



ALBANY LAW SCHOOL
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Trauma Informed Lawyering

March 25, 2021

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Trauma Informed Lawyering

March 25, 2021

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ALBANY LAW SCHOOL
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TRAUMA-INFORMED LAWYERING

March 25, 2021

4-6:30pm

Agenda

4:00pm - 4:05pm

Introduction

- Prof. Jaya Connors, Esq.
Albany Law School

4:05 - 4:35pm

Defining Trauma and Exploring the Effects/Neurobiology of Trauma

- Kayla Snyder
Crime Victims Case Manager
Albany County Crime Victim and Sexual Violence Center
- Mary Armistead, Esq.
Staff Attorney
The Legal Project

4:35pm - 4:55pm

The Trauma of Race and Poverty

- Lorilei Williams, Esq.
Abolitionist and Artist

4:55-5:10pm

The Trauma Exposure Response

- Lorilei Williams, Esq.
Abolitionist and Artist

5:10 – 5:15pm

BREAK

5:15pm-5:55pm

The Trauma-Informed Stance

- Lorilei Williams, Esq.
Abolitionist and Artist
- Mary Armistead, Esq.
Staff Attorney
The Legal Project

5:55 – 6:00pm

BREAK

6:00-6:20pm

Demonstration

- Julina Guo, Esq.
Senior Staff Attorney
The Justice Center at Albany Law School
- Lorilei Williams, Esq.
Abolitionist and Artist
- Mary Armistead, Esq.
Staff Attorney
The Legal Project
- Kayla Snyder
Crime Victims Case Manager
Albany County Crime Victim and Sexual Violence Center

6:20-6:30pm

Questions and Answers

Trauma Informed Lawyering

March 25, 2021

SPEAKER BIOGRAPHIES

LORILEI WILLIAMS, ESQ. (she/they) is an abolitionist and artist dedicated to teaching legal advocates on how to engage in trauma-informed and anti-racist advocacy in their individual capacities and collectively as movement lawyers in nonprofit spaces. Lorilei's work is rooted in their lived experiences of colonialism as the child of an American soldier and Korean migrant, and as the adopted child of a Mexican family with deep roots in Guascuaro, Michoacán (affectionately dubbed "el ombligo del mundo"). Their expertise is further informed by over a decade of professional experiences ranging from volunteer to director at numerous nonprofit organizations across the country, including the Southern Poverty Law Center, Legal Services NYC, and various Catholic Charities nonprofits. Lorilei has been a strategic accomplice to migrants across the nation, including in rural farms in Upstate New York, migrant camps in Tijuana, and multiple detention settings, from unaccompanied minors shelters to rural for-profit mass incarceration facilities in Georgia and Louisiana. Lorilei is also a graduate of the 2018 Racial Justice Institute (RJI) led by the Shriver Center on Poverty Law and serves as a frequent lecturer and coach on lawyering through a racial justice lens. Lorilei's experiences building power in local community groups and among colleagues within nonprofit workspaces are the foundation for their approach and methodology on building sustainable, collaborative direct services advocacy models. Lorilei is admitted to the state bars of New York and Texas and the Southern and Eastern Federal District Courts of New York. They are a graduate of Washington University in St. Louis School of Law and the University of Maryland Global Campus.

MARY ARMISTEAD, ESQ. is a Staff Attorney at The Legal Project, a non-profit civil legal services organization in Albany, New York. In her position, she works specifically with victims of human trafficking, both labor and sex, by providing direct representation in a variety of civil legal proceedings and engaging in capacity-building, education, and policy issues regarding human trafficking. Mary also teaches Immigration Law as an Adjunct Professor of Law at her alma mater, Albany Law School, where she graduated summa cum laude. Prior to The Legal Project, Mary held a clerkship at the New York State Court of Appeals for one year before working as the Staff Attorney of the Immigration Law Clinic at Albany Law School for three years. In this position, Mary both supervised students and maintained a personal docket in providing legal advocacy services and direct representation to detained and non-detained immigrants eligible for humanitarian immigration relief. Her expertise played a critical role in developing law students' ability to provide legal advocacy services and direct representation to clients

seeking U.S. immigration status. She also developed the Special Immigrant Juvenile Pro Bono Attorney panel, wherein she connects clients to and supervises attorneys in providing pro bono representation to vulnerable immigrant children.

KAYLA SNYDER currently works as a Crime Victim Case Manager for Albany County Crime Victim and Sexual Violence Center. She is an experienced professional in the community and human service field utilizing her skills to empower individuals of varying backgrounds to reach their goals. She is familiar with several nonprofit agencies and has established professional contacts in both Albany and Rensselaer County. She is currently pursuing her M.A. in Social and Public Policy with an Advanced Certificate in Public Administration at SUNY Empire State College. Her current research interests are focused on understanding the varying effects of trauma and how to successfully implement trauma informed policy change at direct service and administrative levels. In her spare-time she enjoys hiking, camping and attending live music events.

JULINA GUO, ESQ. is a Senior Staff Attorney in the Immigration Law Clinic at The Justice Center at Albany Law School. Julina represents survivors of domestic violence and crimes, children, and other vulnerable individuals in obtaining humanitarian immigration status. Julina coordinated volunteers for the Detention Outreach Project when the government transferred over 300 asylum-seekers to the Albany County Jail. Julina also participates in advocacy on immigration issues, working closely with other stakeholders such as community-based organizations, law enforcement, and members of Congress. Prior to joining Albany Law School, Julina investigated and prosecuted claims of discrimination at the NYC Commission on Human Rights based on the NYC Human Rights Law, one of the broadest municipal anti-discrimination laws in the nation. Julina also represented survivors of human trafficking and domestic violence in obtaining humanitarian immigration status at Sanctuary for Families, where she was an Immigrant Justice Corps Fellow. She earned a B.A. in Psychology and East Asian Languages & Cultures from Columbia University and a J.D. from Harvard Law School.

Trauma-Informed Lawyering

Thursday, March 25, 2021 4-6:30pm



ALBANY LAW SCHOOL
THE JUSTICE CENTER

Defining Trauma and Exploring the Effects/Neurobiology of Trauma

Kayla Snyder
Crime Victims Case Manager
Albany County Crime Victim and Sexual Violence Center

What is Trauma?

- ▶ “Individual trauma results from an **event**, series of events, or set of circumstances that is **experienced** by an individual as physically or emotionally harmful or threatening and that has lasting **effects** on the individual’s functioning and physical, social, emotional, or spiritual well-being”
 - ▶ Substance Abuse and Mental Health Services Administration (SAMHSA)
- ▶ The Three “Es”:
 - ▶ **Event(s)**
 - ▶ **Experience of the event(s)**
 - ▶ **Effect of the event(s)**

Breakdown of the Three “Es”

- ▶ **Event**

- ▶ The experience of an actual or extreme threat of physical or psychological harm

- ▶ **Experience of the event**

- ▶ How the event impacts an individual on a physical and psychological level

- ▶ **Effect of the event**

- ▶ What symptoms an individual has in response to the event

Effects of Trauma

▶ Feelings of:

- ▶ Powerlessness/helplessness
- ▶ Humiliation/embarrassment
- ▶ Shame/guilt
- ▶ Betrayal
- ▶ Fear/horror
- ▶ Emotional numbing or detachment

▶ Psychological symptoms:

- ▶ PTSD or flashbacks
- ▶ Depression
- ▶ Anxiety
- ▶ Hyper-arousal and easily startled
- ▶ Irritability or anger
- ▶ Difficulty concentrating
- ▶ Fragmented memory

The Neurobiology of Trauma

- ▶ The “emotional brain takes the reins and supersedes their executive functions.”
 - ▶ Front seat:
 - ▶ **Amygdala:** fight or flight response; releases stress hormones
 - ▶ **Right side of brain:** visual, spatial, and tactile senses; intuition and emotion
 - ▶ Back seat:
 - ▶ **Prefrontal cortex:** decision-making/reasoning; regulate attention, awareness, and emotions; initiate conscious/voluntary behavior; inhibit/correct dysfunctional reactions
 - ▶ **Left side of brain:** organization, language, logic

Childhood Trauma

- ▶ ACEs: Adverse Childhood Experiences—i.e. trauma in childhood
- ▶ Affects the developing brain:
 - ▶ Changes the **wiring** and **structure** of the brain
 - ▶ Can have **lifelong effects** on decision-making, working and long-term memory, ability to distinguish danger from safety, reasoning capacity, and social-emotional, language, and cognitive skills.

Triggering Situations and Re-traumatization

▶ Common triggers:

- ▶ Unpredictability
- ▶ Transition
- ▶ Loss of control
- ▶ Feelings of vulnerability, loneliness, or rejection
- ▶ Sensory overload
- ▶ Confrontation
- ▶ Embarrassment or shame
- ▶ Intimacy or even positive attention

▶ Signs of being triggered:

- ▶ Jumping up or lashing out
- ▶ Difficulty tracking questions
- ▶ Difficulty in communicating/expressing thoughts
- ▶ Giving brief, clipped narratives or claiming not to remember
- ▶ Shutting down or appearing to “go somewhere else”: exhibiting flat affect, not following conversation, losing track of thought process

The Trauma of Race and Poverty

Lorilei Williams, Esq.
Abolitionist and Artist

Race and Trauma: What is Race?

- ▶ **Race** is a social construct or idea that
 - ▶ Has been **built** over time
 - ▶ Continues to **evolve** and change
 - ▶ Has **concrete** ramifications for people's lives, and
 - ▶ Has many interconnecting sides or **facets**
- ▶ The process of **racialization** is one way that our society sorts communities and people to allocate resources and access to resources.

Implicit Bias

- ▶ **Implicit bias:** attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner
 - ▶ activated involuntarily and without an individual's awareness or intentional control.
- ▶ Implicit biases are **pervasive**: Everyone possesses them.
- ▶ Implicit and explicit biases are related but distinct mental constructs. They are not mutually exclusive and may even reinforce each other.
- ▶ Our implicit biases do not necessarily align with our declared beliefs or even reflect stances we would explicitly endorse.
- ▶ Implicit biases are **malleable**: the implicit associations that we have formed can be gradually unlearned through a variety of de-biasing techniques.

Racial Trauma

- ▶ **Racial trauma:** reactions to dangerous events and real or perceived experiences of racial discrimination
 - ▶ Include: threats of harm and injury, humiliating and shaming events, and witnessing harm to other people of color
- ▶ **Intersectional oppression:** racial, gender, sexual orientation, and xenophobic microaggressions
 - ▶ contribute to the cumulative effects of racial trauma
- ▶ Racism and ethnoviolence can be life threatening to people of color due to consistent exposure to racial microaggressions, vicarious traumatization, and the invisibility of racial trauma's historical roots

The Trauma Exposure Response

Lorilei Williams, Esq.
Abolitionist and Artist

Trauma-Exposure Response

- ▶ The emotional or physical reaction when **exposed** to the suffering of others
- ▶ Even **just listening** to traumatic stories can cause what many refer to as “secondary trauma” or “vicarious trauma”
- ▶ Signs and symptoms
 - ▶ Anger, irritability, or tearfulness
 - ▶ No time or energy for oneself
 - ▶ Loss of pleasure in work
 - ▶ Feelings of numbness, vulnerability, despair/hopelessness, or alienation
 - ▶ Overwhelming feelings of responsibilities for someone else’s well-being
 - ▶ Over-identification with client’s trauma
 - ▶ Nightmares, hyper-arousal, alterations in sensory experiences
 - ▶ Negative coping mechanisms

Avoiding Secondary Trauma: Self-Care

- ▶ Pay attention to your emotions
- ▶ Use **positive** coping mechanisms
 - ▶ Take **breaks**—not just vacations, but on a daily and weekly basis when needed
 - ▶ Ensure **balance** between work and personal life—perhaps through routine/ritual
 - ▶ Practice **relaxation** techniques regularly (e.g. meditation, yoga)
 - ▶ Maintain your **health**: eat well, get enough sleep, and exercise
- ▶ Seek **support**—both in your personal life and in your institution
 - ▶ Engage with your family, friends, and community
 - ▶ Talk with your supervisor about being overloaded

BREAK

CLE CODE 1: RACE-EQUITY

The Trauma-Informed Stance

Mary Armistead, Esq.
Staff Attorney
The Legal Project

Lorilei Williams, Esq.
Abolitionist and Artist

Keys to a Good Attorney-Client Relationship

- ▶ How does an attorney ensure that their representation is client-centered?
 - ▶ Build a trusting relationship
 - ▶ Communicate effectively with the client
 - ▶ Listen to the client
 - ▶ Explains the law to the client in an understandable way
 - ▶ Allow the client to lead the representation
 - ▶ Be prepared—know the law, develop a legal strategy based on the client’s goals

- ▶ What might influence the dynamics of creating a good attorney-client relationship?
 - ▶ World view
 - ▶ Race
 - ▶ Socioeconomic status
 - ▶ Gender
 - ▶ Sexual orientation
 - ▶ Disability
 - ▶ Religion
 - ▶ Ethnicity
 - ▶ Culture
 - ▶ Trauma

Trauma's impact on building a successful attorney-client relationship

- ▶ **Difficulty building trust**
- ▶ **Communication barriers**
 - ▶ Inability to tell story chronologically or with appropriate details
 - ▶ Re-traumatization while gathering story: triggering, hyper-arousal, and dissociation
 - ▶ Avoidance
- ▶ **Diminished information processing**
- ▶ **Impaired decision-making ability**

- Sara E. Gold, *Trauma: What Lurks Beneath the Surface*, 24 CLINICAL L. REV. 201 (2018).
- Susan Ayres, *Trauma-Informed Advocacy: Learning to Empathize with Unspeakable Horrors*, 26 Wm. & Mary J. Race, Gender & Soc. Just. 225 (2020).
- Talia Kraemer and Eliza Patten, *Establishing a Trauma-Informed Lawyer-Client Relationship (Part One)*, ABA CHILD LAW PRACTICE Vol 33 No. 10 (Oct. 2014), https://www.lsc-sf.org/wp-content/uploads/2015/10/Article_Establishing-a-Trauma-Informed-Lawyer-Client-Relationship.pdf.

What is trauma-informed lawyering?

- ▶ Realigns our view from “What’s wrong with this client?” to “What happened to this client?”
- ▶ Goals:
 - ▶ Create an inclusive, welcoming, and destigmatizing environment by practicing empathy and non-judgment to build trust
 - ▶ Restore control to the client by ensuring client understanding of legal proceedings and empowering the client to make decisions, including those that emphasize their safety
- ▶ Three components:
 - ▶ **identifying** trauma and its effects
 - ▶ **adjusting** the attorney-client relationship
 - ▶ **adapting** litigation strategies

The Trauma-Informed Stance

- ▶ Transparency
- ▶ Predictability and Reliability
- ▶ Patience
- ▶ Client Control
- ▶ Proactive Support

Transparency

- ▶ Express clearly and fully your client's legal case and options
- ▶ Explain your actions (e.g. notetaking) and why you need certain information (e.g. details about traumatic event)
- ▶ Do not hide information unless necessary
- ▶ Explain **your role** and limitations
 - ▶ What services you **do** and **do not** provide
 - ▶ What you **can** and **cannot** accomplish for the client
 - ▶ The client's role as **decision-maker** and your role to effectuate their decisions to the extent possible

• Sara E. Gold, *Trauma: What Lurks Beneath the Surface*, 24 CLINICAL L. REV. 201 (2018).

• Talia Kraemer and Eliza Patten, *Establishing a Trauma-Informed Lawyer-Client Relationship (Part One)*, ABA CHILD LAW PRACTICE Vol 33 No. 10 (Oct. 2014), https://www.lsc-sf.org/wp-content/uploads/2015/10/Article_Establishing-a-Trauma-Informed-Lawyer-Client-Relationship.pdf.

Predictability and Reliability

- ▶ Again, **define your role**
- ▶ Give **reliable** information about your schedule, availability, and means of contact
- ▶ **Repeatedly** preview what's to come, e.g. what topics will be covered in meetings, possible legal outcomes, decisions that need to be made
- ▶ Establish **routines** for meetings
- ▶ **Follow through** on responsibilities, commitments, and appointments
 - ▶ Return phone calls promptly
 - ▶ Provide regular case updates
 - ▶ Avoid cancelling or changing appointments last-minute
- ▶ **DO NOT make promises** that you may not be able to keep

• Sara E. Gold, *Trauma: What Lurks Beneath the Surface*, 24 CLINICAL L. REV. 201 (2018).

• Talia Kraemer and Eliza Patten, *Establishing a Trauma-Informed Lawyer-Client Relationship (Part One)*, ABA CHILD LAW PRACTICE Vol 33 No. 10 (Oct. 2014), https://www.lsc-sf.org/wp-content/uploads/2015/10/Article_Establishing-a-Trauma-Informed-Lawyer-Client-Relationship.pdf.

Patience

- ▶ Understand that building trust and rapport take **time**
- ▶ Ensure meetings include sufficient **time** to address client concerns and to adequately explain and discuss case options/outcomes
- ▶ Drawing out sensitive information over **multiple meetings** may be more manageable for clients
- ▶ Give the client **time** to tell their story with minimal interruptions
 - ▶ practice active listening
- ▶ **Repetition** can be key to client understanding
 - ▶ **Recapping** at the end of meetings
 - ▶ **Reviewing** what is coming in their case
 - ▶ **Writing** key points for the client to take

• Sara E. Gold, *Trauma: What Lurks Beneath the Surface*, 24 CLINICAL L. REV. 201 (2018).

• Talia Kraemer and Eliza Patten, *Establishing a Trauma-Informed Lawyer-Client Relationship (Part One)*, ABA CHILD LAW PRACTICE Vol 33 No. 10 (Oct. 2014), https://www.lsc-sf.org/wp-content/uploads/2015/10/Article_Establishing-a-Trauma-Informed-Lawyer-Client-Relationship.pdf.

Client Control

- ▶ Break down **hierarchical structures** that often dictates lawyer-client relationship and understand the **power of suggestibility** you have
- ▶ Actively empower the client to use their **agency**
 - ▶ **Ask** the client what works for them, e.g. to avoid triggering
 - ▶ **Validate** their strengths
 - ▶ Affirm that client knows what is best for themselves and their situation
 - ▶ Give clients the **option** over whether to disclose certain information
 - ▶ Explain your confidentiality ethical responsibilities
 - ▶ Lay out options clearly: flow charts, role-playing, or diagrams

Options	Benefits (Pros)	Disadvantages (Cons)	Likelihood of Success	Client Reaction
Option 1				
Option 2				

Proactive Support: Thinking Ahead to Identify Triggering Situations

▶ Common triggers:

- ▶ Unpredictability
- ▶ Transition
- ▶ Loss of control
- ▶ Feelings of vulnerability, loneliness, or rejection
- ▶ Sensory overload
- ▶ Confrontation
- ▶ Embarrassment or shame
- ▶ Intimacy or even positive attention

▶ Signs of being triggered:

- ▶ Jumping up or lashing out
- ▶ Difficulty tracking questions
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• Talia Kraemer and Eliza Patten, *Establishing a Trauma-Informed Lawyer-Client Relationship (Part One)*, ABA CHILD LAW PRACTICE Vol 33 No. 10 (Oct. 2014), https://www.lsc-sf.org/wp-content/uploads/2015/10/Article_Establishing-a-Trauma-Informed-Lawyer-Client-Relationship.pdf.

Proactive Support: Techniques to Avoid Triggering

- ▶ Create an environment that is **calm and soothing**
 - ▶ Offer the client **options** within the physical space
 - ▶ Minimize **power differentials** in seating arrangements
 - ▶ Give the client the **opportunity** to determine who attends the meeting
 - ▶ Use appropriate body language and verbal communication
 - ▶ **Do not touch** the client without permission
 - ▶ **Avoid** crossing your arms or putting your hands on your hips or in your pockets
 - ▶ Think about facial expressions: use **gentle eye contact**
 - ▶ **Affirm** how difficult it may be to talk about certain subjects
 - ▶ Give the client **control** over when and whether to disclose sensitive information
 - ▶ Use grounding techniques
 - ▶ **Check in** with the client consistently
 - ▶ Offer **breaks** and chances to get up and **move**
 - ▶ Offer **tangible items** (water, tissue, stress ball)
 - ▶ Take **deep breaths** together
- Sara E. Gold, *Trauma: What Lurks Beneath the Surface*, 24 CLINICAL L. REV. 201 (2018).
- Talia Kraemer and Eliza Patten, *Establishing a Trauma-Informed Lawyer-Client Relationship (Part One)*, ABA CHILD LAW PRACTICE Vol 33 No. 10 (Oct. 2014), https://www.lsc-sf.org/wp-content/uploads/2015/10/Article_Establishing-a-Trauma-Informed-Lawyer-Client-Relationship.pdf.

Proactive Support: Reacting to Triggering

- ▶ **Avoid escalation and react calmly**
 - ▶ **Do not raise your voice**
 - ▶ Do not become defensive or confrontational
 - ▶ Do not startle the client
 - ▶ **Speak slowly** and in short sentences
 - ▶ **Validate** the client's feelings, including frustration with you or the system
- ▶ **Address the triggering event**
 - ▶ Tell the client their reactions are **normal**—there is not something “wrong” with them
 - ▶ Remind the client that they are **safe** with you and that you will wait until they are ready
- ▶ Once the client is ready (e.g. returns to baseline):
 - ▶ Ask what triggered them
 - ▶ Tell them you will try to avoid or give notice of that trigger in the future
 - ▶ Reassure them that that they can let you know if they are uncomfortable

• Sara E. Gold, *Trauma: What Lurks Beneath the Surface*, 24 CLINICAL L. REV. 201 (2018).

• Talia Kraemer and Eliza Patten, *Establishing a Trauma-Informed Lawyer-Client Relationship (Part One)*, ABA CHILD LAW PRACTICE Vol 33 No. 10 (Oct. 2014), https://www.lsc-sf.org/wp-content/uploads/2015/10/Article_Establishing-a-Trauma-Informed-Lawyer-Client-Relationship.pdf.

Practicing Empathy: Parallel-Universe Thinking

- ▶ Avoid hasty decisions
- ▶ Focus on **facts**
- ▶ Brainstorm multiple **alternative explanations** for other people's behavior and speech
- ▶ Examples:
 - ▶ Client doesn't make eye contact
 - ▶ Client is consistently late to or skips meetings
 - ▶ Client asks you the same questions every meeting

Practicing Empathy: Avoiding Judgment in Questioning

- ▶ Feeling judged by someone decreases trust
- ▶ Avoid expressing judgment through questioning
 - ▶ Find non-judgmental corollaries
 - ▶ When did you last use drugs?
 - ▶ Why didn't you leave your abusive spouse?
 - ▶ How could you know what happened if you weren't there?

BREAK

CLE CODE 2: SELF-CARE

Demonstrations

Kayla Snyder
Crime Victims Case Manager
Albany County Crime Victim and
Sexual Violence Center

Lorilei Williams, Esq.
Abolitionist and Artist

Julina Guo, Esq.
Senior Staff Attorney
The Justice Center at Albany Law School

Mary Armistead, Esq.
Staff Attorney
The Legal Project

The background features abstract, overlapping geometric shapes in various shades of purple and magenta, primarily concentrated on the right side of the frame. The shapes include triangles and polygons of different sizes and orientations, creating a dynamic, layered effect. The colors range from light lavender to deep, dark purple.

QUESTIONS & ANSWERS

TRAUMA IN PRACTICE

Establishing a Trauma-Informed Lawyer-Client Relationship (Part One)

Talia Kraemer and Eliza Patten

As a lawyer for youth, you know many of your clients have experienced trauma, particularly those involved in the child welfare or juvenile justice systems. Trauma can affect the most fundamental aspects of the attorney-client relationship.

Even though most lawyers are not mental health professionals, a working understanding of trauma, including its origins and its impacts, can be helpful in anticipating and responding to trauma's effects as they surface in our work with clients.

This two-part article presents strategies for building stronger, more trauma-informed *attorney-client relationships* with youth.

Why focus on the attorney-client relationship?

- *Client trust and engagement.* A client's trauma history can make it

difficult to build trust and actively involve the client with her legal case. By learning to build relationships that better respond to the needs of youth who have experienced trauma, you can improve client engagement and fulfill your mandate as the child's representative.¹

- *Attorney-client interactions.* Childhood trauma can affect a person's cognitive and psychosocial development, including how one thinks, processes information, and communicates with

others. Trauma thus impacts basic attorney-client interactions, such as interviewing, explaining case developments, and counseling and advising clients on case-related decisions.

- *Modeling positive relationships.* Youth who have experienced trauma, particularly in the context of interpersonal relationships, often expect new relationships to reinforce negative beliefs they have developed about themselves and others; for example, that they are inherently unlikeable or "bad," or that adults are untrustworthy and will inevitably hurt them. Many experts agree that one of the best paths to healing for traumatized

(Cont'd on p. 198)

Defining "Trauma"

Trauma "results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being." (Substance Abuse and Mental Health Services Administration, Trauma Definition, www.samhsa.gov/traumajustice/traumadefinition/definition.aspx)

Complex Trauma "describes both children's exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure. These events are severe and pervasive . . . [and] usually begin early in life." (National Child Traumatic Stress Network, *Complex Trauma*, www.nctsn.org/trauma-types/complex-trauma)

For a thorough discussion of the definition of trauma, see "Understanding Trauma and its Impact on Child Victims," by Eva Klain in the September 2014 *CLP*.

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(Cont'd from front page)

youth can be to develop positive, safe relationships.² Like all professionals who work with these youth, lawyers can either aid in the client's healing or magnify a client's vulnerabilities.

Not all court-involved youth have experienced trauma, and reactions to trauma vary among those who have. Some youth experience few or no long-term effects of trauma. Drawing on the public health principle of "universal precaution," we advocate adopting a trauma-informed approach to *all* client relationships, seeking, at minimum, to "do no harm." At best, lawyers can communicate with and counsel their clients more effectively, achieve more authentically client-directed representation, and help clients move beyond their trauma to healthy developmental paths.³

Challenges of Trauma-Informed Lawyering

Childhood trauma affects how a young person perceives and interacts with the world around her. Trauma's impact is not only psychological, but also physiological: children's brains, incomplete at birth, develop in ways that respond to the child's experiences with traumatic stress.⁴ Clients who experience these responses may think and behave in ways that make it more challenging for the lawyer to build trust, communicate effectively, and engage the client in making decisions about her legal case.

This section draws on knowledge from the mental health and medical fields to describe common effects of childhood trauma. Keep in mind that trauma's impact on a young person varies, depending on the type of trauma experienced, whether the trauma was isolated or repeated, the age at which the trauma was experienced, the young person's gender and cultural identity, and the caregiving and social supports available to the young person before and after the traumatic events.⁵ We encourage you to consult

other resources and mental health professionals working directly with your clients to better understand the impact of a client's experiences with trauma.

Building Relationships

Impaired sense of safety. Traumatized youth often have an impaired sense of safety. Having been exposed to acute or chronic threat—such as maltreatment, neglect, or community or domestic violence—they may perceive even neutral environments as threatening, and their brains are primed to go into "survival" mode. Although youths' survival-oriented behaviors are natural and healthy in the face of real danger, they become maladaptive in nonthreatening social contexts.⁶ These behaviors might be how the youth functions day in and day out (i.e., their baseline level of functioning), or youth might exhibit them when something, consciously or unconsciously, reminds them of a past trauma. This latter phenomenon is known as *triggering*, and the thing that prompted the survival response is often referred to as a trauma "trigger."⁷

Youths' survival behaviors vary. Youth may become "*hyperaroused*," a state of heightened energy and alertness to threat. Clients who are hyperaroused might appear jumpy, have frequent outbursts, or become confrontational or aggressive.⁸ Another common response is "dissociation"—mentally shutting down, becoming numb, or having "gone elsewhere." Youth may also deal with perceived threats by altering their behavior and daily patterns to avoid reminders of past trauma.⁹

Dissociation can be harder to recognize than hyperarousal but can still create challenges when building attorney-client relationships. For example, a dissociated client may seem indifferent to the legal proceedings or to the lawyer's efforts at counseling. Avoidance may lead a client to start skipping appointments, causing frustration and logistical challenges for the lawyer.

Controlling emotions. Children exposed to trauma can have trouble

controlling their emotions. The parts of their brains that remain alert to threat have been constantly turned on, while they may have had less opportunity to develop self-regulation skills. They often feel overwhelmed by their emotions and simultaneously lack tools for calming themselves down. To others, they can appear out of control or overly impulsive.¹⁰

Lack of trust. Building trust is a formidable task, particularly with youth who have been exposed to violence or trauma in the context of intimate relationships.¹¹ These youth have learned that adults cannot keep them safe, do not attend to their needs, and may harm them. They are more likely to be hyperalert in social interactions and to misread facial or verbal cues as negative.¹² When building new relationships, youth who have experienced interpersonal trauma may try to push the adult away or provoke an adverse response. The youth may be modeling how she has been treated in past relationships or trying to achieve control by bringing about negative treatment that she considers inevitable.¹³ Clients may engage in behaviors to "test" whether you will ultimately disappoint and reject them, as other adults have done.

Communication and Counseling

Information processing. Youth impacted by trauma may have trouble with information processing and receptive language. Primarily focused on safety and survival, they may miss much of what is said to them, either because they are on the lookout for threat or because they are dissociated.¹⁴ A client may repeatedly glance at the door, jump each time the phone rings, or seemingly daydream instead of following your questions and explanations.

