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# The Trauma-Informed Ethical Decision-Making Model: An Integrative Framework

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**ABSTRACT**

The prevalence of Adverse Childhood Experiences, and recent increase in stress during the COVID-19 crisis necessitates the practice of trauma-informed care in counseling. When addressing ethical concerns that emerge during counseling, attention to the principles of trauma-informed care is of critical importance. The purpose of this conceptual piece is to propose a Trauma-informed Ethical Decision-making Model that integrates trauma-informed standards (SAMHSA, 2014), with the proposed Principles of Trauma-informed Practice, and Kitchener and Anderson's (2011) ethical decision-making model. In addition to a full explanation of the model, an example of this framework in action is provided through the case analysis of client Adam. This Trauma-informed Ethical Decision-making Model provides counselors, particularly counselors-in-training, with a framework for addressing ethical concerns with client survivors of trauma. The framework may also provide counselor educators with a framework to support the development of curriculum regarding trauma-informed practice and ethical decision-making.

**Keywords:** Trauma-Informed, Ethics, Ethical Decision-Making, Decision Making, Counselor Education, Trauma, Stress

Trauma is a public health issue with both individual and systemic impact. Exposure to traumatic events in childhood is correlated with adverse physical and psychological health consequences across the lifespan (Felitti & Anda, 2010; Foege, 1998); exposure to 4 or more categories of Adverse Childhood Experiences (ACE) is correlated with a decreased life expectancy of approximately 20 years (Brown et al., 2009; Felitti et al., 1998). A large-scale study (n=9,508) exploring adults' adverse experiences in childhood determined that more than 50% of adults had experienced at least one ACE (Felitti et al., 1998). The initial ACEs study defined adverse events as including sexual, psychological, and physical abuse, having members of the household who experience substance use, mental health concerns, suicidal ideation, or incarceration (Felitti et al., 1998). More recent iterations of the ACE study determined that approximately 64% of adults had experienced at least one significant adverse event during childhood. Of these participants, 26% had one ACE, 16% had two ACEs, 9.5% had three, and 12.5% had four or more ACEs (Centers for Disease Control, 2016). The relationship between ACEs and negative psychological effects is dose-dependent (Herzog & Schmahl, 2018), with persons with higher ACEs scores (multiple types of adverse experiences in childhood) more likely to experience depression (Tsehay et al., 2020), Post Traumatic Stress Disorder-PTSD (Green et al. 2010), Substance Use Disorders (Choi et al., 2017; Wade et al., 2016), and Borderline Personality Disorder (Lieb et al., 2004; Widom et al., 2009).

Understanding the prevalence of ACEs, and relationship between ACEs and the development of trauma-related disorders, informs our understanding of the incidence of PTSD among the general population. In 2005 the National Comorbidity Study Replication (n=9,282) determined that in the United States, 9.7% of women, and 5.2% of men developed PTSD over the course of their lifetime. The prevalence of PTSD has increased significantly since the start of the COVID-19 pandemic. Panel surveys administered in the United States in June of 2020 (n=5,412) determined that 26.3% of respondents reported symptoms associated with post-traumatic stress, and 13.3% indicated that they had increased their use of substances to cope with stressors associated with the COVID-19 crisis (Czeisler et al., 2020). The unique stressors associated with the ongoing health crisis include social and physical isolation, and grief and loss associated with loss of work and economic resources, and cherished habits and routines (Tucker & Czapla, 2021). Healthcare workers have experienced particularly high rates of behavioral health symptoms, with an estimated 7.4 to 35% of healthcare workers experiencing traumatic stress-related symptoms attributed to the COVID-19 crisis (Benfante et al., 2020), and increased symptoms of anxiety and depression (Pappa et al., 2020). Families with children have experienced additional stress associated with supporting youth who are engaging in learning and school activities remotely (Bansal et al., 2020).

