoughts:** Check for value alignment. Check for accuracy. Replace them. Let go. Think about or do something else. Express them (e.g., journal). Do something creative/meaningful. Make a plan. Talk to someone.
- **Do a blend of mindfulness and physical**. While stretching, walking, so on: What's the closest/farthest sound I hear? What's the closest/farthest thing I see? What's the loudest/quietest sound? How relaxed/tense? So on.
- **Relax physically and mentally**. Slump, stretch out, curl up, let your mind empty, let your mind wander…
- **Do something physical with an empty mind**. As needed, maybe focus on the movement or your breath.
    - These stretches may be good for times like mini breaks: 4 Quick Stretches to Do If You've Been Sitting in the Car for Hours (https://www.self.com/gallery/sos-stretch-long-car-ride)
- **Do something physical while doing something verbally fun/silly/expressive**. E.g., Sing, talk nonsense, recite poetry, make weird sounds, do vocal exercises, mash up stories.

30 second body scan meditation:

This 30-Second Exercise Can Reduce Your Anxiety Significantly (It's True – We've Tried!)

(https://youaligned.com/body-scan-meditation/)

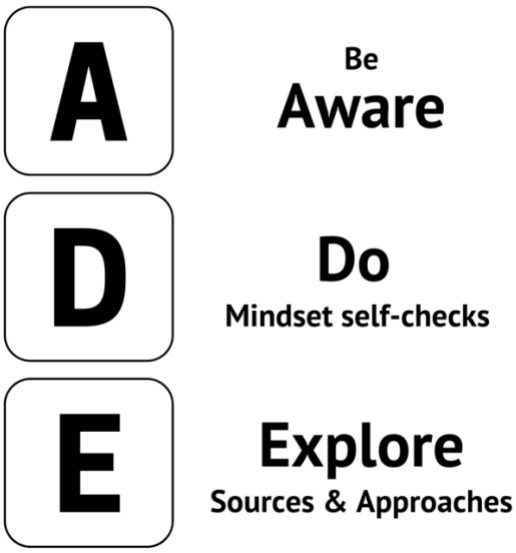
1. Get comfortable
2. Find your breath
3. Become the observer
4. Notice even more
5. Give yourself permission to relax

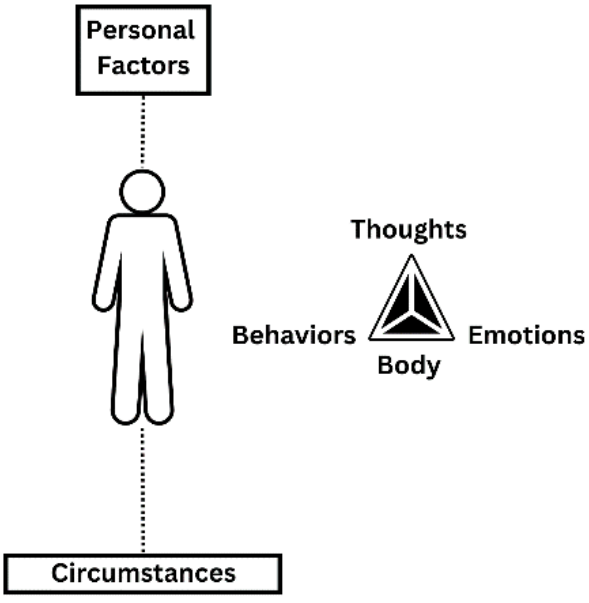
SC-ADE (adapted SBNRR mindfulness practice with the ADE by Gwendolyn Downing):

This can be modified to your needs and time available:

Stop: Stop what you are doing, take the pause, give yourself space. If you need to, use external or internal cues to do this.

Center: Everyone is different. For some, you might skip this and go to "be Aware". For some, it is helpful to pay attention to your breath and take a moment to breathe in whatever way works for you. For others, you might need a different (like grounding) or combined approach. For anyone, you might need to try different approaches at different times.





be Aware of my body, behaviors, thoughts, emotions: Notice what is going on with your body, behaviors, thoughts, emotions. You are not judging yourself, just notice what is going on.

- **Body:** What's happening in my body, from the top of my head to my toes? Am I warm, cold; relaxed, tense; numb, stiff, achy; tired, wired; thirsty, hungry; have a headache; and so on?
- **Behaviors:** What are my behaviors? What are my behaviors communicating to myself or/and others about how I'm doing?
- **Thoughts:** What are my thoughts? Am I present? Thinking about something I'm excited about, something that is bothering me? Any change from my normal? Are they accurate? Line up with my values? So on.
- **Emotions:** What am I feeling? Calm? Happy? Stressed? Furious? Anxious? Need to escape? "Spaced out"? Disconnected? Withdrawn? Bored? Numb? Confident? Proud? Surprised? Embarrassed? Nervous? Indifferent? Envious? Compassionate? So on.

Do mindset self-check: Am I being unbiased, strength-based, empowering, trauma-informed, so on?

Explore possible sources, for what I am aware of in my body, behaviors, thoughts, emotions: Remember individuals in ecological systems; and interaction of body, behaviors, thoughts, and emotions. What is the possible source(s) for what I am aware of? Do I need any assistance to identify the source? Can I identify the source? Is it one or more? What's my best guess, if I can make one? What do I not know? So on. // Queries such as when, where, with who, circumstance(s), how often, when does it not happen.

Explore possible approaches for what I am aware of in my body, behaviors, thoughts, emotions

- Is there something I can do/try about the source?
- Is there something I can do/try about the response?
- Is there anything else I can do/try?

In situations the source(s) aren't known, while trying to determine that, the three questions are still valid. Depending, e.g., prompts: "What's helped you with something else in the past?" "What are some of your strengths or things you enjoy doing; can that help you with this?"

Things that work for me:

What is insidious trauma?

The Three Es of Trauma (SAMHSA, 2023):

- Individual trauma results from an **Event**, series of events, or a set of circumstances
- that an individual **Experiences** as physically, mentally, or emotionally harmful or life threatening
- and that may have lasting adverse **Effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Insidious trauma:

The daily incidents of marginalization, objectification, dehumanization, intimidation, et cetera that are experienced by members of groups targeted by racism, heterosexism, ageism, ableism, sexism, and other forms of oppression, and groups impacted by poverty. (VAWnet, n.d.)

Some of the terms in Insidious trauma:

Read from 1st person point of view

Marginalization: to relegate to an unimportant or powerless position within a society or group.

Objectification: to treat as an object.

Dehumanization: to deprive someone of human qualities, personality, or dignity; to subject. someone to inhuman or degrading conditions or treatment; to address or portray someone in a way that obscures or demeans that person's humanity or individuality.

Intimidation: to make timid or fearful; especially to compel or deter by or as if by threats.

Oppression: unjust or cruel exercise of authority or power.

Insidious trauma questions ©2022-2025 Gwendolyn Downing

Questions about possible experiences one might have had or/and are having:

Have you ever? (To the right) **Because of?** (Below)	Been afraid of what might happen (including what might not happen)?	Had others act in a way you didn't like (e.g., be mean, avoid you, not care)?	Experienced any other injury of any type (e.g., bad water, bad air, no food, bad food, not getting any type of care you need, disasters)?
How much money you don't/do have			
The color of your skin, or anything about your physical appearance, that others would identify as part of a racial/ethnic group(s)			
Where you live now or/and lived before			
You appear male, female, other			
You have, or look like you have, a disability (acknowledging the issues regarding the word "disability" for some ways it's used)			
Your age or the age you appear			
The way you dress or/and make your physical appearance, that would identify you as part of a group(s)			
What gender(s) you are sexually attracted to			
Other			

Reflection areas:

You

Individuals in your life

Others, including those you work with/for

Questions:

While going through the definition(s), what was something significant to you?

While going through the reflection, what was something significant to you?

What is one way you think insidious trauma applies to your work?

Ethics:

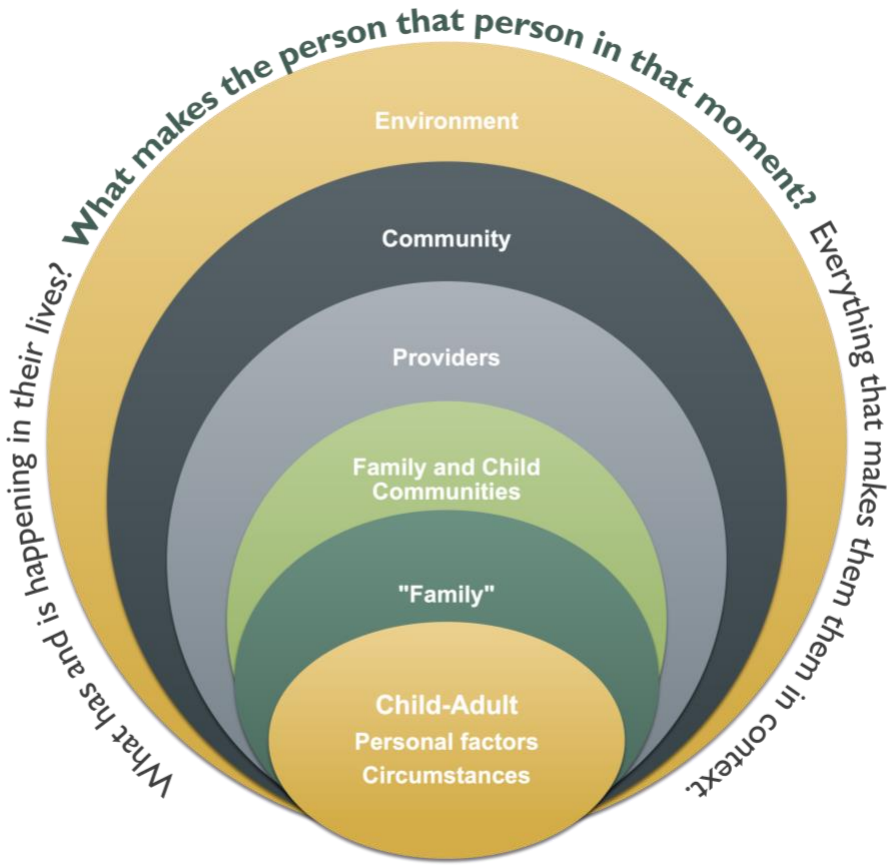
What is one way you think this applies to ethical considerations in your work, from self-care to service provision?

Possible impacts of insidious trauma

Not everyone all the time:

Everyone has their personal factors and circumstances; in which there are intrinsic, adaptive, and protective factors. And even if appears to be happening – trajectory isn't determination.