Impaired self-expression. Clients may also have trouble expressing themselves. Dr. Susan Craig explains that instability in early childhood can impair the development of sequential memory, whereby children learn to

organize and remember information and experience in a linear fashion.¹⁵ Further, youth who are neglected or maltreated often have less exposure to verbal language in their early relationships. In particular, talk tends to be instrumental, rather than focused on expressing feelings and needs.¹⁶ These deficits can make it harder for youth to construct clear narratives or verbally express their emotions.¹⁷

Youth may also have grown up in homes where secrets are common and disclosure is discouraged, inhibiting the youth's comfort speaking up about experiences. Overall, a client's experiences with trauma can create many barriers to getting a smooth or reliable narrative from the client. Instead, lawyers may find that clients' narratives involve long, confusing discourses, include gaps in recall, or appear split off from emotion.¹⁸

Difficulty sharing trauma histories. Challenges arise when clients are asked to discuss matters directly relating to their trauma histories. Youth may be hesitant to share their experiences because adults have told them not to talk about their traumas or, when the youth did, shut them down or rejected their accounts as untrue. Clients may also keep quiet out of shame, feeling they bear responsibility or "deserved it," or out of loyalty to family or others involved in their traumas.¹⁹

Decision making. Trauma's cognitive impacts may also affect how youth approach case-related decision making. Children exposed to violence may have trouble understanding cause and effect, having been subjected to harm without any apparent cause. As Dr. Craig explains, because their own behavior has led to unpredictable responses from others, these youth may not see themselves as capable of impacting outcomes and may struggle with predicting consequences.²⁰

Building Better Attorney-Client Relationships

A strong working relationship is key to effectively represent youth who have experienced trauma. In addition to facilitating traditional lawyering functions, discussed further in part two of this article, building strong relationships with traumatized clients has value in and of itself. While maintaining perspective about your relative importance and place in your clients' lives, also recognize that all positive relationships can be restorative, allowing a young person gradually to change negative beliefs she has developed about herself, how she can expect to be treated by others, or what is possible for her.²¹

Adopting a Trauma-Informed "Stance"

Trauma-informed lawyering is not a step-by-step formula. In part, it rests upon characteristics intrinsic to all positive human relationships: empathy, responsive listening, restraint from judgment, demonstration of authentic care and concern. At the same time, lawyers should incorporate changes into their practice that respond to the vulnerabilities common among traumatized youth. Drawing on a framework recommended by Dr. John Sprinson, we suggest lawyers begin by adopting a trauma-informed "stance": a set of principles that inform your interactions with your client at all times. These principles seek to avoid exacerbating the client's impaired sense of safety, difficulty with trust, and negative beliefs about herself and her relationships with others.

The basic elements of a trauma-informed stance are:

1. **Transparency** – Be fully transparent with the client about her legal case, in age-appropriate terms. Transparency promotes trust and minimizes the youth's feelings of powerlessness—a common trauma "trigger"—in the face of what is likely a bewildering or overwhelming process. Transpar-

ency also helps distinguish your relationship from past relationships the client may have had that were characterized by secrets or mystification.

2. **Predictability** – Repeatedly preview for the client what is to come, both in the attorney-client relationship and in the broader legal process. For example, regularly preview upcoming case milestones, decisions the client will have to make, and events the client will need to attend, such as court hearings or meetings. Create routines with the client, such as always holding meetings on the same day or in the same place. Because of their heightened alertness to threat, youth who have experienced trauma often have difficulty with the unfamiliar or unexpected, whereas predictability and routine can help them feel safe.
3. **Client Control** – Give clients a voice in decisions that affect them, in a way that is purposeful and exceeds baseline ethical requirements. Actively empower the client to exercise her agency by validating the client's strengths and helping her develop decision-making and related life skills. These efforts counteract feelings of powerlessness caused by past traumas and can also provide a sense of mastery, which research shows is critical for healthy development post trauma.
4. **Reliability** – Be reliable, always following through on responsibilities, commitments, and appointments. Never make a promise that you might break. Commitment to this principle should go beyond basic requirements of professionalism. A youth who has experienced trauma, particularly in the context of relationships, often expects betrayal and disappointment from others. Even minor breaks in trust reinforce the client's belief that adults are untrustworthy and potentially dangerous.

5. **Proactive Support** – Anticipate issues that may arise during your representation and in the legal case that may be distressing or destabilizing for your client. Consult with mental health professionals and other adults in the client’s life to identify situations that may be stressful or even “triggering,” as well as supports that will be available to your client when needed.
6. **Patience** – Building connections takes time. Despite your best intentions, missteps with the client

against your client’s wishes to avoid “blindsiding” the client and creating a sense of betrayal.

- In client-driven representation, emphasize the client’s power and agency. Many young children have trouble understanding that they, not the adult lawyer, have decision-making power. This tendency can be exacerbated in youth who respond to trauma by being excessively compliant with adults, either out of fear that missteps might yield retribution or as symptomatic

because it helps establish boundaries in the attorney-client relationship. Many traumatized youth have experienced grievous violations of their personal boundaries, or have grown up in environments where the lines between children and adults are blurred.²³ Establishing clear boundaries creates predictability and can help the youth feel safe. It is especially important not to create a false sense that you can rescue your client or her family, or to foster a dependence on you that will become another loss to your client when your role in her life is over. Recall that your journey with the client has a beginning, middle, and an end. Preview that end from the beginning, and keep it alive throughout the relationship, as a conscious recognition of the limits of your availability.

Repairing Ruptures. While building strong client relationships, recognize that ruptures in the relationship are inevitable. Creating opportunities to repair those ruptures is part of strengthening the relationship with the client.²⁴ Despite best intentions, you risk doing or saying something that breaks the client’s trust or triggers survival responses. Clients may also try to push you away, or transfer to you feelings, such as anger or frustration, that they cannot bear. If you can stay calm and committed, or bear something the client finds unmanageable, the client benefits from observing that capacity in another.

By remaining engaged and reliable, you disprove the client’s belief that you will abandon her or that her feelings are “too much” to handle.²⁵ This also shows respect for your client’s adaptive behaviors by recognizing that such adaptations were born out of self-preservation. It is not your role as lawyer to suggest the client abandon these behaviors for your sake.

Preparing for and Responding to Triggering

Among the more severe trauma-related reactions you might encounter

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are certain. You will likely disappoint the client, and the client may blow up at you or push you away. Remain patient, present, and available to the client. This shows that you will not desert her despite inevitable bumps in the relationship or her efforts to “test” you.

of a dissociative response to the trauma. Clients who respond to trauma by acting out versus shutting down are often seeking power and recognition. Offering them an alternate way to be seen and heard and have their voice respected in the attorney-client relationship may disrupt their internal belief that acting out and aggression are the only means to obtain status and recognition.

Role Definition and Boundaries

Roles. Adopting a trauma-informed “stance” creates the background conditions for strong client relationships. It is also crucial to have clear conversations with the client about your role. This maximizes predictability and provides a baseline against which the client can evaluate your reliability. We suggest covering the following topics as soon as possible with the client. Note that it may be necessary to revisit conversations about your role repeatedly during the representation.

- Explain your role, services you do and do not provide, and what you can and cannot expect to accomplish for the client.
- Clarify how you differ from other adults in the client’s life and in the legal case.
- Explain the client’s role and which decisions are within her control. If you represent the client’s “best interests,” be clear early on about when you might need to advocate

- Explain confidentiality and its limits.
- Give the client reliable information about your schedule, availability, and how to contact you. You do not need to be available at all times to be “reliable;” it is better to have scheduled check-ins that you are able to keep.
- Explore the client’s assumptions about the attorney-client relationship. Has the client had prior attorneys? What were those relationships like? What worked well, and what didn’t? By asking the client to express her opinions about working with an attorney, you can better anticipate bumps in your relationship and avoid creating a dynamic that the client feels powerless to alter in the future.²²

Boundaries. Role definition is crucial

over the course of the representation is “triggering,” which occurs when something in the youth’s environment activates a memory of the trauma, evoking an intense and immediate reaction from the youth.²⁶ As revisiting content related to a specific traumatic event can be triggering, so can the *effects* of a traumatic event. For example, the emotional state of hyperarousal, which the client may have felt while experiencing the trauma, can itself be a trigger.²⁷ Common triggers include unpredictability; transition; loss of control; feelings of vulnerability, loneliness, or rejection; sensory overload; confrontation; embarrassment or shame; intimacy; and even positive attention.²⁸ While most lawyers are not trained to judge in a clinical sense whether a client is being “triggered,” the following reactions can be signs that a client may be triggered:²⁹

1. Jumping up or lashing out
2. Difficulty tracking the lawyer’s questions
3. Difficulty making oneself clearly understood (e.g., a long tangled narrative)
4. The client gives a brief, clipped narrative, or claims not to remember.
5. The client shuts down, develops a flat affect, becomes lost in the conversation, can’t remember what she was talking about, or appears to have “gone somewhere else.”
6. Regressive behaviors (e.g., thumb sucking)
7. With the client’s consent, consult mental health providers and other adults in your client’s life to understand what things are known to trigger your client and how your client reacts (and subsequently recovers) when triggered. Ideally, each client who comes into contact with the legal system should receive appropriate assessments of her present level of functioning, trauma history, needs, and strengths, and have access to

coordinated services as needed.

In addition to seeking individualized guidance, the following roadmap can guide your response if you are with the client when she is in a triggered state.³⁰ These recommendations also apply when a client is in a lesser state of emotional distress, and are useful when you are unsure if the client is being “triggered.”

- Trust your ability to read the client. If it appears your client is becoming distressed, address that distress instead of simply moving forward.
- When someone’s “survival brain” has been triggered, that turns off the prefrontal cortex—the brain’s reasoning center. Dr. Joyce Dorado uses the analogy that the “rider is off the horse.” Before doing anything else to ameliorate the situation, get the rider back on the horse. Do nothing to startle the young person; do not be confrontational and do not escalate the situation. Do what you can to help the youth feel safe and in control. Give gentle reminders that the youth is safe, you are here, and you will wait for her to tell you when she is ready. Once the rider is back “on the horse,” you can ask what led to her distress.³¹
- Tell the client her reactions to trauma are normal. There is not something “wrong” with her.
- Tell the client you will watch for signs that she is becoming upset in the future, to help her anticipate and ward off those moments. In so doing, you counter past relationships the youth may have had with adults who were not attuned to her needs.
- Prepare for the next time you are going to confront the trigger. Thank the client for letting you know she was uncomfortable, and tell her she can let you know next time she is getting upset. If it will be necessary to confront

the trigger again during the legal case discuss this with the client, as well as how it fits with your efforts to help her attain her goals.

- Ensure the client has trusted adult(s) to follow up with as needed.
- If your client is willing to participate, link her to trauma-focused therapy that can help her develop strategies for regulating emotions. These therapies often rely on parent or caregiver involvement. You can also identify caring adults who may be willing to help the client build these critical emotion-regulation skills.

Conclusion

To create a solid foundation for working effectively with traumatized youth, lawyers should focus on building strong attorney-client relationships that respond to common effects of childhood trauma. Part Two of this article will address strategies for interviewing and counseling traumatized youth and talking with them directly about their trauma experiences.

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not necessarily represent the official position or policies of the U.S. Department of Justice or ABA.

Endnotes

1. This article focuses on the traditional lawyer-client role; however, the recommendations also apply to lawyers who practice in jurisdictions where their role is a modified lawyer role requiring representation of the child client's "best interests."

2. Vandervort, Frank E., Jim Henry & Mark Sloane. *Building Resilience in Foster Children: The Role of the Child's Advocate*, 2012, 11; Cole, Susan F., et al. *Helping Traumatized Children Learn: Supportive School Environments for Children Traumatized by Family Violence*, 2005, 38-39.

3. Attorneys familiar with guidance on lawyering for children may recognize that some of our recommendations mirror that guidance. Some proposals may already be considered good practice in light of considerations about child and adolescent development, the context in which lawyers and/or other public officials find themselves involved in the private sphere of the family, or attorney ethics requirements. We restate them here to introduce trauma as another motivation for those practices.

4. Jack P. Shonkoff et al. *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, 2012, e235-38; American Academy of Pediatrics. *Helping Foster and Adoptive Families Cope with Trauma*, 2013, 2-4 ("AAP").

5. Vandervort et al., 2012, 3; Bassuk, Ellen L., Kristina Konnath & Katherine T. Volk. *Understanding Traumatic Stress in Children*, 2006, 3.

6. AAP, 2013, 8; Craig, Susan E. *Reaching and Teaching Children Who Hurt*, 2008, 98-99; Kinniburgh, Kristine et al. "Attachment, Self-Regulation, and Competency." *Psychiatric Annals*, 2005, 427-28.

7. Craig, Susan E. *Reaching and Teaching Children Who Hurt*, 2008, 100.

8. AAP, 2013, 8; Perry, Bruce D. *Effects of Traumatic Events on Children: An Introduction*, 2003, 2-5; Vandervort, 2012, 4.

9. AAP, 2013, 8; Perry, 2003, 7-8; Vandervort et al., 2012, 4.

10. AAP, 2013, 12; Craig, 2008, 98-99; Kinniburgh et al., 2005, 427-28.

11. Craig, 2008, 96.

12. Kinniburgh et al., 2005, 428.

13. Craig, 2008, 90; Sprinson, John & Ken Berrick. *Unconditional Care: Relationship-Based, Behavioral Intervention with Vulnerable Children and Families*, 2010, 58-59.

14. Cole et al., 2005, 21-24; Craig, 2008, 51-52.

15. Craig, 2008, 26-27.

16. Cole et al., 2005, 25.

17. Craig, 2008, 47-48.

18. Dr. John Sprinson, Training at Legal Services for Children, Feb. 8, 2013 (on file with authors) ("Sprinson Training 2/8/13").

19. Sprinson Training 2/8/13.

20. Craig, 2008, 22-24.

21. As Sprinson and Berrick explain, "Children . . . are actively construing their experience and working to construct images of what drives the behavior of others, of who they are in relation to others, and of what they can expect in the future. . . . [A] child who has suffered a pattern of sustained hurtful early experiences such as loss, neglect, or abuse will have a way of representing the self and the world that is consistent with or reflects that experience. She may believe she is bad, damaged, or in some way deserving of this treatment and will expect the treatment to continue. . . . These ideas are not easy to revise in the face of new experience and are especially resistant to alteration by language." Thus, adults working with these youth should "work to provide the

child with experiences in relationships that are different from those encountered in past relationships and to support the child in very gradually constructing a new model of how these relationships might unfold." Sprinson & Berrick, 2010, 57-59.

22. Sprinson Training 2/8/13.

23. Sprinson & Berrick at 7; Craig, 2008, 90.

24. Sprinson & Berrick, 2010, 47.

25. Sprinson Training 2/8/13.

26. Craig, 2008, 100-01.

27. Ibid.

28. Dorado, Joyce. Healthy Environments and Response to Trauma in Schools (HEARTS), University of California San Francisco (UCSF). *Promoting School Success for Students Who Have Experienced Complex Trauma: Creating Trauma-Sensitive School Environments*, 2013, 29 (on file with authors).

29. Dr. John Sprinson, Training at Legal Services for Children, Feb. 22, 2013 (on file with authors).

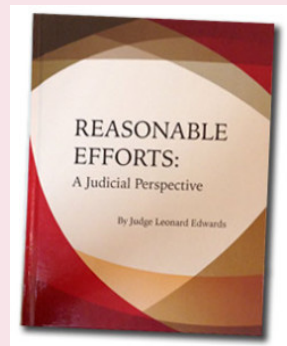
30. We are grateful to Dr. John Sprinson and Gena Castro Rodriguez for their assistance in compiling these recommendations.

31. Dorado, 2013, 36, 39.

NEW IN PRINT

New Book on Reasonable Efforts

Judge Leonard Edwards, a former California child welfare judge for over two decades, has released a book on reasonable efforts in child welfare cases: *Reasonable Efforts: A Judicial Perspective*.



The book comes from the view of a judicial officer in a dependency court. It explains the judge's role and how reasonable efforts can be a tool in providing oversight of prevention, reunification, and other permanency options.

The book explains the history and current state of the law, including legal requirements for findings at different stages, aggravated circumstances, and state statutory and case law on reasonable efforts. It examines reasonable efforts in common contexts, including inadequate housing, poverty, visitation, domestic violence, substance abuse, mental health, engaging fathers and relatives, and incarcerated parents.

Tips and tools around best practices focus on quality legal representation, frontloading services, and cultural competence. Tools in the appendices include sample forms and benchcards.

Order from the National Council of Juvenile and Family Court Judges, Cheryl Davidek, cdavidek@ncjfcj.org, 775/784-6012. The book is free but there is a fee for shipping and handling.

October 01, 2014

Establishing a Trauma-Informed Lawyer-Client Relationship

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This is the second article in a series focused on advocating for children and families impacted by trauma. The first article, "[Understanding Trauma and its Impact on Child Victims](#)," by Eva Klain, appeared in the September 2014 issue.

As a lawyer for youth, you know many of your clients have experienced trauma, particularly those involved in the child welfare or juvenile justice systems. Trauma can affect the most fundamental aspects of the attorney-client relationship.

Even though most lawyers are not mental health professionals, a working understanding of trauma, including its origins and its impacts, can be helpful in anticipating and responding to trauma's effects as they surface in our work with clients.

This two-part article presents strategies for building stronger, more trauma-informed attorney-client relationships with youth.

Why focus on the attorney-client relationship?

- **Client trust and engagement.** A client's trauma history can make it difficult to build trust and actively involve the client with her legal case. By learning to build relationships that better respond to the needs of youth who have experienced trauma, you can improve client engagement and fulfill your mandate as the child's representative.¹
- **Attorney-client interactions.** Childhood trauma can affect a person's cognitive and psychosocial development, including how one thinks, processes information, and communicates with others. Trauma thus impacts basic attorney-client interactions, such as interviewing, explaining case developments, and counseling and advising clients on case-related decisions.
- **Modeling positive relationships.** Youth who have experienced trauma, particularly in the context of interpersonal relationships, often expect new relationships to reinforce negative beliefs they have developed about themselves and others; for example, that they are inherently unlikeable or "bad," or that adults are untrustworthy and will inevitably hurt them. Many experts agree that one of the best paths to healing for traumatized youth can be to develop positive, safe relationships.² Like all professionals who work with these youth, lawyers can either aid in the client's healing or magnify a client's vulnerabilities.

Not all court-involved youth have experienced trauma, and reactions to trauma vary among those who have. Some youth experience few or no long-term effects of trauma. Drawing on the public health principle of "universal precaution," we advocate adopting a trauma-informed approach to all client relationships, seeking, at minimum, to "do no harm." At best, lawyers can communicate with and counsel their clients more effectively, achieve more authentically client-directed representation, and help clients move beyond their trauma to healthy developmental paths.³

Challenges of Trauma-Informed Lawyering

Childhood trauma affects how a young person perceives and interacts with the world around her. Trauma's impact is not only psychological, but also physiological: children's brains, incomplete at birth, develop in ways that respond to the child's experiences with traumatic stress.⁴ Clients who experience these responses may think and behave in ways that make it more challenging for the lawyer to build trust, communicate effectively, and engage the client in making decisions about her legal case.

This section draws on knowledge from the mental health and medical fields to describe common effects of childhood trauma. Keep in mind that trauma's impact on a young person varies, depending on the type of trauma experienced, whether the trauma was isolated or repeated, the age at which the trauma was experienced, the young person's gender and cultural identity, and the caregiving and social supports available to the young person before and after the traumatic events.⁵ We encourage you to consult other resources and mental health professionals working directly with your clients to better understand the impact of a client's experiences with trauma.

Building Relationships

Impaired sense of safety. Traumatized youth often have an impaired sense of safety. Having been exposed to acute or chronic threat—such as maltreatment, neglect, or community or domestic violence—they may perceive even neutral environments as threatening, and their brains are primed to go into “survival” mode. Although youths' survival-oriented behaviors are natural and healthy in the face of real danger, they become maladaptive in nonthreatening social contexts.⁶ These behaviors might be how the youth functions day in and day out (i.e., their baseline level of functioning), or youth might exhibit them when something, consciously or unconsciously, reminds them of a past trauma. This latter phenomenon is known as triggering, and the thing that prompted the survival response is often referred to as a trauma “trigger.”⁷

Youths' survival behaviors vary. Youth may become “hyperaroused,” a state of heightened energy and alertness to threat. Clients who are hyperaroused might appear jumpy, have frequent outbursts, or become confrontational or aggressive.⁸ Another common response is “dissociation”—mentally shutting down, becoming numb, or having “gone elsewhere.” Youth may also deal with perceived threats by altering their behavior and daily patterns to avoid reminders of past trauma.⁹

Dissociation can be harder to recognize than hyperarousal but can still create challenges when building attorney-client relationships. For example, a dissociated client may seem indifferent to the legal proceedings or to the lawyer's efforts at counseling. Avoidance may lead a client to start skipping appointments, causing frustration and logistical challenges for the lawyer.

Controlling emotions. Children exposed to trauma can have trouble rolling their emotions. The parts of their brains that remain alert to threat have been constantly turned on, while they may have had less opportunity to develop self-regulation skills. They often feel overwhelmed by their emotions and simultaneously lack tools for calming themselves down. To others, they can appear out of control or overly impulsive.¹⁰

Lack of trust. Building trust is a formidable task, particularly with youth who have been exposed to violence or trauma in the context of intimate relationships.¹¹ These youth have learned that adults cannot keep them safe, do not attend to their needs, and may harm them. They are more likely to be hyperalert in social interactions and to misread facial or verbal cues as negative.¹² When building new relationships, youth who have experienced interpersonal trauma may try to push the adult away or provoke an adverse response. The youth may be modeling how she has been treated in past relationships or trying to achieve control by bringing about negative treatment that she considers inevitable.¹³ Clients may engage in behaviors to “test” whether you will ultimately disappoint and reject them, as other adults have done.

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Proactive Support – Anticipate issues that may arise during your representation and in the legal case that may be distressing or destabilizing for your client. Consult with mental health professionals and other adults in the client’s life to identify situations that may be stressful or even “triggering,” as well as supports that will be available to your client when needed.

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- Clarify how you differ from other adults in the client’s life and in the legal case.
- Explain the client’s role and which decisions are within her control. If you represent the client’s “best interests,” be clear early on about when you might need to advocate against your client’s wishes to avoid “blindsiding” the client and creating a sense of betrayal.
- In client-driven representation, emphasize the client’s power and agency. Many young children have trouble understanding that they, not the adult lawyer, have decision-making power. This tendency can be exacerbated in youth who respond to trauma by being excessively compliant with adults, either out of fear that missteps might yield retribution or as symptomatic of a dissociative response to the trauma. Clients who respond to trauma by acting out versus shutting down are often seeking power and recognition. Offering them an alternate way to be seen and heard and have their voice respected in the attorney-client relationship may disrupt their internal belief that acting out and aggression are the only means to obtain status and recognition.

- Explain confidentiality and its limits.
- Give the client reliable information about your schedule, availability, and how to contact you. You do not need to be available at all times to be “reliable;” it is better to have scheduled check-ins that you are able to keep.
- Explore the client’s assumptions about the attorney-client relationship. Has the client had prior attorneys? What were those relationships like? What worked well, and what didn’t? By asking the client to express her opinions about working with an attorney, you can better anticipate bumps in your relationship and avoid creating a dynamic that the client feels powerless to alter in the future.²²

Boundaries. Role definition is crucial because it helps establish boundaries in the attorney-client relationship. Many traumatized youth have experienced grievous violations of their personal boundaries, or have grown up in environments where the lines between children and adults are blurred.²³ Establishing clear boundaries creates predictability and can help the youth feel safe. It is especially important not to create a false sense that you can rescue your client or her family, or to foster a dependence on you that will become another loss to your client when your role in her life is over. Recall that your journey with the client has a beginning, middle, and an end. Preview that end from the beginning, and keep it alive throughout the relationship, as a conscious recognition of the limits of your availability.

Repairing Ruptures. While building strong client relationships, recognize that ruptures in the relationship are inevitable. Creating opportunities to repair those ruptures is part of strengthening the relationship with the client.²⁴ Despite best intentions, you risk doing or saying something that breaks the client’s trust or triggers survival responses. Clients may also try to push you away, or transfer to you feelings, such as anger or frustration, that they cannot bear. If you can stay calm and committed, or bear something the client finds unmanageable, the client benefits from observing that capacity in another.

By remaining engaged and reliable, you disprove the client’s belief that you will abandon her or that her feelings are “too much” to handle.²⁵ This also shows respect for your client’s adaptive behaviors by recognizing that such adaptations were born out of self-preservation. It is not your role as lawyer to suggest the client abandon these behaviors for your sake.

Preparing for and Responding to Triggering

Among the more severe trauma-related reactions you might encounter over the course of the representation is “triggering,” which occurs when something in the youth’s environment activates a memory of the trauma, evoking an intense and immediate reaction from the youth.²⁶ As revisiting content related to a specific traumatic event can be triggering, so can the effects of a traumatic event. For example, the emotional state of hyperarousal, which the client may have felt while experiencing the trauma, can itself be a trigger.²⁷ Common triggers include unpredictability; transition; loss of control; feelings of vulnerability, loneliness, or rejection; sensory overload; confrontation; embarrassment or shame; intimacy; and even positive attention.²⁸ While most lawyers are not trained to judge in a clinical sense whether a client is being “triggered,” the following reactions can be signs that a client may be triggered:²⁹

- 1 Jumping up or lashing out
- 2 Difficulty tracking the lawyer’s questions
- 3 Difficulty making oneself clearly understood (e.g., a long tangled narrative)

- 4 The client gives a brief, clipped narrative, or claims not to remember.
- 5 The client shuts down, develops a flat affect, becomes lost in the conversation, can't remember what she was talking about, or appears to have "gone somewhere else."
- 6 Regressive behaviors (e.g., thumb sucking)
- 7 With the client's consent, consult mental health providers and other adults in your client's life to understand what things are known to trigger your client and how your client reacts (and subsequently recovers) when triggered. Ideally, each client who comes into contact with the legal system should receive appropriate assessments of her present level of functioning, trauma history, needs, and strengths, and have access to coordinated services as needed.

In addition to seeking individualized guidance, the following roadmap can guide your response if you are with the client when she is in a triggered state.³⁰ These recommendations also apply when a client is in a lesser state of emotional distress, and are useful when you are unsure if the client is being "triggered."

- Trust your ability to read the client. If it appears your client is becoming distressed, address that distress instead of simply moving forward.
- When someone's "survival brain" has been triggered, that turns off the prefrontal cortex—the brain's reasoning center. Dr. Joyce Dorado uses the analogy that the "rider is off the horse." Before doing anything else to ameliorate the situation, get the rider back on the horse. Do nothing to startle the young person; do not be confrontational and do not escalate the situation. Do what you can to help the youth feel safe and in control. Give gentle reminders that the youth is safe, you are here, and you will wait for her to tell you when she is ready. Once the rider is back "on the horse," you can ask what led to her distress.³¹
- Tell the client her reactions to trauma are normal. There is not something "wrong" with her.
- Tell the client you will watch for signs that she is becoming upset in the future, to help her anticipate and ward off those moments. In so doing, you counter past relationships the youth may have had with adults who were not attuned to her needs.
- Prepare for the next time you are going to confront the trigger. Thank the client for letting you know she was uncomfortable, and tell her she can let you know next time she is getting upset. If it will be necessary to confront the trigger again during the legal case discuss this with the client, as well as how it fits with your efforts to help her attain her goals.
- Ensure the client has trusted adult(s) to follow up with as needed.
- If your client is willing to participate, link her to trauma-focused therapy that can help her develop strategies for regulating emotions. These therapies often rely on parent or caregiver involvement. You can also identify caring adults who may be willing to help the client build these critical emotion-regulation skills.

Conclusion

To create a solid foundation for working effectively with traumatized youth, lawyers should focus on building strong attorney-client relationships that respond to common effects of childhood trauma. Part Two of this article will address strategies for interviewing and counseling traumatized youth and talking with them directly about their trauma experiences.

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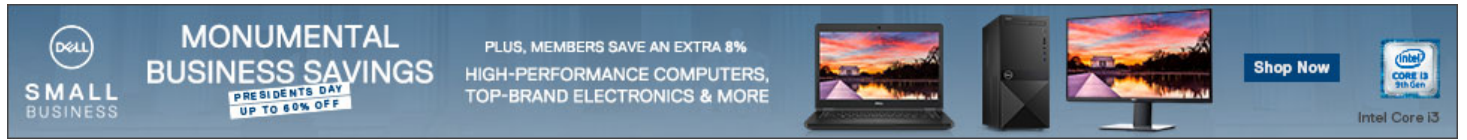
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Endnotes

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16. Cole et al., 2005, 25.
17. Craig, 2008, 47-48.
18. Dr. John Sprinson, *Training at Legal Services for Children*, Feb. 8, 2013 (on file with authors) (“Sprinson Training 2/8/13”).
19. Sprinson Training 2/8/13.
20. Craig, 2008, 22-24.
21. As Sprinson and Berrick explain, “Children . . . are actively construing their experience and working to construct images of what drives the behavior of others, of who they are in relation to others, and of what they can expect in the future. . . . [A] child who has suffered a pattern of sustained hurtful early experiences such as loss, neglect, or abuse will have a way of representing the self and the world that is consistent with or reflects that experience. She may believe she is bad, damaged, or in some way deserving of this treatment and will expect the treatment to continue. . . . These ideas are not easy to revise in the face of new experience and are especially resistant to alteration by language.” Thus, adults working with these youth should “work to provide the child with experiences in relationships that are different from those encountered in past relationships and to support the child in very gradually constructing a new model of how these relationships might unfold.” Sprinson & Berrick, 2010, 57-59.
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POST-TRAUMATIC STRESS DISORDER

How PTSD and Trauma Affect Your Brain Functioning

Neuroscience explains the anxiety and hypervigilance of people with PTSD.

Posted Sep 29, 2018



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About 10 percent of women and 4 percent of men will develop Post-Traumatic Stress Disorder (PTSD) over their lifetimes. Men and women who have experienced sexual trauma are at increased risk, especially if the trauma occurred at a young age or was repeated.

PTSD is a mental health condition that may involve disturbances in threat perception, threat sensitivity, self-image, and emotional functioning. It can cause serious disruption in the ability to have healthy, satisfying relationships or tolerate life's uncertainties, failures, and rejections without excess distress. It can also cause phobias, sleep

disturbance, negative mood, anxiety, and attention/concentration difficulties that interfere with academic or career success. Research in neuroscience suggests impaired functioning in brain areas responsible for threat detection/response and emotion regulation account for many PTSD symptoms.

What Is PTSD?

PTSD is a mental health condition that can develop in response to a trauma that may have occurred recently or in the distant past. Generally, the trauma would involve some sense of threat to life or threat of bodily harm affecting either you or a loved one. Core symptoms of PTSD include some type of re-experiencing (e.g., nightmares, flashbacks, or emotional flooding), attempts to avoid reminders of the event or associated emotions, hyper-arousal (e.g., feeling constantly on edge), and distressing thoughts or emotional reactions. These symptoms need to last for at least two weeks and interfere with functioning or cause significant distress.

What Brain Areas are Implicated in PTSD?