The prevalence of early trauma-exposure and negative health outcomes associated with the trauma-response ensure that helping professionals will interface with these individuals over the course of their professional practice. When working with survivors of multiple adverse experiences, mental health counselors are often faced with unique ethical concerns. For example, individuals who have experienced

significant trauma and develop PTSD symptoms are more likely to engage in aggressive behavior than those who have experienced trauma and not developed symptoms of PTSD (Lasko et al., 1994; Tull et al., 2007). Although there is a relationship between PTSD and aggressive behavior, the majority of persons who experience PTSD symptoms are not at risk of engaging in aggressive behavior; the likelihood of engaging in aggressive behavior is associated with multiple intersecting risk factors (e.g., severe hyperarousal, trait physical aggression, and severe substance use) (Barrett et al., 2014). The relationship between PTSD and aggressive behavior has been attributed to difficulties with emotional regulation, and avoidance of internal experiences and emotions (Tull et al., 2007). Furthermore, clients with PTSD experience neurobiological changes, with altered activation in the anterior cingulate cortex (ACC), amygdala, and medial prefrontal cortex (mPFC). These changes in activation have been associated with decreased cognitive control and executive function, difficulty minimizing fear and regulating emotions, and inability to successfully process and store traumatic memory (Ousdal et al., 2018; Yao & Hsieh, 2019). When confronted with particularly difficult emotions or trauma-related triggers, clients with PTSD may present to session with concerns that challenge the clinician's ethical decision-making process.

At this time, the Council for Accreditation of Counseling and Related Education Programs (CACREP) accredited counselor education programs provide training in trauma-informed care, and ethical principles, practice, and decision-making models (CACREP, 2015). Despite this emphasis, the intersection between trauma-informed care and ethical decision-making remains relatively unexplored. The current focus in trauma education for counselors emphasizes the negative effects of trauma, and the need for a trauma informed approach to behavioral health treatment (Chatters & Liu, 2020). At this time, the role of a trauma-informed understanding of client behavior when confronted with an ethical dilemma is not well elucidated.

The purpose of this conceptual piece is to introduce a trauma-informed ethical decision-making framework that integrates the trauma-informed standards of care (SAMHSA, 2014), with the authors proposed Principles of Trauma-informed Practice, and Kitchener and Anderson's (2011) organized ethical decision-making model. The proposed Principles of Trauma-informed Practice are informed by key concepts articulated in the literature regarding attachment theory, neurobiology of trauma response, intergenerational trauma, minority stress, and the impact of trauma on cognitive schema, community, and the clinician. These principles and ethical decision-model are then integrated and applied to the case of client "Adam".

The proposed trauma-informed ethical decision-making model is a necessary advancement, as it provides behavioral health providers with a framework that addresses the unique ethical implications associated with working with survivors of trauma. Counselor educators may utilize this trauma-informed ethical decision-making framework to inform the development of curriculum or educate counselors-in-training (CIT) in the inclusion of a trauma-informed perspective when engaging in ethical decision making. Using this framework to develop counselor training curriculum honors the lasting impacts of trauma experienced during infancy and childhood; this emphasis ensures applicability for all counselors and CITs, to

include school counselors, clinical mental health counselors, substance use counselors, and rehabilitation counselors. This integrative framework attends to general factors that may contribute to a counselor or CIT's decision-making process when working with survivors of trauma and allows space for the assimilation of this model with all counseling approaches and modalities.

## PROPOSED INTEGRATIVE CONCEPTUAL FRAMEWORK

The ages and stages of development during which trauma is experienced impacts how and where in the body trauma is stored, thus the criteria for what constitutes "trauma" is an evolving concept (van der Kolk, 1994). Practitioners may refer to the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) for understanding how PTSD may manifest for children under age 5, to include unique outward or internalized behaviors and beliefs. Children and adolescents also present with different types of experiences and thus require methods that are specific to their developmental needs. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) describes a trauma-informed approach appropriate for clients across the lifespan. According to this approach, trauma consists of the "three E's": Events that include perceived threat of death to self or others, how the individual Experiences or makes meaning of the event, and the Effects the event has on the individual. When employing a trauma-informed approach, the helping professional attends to interplay between the Events the client survived, the client's understanding of their Experience, and the short and long-term Effects of exposure to adversity (SAMHSA, 2014).