Who we are in context:



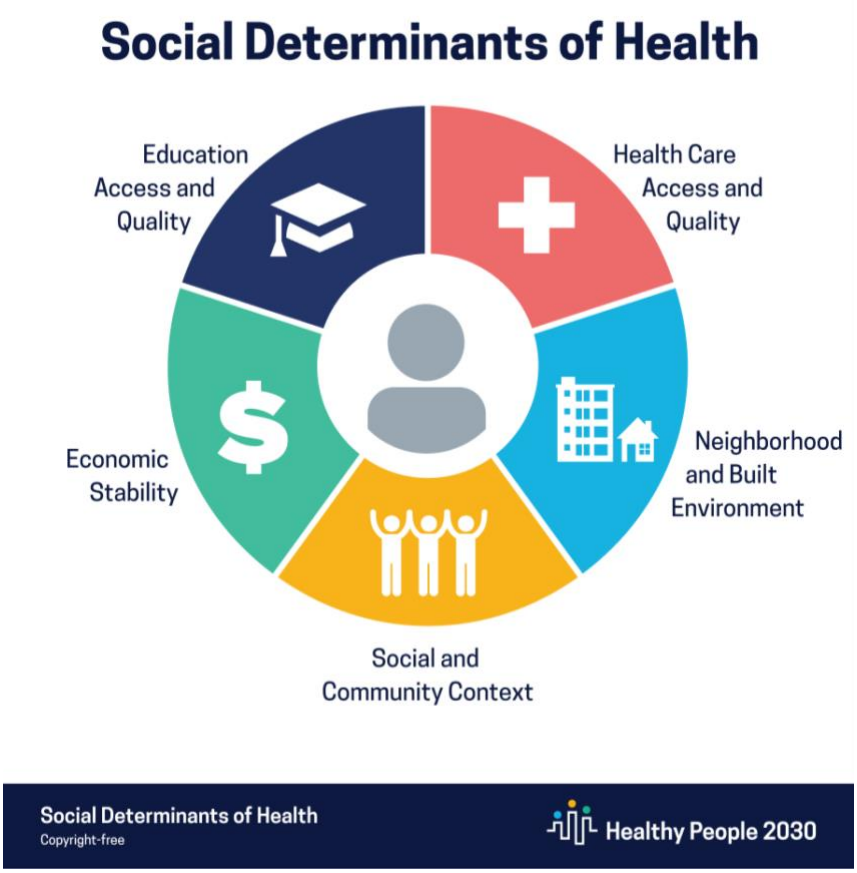
- Strengths
- Protective factors
- Historical trauma
- Inter-generational trauma
- Daily life stress
- Burnout
- Adversity
- Past or/and current trauma: Direct; Indirect; Acute; Chronic; Complex; Insidious; Collective/organizational/community; Vicarious; Secondary traumatic stress

Personal factors in our ecological context

Highlight *interconnection*

- Sources of insidious trauma are from outside the individual
- There is whatever impacts to the individual
- The impacts of the individual on the system

Social Determinants of Health Example



https://health.gov/healthypeople/priority-areas/social-determinants-health

Examples of SDOH include: Safe housing, transportation, and neighborhoods**;** Racism, discrimination, and violence; Education, job opportunities, and income**;** Access to nutritious foods and physical activity opportunities**;** Polluted air and water**;** Language and literacy skills

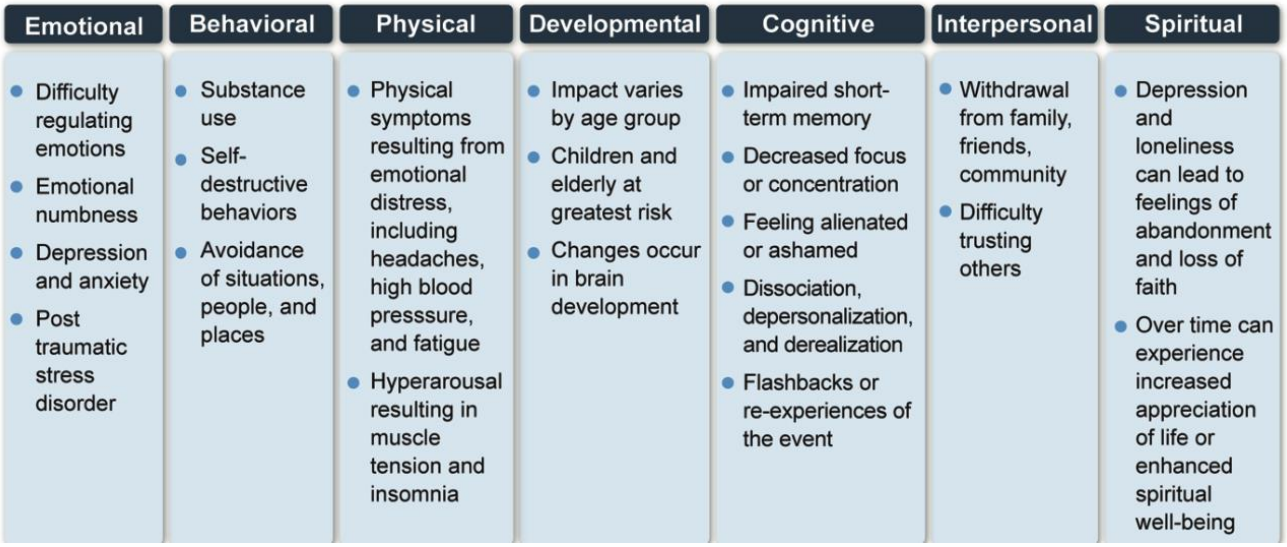
Health – Mental health: access, quality, impact

Think about: Insidious trauma with the SDOH ***AND*** Insidious trauma, mental health, and SDOH

1) Think how the sources of insidious trauma might be a source/contributing source for issues with the SDOH

2) Think how the possible personal impacts of insidious trauma might interact with our SDOH - that interconnection in the ecological context.

Impact of Trauma on Individuals



Emotional	Behavioral	Physical	Developmental	Cognitive	Interpersonal	Spiritual
• Difficulty regulating emotions • Emotional numbness • Depression and anxiety • Post traumatic stress disorder	• Substance use • Self-destructive behaviors • Avoidance of situations, people, and places	• Physical symptoms resulting from emotional distress, including headaches, high blood presssure, and fatigue • Hyperarousal resulting in muscle tension and insomnia	• Impact varies by age group • Children and elderly at greatest risk • Changes occur in brain development	• Impaired short-term memory • Decreased focus or concentration • Feeling alienated or ashamed • Dissociation, depersonalization, and derealization • Flashbacks or re-experiences of the event	• Withdrawal from family, friends, community • Difficulty trusting others	• Depression and loneliness can lead to feelings of abandonment and loss of faith • Over time can experience increased appreciation of life or enhanced spiritual well-being

https://www.samhsa.gov/resource/ebp/practical-guide-implementing-trauma-informed-approach

Allostatic load:

Allostasis is the process by which the body responds to stressors to regain homeostasis. Allostatic load/overload is the related effects in the body, from repeat or chronic stress.

Original term from Bruce S McEwen and Eliot Stellar, 1993

Weathering:

Chronic exposure to experiences like racism, can lead to earlier health deterioration; both earlier health conditions (morbidity) and earlier death (mortality).

Original term from Arline Geronimus, 1992

Moral distress and secondary traumatic stress – insidious trauma

Adapted from: National Child Traumatic Stress Network's learning center: Cuellar, R., Hendricks, A., Clarke, M., Sprang, G., & the NCTSN Secondary Traumatic Stress Collaborative Group. (2021). Secondary Traumatic Stress: Understanding the Impact on Professionals in Trauma-Exposed Workplaces. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

Moral Distress

"Stress that occurs when one believes they know the right thing to do, but institutional or other constraints make it difficult to pursue the desired course of action."

Secondary Traumatic Stress (STS)

- Symptoms similar to, and at its most severe meet the criteria for, PTSD – from being indirectly exposed to another person's direct traumatic experience(s).
- Can impact children/youth and adults.

Moral distress, STS, and insidious trauma

- Connected to - my partner, my child, my child's friend, my friend, my colleague, etc
- Working with - any formal role, including volunteer

- The daily incidents of marginalization, objectification, dehumanization, intimidation, et cetera, experienced by those I'm connected to/work with, can create moral distress or STS.
- One may be both personally experiencing insidious trauma (outside of or/and at work)- as well as any moral distress/STS from those they're connect to/working with.
- If any part(s) of my identity/circumstance is part of the group that can experience insidious trauma, I may have additional vulnerabilities, such as:
    - Identification with individuals of a similar identity(ies) or with similar experiences.
    - Being asked/feeling compelled to contribute expertise about my marginalized identity(ies).
    - Having a greater load than others.
        - Higher workloads and being asked to take on additional responsibilities.
    - Work specific - Lack of safety or support in their agency.

Reflections:

- If experiencing insidious trauma outside/at work + moral/STS from insidious trauma -- possible impacts in creating safety for others?
- If experiencing moral/STS from insidious trauma -- possible impacts in creating safety for others?
- Think about _____, with either of the above -- possible impacts in creating safety?

Questions:

We Covered: Not everyone all the time; Context; Social Determinants of Health; Impact of trauma; Allostatic load; Weathering; Moral distress and secondary traumatic stress

One thing significant to you from what we covered?

Thoughts on how being aware of the possible impacts, can be a stressor?

G: Thoughts on how these tie to creating physical and psychological safety, for ourselves and others?
E: Thoughts on how within our ethics, this ties to creating physical and psychological safety for ourselves and others?

G: How much hope there is, in us doing better, as individuals and a society.
E: How much hope there is, in us doing better, as individuals and a society; including considering this within our ethics.

Ethics foundations

Ecological system and quote by Dr. Angela Coombs

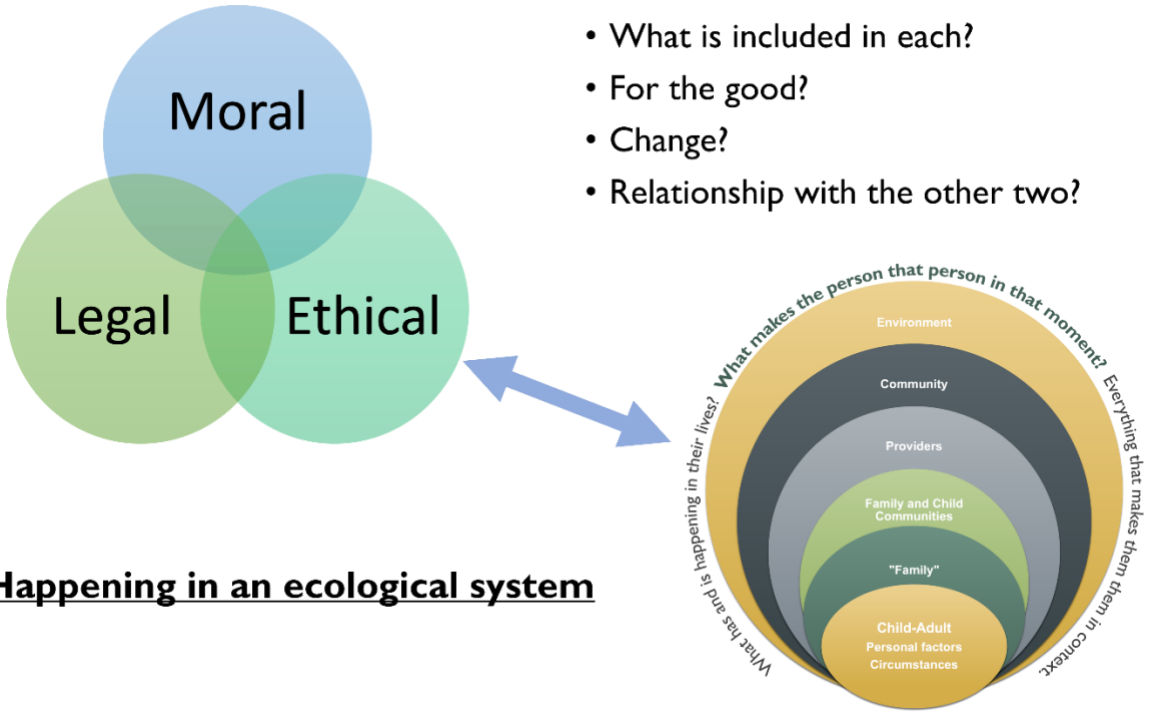
Ethics are created within ecological systems, by individuals, who each have their own ecological system. And positive or negative there is interconnection. At least 2 possible points of that:

- The impact of the system on the individuals before they create ethics
- Then the impact of those ethics on the system

"Historically medicine in general, and also psychiatry, have looked at themselves as immune to the impact of society, and culture, as if unbiased and totally just trying to be scientific. But you see from the very beginning ways that people try to make sense of what they are seeing that are completely shaped and informed by the ways in which the world is biased." Angela Coombs Psychiatrist; clip from PBS's Mysteries of Mental Illness – Hysteria (2021).

What does it mean to be ethical?

	Moral	**Ethical**	**Legal**
Definition	A person's standards for what is and is not acceptable for them	According to an external code/rules. Any group can have an external code.	Somewhere there is a law
For the good?	Doesn't have to be, and even if intended to be, might not be	Doesn't have to be, and even if intended to be, might not be	Doesn't have to be, and even if intended to be, might not be
Changeable?	Can change	Can change	Can change
Relationship with other two?	Might align or might have conflicts	Might align or might have conflicts	Might align or might have conflicts
Enforceable?	No	Depends	Usually



Codes and Rules

In general, not always:

- **Considerations/Principles/Values**: Guides/aspirations for behaviors and decisions
- **Standards**: Held accountable for

Know yours

Read more than yours: Can help with understanding of the field and colleagues, and give ideas

Section questions:

From what was covered, what was something significant to you?

Thoughts about morals, ethics, and laws happening in an ecological system?