PTSD symptoms develop due to dysfunction in two key regions:

The Amygdala

This is a small almond-shaped structure located deep in the middle of the temporal lobe. The amygdala is designed to:

- Detect threats in the environment and activate the “fight or flight” response
- Activate the sympathetic nervous system to help you deal with the threat
- Help you store new emotional or threat-related memories

- Regulate attention and awareness
- Make decisions about the best response to a situation
- Initiate conscious, voluntary behavior
- Determine the meaning and emotional significance of events
- Regulate emotions
- Inhibit or correct dysfunctional reactions

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When your brain detects a threat, the amygdala initiates a quick, automatic defensive (“fight or flight”) response involving the release of adrenaline, norepinephrine, and glucose to rev up your brain and body. Should the threat continue, the amygdala communicates with the hypothalamus and pituitary gland to release cortisol. Meanwhile, the medial part of the prefrontal cortex consciously assesses the threat and either accentuates or calms down the “fight or flight” response.

Studies of response to threat in people with PTSD show:

- A hyper reactive amygdala
- A less activated medial PFC

In other words, the amygdala reacts *too* strongly to a potential threat while the medial PFC is impaired in its ability to regulate the threat response.

Consequences of Brain Dysfunctions in PTSD

Hyperarousal

Because the amygdala is overactive, more norepinephrine is released in response to threat and its release is not well-regulated by the PFC.

Effects of excess norepinephrine include:

1. Hyperarousal.
2. Hypervigilance
3. Increased wakefulness and sleep disruption

As a result of hyperarousal, people with PTSD can get emotionally triggered by anything that resembles the original trauma (e.g., a sexual assault survivor telling her story on TV, a loud noise, or passing somebody who looks like their assailant). Symptoms of hypervigilance means they are frequently keyed up and on edge, while increased wakefulness means they may have difficulty sleeping or wake up in the middle of the night.

leading them to be more impulsive. The orbital PFC is a part of the PFC that can inhibit motor behavior (physical action) when it is not appropriate or necessary. In people with PTSD, the orbital PFC has lower volume and is less activated. This means that people with PTSD have less control over reactive anger and impulsive behaviors when they are emotionally triggered. Reactive anger can cause damage to career success and interfere with relationship functioning.

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Increased Fear and Anger and Decreased Positive Emotionality

People with PTSD often report feeling an excess of negative emotion and little positive emotion. They may have difficulty enjoying their day-to-day activities and interactions. This could be the result of a hyperactive amygdala communicating with the insula, an area of the brain associated with introspection and emotional awareness. The amygdala-insula circuit also impacts the medial PFC, an area associated with assigning meaning to events and regulating emotions. Research shows overactivity of the amygdala-amygdala-insula circuit can suppress the medial PFC, thereby interfering with the ability to regulate negative emotions and assign more positive meaning to events.

How Treatments Affect the Brains of People with PTSD

Some studies show that psychotherapies which include repeated exposure to trauma cues can enhance the ability of the PFC to assign less threatening or more positive meanings to trauma-related events.

Antidepressants seem to have a similar effect. Mindfulness interventions lasting 10 to 12 weeks have been shown to decrease amygdala volume and increase the connectivity between the amygdala and PFC.

Mindfulness seems to make the amygdala less reactive and the PFC more able to calm down the threat response. But some people with PTSD may have difficulty tolerating being mindful or confronting their trauma actively. Avoidance is a hallmark of PTSD and some patients may need more support and relationship-building before they are ready to face their distressing feelings.

Summary

Research suggests that the brains of people with PTSD differ from brains of those without PTSD in two main ways:

- They are hyperactive to threat (amygdala).
- They have difficulty regulating or damping down anxiety and anger (medial PFC).

Effective treatments for PTSD seem to address these brain dysfunctions by either decreasing the reactivity of the amygdala or increasing the ability of the PFC to calm it down. Therapists who are trained to recognize and treat the signs of PTSD can be much more effective in reducing the considerable suffering associated with their trauma experience. Educating patients about their symptoms and the neurobiology of PTSD can be de-shaming and increase their self-compassion and sense of control.

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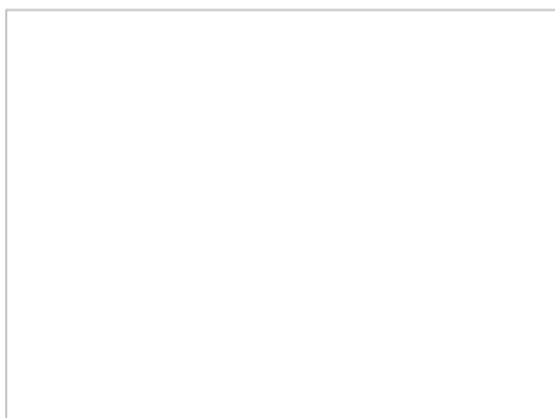
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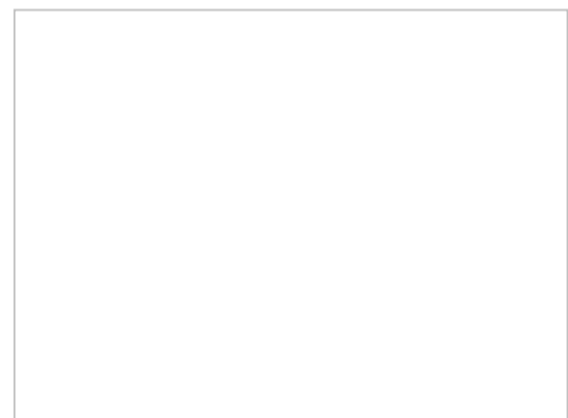
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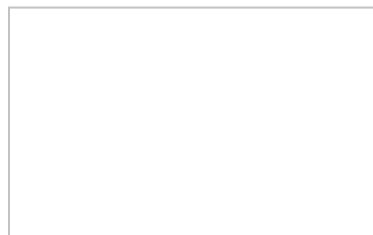
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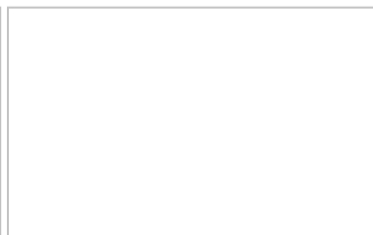
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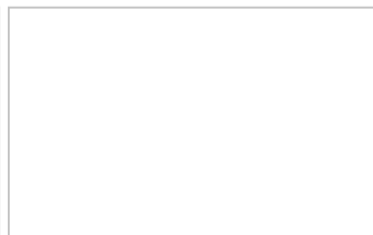
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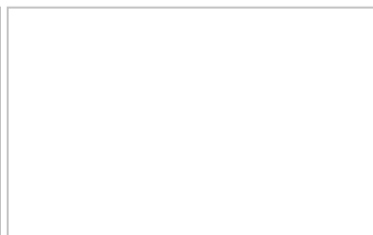
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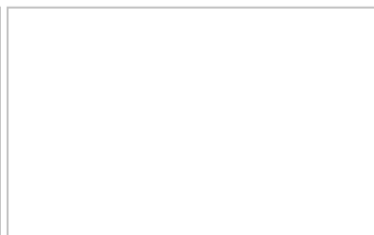
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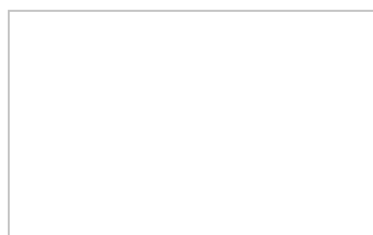
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THE PEDAGOGY OF TRAUMA-INFORMED LAWYERING

SARAH KATZ & DEEYA HALDAR*

“Trauma-informed practice” is an increasingly prevalent approach in the delivery of therapeutic services, social and human services, and now legal practice. Put simply, the hallmarks of trauma-informed practice are when the practitioner puts the realities of the client’s trauma experiences at the forefront in engaging with the client, and adjusts the practice approach informed by the individual client’s trauma experience. Trauma-informed practice also encompasses the practitioner employing modes of self-care to counterbalance the effect the client’s trauma experience may have on the practitioner.

This article posits that teaching trauma-informed practice in law school clinics furthers the goals of clinical teaching, and is a critical aspect of preparing law students for legal careers. Trauma-informed practice is relevant to many legal practice areas. Clients frequently seek legal assistance at a time when they are highly vulnerable and emotional. As clinical professors who each supervise a family law clinic, we of course teach our students how to connect with their clients, while drawing the appropriate boundaries of the attorney-client relationship. Equally challenging and important is helping our students cultivate insight into identifying and addressing trauma and its effects. Many of our clinics’ clients are survivors of intimate partner violence or have experienced other significant traumatic events that are relevant to their family court matters. Law students should learn to recognize the effects these traumatic experiences may have on their clients’ actions and behaviors. Further, law students should learn to recognize the effect that their clients’ stories and hardships are having on their own advocacy and lives as a whole. It is particularly crucial that we educate our law students about the effects of vicarious trauma and help them develop tools to manage its effects as they move through their clinical work and ultimately into legal practice.

This article argues that four key characteristics of trauma-informed lawyering are: identifying trauma, adjusting the attorney-cl-

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ent relationship, adapting litigation strategy, and preventing vicarious trauma. Specifically, the article discusses how to teach trauma-informed lawyering through direct examples of pedagogical approaches.

INTRODUCTION

When Victoria¹ came into the clinic for an intake appointment with a law student, the student knew only that this was a child and spousal support case. After explaining the goals and purpose of an intake interview, the law student asked a simple question: what legal problem brings you here today? Victoria broke down crying and began explaining that about two years before, she learned that her husband of twenty-one years had been sexually abusing their now thirteen year-old daughter and fifteen year-old son since they were small children. Victoria stated that her husband had sometimes physically abused her, but she knew nothing of the sexual abuse. After the disclosure, she had filed for and been granted a protection order in Tennessee on behalf of herself and her children. She then moved with her children from the marital home in Tennessee to Philadelphia to be with family. The Tennessee protection order expired, and because of threatening phone messages received from her husband, she had sought a protection order again in Philadelphia. A local domestic violence legal services agency had referred her to the clinic for help with a child and spousal support case.

During the meeting with the law student, Victoria became increasingly upset, and continued to share details of the abuse she and her children had suffered. Victoria seemed intent on convincing the law student that she really had not known about the abuse of her children while it was happening. The law student offered tissues and told Victoria repeatedly that he believed her, and that it must have been so awful to make this realization. When the law student tried to move the focus of the conversation to the pending support case, it turned out that Victoria had not brought any of the paperwork she had been asked to bring by the clinic's office manager. The law student got as much information as Victoria could provide, and then explained that for the clinic to see if it could help her with the case, he would need to see the paperwork. The law student and Victoria scheduled another appointment, and the law student provided Victoria a written list of the needed documents. The law student discussed with his supervisor, and later shared in class case rounds, how challenging the interview had been. Victoria did bring the needed documents to the second appointment, and the clinic ultimately accepted the case.

¹ This case description is based on the experience of a client represented by Professor Katz's clinic. Names and identifying information have been changed.

Prior to going to court, Victoria called the law student asking if she could just not attend the court date, because she was terrified of seeing her husband. The law student calmly explained that Victoria needed to be present if she wanted to pursue the support claim. They scheduled a time to meet the day before court, and the law student spent a lot of time reviewing with Victoria exactly what occurs in a support hearing, including where she and others would sit, what types of questions would be asked, and what the law student would be doing. The law student also arranged to meet Victoria prior to the hearing time at a location near the courthouse, so they could walk into court together. Because the litigation became very contentious and there were multiple court hearings, the law student repeated this approach each time there was a court hearing. He also encouraged Victoria to speak with her therapist about her anxiety over dealing with her husband. Ultimately the support case was resolved favorably for Victoria.

While many reading would view the description of the law student's handling of the case above as simply "good lawyering," it is also an example of "trauma-informed practice." "Trauma-informed practice" is an increasingly prevalent approach in the delivery of therapeutic services, social and human services, and now legal practice. Put simply, the hallmarks of trauma-informed practice are when the practitioner, here a law student, puts the realities of the clients' trauma experiences at the forefront in engaging with clients and adjusts the practice approach informed by the individual client's trauma experience. Trauma-informed practice also encompasses the practitioner employing modes of self-care to counterbalance the effect the client's trauma experience may have on the practitioner.

Although there is a body of clinical legal education literature devoted to the value of teaching and developing law students' empathy toward their clients, less attention has been devoted to the importance of teaching trauma-informed practice, the pedagogy of teaching law students to recognize and understand trauma, and the effect of vicarious trauma on law students (and attorneys) who work with clients who have experienced serious trauma. Clients frequently seek legal assistance at a time when they are highly vulnerable and emotional. In practice areas such as family law, immigration, child welfare, criminal law and others, by necessity, clients must share some of the most intimate and painful details of their lives. In our family law clinics, our students are taught how to connect with their clients, while drawing the appropriate boundaries of the attorney-client relationship. Equally challenging and important is helping our students cultivate insight into identifying and addressing trauma and its effects. Many of

our clinics' clients are domestic violence survivors or have experienced other significant traumatic events that are relevant to their family court matters. Law students must learn to recognize the effects these traumatic experiences may have on their clients' actions and behaviors. Further, law students must learn to recognize the effect that their clients' stories and hardships are having on their own advocacy and lives as a whole. It is particularly crucial that we educate our law students about the effects of vicarious trauma and help them develop tools to manage its effects as they move through their clinical work, and ultimately into legal practice.

Although the authors draw from their own experience teaching family law clinics, other types of law school clinics could likely benefit from the pedagogy of trauma-informed lawyering, such as immigration law, criminal law, juvenile law, and veterans' rights law.² A significant body of literature exists regarding working with traumatized children involved in the legal system, including in the law school clinical context.³ It is the authors' intention that this article will provide tools for teaching trauma-informed practice in all law school clinic settings, while the examples offered are specific to family law experience.

This article proceeds in three sections. The first section will further explore trauma-informed practice, and what is meant by the terms "trauma," and "vicarious trauma." The second section will argue why teaching trauma-informed lawyering in a clinical legal educa-

² See, e.g., Lynette M. Parker, *Increasing Law Students' Effectiveness When Representing Traumatized Clients: A Case Study of the Katherine & George Alexander Community Law Center*, 21 GEO. IMMIGR. L.J. 163 (2007) (discussing students in immigration clinic begin confronted with traumatized client seeking asylum); Ingrid Loreen, *Therapeutic Jurisprudence & The Law School Asylum Clinic*, 17 ST. THOMAS L. REV. 835, 845 (2005) (arguing that students need training in therapeutic jurisprudence topics, including trauma training in order to adequately serve traumatized clients seeking asylum); Sarah Mourer, *Study, Support, and Save: Teaching Sensitivity in the Law School Death Penalty Clinic*, 7 U. MIAMI L. REV. 357 (2013) (discussing students exposed to clients with trauma histories in the Miami Law Death Penalty Clinic); Capt. Evan R. Seamone, *The Veterans' Lawyer as Counselor: Using Therapeutic Jurisprudence to Enhance Client Counseling for Combat Veterans with Posttraumatic Stress Disorder*, 202 MIL. L. REV. 185 (2009).

³ See Carolyn Salisbury, *From Violence and Victimization to Voice and Validation: Incorporating Therapeutic Jurisprudence in a Children's Law Clinic*, 17 ST. THOMAS L. REV. 623 (2005). See also Renee DeBoard-Lucas, Kate Wasserman, Betsy McAlister Groves & Megan Bair-Merritt, *16 Trauma-Informed, Evidence-Based Recommendations for Advocates Working with Children Exposed to Intimate Partner Violence*, 32(9) CHILD L. PRAC. 136 (2013); JEAN KOH PETERS, REPRESENTING CHILDREN IN CHILD PROTECTIVE PROCEEDINGS: ETHICAL AND PRACTICAL DIMENSIONS 9 (2007); NATIONAL CHILD TRAUMATIC STRESS NETWORK, BIRTH PARENTS WITH TRAUMA HISTORIES AND THE CHILD WELFARE SYSTEM: A GUIDE FOR JUDGES AND ATTORNEYS, available at <http://www.nctsn.org/products/birth-parents-trauma-histories-child-welfare-system-guide-birth-parents-2012> (last viewed Dec. 20, 2015).

tion setting makes sense. The third section will identify four hallmarks of trauma-informed legal practice: (1) identifying trauma; (2) adjusting the lawyer-client relationship; (3) adapting litigation strategy; and (4) preventing vicarious trauma. The article then discusses how to incorporate these hallmarks of trauma-informed lawyering as teaching goals in law school clinics through direct examples of pedagogical approaches.

I. DEFINING TRAUMA-INFORMED PRACTICE

Trauma-informed practice has gained traction in the therapeutic world for at least the last decade. As one practitioner has explained, “[t]rauma-informed practice incorporates assessment of trauma and trauma symptoms into all routine practice; it also ensures that clients have access to trauma-focused interventions, that is, interventions that treat the consequences of traumatic stress. A trauma-informed perspective asks clients not ‘What is wrong with you?’ but instead, ‘What happened to you?’”⁴ As psychiatrist Sandra Bloom has written, “It connects a person’s behavior to their trauma response rather than isolating their actions to the current circumstances and assuming a character flaw.”⁵ A trauma-informed system also focuses on how services are delivered, and how service-systems are organized.⁶ These approaches in the therapeutic context have begun to profoundly inform the delivery of other types of human and social services, such as child welfare,⁷ law enforcement, and the courts.⁸ But in order to understand what is meant by trauma-informed practice, an understanding of trauma, and vicarious trauma is necessary; this section will define and explain these terms, and then return to a discussion of how trauma-

⁴ Nancy Smyth, *Trauma-Informed Social Work Practice: What Is It and Why Should We Care?*, SOCIAL WORK/SOCIAL CARE & MEDIA (Mar. 20, 2012), available at <http://swscmedia.wordpress.com/2012/03/20/trauma-informed-social-work-practice-what-is-it-and-why-should-we-care-opinion-piece-by-dr-nancy-smyth/> (citing SANDRA L. BLOOM, & BRIAN FARRAGHER, *DESTROYING SANCTUARY: THE CRISIS IN HUMAN SERVICES DELIVERY SYSTEMS* (2011)).

⁵ Sandra L. Bloom, *Why Should Philadelphia Become a Trauma-Informed City*, Briefing Paper Prepared for the Philadelphia Mayoral Forum, sponsored by the Scattergood Foundation (2015), available at <http://sanctuaryweb.com/Portals/0/Bloom%20Pubs/2015%20Bloom%20Why%20should%20Philadelphia%20become%20a%20Trauma.pdf>.

⁶ Sandra L. Bloom, *The Sanctuary Model of Trauma-Informed Organizational Change*, 16 (1) THE SOURCE 12, 14 (Nat’l Abandoned Infants Resource Center, 2007).

⁷ ABA CENTER FOR CHILDREN & THE LAW, *IMPLEMENTING TRAUMA-INFORMED PRACTICES IN CHILD WELFARE* (2013) available at <http://childwelfaresparc.org/wp-content/uploads/2013/11/Implementing-Trauma-Informed-Practices.pdf>.

⁸ SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, *ESSENTIAL COMPONENTS OF TRAUMA-INFORMED JUDICIAL PRACTICE*, available at http://www.nasmhpd.org/sites/default/files/JudgesEssential_5%201%202013finaldraft.pdf (last viewed Dec. 20, 2015) [hereinafter SAMHSA].

informed practice is implemented.

A. Understanding Trauma

An event is defined as traumatic when it renders an individual's internal and external resources inadequate, making effective coping impossible.⁹ A traumatic experience occurs when an individual subjectively experiences a threat to life, bodily integrity or sanity.¹⁰ The American Psychological Association further defines trauma as:

[An] emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives.¹¹

External threats that result in trauma can include “experiencing, witnessing, anticipating, or being confronted with an event or events that involve actual or threatened death or serious injury, or threats to the physical integrity of one's self or others.”¹²

Trauma can take many different forms. A 1997 study found that about one third of the population will experience severe trauma at some point.¹³ The most common sources of trauma, experienced by 15 to 35 percent of the people surveyed, included witnessing someone being hurt or killed, or being involved in a fire, flood, or other such life-threatening accidents.¹⁴ Other common experiences included robbery and sudden deaths of loved ones.¹⁵ An estimated 0.5 percent of people (1.2 million) in the United States were victims of a violent crime in 2014.¹⁶ Researchers have begun to confirm the interconnection between the effects of racism and trauma.¹⁷ Further the intercon-

⁹ Richard R. Kluft, Sandra L. Bloom, & John D. Kinzie, *Treating the Traumatized Patient and Victims of Violence*, in 86 NEW DIRECTIONS IN MENTAL HEALTH SERVICES 79 (2000) (citing B. A. Van der Kolk, *The Compulsion to Repeat the Trauma: Re-enactment, Re-victimization, and Masochism*, 12 PSYCHIATRIC CLINICS OF N. AM. 2 (1989)).

¹⁰ LAURIE A. PEARLMAN & KAREN SAAKVITNE, TRAUMA AND THE THERAPIST: COUNTERTRANSFERENCE AND VICARIOUS TRAUMATIZATION IN PSYCHOTHERAPY WITH INCEST SURVIVORS 60 (1995).

¹¹ *Trauma*, AMERICAN PSYCHOLOGICAL ASSOCIATION, <http://www.apa.org/topics/trauma/> (last viewed Dec. 20, 2015).

¹² *Id.*

¹³ S.D. Solomon & J.R.T. Davidson, *Trauma: Prevalence, Impairment, Service Use, and Cost*, 58 J. CLINICAL PSYCHIATRY (SUPPL. 9) 5-11, 7 (1997).

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ Jennifer L. Truman & Lynn Langton, *Criminal Victimization, 2014* at 1 (U.S. Dept. of Justice Sept. 29, 2015), available at <http://www.bjs.gov/content/pub/pdf/cv14.pdf>.

¹⁷ See, e.g., Dottie Lebron, Laura Morrison, Dan Ferris, Amanda Alcantara, Danielle Cummings, Gary Parker & Mary McKay, *The Trauma of Racism* (McSilver Institute for

nection between urban poverty and trauma has been established.¹⁸

Intimate partner violence and child maltreatment are other examples of trauma, and are far more prevalent than is often acknowledged. On average, twenty four people per minute are victims of rape, physical violence, or stalking by an intimate partner in the United States—more than twelve million women and men over the course of a year.¹⁹ Nearly three in ten women and one in ten men in the US have experienced rape, physical violence, and/or stalking by a partner and report a related impact on their functioning.²⁰ A reported 1.71% of children are maltreated in the United States.²¹

The rates of abuse are higher among the population of litigants in family court. The anecdotal experience of our family law clinics is many of our clients have experienced serious incidents of physical or sexual abuse by an intimate partner, and in the past as a child. They may also have witnessed or experienced their own child(ren) being physically or sexually abused. These anecdotal observations are supported by empirical study. For example, one study indicated that 80% of parents who were separating or divorcing were able to agree on custody and parenting time with their children. But among the 20% of parents who needed the court to intervene to decide custody, domestic violence was remarkably prevalent, and a domestic violence allegation was substantiated in 41-55% of these cases.²² In fact, experts have noted the “majority of parents in ‘high-conflict divorces’ involving child custody disputes report a history of domestic violence.”²³ The National Center for State Courts has found documented evidence in court records of domestic violence in 20-55% of contested custody cases.²⁴

Poverty Policy & Research, NYU 2015), available at <http://www.mcsilver.org/wp-content/uploads/2015/04/Trauma-of-Racism-Report.pdf>; Glenn H. Miller, *Commentary: The Trauma of Insidious Racism* 37(1) J AM. ACAD. PSYCHIATRY LAW 41, 42 (Mar. 2009).

¹⁸ See, e.g., KATHRYN COLLINS ET AL., UNDERSTANDING THE IMPACT OF TRAUMA AND URBAN POVERTY ON FAMILY SYSTEMS: RISKS, RESILIENCE & INTERVENTIONS (Family Informed Trauma Treatment Center 2010).

¹⁹ CENTERS FOR DISEASE CONTROL, UNDERSTANDING INTIMATE PARTNER VIOLENCE FACT SHEET, available at, <http://www.cdc.gov/ViolencePrevention/pdf/IPV-FactSheet.pdf> (last viewed Dec. 20, 2015).

²⁰ *Id.*

²¹ U.S. DEPT. OF HEALTH AND HUMAN SERVICES, FOURTH NATIONAL INCIDENCE STUDY OF CHILD ABUSE AND NEGLECT (NIS-4): REPORT TO CONGRESS, at 3-3 (2010).

²² Janet R. Johnson, Soyoun Lee, Nancy W. Oleson, & Marjorie G. Walters., *Allegations and Substantiations of Abuse in Custody-Disputing Families*, 43 FAM. CT. REV. 283, 289-290 (2005).

²³ PETER JAFFE, MICHELLE ZERWER, SAMANTHA POISSON, ACCESS DENIED: THE BARRIERS OF VIOLENCE AND POVERTY FOR ABUSED WOMEN AND THEIR CHILDREN AFTER SEPARATION 1 (2002).

²⁴ NATIONAL CENTER FOR STATE COURTS, DOMESTIC VIOLENCE AND CHILD CUSTODY DISPUTES: A RESOURCE HANDBOOK FOR JUDGES AND COURT MANAGERS 5 (1997).

The trauma experiences of clients have a direct relationship to how they relate to their attorneys and the courts, because trauma has a distinct physiological effect on the brain, which in turn affects behavior in the short-term and long-term. Colloquially, this evolutionary response is sometimes referred to as a “flight, fight, freeze.” As one writer has explained:

The brain’s prefrontal cortex—which is key to decision-making and memory—often becomes temporarily impaired. The amygdala, known to encode emotional experiences, begins to dominate, triggering the release of stress hormones and helping to record particular fragments of sensory information. Victims can also experience tonic immobility—a sensation of being frozen in place—or a dissociative state.²⁵

Subsequently, a traumatic experience becomes encoded as a traumatic memory and is stored in the brain via a pathway involving high levels of activity in the amygdala, making recall of the traumatic event highly affectively charged.²⁶ Recall, either intentional or through inadvertent exposure to internal or external stimuli related to the trauma, leads to the release of stress hormones.²⁷ For many individuals who have experienced trauma, specific conditioned stimuli may be linked to the traumatic event (unconditional stimulus) such that re-exposure to a similar environment produces recurrence of fear and anxiety similar to what was experienced during the trauma itself.²⁸ Thus the physiological effects of trauma can manifest far after the traumatic incident occurs, as the amygdala does not always discriminate between real dangers and memory from a past dangerous situation.

In response to traumatic experiences, an individual may feel intense fear, helplessness, or horror.²⁹ People process these reactions differently, resulting in different indicators of trauma.³⁰ Four common behaviors are: anxiety and depression, intense anger towards self or others, the formation of unhealthy relationships, and denial.³¹ Yet, although these common behaviors can result from trauma, the reac-

²⁵ Rebecca Ruiz, *Why Don’t Cops Believe Rape Victims?*, SLATE (June 19, 2013), http://www.slate.com/articles/news_and_politics/jurisprudence/2013/06/why_cops_don_t_believe_rape_victims_and_how_brain_science_can_solve_the.html.

²⁶ Ronald A. Ruden, *Neurobiology of Encoding Trauma*, in *THE ENCYCLOPEDIA OF TRAUMA: AN INTERDISCIPLINARY GUIDE* (Charles R. Figley ed.) 228, 230-231 (2012).

²⁷ *Id.*

²⁸ Dennis Charney, *Psychobiological Mechanisms of Resilience and Vulnerability: Implications for Successful Adaptation to Extreme Stress*, 2 *AM. J. PSYCHIATRY* 161 (2004).

²⁹ Kluft et al., *supra* note 9, at 1.

³⁰ *Id.* at 3.

³¹ Sandra L. Bloom, *The Grief That Dare Not Speak Its Name Part I: Dealing With the Ravages of Childhood Abuse*, *PSYCHOTHERAPY REV.* 2 (9), 408, 408-409 (2000). *See also* JUDITH HERMAN, *TRAUMA AND RECOVERY: THE AFTERMATH OF VIOLENCE – FROM DOMESTIC TO POLITICAL TERROR*, 88-95 (1992).

tions to traumatic events can look different among individuals because although trauma is a common human experience, it is affected by a wide range of “personality styles, ego strengths, diatheses for mental and physical illnesses, social supports, intercurrent stressors, and cultural backgrounds.”³² Thus, the reactions to trauma are psychobiologic and are influenced by complex individual and social contexts, all of which determine the ways in which each individual processes trauma.³³ As a result there are no universal indicators of, or responses to, traumatic events.³⁴

The responses to trauma can be short term or long term.³⁵ Short-term consequences can include re-experiencing the traumatic event, such as having recurrent or intrusive distressing recollections of the event, acting or feeling as if the event is recurring, or avoidance of stimuli associated with the trauma.³⁶ Avoidance may include efforts to avoid thoughts, feelings, or conversations associated with the trauma, efforts to avoid activities, places, or people that arouse recollections of the trauma. Avoidance can also include amnesia for aspects of the trauma, detachment or estrangement from others, defensive mumbling, or dissociative symptoms.³⁷ Dissociation may consist of a diminished awareness or realization of ones surroundings, problems with concentration and attention, or increased arousal.³⁸ Increased arousal refers to such symptoms as experiencing difficulty falling or staying asleep, hypervigilance, or an exaggerated startle response.³⁹

Long-term consequences may include persistence of the short term symptoms, chronic guilt and shame, a sense of helplessness and ineffectiveness, a sense of being permanently damaged, difficulty trusting others or maintaining relationships, vulnerability to re-victimization, and becoming a perpetrator of trauma.⁴⁰ The responses may also be triggered or exacerbated by anniversaries of traumatic events or stressors that are suggestive of the past trauma.⁴¹

B. Understanding Vicarious Trauma

Vicarious trauma, also sometimes called “compassion fatigue” or “secondary trauma,” is a term for the effect that working with survi-

³² Kluff et al., *supra* note 9, at 3.

³³ *Id.* at 1.

³⁴ *Id.* at 3.

³⁵ *Id.* at 4.

³⁶ *Id.* at 4.

³⁷ *Id.* at 4-5; HERMAN, *supra* note 31, at 89.

³⁸ HERMAN, *supra* note 31, at 94.

³⁹ *Id.* at 5.

⁴⁰ *Id.* at 4.