Building upon the concept of trauma, trauma-informed practitioners attend to the "four R's", or key assumptions about the impact of trauma. The "four R's" include Realization that the need to survive may significantly impact how an individual navigates the world and copes with difficult experiences, emotions, thoughts, and physiological processes. The second R references trauma-informed clinicians need to Recognize the symptoms and signs of post trauma response, such as hypervigilance, hyperarousal, difficulty regulating emotions, and impaired decision-making process. The third R is the clinician or treatment agency's Response to the needs and experiences of trauma survivors, from agency policies to the language and behaviors of clinicians. The final R refers to the need for clinicians and agencies to "resist Re-traumatization of clients" (SAMHSA, 2014, p. 14). Counselors who aim to avoid Re-traumatizing clients are aware that certain behaviors and ways of interacting with clients may remind or trigger memories of adverse experiences, and thus actively work to adapt their practices to ensure client emotional and psychological safety in all spaces and clinical situations (SAMHSA, 2014).

Once a clinician understands the three E's as they apply to their clientele and attends to the four R's in their clinical practice, they have established the foundation necessary to employ the six key principles of trauma-informed care. These six principles guide client treatment at the systems and individual level, with clinicians attending to (SAMHSA, 2014):

1. **Safety:** Clients feel safe in the physical space, and experience psychological and emotional safety in all interactions with the clinician and agency staff.
2. **Trustworthiness and transparency:** Maintaining trustworthiness with clients is essential; clinicians and agency staff ensure transparency with all decision-making.
3. **Peer support:** Clinicians aim to incorporate support of other trauma survivors – or peers – in the clients' treatment process as a means of supporting healing and recovery.
4. **Collaboration and mutuality:** Counselors cultivate a collaborative partnership with clients, providing consultation rather than expert advice.
5. **Empowerment, voice and choice**: Counselors understand that a key characteristic of trauma is disempowerment, and thus work to increase client and community empowerment in treatment. Counselors elicit client motivation for change, and ensure that the clients' goals and desires guide treatment.
6. **Cultural, historical, and gender issues:** The clinician and agency actively work to identify and alter processes and practices that reinforce racist, ableist, homophobic, transphobic, xenophobic, and other harmful biases. Trauma-informed helpers and organizations engage in reflective practice, adapting processes to work towards meeting the needs of all communities.

These principles provide counselors with specific areas of attention to ensure that their clinical practice meets the needs of clients who have experienced adversity. In order to create a bridge between the SAMHSA (2014) 6 principles of trauma-informed care and the proposed trauma-informed ethical decision-making model, the authors propose specific principles of trauma-informed ethical practice. Figure 1 [available in separate document] illustrates the developmental trajectory of the proposed principles of trauma-informed ethical practice, and trauma-informed ethical decision-making model. The illustration also shows the role of each component of SAMSHA's (2014) trauma-informed care model.

**Principles of Trauma-informed Ethical Practice**

Counselors practicing trauma-informed ethical decision-making utilize their knowledge of individuals' response to trauma to inform how they interpret and understand the client's behavior, thought process, ability to relate and attune with others, and emotional experience. This understanding informs every step of the ethical decision-making process. The proposed principles outlined below build upon the SAMHSA (2014) three E's, four R's, and 6 key principles of trauma-informed care. Key concepts, to include ACEs and their long-term impact (Anda, 2007; Felitti et al., 1998; Felitti, 2009; Wade et al., 2016) further inform the principles of trauma-informed ethical practice. Counselors employing the principles of trauma-informed ethical practice engage in the following:

***Attachment and Developmental Considerations***

Recognize that reminders of attachment wounds may shift the client's perspective such that they view the world from the lens of a much younger version of themselves; that they may return to a cognitive space where certain developmental tasks remain unmastered (Pearlman & Courtois, 2005). Client survivors may also relate and attune to social contacts and significant others differently due to attachment wounds.