Thoughts about morals, ethics, and laws in an ecological system, as it relates to insidious trauma?
Any next step? (e.g., review yours in general; review it with a different lens; read a peer's)

Ethical considerations for insidious trauma examples

Considerations/Principles/Values:

This list is considerations/principles/values, you want to think of as guides for ethical behaviors and decisions (these are generally not accountable standards). This list: does not have every point from all sources; some of the points were compiled into similar/different labels; and not all points listed are included in all the sources.

- **Beneficence**
- **Nonmaleficence**
- **Competence**
- **Contribution to society**
- **Diversity/Inclusion**
- **Importance of Human Relationships**
- **Integrity/Trustworthiness**
- **Justice** – individual and large scale
- **Respect for rights and dignity/worth**
- **Responsibility/Diligence** – in all aspects of profession, and as a representative
- **Self-care -** all areas of self-care, including, protecting yourself and your personal interests

Ethical sources

- AAMFT
- ACA
- AMA-APA***NOTE
- APA
- NAADAC/NCC-AP
- NACP/NOVA
- NASW

See Appendix A for complete considerations/principles/values from sources.

Thoughts?

Anything you would like to add?

For insidious trauma, what is a specific value from your ethical source(s) that you are thinking about? If you don't have values in your ethical source(s), what is one you are thinking about?

Standards

Rough groupings, non-inclusive

Avoid Harm **ACA:** A.4. Avoiding Harm and Imposing Values **APA:** Section 3, Human relations

Competence **AAMFT:** Standard 3: Professional competence and integrity **ACA:** C.2 Professional competence **APA:** Section 2, Competence **ASPPB:** Rule A, Competence **NAADAC/NCC-AP:** Principle 3 Professional responsibility and workplace standards **NACP/NOVA**: III. In their professional conduct **NASW:** 1.04 and 4.01 Competence **NVASC:** Standard 1.3 **OK-LBP:** 86:20-5-2 Competence **OK-LMFT:** 86:15-3-3 Professional competence and integrity **OK-LPC:** 86:10-3-2. Competence

Discrimination **AAMFT:** 1.1 Non-Discrimination **ACA:** C.5 Nondiscrimination **APA:** Section 3, Human relations **ASPPB**: None specific - Rule D, Welfare of Clients (stereotyping; preserving human rights); Rule E, Welfare of supervisees, research participants and students **NAADAC/NCC-AP**: Principle 1 The counseling relationship 1.6 Discrimination; Principle 3 Professional responsibility and workplace standards 3.3 Discrimination **NACP/NOVA** III. In their professional conduct **NASW:** 4.02 Discrimination **NVASC:** Standard 3.9 **OK-LADC**: 38:10-3-3. Client welfare; Appendix A Code of Ethics: F **OK-LBP:** 86:20-5-3 Client welfare (a) **OK-LCSW:** 675:20-1-5 Social worker's conduct and comportment as a social worker (b) **OK-LMFT:** 86:15-3-1 Responsibility to clients (b) **OK-LPC:** 86:10-3-3. Client welfare (a)

Diversity **ACA:** A.2.c; B.1.a; C.2.a; E.5.b; E.5.c; E.8; F.2.b; F.7.c; F.11; H.5.d; **APA:** 9.06 **NAADAC/NCC-AP:** Principle 1 The counseling relationship 1.5 Diversity; Principle 3 Professional responsibility and workplace standards 3.21 Multicultural competence; Principle 4 Working in a culturally diverse world **NACP/NOVA** I. In relationships with every client; II. In relationships with colleagues, other professionals, and the public **NASW:** 1.05 Cultural Competence, 6.04 Social and political action

Responsibility **NAADAC/NCC-AP:** Principle 3 Professional responsibility and workplace standards. **NASW:** 5.01 Integrity of the profession **NVASC:** Standard 1.3 **OK-LADC:** 38:10-3-2. Code of ethics (a) and (b) **OK-LBP:** 86:20-5-1 Responsibility **OK-LMFT:** 86:15-3-1 Responsibility to clients (a) **OK-LPC:** 86:10-3-1. Responsibility

Self-care **NACP/NOVA:** I. In relationships with every client **NVASC:** Standard 3.10 **OK-LADC**: Appendix A Code of Ethics: M and J.

National:

American Association for Marriage and Family Therapy. (2015). *Revised AAMFT Code of Ethics (effective January 1, 2015)*. https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx

American Counseling Association. (2014). *ACA code of ethics.* https://www.counseling.org/resources/ethics

American Psychiatric Association. (2013). *American Psychiatric Association's Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (2013 Edition).* https://www.psychiatry.org/psychiatrists/practice/ethics

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct (2002, amended effective June 1, 2010, and January 1, 2017)*. http://www.apa.org/ethics/code/index.html

Association of State and Provincial Psychology Boards. (2018). *Code of conduct (January 1, 2018; Modified for non-substantive changes, September 14, 2018).* https://www.asppb.net/page/Guidelines

Office for Victims of Crime (OVC), U.S. Department of Justice (DOJ), *National Victim Assistance Standards Consortium (NVASC) Standards for Victim Assistance Programs and Providers* https://www.ovcttac.gov/resourceLibrary/index.cfm?nm=tsd&jcKey=NVASC ; and https://ovc.ojp.gov/sites/g/files/xyckuh226/files/model-standards/6/ethical_standards.html

NAADAC National Association for Addiction Professionals (Jan 1, 2021) *NAADAC, the Association for Addiction Professionals, NCC AP: The National Certification Commission for Addiction Professionals, Code of Ethics*. https://www.naadac.org/code-of-ethics

National Association of Social Workers (2021) *Code of Ethics of the National Association of Social Workers (January 1, 1996, Updated 2021).* https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

National Organization for Victim Assistance (NOVA) and National Advocacy Credentialing Program (NACP) (2021) *Code of Professional Ethics for Victim Assistance Providers (Adopted April 22, 1995; Revised January 2021)* https://www.trynova.org/office-for-advocacy-ethics/

Oklahoma:

Oklahoma Administrative Code. Title 38. Oklahoma Board of Licensed Alcohol and Drug Counselors. Chapter 10. https://rules.ok.gov/code and https://www.okdrugcounselors.org/laws.php

Oklahoma Administrative Code. Title 86. State Board of Behavioral Health Licensure. Chapter 10. Licensed Professional Counselors. https://rules.ok.gov/code and https://oklahoma.gov/behavioralhealth/acts-and-regulations.html

Oklahoma Administrative Code. Title 86. State Board of Behavioral Health Licensure. Chapter 15. Licensed Marital and Family Therapists. https://rules.ok.gov/code and https://oklahoma.gov/behavioralhealth/acts-and-regulations.html

Oklahoma Administrative Code. Title 86. State Board of Behavioral Health Licensure. Chapter 20. Licensed Behavioral Practitioners. https://rules.ok.gov/code and https://oklahoma.gov/behavioralhealth/acts-and-regulations.html

Oklahoma Administrative Code. Title 575. State Board of Examiners of Psychologists. Chapter 10. https://rules.ok.gov/code and https://www.ok.gov/psychology/

Oklahoma Administrative Code. Title 675. State Board of Licensed Social Workers. Chapter 20. https://rules.ok.gov/code and https://oklahoma.gov/socialworkers.html

Questions:

Thoughts?

Anything you would like to add?

Take a couple of moments and either in the handout or in your rules, ID specifics.

What is one-way insidious trauma, should be considered with one standard from your license(s)/certification(s) (not limited to what was listed)?

Ethical code timeline example

Organization	Year founded	Year of first code
American Psychiatric Association	1844	1973
American Medical Association	1847	1847
American Psychological Association	1892	1952/53
American Personnel and Guidance Association (ACA)	1952	1961
American Bar Association	1878	1908
WMA: Declaration/International Code of Medical Ethics	1947	1948/1949
World Psychiatric Association: Declaration of Hawaii	1950	1977
WMA: Declaration of Helsinki – human subjects	1947	1964
Nuremberg Code in 1948; Guidelines for Human Experimentation of 1931; Berlin code of 1900.	(Ghooi, et al, 2011)	1900-1948
National Research Act – Belmont Report		1974 -1979

Reminder: Having an ethical code, didn't/doesn't mean there were/are enforceable standards.

Thoughts?

Thoughts or questions, about the role of morals/society/culture on the development of the codes?

Thoughts or questions about the impact on trust, for those needing, seeking, or being forced into contact with the field? (ethics now)

Thoughts on how any parts discussed were impacted by or/and now impact sources of insidious trauma, both in and out of the field?

Thoughts on why in 2,500ish years we are where we are?

The Field and Insidious Trauma – General and Ethical Considerations

Past and present examples of the field and insidious trauma, and the impact on ethical considerations.

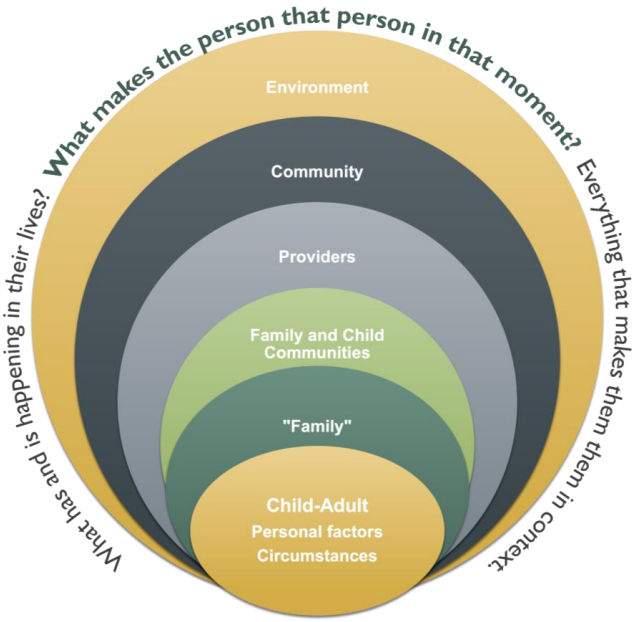
The field and insidious trauma - past and present:

The field has been, is, and might be, part of the problem. It has been, is, and can be, part of the solution and healing.

Quote: “Historically medicine in general, and also psychiatry, have looked at themselves as immune to the impact of society, and culture, as if unbiased and totally just trying to be scientific. But you see from the very beginning ways that people try to make sense of what they are seeing that are completely shaped and informed by the ways in which the world is biased.” Angela Coombs Psychiatrist; clip from PBS’s Mysteries of Mental Illness – Hysteria (2021).

Then and Now

Insidious trauma sources and impacts



Racism

Apology to People of Color for APA's Role in Promoting, Perpetuating, and Failing to Challenge Racism, Racial Discrimination, and Human Hierarchy in U.S. - Resolution adopted by the APA Council of Representatives on October 29, 2021; History of Racism in American Psychology PowerPoint deck.

Summary of Harms

The historical review indicates that psychologists have, in both the past and present:

- Established and participated in scientific models and approaches rooted in scientific racism
- Created, sustained, and promulgated ideas of human hierarchy through the construction, study, and interpretation of racial difference
- Promoted the idea that racial difference is biologically based and fixed
- Used psychological science and practice to support segregated and subpar education for people of color
- Created and promoted widespread use of psychological tests and instruments that discriminated against people of color
- Failed to take concerted action in response to calls for an end to testing and psychometric racism
- Supported the widespread use of educational assessments and interventions that were lucrative for the field of psychology, but harmed people of color
- Provided ideological support for and failed to speak out against the colonial framework of the boarding and day school systems for First Peoples of the Americas
- Created, sustained, and promoted a view of people of color as deficient or damaged
- Applied psychological science and practice to oppose "race-mixing" and to support segregation, sterilization, and antimarriage laws, using the ideas of early 20th century eugenics
- Failed to represent the approaches, practices, voices, and concerns of people of color within the field of psychology and within society
- Failed to respond or responded too slowly in the face of clear social harms to people of color

Thoughts?

Thoughts about how this applies to your work?

Ethics:

"…in both past and present"

Thoughts about morals, ethics, and laws, as part of the harms and as part of repairing the harms?

Thoughts about impact on current ethical considerations?