⁴¹ *Id.*

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vors of trauma may have on counselors, therapists, doctors, attorneys, and others who directly help them.⁴² Vicarious traumatization refers to harmful changes that occur in professionals' views of themselves, others, and the world, as a result of exposure to the graphic or traumatic experiences of their clients.⁴³ As psychologist Mark Evces has written, "[s]econdary, or indirect, traumatic exposure is not limited to mental health providers. Anyone who repeatedly and empathically engages with traumatized individuals can be at risk for distress and impairment due to indirect exposure to others' traumatic material."⁴⁴

Vicarious trauma is distinct from "burnout," which refers to the toll that work may take over time.⁴⁵ Burnout can usually be remedied by taking time off, by moving to a new job. Vicarious trauma is a state of tension or preoccupation with clients' stories of trauma.⁴⁶ It may be marked by either an avoidance of clients' trauma histories (almost a numbness to the trauma) or by a state of persistent hyperarousal.⁴⁷

Professionals experiencing vicarious trauma may experience painful images and emotions associated with their clients' traumatic memories and may, over time, incorporate these memories into their own memory systems.⁴⁸ As a result, there may be disruptions to schema in five areas.⁴⁹ These are safety, trust, esteem, intimacy, and control, each representing a psychological need.⁵⁰ Each schema is experienced in relation to self and others. The harmful effects of vicarious trauma occur through the disruptions to these schemas.⁵¹ Vicarious trauma "has been described as a common, long-term response to working with traumatized populations, and as part of a continuum of helper reactions ranging from vicarious growth and resilience to vicarious traumatization and impairment."⁵²

As a normal response to the continuing challenges to their beliefs

⁴² AMERICAN COUNSELING ASSOCIATION, VICARIOUS TRAUMA FACT SHEET #9, *available at*, <http://www.counseling.org/docs/trauma-disaster/fact-sheet-9—vicarious-trauma.pdf?sfvrsn=2> (last viewed Dec. 20, 2015).

⁴³ Katie Baird & Amanda C. Kracen, *Vicarious Traumatization and Secondary Traumatic Stress: A Research Synthesis*, 19 COUNSELING PSYCHOL. Q. 181 (2006).

⁴⁴ Mark R. Evces, *What is Vicarious Trauma?*, in VICARIOUS TRAUMA AND DISASTER MENTAL HEALTH: UNDERSTANDING RISKS AND PROMOTING RESILIENCE, 9, 10 (Gertie Quintangon & Mark R. Evces, eds.) (2015).

⁴⁵ Lisa McCann & Larie A. Pearlman, *Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims*, 3 J. TRAUMATIC STRESS 131, 133 (1990).

⁴⁶ AMERICAN COUNSELING ASSOCIATION, *supra* note 42.

⁴⁷ *Id.*

⁴⁸ McCann & Pearlman, *supra* note 45, at 144.

⁴⁹ Baird & Kracen, *supra* note 43.

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² Evces, *supra* note 44, at 11.

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and values, individuals experiencing vicarious trauma may exhibit varying symptoms.⁵³ Some of these symptoms include: denial of clients' trauma, over-identification with clients, no time and energy for oneself, feelings of great vulnerability, experiencing insignificant daily events as threatening, feelings of alienation, social withdrawal, disconnection from loved ones, loss of confidence that good is still possible in the world, generalized despair and hopelessness, loss of feeling secure, increased sensitivity to violence, cynicism, feeling disillusioned by humanity, disrupted frame of reference, changes in identity, world view, and spirituality, diminished self-capacities, impaired ego resources, and alterations in sensory experiences.⁵⁴

C. Understanding Trauma-Informed Practice

The increase in studies on trauma and vicarious trauma, and the various measures taken to mitigate the effects of the two have resulted in a systemic approach to how human services can be delivered to address the concerns of trauma and vicarious trauma simultaneously. "A trauma-informed approach to services or intervention acknowledges the prevalence and impact of trauma and attempts to create a sense of safety for all participants, whether or not they have a trauma-related diagnosis."⁵⁵ To be trauma-informed means to be educated about the impact of interpersonal violence and victimization on an individual's life and development.⁵⁶ Providing trauma-informed services requires all the staff of an organization to understand the effects of trauma on the people being served, so that all interactions with the organization reduce the possibility of retraumatization and are consistent with the process of recovery.⁵⁷ Trauma-informed practice recognizes the ways in which trauma impacts systems and individuals.⁵⁸ Becoming trauma informed results in the recognition that behavioral

⁵³ *Id.*

⁵⁴ Christian Pross, *Burnout, vicarious traumatization and its prevention*, 16 TORTURE 1 (2006).

⁵⁵ SAMSHA, *supra* note 8, at 1.

⁵⁶ Denise E. Elliott and Paula Bjelajac et al., *Trauma-Informed or Trauma Denied: Principles and Implementation of Trauma-Informed Services for Women*, 33(4) JOURNAL OF COMMUNITY PSYCHOLOGY, 461-477, 462 (2005).

⁵⁷ *Id.*

⁵⁸ Whereas vicarious trauma impacts individuals exposed to trauma victims, organizations working with a traumatized population can experience organizational trauma, in which an organization's adaptation to chronic stress can create "a state of dysfunction that in some cases virtually prohibits the recovery of the individual clients who are the source of its underlying and original mission, and damages many of the people who work within it." SANDRA L. BLOOM, & BRIAN FARRAGHER, DESTROYING SANCTUARY: THE CRISIS IN HUMAN SERVICES DELIVERY SYSTEMS 14 (2011). See also Shana Hormann and Pat Vivian, *Toward and Understanding of Traumatized Organizations and How to Intervene in Them*, 11(3) TRAUMATOLOGY 159, 160-164 (September 2005).

symptoms, mental health diagnoses, and involvement in the criminal justice system are all manifestations of injury, rather than indicators of sickness or badness – the two current explanations for such behavior.⁵⁹ As a result, trauma-informed services and programs are more supportive (rather than controlling and punitive), avoid retraumatizing and punishing those served, and avoid vicarious traumatization of those serving the survivors.⁶⁰

In particular, trauma-informed practice has had a significant impact in the fields of domestic violence,⁶¹ health care, child welfare, law enforcement and judicial administration. As discussed in the next section, trauma-informed practice has also informed the practice of law.

II. THE TRAUMA-INFORMED LAWYER

The concepts of trauma-informed practice have begun to have a profound effect on attorneys who routinely work with trauma survivors.⁶² Particularly for attorneys in practice areas such as domestic vi-

⁵⁹ SANDRA L. BLOOM & BRIAN FARRAGHER, *RESTORING SANCTUARY: A NEW OPERATING SYSTEM FOR TRAUMA-INFORMED SYSTEMS OF CARE*, 1, 7-9 (2013).

⁶⁰ For example, one model used to accomplish these goals is the Sanctuary Model, a trauma-informed method for changing organizational culture, created by psychiatrist Sandra Bloom. The Sanctuary Model can be described as a “plan, process, and method for creating trauma-sensitive, democratic, nonviolent cultures that are far better equipped to engage in the innovative treatment planning and implementation that is necessary to adequately respond to the extremely complex and deeply embedded injuries that children, adults, and families have sustained.” Sandra L. Bloom, *The Sanctuary Model of Organizational Change for Children’s Residential Treatment*, *THERAPEUTIC COMMUNITY: THE INTERNATIONAL JOURNAL FOR THERAPEUTIC AND SUPPORTIVE ORGANIZATIONS* 26(1): 65-81, 70-71 (2005). The Sanctuary Model proposes seven characteristics that would result in an organization being trauma informed: a culture of nonviolence, which means committing to safety skills and higher goals; a culture of emotional intelligence, which means to teach and model emotional management skills; a culture of social learning, which involves creating an environment that promotes conflict resolution and transformation; a culture of shared governance, which involves encouraging self-control, self-discipline, and healthy authority figures; a culture of open communication; a culture of social responsibility, which involves building healthy relationships and connections; and a culture of growth and change, which requires restoring hope, meaning and purpose by actively working through loss/trauma. *Id.* at 71.

⁶¹ Joshua M. Wilson, Jenny E. Fauci, & Lisa A. Goodman, *Bringing trauma-informed practice to domestic violence programs: A qualitative analysis of current approaches*, 85(6) *AM. J. OF ORTHOPSYCHIATRY* 586, 587 (2015).

⁶² See LISA PILNIK & JESSICA R KENDALL, *OFFICE JUVENILE JUSTICE AND DELINQUENCY PREVENTION, IDENTIFYING POLYVICTIMIZATION AND TRAUMA AMONG COURT-INVOLVED CHILDREN AND YOUTH: A Checklist and Resource Guide for Attorneys and Other Court-Appointed Advocates* (2012), <http://www.ojjdp.gov/programs/safestart/IdentifyingPolyvictimization.pdf>. KAREN REITMAN, *ATTORNEYS FOR CHILDREN GUIDE TO INTERVIEWING CLIENTS: INTEGRATING TRAUMA INFORMED CARE AND SOLUTION FOCUSED STRATEGIES* (2011); Barbara Glesner Fines & Cathy Madsen, *Caring Too Little, Caring Too Much: Competence and the Family Law Attorney*, 75 *UMKC L. REV.* 965 (2007); Lynda Murdoch, *Psychological Consequences of Adopting a Therapeutic Lawyering Approach: Pitfalls and Protecting Strategies*, 24 *SEATTLE U.L. REV.* 483 (2000); Susan Daicoff,

olence, immigration, and child welfare, the principles of trauma-informed practice have altered the way legal services are delivered.⁶³ In fact, trauma-informed practice can have relevance to all areas of practice, as clients may present with a trauma history whether central to the subject of the representation or not.

Trauma-informed practice can be particularly salient for attorneys because traditionally attorneys are trained to separate emotions from the law in order to competently analyze legal problems.⁶⁴ By borrowing trauma-informed techniques developed in the therapeutic context, attorneys are learning to provide more effective representation.⁶⁵ Attorneys can learn how to identify trauma, and to adjust their methods of counseling and representation to incorporate an understanding of their clients' trauma history. Attorneys can also help clients identify the need for behavioral health intervention, or help clients secure trauma-informed therapeutic services.⁶⁶ Attorneys can also employ methods of self-care to prevent vicarious traumatization. Systemic implementation of these methods form trauma-informed legal practice. Domestic violence legal centers, immigration legal centers, and other public interest legal services offices have become particularly adept at incorporating these practices into daily legal work. This article posits that clinical law professors can and should incorporate this methodology into law school clinics.

The experience of Victoria, the client described at the beginning of this article, is a good example of trauma-informed lawyering at work. First, the law student handling the case was trained to recognize trauma. In other words, the student could recognize that the

Law as a Healing Profession: The "Comprehensive Law Movement", 6 PEPP. DISP. RESOL. L.J. 1 (2006); MARJORIE SILVER, THE AFFECTIVE ASSISTANCE OF COUNSEL: PRACTICING LAW AS A HEALING PROFESSION (2007); Marjorie Silver, *Love, Hate, and Other Emotional Interferences in the Lawyer/Client Relationship*, 6 CLIN. L. REV. 259 (1999); Marjorie A. Silver, *Supporting Attorneys' Personal Skills*, 78 REV. JUR. U.P.R. 147, 148 (2009); MARY MALEFYT SEIGHMAN, ERIKA SUSSMAN, & OLGA TRUJILLO, REPRESENTING DOMESTIC VIOLENCE SURVIVORS WHO ARE EXPERIENCING TRAUMA AND OTHER MENTAL HEALTH CHALLENGES: A HANDBOOK FOR ATTORNEYS, available at <http://www.nationalcenterdvtraumamh.org/publications-products/attorneys-handbook/> (last viewed Dec. 20, 2015).

⁶³ Both authors had the opportunity as legal services attorneys to work in family law practices that trained staff in and applied methods of trauma-informed practice.

⁶⁴ Parker, *supra* note 2.

⁶⁵ *Id.* See also AMERICAN BAR ASSOCIATION, ABA POLICY ON TRAUMA-INFORMED ADVOCACY FOR CHILDREN & YOUTH (Feb. 10, 2014), http://www.americanbar.org/content/dam/aba/administrative/child_law/ABA%20Policy%20on%20Trauma-Informed%20Advocacy.authcheckdam.pdf; Eliza Patten & Talia Kraemer, *Practice Recommendations for Trauma-Informed Legal Services* (July 2013), available at http://www.americanbar.org/content/dam/aba/administrative/child_law/5C_Patten%20Kraemer_Practice%20Recommendations%20for%20Trauma%20Informed%20Legal%20Services.authcheckdam.pdf.

⁶⁶ See PILNIK & KENDALL, *supra* note 62.

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physical abuse that Victoria had experienced, as well as the knowledge that her children had been sexually abused, were traumatic experiences which would profoundly affect the attorney-client relationship and the nature of the representation, even though the abuse allegations were not directly pertinent to the case. If the law student not been trained in trauma-informed practice, he might have been more dismissive of the client's insistence on telling her trauma story. Instead, the law student exhibited patience and affirmation for the client that ultimately enabled the client to develop a trusting relationship with the law student. Similarly, the law student adjusted his approach to counseling the client and preparing the client for court, based upon the law student's acknowledgement and understanding of the client's trauma experience. Instead of simply preparing the client for the kinds of testimony and evidence that would be requested, the law student took into account how terrifying it was for the client to go to court against her abusive ex-husband. The student also encouraged the client regarding the importance of continuing in therapy, drawing clear lines between the kind of counseling the law student could provide, and support that could be provided by a therapist. Finally, the law student also had opportunities for self-reflection and sharing through supervision to allow him to process the impact of working with a client who had experienced severe trauma.

Rather than waiting until lawyers enter practice to learn these skills, law schools can and should teach trauma-informed lawyering, particularly in the law clinic setting.⁶⁷ Teaching trauma-informed lawyering in law school clinics bolsters and builds upon existing approaches to clinical pedagogy. Clinical legal education has traditionally emphasized teaching social justice values, client-centered lawyering and the acquisition of practical lawyering skills,⁶⁸ and teaching trauma-informed lawyering reinforces each of these areas. Further, trauma-informed lawyering builds upon existing clinical pedagogical literature on therapeutic jurisprudence, empathy and emotional intelligence, and vicarious trauma.⁶⁹ Law school clinics are particularly well-suited to teach trauma-informed lawyering because

⁶⁷ See, e.g., Jill Engle, *Taming the Tigers: Domestic Violence, Legal Professionalism and Well-Being*, 4 TENN. J. RACE, GENDER & SOC. JUST. 1 (2015); Joan Meier, *Teaching Lawyering With Heart, forthcoming in VIOLENCE AGAINST WOMEN* (2015), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2685926##.

⁶⁸ See, e.g., Stephen Wizner, *Beyond Skills Training*, 7 CLIN. L. REV. 327, 338 (2001); David Binder and Paul Bergman, *Taking Lawyering Skills Training Seriously*, 10 CLIN. L. REV. 191 (2003); Katherine Kruse, *Fortress in the Sand: The Plural Values of Client-Centered Representation*, 12 CLIN. L. REV. 369 (2006).

⁶⁹ See, e.g., MARJORIE A. SILVER, *THE AFFECTIVE ASSISTANCE OF COUNSEL: PRACTICING LAW AS A HEALING PROFESSION* (2007).

of the focus on reflective practice, and their capacity to teach law students important practice skills to take into their legal careers.

*A. Teaching Trauma-Informed Lawyering Fits with the Values of
Clinical Pedagogy and into Already Existing
Clinical Theoretical Areas*

Teaching trauma-informed lawyering in law school clinics furthers the value clinical legal education places on teaching social justice principles and the notion of client-centered lawyering.

1. Social Justice

Clinical legal education has always had a social justice focus, in its mission to provide much-needed legal services for the indigent, and also in its goals of exposing law students to the lack of legal services for the poor, and to the limits and realities of the legal system. The first clinics were established and developed in the 1920s and 1930s as a way to supplement traditional, doctrinal classes taught in the Langdellian case method. However, clinical legal education did not really take hold in law schools until the 1960s and 1970s. A crucial event in the development of clinical pedagogy was the establishment of the Council on Legal Education and Professional Responsibility (CLEPR), by William Pincus, Vice President of the Ford Foundation. The mission of the CLEPR was to provide legal services to the poor, and in order to do so, CLEPR funded several law school clinics, significantly affecting legal education by infusing clinical legal education with a social justice purpose.⁷⁰

Although the initial mission of law school clinics was to provide access to legal services for low-income clients, as clinical pedagogy developed, clinics developed the added function of exposing students to the realities of the legal system, and in particular its limitations for meeting the goals of indigent individuals.⁷¹ Teaching trauma-informed lawyering in clinics reinforces the social justice value of clinical education because it causes students to be exposed to the realities and limits of the legal system.⁷² Teaching trauma enables students to see, though the experiences of their trauma-affected client, how, for that particular individual, legal doctrines, theories, or the litigation

⁷⁰ *Id.* at 338 (“From the beginning of the clinical legal education movement, experiential learning and skills-training were seen as the means for achieving the justice goal articulated by William Pincus, not as ends in themselves.”).

⁷¹ Lauren Carasik, *Justice in the Balance: An Evaluation of One Clinic’s Ability to Harmonize Teaching Practical Skills, Ethics, and Professionalism with a Social Justice Mission*, 16 S. CAL. REV. L. & SOC. JUST. 23, 39-40 (2006).

⁷² See, e.g., Wizner, *supra* note 68.

system may or may not work to achieve the client's stated goals.⁷³ Recognition that the legal system may not always be an effective mechanism of pursuing the client's goals is particularly relevant when the client has experienced trauma. This statement is particularly true in light of the fact that for a traumatized client, court proceedings may run the risk of causing the client to relive or confront the trauma, and court proceedings themselves may cause further trauma to the client.

Additionally, teaching students trauma-informed lawyering, and specifically focusing on the ways in which the current legal system may not be able to meet a client's goals, encourages students to think critically about the legal system as it affects litigants who have been subject to trauma in their lives.⁷⁴ By learning about trauma-informed lawyering and thinking critically about the legal system, students will begin to think not only about procedural justice, defined as access to the courts or representation in court, but also about true substantive justice for litigants, a term which "could be perceived to require disassembling the existing power structure in order to precipitate a redistribution of resources."⁷⁵ Thinking critically about the legal system, developing strong professional values, and developing an appreciation for the important role that attorneys play in society are all sub-parts of the larger clinical goal of teaching social justice to law students through their clinical work.⁷⁶

The importance of teaching trauma-informed lawyering to clinic students to further the social justice goal of clinics is underscored by the literature on therapeutic jurisprudence, which focuses on the extent to which the law enhances or inhibits the wellbeing of those who are affected by it.⁷⁷ The practice of trauma-informed lawyering can be a natural extension of the teachings of therapeutic jurisprudence. Therapeutic jurisprudence is a lens for viewing litigation⁷⁸ and concerns itself with the therapeutic and anti-therapeutic goals that flow from legal rules, procedures, and the operation of the legal system.⁷⁹

⁷³ *Id.* at 351.

⁷⁴ Leigh Goodmark, *Clinical Cognitive Dissonance: The Values and Goals of Domestic Violence Clinics, the Legal System, and the Students Caught in the Middle*, 20 J. OF LAW & POLICY 301, 314 (2012) (quoting Sue Bryant & Maria Arias, *Case Study: A Battered Women's Rights Clinic: Designing a Clinical Program which Encourages a Problem Solving Vision of Lawyering*, 42 WASH. U. J. URB. & CONTEMP. L. 207, 212-215 (1992)).

⁷⁵ Carasik *supra* note 71, at 45 (citing John O. Calmore, "Chasing the Wind": Pursuing Social Justice, Overcoming Legal Mis-Education, and Engaging in Professional Re-Socialization, 37 LOY. L.A. L. REV. 1167, 1175 (2004)).

⁷⁶ Stephen Wizner, *Is Social Justice Still Relevant?*, 32 B.C. L. J. & SOC. JUST. 345 (2012) (exploring the social justice mission of law school clinics).

⁷⁷ See, e.g., Susan L. Brooks, *Using Therapeutic Jurisprudence to Build Effective Relationships with Students, Clients, and Communities*, 13 CLIN. L. REV. 213 (2006).

⁷⁸ David B. Wexler, *Therapeutic Jurisprudence*, 20 TOURO L. REV. 353 (2004).

⁷⁹ *Id.*

One of the crucial principles is the emphasis on voice and validation for clients. Pursuant to a therapeutic jurisprudence perspective, achieving voice and validation has special significance and importance for survivors of violence.⁸⁰ Survivors need to be accorded a sense of “voice,” the ability to tell their side of the story, and “validation,” the sense that what they have to say is taken seriously. By acknowledging and honoring the client’s trauma experience, lawyers can help give voice to the client’s perspective. Therapeutic jurisprudence scholars emphasize that these survivors should be treated with dignity and respect, which will diminish the extent to which they feel coerced and gives them a sense of voluntary choice.⁸¹ Rather than viewing the client’s trauma experience as a weakness, a therapeutic jurisprudence approach emphasizes the resilience of the client.⁸² Teaching trauma-informed lawyering to clinic students furthers these therapeutic jurisprudence goals and causes students to think more about the meaning of the broader clinical goal of social justice.⁸³

2. Client-Centered Lawyering

Teaching trauma-informed lawyering in clinics also reinforces one of clinical legal education’s central tenets, the importance of client-centered lawyering. Client-centered lawyering focuses on understanding clients’ perspectives, emotions, and values, including the possible effects of prior trauma on a client’s decisions and actions.⁸⁴ Client-centered lawyering is perhaps the central value in many current law school clinics, particularly in clinics where clients are individual litigants. The goals of client-centered lawyering focus on maintaining respect for a client’s decision-making authority within the lawyer-client relationship. In the client-centered lawyering paradigm, the lawyer should remain neutral as to the goals of the representation.⁸⁵ Unlike

⁸⁰ Carolyn S. Salisbury, *From Violence and Victimization to Voice and Validation: Incorporating Therapeutic Jurisprudence in A Children’s Law Clinic*, 17 ST. THOMAS L. REV. 623, 654-55 (2005).

⁸¹ Bruce J. Winick, *Applying the Law Therapeutically in Domestic Violence Cases*, 69 UMKC L. REV. 33, 63 (2000).

⁸² Pilar Hernandez & David Gangsei, *Vicarious Resilience: A New Concept in Work with Those Who Survive Trauma*, 46 FAMILY PROCESS 229 (2007).

⁸³ Closely related to therapeutic jurisprudence is the literature on restorative justice, which focuses on having all of the individuals who have been affected by a particular act come together and agree on how to repair the harm. According to restorative justice principles, the focus of the process is on healing, rather than finding a way to hurt the offender in a way that would be proportional to the victim’s hurt. See John Braithwaite, *A Future Where Punishment is Marginalized: Realistic or Utopian?* 46 UCLA L. REV. 1727, 1743 (1999).

⁸⁴ Kruse, *supra* note 68, at 377 (describing the cornerstones of client-centered lawyering).

⁸⁵ *Id.* at 376.

traditional doctrinal law school classes which focus on appellate court decisions, a clinic with a client-centered philosophy helps the client solve their identified problems, through either legal or non-legal means. The four central tenets of client-centered lawyering can be summarized as follows: 1) it draws attention to the critical importance of non-legal aspects of a client's situation; 2) it cabins the lawyer's role in the representation within limitations set by a sharply circumscribed view of the lawyer's professional expertise; 3) it insists on the primacy of client decision-making; and 4) it places a high value on lawyers' understanding their clients' perspectives, emotions, and values.⁸⁶ A lawyer's principal role in a client-centered lawyering model is to help the client solve a problem, not simply to identify and apply legal rules.⁸⁷ Teaching trauma-informed lawyering to clinic students in law clinics reinforces all of the main tenets of client-centered lawyering.

Teaching trauma-informed practice as part of client-centered lawyering improves the client's experience of representation, by encouraging students to consider the non-legal aspects of a client's situation, and also places a high value on the law student's understanding of a client's perspectives, emotions, and values. Teaching about the possible effects of trauma on clients encourages students to look at the client outside of the narrow context of litigation, and to consider the other effects of her life experiences. Additionally, trauma-informed lawyering, with its emphasis on the effects of prior trauma, persuades students to look at what the client may be seeking from the representation, and to consider whether the litigation process will achieve that goal, or whether that goal is best achieved by non-legal methods. The student must take into account the effect of the trauma on the client and the effect on the client's current decision-making, even though that decision process may be different from the process that the student is using to make a decision as a legal advocate.

The theory behind client-centered law practice is based on the influence of other social sciences on law, particularly psychology, in which empathy is considered a useful skill for supporting clients.⁸⁸ Law students will be better able to incorporate empathy into their interactions with clients if they are trained in trauma. The literature on emotional intelligence and the literature on the clinical pedagogy of teaching empathy focus on the legitimacy of emotions and their

⁸⁶ *Id.* at 377.

⁸⁷ *Id.* at 376-77 (quoting Binder's textbook).

⁸⁸ Emily Gould, *The Empathy Debate: The Role of Empathy in Law, Mediation, and the New Professionalism*, 36-FALL VT. B.J. 23, 24 (2010). See also Sarah Buhler, *Painful Injustices: Encountering Social Suffering in Clinical Legal Education*, 19 CLIN. L. REV. 405 (2013).

relevance to our actions and decisions, and also on the need and manner in which the clinical supervisor facilitates a process through which law students interpret their emotional experiences as advocates, a process which will positively affect the representation.⁸⁹ Trauma-informed clinic students will better empathize with their clients. Empathy can be a key part of the information-gathering function of a client interview and client counseling.⁹⁰ Empathy encompasses several different phenomena: feeling the emotions of another; understanding another's situation or experience; and taking actions based on another's situation.⁹¹ Similarly, the literature regarding teaching empathy to law students in a clinical context explores the concept of "identification." Identification can be defined as taking on the attitudes, behaviors, and perspectives of others.⁹² Identification and empathy allow an attorney to "enter" into the emotional state of the client,⁹³ which provides the attorney with a far more complex understanding of the client and the client's legal needs. With clients in particularly difficult situations, such as clients who have experienced trauma or torture, a student may become overwhelmed by the experiences of suffering and therefore fail to identify and empathize with the client.⁹⁴ Teaching law students to identify trauma and its effects on clients will aid in identification with a client in a situation where identification and empathy might otherwise not be possible, and will enable the student to achieve a greater empathy for and understanding of the client's perspectives and needs. Trauma-informed clinic students will achieve greater empathy with a client, and also will use that empathy to adjust the attorney-client relationship or to adjust the litigation strategy.

Teaching trauma-informed lawyering in law clinics will also encourage students to circumscribe their view of their own expertise, emotional understanding and role as law students in the representation, and will encourage students to focus on the primacy of client decision-making as emphasized in the client-centered lawyering model.⁹⁵ In the client-centered lawyering model, the lawyer and the client work together as problem-solvers, and the client is able to

⁸⁹ See, e.g., Laurel E. Fletcher & Harvey M. Weinstein, *When Students Lose Perspective: Clinical Supervision and the Management of Empathy*, 9 CLIN. L. REV. 135 (2002); Gould, *supra* note 88; see also, Silver, *supra* note 69 at 5.

⁹⁰ Fletcher & Weinstein, *supra* note 89.

⁹¹ John E. Montgomery, *Incorporating Emotional Intelligence Concepts into Legal Education: Strengthening the Professionalism of Law Students*, 39 U. TOL. L. REV. 323, 336-37 (2008).

⁹² *Id.*

⁹³ *Id.* at 142.

⁹⁴ Fletcher & Weinstein, *supra* note 89, at 143.

⁹⁵ Kruse, *supra* note 68, at 377.

choose what s/he wants from the lawyer and the legal system.⁹⁶ A lawyer working in a client-centered model should listen to all of the client's concerns, not just the facts which are deemed legally relevant.⁹⁷

B. Acquisition of Practical Lawyering Skills: Teaching Trauma-Informed Lawyering Makes Students Better Advocates

Another central value in clinical pedagogy is that students should acquire practical lawyering skills, by gaining experience in practice and by participating in the lawyer/client relationship.⁹⁸ Students are generally more motivated to learn because they are given a tremendous amount of responsibility over the case of a real-life individual, and this responsibility leads to greater identification with the client and other individuals who are similarly situated.⁹⁹ Clinics are particularly well-suited for teaching trauma-informed lawyering because students are readily able to put into practice with their clients the trauma-informed lawyering goals of identifying trauma, adjusting the attorney-client relationship, adjusting the litigation strategy, and preventing vicarious trauma.

Clinics are also ideally suited to teaching trauma-informed lawyering to students because clinics are one of the primary vehicles through which law students learn the practical aspects of professional responsibility. The Model Rules of Professional Conduct summarizes the duty of competent representation as follows: "A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation."¹⁰⁰ When representing clients who have survived trauma in the past, the duty of competent representation requires not only legal knowledge and preparation, but also requires a thorough understanding of the ways in which trauma may present in clients, and of the ways prior trauma may affect the attorney-client relationship and the litigation process. Competent representation may also mean acknowledging the limits of the attorney's role, and using mental health professionals as supports when necessary.

Teaching trauma-informed lawyering will cause students to become better, more effective advocates who are able to fulfill the duty

⁹⁶ Jane Stoeber, *Transforming Domestic Violence Representation*, 101 KY. L.J. 483, 496 (2012-2013).

⁹⁷ *Id.* at 498.

⁹⁸ See, e.g., David Binder & Paul Bergman, *supra* note 68, at 194-95, 198.

⁹⁹ See Carolyn Grose, *Beyond Skills Training, Revisited: The Clinical Education Spiral*, 19 CLIN. L. REV. 489, 511 (2013) (Grose refers to a student's participation in the lawyer-client relationship as "the heart of clinical pedagogy.").

¹⁰⁰ MODEL RULES OF PROF'L CONDUCT §1.1 (2015).

of competent representation. Through learning about trauma-informed lawyering, law students will become better advocates because they will gain better interviewing skills; more effectively build trust with their clients; and more effectively tackle problems that clients face. Students will also be better prepared for hearings, and better able to prepare their clients for hearings.¹⁰¹ Students who interview clients may be better able to identify signs of such trauma such as: clients experiencing difficulty telling their story in a linear manner; clients describing violent or upsetting events in a flat, detached matter; clients seeming disassociated or emotionally absent during interviews; and clients not remembering key details of abuse.¹⁰²

Here is another example of how law students are able to implement trauma-informed practice to better represent their clients:

Jane¹⁰³ came to the clinic seeking representation for her two family law cases. She had filed a Protection From Abuse (PFA) petition against her boyfriend, Tom, because he had become physically abusive a few months before, and on the last night they were together, beat her and tried to run her over with his car. Jane had a daughter, Anne. When Anne's father, Mark learned of the abuse by Tom, he didn't give Anne back to Jane for a month after a weekend visit. Jane had to involve the police to get Anne back. Mark filed a custody modification petition asking the court to give him primary physical custody of Anne. Jane filed a contempt of custody petition against him for keeping Anne away from her.