***Physiological and Neurobiological Changes***

Understand that clients may find themselves experiencing significant physiological changes associated with fight, flight, freeze (Levine, 1997; 2010), cling (Herbert, 1996), or fawn response (Walker, 2013). Clients may also experience compromised inhibitory control due to alterations in activation in the amygdala, ACC, and hippocampus (Yao & Hsieh, 2019).

***Intergenerational and Historical Trauma***

Acknowledge the role of intergenerational, historical, and institutional trauma in clients' worldview, and persistent belief that the world is a dangerous place, and that others cannot be trusted (Herman, 2015; Janoff-Bulman, 1985).

***Minority Stress***

Minority stress plays a significant role in clients' psychological processes, behavioral health, and physical health (Keuroghlian, 2018). The adverse impact of microaggressions, racism and ethnoviolence, homophobia, xenophobia, transphobia, and all forms of violence and hate perpetrated against persons of minority groups (Helms et al., 2010; Tigert, 2009) must be considered as part of a client's experience as relates to an ethical dilemma.

***Cognitive Schema***

Understand the role of cognitive schema in clients' pattern of avoidance of trauma-related cues, and how this pattern of behavior may impact their PTSD symptoms (Resick et al., 2017).

***Self-Concept***

Acknowledge the degradation of clients' self-concept and self-worth that may occur during certain abuse and adverse experiences (i.e., the "grooming" process involved in ongoing sexual abuse and assault), and the role of these experiences in clients' beliefs that they are incompetent and unworthy (Herman, 2015; Janoff-Bulman, 1985). Self-concept may also improve and expand, with clients experiencing positive changes as a result of exposure to adversity, to include

improvements in: "personal strength, relating to others, new possibilities in life, appreciation of life, and spirituality" (Calhoun & Tedeschi, 2012, p. 7).

### *Protective Behaviors*

Recognize clients' protective behaviors and thought processes, such as minimizing the impact of their trauma by believing that "others have it worse", or denying the existence of adverse experiences in childhood (Bernstein & Fink, 1998; Church et al., 2017). Protective behaviors may overlap with avoidance behaviors, as described in DSM-5 diagnostic criteria for PTSD (American Psychiatric Association, 2013).

### *Family and Community*

Acknowledge the varied role of family systems in perpetuating cycles of abuse and exposure to adversity, as well providing safe havens of love, support, and community for those healing from traumatic experiences (Figley & Kiser, 2013). This principle may overlap with aspects of the principle "Intergenerational Trauma and Historical Trauma".

### *Clinician Health and Wellbeing*

Recognize the impact of working with survivors of trauma and adversity on clinicians' health and wellbeing (van Dernoot Lipsky, 2009), and work to increase our awareness of vicarious trauma (McCann & Pearlman, 1990), compassion fatigue (Figley, 1995), and burnout (Lee & Ashworth, 1996) in ourselves and our colleagues. Adequate attention to one's own health and wellbeing, and active engagement in reflective practice (Laurieu & Dickson, 2009) is essential when engaging in trauma reprocessing with clients.

The preceding descriptions for each of the Principles of Trauma-informed Ethical Practice merely scratch the surface of the wealth of information available. A full review of the literature for each principle is beyond the scope of this conceptual piece. Counselor educators are encouraged to utilize these principles as a framework to inform the development of curriculum. In the text that follows, the case of Adam is described. Using Kitchener's (2011) model to structure the process, the proposed principles of trauma-informed ethical decision-making are applied to the case of Adam, an individual whose disclosures in session challenge the counselor and/or CIT to consider the ethical implications of their course of action.

## APPLICATION TO THE CASE OF ADAM

Adam is a 39-year-old Hispanic cisgender male who reports a significant trauma history that includes childhood sexual abuse, extreme poverty, and experiences of neglect and abuse. He has an ACE score of 10, has been diagnosed with Post Traumatic Stress Disorder (PTSD), and reports current distress associated with persistent symptoms. Adam reports belonging to a prominent gang in the Southwest

United States since the age of 12; he says that he is currently "not really active" in the gang, as he is "focusing on raising my foster kids". Adam has been seeing a counselor named Alice for outpatient counseling services for about 6 months at a community-based counseling agency, with his treatment focusing on trauma processing and managing difficult emotions associated with trauma triggers.