Values: beneficence, nonmaleficence, competence, contribution to society, diversity/inclusion, importance of human relationships, integrity/trustworthiness, justice, respect for rights and dignity/worth, responsibility/diligence, self-care

Standards: avoid harm, competence, discrimination, diversity, responsibility, self-care

How might points included in this summary, similarly apply to other groups impacted by insidious trauma?

Mental Illness - Experimental Treatments and Eugenics

MYSTERIES OF MENTAL ILLNESS: Experimental Treatments and the Rise of Eugenics:

Description: By the early 20th century, mental asylums had become extremely overcrowded, and very little was known about how to treat these patients. Out of view from the public eye, desperate doctors experimented with new treatments. When treatments failed, patients were labeled biologically defective, fueling the Eugenics program, and the involuntary sterilization of thousands of patients."

Thoughts after:

Then and Now:

What are parallel points that are happening, at least in some form, currently?

- They didn't know what caused mental illness
- Experimental therapies
- 1927 Nobel prize treating psychosis with malaria therapy; wasn't curing MI, was curing syphilis of the brain
- "When had to explain away the fact they'd originally promised they'd cure all these people they put into asylums and then couldn't; they said Well really that was because they were biologically defective, they weren't fully human, they were degenerates."
- Language became extremely extremely harsh
- "It is for the best interest of the patients and of society that any inmate in the institution under his care should be sexually sterilized." HB D91- 1928 Mississippi law, other states similar laws, fueled by eugenics. Later, said often without knowledge.
- Francis Galton's lab for National Eugenics – appealed to conservatives and progressives
- "It's important to understand, that the people doing these things, were very often true believers in what they were doing. They sincerely thought that their interventions, were therapeutic and well-motivated." Andrew Scull – Historian

Eugenics additional – slide 1900-1925 (cont.)

1914: Psychologist Henry Goddard, a pioneer of the U.S. testing movement, serves as the psychology representative on the Committee to Study and Report on the Best Practical Means of Cutting Off the Defective Germ-Plasm in the American Population. The Committee, established by the Research Committees of the Eugenics Section of the American Breeders Association, recommended segregation, and sterilization as the best methods of preserving "the blood of the American people" (Laughlin, 1914, p. 6). The Committee called on psychology to help determine standards and tests for identifying "mental degenerates and defectives proposed for sterilization" (p. 7). By 1930, 35,000 people in the U.S. had been sterilized, mostly individuals who had been deemed "feebleminded" or socially or mentally unfit (Greenwood, 2017). Many of these individuals were immigrants, Black people, First Peoples of the Americas, poor White people, and people with disabilities (Kevles, 1998). (APA's History of Racism in American Psychology).

Application:

Use our understanding of ecological interconnection and think through how insidious trauma sources and impacts played a role in these points both then and now.

Ethics:

<u>Video terms, eugenics, and insidious trauma</u>

Start:

- "Mental illness" (another training)

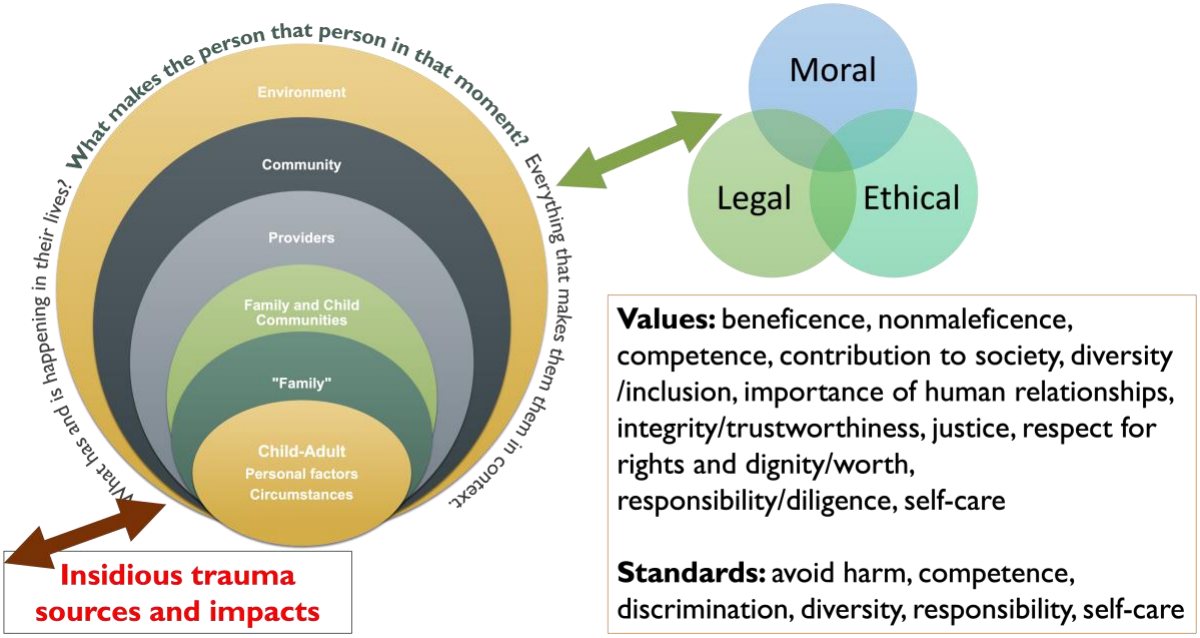
When treatment didn't' work:

- Biologically defective
- Not fully human
- Degenerates

Similar laws, fueled by Eugenics:

- Mentally ill and deficient categorized inferior
- …Insane, feeble minded, criminals, and other defectives…
- Genetically feeble should be winnowed out

Review: Eugenics additional – slide 1900-1925 (cont.)



General rewording for "Now"

- The source of this client's mental health issue?
- Experimenting with treatment or approach?
- The EBT, award winning or not?
- Failure to engage in treatment or unsuccessful treatment outcomes – client's fault, practitioner's fault, or/and system's fault?
- Language? (e.g., what we use – how does that impact individual/stigma/so on; what's billable; what's required; what the client prefers; what does the client choose to have included/excluded in documentation)
- "It is for the best interest of the patients and of society…" – what laws have that/similar now?
- Francis Galton's lab for National Eugenics – appealed to conservatives and progressives" – Who are your affinity groups? What checks can you try?
- "It's important to understand, that the people doing these things, were very often true believers in what they were doing. They sincerely thought that their interventions, were therapeutic and well-motivated. – Andrew Skull, historian" – current situations in our field?

Thought/discussion options:

- ✓ Our understanding of ecological interconnection, and insidious trauma sources and impacts, and our moral, ethical, and legal lens (for "then", groups that had ethics in the early 1900s were the AMA and ABA)

How does the "then" list impact current ethical considerations? (e.g., still impacting system; ind/grp within insidious trauma def, current distrust)

How does the "now" list impact/connect to current ethical considerations?

Heterosexism

American Psychiatric Association. (n.d.) Best Practice Highlights: Lesbian, Gay, Bisexual, Transgender and people who may be questioning their sexual orientation or sexual identity (LGBTQ). Prepared by Robert Paul Cabaj, M.D.

DSM-I (1952) – Homosexuality is listed as a sociopathic personality disturbance.

APA adopts first code1952, effect in 1953

ACA first code is 1961

DSM-II (1968) – Homosexuality continues to be listed as a mental disorder

May 1972 speech that helped lead to DSM changes in 1973/1974

AMA-APA first code is 1973

DSM-II (1974) – Homosexuality is no longer listed as a category of disorder. The diagnosis is replaced with the category of "sexual orientation disturbance".

DSM-III (1980) – The diagnosis of ego-dystonic homosexuality replaces the DSM-II category of "sexual orientation disturbance." Introduces gender identity disorder.

DSM-III-R (1987) – Ego-dystonic homosexuality is removed and replaced by "sexual disorder not otherwise specified," which can include "persistent and marked distress about one's sexual orientation."

DSM-V (2013)– Includes a separate, non-mental disorder diagnoses of gender dysphoria to describer people who experience significant distress with the sex and gender they were assigned at birth.

Thoughts?

Thoughts about how this applies to your work?

Eugenios, J. (May 2, 2022). 'I am a homosexual. I am a psychiatrist': How Dr. Anonymous changed history. NBC News. https://www.nbcnews.com/nbc-out/out-news/-homosexual-psychiatrist-dr-anonymous-changed-history-rcna26836

Ethics:

Thoughts?

Thoughts about the ecological system: how the field was impacting both outside the field and those inside the field; and then how those inside the field impacted the field and creating change; and then those changes in the field led to how the field impacted both outside and in?

Thought from an ethical/group norm perspective: this was a diagnosis, so it was right to diagnose, treat, so on; that what is ethical isn't always right; and it's on us to help the field to be and have ethics that match what is

Ableism

The CDC's current estimated prevalence of disability for adults is "Up to 1 in 4 (27%)".

Sexism:

American Psychological Association Committee for Women in Psychology (2004). *52 Resolutions and Motions Regarding the Status of Women in Psychology: Chronicling 30 Years of Passion and Progress.* https://www.apa.org/pi/women/resources/reports/52-resolutions.pdf "In 1969, during the height of activism, APA members frustrated over the sexism, and lack of sensitivity and representation within the association, formed the Association for Women Psychologists (AWP). Women were discouraged from graduate programs in psychology by listings that stated "MEN PREFERRED (Exhibit 1);" professional meetings continued to be scheduled in locations and establishments that discriminated against women; and women were greatly underrepresented on APA's boards and committees - very few members were women. In 1970 members from AWP presented a historic list of 52 resolutions that dealt with employment, education, child and health care facilities, psychological theories and practice, conventions, equity in decision-making, and the general status of women."

Chrisler, J. C., & Smith, C. A. (2004). Feminism and psychology. In M. A. Paludi (Ed.), *Praeger guide to the psychology of gender* (pp. 272–291). Praeger Publishers/Greenwood Publishing Group. https://psycnet.apa.org/record/2004-21898-013 ABSTRACT: Feminism and psychology have a history of mutual influence. For example, sexist theories that were developed and promulgated by psychologists and psychiatrists were among the first targets of feminist activists in the second wave of the women's movement. Classic feminist books took aim at Sigmund Freud, Erik Erikson, and other male psychologists and psychoanalysts whose theories described the psychology of women in ways that justified, as well as maintained, a power imbalance in favor of men. One might say that sexism in psychology was one of the sparks that ignited the women's liberation movement. The women's movement, in turn, had an enormous influence on women psychologists and psychology students. Excited by consciousness-raising groups and inspired by feminist political activism, many women psychologists and psychologists-to-be labeled themselves feminists and set out to make changes that would alter the direction of psychological science, practice, and training. It is the influence in this direction from feminism to psychology that will be the focus of this chapter.

Summary

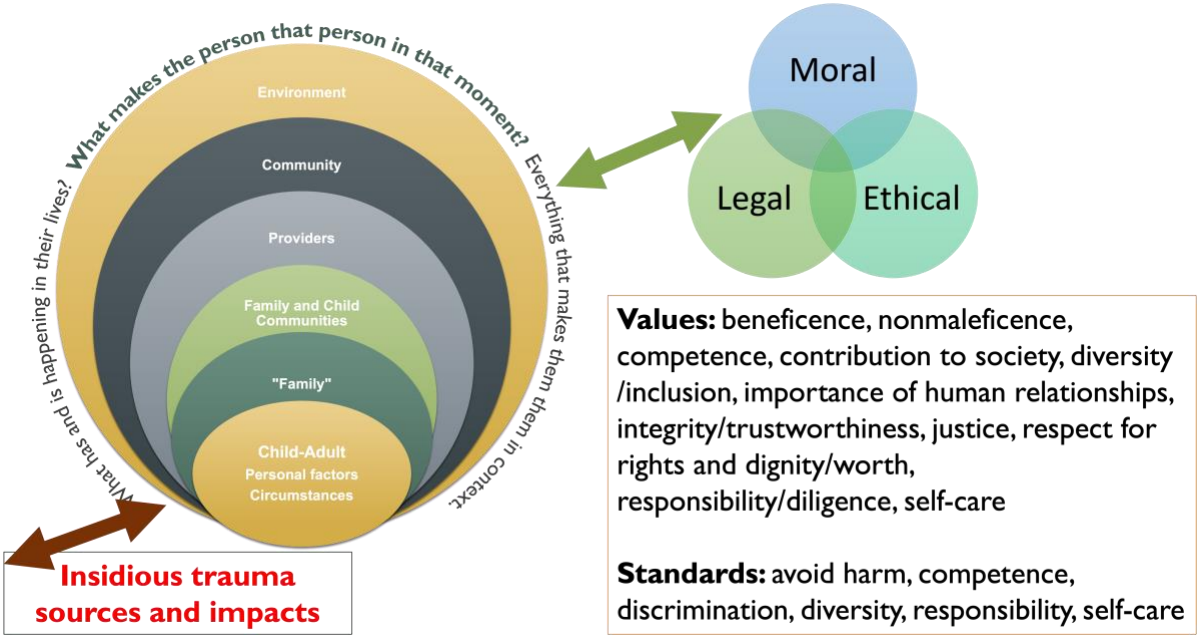
Insidious trauma:	**The field's role in:**	**Ethical codes/rules:**
The daily incidents of marginalization, objectification, dehumanization, intimidation, et cetera that are experienced by members of groups targeted by ▪ racism, ▪ heterosexism, ▪ ageism, ▪ ableism, ▪ sexism, ▪ and other forms of oppression, ▪ and groups impacted by poverty	▪ Creating/perpetuating in general population ▪ Discrimination in the field tied to research, screening, assessment, treatment ▪ Discrimination in the field toward those working within the field or trying to ▪ Impacting the whole system of care, such as in access to and set up of services	▪ Morals, ethics, and laws ▪ Ethical isn't always right. And it's on us, to help the field to be and have ethics that match what is. ▪ Impact on ethical considerations

The field's role in:
▪ Solutions and healing

What are some of your examples of the field and insidious trauma?