Jane missed the first two appointments and arrived two hours late for her third appointment with the law student assigned to her case. During her meeting, which was to begin to prepare for the PFA case against Tom, Jane only wanted to talk about Anne and whether she might lose custody. She became very emotional when talking about the custody case. Jane was angry with Mark for keeping Anne for so long and said that she hoped he would be punished by the Judge for what he did. Jane did not remember when the abuse by Tom began, when he tried to run her over, or when she had gone to the police. She also did not remember when Mark had kept Anne from a month, or the date when she was able to get Anne back.

¹⁰¹ Parker, *supra* note 2.

¹⁰² See NAT'L CENTER ON DOMESTIC VIOLENCE, TRAUMA & MENTAL HEALTH, SUPPORTING SURVIVORS IN CONTESTED CUSTODY CASES: TRAUMA-INFORMED STRATEGIES FOR BUILDING ON PARENTING STRENGTHS WHERE MENTAL HEALTH IS A FACTOR (March 2014), available at <http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/01/Supporting-Survivors-in-Custody-Cases-April-7-FINAL-v3.pdf>.

¹⁰³ This case description is based on the experience of a client represented by Professor Haldar's clinic. Names and identifying information have been changed.

Rather than thinking a client is difficult or uncooperative, a student who has been taught trauma-informed lawyering will be able to recognize the preceding characteristics as signs of trauma, and will develop the skills to counteract the specific trauma symptoms which arise during client interviews.¹⁰⁴ These skills include developing mechanisms to: interview and prepare clients' cases with minimal re-traumatization; work with emotional clients more effectively by validating their feelings; focus or re-focus clients who are avoiding talking about a traumatic experience; help clients remember significant details; anticipate and handle clients who are late to an appointment or who miss the appointment entirely; define the role of the legal advocate, as opposed to a therapist or social worker; and build trust with the client. In short, teaching trauma-informed lawyering will allow students to specifically tailor their interviewing and case preparation to the client's individual circumstances, which include past trauma.

During the first meeting with Jane, the law student recalled the guest lecture by an area psychologist regarding trauma and recognized the indicators of trauma in Jane's actions. He told her that both the abuse by Tom and having Anne taken away from her must have been very difficult for her. He told her that during that first meeting, they would talk about what she most wanted to discuss, and then he and Jane together planned a timeline of appointments to get ready for both the PFA hearing and the custody hearing. The law student explained the purpose of each hearing and how the Judge would make a decision in each case. The law student let Jane know what documents she needed to bring to each meeting.

Additionally, the law student was able to use the police report filed when Jane got Anne back to determine when Mark had taken her and returned her. He also looked at Tom's date of arrest and Jane's PFA petition to get a rough timeframe of when the abuse happened, and Jane was able to supplement that information.

During a later meeting to prepare for the custody hearing, Jane revealed that as part of the abuse, Tom had forced her to join him in his drug use. Substance abuse was particularly emotionally difficult for Jane to discuss, because she and Anne's father Mark both had severe addiction issues when they were together, and they both stopped using when Jane became pregnant with Anne. Because the law student had this important bit of information, he was able to inform Jane that it was very common for custody judges to ask litigants to take drug tests, particularly if there is a history of drug abuse. He also discussed with her the importance of continuing to attend her substance abuse meetings,

¹⁰⁴ Parker, *supra* note 2, at 182.

which served as a support for her in staying drug-free.

The law student went over Jane's direct examination with her several times before each hearing. He stressed the importance of being on time for the hearing, told her exactly who would be in the courtroom, and what each party might say. He emphasized that although she felt very emotional about the events, it was important to remember to answer only the questions asked of her in court. The law student reminded her the day before each time she had to be in court, and would meet her just inside the entrance to the courthouse. The custody judge decided not to modify the order in Jane's custody case with Mark, and the Protection From Abuse judge granted Jane a final protection order.

The enhanced interview skills that students learn when taught trauma-informed lawyering can help to nurture a trusting relationship between the client and the student lawyer. The law student and the client can then analyze risks, review and develop safety plans, and devise legal strategies together. Building this kind of a trusting relationship may help avoid a situation in which a client does not reveal crucial information. In addition to hearings, building a trusting relationship between a client and a law student recognizes the fact that advocating effectively for a client may not always involve an adversarial, court-centered litigation strategy. In fact, any form of litigation may not be the best way for the client to achieve her goals. Encouraging a client to speak as freely as possible about the past trauma, as well as her current experiences, can lead both parties to exchange important information so that they can most productively discuss the next steps to take in a client's case. Students will also be able to more effectively prepare for hearings if they are trained in trauma-informed lawyering. Once students understand which types of events can trigger the trauma of a client, they can work to lessen that potential.¹⁰⁵

Additionally, teaching trauma-informed lawyering will also cause students to more effectively tackle clients' trauma-related problems. For example, in family law cases, two of the most significant problems with the domestic violence survivor client population are mental health issues, often caused or exacerbated by the trauma and more recent trauma-related triggers, and substance abuse, which may also be cause or heightened by a traumatic situation. A crucial aspect of trauma-informed legal practice is recognizing the limits of lawyers' professional role, and knowing when to help the client seek behavioral health supports. Particularly for law students who are in the midst of

¹⁰⁵ See Parker, *supra* note 2, at 177-178 (discussing the importance of credible testimony in political asylum cases, where a traumatized client may have difficult expressing emotion).

cultivating their professional identities, and are still developing their competency at lawyering skills, it is important to underscore their professional boundaries.

An additional important aspect of clinical pedagogy is the importance of teaching students how to integrate being lawyers with the rest of their lives as they move forward as practicing attorneys. Recent research indicates that attorneys exhibited a higher level of vicarious traumatization compared to mental health professionals, at least in part because they felt that they had not received systemic education regarding the effects of trauma in their clients and themselves.¹⁰⁶ If explicitly taught trauma-informed lawyering, law clinic students will be more effectively prepared to handle their own feelings upon hearing their clients' traumatic stories, and will as a result suffer less from vicarious trauma and burnout.¹⁰⁷ Teaching trauma-informed lawyering in clinics creates foundations for students for positive self-care as they pursue and develop their legal careers.

III. THE PEDAGOGY OF TRAUMA-INFORMED LAWYERING: HOW TO TEACH TRAUMA-INFORMED LAWYERING IN LAW CLINICS

While acknowledging that teaching trauma-informed practice is an important goal, clinical law professors may struggle with how to integrate it into their clinics. This section will first describe four key hallmarks of trauma-informed lawyering: (1) identifying trauma; (2) adjusting the attorney-client relationship; (3) adapting litigation strategy; and (4) preventing vicarious trauma. The following section will give concrete examples of how to teach these hallmarks in law clinics.

A. *The Hallmarks of Trauma-Informed Lawyering*

The authors have identified four teaching goals that we believe are the key hallmarks of trauma-informed lawyering:

Identifying Trauma. Simply learning to identify trauma can go a long way in making an attorney more effective. Arguably, an attorney's ability to communicate with clients and develop a relationship of trust with clients is critical to attorney competence.¹⁰⁸ An attorney need not be a mental health expert to recognize that what the client is describing, or behavior the client in exhibiting, is indicative of trauma. Unless the law student has a previous professional background in

¹⁰⁶ See, e.g., Andrew P. Levin & Scott Greisberg, *Vicarious Trauma in Attorneys*, 24 *PACE L. REV.* 245, 252 (2003).

¹⁰⁷ *Id.* at 251-252.

¹⁰⁸ Fines & Madsen, *supra* note 62.

trauma-related practice, law students tend not to be particularly aware of how trauma is defined or presents. A client who has experienced trauma needs to be able to feel safe in the attorney-client relationship, and an attorney who can be both affirming and empathetic to the client will help create that feeling of safety.

Adjusting Attorney-Client Relationship. Once an attorney has recognized that a client has experience with trauma, the attorney can adjust the attorney-client relationship accordingly. Trauma may affect the attorney's ability to get the whole story, and law students need training in these techniques. Because trauma manifests differently in different people, the attorney should be versed in a variety of strategies to work with the client. For example, the client may be very withdrawn, and the attorney will need to help the client gain a sense of trust and safety in order to get necessary information to prepare the case.¹⁰⁹ Another client might be highly emotional, flooding the attorney with a lot of information; the attorney will need to employ strategies to focus the client on key facts pertinent to the representation.¹¹⁰ Another client may be angry or suspicious, and the attorney will need to put continued focus on transparency and trust.¹¹¹ Cultivating these strategies will make the attorney more effective in developing a relationship with clients and handling their cases.

Adapting Litigation Strategy. The client's trauma experience may also change the attorney's litigation strategy in a variety of ways. Court can be overwhelming or frightening to many clients, but a client with a trauma history may have a particularly difficult time coping.¹¹² Law students need to be introduced to these topics to effectively prepare their clients. To the extent the client needs to testify about the traumatic events, the client may have difficulty telling the story consistently and credibly. The attorney can help the client by making the situation as predictable as possible by de-sensitizing the client by rehearsing.¹¹³ The attorney may make certain adaptations for the client, like making a plan to take a break if the testimony becomes too trying, or enlisting the support of a mental health provider or other support person in preparing for or attending court.¹¹⁴ Finally, the

¹⁰⁹ Judy I. Eidelson, *Representing Traumatized Clients*, Phila. Bar Assoc. Family Law Section, Nov. 4, 2013.

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² See generally Ann E. Freedman, *Fact-Finding in Civil Domestic Violence Cases: Secondary Traumatic Stress & the Need for Compassionate Witnesses*, 11 AM. U.J. GENDER SOC. POL'Y & L. 567 (2003).

¹¹³ Eidelson, *supra* note 109, at slide 13.

¹¹⁴ *Id.*

attorney may need to give extra thought to how the client will be able to testify about the traumatic experiences in court.¹¹⁵ By employing these strategies, the attorney may make court more palatable for the client and simultaneously more successfully advocate for the client's position.

Preventing Vicarious Trauma. Attorneys working with clients who have experienced severe trauma can also take preventive measures to avoid vicarious trauma. The risks of vicarious trauma for attorneys working with survivors of trauma may be even higher than those in other helping professions, because those in the legal profession tend to have higher caseloads,¹¹⁶ and to not be trained in the dynamics of trauma.¹¹⁷ Particularly in a high volume practice, with limited resources, attorneys are at a high risk of developing clinically significant symptoms of vicarious trauma.¹¹⁸ Although it is unlikely that law students in a clinic practice setting will develop vicarious trauma, it is important that they become aware of the risks and prevention measures at the start of their practice experience. One of the most important preventive measures for attorneys is to diversify and manage case load, so that the attorney has the opportunity to work with trauma survivors as well as clients who have not experienced severe trauma, and so the attorney does not become overwhelmed with too many cases.¹¹⁹ Further, attorneys can create a workplace culture that acknowledges the potential for vicarious trauma. This can include creating spaces for supervision and peer support, and encouraging open communication about the effect of the work.¹²⁰

B. Incorporating the Hallmarks of Trauma-Informed Lawyering as Teaching Goals

This next section will give concrete examples of how to achieve the teaching goals of (1) identifying trauma; (2) adjusting the attorney-client relationship; (3) adapting litigation strategy; and (4) preventing vicarious trauma.

Consider the examples of the clients Victoria and Jane, from the perspective of the clinical professor. The law students who worked

¹¹⁵ *Id.*

¹¹⁶ Levin, *supra* note 106.

¹¹⁷ Fines & Madsen, *supra* note 62, at 992. See also Yael Fischman, *Secondary trauma in the legal professions, a clinical perspective*, 18 TORTURE 107 (2008).

¹¹⁸ Andrew P. Levin et al., *Secondary Traumatic Stress in Attorneys and their Administrative Support Staff Working With Trauma-Exposed Clients*, 199 J. OF NERVOUS & MENTAL DISEASE 946, 953 (2011).

¹¹⁹ Fines & Madsen, *supra* note 62, at 993.

¹²⁰ *Id.* at 994.

with Victoria and Jane had been introduced to the concepts of trauma-informed practice in clinical seminar. The clinical professor had informed the students at orientation that learning to identify trauma, understand the effect of trauma on clients' behavior, and alter the attorney-client relationship and litigation strategy accordingly, were part of the teaching goals for the clinic. The clinical professor brought in an outside speaker to talk to the class about the dynamics of intimate partner violence, and also brought in a psychologist to discuss the impact of trauma on the brain, and how it may manifest. The clinical professor reinforced these lessons through reflection exercises such as case rounds, journaling, supervision and evaluation. And finally, the clinical professor introduced the concept of vicarious trauma, and educated the law students on how to prevent it, by focusing on creating confidential space to talk about the effect the work and clients had on the students, as well as underscoring the importance of good self care. By incorporating these teaching methods into the clinic, the professor created an environment where clients like Victoria and Jane can feel supported and empowered through the experience of representation by the clinic, and the law students are prepared to be excellent advocates on their behalf.

1. *Identifying Trauma*

To teach law students to identify trauma, the students must learn the definition of trauma and why it is relevant to the practice area in the clinic. Law students may incorrectly assume that in teaching about trauma, we are asking them to step outside the bounds of their role as attorney; in contrast, the purpose is to enhance their capacity to build an effective attorney-client relationship.¹²¹ In the context of family law clinics, whether the clinic has a specific domestic violence focus or not, identifying trauma can be introduced by contextualizing what we know about the population that relies on family courts to resolve disputes, specifically that there is a high prevalence of family violence.¹²² In other clinical settings, there may be other common types of trauma with which clients present; for example in an immigration clinic, there may be high rates of clients who witnessed family members or other individuals be harmed in tragic ways. In a child or family advocacy clinic, there may be many clients who have experienced severe child abuse or neglect.

¹²¹ Parker, *supra* note 2, at 169.

¹²² Janet Johnson et al., *supra* note 22. The link between child custody decisions and domestic violence is one that has been acknowledged by state legislatures and courts. See Naomi R. Cahn, *Civil Images of Battered Women: The Impact of Domestic Violence on Child Custody Decisions*, 44 VAND. L. REV. 1041, 1062 (1991).

It is important to help the students shape what is meant when we refer to trauma. The word “trauma” is tossed around a lot (“*My favorite tv show is on summer hiatus and I am SO traumatized!*”; “*My child was lost in the department store for 10 minutes and I was so traumatized!*”). Although trauma is subjective to a specific individual’s ability to cope, not every bad experience is a traumatic one. And not every client who has experienced trauma carries a diagnosis of post-traumatic stress disorder. Further, in teaching about trauma, there is a risk that students will essentialize clients’ experiences, assuming they all share common histories or characteristics. By focusing on the particular commonalities and needs of the population served by the clinic, the professor can guide students toward being alert to relevant information in the client’s history and/or experience which may have an effect on the nature of the representation.

To teach students to identify trauma, the professor may elect to bring in a psychiatrist or psychologist to class, who can speak about how trauma presents and how it affects the brain. With some research and preparation, the clinical professor may also elect to teach this information on her own. The outside speaker or the professor can also focus on some of the common ways trauma presents in the population served by the clinic, and suggest or model strategies for working with these types of clients. For some clients the content of the representation will be specific to the trauma experience, such as representation in a protection order matter regarding abuse perpetrated by the opposing party, or representation in a custody matter about child abuse perpetrated by the opposing party. There are also times where the student may have to deduce that a backdrop of trauma is affecting the client’s demeanor or ability to relate to the student, such as representation in a child welfare case concerning allegations of mother’s mental health issues. With a basic understanding of how trauma may present, the student can develop greater sensitivity toward the client, and be alert to (sometimes subtle) indications that the client has experienced trauma.

Frequently, students have preconceived notions about how a survivor will present; the student expects the client to be forthcoming and compliant in relaying her story. An effective way to teach law students to identify trauma is to incorporate this learning goal into exercises focused on learning interviewing skills. For example toward the beginning of the semester, the authors utilize Laurie Shanks’ storytelling exercise to teach students about how difficult it sometimes is for clients to share intimate details of their lives.¹²³ In this exercise, students

¹²³ Laurie Shanks, *Whose Story is it, Anyway? – Guiding Students to Client-Centered Interviewing Through Storytelling*, 14 CLIN. L. REV. 509, 516-517 (2008).

are paired in class and then asked to tell a story to each other about something that changed their life; the other student is then charged with telling her partner's story to the rest of the class, and a discussion ensues about the challenges and obstacles of telling someone else's narrative.¹²⁴ Although not specifically a trauma-related exercise, it can create a forum to underscore some of the barriers to effective fact gathering with clients who have experienced trauma. As Psychologist Judy Eidelson has hypothesized, some of these internal barriers for the interviewer may include fear of what we might have to hear, fear of not knowing how to respond, fear of losing composure, our own moral judgments, and idealization of the trauma survivor followed by disillusionment.¹²⁵

The law student should ensure that her representation creates no additional harm.¹²⁶ Clients' trauma history may affect representation by making it difficult to get the whole story (because of avoidance) and to get a consistent story (traumatic memories get stored in the brain in disconnected ways).¹²⁷ In addition to disruptions to the client's memory of the relevant events, the client may experience shame, hopelessness, traumatic flashbacks and/or distrust in being asked about the traumatic events.¹²⁸ Because trauma presents differently, it is helpful to make students aware that it is quite common for a trauma survivor to present as withdrawn and with flat emotion, *or* to flood with an overload of information, *or* to be angry and/or suspicious.¹²⁹ Through hypotheticals or role plays, the professor can brainstorm with the students effective strategies for working with each type of client. For example, with the withdrawn client, the client may feel more in control of the interview if the law student affirms how difficult it is to share the information.¹³⁰ With the flooding client, it can be valuable to be upfront and transparent about the goals and focus of the interview.¹³¹ With the angry or suspicious client, it can be beneficial to validate the client's frustration while not getting defensive.¹³²

All of the above teaching strategies can be reinforced throughout the students' work in the clinic through supervision and reflection. The student may need help or feedback around why a particular client interview did not go as smoothly as planned, or assistance with

¹²⁴ *Id.* at 518-526.

¹²⁵ Eidelson, *supra* note 109.

¹²⁶ SEIGHMAN ET AL., *supra* note 63, at 5., at 5.

¹²⁷ Eidelson, *supra* note 109, at slide 3.

¹²⁸ *Id.*

¹²⁹ *Id.* at slides 6-11.

¹³⁰ *Id.* at slide 7.

¹³¹ *Id.* at slide 9.

¹³² *Id.* at slide 10.

strategizing how to most effectively handle a particularly challenging client interview. Not every student will immediately draw the connection between the lessons learned about trauma in class and a client's particular behavior. For example, the student may feel frustrated by a client's repeated cancellation of appointments, or unwillingness to talk about key events in her history. By introducing trauma-informed practice early, the clinical professor can redirect the student to these lessons. In the authors' clinics, we frequently revisit how a client's trauma history may be affecting the law student-client relationship through supervision and case rounds.

2. *Adjusting the Attorney Client Relationship*

Once students learn to identify trauma in their clients, the next step is to enable the student to make adjustments to their strategy for building an attorney-client relationship. As mentioned above, an outside speaker or the clinical professor can teach students about how trauma or indicators of trauma may manifest in clients. In the family law context, both Professor Katz and Professor Haldar bring in outside speakers from a local domestic violence agency, who can talk about the dynamics of domestic violence. These speakers introduce the students to basic concepts like the idea that domestic violence is about power and control,¹³³ and that there is a cycle of abuse.¹³⁴ Without this backdrop, it can be hard for students to understand why their clients behave in certain ways: *Why did she decide to drop this protection order?*¹³⁵ *Why didn't she show up to court, I thought this case was important to her!*¹³⁶

Once students are informed about the effects their clients' trauma experience may have on the client's behavior, the clinical professor can help the students develop strategies for working with these clients. Such strategies can be integrated into lessons on client counseling through hypotheticals or simulations, as well as addressed through supervision and reflection. Because trauma presents differently in different clients, students need to be versed in a wide array of strategies. Students should learn that working with clients with trauma experience requires investing extra time in the attorney-client relationship, perhaps scheduling more in-person meetings than might otherwise be usual practice, and being particularly patient and consistent with the

¹³³ See generally LENORE E. WALKER, *THE BATTERED WOMAN* (1979).

¹³⁴ *Id.*

¹³⁵ James C. Roberts, Loreen Wolfer & Marie Mele, *Why Victims of Intimate Partner Violence Withdraw Protection Orders*, 23 J. FAM. VIOL. 369 (2008).

¹³⁶ Avoidance or withdrawal are common ways for clients' trauma to manifest. See Eidelson, *supra* note 109, at slides 6-7.

client. Student can also help the client identify and acknowledge how the trauma experience impacts their interactions with their law student, the opposing party or the judge. Transparently engaging the client in developing solutions can be empowering to the client and lays a strong foundation for a meaningful attorney-client relationship.¹³⁷ The student can also become versed in contemplating non-legal solutions with the client, such as referrals to trauma-informed therapy, connections to other social services or supports, or reliance on trusted family or friends.

Clinical professors should be aware that students, just like clients, may also present with their own trauma history. Working with particular clients may present triggers for certain students. While this will be addressed further in the discussion of vicarious trauma in Section III. B. 4., *infra*, the clinical professor can help students be mindful that the experience of listening to someone else's trauma history is not neutral. The students can be encouraged to be reflective with regard to their own reactions and responses to clients.

3. *Adapting Litigation Strategy*

Preparing a client with trauma experience for court requires particularized strategies which law students can learn through a clinic. The experience of going to court in and of itself can be re-traumatizing, particularly because the trier of fact may not know the client has a trauma history, or may not be aware of how trauma presents. To the extent that the client may have to testify about the traumatic events, many triers of fact might assume that if something really horrible happened that the client will be able to testify about it with great specificity.¹³⁸ In contrast, clients with trauma experience can make terrible witnesses for a variety of reasons.¹³⁹ First, because the brain stores memories in mismatched ways, the client may be unable to present a linear narrative.¹⁴⁰ Second, the client may not remember key elements of what occurred; while this may make a trier of fact question client's credibility, it is a normal trauma reaction.¹⁴¹ Third, a client's emotions or lack thereof may unnerve or misguide the trier of

¹³⁷ SEIGHMAN ET AL., *supra* note 63, at 7.

¹³⁸ Joan Meier, *Symposium: Domestic Violence, Child Custody & Child Protection: Understanding Judicial Resistance And Imagining Solutions*, 11 AM. U. J. GENDER SOC. POL'Y 657, 662 (2003) ("The failure of many courts to apply new understandings of domestic violence in cases concerning custody actually contrasts sharply with the demonstrable increases over the past ten years in judicial awareness and sensitivity to domestic violence in more standard 'domestic violence' cases, such as civil protection orders or criminal prosecutions.").

¹³⁹ Parker, *supra* note 2, at 171.

¹⁴⁰ Eidelson, *supra* note 109.

¹⁴¹ Parker, *supra* note 2, at 171.

fact: the client may appear with a flat affect; or the client may want to tell the full story in a rush of hysterical emotion; or the client may appear angry (thus making her seem like the aggressor) or the client may simply disassociate and not be able to articulate what happened at all.¹⁴²

Extra time spent on preparation can go a long way in making the litigation process palatable for clients with trauma experience. The student can spend extra time preparing the client for what to expect in the courtroom, reviewing details as mundane as where everyone will sit or stand, to what types of questions will be asked. The more the experience of court can become normalized and predictable for a client, the more likely they will be able to cope. In addition, because constantly re-telling the story of the traumatic events can be re-traumatizing for the client, dividing the preparation into shorter sessions can help minimize the risk of re-traumatization.¹⁴³

Students can utilize extra preparation time to work on mental safety-planning with the client. For example, the student can work with the client around how they will handle being asked difficult questions, or where to focus their energy when the opposing party is talking. The student and client can set up a safety signal, whereby the student can ask for a break in the testimony should it become too overwhelming for the client. Allowing the client to be an active participant in planning for how to handle going to court can help empower the client and normalize the experience of the court hearing.

The student can spend extra time preparing the client for the worst possible case outcomes (e.g. *The worst thing that may happen is that the judge grants his petition for shared custody*). Being able to visualize the possible results will help normalize the experience of court.

Finally, although difficult, students can seek to educate the trier of fact about dynamics of trauma through the litigation process. Some resources exist for training judges in a more systemic manner.¹⁴⁴

4. Preventing Vicarious Trauma

Perhaps the most crucial aspect of the pedagogy of teaching trauma-informed lawyering in law clinics, and certainly the aspect that students have the greatest need to carry forward with them in their legal practice, is the awareness of vicarious trauma and the need

¹⁴² Eidelson, *supra* note 109. One client in Professor Katz's clinic, after repeated questioning in court about the history of intimate partner violence between the parties simply blurted out "he has a hand problem!" (meaning "he puts his hands on me").

¹⁴³ Parker, *supra* note 2, at 176.

¹⁴⁴ SAMSHA, *supra* note 8.

to take preventive measures against its effects. While students may not be likely to experience vicarious trauma in their clinical work, it is important that they learn about the risks, and are able to implement preventive measures starting with their clinical legal work. Preventive measures can be implemented in a number of ways. First, in the authors' clinical courses, the possibility and effects of vicarious trauma are explicitly taught and the authors are each transparent with their students about the preventive measures that are being implemented. When new students begin, as mentioned previously, a psychologist speaks with the students about the effects of trauma on clients, but also discusses the issue of vicarious trauma and how to identify vicarious trauma symptoms and also to protect oneself against vicarious trauma. Students read material about the effects of trauma and the effects of vicarious trauma on professionals who work with trauma survivors, and discuss the effects of vicarious trauma in class.¹⁴⁵

It is also possible and crucial to consider vicarious trauma when structuring clinical courses. One of the best ways to prevent vicarious trauma is balance and limit caseloads.¹⁴⁶ For example, cases should be distributed among students such that the cases involving clients with significant trauma histories are evenly distributed among the students. In Professor Haldar's clinic, where students handle both Protection From Abuse and custody cases, students are assigned both kinds of cases to increase the chance that each student will have at least a few clients who have not recently experienced traumatic events. Thus, every effort is made to ensure that no one student will have only clients who have recent trauma histories, and this balance is a significant factor to protect against vicarious traumatization.

Another recognized prevention technique is to create safe space for practitioners to talk about the effects of working with their clients with trauma histories on a regular basis.¹⁴⁷ In a law school clinic, this can be accomplished through supervision and reflection, and through effective use of case rounds. Both Professor Haldar and Professor Katz ask students to reflect upon vicarious trauma-related topics specifically in their journal assignments. The journal entries call for students to think specifically about whether and how they are being

¹⁴⁵ In addition to journal assignments, sample assignments might include role playing a client interview session when a client discusses a traumatic past event or reading articles about the effects of vicarious trauma in the therapy context and discussing in class the similarities and differences in the legal context.

¹⁴⁶ T. Bober and C.D. Regehr, *Strategies for Reducing Secondary or Vicarious Trauma: Do They Work?*, 6 BRIEF TREATMENT AND CRISIS INTERVENTION 1-9, 7 available at <http://dx.doi.org/10.1093/brief-treatment/mhj001> (last viewed Dec. 20, 2015).

¹⁴⁷ Barbara Dane, *Child Welfare Workers: An Innovative Approach for Interacting with Secondary Trauma*, 36 (1) J. OF SOC. WORK EDUC., 27, 34-35 (2000).

affected by their clients' trauma histories, and whether they are experiencing vicarious trauma symptoms.

In clinics, students should be taught explicit strategies to prevent vicarious trauma that they can carry forward with them into their legal practices. One very effective way to teach students about preventing vicarious trauma is to encourage good self-care and model good self-care. Self-care, in the sense of setting appropriate boundaries between the advocate and the client, is recognized to be a protective factor against vicarious trauma.¹⁴⁸ Sandra Bloom divides self-care into several components: personal physical; personal psychological; personal social; personal moral; professional; organizational/work setting; societal.¹⁴⁹ In the beginning of the semester, along with a discussion of vicarious trauma, clinical professors may choose to encourage their students to develop their own self-care plans, incorporating all of the different components of self-care. In case rounds and supervision, students and the professor can refer back to these self-care plans as needed, especially when working with clients with trauma histories.

Clinical professors may also find it helpful to themselves model good self-care techniques for students. For instance, professors can be transparent about making sure they themselves get to exercise regularly, or about using mental health counseling if needed. Specific discussion of mental health services, and of their availability, may also help students to avoid the effects of vicarious trauma, as knowledge of mental health services is a protective factor.¹⁵⁰

Although not strictly vicarious trauma, it is also important to note here that students often come to our clinics with their own trauma histories; in fact, it is often a student's own trauma history which motivates them to enroll in the clinic to assist clients with similar issues. Of course, working with clients with trauma histories can be triggering for students with their own trauma histories. A crucial aspect of the

¹⁴⁸ Prof. Katz gives the following prompt: *Vicarious trauma, also sometimes called compassion fatigue or secondary trauma, is a term for the effect that working with survivors of trauma may have on counselors, therapists, doctors, lawyers and others who directly help them. Vicarious traumatization refers to harmful changes that occur in professionals' views of themselves, others, and the world, as a result of exposure to the graphic and/or traumatic experiences of their clients. Vicarious trauma occurs in someone who is not the primary person experiencing the trauma. Vicarious trauma happens when a secondary person is exposed to the original victim or offender, likely in the course of their profession.*

In the practice of family law, our clients share some of the most painful and intimate details of their lives. Please use this journal entry to reflect on how you manage your reactions to these stories, and coping mechanisms you are developing to maintain balance as you move through this work.

¹⁴⁹ Sandra L. Bloom, *Caring for the Caregiver: Avoiding and Treating Vicarious Traumatization*, in *SEXUAL ASSAULT: VICTIMIZATION ACROSS THE LIFESPAN – A CLINICAL GUIDE* 459, 466-467 (A.P. Giardino, E. M. Datner, and J.B. Asher eds.) (2003).

¹⁵⁰ Parker, *supra* note 2, at 178, 198.

pedagogy of trauma-informed lawyering consists of acknowledging for law students that they may have their own trauma histories that have an effect on them as they proceed in their legal careers, particularly in working with clients with trauma histories. It is important to create a space for students to talk about and/or reflect on their own trauma experience as needed, as they proceed in working with clients with trauma histories.