One session, Adam informs Alice that he has been "hiding guns and riffles and extra ammunition in the ceiling of my shop". He states that he started "saving things up" after he was awarded guardianship of his cousin's 5 children, because "I'm just so angry…and I don't know when I might need to protect them". Adam mentions that "it's hard not to go end his [the cousin's boyfriend] life…he touched [molested] those kids…I know it". Adam states that he has been acquiring and hiding firearms and ammunition since the foster children were placed under his and his spouse's care. He shares that the feelings of anger and rage "that I had so much when I was a kid" had decreased over the last two decades, but it seemed to return once the children were in his care.

During a previous session, Alice and Adam had completed a safety plan that included discussing violent thoughts with his spouse, as she is one of his primary supports. Alice asks whether Adam would like to contact his spouse in session to discuss these difficult thoughts and emotions. Adam elects to contact his spouse in session, and discloses his anger, and fantasies of harming/killing his cousin's boyfriend. While talking to his spouse, Adam does not share about his access to firearms and ammunition. The session ends with Adam indicating that he is "feeling less angry", and Adam and his spouse agreeing to implement Adam's safety plan over the next week. Following session, Alice feels unsure about what her next steps may be.

## Application of the Trauma-Informed Ethical Decision-Making Model

The following case analysis utilizes Kitchener's (2011) ethical decision-making model to structure the process of selecting a course of action. The proposed principles of trauma-informed ethical decision-making provide a lens through which to view the client's thoughts, emotions, behaviors, and ability to relate to and connect with others. The proposed principles of trauma-informed ethical decision-making elucidated above are integrated with SAMHSA's (2014) principles of trauma-informed care. The integration of these concepts and principles provides a lens through which to view the ethical decision-making process, as well as a series of critical considerations to guide the selection of a course of action. Table 1 [available in a separate document] outlines the integration of the decision-making model, and trauma-informed principles. The case analysis outlined below provides an example of the application of this trauma-informed ethical decision-making model to the case of "Adam", a client presenting to counseling with homicidal ideation.

### *Step 1: Pause and think about your response (Kitchener & Anderson, 2011)*

The first step in Kitchener's (2011) ethical decision-making model is for the counselor to pause and consider their response to the situation. In the case of Adam, the ethical dilemma posed is counselor Alice's next steps in addressing Adam's reported homicidal ideation. The clinician's initial response may include concern or shock regarding the client's disclosure of violent fantasies, and steps taken to prepare for perpetrating violence. The first step of this process is for the counselor to consider their internal experience in session, and how this may impact their interpretation of the client's disclosure. The trauma-informed principle addressed is "clinician health and wellbeing".

When attending to this principle the counselor pauses and engages in reflective practice (Laurieu & Dickson, 2009), considering their choices regarding interventions and behaviors in session, and how these choices and behaviors are influenced by their perceptions and internal experience. Confronted with Adam's disclosure of violent fantasies, the counselor may experience their own trauma response, defined by van Dernoot Lipsky (2009) as "when external trauma becomes internal reality" (p. 42). Pausing and noticing one's internal experience in session and throughout the decision-making process ensures that the counselor is taking into account how their own experience may impact their perceptions and choices. During this initial step, and each step of the trauma-informed ethical decision-making process, counselors are strongly encouraged to seek supervision and/or consult with colleagues.