What is one way you think the issues of the mental health field and insidious trauma applies to your work?

Ethics:



What is one way you think the issues of the field and insidious trauma, applies to ethical considerations in your work?

Ethical decision-making

Three general categories

- Simple, right-wrong
- Complex, right-wrong
- Complex, it depends

Can you think of an example for each?

Approach: An ethical decision-making model. Why can this be beneficial?

Ethical Decision-Making Model at a glance

EDDMs – there are a lot of models

- You may already have a model that works better for you
- You may decide to make your own at-a-glance

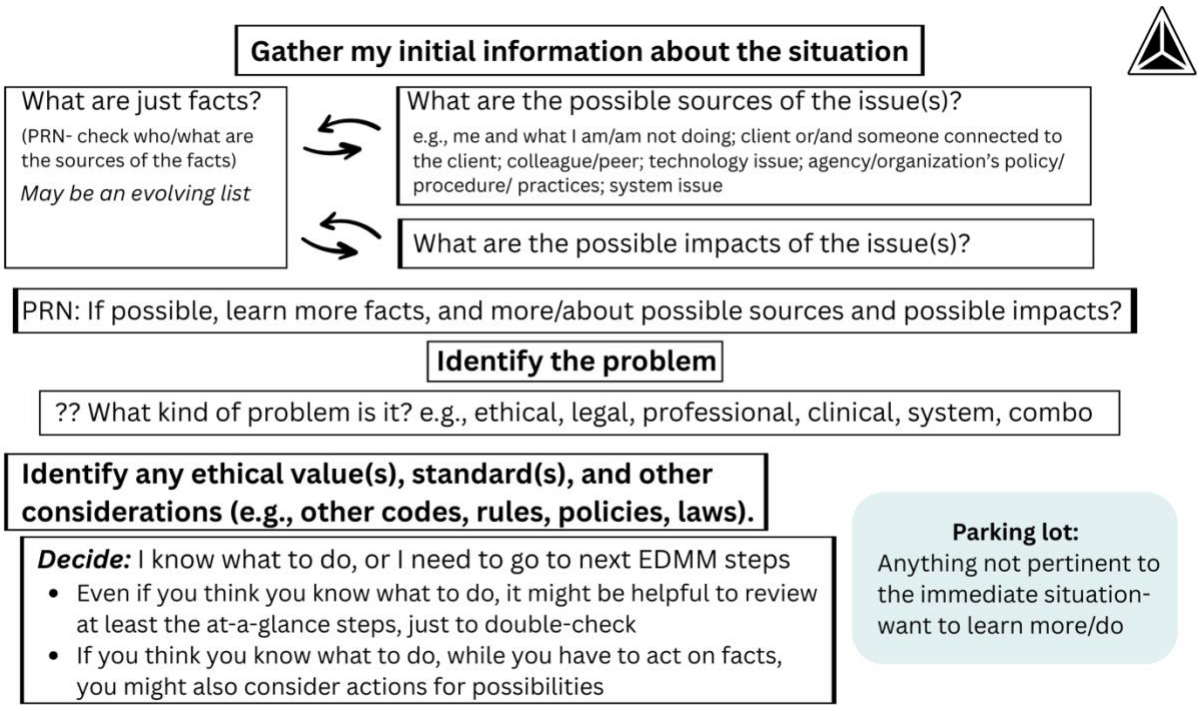
Adapted from: Forester-Miller, H., & Davis, T. E. (2016). Practitioner's guide to ethical decision making (Rev. ed.). Originally retrieved from https://www.counseling.org/knowledge-center/ethics/ethical-decision-making; retrieved from https://www.counseling.org/docs/default-source/ethics/practioner-39-s-guide-to-ethical-decision-making.pdf

During each step stay aware of your pyramid (body, behavior, thoughts, emotions).

1. Gather information and identify the problem.
2. Identify any ethical value(s), standard(s), and other considerations; and decide.
3. Determine the nature and dimensions of the dilemma.
    - (PRN) Examine implications for ethical values
    - Consult the literature
    - Consult with peers/supervisor
    - Consult with state/national/other professional organizations
4. Generate potential courses of action.
5. Consider the potential consequences of all options and determine a course of action.
6. Evaluate the selected course of action.
7. Implement the course of action.
8. After implementation, assess; and consider how the situation might be prevented in the future.

Don't forget: documentation and parking lot

Steps 1 and 2 discussion:



Thoughts?

How does your current approach compare?

If you don't already have an ethical decision-making model, or consistently use the one you have, what is your next step?

What are dilemmas you might need this model for? (e.g., differing points in ethical codes; hours best for me vs best for client; between ethics and payor source/policy/law)

Problem Based Learning example steps (PBL-5)

1. What are facts? (Remember to question, e.g., as applicable, the source of the info)
2. What are possibilities? (Both sources of issues and impacts)
3. If you can, what can you do to learn more about the possibilities?
4. What are your next steps?
    - based on facts
    - to learn more about the possibilities
5. Anything additional you want to learn about?

Example vignette:

Decision-making model grid example

Google drive link to Word version

✓ During each step be aware of your pyramid (body, behavior, thoughts, emotions)

<table>
<tr><td colspan="2">1. Gather information and identify the problem.</td><td></td></tr>
<tr><td colspan="3">Gather my initial information about the situation
PRN: If possible, learn more facts, and more/about possible sources and possible impacts</td></tr>
<tr><td rowspan="2">Just facts (PRN- check who/what are the sources of the facts) May be an evolving list</td><td colspan="2">Possible sources of the issues(s) e.g., me and what I am/am not doing; client or/and someone connected to the client; colleague/peer; technology issue; agency/organization’s policy/procedure/practices; system issue</td></tr>
<tr><td colspan="2">Possible impacts of the issue(s)</td></tr>
<tr><td colspan="2">Identify the problem. And ?? What kind of problem is it? (e.g., ethical, legal, professional, clinical, system, combo)</td><td></td></tr>
<tr><td colspan="2">2. Identify any ethical value(s), standard(s), and other considerations (e.g., other codes, rules, policies, laws); and decide: I know what to do, or I need to go to next steps.</td><td></td></tr>
<tr><td colspan="2">3. Determine the nature and dimensions of the dilemma.
▪ (PRN) Examine implications for ethical values
▪ Consult the literature
▪ Consult with peers/supervisor
▪ Consult with state/national/other professional organizations</td><td></td></tr>
<tr><td colspan="2">4. Generate potential courses of action.</td><td></td></tr>
<tr><td colspan="2">5. Consider the potential consequences of all options and determine a course of action.</td><td></td></tr>
<tr><td colspan="2">6. Evaluate the selected course of action.</td><td></td></tr>
<tr><td colspan="2">7. Implement the course of action.</td><td></td></tr>
<tr><td colspan="2">8. After implementation, assess; and consider how the situation might be prevented in the future</td><td></td></tr>
<tr><td colspan="2">Parking Lot</td><td></td></tr>
</table>

PBL-5 Grid

What are facts?	
What are possibilities? (sources/impacts)	
If you can, what can you do to learn more about the possibilities?	
What are your next steps, based on facts?	
What are your next steps to learn more about the possibilities?	
Anything additional you want to learn about?	

Vignettes for ethics and insidious trauma

These three vignettes are about clinicians, who are part of a small private practice group, Harbor Counseling Services. One of the agency's core values is "Nothing about us, without us; without the onus on us."

Part 1:

For these vignettes:

This is a first pass run through – so keep it simple.

- Consider everyone in the vignette, and note if there are points where (there may or may not be all 4 categories):
    1. Being handled ethically
    2. Being handled unethically
    3. An ethical decision possibly needed
    4. An ethical decision needed
- Note the applicable standard(s) or value(s)
- Identify if there are points there isn't something specific in your license/certification's standards, but is an issue, you think that for the individual(s), services, and profession, should be brought up to a governing body or/and other action taken.
- Stay aware of your pyramid (body, behavior, thoughts, emotions), and self-identify any reaction(s) you have, to pieces of the individuals' identities or their situations. Is it a biased reaction? Is it a resonating reaction (positive/negative/mixed) of something you personally identify with? You do not have to share anything you note of your reactions with anyone else. That stated, there will be an option during ethical planning, where individually or in a separate group(s) (two or more), you can self-process/discuss your reactions from the vignettes, or/and any part of today, and how those tie to your ethical behaviors and decisions.

Questions:

1. While/from going through the process in Part 1, what is one thing significant to you?

2. Why do you think you were asked to identify what was being handled ethically?

Part 2:

Use an ethical decision-making model (you may use the model provided, or one that works better for you) for one area identified as either "an ethical decision possibly needed" or "an ethical decision needed". Again, during the process, stay aware of your pyramid.

✓ During each step be aware of your pyramid (body, behavior, thoughts, emotions)

<table>
<tr><td colspan="2">9. Gather information and identify the problem.</td><td></td></tr>
<tr><td colspan="3">Gather my initial information about the situation
PRN: If possible, learn more facts, and more/about possible sources and possible impacts</td></tr>
<tr><td>Just facts (PRN- check who/what are the sources of the facts) May be an evolving list</td><td colspan="2">Possible sources of the issues(s) e.g., me and what I am/am not doing; client or/and someone connected to the client; colleague/peer; technology issue; agency/organization's policy/procedure/practices; system issue</td></tr>
<tr><td></td><td colspan="2">Possible impacts of the issue(s)</td></tr>
<tr><td colspan="2">Identify the problem. And ?? What kind of problem is it? (e.g., ethical, legal, professional, clinical, system, combo)</td><td></td></tr>
<tr><td colspan="2">10. Identify any ethical value(s), standard(s), and other considerations (e.g., other codes, rules, policies, laws); and decide: I know what to do, or I need to go to next steps.</td><td></td></tr>
<tr><td colspan="2">11. Determine the nature and dimensions of the dilemma.
▪ (PRN) Examine implications for ethical values
▪ Consult the literature
▪ Consult with peers/supervisor
▪ Consult with state/national/other professional organizations</td><td></td></tr>
</table>

12. Generate potential courses of action.	
13. Consider the potential consequences of all options and determine a course of action.	
14. Evaluate the selected course of action.	
15. Implement the course of action.	
16. After implementation, assess; and consider how the situation might be prevented in the future	
Parking Lot	

While/from going through the process in Part 2, what is one thing significant to you?