CONCLUSION

As this article explains, teaching trauma-informed lawyering is a critical aspect of law students' education in the clinical legal educational setting, particularly in clinics which focus on practice areas where clients' trauma experiences are the direct subject of the representation. This article is not meant to be an exhaustive treatise on how to teach these subjects in law school clinics. Rather the message is simple: a little knowledge about trauma goes a long way in helping students adjust their practice skills to competently and zealously represent clients who have experienced trauma. By implementing the four hallmark teaching goals of trauma-informed lawyering, clinical law professors can not only enhance the advocacy of their students while in the clinic, but also convey lasting skills which will set their students on the path to being excellent lawyers throughout their careers.

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Prepared by
SAMHSA's Trauma and Justice Strategic Initiative
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Introduction

Trauma is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. It is an almost universal experience of people with mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. ***In order to maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.***

The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders.^{1,2,3,4,5} Research has also indicated that with appropriate

supports and intervention, people can overcome traumatic experiences.^{6,7,8,9} However, most people go without these services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders and chronic physical diseases.^{1,10,11}

With appropriate supports and intervention, people can overcome traumatic experiences.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma.^{12,13} Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems.^{5,14} Young people bring their experiences of trauma into the school systems, often interfering with their school success. And many patients in primary care similarly have significant trauma histories which has an impact on their health and their responsiveness to health interventions.^{15,16,17}

In addition, the public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing. The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems.

Thus, the pervasive and harmful impact of traumatic events on individuals, families and communities and the unintended but similarly widespread re-traumatizing of individuals within our public institutions and service systems, makes it necessary to rethink doing “business as usual.” In public institutions and service systems, there is increasing recognition that many of the individuals have extensive histories of trauma that, left unaddressed, can get in the way of achieving good health and well-being. For example, a child who suffers from maltreatment or neglect in the home may not be able to concentrate on school work and be successful in school; a women victimized by domestic violence may have trouble performing in the work setting; a jail inmate repeatedly exposed to violence on the street may have difficulty refraining from retaliatory violence and re-offending; a sexually abused homeless youth may engage in self-injury and high risk behaviors to cope with the effects of sexual abuse; and, a veteran may use substances to mask the traumatic memories of combat. The experiences of these individuals are compelling and, unfortunately, all too common. Yet, until recently, gaining a better understanding of how to address the trauma

experienced by these individuals and how to mitigate the re-traumatizing effect of many of our public institutions and service settings was not an integral part of the work of these systems. Now, however, there is an increasing focus on the impact of trauma and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their “business” under the framework of a trauma-informed approach.

There is an increasing focus on the impact of trauma and how service systems may help to resolve or exacerbate trauma-related issues. These systems are beginning to revisit how they conduct their business under the framework of a trauma-informed approach.

Purpose and Approach: Developing a Framework for Trauma and a Trauma-Informed Approach

PURPOSE

The purpose of this paper is to develop a working concept of trauma and a trauma-informed approach and to develop a shared understanding of these concepts that would be acceptable and appropriate across an array of service systems and stakeholder groups. SAMHSA puts forth a framework for the behavioral health specialty sectors, that can be adapted to other sectors such as child welfare, education, criminal and juvenile justice, primary health care, the military and other settings that have the potential to ease or exacerbate an individual’s capacity to cope with traumatic experiences. In fact, many people with behavioral health problems receive treatment and services in these non-specialty behavioral health systems. SAMHSA intends this

framework be relevant to its federal partners and their state and local system counterparts and to practitioners, researchers, and trauma survivors, families and communities. The desired goal is to build a framework that helps systems “talk” to each other, to understand better the connections between trauma and behavioral health issues, and to guide systems to become trauma-informed.

APPROACH

SAMHSA approached this task by integrating three significant threads of work: trauma focused research work; practice-generated knowledge about trauma interventions; and the lessons articulated by survivors

of traumatic experiences who have had involvement in multiple service sectors. It was expected that this blending of the research, practice and survivor knowledge would generate a framework for improving the capacity of our service systems and public institutions to better address the trauma-related issues of their constituents.

To begin this work, SAMHSA conducted an environmental scan of trauma definitions and models of trauma informed care. SAMHSA convened a group of national experts who had done extensive work in this area. This included trauma survivors who had been recipients of care in multiple service system; practitioners from an array of fields, who had experience in trauma treatment; researchers whose work focused on trauma and the development of trauma-specific interventions; and policymakers in the field of behavioral health.

From this meeting, SAMHSA developed a working document summarizing the discussions among these experts. The document was then vetted among federal agencies that conduct work in the field of trauma. Simultaneously, it was placed on a SAMHSA website for public comment. Federal agency experts provided rich comments and suggestions; the public comment site drew just over 2,000 respondents and 20,000 comments or endorsements of others' comments. SAMHSA reviewed all of these comments, made revisions to the document and developed the framework and guidance presented in this paper.

*The key questions addressed
in this paper are:*

- **What do we mean by trauma?**
- **What do we mean by a trauma-informed approach?**
- **What are the key principles of a trauma-informed approach?**
- **What is the suggested guidance for implementing a trauma-informed approach?**
- **How do we understand trauma in the context of community?**

SAMHSA's approach to this task has been an attempt to integrate knowledge developed through research and clinical practice with the voices of trauma survivors. This also included experts funded through SAMHSA's trauma-focused grants and initiatives, such as SAMHSA's National Child Traumatic Stress Initiative, SAMHSA's National Center for Trauma Informed Care, and data and lessons learned from other grant programs that did not have a primary focus on trauma but included significant attention to trauma, such as SAMHSA's: Jail Diversion Trauma Recovery grant program; Children's Mental Health Initiative; Women, Children and Family Substance Abuse Treatment Program; and Offender Reentry and Adult Treatment Drug Court Programs.

Background: Trauma — Where We Are and How We Got Here

The concept of traumatic stress emerged in the field of mental health at least four decades ago. Over the last 20 years, SAMHSA has been a leader in recognizing the need to address trauma as a fundamental obligation for public mental health and substance abuse service delivery and has supported the development and promulgation of trauma-informed systems of care. In 1994, SAMHSA convened the Dare to Vision Conference, an event designed to bring trauma to the foreground and the first national conference in which women trauma survivors talked about their experiences and ways in which standard practices in hospitals re-traumatized and often, triggered memories of previous abuse. In 1998, SAMHSA funded the Women, Co-Occurring Disorders and Violence Study to generate knowledge on the development and evaluation of integrated services approaches for women with co-occurring mental and substance use disorders who also had histories of physical and or sexual abuse. In 2001, SAMHSA funded the National Child Traumatic Stress Initiative to increase understanding of child trauma and develop effective interventions for children exposed to different types of traumatic events.

The American Psychiatric Association (APA) played an important role in defining trauma. Diagnostic criteria for traumatic stress disorders have been debated through several iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a new category of Trauma- and Stressor-Related Disorders, across the life-span, included in the recently released DSM-V (APA, 2013). Measures and inventories of trauma exposure, with both clinical and research applications, have proliferated since the 1970's.^{18,19,20,21} National trauma research and practice centers have conducted significant work in the past few decades, further refining the concept of trauma, and developing effective trauma assessments and treatments.^{22,23,24,25} With the advances in neuroscience, a biopsychosocial approach to traumatic experiences has begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental and substance use disorders across the life-span.^{3,25}

Simultaneously, an emerging trauma survivors movement has provided another perspective on the understanding of traumatic experiences. Trauma survivors, that is, people with lived experience of trauma, have powerfully and systematically documented their paths to recovery.²⁶ Traumatic experiences complicate a child's or an adult's capacity to make sense of their lives and to create meaningful consistent relationships in their families and communities.

Trauma survivors have powerfully and systematically documented their paths to recovery.

The convergence of the trauma survivor's perspective with research and clinical work has underscored the central role of traumatic experiences in the lives of people with mental and substance use conditions. The connection between trauma and these conditions offers a potential explanatory model for what has happened to individuals, both children and adults, who come to the attention of the behavioral health and other service systems.^{25,27}

People with traumatic experiences, however, do not show up only in behavioral health systems. Responses to these experiences often manifest in behaviors or conditions that result in involvement with the child welfare and the criminal and juvenile justice system or in difficulties in the education, employment or primary care system. Recently, there has also been a focus on individuals in the military and increasing rates of posttraumatic stress disorders.^{28,29,30,31}

With the growing understanding of the pervasiveness of traumatic experience and responses, a growing number of clinical interventions for trauma responses have been developed. Federal research agencies, academic institutions and practice-research partnerships have generated empirically-supported interventions. In SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) alone there are over 15 interventions focusing on the treatment or screening for trauma.

These interventions have been integrated into the behavioral health treatment care delivery system; however, from the voice of trauma survivors, it has become clear that these clinical interventions are not enough. Building on lessons learned from SAMHSA's Women, Co-Occurring Disorders and Violence Study; SAMHSA's National Child Traumatic Stress Network; and SAMHSA's National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraints, among other developments in the field, it became clear that the organizational climate and conditions in which services are provided played a significant role in maximizing the outcomes of interventions and contributing to the healing and recovery of the people being served. SAMHSA's National Center for Trauma-Informed Care has continued to advance this effort, starting first in the behavioral health sector, but increasingly responding to technical assistance requests for organizational change in the criminal justice, education, and primary care sectors.

FEDERAL, STATE AND LOCAL LEVEL TRAUMA-FOCUSED ACTIVITIES

The increased understanding of the pervasiveness of trauma and its connections to physical and behavioral health and well-being, have propelled a growing number of organizations and service systems to explore ways to make their services more responsive to people who have experienced trauma. This has been happening in state and local systems and federal agencies.

States are elevating a focus on trauma. For example, Oregon Health Authority is looking at different types of trauma across the age span and different population groups. Maine's "Thrive Initiative" incorporates a

trauma-informed care focus in their children's systems of care. New York is introducing a trauma-informed initiative in the juvenile justice system. Missouri is exploring a trauma-informed approach for their adult mental health system. In Massachusetts, the Child Trauma Project is focused on taking trauma-informed care statewide in child welfare practice. In Connecticut the Child Health and Development Institute with the state Department of Children and Families is building a trauma-informed system of care throughout the state through policy and workforce development. SAMHSA has supported the further development of trauma-informed approaches through its Mental Health Transformation Grant program directed to State and local governments.

Increasing examples of local level efforts are being documented. For example, the City of Tarpon Springs in Florida has taken significant steps in becoming a trauma-informed community. The city made it its mission to promote a widespread awareness of the costly effects of personal adversity upon the wellbeing of the community. The Family Policy Council in Washington State convened groups to focus on the impact of adverse childhood experiences on the health and well-being of its local communities and tribal communities. Philadelphia held a summit to further its understanding of the impact of trauma and violence on the psychological and physical health of its communities.

SAMHSA continues its support of grant programs that specifically address trauma.

At the federal level, SAMHSA continues its support of grant programs that specifically address trauma and technical assistance centers that focus on prevention, treatment and recovery from trauma.

Other federal agencies have increased their focus on trauma. The Administration on Children Youth and Families (ACYF) has focused on the complex trauma of children in the child welfare system and how screening and assessing for severity of trauma and linkage with trauma treatments can contribute to improved well-being for these youth. In a joint effort among ACYF, SAMHSA and the Centers for Medicare and Medicaid Services (CMS), the three agencies developed and issued through the CMS State Directors' mechanism, a letter to all State Child Welfare Administrators, Mental Health Commissioners, Single State Agency Directors for Substance Abuse and State Medicaid Directors discussing trauma, its impact on children, screening, assessment and treatment interventions and strategies for paying for such care. The Office of Juvenile Justice and Delinquency Prevention has specific recommendations to address trauma in their Children Exposed to Violence Initiative. The Office of Women's Health has developed a curriculum to train providers in

primary care on how to address trauma issues in health care for women. The Department of Labor is examining trauma and the workplace through a federal interagency workgroup. The Department of Defense is honing in on prevention of sexual violence and trauma in the military.

As multiple federal agencies representing varied sectors have recognized the impact of traumatic experiences on the children, adults, and families they serve, they have requested collaboration with SAMHSA in addressing these issues. The widespread recognition of the impact of trauma and the burgeoning interest in developing capacity to respond through trauma-informed approaches compelled SAMHSA to revisit its conceptual framework and approach to trauma, as well as its applicability not only to behavioral health but also to other related fields.

SAMHSA's Concept of Trauma

Decades of work in the field of trauma have generated multiple definitions of trauma. Combing through this work, SAMHSA developed an inventory of trauma definitions and recognized that there were subtle nuances and differences in these definitions.

Desiring a concept that could be shared among its constituencies — practitioners, researchers, and trauma survivors, SAMHSA turned to its expert panel to help craft a concept that would be relevant to public health agencies and service systems. SAMHSA aims to provide a viable framework that can be used to support people receiving services, communities, and stakeholders in the work they do. A review of the existing definitions and discussions of the expert panel generated the following concept:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

THE THREE “E’S” OF TRAUMA: EVENT(S), EXPERIENCE OF EVENT(S), AND EFFECT

Events and circumstances may include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. This element of SAMHSA’s concept of trauma is represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as “trauma and stressor-related disorders” to include exposure to a traumatic or stressful event as a diagnostic criterion.

The individual’s **experience** of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another (e.g., a child removed from an abusive home experiences this differently than their sibling; one refugee may experience fleeing one’s country differently from another refugee; one military veteran may experience deployment to a war zone as traumatic while another veteran is not similarly affected). How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event, or a force of nature) has power over another. They elicit a profound question of “why me?” The individual’s experience of these events or circumstances is shaped in the context of this powerlessness and questioning. Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. When a person experiences physical or sexual abuse, it is often accompanied by a sense of humiliation, which can lead the person to feel as though they are bad or dirty, leading to a sense of self blame, shame and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal,

shattering a person’s trust and leaving them feeling alone. Often, abuse of children and domestic violence are accompanied by threats that lead to silencing and fear of reaching out for help.

How the event is experienced may be linked to a range of factors including the individual’s cultural beliefs (e.g., the subjugation of women and the experience of domestic violence), availability of social supports (e.g., whether isolated or embedded in a supportive family or community structure), or to the developmental stage of the individual (i.e., an individual may understand and experience events differently at age five, fifteen, or fifty).¹

The long-lasting adverse **effects** of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognize the connection between the traumatic events and the effects. Examples of adverse effects include an individual’s inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions. In addition to these more visible effects, there may be an altering of one’s neurobiological make-up and ongoing health and well-being. Advances in neuroscience and an increased understanding of the interaction of neurobiological and environmental factors have documented the effects of such threatening events.^{1,3} Traumatic effects, which may range from hyper-vigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally, and emotionally. Survivors of trauma have also highlighted the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences.

SAMHSA's Trauma-Informed Approach: Key Assumptions and Principles

Trauma researchers, practitioners and survivors have recognized that the understanding of trauma and trauma-specific interventions is not sufficient to optimize outcomes for trauma survivors nor to influence how service systems conduct their business.

The context in which trauma is addressed or treatments deployed contributes to the outcomes for the trauma survivors, the people receiving services, and the individuals staffing the systems. Referred to variably as “trauma-informed care” or “trauma-informed approach” this framework is regarded as essential to the context of care.^{22,32,33} SAMHSA’s concept of a trauma-informed approach is grounded in a set of four assumptions and six key principles.

A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.

A trauma informed approach is distinct from trauma-specific services or trauma systems. A trauma informed approach is inclusive of trauma-specific interventions, whether assessment, treatment or recovery supports, yet it also incorporates key trauma principles into the organizational culture.

Referred to variably as “trauma-informed care” or “trauma-informed approach” this framework is regarded as essential to the context of care.

THE FOUR “R’S: KEY ASSUMPTIONS IN A TRAUMA-INFORMED APPROACH

In a trauma-informed approach, all people at all levels of the organization or system have a basic **realization** about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals. People’s experience and behavior are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past (i.e., a client dealing with prior child abuse), whether they are currently manifesting (i.e., a staff member living with domestic violence in the home), or whether they are related to the emotional distress that results in hearing about the firsthand experiences of another (i.e., secondary traumatic stress experienced by a direct care professional). There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in prevention, treatment, and recovery settings. Similarly, there is a realization that trauma is not confined to the behavioral health specialty service sector, but is integral to other systems (e.g., child welfare, criminal justice, primary health care, peer-run and community organizations) and is often a barrier to effective outcomes in those systems as well.

People in the organization or system are also able to **recognize** the signs of trauma. These signs may be gender, age, or setting-specific and may be manifest by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance, and supervision practices.

The program, organization, or system **responds** by applying the principles of a trauma-informed approach to all areas of functioning. The program, organization, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly. Staff in every part of the organization, from the person who greets clients at the door to the executives and the governance board, have changed their language, behaviors and policies to take into consideration the experiences of trauma among children and adult users of the services and among staff providing the services. This is accomplished through staff training, a budget that supports this ongoing training, and leadership that realizes the role of trauma in the lives of their staff and the people they serve. The organization has practitioners trained in evidence-based trauma practices. Policies of the organization, such as mission statements, staff handbooks and manuals promote a culture based on beliefs about resilience, recovery, and healing from trauma. For instance, the agency's mission may include an intentional statement on the organization's commitment to promote trauma recovery; agency policies demonstrate a commitment to incorporating perspectives of people served through the establishment of client advisory boards or inclusion of people who have received services on the agency's board of directors; or agency training includes resources for mentoring supervisors on helping staff address secondary traumatic stress. The organization is committed to providing a physically and psychologically safe environment. Leadership ensures that staff work in an environment that promotes trust, fairness and transparency. The program's, organization's, or system's response involves a universal precautions approach in which one expects the presence of trauma in lives of individuals being served, ensuring not to replicate it.

A trauma-informed approach seeks to **resist re-traumatization** of clients as well as staff. Organizations often inadvertently create stressful or toxic environments that interfere with the recovery of clients, the well-being of staff and the fulfillment of the organizational mission.²⁷ Staff who work within a trauma-informed environment are taught to recognize how organizational practices may

trigger painful memories and re-traumatize clients with trauma histories. For example, they recognize that using restraints on a person who has been sexually abused or placing a child who has been neglected and abandoned in a seclusion room may be re-traumatizing and interfere with healing and recovery.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific.

SIX KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

1. Safety
2. Trustworthiness and Transparency
3. Peer Support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice
6. Cultural, Historical, and Gender Issues

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

The six key principles fundamental to a trauma-informed approach include:^{24,36}

- 1. Safety:** Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.
- 2. Trustworthiness and Transparency:** Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.
- 3. Peer Support:** Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term “Peers” refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as “trauma survivors.”
- 4. Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. As one expert stated: “one does not have to be a therapist to be therapeutic.”¹²
- 5. Empowerment, Voice and Choice:** Throughout the organization and among the clients served, individuals’ strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery.³⁴ Staff are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff need to feel safe, as much as people receiving services.
- 6. Cultural, Historical, and Gender Issues:** The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); offers access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

Guidance for Implementing a Trauma-Informed Approach

Developing a trauma-informed approach requires change at multiple levels of an organization and systematic alignment with the six key principles described above. The guidance provided here builds upon the work of Harris and Falot and in conjunction with the key principles, provides a starting point for developing an organizational trauma-informed approach.²⁰ While it is recognized that not all public institutions and service sectors attend to trauma as an aspect of how they conduct business, understanding the role of trauma and a trauma-informed approach may help them meet their goals and objectives. Organizations, across service-sectors and systems, are encouraged to examine how a trauma-informed approach will benefit all stakeholders; to conduct a trauma-informed organizational assessment and change process; and to involve clients and staff at all levels in the organizational development process.

The guidance for implementing a trauma-informed approach is presented in the ten domains described below. This is not provided as a “checklist” or a prescriptive step-by-step process. These are the domains of organizational change that have appeared both in the organizational change management literature and among models for establishing trauma-informed care.^{35,36,37,38} What makes it unique to establishing a trauma-informed organizational approach is the cross-walk with the key principles and trauma-specific content.

TEN IMPLEMENTATION DOMAINS

- 1. Governance and Leadership**
- 2. Policy**
- 3. Physical Environment**
- 4. Engagement and Involvement**
- 5. Cross Sector Collaboration**
- 6. Screening, Assessment, Treatment Services**
- 7. Training and Workforce Development**
- 8. Progress Monitoring and Quality Assurance**
- 9. Financing**
- 10. Evaluation**

GOVERNANCE AND LEADERSHIP: The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach; there is an identified point of responsibility within the organization to lead and oversee this work; and there is inclusion of the peer voice. A champion of this approach is often needed to initiate a system change process.

POLICY: There are written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission. Organizational procedures and cross agency protocols, including working with community-based agencies, reflect trauma-informed principles. This approach must be “hard-wired” into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.

PHYSICAL ENVIRONMENT OF THE ORGANIZATION:

The organization ensures that the physical environment promotes a sense of safety and collaboration. Staff working in the organization and individuals being served must experience the setting as safe, inviting, and not a risk to their physical or psychological safety. The physical setting also supports the collaborative aspect of a trauma informed approach through openness, transparency, and shared spaces.

ENGAGEMENT AND INVOLVEMENT OF PEOPLE IN RECOVERY, TRAUMA SURVIVORS, PEOPLE RECEIVING SERVICES, AND FAMILY MEMBERS RECEIVING SERVICES:

These groups have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning (e.g., program design, implementation, service delivery, quality assurance, cultural competence, access to trauma-informed peer support, workforce development, and evaluation.) This is a key value and aspect of a trauma-informed approach that differentiates it from the usual approaches to services and care.

CROSS SECTOR COLLABORATION: Collaboration across sectors is built on a shared understanding of trauma and principles of a trauma-informed approach. While a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization’s mission is a critical aspect of building collaborations. People with significant trauma histories often present with a complexity of needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could then undermine the progress of the individual.

SCREENING, ASSESSMENT, AND TREATMENT SERVICES:

Practitioners use and are trained in interventions based on the best available empirical evidence and science, are culturally appropriate, and reflect principles of a trauma-informed approach. Trauma screening and assessment are an essential part of the work. Trauma-specific interventions are acceptable, effective, and available for individuals and families seeking services. When trauma-specific services are not available within the organization, there is a trusted, effective referral system in place that facilitates connecting individuals with appropriate trauma treatment.

TRAINING AND WORKFORCE DEVELOPMENT:

On-going training on trauma and peer-support are essential. The organization’s human resource system incorporates trauma-informed principles in hiring, supervision, staff evaluation; procedures are in place to support staff with trauma histories and/or those experiencing significant secondary traumatic stress or vicarious trauma, resulting from exposure to and working with individuals with complex trauma.

PROGRESS MONITORING AND QUALITY ASSURANCE:

There is ongoing assessment, tracking, and monitoring of trauma-informed principles and effective use of evidence-based trauma specific screening, assessments and treatment.

FINANCING: Financing structures are designed to support a trauma-informed approach which includes resources for: staff training on trauma, key principles of a trauma-informed approach; development of appropriate and safe facilities; establishment of peer-support; provision of evidence-supported trauma screening, assessment, treatment, and recovery supports; and development of trauma-informed cross-agency collaborations.

EVALUATION: Measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma and appropriate trauma-oriented research instruments.

To further guide implementation, the chart on the next page provides sample questions in each of the ten domains to stimulate change-focused discussion. The questions address examples of the work to be done in any particular domain yet also reflect the six

key principles of a trauma-informed approach. Many of these questions and concepts were adapted from the work of FalLOT and Harris, Henry, Black-Pond, Richardson, & Vandervort, Hummer and Dollard, and Penney and Cave.^{39, 40, 41,42}

While the language in the chart may seem more familiar to behavioral health settings, organizations across systems are encouraged to adapt the sample questions to best fit the needs of the agency, staff, and individuals being served. For example, a juvenile justice agency may want to ask how it would incorporate the principle of safety when examining its physical environment. A primary care setting may explore how it can use empowerment, voice, and choice when developing policies and procedures to provide trauma-informed services (e.g. explaining step by step a potentially invasive procedure to a patient at an OBGYN office).

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH

KEY PRINCIPLES					
Safety	Trustworthiness and Transparency	Peer Support	Collaboration and Mutuality	Empowerment, Voice, and Choice	Cultural, Historical, and Gender Issues
10 IMPLEMENTATION DOMAINS					
Governance and Leadership	<ul style="list-style-type: none"> • How does agency leadership communicate its support and guidance for implementing a trauma-informed approach? • How do the agency’s mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports? • How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories? 				
Policy	<ul style="list-style-type: none"> • How do the agency’s written policies and procedures include a focus on trauma and issues of safety and confidentiality? • How do the agency’s written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery? • How do the agency’s staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training? • How do human resources policies attend to the impact of working with people who have experienced trauma? • What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation? 				

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH

(continued)

10 IMPLEMENTATION DOMAINS <i>continued</i>	
Physical Environment	<ul style="list-style-type: none"> • How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff? • In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this? • How has the agency provided space that both staff and people receiving services can use to practice self-care? • How has the agency developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities).
Engagement and Involvement	<ul style="list-style-type: none"> • How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services? • How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information? • How is transparency and trust among staff and clients promoted? • What strategies are used to reduce the sense of power differentials among staff and clients? • How do staff members help people to identify strategies that contribute to feeling comforted and empowered?
Cross Sector Collaboration	<ul style="list-style-type: none"> • Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions? • Are collaborative partners trauma-informed? • How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services? • What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?
Screening, Assessment, Treatment Services	<ul style="list-style-type: none"> • Is an individual's own definition of emotional safety included in treatment plans? • Is timely trauma-informed screening and assessment available and accessible to individuals receiving services? • Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services? • How are peer supports integrated into the service delivery approach? • How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, are gender-specific trauma services and supports available for both men and women? • Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding? • How are these trauma-specific practices incorporated into the organization's ongoing operations?

SAMPLE QUESTIONS TO CONSIDER WHEN IMPLEMENTING A TRAUMA-INFORMED APPROACH

(continued)

10 IMPLEMENTATION DOMAINS <i>continued</i>	
Training and Workforce Development	<ul style="list-style-type: none"> • How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences? • How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions? • How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions? • How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person's experience of trauma, access to supports and resources, and opportunities for safety? • How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors. • What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work? • What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization's workforce?
Progress Monitoring and Quality Assurance	<ul style="list-style-type: none"> • Is there a system in place that monitors the agency's progress in being trauma-informed? • Does the agency solicit feedback from both staff and individuals receiving services? • What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency? • How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes? • What mechanisms are in place for information collected to be incorporated into the agency's quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?
Financing	<ul style="list-style-type: none"> • How does the agency's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development? • What funding exists for cross-sector training on trauma and trauma-informed approaches? • What funding exists for peer specialists? • How does the budget support provision of a safe physical environment?
Evaluation	<ul style="list-style-type: none"> • How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach? • How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey? • What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality? • What measures or indicators are used to assess the organizational progress in becoming trauma-informed?

Next Steps: Trauma in the Context of Community

Delving into the work on community trauma is beyond the scope of this document and will be done in the next phase of this work. However, recognizing that many individuals cope with their trauma in the safe or not-so safe space of their communities, it is important to know how communities can support or impede the healing process.

Trauma does not occur in a vacuum. Individual trauma occurs in a context of community, whether the community is defined geographically as in neighborhoods; virtually as in a shared identity, ethnicity, or experience; or organizationally, as in a place of work, learning, or worship. How a community responds to individual trauma sets the foundation for the impact of the traumatic event, experience, and effect. Communities that provide a context of understanding and self-determination may facilitate the healing and recovery process for the individual. Alternatively, communities that avoid, overlook, or misunderstand the impact of trauma may often be re-traumatizing and interfere with the healing process. Individuals can be re-traumatized by the very people whose intent is to be helpful. This is one way to understand trauma in the context of a community.

A second and equally important perspective on trauma and communities is the understanding that communities as a whole can also experience trauma. Just as with the trauma of an individual or family, a community may be subjected to a community-threatening event, have a shared experience of the event, and have an adverse, prolonged effect. Whether the result of a natural disaster (e.g., a flood, a hurricane or an earthquake) or an event or circumstances inflicted by one group on another (e.g., usurping homelands, forced relocation, servitude, or mass incarceration, ongoing exposure to violence in the community), the resulting trauma is often transmitted from one generation to the next in a pattern often referred to as historical, community, or intergenerational trauma.

Communities can collectively react to trauma in ways that are very similar to the ways in which individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation. Communities are often profoundly shaped by their trauma histories. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma.

Many people who experience trauma readily overcome it and continue on with their lives; some become stronger and more resilient; for others, the trauma is overwhelming and their lives get derailed. Some may get help in formal support systems; however, the vast majority will not. The manner in which individuals and families can mobilize the resources and support of their communities and the degree to which the community has the capacity, knowledge, and skills to understand and respond to the adverse effects of trauma has significant implications for the well-being of the people in their community.

Conclusion

As the concept of a trauma-informed approach has become a central focus in multiple service sectors, SAMHSA desires to promote a shared understanding of this concept. The working definitions, key principles, and guidance presented in this document represent a beginning step toward clarifying the meaning of this concept. This document builds upon the extensive work of researchers, practitioners, policymakers, and people with lived experience in the field. A standard, unified working concept will serve to advance the understanding of trauma and a trauma-informed approach for public institutions and service sectors.

Endnotes

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TRAUMA: WHAT LURKS BENEATH THE SURFACE

WESTLAW LAWPRAC INDEX

LED--Law School & Continuing Legal Education

Scholarship in the behavioral health field demonstrates that an overwhelming majority of clients experiencing urban poverty, and particularly low-income clients living with chronic medical and mental health issues, have endured trauma as children and adults. While legal scholars and service providers have begun to discuss the role that trauma plays in the client's interactions with the lawyer, the dialogue has largely focused on trauma relevant to the subject matter of the legal representation. This article expands current scholarship by asserting that given the prevalence of trauma, the lawyer serving the urban poor should presumptively adopt a trauma-informed practice approach regardless of the subject matter of the representation. The lawyer engaging in a trauma-informed practice can enrich the client experience generally and enrich it significantly for the many clients who come to the lawyer-client relationship with a history of trauma.