***Step 2: Review the available information (Kitchener & Anderson, 2011)***

The second step of Kitchener's (2011) model includes a thorough review of all available information. In the case of Adam, his extensive trauma history, and current symptoms of PTSD warrant attention to the principle "physiological and neurobiological changes". Adam describes his feelings of rage and anger as increasing significantly after his cousin's children were placed in his care. This information, along with Adam's PTSD diagnosis and ACES score, imply that Adam's body may be experiencing the cascade of neurobiological substances needed to prepare the body to fight a perceived threat (with the threat identified as Adam's cousin's boyfriend). The changes in the body and brain that prepare Adam to fight the perceived threat also impair the functionality of his prefrontal cortex, thus decreasing inhibitory control (Yao & Hsieh, 2019). Considering the relationship between Adam's physiological experience, and psychological processes ensures that the counselor views Adam's behaviors within the greater context of the trauma response.

This step also requires attention to "attachment and developmental considerations", "minority stress", "cognitive schema", and "self-concept". A full review of Adam's biopsychosocial intake assessment and trauma history will provide essential insight about the relationship between Adam's anger, rage, and violent fantasies, and his own trauma history. Further exploration of Adam's relationship to key attachment figures, and age at which key traumatic incidents occurred (and duration and severity of neglect), may provide important information about his developmental trajectory (e.g., developmental tasks that were not

mastered, such as ability to self soothe and regulate difficult emotions). Adam's experience as a Hispanic male of low Socio-Economic Status has included frequent microaggressions perpetrated by community members. For example, during a previous session (not listed in the initial case study) Adam reports noticing that a person locked their car doors when he walks by, and that someone at the local grocery store asked why his complexion was different from that of his foster children.

When exploring all of the information available (step 2), it is essential that the counselor consider the impact of these experiences on Adam's cognitive schema, i.e. his belief that the world is a dangerous place and that access to an arsenal of firearms is required for him to maintain a sense of safety. Surviving trauma also impacts Adam's self-concept, such that he equates his competency with his ability to protect his foster children from harm. In addition to exploring the relationship between trauma response and adaptation, and Adam's thoughts, feelings, and behaviors, it is critical that the counselor fully assess Adam's homicidal ideation and potential threat to others.

***Step 3: Identify possible options (Kitchener & Anderson, 2011)***

The third step requires the counselor to identify possible options for addressing the ethical dilemma. When employing this integrative model, the counselor also attends to each of SAMHSA's (2014) 6 Principles, to include: Safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; cultural, historic, and gender issues.

Given Adam's trauma history, attending to safety is essential. Establishing and enhancing safety requires the counselor to broach cultural differences and name the oppressive lived experiences Adam has experienced. Broaching with Adam ensures transparency and inclusion of his identities in the therapeutic process. In maintaining safety, the counselor communicates with transparency about decisions regarding the course of treatment, and how the counselor navigates the ethical decision-making process. The increased transparency provides Adam with a clear understanding of the counselor's mindset and process and helps to establish a sense of trust and safety with the counselor and therapeutic process.

While attending to SAMHSA's (2014) 6 principles, the counselor also considers the role of the "family and community". Alice has attended to "family and community" by including Adam's spouse in the safety planning process and utilizing his secure attachment with his significant other as a source of grounding in session. Alice may also attend to "family and community" by identifying options for peer support to provide Adam additional spaces to explore anger and childhood trauma with other survivors. The engagement in peer support provides an additional layer of support as Adam navigates his symptoms of PTSD and increased distress. Alice must also communicate with Adam about the collaborative nature of the therapeutic process to prevent or reduce an imbalance of power within the counseling relationship. In working to be transparent, Adam should experience Alice as collaborative, and therapy as a strengths-focused and empowering space.

Adam's history creates equity issues in therapy that require Alice to be mindful of the messages communicated to him during treatment. The counselor is encouraged to communicate empowerment, voice, and choice throughout the therapeutic process. Returning power to Adam in vulnerable moments further enhances trust and safety. Lastly, the counselor will examine agency practices, paperwork, and communication with clients to ensure discrimination, oppression, or marginalization are not perpetuated within the counseling practice (Ratts et al., 2015). This may include examining intake paperwork for demographic questions that provide diverse identity-related responses, as well as the types of questions asked. Alice will also want to explore the formats of counseling services available (i.e., telehealth available to increase accessibility for individuals with disabilities), and types of questions asked by administrative staff before and during initial appointments.