Noah

Noah, a 46-year-old Black cis-gender homosexual male, is an LCSW who works with LGBTQIA2S+ youth and adults. However, while he wants to focus on the LGBTQIA2S+ population, for the last year, he has been increasingly asked to address race issues, both in practice and in consultation for members of his behavioral health network. With clients, he is fine if race is an intersecting issue, but doesn't want to work outside his identified population of focus; and that isn't always a welcome distinction for those seeking services nor those wanting to refer. Then with his networking group, he utilizes different responses depending on: if they are flat out wrong in how they approach him; are at least well intentioned and trying; or are asking appropriately (have already learned what they can on their own, and respectfully approach him within the context of their existing relationship with him). He's not sure with the first two groups he is handling things as well as he could, maybe should, but he also knows it shouldn't be on him to handle their requests one way or the other to being with. With the third group, he appreciates their efforts to do better and their approach, but he has just been at capacity, and struggles both to respond and in any responses.

Then, on top of this, three months ago, a few things happened. His 9-year-old daughter had a bad experience at school with a substitute teacher during an assignment about "your family" and was later bullied; and those events led to all the related things since. And, there was also another national headline incident of hate-crimes towards some LGBTQIA2S+ individuals, which triggered issues for some of his clients, that led to an increase in service needs.

With all these things going on, he started/is having difficulty with sleep, his blood pressure became/is elevated, and he had/has these moments of wanting to get away from everything; work, family, the planet. Nothing suicidal, just stupid weary. He let both his partner and his co-workers know, accessed therapy, and has decided to work towards a shift in his work; where he will still work with clients part-time, and the rest of the time do training and advocacy, to create more of a societal difference. And next week, he's going on vacation with his family.

Right now, Noah needs to prepare for two emergency sessions. He has a 15yo trans male client, who lives in a state that just passed legislation banning all forms of gender-affirming medical treatment for transgender youth; and this change directly impacts his client. His client is in a semi-crisis state, but Noah's not worried about that, he knows they can work through this together. His concern is about the client's caregiver who called, who also isn't in a good place, and was making all kinds of statements that might be taken as threatening to those unfamiliar with the caregiver's default way of expressing themselves when really upset (something that's been discussed before). If the caregiver is overheard by the wrong person, there is all that can come from that. Then, Noah also keeps thinking, what if this was the event that pushed the caregiver into meaning some of what they were saying? Either way, he is concerned, and wants to be prepared for the individual session with his client, and the conjoint family session. He begins preparing, and then starts noticing he's not feeling well. He checks and his blood pressure is too elevated. Argh. If he rests, he *should* be okay in time for the sessions, but he won't be prepared. He leans back to rest and think through his options.

Solveig

Solveig, a 31-year-old White cis-gender heterosexual female, is an LPC who sees minors with disabilities. Her newest client is Immokalee, a 16-year-old Cherokee female, with Down syndrome and a prior diagnosis of ADHD. A year ago, as a tornado took out the family's home, Immokalee was on-site in a shelter, with her mom and younger brother. And after, the family was in a situation that led to having to relocate. Their new location in multiple ways is a text-book example of "how to be the source of insidious trauma"; including for their racial identity, and Immokalee having Down syndrome (which they view as a divine gift and a positive addition to the diversity of the world). Solveig is confident about her skills with Down syndrome, ADHD, and trauma. And then for Immokalee and her parents' request to include some of their personal First People culture's aspects into treatment, Solveig: was honest with them about her current understanding of both best practices for that and their specific culture; explained potential risks, benefits, and ethical considerations; and is listening to and learning from them, studying, consulting with two appropriate professionals, and documenting.

Next week she is supposed to be attending a 2-day advanced skills training for an EBP she is certified in. She had reached out to the training coordinator as soon as she registered (she knows a lot of groups don't review accommodations until closer to training), and explained she has dyslexia and as part of her accommodations would need appropriately prepared materials in advance. The first problem with her request was most of the trainers weren't going to have their presentations done until the day before. Then today, she had received materials, from so far, the only one of the other trainers who had submitted their materials early to send to her; and the PowerPoint hadn't been checked for accessibility, and the supporting handouts weren't formatted for a screen reader. And she gets it, she does. Her colleagues are doing the best they can with their workloads and time commitments. Most haven't been trained in just basic accessibility. And even when there are those who do have knowledge of what is needed for accessibility, they often truly don't have the time or/and resources needed to do something to standards. Overall, it's a larger field and societal issue. But it also means what it means for her; and in turn, the time it will take to get the information implemented for her clients.

This afternoon, Solveig has a quandary. A month ago, a 17-year-old Deaf male client, she had been seeing for trauma and depression, experienced first episode psychosis, was hospitalized, and then diagnosed with early-onset schizophrenia. Due to her knowing her own competence and time commitment limits, and the limits of the Harbor group, she wants to refer him to a provider with both FEP experience and the ability to provide or connect him with appropriate support services. And finding another provider had been challenging for all kinds of reasons. The nearest state operated Navigate team is 45 minutes away and they didn't/don't have an opening. Then, other providers she checked with: didn't feel comfortable working with an ASL interpreter (Solveig is the only therapist in the area who provides services in ASL), didn't take his insurance, or had a long wait list. She had finally found a "They're better than me, if not the best option". But now, the client and family have changed their minds and decided they don't want to go there due to bad experiences with using interpreters for therapy. He is supposed to discharge tomorrow, and she has a decision to make.

Pilar

Pilar, a 70-year-old Latine cis-gender heterosexual female, is a psychologist who works two days a week, sees adults only, and enjoys being able to provide bilingual services. While she only sees adults now, she has years of experience with all ages; and to help, sometimes covers for her co-workers when they are on leave, as she is doing for Noah this week.

It's 2pm Friday, and she gets a call from the CPS worker of one of Noah's former clients, Fin, who is 16-years-old, Black, identifies as non-binary, has a significant history of trauma, and struggles with CPTSD and depression. The worker explains a situation happened at school, and the school feels that Fin should be taken to the ER for an inpatient evaluation. Fin states ze doesn't need to, that the school is being biased, because of hir race, gender identification, and custody status. The worker says, "Listen, I'm young, white, and new to the field. One of the things Noah helped me understand is because of hir skin color, just like ze is more likely to be pulled over or arrested, ze is more likely to be hospitalized. And the chain to that starts before ze ever gets to official assessment. And then there are hir pronouns and being in custody. That said, Fin has had a rough patch the last few weeks, and while I know some of hir symptoms are just life for hir for now, I was thinking of calling Noah anyway about assessing if ze need to start sessions again. And so, with that, and hir history, I also am scared Fin might really be having suicidal thoughts. I know ze hasn't seen Noah in 4 months, but he said we could always call."

Pilar quickly processes: This is not a current client, but a relatively recent former. If Fin needs services now, Noah is not taking any new clients, their agency's best alternative is about to go on maternity leave, but there is that new clinician candidate that will work, especially with extra consultation. As far as what the worker is saying about possible racial bias, valid, as Pilar knows from both a personal and professional basis. And the other possible biases, also valid. Pilar also knows for a fact there are certain local ER staff more inclined to hospitalize due to different biases; and that when a patient is brave enough to speak out, the ER clears the staff. But still, Fin might need that level of care. --- Pilar tells the worker to bring Fin in to see her for an assessment; and then accesses hir prior chart to familiarize herself before they arrive.

Pilar turns her attention to where she is with one of her clients, Arzu, a 56-year-old female, originally from Nepal. Arzu moved to America with her parents, when she was 34, to live near other family. A few years ago, by family decision, her full-time role became caregiver for her parents and assisting or caring for other family members. Arzu has shared incidents that to Pilar indicate Arzu is sometimes taken advantage of or controlled (she is financially dependent on the family). Arzu also reports experiencing issues with her health and mental health, as a response to these incidents. Arzu came to counseling, not because she was concerned for herself, but because her struggles were impacting her doing her best by her family. Pilar has been trying to be cognizant of and balance: cultural humility; that Arzu personally values familial needs over individual needs; that autonomy and independence aren't always the goal; the physical and mental impacts on Arzu; and that she has individual needs. But at this point, Pilar is worried that it seems they aren't making real progress, and knows she needs to think it through before their next session.

Develop/expand plans to address insidious trauma in our work – General and Ethics

Focuses:

- As a person and any role(s) one might have
- Self-care and secondary traumatic stress
- Clinical specific – if non-clinical, as needed for yourself and others

Optional resource share, QR code or/and link to Google doc:

Ethical considerations:

- The values and standards we have used today
- Do you have any others specific to your license/certification you've identified?

MYSTERIES OF MENTAL ILLNESS: Decolonizing Mental Health | Overview:

https://www.pbs.org/video/decolonizing-mental-health-overview/

Description: Like other healthcare industrial complexes, the mental health field operates around a centre defined by a whiteness of theory and practice. It's a colonization that has rarely ever been questioned and the need to dismantle it has never been more urgent. Mental health practitioners serving racialized groups come together to shed light on the racism that undercuts their progressive practices

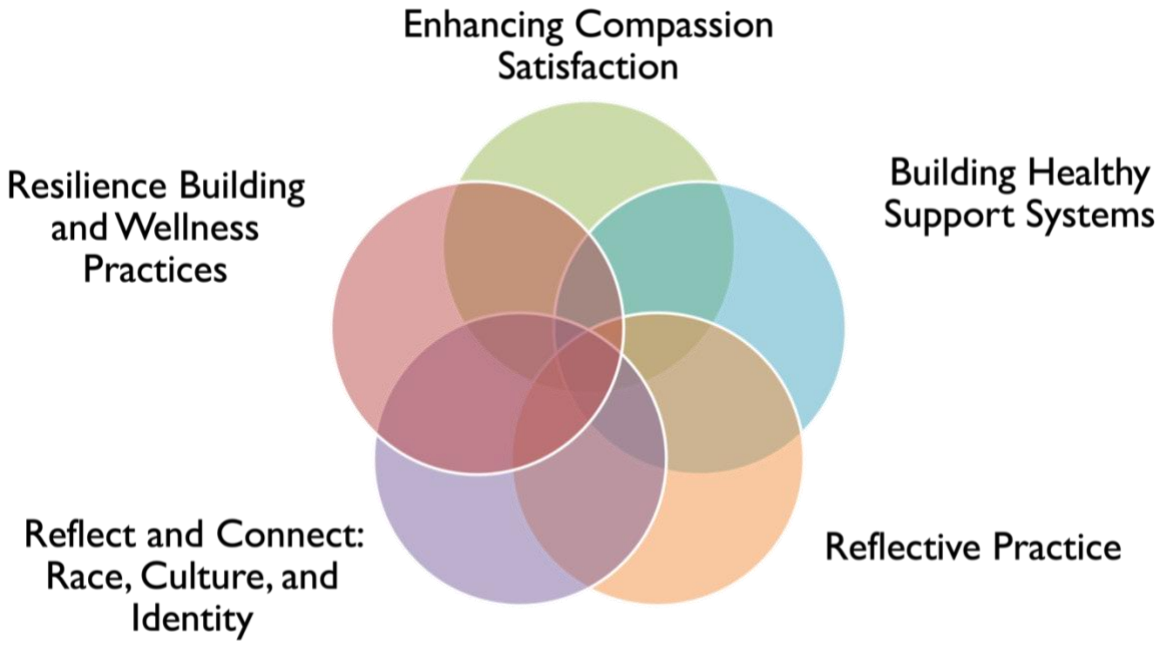
Thoughts?

What are some of the ethical considerations you identified?

For as a person and any role one might have examples

- **Start with ourselves** - Examine own biases, blind spots, behaviors, so on -- Even if you are experiencing insidious trauma, there might be areas you unknowingly contribute.
- **Include a lens of** "How might insidious trauma be a source/contributing source to what this individual is experiencing/exhibiting?" Also, the personal application.
- **Practice the best self-care we can** - Learn more about self-care, including ways to mitigate STS; Be more intentional; Reach out for help, as safe to do so.
- **Learn more about the issue**
- **Create awareness** – help others understand the issue, possible impacts, and things to do.
- **Advocate for change** – if possible, search for partners who are already doing advocacy work, and team up for greater impact.
    - Consider your role in where the field/profession is going.
- **Incorporate into the work you are already doing** – e.g., part of a group, such as parent, neighborhood, business, so on; or your part of a specific initiative, like trauma informed change, healthy workplace – risk/protective factors for STS.
- **Safety** - Think of insidious trauma's interplay with creating physical and psychological safety in Environment, Practice, and Policy – home, business, neighborhood, system, field of work, agency, role(s), so on
    - **Question** – What insidious trauma sources are present in our (fill in the blank)? What is the evidence based, based on?
    - **Role(s)** – presentations/trainings, administration, research, supervision, so on
    - **Set up** – location, hours, costs, languages, honoring distrust of systems – and system created biases against receiving services (fear of discrimination for services/dx)
    - **Accessibility** – physical set up, materials
    - **Pragmatics** – transportation, child-care
    - **Culture** – self-care, supportive, interactions with colleagues

Example of "Recommended strategies to mitigate STS" from NCTSN



Enhancing compassion satisfaction:

We all have bad days at work, but there are also moments that remind us why we do this work.