I. INTRODUCTION

*When we first met Ms. A.,¹ she was thirty years old and raising *202 four children on her own. She worked the night shift preparing and serving food in the student center at a local university. When she wasn't working, Ms. A.'s priority was to take care of her children. Her two youngest children, who were 13 months and three years old at the time, were not yet in school and Ms. A. cared for them during the day. Ms. A.'s son, who was ten, had severe asthma and HIV. Ms. A.'s oldest daughter was fifteen and struggling to keep up in the ninth grade. She was frequently late to or absent from school, and was involved in fights with classmates. Ms. A. had her own health issues, including acute pancreatitis and HIV, which generally took a back burner to the more immediate needs of her children.*

Ms. A. had a contentious relationship with the father of her oldest daughter, and based on her concerns about his drug use, tried to minimize the time her daughter spent with her father. For the year leading up to our lawyer-client relationship with Ms. A., the fifteen-year-old had been spending increasingly more time at her father's home, in an environment that Ms. A. did not think offered proper supervision. The father had recently threatened to seek custody of his daughter. The father of Ms. A.'s son, whom she described as the love of her life and to whom she had been married, was killed in a tractor trailer accident when her son was a toddler. Shortly after his death, Ms. A. began experiencing repeated flare-ups of her acute pancreatitis causing her to miss a lot of work. Ms. A. was ultimately terminated from her dining services job for excessive absenteeism and, as a result, she lost her family's employer-funded health insurance. For the next couple of years, Ms. A. relied on the emergency

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room to treat her medical needs as well as her son's asthma. Ms. A. began receiving Social Security disability benefits and did her best to financially support her family.

In the years following the death of her husband, Ms. A. began a relationship with a man who was physically and emotionally abusive towards her. This man became the father of Ms. A.'s two youngest children.

Before we met Ms. A., she and her children experienced a period of homelessness. With the support of a psychiatrist and social worker at the HIV medical clinic where Ms. A. received her primary care, Ms. A. slowly regained her health and was eventually able to return to the workforce. Once receiving a paycheck again, Ms. A. was able to separate from the man who abused her and move into her own apartment *203 with her children.

Further complicating Ms. A.'s life, within weeks of Ms. A.'s return to work, Ms. A.'s mother died. Ms. A.'s mother was her self-described "best friend" and sole source of emotional support. The loss hit Ms. A. extremely hard.

Ms. A. did not share with the student attorneys representing her any of these experiences at the time she sought legal representation, nor did the student attorneys ask questions that might have elicited some of this history. Ms. A.'s experiences were deeply personal and they were not relevant to the legal matter for which she sought legal representation. Indeed, Ms. A. sought legal help after receiving a notice from the Social Security Administration terminating her disability benefits, and directing her to repay within thirty days approximately \$35,000 that Social Security claimed it had overpaid her. Ms. A. sought legal assistance because she had no financial ability to repay any of the overpayment. Slowly, over the course of the student attorneys' almost two-year relationship with Ms. A., she shared some of her difficult and personal experiences.

Although Ms. A.'s experiences were not substantively relevant to the Social Security overpayment matter for which Ms. A. initially sought the legal clinic's assistance, would the student attorneys' knowledge of them earlier in their relationship have changed their lawyering approach? Did Ms. A.'s experiences affect the way she communicated with the student attorneys? Did they affect how much, and how soon, she trusted the student attorneys? Did they affect the credibility of the information Ms. A. shared with the student attorneys? Would the student attorneys have engaged with, or understood, Ms. A. differently had they known that Ms. A. had experienced homelessness, domestic violence, the death of her husband, financial instability, raising a son with chronic health conditions, and her own chronic health conditions? Should they have?

The answers to these questions highlight the role that trauma plays in the relationship between the lawyer and the client. Legal scholars and practitioners know that establishing a trusting relationship in which the client is able to share information relevant to the case, including not only relevant factual details about the substantive legal matter, but also the ethical, moral, and personal considerations that are relevant to client decision-making,² is critical to good representation. Just as world view,³ race, class, gender, sexual orientation, *204 disability, religion, ethnicity, socio-economic status, and culture⁴ influence client behavior and decision-making, so, too, does trauma.

Scholarship in the behavioral health field demonstrates that an overwhelming majority of clients experiencing urban poverty, and particularly low-income clients living with mental health issues and chronic physical conditions including HIV, have endured trauma during their lifetime.⁵ Experiences such as those endured by Ms. A. as well as others including witnessing or experiencing violence in the client's home and community, difficulty paying rent, eviction, homelessness, substance abuse, mental health challenges, discrimination, and loss of a loved one constitute trauma.⁶

Equipped with a developing understanding of trauma, the student attorneys representing Ms. A. presumptively engaged in a trauma-informed lawyering approach. While this approach mirrors much of client-centered lawyering generally, it extends the practice through its acute awareness of trauma and places specific emphasis on ensuring the client's physical and emotional safety in which trust plays a large role, and on intentionally creating opportunities for the client to rebuild control over their life in large part through empowering client decision-making. While client-centered lawyering is a trauma-informed practice approach, the lawyer's heightened awareness of the prevalence and influence of trauma allows the lawyer to be more deliberate about taking steps to provide better representation to the client who has experienced trauma.

While legal scholars and legal service providers have begun to discuss the role that traumatic experiences play in the client's interaction with the lawyer, the dialogue has largely focused on trauma relevant *205 to the subject matter of the legal representation. Sarah Katz and Deeya Haldar recently wrote an article emphasizing the importance of helping law students identify and address the effects of their client's traumatic experiences in the context of a family law clinic where many clients experienced trauma relevant to their family court matters. Katz and Haldar recognize that clients, based on the nature of the subject matter of certain cases, frequently seek legal assistance at times when they are highly vulnerable and emotional, and that they must share painful and intimate details of their lives.⁷ For these reasons, Katz and Haldar recommend that lawyers representing clients in practice areas such as family law,⁸ immigration,⁹ criminal law,¹⁰ juvenile law and child welfare,¹¹ and veterans rights law,¹² practice trauma-informed lawyering.¹³

This article expands current scholarship by asserting that given the prevalence of trauma, lawyers serving the urban poor should presumptively adopt a trauma-informed practice approach regardless of the subject matter of the representation.¹⁴ The lawyer engaging in a *206 trauma-informed practice can enrich the client experience generally and enrich it significantly for the many clients who come to the lawyer-client relationship with trauma histories. The recommendation that lawyers serving the urban poor engage in trauma-informed practice fits squarely within existing scholarship about client-centered lawyering, cross-cultural lawyering, and therapeutic jurisprudence.

Section I of the article defines trauma, and discusses the long-term effects that traumatic experiences may have on client behavior. Section II explores how trauma's effects may influence the lawyer-client relationship. Section III argues that trauma-informed lawyering is an approach that lawyers should presumptively take to improve their client representation, and concludes by recommending that: (1) lawyers and judges receive training on the influence of trauma; (2) while formal or informal inter-professional partnerships (including law, social work, behavioral health, medicine, and nursing) are particularly well-suited to offer comprehensive trauma-informed care to individuals experiencing urban poverty, lawyers working with clients alone can improve the quality of their services by broadening their understanding of trauma and providing trauma-informed legal care; and (3) empirical research be undertaken to measure health and therapeutic outcomes to clients as a result of trauma-informed legal intervention.

*207 II. UNDERSTANDING TRAUMA AND ADVERSE CHILDHOOD EXPERIENCES

Trauma is a common experience for adults and children in the United States, and is especially common for people with mental and substance use disorders.¹⁵ National epidemiological studies show that approximately 70% of adults in the United States have experienced one or more traumatic events.¹⁶ Research further shows that families living in urban poverty encounter multiple traumas over many years, and that they are less likely than families living in wealthier communities to have access to the resources that may help support them through their traumatic experiences. As a result, families living in urban poverty tend to experience the negative effects of trauma at higher rates than families in wealthier communities.¹⁷

According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), “[i]ndividual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual wellbeing.”¹⁸ To help understand this definition of trauma, SAMSHA conceptualizes trauma around three “E’s”: (1) event(s), (2) experience of the event(s), and (3) effect.¹⁹

With respect to the first element, exposure to a traumatic or stressful event, trauma involves an individual's experience of an “actual or extreme threat of physical or psychological harm.”²⁰ The lawyer would likely recognize that events such as the client's sudden loss of a loved one, child abuse, and domestic violence constitute traumatic events. However, the lawyer untrained about trauma may not consider that traumatic events can also include exposure to or witnessing natural disasters, community or school violence, house fires, accidents, *208 illnesses, crime, and homelessness.²¹ The lawyer untrained about trauma may likely not realize that broader societal experiences such as racism, which may cause the client to feel unsafe based

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on the risk of targeted violence and discrimination;²² and poverty,²³ which may cause the client to worry routinely about hunger, violence, illness and accidents, and economic strain²⁴ similarly constitute trauma.

Indeed, families exposed to urban poverty face a disproportionate risk of exposure to trauma based on factors such as low neighborhood safety, daily hassles, and racial discrimination.²⁵ In a 2008 study with families in Baltimore City conducted by the Family Informed Trauma Treatment (FITT) Center and Maryland Coalition of Families for Children's Mental Health, many adult family members reported coping with very high levels of stress. The study found the most common form of trauma reported by the families in Baltimore City was exposure to domestic and community violence frequently related to drug use and distribution. Families also reported struggling with the responsibilities and lack of resources needed to care for more than one generation.²⁶

Because what may be traumatic to one person may not necessarily be traumatic to another,²⁷ the second component of trauma relates to the individual's experience of the event and how the event impacts the individual both physically and psychologically. Factors such as the nature and severity of the traumatic incident, prior traumatic experiences, including child abuse, individual or family psychiatric history, accumulation of life stressors, cultural beliefs, the availability and strength of a support system, low socio-economic status, lack of education, and the individual's developmental stage and *209 ability to process the event, influence an individual's response to an event.²⁸

Finally, trauma is defined by the adverse effects it has on the individual. Traumatic experiences often cause a person to question, "Why me?" and cause the person to feel powerless, humiliated, guilty, shameful, betrayed, or silenced. Trauma's effects can happen immediately or have a delayed onset. The effects can be short-lived or long lasting.²⁹

Similar to the difficulties shared by Ms. A., adult family members in the 2008 study of families in Baltimore City reported significant sleep and health problems. Some study participants had trouble keeping jobs because of the disruptions and stress caused by trauma.³⁰

Due to physiological changes in the brain, including the increased release of stress hormones and alterations in systems that detect danger and safety,³¹ people experiencing trauma can feel intense fear, helplessness, horror, emotional numbing, or detachment. They may experience physiological hyper-arousal including difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, an exaggerated startle response, or being in a constant state of arousal.³² They may have difficulties trusting others, and a tendency to develop unhealthy relationships.³³ Finally, people who have experienced trauma may re-experience traumatic memories through dreams *210 or flashbacks, and they may avoid people, places, and things related to the trauma.

A. The Adverse Childhood Experiences (ACEs) Study

In addition to the traumatic events that many clients experience as adults--and that may or may not be relevant to the subject matter of the legal matter for which the client seeks representation--research also suggests that many clients have experienced traumatic stress as children. Indeed, according to the Centers for Disease Control and Prevention, one in five Americans was sexually molested as a child; one in four was beaten by a parent to the point of a mark being left on their body; a quarter of Americans grew up with alcoholic relatives; and one of eight Americans witnessed their mother being physically abused.³⁴ The Adverse Childhood Experiences (ACEs) Study and the robust medical research that has followed over the past twenty years demonstrate that childhood trauma has profound effects on brain development and, consequently, negative effects on adult behavior.³⁵

The ACEs Study was jointly conducted over several years in the mid-to-late 1990s by the Centers for Disease Control and Prevention and Kaiser Permanente. The groundbreaking study aimed to determine the relationship between adverse childhood experiences and the leading causes of death in adulthood. The study measured the relationship between exposure to childhood

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emotional, physical or sexual abuse, or household dysfunction during childhood--known as adverse childhood experiences (ACEs)--and adult health risk behavior, health, and disease.³⁶

The ACEs Study found that the more ACEs a person experienced in childhood, the more those people in adulthood experienced health risk behaviors and diseases that contributed to the leading causes of mortality in the United States at the time, namely, smoking, severe obesity, physical inactivity, depressed mood, suicide attempts, alcoholism, drug abuse, parental drug abuse, a high lifetime number of sexual partners and a history of having a sexually transmitted disease, *211 heart disease, cancer, stroke, chronic bronchitis, emphysema, diabetes, hepatitis, and skeletal fractures.³⁷

Numerous medical journal articles have been published since the release of the initial ACEs Study in 1998, and the CDC has continued to monitor the health impact on the original ACEs study participants.³⁸ Based on the results of the ACEs Study as well as the medical research that has followed, there is a well-established correlation between childhood traumatic events such as traumatic loss, separation, bereavement, domestic violence, impaired caregiver, emotional abuse, physical abuse, neglect, sexual abuse, community violence, sexual assault, and school violence, with negative adult health outcomes including obesity, diabetes, depression, suicide attempts, sexually transmitted infections, HIV, heart disease, cancer, stroke, and chronic obstructive pulmonary disease (COPD).³⁹ Additionally, there is a strong correlation between childhood traumatic events with mental health problems, smoking, alcoholism, drug use, self-injury, risky sexual encounters,⁴⁰ homelessness, prostitution, criminal behavior, unemployment, parenting problems, high utilization of health and social services, and shortened lifespan.⁴¹

Studies confirm that high percentages of adults experiencing these health and social issues have, in fact, been affected by repeated and chronic trauma throughout their lifetime, including during childhood.⁴² Based on this research, and the fact that the adult clients in *212 the HIV Legal Clinic universally experience some combination of HIV, mental health and physical impairments, addiction, poverty, housing instability, and unemployment, it follows that most, if not all, of the clients have experienced trauma in their lifetime, likely during critical stages of child development. When I previously represented low-income clients in a domestic violence clinic and, before that, worked with families in an urban public child welfare system, the client experiences were similar.

Indeed, in a book that chronicles the lives of adult patients at an HIV medical clinic in Baltimore City, many patients share stories of trauma that they experienced as children.⁴³ For example, Kathy B., a fifty-four-year-old woman living with HIV who struggled with drug use as an adult, describes being sexually abused as a child and remembers sleeping in the bathtub in her basement because it was the only safe place in her home where she could avoid her abuser.⁴⁴ Alex B., a low-income man living with HIV, remembers that when he was in elementary school, loud pounding routinely woke him up between 5:30 and 6:30 in the morning from police raids in his home.⁴⁵ Finally, Carmichael shared that when he was six years old, his cousin used to make him crawl under the porch and try to penetrate him.⁴⁶

These experiences are not unique to clients living with HIV. Sarah Katz and Deeya Haldar note in their article about trauma-informed pedagogy that many of the clients in their family law clinics similarly experienced trauma when they were children.⁴⁷

B. Understanding How Childhood Trauma Impacts the Developing Brain

Traumatic experiences impact children differently than they do adults. This is because childhood trauma occurs during critical periods of childhood cognitive and emotional development.⁴⁸ It disrupts both *213 the “brain architecture”⁴⁹ as well as normal developmental processes. It also differs from adult trauma in that childhood trauma is predominantly interpersonal in nature and most often occurs based on the action or inaction of the attachment figure responsible for protecting the child.⁵⁰ Finally, childhood trauma tends to occur in clusters such that children who experience trauma likely experience more than one type of adversity.⁵¹ And the more different types of trauma experienced during childhood, the greater the likelihood of functional impairments and high-risk behaviors in adolescence, leading to negative health and social outcomes in adulthood.⁵²

Based on the combination of factors unique to childhood trauma, exposure to adverse childhood experiences leads not only to the resultant health and social consequences established by the ACEs studies, but also to cognitive, behavioral and emotional symptoms that are both more severe and qualitatively different than symptoms resulting from trauma experienced as an adult.⁵³

***214** Scientists now understand that early childhood trauma changes the wiring and structure of the brain.⁵⁴ Childhood trauma has relatively recently been shown to cause anatomical changes in the size and connections in the developing--and quite malleable--brains of young children.⁵⁵ There are three primary regions of the brain that play a role in a person's response to stress--the amygdala, the hippocampus, and the prefrontal cortex. The amygdala is responsible for detecting fear and preparing for emergency events. As with trauma experienced by adults, when the amygdala senses fear, it activates the body's stress response, which is known as the "fight or flight" response.⁵⁶ When a person is under stress, the amygdala tells the hypothalamus to begin the chain of events that ultimately leads to the production and release of stress hormones.⁵⁷ While temporary increases in these stress hormones are normal--and, in fact, necessary to trigger a protective reaction in dangerous situations--excessively high levels or long-term exposure to stress hormones as a child, can damage the developing brain.⁵⁸

Under normal circumstances, the hippocampus, which stores long-term memory, and the prefrontal cortex, which is responsible for ***215** developing executive functions such as decision-making, short-term memory, behavioral self-regulation, and impulse control, are able to stop an increased release of stress hormones. However, because toxic stress at an early age changes the architecture and connectivity both between and within the hippocampus and the prefrontal cortex, early childhood trauma prevents these parts of the brain from reducing the increase in stress hormones and causes a person's response to fear to go haywire--sometimes overreacting to minor events and, at other times, underreacting to danger.⁵⁹

The likelihood and extent of changes in the brain depends on the type of response to the trauma experienced. Given that individual children--like adults--respond to stress differently, the extent to which early childhood traumatic experiences disrupt brain development is dependent on numerous factors including the intensity and duration of the child's individual response,⁶⁰ and the presence or absence of supportive, adult relationships in the face of trauma.⁶¹ Children who experience trauma of the type measured in the ACEs Study and subsequent line of research such as traumatic loss, bereavement, exposure to domestic violence, emotional abuse, impaired caretaker, physical abuse, neglect, sexual abuse, and community violence, and who lack relationships with adults who can help support them through these experiences, are more likely to exhibit changes in the structure and functioning of their brains during critical periods of development.⁶²

Unlike adult trauma, when children experience trauma during this critical time in development, it stunts their learning about how to regulate emotion and interact with others in a healthy way,⁶³ and can result in lifelong difficulties in regulating emotion and behavior, and controlling mood and impulsivity.⁶⁴ This phenomenon can later present in adulthood as anxiety, depression, anger, aggression, social isolation,⁶⁵ feelings of low self-esteem, self-blame, helplessness, hopelessness (especially in women),⁶⁶ expectations of rejection and ***216** loss, and trouble concentrating.⁶⁷ People affected by childhood trauma commonly feel unsafe, guarded, stressed, and mistrustful.⁶⁸ They may have trouble interacting with family members, neighbors, co-workers and supervisors.⁶⁹

Because the structure of the brain may be affected, in addition to self-regulatory problems, childhood trauma can impair lifelong decision-making, working and long-term memory; ability to distinguish danger from safety; social-emotional, language and cognitive skills; reasoning capacity;⁷⁰ and result in problems demonstrating autonomy and initiative.⁷¹

How might feelings of stress, anxiety, depression, anger, or low self-esteem present in the context of the client's relationship with the lawyer? How might the client's difficulties with trust affect the lawyer's ability to provide high quality representation to the client? How might impairments in decision-making, memory, language, and cognitive skills impede the client-lawyer relationship? Are these behaviors necessarily the result of trauma? Does the underlying cause of the behavior matter in terms of the lawyer's approach to representation?

III. THE INFLUENCE OF TRAUMA ON THE LAWYER-CLIENT RELATIONSHIP

David Binder and Susan Price first introduced the theory of client-centered representation in the clinical literature in the first edition of their interviewing and counseling text⁷² and it continues to be the central value in many law school clinics, particularly those representing individual clients.⁷³ It is an approach to problem solving. The *217 model, which derived from the teachings of humanistic psychology aiming to put the therapeutic client in the position to solve their own unhappiness,⁷⁴ places the client in the central role in the lawyer-client relationship.⁷⁵ Client-centered lawyering promotes decision-making by the client who is in the best position to weigh the non-legal consequences of various potential courses of action.⁷⁶ In ensuring that decisions truly reflect the client's desires, values, and priorities--and not the lawyer's⁷⁷ -- client-centered lawyering requires the lawyer to understand the client's "frame of reference" to provide them with the capacity to make choices that affect their life.⁷⁸

Client-centered lawyering requires that the lawyer interact and communicate with the client in a manner that the client truly understands so that the client has the capacity to make an informed decision about the available choices.⁷⁹ To do this, the lawyer is cognizant that factors such as personal relationships,⁸⁰ world view,⁸¹ race, class, gender, sexual orientation, disability, religion, ethnicity, socio-economic status, and culture⁸² influence the many dimensions of the lawyer-client *218 relationship including forming a trusting lawyer-client relationship that facilitates both the client's willingness and comfort in sharing candid, and sometimes deeply personal or "unfavorable" information; evaluating client credibility; developing client-centered case strategies and solutions; and exchanging information between the lawyer and the client involving communication and comprehension, memory, concentration, and cognitive abilities.⁸³ So, too, does trauma influence these processes. Consider the below examples.

A couple of weeks into the student attorneys' relationship with Ms. A. (the composite client whose narrative opens this article), the student attorneys scheduled a client meeting to review documentation relevant to the case. The student attorneys asked Ms. A. to bring all of her written correspondence with the Social Security Administration as well as bills and documentation of her expenses to help prove she was financially unable to repay the alleged overpayment. Despite having confirmed the meeting time and location with Ms. A. by phone, Ms. A. did not show up for the meeting. Nor did she return any of the student attorneys' phone calls about the missed meeting. Having spent time preparing for the meeting and knowing that gathering this evidence was necessary to helping Ms. A., the student attorneys felt frustrated by Ms. A.'s seeming disappearance.

A week or so after the missed meeting, Ms. A.'s long-time social worker told the student attorneys that Ms. A. did, in fact, set out to go to the meeting. However, when Ms. A. got off the bus by the law school, Ms. A. realized that she had left all of the paperwork the student attorneys asked her to bring on the bus. Ms. A. shared with her social worker that she felt that she had "messed up" and went home. She told her social worker that she was too embarrassed to face the student attorneys.

While the student attorneys will never know if Ms. A.'s decision to go home rather than tell them she lost her paperwork was influenced by any experiences of trauma in her life, the lawyer should be aware that it might be. Avoidance of difficult or uncomfortable situations is, indeed, a common trauma response.⁸⁴ Similarly, it is possible that trauma played a part in Ms. A. blaming herself for having *219 "messed up," and expecting that the student attorneys would reject her by expressing anger or deciding they no longer were able to help her. Especially in a situation like this where the client has not yet developed a relationship of trust with the lawyer and may not feel emotionally safe, it is possible that Ms. A.'s behavior was influenced by trauma.

In representing clients with a history of trauma, there is great potential for the lawyer and client to misinterpret each other's body language and conduct and, thus, misperceive one another's message or attitude.⁸⁵ If the student attorneys representing Ms. A. had not been trained about trauma, they may have attributed Ms. A.'s behavior to a lack of respect for their time or a scheduling conflict or transportation problems or forgetfulness. While it is possible that any of these factors may have contributed to Ms.

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A.'s conduct, by recognizing the influence of trauma, the lawyer expands their understanding of the range of uncertainties that influence client behavior and perspective.

In her article delineating five habits to build cross-cultural competency skills in lawyers, Susan Bryant describes a scenario in which a client in a custody matter does not follow through on setting up counseling for her eight-year-old daughter, despite having told the student attorney that she would do so. The student attorney in the case study attributes the client's inaction to either the client's indifference about the case or distrust of the student attorney's advice. Through Professor Bryant's habit of "parallel universes," the student explores multiple parallel universes to explain the client's behavior including: the client has never gone to a therapist and is frightened; in the client's experience, only people who are crazy see therapists; the client has no insurance and is unable to pay for therapy; the client cannot accept that the court will ever grant custody to the husband, given that he was not the primary caretaker; the client did not think that she needed to get her child into therapy immediately; the client was procrastinating, or that race and class differences between the lawyer and client may account for the client's failure to follow her lawyer's advice.⁸⁶

Bryant describes that the point of the parallel universe habit is to "become accustomed to challenging oneself to identify the many alternatives to the interpretations to which we may be tempted to leap, on insufficient information" and that by "engaging in parallel universe thinking, lawyers are less likely to assume--usually on the basis of limited information--that they understand the reasons for clients' behaviors." *220⁸⁷ Given the prevalence of trauma, might another explanation for the client's behavior be that, as a response to trauma, the client cannot foresee a positive outcome regardless of whether she pursues counseling? Or, that as a result of past trauma, she does not trust the lawyer's advice? Or, that she does not trust the therapist? Or, that as a result of trauma, she lacks the initiative to set up the counseling? Or, perhaps, the client may have been in therapy in the past herself, and the thought of engaging her child in therapy triggered thoughts about the traumatic events that caused the client to seek therapy, causing the client to avoid the issue in order to protect herself emotionally? Given the possibility that the client's inaction was influenced by trauma, the lawyer trained about the prevalence of trauma and trauma-informed lawyering, may have been able to anticipate the client's possible trauma-related concerns, and been able to either address the concerns or discuss alternative options.

As another example, student attorneys represented a low-income client living with HIV, posttraumatic stress disorder, addiction, and a history of experiencing and witnessing violence, in a Social Security disability hearing. Based on the student attorneys' extensive fact investigation, they knew that the client had significant difficulties controlling his emotions and anger, and an extreme inability to get along with others. One day, the client called the clinic office and a student attorney not representing the client answered the shared phone line. When that student attorney, who did not know the client's history or constellation of symptoms, told the client that her colleague was not in the office and offered to take a message, the client became extremely angry, raised his voice, and in the student's words "chewed her out" for answering her colleague's phone. Angered by the encounter, the student attorney instinctively attributed the client's behavior to rudeness and disrespect, and spoke sternly to the client. Could the client's outburst instead reflect difficulties regulating mood and emotion, and controlling anger as a result of a history of trauma? Without knowing the details of the client's trauma history, how might an awareness of the prevalence of trauma have changed the student's feelings about the phone call? How might it have changed the student's interaction with the client on the phone? How might the student attorney's curt interaction with the client have affected the client's ongoing relationship with the assigned student attorney and the clinic?

As yet another example of how trauma's effects might be seen in the context of the lawyer-client relationship, student attorneys represented a client who, as a result of the termination of her employment *221 and loss of income, accumulated hundreds of thousands of dollars in hospital and other debt. When the student attorneys learned of the client's financial situation, they asked her to bring in her bills and offered to sort through them together. The client brought in many months' worth of unopened overdue bills and collection notices that, had the client dealt with them earlier, could likely have been resolved through informal negotiation with creditors. The client, explaining why she did not open her mail and instead tossed it into a garbage bag, simply told the student attorneys that "nothing good ever comes in the mail." Similar to Ms. A.'s avoidance reaction when she lost important paperwork on the bus, is it possible that this client's decision to ignore her mail for many months could be explained, at least in part, by deeply rooted feelings of hopelessness or problems in initiative resulting from trauma?

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A scenario that reflects the significance of the lawyer and client being able to exchange accurate and understandable information is when a student attorney conducted an initial interview with a client who wanted to take legal steps to ensure that if she died, her daughter would not be cared for by the father, with whom the family was presently living. The client's speech was impaired as a result of a stroke she suffered in her late teens. The client could not, or would not, explain why she was concerned about dying, nor why she was concerned about the father raising her daughter. In order to best advise the client, the student attorney needed to understand more about the bases for the client's concerns.⁸⁸

As this situation highlights, a critical component of the lawyer-client relationship involves the client providing factual information to the lawyer regarding the nature of the client's problem. The lawyer routinely asks questions seeking additional factual information and clarifying facts that the lawyer may not understand or that may appear inconsistent. The lawyer will likely ask questions to try to get a complete picture of the factual situation, as well as ascertain the client's goals and glean insights into the factors that may be influencing the client's values and priorities.

In addition to the trust required to reveal intimate, and potentially embarrassing, information, from a purely cognitive standpoint, the client's ability to communicate the information in a way that the lawyer may best understand depends on multiple skills that may be ***222** impaired as a result of having experienced trauma. Indeed, if the client tries to explain her reasons for engaging in particular behavior in a way that does not make sense to the lawyer, or the client tells the story in a way that the lawyer perceives to be disorganized or illogical, the lawyer may assess that the client lacks credibility or that the client is not a reliable communicator of information. There are many factors that can interfere with the lawyers' and clients' abilities to understand one another's goals, behaviors, and communications. Susan Bryant recognized that cultural differences are one such factor,⁸⁹ and Robert Dinerstein has more generally cautioned that lawyers should not expect clients to be clear about their goals or to know, or express, how the lawyer can help them.⁹⁰

In the example of the client concerned about her daughter's father, the student attorney easily could have attributed the client's impaired communication to her having suffered a stroke. The student attorney could have spoken more slowly or suggested that they reschedule the meeting for a time when perhaps the client's mother could participate to help the client communicate with the lawyer. Instead, the student attorney chose to engage with the client in a trauma-informed manner with a deliberate awareness of the prevalence of trauma and the possibility that the client's impaired language and cognitive skills may, at least in part, be the result of trauma.

Given the likelihood of trauma, the student attorney was aware of the importance of fostering feelings of safety and trust. The student attorney made the client feel safe by reassuring her about client confidentiality, and expressly explaining that she wanted to ensure that the client and her son felt safe. The student attorney exhibited patience by asking open-ended questions and reassuring the client that the student attorney was not in a rush. The student attorney listened patiently to everything the client said, further signaling to the client that she had time. The student attorney was candid and transparent with the client about what she hoped to accomplish during the meeting and why it was important that she understand the bases of the client's concerns so that she could best help. The student attorney asked the client if she felt safe at home, and if she felt that her daughter was safe.

The client ultimately shared that her daughter's father had been sexually, physically, and verbally abusive towards her for years, and that despite her requests that he leave the home, the father refused. The client shared that although her mother lived in the same home with the client and the father, the sister was unaware of the abuse. Once the client began confiding in the student attorney, the client was ***223** adamant that, because the mother was dealing with the stress of her own health issues, the client did not want her mother to know about the abuse.

While there were certainly no easy solutions to the client's problems, with a more complete understanding of the client's complex situation, the student attorney was better able to unpack the issues and discuss legal and non-legal options, as well as connect the client to supportive and therapeutic services. With the client's permission, the student attorney shared the client's situation with the client's therapist and social worker (neither of whom knew about the abuse), and organized multiple meetings involving the social worker, therapist, client, and student attorney to develop a safety plan for the client and her daughter. Had the student attorney assumed that the primary cause of the client's impaired communication was the stroke and chosen to reschedule the initial meeting to invite the mother, the client may not have returned to the legal clinic for help.