In addition to considering ways of reducing the perpetuation of oppressive practices in the counseling environment, Alice must also consider the history of Adam's family and community as this may contribute to the ongoing threat felt by Adam. Addressing certain ethical concerns may not address the larger systemic problems for this client. Conceptualizing Adam's self-concept as it relates to his history of trauma provides additional opportunities for exploration before selecting a course of action.

***Step 4: Consult the Ethics Code (Kitchener & Anderson, 2011)***

The fourth step in the ethical decision-making process requires consultation with one's professional codes of ethics. Alice may hold various licenses as a counselor (i.e., licensed professional counselor, licensed addiction counselor). Each type of licensure may have a unique professional code of ethics; for example, should Alice hold both licensure as an addictions counselor and mental health counselor, she will need to consult the National Association of Alcohol and Drug Abuse Counselors (NAADAC) (NAADAC, 2021), as well as the American Counseling Association (ACA) (ACA, 2014). Assuming Alice maintains only a mental health counseling credential, she must consider the ethical principles and guidance outlined in the ACA (2014) Code of Ethics.

Items from the ACA (2014) Code of Ethics Alice may need to consider: E.1.a. Assessment - specifically regarding lethality assessment; B.1. Respecting Client Rights – as pertains to client's right to have his information, thoughts, and feelings kept in confidence; and B.2.a. Serious and Foreseeable Harm and Legal Requirements – Alice must decide whether Adam's disclosures indicate serious and foreseeable harm to others, and thus require a breach in confidentiality to ensure other's safety.

***Step 5: Assess the foundational ethical issues (Kitchener & Anderson, 2011)***

Once Alice has consulted with the appropriate code of ethics, she must explore those foundational ethical issues and principles that guide her decision-making. The primary ethical principle to be considered with Adam's case is nonmaleficence, or

"avoiding actions that cause harm" (ACA, 2014, p. 3). Alice's immediate concern is ensuring that her client does not harm or kill others, and that her actions as Adam's therapist ensures the safety of both her client, and community members.

**Step 6**: ***Identify legal issues and agency policy (Kitchener & Anderson, 2011)***

As Alice is gathering information and documenting her decision-making process, she must consider both her legal obligations, as well as the agency's policies. The landmark case Tarasoff v. Regents of the University of California (1976) is of particular relevance when considering the Alice's course of action. The Tarasoff case established that persons with a "special relationship" with a client who "presents a serious danger of violence to another" is obligated to attempt to "protect the intended victim" (Tarasoff, 1976, p. 340). Following the Tarasoff verdict, 50 states have initiated mandatory reporting laws for medical and mental health professionals (Adi & Mathbout, 2018).

In order to adequately address this step in the decision-making process, Alice must consider the mandatory reporting laws for the location where the client disclosed these violent fantasies. Furthermore, Alice ought to consult with her agency's clinical director to ensure that her selected course of action aligns with agency policy. This consideration is of particular importance, as Alice's agency may require Alice to refer Adam to another treatment facility for a higher level of care (e.g., if Alice is working at a training clinic, clients experience suicidal or homicidal ideation may be referred to another facility; this policy would be outlined in the agency's consent to treatment form). After consulting legal guidelines, and agency policies, Alice must consider current information, and ensure that a thorough threat assessment has been completed regarding Adam's homicidal ideation. Additional information critical to the counselor's decision-making process Adam's lived experiences as a person of color who has a history of experiencing microaggressions, and the socio-economic consequences of oppression, and historical trauma.

***Step 7: Reassess options and identify a plan (Kitchener & Anderson, 2011)***

At this point in the decision-making process, Alice will reflect on all possible courses of action and select next steps. While reviewing each possible action, Alice must continue to employ a trauma-informed lens, considering how each course attends to the SAMHSA (2014) six principles, as well as those principles of trauma-informed ethical practice that are most salient to Adam's case. One possible course of action might include Alice conducting a follow up call with Adam the day after session to check in and offer to schedule an additional session prior to Adam's weekly meeting. During their next session, Alice may complete a thorough threat assessment to exploring status of homicidal ideation/thoughts, current planning and means and access to means, the presence of protective factors, past experiences with violence, and Adam's future expectations (Merrill, 2013). Since Adam's significant other has played a significant role in maintaining safety, Alice may collaborate with

Adam about ways to employ his spouse's support and possibly the support of others.