- Think about a rewarding moment at your job.
- What are 3 things that you love/enjoy about your job?
- Think about 5 people whose lives you've touched.
- Why did you take your current job?
- What are 3 compliments you have received from your co-workers, or 3 things you think you do well?

Building healthy support systems:

- Form or attend a process/consult group.
- Ask to take a walk and/or debrief with a co-worker.
- Leave a note of gratitude for a co-worker.
- Give a compliment or praise for a job well done.

- Share “moments of grace & goosebumps” with your team.
- Eat lunch together, go for a coffee/tea break, or bring snacks to a meeting.
- Tell a joke/funny story or show photos to a co-worker.

Reflective practice:

- What are your most salient signs and symptoms of work distress? When are you most likely to notice these come up, and when could you take stock on a regular basis?
- What client encounters or histories/stories tend to bring up strong emotions and reactions in you? How might this connect to your own history, family norms, or personal vulnerabilities? How might this influence or change your interactions with clients/situations that tend to activate these “hot or soft spots” for you? What has helped you to respond effectively in the past?
- What emotions tend to be most difficult for you to feel during the workday (with clients or co-workers)? How might this relate to the way emotions were handled in your own family of origin (e.g., which emotions were “allowed” or not) or from other key influences?

Reflective practice with co-workers, low-impact debriefing:

- Have conversations in private.
- Engage in Low-Impact Processing with co-workers when you feel stuck or ruminative.
    1. Self-Awareness
    2. Fair Warning
    3. Consent
    4. Limited Disclosure (avoid “**sliming**” your co-workers!)
- Refrain from one-upmanship when describing trauma or workplace stressor stories.

Reflect and Connect: Race, Culture, and Identity

Consider your own identities. How do your identities influence…

- …the way you see the world?
- …the way you see your work?
- …the way you understand the children and families with whom you work?

Check in with yourself…

- When you think about your work and your community, how do you feel?
- How do factors related to your identities contribute to your resilience and/or your experience of STS?
- Do you have someone to talk to about how you are feeling?

Connect with others to build mutual support around how your identities, cultures, race, and history may affect your responses to your work.

- Informal, supportive discussions with peers
- Regular peer processing groups
- Peer support and/or mentorship outside of your organization

Seek out and participate in traditional, cultural, and community healing, ceremonies, and supports.

Be honest and real about current injustices and challenges while also holding space for idealism, hope, and building change for future generations.

Clinical examples

Keep in mind: being aware of sources and impacts of insidious trauma, safety, possible healing

- **Intakes:** Are you incorporating anything about insidious trauma?
- **Screening and assessments:**
    - In general, are they appropriate for your client? Is how they are administered?
    - Are you incorporating anything about insidious trauma?
    - How do you respond to mistrust of diagnoses?
- **Diagnosing:** How might both sources and impact of insidious trauma impact diagnosing? Concerns with over, under, or mis diagnosing?
- **Treatment:**
    - TF-CBT example: TF-CBT and Racial Socialization Implementation Manual; TF-CBT IDD Implementation Guide and Supplemental Resource Guide; TF-CBT LGBTQ Implementation Manual; Culturally Modified-Trauma-Focused Cognitive Behavioral Therapy (CM-TFT) for Hispanic and Latino; Honoring Children, Mending the Circle: Cultural Adaptation of Trauma-Focused Cognitive-Behavioral Therapy for American Indian and Alaska Native Children
- **Documentation:** Are you including biases? What language are you using?
- **Resources for clients:** Such as handouts for their primary care or/and other providers

Plan

What is one thing you are going to do/thinking about doing - new, more, or differently?

Ideas for planning:

- List things you will do/try; what you might need to do it; when you'll do it (maybe set calendar goals); how you'll know if it works; PDSAs.
- List things you want to learn more about, where/who you can access to learn more about them, and when you'll do it.

Ethics: Based on your ethical source(s) and role(s), work on development/enhancement of plan for ethical considerations.

Planning space

Optional: self-processing or discussion group(s):

If you would like to self-process or discuss your reactions to any part of today, and how that ties to your ethical behaviors and decisions.

Before we end…:

The Monkey Business Illusion, Daniel J. Simons – YouTube
(https://www.youtube.com/watch?v=IGQmdoK_ZfY)

What are we missing with insidious trauma?

- Blind spots for what is known?
- What are some sources of insidious trauma, “we” might not recognize yet?

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Appendix A: Ethical considerations/principles/values

AAMFT

Aspirational Core Values: The following core values speak generally to the membership of AAMFT as a professional association, yet they also inform all the varieties of practice and service in which marriage and family therapists engage. These core values are aspirational in nature, and are distinct from ethical standards. These values are intended to provide an aspirational framework within which marriage and family therapists may pursue the highest goals of practice.

The core values of AAMFT embody:

1. Acceptance, appreciation, and inclusion of a diverse membership.
2. Distinctiveness and excellence in training of marriage and family therapists and those desiring to advance their skills, knowledge and expertise in systemic and relational therapies.
3. Responsiveness and excellence in service to members.
4. Diversity, equity and excellence in clinical practice, research, education and administration.
5. Integrity evidenced by a high threshold of ethical and honest behavior within Association governance and by members.
6. Innovation and the advancement of knowledge of systemic and relational therapies.

ACA

Professional values are an important way of living out an ethical commitment. The following are core professional values of the counseling profession:

- enhancing human development throughout the lifespan;
- honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts;
- promoting social justice;
- safeguarding the integrity of the counselor–client relationship; and practicing in a competent and ethical manner.

These professional values provide a conceptual basis for the ethical principles enumerated below. These principles are the foundation for ethical behavior and decision making. The fundamental principles of professional ethical behavior are

- *autonomy*, or fostering the right to control the direction of one's life;
- *nonmaleficence*, or avoiding actions that cause harm;
- *beneficence*, or working for the good of the individual and society by promoting mental health and well-being;
- *justice*, or treating individuals equitably and fostering fairness and equality;
- *fidelity*, or honoring commitments and keeping promises, including fulfilling one's responsibilities of trust in professional relationships; and
- *veracity*, or dealing truthfully with individuals with whom counselors come into professional contact.

AMA-APA

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Section 1 - A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

Section 2 - A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

Section 3 - A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

Section 4 - A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

Section 5 - A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health

Section 6 - A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

Section 7 - A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

Section 8 - A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

Section 9 - A physician shall support access to medical care for all people. professionals when indicated.

APA

General Principles: This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

Principle A: Beneficence and Nonmaleficence Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their

influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Principle B: Fidelity and Responsibility Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

Principle E: Respect for People's Rights and Dignity Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making.

Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices

NAADAC/NCC-AP

In addition to identifying specific ethical standards, NAADAC shall recommend consideration of the following when making ethical decisions:

1. Autonomy: To allow each person the freedom to choose their own destiny.
2. Obedience: The responsibility to observe and obey legal and ethical directives.
3. Conscientious Refusal: The responsibility to refuse to carry out directives that are illegal and/or unethical.
4. Beneficence: To help others.
5. Gratitude: To pass along the good that we receive to others.
6. Competence: To possess the necessary skills and knowledge to treat the clientele in a chosen discipline and to remain current with treatment modalities, theories and techniques.
7. Justice: Fair and equal treatment, to treat others in a just and fair manner.
8. Stewardship: To use available resources in a judicious and conscientious manner; to give back.
9. Honesty and Candor: To tell the truth in all dealing with clients, colleagues, business associates and the community.
10. Fidelity: To be true to your word, keeping promises and commitments
11. Loyalty: The responsibility to not abandon those with whom you work
12. Diligence: To work hard in the chosen profession, to be mindful, careful and thorough in the services delivered
13. Discretion: Use of good judgment, honoring confidentiality and the privacy of others

14. Self-improvement: To work on professional and personal growth to be the best you can be
15. Non-malfeasance: Do no harm to the interests of the client
16. Restitution: When necessary, make amends to those who have been harmed or injured
17. Self-interest: To protect yourself and your personal interests.

NACP/NOVA

Victims of crime and the criminal justice system expect every paid or volunteer Victim Assistance Provider to act with integrity, to treat all victims and survivors of crime–their clients–with dignity and compassion in an inclusive, equitable, anti-racist and accessible manner, and to uphold principles of justice for accused and accuser alike. To these ends, this Code will govern the conduct of Victim Assistance Providers:

NASW

Ethical Principles: The following broad ethical principles are based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These principles set forth ideals to which all social workers should aspire.

Value: Service **Ethical Principle:** Social workers' primary goal is to help people in need and to address social problems. - Social workers elevate service to others above self-interest. Social workers draw on their knowledge, values, and skills to help people in need and to address social problems. Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service).

Value: Social Justice **Ethical Principle:** Social workers challenge social injustice. - Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities

seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

Value: Dignity and Worth of the Person **Ethical Principle:** Social workers respect the inherent dignity and worth of the person. - Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

Value: Importance of Human Relationships **Ethical Principle:** Social workers recognize the central importance of human relationships. - Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities.

Value: Integrity **Ethical Principle:** Social workers behave in a trustworthy manner. - Social workers are continually aware of the profession's mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers should take measures to care for themselves professionally and personally. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.

Value: Competence **Ethical Principle:** Social workers practice within their areas of competence and develop and enhance their professional expertise. - Social workers continually strive to

increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

Last paragraph of Purpose: Professional self-care is paramount for competent and ethical social work practice. Professional demands, challenging workplace climates, and exposure to trauma warrant that social workers maintain personal and professional health, safety, and integrity. Social work organizations, agencies, and educational institutions are encouraged to promote organizational policies, practices, and materials to support social workers' self-care.

Appendix B: Sources for self-care and secondary traumatic stress

CalTrin (California Training Institute) (https://www.caltrin.org/)

- **CalTrin Self-Paced Courses**
  - Understanding Compassion Fatigue and Secondary Traumatic Stress
  - Strategies for Addressing Compassion Fatigue and Secondary Traumatic Stress
- **CalTrin Training Archive**
  - Secondary Traumatic Stress and Reflective Practice/Supervision
  - Trauma, Compassion Fatigue & Secondary Traumatic Stress
  - Organizational Strategies: Addressing Compassion Fatigue & Secondary Traumatic Stress

Secondary Traumatic Stress Consortium – free resources
(https://www.stsconsortium.com/free-resources)

Secondary Traumatic Stress: Understanding the impact on professionals in trauma exposed workplaces - NCTSN Learning Center (https://learn.nctsn.org/)

Southern Regional Children's Advocacy Center – Secondary Traumatic Stress Resources
(https://www.srcac.org/reflect-refuel-reset/)

University of Kentucky Center on Trauma and Children's Secondary Traumatic Stress Innovations and Solutions Center (https://ctac.uky.edu/projects-and-programs/secondary-traumatic-stress-innovations-and-solutions-center-sts-isc)

- Staying Inside the Window of Tolerance: An Advanced Training on Secondary Traumatic Stress and Resiliency

Using the Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision - NCTSN (https://www.nctsn.org/resources/using-secondary-traumatic-stress-core-competencies-trauma-informed-supervision)

Virtual Calming Room - Sacramento City Unified School District (https://calmingroom.scusd.edu/): Has strategies and tools for students, families, and staff.

NOTE: Some things to consider when using hotlines or mental health/wellness apps/online services.

- How do they protect my privacy? Are there steps I can take to protect my privacy?
- Are they ethical in their practices?
- What is the benefit/cost/risk of using them?

Appendix C: Sources for trauma-informed approaches

Physical and psychological safety in Environment, Practice, and Policy

Trauma-Informed Approaches

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach 2014 (https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884) This manual introduces a concept of trauma and offers a framework for becoming a trauma-informed organization, system, or service sector. The manual provides a definition of trauma and a trauma-informed approach, and offers 6 key principles and 10 implementation domains.

SAMHSA's Practical Guide for Implementing a Trauma-Informed Approach 2023 (https://www.samhsa.gov/resource/ebp/practical-guide-implementing-trauma-informed-approach) This practical guide updates and expands the discussion presented in SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach Resource from 2014. The primary goal of this guide is to provide implementation strategies across multiple domains based on the original publication.

Considerations

Older Adults' Equity Collaborative's *Equity Assessment Checklist* (https://resourcelibraryadmin.nyam.org/resource-library/oaec-equity-checklist/)
This equity self-assessment aims to help agencies determine how effectively they are supporting communities of greatest social need (GSN). It also aims to aid in identifying areas of growth. To get started, mark the boxes next to the actions your agency or team is taking to be more inclusive to this range of service recipients. Please note that this is not an all-encompassing list of items necessary to serve GSN clients in your communities. Communities of Greatest Social Need (GSN) include: Black; Latino; Indigenous and Native American; Asian American and Pacific Islander; other persons of color; members of religious

minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; and persons who live in rural areas.

SAMHSA TIP 59: Improving Cultural Competence (https://www.samhsa.gov/resource/ebp/tip-59-improving-cultural-competence)

United Spinal Association's Disability Etiquette, Tips On Interacting With People With Disabilities (https://www.unitedspinal.org/pdf/DisabilityEtiquette.pdf)

Grid and questions from other trainings

	Physical Safety	Psychological Safety
Environment		
Practice		
Policy		

- Things we are already doing well
- Things we know we could do/try differently
- Things we want to think/talk/ask/learn more about

Appendix D: Sources for clinical

Being Informed, Screening, Assessment, and Treatment

The following has a mix for being informed, screening, assessment, or/and treatment.

Anthropology in the clinic: the problem of cultural competency and how to fix it. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1621088/) This approach isn't always appropriate, it's just one to be aware of if needed.

APA *Guidelines for Assessment and Intervention with Persons with Disabilities* (https://www.apa.org/pi/disability/resources/assessment-disabilities).

Improving Cultural Competency for Behavioral Health Professionals – HHS course (https://thinkculturalhealth.hhs.gov/education/behavioral-health) "Learn how to better respect and respond to your client's unique needs in this free, online training." Has free CEs.

Mental Health, Trauma, and Disability – Children/Youth: Three documents to supports a child or youth with a developmental delay or/and a disability who has experienced trauma. These documents are for caregivers, mental health providers, and others. Gwendolyn Downing.

Intakes

Polyvictimization Assessment Tool and Resource Guidebook

This is a **non-diagnostic** tool that was created through the Office for Victims of Crime. It is available in English, Spanish, Russian, and gender-neutral versions. The below resources and more are available from the Family Justice Center Alliance (https://www.familyjusticecenter.org/)

- Polyvictimization Assessment Tool – English Version: The Polyvictimization Assessment Tool (Assessment Tool) was developed to examine a survivor's entire life experience of trauma and victimization, from childhood to adulthood. The Assessment Tool covers 27 events and

18 sections, each broken down into three categories (Child and Teen, Adult, In the Last Year). The symptoms category allows staff to triage current symptoms and allows for a deep historical understanding of when these symptoms developed and how long they have been present in the survivor's life.

- Polyvictimization Assessment Tool Resource Guidebook: Created by the Alliance, under the Creating Pathways to Justice, Hope, and Healing Polyvictimization Demonstration Initiative, this Guidebook is designed as a 'how-to' for frontline staff implementing the Polyvictimization Assessment Tool. This Guidebook is a reference for staff and Centers before they ever utilize the Tool with a survivor. This Guidebook also contains an appendix of resources by national experts on the categories of trauma and symptomology as well as the Polyvictimization Assessment Tool in English, Spanish, and Russian.

Screening and assessments

Oklahoma TF-CBT Resources & Information for Working with Diverse Populations (https://oklahomatfcbt.org/resources-information-for-working-with-diverse-populations/)

- Assessing PTSD in Racial Ethnic Minorities

Treatment

SPARCS

Structured Psychotherapy for Adolescents Responding to Chronic Stress https://www.nctsn.org/interventions/structured-psychotherapy-adolescents-responding-chronic-stress

TF-CBT

Trauma-Focused Cognitive Behavioral Therapy National Therapist Certification Program (https://tfcbt.org/)

- TF-CBT and Racial Socialization
- TF-CBT IDD Implementation Guide
    - Supplemental Resource Guide
- TF-CBT LGBTQ Implementation Manual

Culturally Modified-Trauma-Focused Cognitive Behavioral Therapy (CM-TFT) for Hispanic and Latino

- NCTSN CMTFT fact sheet
- NCTSN CMTFT culture specific fact sheet

Honoring Children, Mending the Circle: Cultural Adaptation of Trauma-Focused Cognitive-Behavioral Therapy for American Indian and Alaska Native Children

Oklahoma TF-CBT Resources & Information for Working with Diverse Populations (https://oklahomatfcbt.org/resources-information-for-working-with-diverse-populations/)

- Adapting TF-CBT for American Indian and Alaska Native Children
- Adapting an Evidence Based Child Trauma Treatment for American Indian and Alaska Native Populations
- Webinar – Enhancing Healing Through the Incorporation of Familial Culture and Spirituality in TF-CBT
- Assessing PTSD in Racial Ethnic Minorities

Appendix E: Additional sources

This page is in development.

Appendix: F Medical – Mental Health - Psychology

Medical – Mental Health – Psychology: A rough select timeline

Patient Care	
Beginning of the Hippocratic oath - multiple contributors	5th century BCE
Mental Hygiene to Mental Health	
The term "mental hygiene" first used	1843
Clifford Beers' book Founding meeting of the National Committee for Mental Hygiene	1908
First International Congress on Mental Hygiene	1933
Roughly official change to "mental health" 1946 - The International Health Conference decides to establish the World Health Organization (WHO); A Mental Health Association is founded in London 1948 – The WHO established; The first International Congress on Mental Health	1946 -1948
National Institute of Mental Health established	1946-1949
While there were prior orgs, SAMHSA established	1992
Field of Psychology	
Arguable. First experimental theory in Germany, 1854. First labs began in Germany and the US 1875-1879.	1854-1879

Organization	**Year founded**	**Year 1st ethics**
American Psychiatric Association	1844	1973
American Medical Association	1847	1847
American Psychological Association	1892	1952/53
American Personnel and Guidance Association (ACA)	1952	1961
American Bar Association	1878	1908
WMA -Declaration/International Code of Medical Ethics	1947	1948/1949
World Psychiatric Association – Declaration of Hawaii	1950	1977
Ethics regarding research and human subjects		
WMA - Declaration of Helsinki, human subjects	1947	1964
Nuremberg Code in 1948; Guidelines for Human Experimentation of 1931; Berlin code of 1900.	(Ghooi, et al, 2011)	1900-1948
National Research Act – Belmont Report		1974 -1979

Reminder: Having an ethical code, didn't/doesn't mean there were/are enforceable standards.

Appendix G: Gwen's TIDAL facilitation lens ©2024 - synopsis

Overview

To facilitate, loosely, is to bring something about, and do so as smoothly and effectively as possible. And whatever I'm doing, from beginning to end, I want to have a TIDAL facilitation lens:

- Trauma-informed
- Insidious trauma sources
- Diversity – Individuality
- Accessibility
- Life

Things I might facilitate

Parts of life. Meeting, presentation, training, moderating, consulting, materials, so on.

What I want to keep in mind as I plan, prepare, do, and follow-up

- **Trauma-informed:** Trauma-informed approaches for creating physical and psychological safety.
- **Insidious trauma sources[(1)]:** How the sources may/do impact my facilitation, and what I can do/try.
- **Diversity-individuality:** One person or a multitude, there is all the possible diversity. And even in groups that have a fairly congruent culture, there is still individuality.
- **Accessibility:** The CDC's prevalence estimate is 1 in 4 adults have some kind of disability[(2)], the broader applicability, and accessibility considerations and practices.
- **Life:** There are the typical daily components of our lives that need to be considered, and that "life happens".

Why is the TIDAL lens important?

I start with values, such as outcomes, quality, connection; and then as applicable, standards, such as best practice, policies, 508.

I hope this inspires thoughts and dialogue - Possible next steps

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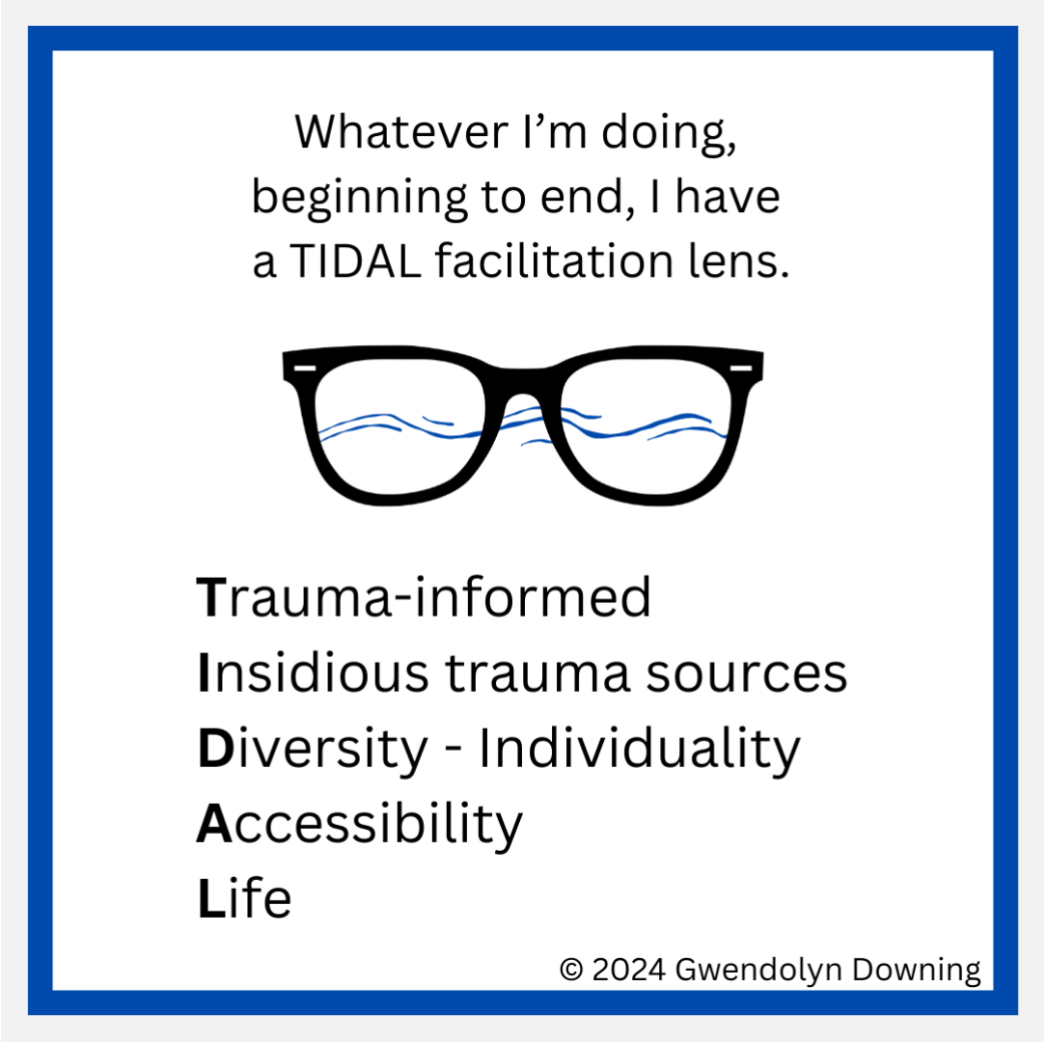

1- Insidious trauma Is the daily incidents of marginalization, objectification, dehumanization, intimidation, et cetera that are experienced by members of groups targeted by racism, heterosexism, ageism, ableism, sexism, and other forms of oppression, and groups impacted by poverty (VAWnet).

2- Use of the word "Disability" I understand the issues regarding the word "disability" for some ways it is used. I use it now and other times, as it is expedient.