***Step 8: Implement and document the process (Kitchener & Anderson, 2011)***

Once the plan is implemented, Alice must document each step taken, and continue to work with her clinical supervisor and/or consult with colleagues. The counselor should communicate their plan of action with the client, as this ensures transparency, and helps to maintain the client's sense of safety. Counselors ought to dedicate time in session to explore the counselor's chosen course of action, and the potential impact. While implementing the plan of action, Alice must consider the interplay between the most salient trauma-informed ethical decision-making principles, and how this has changed or evolved since the implementation of the plan.

***Step 9: Reflect on the outcome of your decision (Kitchener & Anderson, 2011)***

As the counselor reflects on the outcomes associated with their decision, it is essential that they include both their supervisor and colleagues with whom they consulted (while honoring client privacy) and the client (Herlihy & Corey, 2014). Given the extensive considerations examined while using the Trauma-informed Ethical Decision-making Model, Alice can reflect on the experience of going through each step, if anything was missed, and the importance of incorporating each facet of the client's experience in the decision-making process.

## DISCUSSION & IMPLICATIONS FOR PRACTICE

When employing a trauma-informed lens, ethical decision-making follows a recursive course, with the counselor considering the role of the most applicable aspects of trauma-informed care (SAMHSA, 2014), and Principles of Trauma-informed Ethical Practice during each step of the decision-making process. Although any ethical decision-making model may be used with the Principles of Trauma-informed Ethical Practice, Kitchener and Anderson's (2011) decision-making model is utilized here to illustrate the application of these principles during the decision-making process. Table 1 [available in separate document] below summarizes the proposed Trauma-informed Ethical Decision-making Model, outlining the most applicable aspects of trauma-informed care (SAMHSA, 2014), and Principles of Trauma-informed Ethical Practice during each step of Kitchener and Anderson's (2011) decision-making process.

Counselor educators who wish to utilize the Trauma-informed Ethical Decision-making Model may incorporate the model in a classroom in a variety of ways. Educators may introduce the decision-making model, then provide the case of Adam or other case studies and walk students through the ethical decision-making process. Students may also be provided with a case study and the model (outlined in Table 1 [available in separate document]) and asked to collaborate with group partners as they work through applying the framework and principles and choosing

a course of action. With each step, students may explore the associated task (e.g. identify possible options), considerations for trauma-informed practice, and related Principles of Trauma-informed Ethical Practice. Counselor educators may also utilize the Principles of Trauma-informed Ethical Practice as key areas of focus while developing curriculum. For instance, one of the authors of this text explores one principle per week over the course of a 16-week trauma-focused counseling course. It would be prudent of counselor educators to discuss with students the application of this model in a variety of treatment settings. Teaching the foundational concepts associated with this model, as well as its practical application can cultivate sustainability and ethically sound decision-making.

The prevalence of stress and exposure to adversity during the COVID-19 crisis reinforces the need for mental health professionals to engage in trauma-informed care. Trauma-informed practice is of critical importance when addressing ethical concerns or dilemmas that arise during counseling practice. The primary objective of the proposed Trauma-informed Ethical Decision-making Model is to provide counselors, particularly counselors-in-training, with a framework for addressing ethical concerns with client survivors of trauma. Another key purpose of this integrative conceptual model is to provide counselor educators with a framework to support the development of curriculum regarding trauma-informed practice and ethical decision-making. The provided case analysis of Adam provides clinicians, and counselor educators with an example of this model in action. Implementation of the Trauma-informed Ethical Decision-making Model in counselor training courses ensures counselors-in-training make the most informed, trauma-sensitive decisions when counseling survivors of trauma.

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