Another example highlighting how the client's trauma-related cognitive impairments may impede communication between the lawyer and the client can be seen in the short-term limited representation cases that the HIV Legal Clinic handles. Student attorneys offer weekly brief legal advice to patients at an HIV medical clinic in Baltimore City. Many of the client's stories of childhood trauma are shared in the book, *Life Don't Have to End*.⁹¹ Clients typically meet with a student attorney one time for approximately thirty minutes to one hour. Based on the time constraints and the limited nature of the representation, it is important that the student attorney quickly and accurately gain an understanding of the facts relevant to the client's problem. It is equally important that, based on that understanding, the student attorney provide information and advice to the client in a way that the client understands.

Particularly in this fast-paced setting, the student attorneys find it difficult to elicit a logical and understandable story from the client. Similar to what Susan Bryant describes in connection with cross-cultural lawyering, clients frequently get lost in their stories or wander all over the place.⁹² In addition to other factors that impede clear and organized storytelling, might trauma-related impairments in cognitive abilities and communication skills influence the client's ability to stay focused on the facts relevant to the problem? Might a client's trauma-related memory difficulties cause the client to confuse or forget details *224 that are relevant to the logical coherence of the story? Might the client disassociating from a problem as a response to trauma have difficulty providing information to the lawyer at all?

In addition to the challenge of relaying accurate and clear information from the client to the lawyer, there exists the related problem of communicating understandable information from the lawyer to the client. In many cases, but almost universally in the brief advice cases, clients routinely nod their heads and say little in response to the student attorneys' attempts to explain substantive or legal process issues such as Social Security disability or SSI benefits eligibility or appeal rights, overpayments, or return to work rules for disability or SSI recipients. Clients routinely thank the student attorneys profusely for their help and do not ask any questions. Like the example cited by Susan Bryant in *The Five Habits: Building Cross-Cultural Competence*, in response to questions by the student attorney such as "Do you have any questions?" or "Does this make sense?" clients typically say they understand and do not ask questions.⁹³

Does this mean that the client truly understands? Might the client's statement of understanding mean something other than true comprehension? While there could be a variety of reasons for this behavior, impaired cognitive, language or reasoning skills as a result of trauma, or anxiety about initiating conversation with the lawyer as a result of trauma, could play a role in this behavior. To the extent the client experiences anxiety about interacting with the lawyer based on distrust or concern that the lawyer will not understand or be able to help, the client's response to this anxiety could be to avoid the encounter altogether.⁹⁴

*225 Whether or not a client has experienced trauma, developing a trusting lawyer-client relationship is critical to facilitating the client's willingness and ability to share information with the lawyer, as well as to ask questions or "challenge" the lawyer's advice. Within the client-centered framework, critical aspects of the lawyer-client relationship involve the lawyer's ability to form a trusting relationship with the client to allow genuine and accurate communication in order to develop case strategies, theories, and solutions that accurately reflect the client's situation, and understand the client's values, attitudes, and priorities by assigning the correct meaning to the client's words, expressions, and behaviors.⁹⁵ While there are many factors that influence the degree to which the lawyer and client develop a trusting relationship, including respective personalities, the client's past experience with a lawyer or the legal system, and cultural differences,⁹⁶ for the client who has experienced trauma, the client is even more likely to come to the lawyer-client relationship with deeply rooted feelings of distrust. For the client who has experienced trauma--particularly interpersonal trauma that impacts normal attachment, like that typically associated with childhood trauma--it may be even more difficult to form a trusting relationship with the lawyer.

As these examples highlight, just as cross-cultural lawyering scholars have expanded lawyers' awareness of the many influences on the lawyer-client relationship to include cultural differences and similarities,⁹⁷ emerging trauma-informed lawyering literature contributes that trauma, through its effects on client decision-making, trust, communication, problem-solving and reasoning capacity, memory, and concentration,⁹⁸ similarly influences the dynamics of the lawyer-client relationship.⁹⁹

IV. TRAUMA-INFORMED LAWYERING

Given the prevalence of trauma and the effects it can have on client behavior and the lawyer-client relationship, good lawyering requires *226 that the lawyer develop trauma-informed competencies. A long line of clinical scholarship expands the methods of client-centeredness initially developed by Binder and Price.¹⁰⁰ Trauma-informed lawyering further contributes to this approach and good lawyering generally, particularly for the many clients who have experienced trauma.¹⁰¹

In addition to seeking to improve legal outcomes for the client who has experienced trauma, trauma-informed lawyering also improves the experience for the client generally and, for the client with a history of trauma, does so significantly. Fitting squarely within the scholarship of therapeutic jurisprudence, which recognizes that the lawyer is a “therapeutic agent” whose actions impact the mental health and psychological well-being of the client,¹⁰² trauma-informed lawyering promotes the overall well-being of clients by not only making legal services accessible for the client who may otherwise be unable to access justice due to trauma-related barriers,¹⁰³ but also promoting healing and resiliency through a relationship built on trust, safety, and respect.¹⁰⁴

Given that clients come to lawyers to address problems that have legal as well as non-legal components, and that they come to lawyers oftentimes frustrated by their experiences, as well as interactions with *227 systems and bureaucracies, a positive interaction with the lawyer can provide support, alleviate stress and anxiety, and result in increased client satisfaction. As expressed by Mr. W., a former clinic client:

I have been very untrusting, and somewhat critical of dealing with the bureaucracy of Social Security. I experienced a 100% willingness by your [l]egal students, to assist me with ... [my Social Security disability] matters. ... I was left feeling confident with the research result. I can now deal with my issue with a more positive outlook. ... What a display of humanism presented. ... Thank you so much for this beneficial program, which has alleviated many sleepless night and emotional stress.¹⁰⁵

The lawyer can develop trauma-informed competencies by adopting approaches to practice common in the field of behavioral health.

A. Defining Trauma-Informed Practice

The concept “trauma-informed care” or “trauma-informed practice” has become increasingly prevalent in recent years, particularly in the legal services community serving victims of known abuse.¹⁰⁶ This *228 mode of service delivery has been accompanied by an ever-growing interest in training opportunities offered to service providers--most commonly in the behavioral health contexts of nursing, social work, psychiatry, and psychology.¹⁰⁷ While there is no uniform model that defines the trauma-informed care approach,¹⁰⁸ it is best understood as *229 an approach to engaging people with histories of trauma that reflects a philosophy, culture and understanding about trauma symptoms,¹⁰⁹ and that recognizes the role that trauma has played in their lives.¹¹⁰

Trauma-informed care is a “strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.”¹¹¹ Importantly, trauma-informed care, which aims to improve all aspects of service delivery to people who have experienced trauma, is different from trauma-specific interventions or treatment, which directly addresses the impact of trauma in order to decrease symptoms and treat the effects of trauma.¹¹²

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Four themes that cut across most definitions of trauma-informed care are: (1) trauma awareness, (2) emphasis on safety, (3) opportunities to rebuild control, and (4) strengths-based approach.¹¹³ In terms of trauma awareness, trauma-informed service providers incorporate an “understanding of trauma” into their work.¹¹⁴ Being trauma-informed fundamentally involves recognizing that “behavioral symptoms, mental health diagnoses, and involvement in the criminal justice system are all manifestations of injury rather than indicators of sickness or badness--the two current explanations for such behavior.”¹¹⁵ Consistent with this recognition, the National Center for Trauma Informed Care (NCTIC) suggests that the service delivery approach should be changed from one that asks, “What’s wrong with you?” to one that asks, “What has happened to you?”¹¹⁶ Critical pieces of raising awareness of how behaviors may reflect responses to traumatic experiences include staff training, consultation, and supervision.¹¹⁷ *230 Being trauma-informed means that all staff of an organization must understand the effects of trauma on the people being served so that all interactions with the organization are consistent.¹¹⁸

Since many people who have experienced trauma may feel--and some may in fact be--unsafe, a trauma-informed approach to service ensures physical and emotional safety. A safe environment includes maintaining privacy and confidentiality, and fostering mutual respect,¹¹⁹ including respect for cultural differences.¹²⁰ Emphasizing safety also includes avoiding potential triggers that could re-traumatize those receiving services.¹²¹ Because interpersonal trauma in particular often involves boundary violations and abuse of power, to ensure emotional safety, trauma-informed practice must set clear roles and boundaries that are established through collaborative decision-making.¹²²

Next, trauma-informed practice emphasizes the importance of choice in an effort to restore the control that is frequently taken away as a result of traumatic events.¹²³ Finally, trauma-informed practice focuses on people's strengths and develops coping skills in a future-oriented setting.¹²⁴

B. Trauma-Informed Lawyering in Practice: Philosophical Framework and Concrete Strategies

Both because the lawyer is not trained to diagnose trauma or attribute specific client behavior to trauma, and because leaving trauma-informed lawyering to those cases where the lawyer attempts to identify relevant trauma will likely overlook clients who could benefit from the approach, lawyers representing clients experiencing urban poverty can improve the quality of representation by uniformly adopting a trauma-informed approach. While this approach may result in *231 the lawyer providing trauma-informed services for clients who may not be affected by trauma, trauma-informed lawyering will enrich the lawyer-client relationship generally, and enrich it significantly for the client with a history of trauma.¹²⁵

Applying the behavioral health tenets of trauma-informed care to the context of legal services, much of good lawyering already incorporates trauma-informed practices. Indeed, strategies such as developing rapport, building trust, and promoting the clear and accurate exchange of information through active listening, are trauma-informed practices. However, for the client who comes to the lawyer-client relationship with deep feelings of distrust, disempowerment, anxiety, and hopelessness; impaired cognitive and language skills; or an inability to regulate mood as a result of trauma, the lawyer's usual tools to build trust and rapport may be insufficient.

Establishing trust with a client who inherently distrusts due to trauma requires the lawyer to fundamentally understand what trauma is and the client's possible responses to that trauma. The first step in trauma-informed lawyering is for the lawyer to adopt a mindset in which the lawyer considers the many possible explanations for the client's behavior, and avoids making assumptions or judgments. The lawyer should consistently try to consider behavior from the perspective of the client and ask themselves, “What might be happening?”¹²⁶ With this foundational mindset in play, the lawyer can then utilize concrete tools to facilitate information gathering and communication, and promote trust and safety that may resonate with the client affected by trauma.

***232 1. Philosophical Framework**

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Inasmuch as trauma-informed care is a way of thinking--a philosophical framework--more than a formulaic approach, its implementation in the legal setting most fundamentally requires the lawyer to come to the lawyer-client relationship with the mindset of "What happened or is happening to the client?" as opposed to "What is wrong with the client?"¹²⁷ Adopting this way of thinking will help the lawyer interact with the client with respect and equality and in a way that helps empower the client who may feel broken or weakened as a result of trauma.¹²⁸ A client testimonial shared during a trauma training held in 2017 at the University of Baltimore highlights the significance of this mindset:

During every incarceration, every institutionalization, every court-ordered drug treatment program, it was always the same: I was always treated like a hopeless case. All people could see was the way I looked or the way I smelled. It wasn't until I finally entered a recovery-oriented, trauma-informed treatment program, where I felt safe and respected, that I could begin to heal. ... Someone finally asked me, "What happened to you?" instead of "What's wrong with you?"¹²⁹

To adopt this way of thinking, the lawyer must understand the widespread prevalence and impact of trauma, as well as recognize signs and symptoms of trauma-related behavior.¹³⁰ With training on the prevalence and effects of trauma, the lawyer will be able to consider a broader range of explanations for a client's behavior and develop more empathy and understanding of the client's goals and values. The lawyer's awareness of trauma expands the lawyer's thinking about the range of possible explanations for client behavior.¹³¹ *233 Particularly at times when the lawyer is judging the client's behavior negatively such as when the lawyer feels frustrated that the client did not show up for a scheduled meeting, or when the lawyer feels disrespected that the client yelled at them on the phone,¹³² when the client tells their story in an illogical or disjointed way, or when the lawyer feels annoyed that the client did not follow through on the lawyer's advice, the lawyer who is overtly aware of an expanded range of possible explanations for the client's behavior, including trauma, may feel less judgmental and engage with the client more patiently and respectfully.

Lawyers can begin to understand the influence of trauma on the lawyer-client relationship by seeking out training opportunities and by engaging with behavioral health professionals with expertise in trauma and staying current on this developing dialogue within the legal community. While training opportunities for lawyers are most often geared toward lawyers representing clients in cases in which the trauma is relevant to the legal matter,¹³³ the lessons are equally applicable for cases not involving abuse. In the HIV Legal Clinic, Kathleen Connors, a social worker,¹³⁴ teaches a class about poverty and trauma, and facilitates case rounds in which she guides law students to recognize the many sources of possible trauma in their clients' lives. Connors facilitated a similar session for the first time in fall 2016, during the University of Maryland Carey School of Law's clinic-wide orientation, including students working with low-income clients in the areas of criminal, landlord-tenant, gender violence, tax, mediation, and disability rights law.

While expanding the range of possible explanations for the client's behavior, the lawyer must take care to avoid making assumptions about the client's experience of trauma or its effects. While the lawyer can improve the experience for the client by recognizing the possibility of trauma, the lawyer must take care to avoid creating or *234 perpetuating stereotypes. As cross-cultural scholarship teaches, no single characteristic singularly defines a person's experience. As with other areas of difference, the lawyer must remain "cognizant and critical" about the assumptions that they bring to the lawyer-client relationship,¹³⁵ and simultaneously recognize that no single characteristic or behavior defines an individual's experience.¹³⁶ To the extent that the lawyer can be aware of the prevalence of trauma and its possible effects, yet not assume its existence in every case, the lawyer will be in a better position to exercise the necessary professional judgment about possible strategies and approaches to take in a specific interaction.¹³⁷

2. Practical Strategies

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In addition to adopting a philosophical framework through which the lawyer considers the range of possibilities that may be influencing client behavior-- including experiences that the lawyer may not understand--the lawyer can also use concrete tools to promote trust and emotional or physical safety, as well as to empower client decisionmaking. Inasmuch as establishing and maintaining a lawyer-client relationship of trust and safety is critical to promoting open and accurate communication, client engagement, and client satisfaction, the lawyer can improve the quality of representation by incorporating some or all of the following strategies into their practice.

Transparency. Because the client affected by trauma may feel confused or overwhelmed by the legal process, it is important that the lawyer be fully transparent with the client about the legal case in order to facilitate trust and minimize feelings of powerlessness.¹³⁸ This strategy can be effective in various situations in the lawyer-client relationship. *235 For example, in the case of Ms. A., where the student attorneys felt uncomfortable asking Ms. A. personal questions about her relationship with her children's father, the student attorneys could explain why they are asking the questions. Transparency about the lawyer's role, especially in situations in which the lawyer needs to ask questions that might seem irrelevant or call for stigmatized information, is a helpful tool in promoting a good lawyer-client relationship.

As another example, student attorneys in the HIV Legal Clinic must ask clients for documentation verifying they are living with HIV to comply with the requirements of a Ryan White HIV/AIDS Program Grant. While this can be an uncomfortable conversation with all clients, for the client whose legal matter is wholly unrelated to their HIV status, the question could impede the lawyer-client relationship from its inception. To promote trust, the student attorney is transparent about why they need to ask the question, that is, that the clinic receives grant funding to provide free legal services for people living with HIV and the funder requires documentation verifying that the client is eligible for services under the grant. When explained in this context, the client does not appear taken aback by the request.

As another example, in situations in which the client floods the lawyer with an overload of information, or wanders from topic to topic in a seemingly unfocused way, the lawyer's candor and transparency about what they want to accomplish and the purpose of the interview may help focus the meeting.¹³⁹ As with the clinic's onsite brief advice cases where the student attorneys meet with clients back-to-back every hour, the students often struggle to balance efficiency with patiently allowing the client to tell their story at the client's own pace. Particularly in a time-limited interaction such as this, the lawyer's candor and transparency about what they want to accomplish may help focus the discussion. Through transparency, the lawyer may also better engage the client in developing solutions to some of the challenges they may have interacting with the lawyer, the opposing party, or the judge.¹⁴⁰

Yet another example is the lawyer's note taking during a client meeting. While taking notes may signal to the client that the lawyer wants to remember everything the client says, some clients may find note taking to be objectifying.¹⁴¹ Because the lawyer often needs to take notes to remember important information for the case, being *236 transparent about this need can dispel the client's suspicions. For example, the lawyer should ask the client if it is okay that they take notes and explain that they typically takes notes in order to ensure that they accurately capture what the client says. With this kind of explanation, the client gains control of the lawyer's note taking. With a client who seems uncomfortable with the lawyer's note taking, the lawyer may also read back a summary of the notes so the client knows they are accurate. Transparency around note taking communicates to the client that the lawyer thinks accuracy is important.¹⁴²

Predictability. The lawyer might help the client feel emotionally and physically safe by previewing what lies ahead in terms of the lawyer-client relationship and the broader legal process. Recognizing that the legal process may be unfamiliar and scary for the client, especially for the client predisposed to anxiety as a result of trauma, consistently keeping the client informed of future steps and explaining things in advance may increase their sense of safety and security.¹⁴³ To promote trust and safety through predictability, the lawyer should consider scheduling more frequent meetings with the client.¹⁴⁴ The lawyer could also schedule meetings on regular days and times.¹⁴⁵ Even if regular in-person meetings are not feasible for whatever reason, including lack of time, transportation, or childcare, the lawyer could ask the client if they want to schedule weekly phone check-ins at the same day and time each week.

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Clearly defining roles and responsibilities also maximizes predictability, especially with clients whose traumatic experiences may have resulted from unhealthy relationships and who, as a result, may be unclear about boundaries and roles. The lawyer should discuss with the client early in the relationship the lawyer's role, the nature of the services that the lawyer does and does not provide, and what the lawyer can and cannot accomplish for the client. Similarly, the lawyer should explain the client's role, emphasizing the client's decision-making power and agency. The lawyer should explain confidentiality, and provide the client with reliable information about the lawyer's schedule, availability, and contact information.¹⁴⁶ The lawyer may also explore *237 the client's assumptions about the lawyer-client relationship, and ask about the client's prior experiences with a lawyer or the legal system, as well as what went well and what did not go well.¹⁴⁷

Patience. Because building trust takes time, the lawyer needs to invest extra time in developing the lawyer-client relationship, and exercise patience and consistency in their dealings with the client.¹⁴⁸ As such, the client must feel that the lawyer is patient, present, and available.¹⁴⁹ Melissa Tyner, who directs the University of California at Los Angeles (UCLA) School of Law's veterans clinic, reports that the trauma-informed approach employed in her clinic involves the law students "tak[ing] pains to establish rapport" with clients who have likely suffered PTSD or brain injuries.¹⁵⁰

When time permits, exercising patience might mean allowing more time for a client meeting, scheduling more frequent in-person meetings with the client than would otherwise be necessary, or offering breaks during a meeting.¹⁵¹ However, for the busy lawyer, investing extra time in the lawyer-client relationship may be challenging. Given the realities of practice, the lawyer often meets with the client in time-limited situations such as the one-hour brief advice sessions in the HIV Legal Clinic, or in a courthouse hallway during a short break in proceedings. Recognizing that the message to be communicated through the lawyer's exercise of patience is that the lawyer has time for the client, and that the client and the client's case is important, the lawyer can convey this intent even in the face of time constraints.

For example, the busy lawyer might try to schedule short, but more frequent, check-ins with the client to convey her presence in the relationship.¹⁵² Clients frequently seek the HIV Legal Clinic's representation in SSI or Social Security disability appeals having unsuccessfully applied for benefits for years. For those clients who were previously represented by counsel, clients often complain not about the outcome of their previous cases but, rather, about the fact that they had so little contact with their lawyer during the approximate nineteen-month wait time for a Social Security hearing in Baltimore City.¹⁵³ Based on this lack of communication, clients have reported *238 feeling that the lawyer did not provide good representation, that the lawyer did not know enough about the client's situation, and that they did not trust the lawyer.

Even when the lawyer lacks time, using the strategy of transparency, the lawyer can make sure that the client knows they are important by overtly addressing the time limitation. For example, the lawyer with only forty-five minutes to meet with a client for a brief advice session could acknowledge that the meeting might feel rushed based on the time allotted for the meeting, and assure the client that that this does not mean that the lawyer does not care about the client or the issue. Similarly, in situations where the lawyer only has five minutes to talk on the phone to the client, the lawyer can expressly acknowledge the limitation and schedule a follow up call on another specific date. By being transparent, the lawyer communicates that the client is important, and that the lawyer is committed to the client and to the case even when time limitations might signal otherwise.¹⁵⁴ To prove that the lawyer is reliable, the lawyer must then follow through on their promise to talk at a later date.

Client Storytelling. When circumstances permit, the lawyer who allots extra time for meeting with the client allows the lawyer to create space for another trauma-informed strategy--storytelling. For the client who has difficulty remembering information as a result of trauma, permitting the client to share their story without interruption can facilitate the client's memory. To create a space for storytelling, the lawyer should first explain to the client the information the lawyer wants to know, and then give the client space to tell their story without interruption. The lawyer must become comfortable with pauses and periods of silence that signal to the client that the lawyer has time, and allows the client to feel in control of how to tell their story. Rather than interrupting the client's storytelling, the lawyer could jot down any questions and save them for the end of the interview.

Another technique that may encourage the client to trust the lawyer and share information is for the lawyer to encourage the client to share more--or even different--information with the lawyer at a later date. The lawyer can communicate that they understand

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that it is sometimes difficult to share information with someone the client just met, and that the client can share information if the client remembers anything after the meeting--even if it might be different than what the client shared that day.¹⁵⁵

Physical Environment. Creating a sense of emotional and physical safety for the client might involve ensuring that the physical environment *239 is calm and soothing. As one example, the John Marshall Law School opened a veteran's clinic in 2013 in a space designed with deliberate attention to creating a "calm environment with muted paint colors and sound-insulated windows that let in plenty of natural light."¹⁵⁶ While this is certainly one good way to create a calm space, lawyers do not necessarily need to renovate their office space to enhance safety and create a calm environment for the client.

Offering the client options within the physical space is another good technique to promote the client's feelings of safety and control which, in turn, can reduce anxiety, foster trust, and facilitate good communication and informed decision-making. For example, the lawyer can be thoughtful about where to conduct and whom to include in client meetings to maximize the client's comfort. Even in an office without natural light or significant space, the lawyer should ensure that the room is well lit. To the extent possible, the lawyer should create options for the client to choose where to sit. The client may not want to sit with their back to the door, or may not want the lawyer to be seated between the client and the door.¹⁵⁷ To the extent possible, the lawyer should sit beside rather than across a table or desk from the client in an effort to minimize power differences.¹⁵⁸

While Ellmann, Dinerstein, Gunning, Kruse, and Shalleck do not reference trauma-informed lawyering by name in their book and article on legal interviewing and counseling, they do discuss approaches to lawyering that fit within the trauma-informed framework.¹⁵⁹ For example, they discuss the importance of "context" in shaping the lawyer-client interaction, and use the example of the lawyer's choice about where to conduct a client meeting. They question whether meeting at the client's home is considered a routine option or whether it would be viewed by the lawyer as "an atypical response to an extraordinary situation," and note that such norms are important in shaping the lawyer's views about the range of available choices in developing the lawyer-client relationship.¹⁶⁰ They similarly consider the lawyer's decision about whether to include or exclude a family member in the client interview, acknowledging that the presence of a support person may well impact the client's comfort, trust, willingness or ability to express their desires, and even the relationship they have with that person.¹⁶¹

*240 *Body Language and Verbal Communication.* The lawyer must also be aware how their words, body language, and conduct might inadvertently heighten the client's already existing feelings of low self-esteem, self-blame, rejection, or hopelessness. The lawyer should strive to use relaxed body language and verbal communication when interacting with the client.

In the example in which the student attorney felt that the client "chewed her out" for answering her colleague's phone line, what strategies might the student attorney have tried to utilize in an effort to deescalate the client's anger? After first considering the many explanations for the client's loss of emotional control to prevent the student from concluding that the client was rude, the student attorney might then have used verbal communication strategies. Concrete strategies to restore calm include speaking slowly, using short sentences, and speaking calmly without raising one's voice. By modeling calm behavior, and taking care to dissipate conflict between the lawyer and the client, these verbal communication strategies can serve to communicate safety and give control to the client.¹⁶² Likewise, the lawyer might defuse the client's anger or hostility by validating the client's frustration, and being conscious to not become defensive, which could escalate angry behavior.¹⁶³

In the instance where Ms. A. left all of her paperwork on the bus and decided to go home, when the student attorneys finally connected with the client more than a week after she missed the meeting, they were careful not to say to Ms. A., "Why did you miss the meeting?"--a question that could lead Ms. A. to feel that the lawyer thought she did something wrong--and, instead, asked, "What happened?"--an open-ended question that conveys that the client's behavior was caused by some external experience. Phrasing the question as "What happened?" will help foster trust and comfort, particularly so for the *241 client who has experienced trauma.¹⁶⁴

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The lawyer may also employ strategies to try to dissipate certain behaviors the lawyer knows may be manifestations of trauma, such as appearing withdrawn, angry, or suspicious. The lawyer might make the withdrawn client feel more in control of the interview by overtly affirming how difficult it is to share information.¹⁶⁵

Since both of these interactions occurred on the phone, the student attorneys could not engage with the client through body language. However, in an in-person interaction in which the client seems to lose control of their emotions or becomes upset, the lawyer can often make the client feel safe--and counter the client's reaction of fear--through body language. For example, the lawyer might try sitting at a slight angle so that the lawyer is not facing the client head on or towering over the client. The lawyer should never touch the client without the client's consent. The lawyer should give the client sufficient space and not crowd the client. The lawyer should use gentle eye contact that communicates sincerity and genuineness. The lawyer should not cross their arms, or put their hands on their hips or in their pockets. The lawyer should avoid abrupt movements. And, finally, the lawyer can model calm behavior by breathing slowly and staying relaxed.¹⁶⁶

Client Control/Empowerment. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in trauma-informed care, “[i]mportance is placed on partnering and the leveling of power differences. ... Healing happens in relationships and in the meaningful sharing of power and decision-making.”¹⁶⁷ To counteract the client's feelings of powerlessness often resulting from traumatic events, the lawyer should promote client decision-making in a lawyer-client partnership that will help the client regain control over their life.¹⁶⁸ For clients who have experienced trauma, the lawyer's client-centered framework can be improved by employing strategies to overcome possible feelings of client powerlessness that may impede decision-making. For example, in a situation in which the lawyer has *242 trouble connecting with the client because the client either shuts down, or appears angry or agitated, the lawyer can try stopping the interview for a moment and overtly asking the client what might help. Even if the client does not have a suggestion to offer, by employing this strategy, the lawyer communicates that the client is in control and that the lawyer is willing and committed to allowing the client to take the lead to create a safe space.¹⁶⁹

In terms of substantive case strategy, the lawyer should also strive to work in partnership with the client when possible to promote the client's feelings of control. For example, in the Social Security overpayment case with Ms. A., the student attorneys explored arguing an innovative “trauma defense” in support of Ms. A.'s request for waiver of her overpayment theorizing that Ms. A.'s delay of just a few months in reporting her return to work to the Social Security Administration was due to her prioritizing the safety of herself and her family during the period of homelessness and domestic violence. When discussing the potential case theory with Ms. A., she adamantly opposed it. Ms. A. did not want her narrative to involve any mention of her personal family situation and, instead, was insistent that her story remain focused on the fact that she told Social Security about her return to work within a reasonable timeframe. Ms. A. did not want to admit any delay in reporting her return to work, nor make any excuse for it. Allowing Ms. A. to control the narrative she wanted to tell, the student attorneys developed a new case theory. Not only did they empower Ms. A., they also were successful in discharging the \$35,000 overpayment.¹⁷⁰

Reliability. In order to foster the trust that is critical to establishing a good lawyer-client relationship, particularly with the client who has difficulty trusting other people as a result of trauma, the trauma-informed lawyer must consistently follow through on tasks,¹⁷¹ including returning phone calls promptly, providing case updates regularly, and completing any other task undertaken in a timely manner. For example, to alleviate the anxiety that one of the clinic's transgender clients felt about the legal process in his name change and gender identity case, the attorney went to great lengths to provide weekly updates to the client about the legal process, even when there were no *243 significant developments to report. The client communicated how the case updates helped reduce his anxiety in an e-mail that read: “I'm so anxious but I do thank you from the bottom of my heart for staying on top of everything it makes me feel like the process is going at a consistent speed.”¹⁷²

Avoid Re-Traumatization. The trauma-informed lawyer should also anticipate issues or interactions that may be particularly difficult for the client and seek to avoid “triggering” or activating a memory of the trauma.¹⁷³ A central tenet of trauma-informed lawyering is to do no additional harm.¹⁷⁴ For example, before exploring their possible case theory with Ms. A. about her need to prioritize safety, and asking Ms. A. questions about what they suspected was an abusive relationship with her children's father, the student attorneys consulted with the clinical social worker who teaches the clinic class on trauma. The

students were concerned that Ms. A. might react negatively to their questions, and that they might damage their relationship with Ms. A. by asking them or that they might trigger a trauma response. Based on the consultation, the student attorneys realized that their concern was as much about their own discomfort broaching the topic as it was about potentially re-triggering trauma for the client. The social worker confirmed that assuming the questions were asked in a respectful, non-threatening way in the context of the trusting and safe lawyer-client relationship that had been established, it could in fact be beneficial for the client to talk about the abusive relationship if she wanted.¹⁷⁵ According to the social worker, if the client sensed the student attorneys' discomfort discussing personal aspects of the client's situation, the client might feel judged, which, in turn, might foreclose open communication and trust.¹⁷⁶

V. CONCLUSION

Given the prevalence of trauma, lawyers representing clients experiencing urban poverty should presumptively adopt a trauma-informed *244 practice approach regardless of the subject of the legal matter. Trauma-informed lawyering will enable the client to engage more deeply in the lawyer-client relationship, thereby enriching the client experience generally, and significantly so for the client with a history of trauma.

Just as lawyers can enrich the client experience by providing trauma-informed representation, so, too, can the judicial system and administrative agencies promote healing and access to justice for marginalized populations.¹⁷⁷ While there has been some system reform in recent years to incorporate trauma-informed practices in systems where consumers have experienced abuse, such as child welfare agencies and family courts,¹⁷⁸ the approach has not been adopted in other settings.

In addition to training lawyers, courts, and administrative agencies on the prevalence and influence of trauma, creating formal and informal inter-professional partnerships among lawyers and social workers, in particular, offers a rich opportunity to provide comprehensive care to individuals affected by trauma. While lawyers alone can improve the quality of their legal services by understanding and practicing trauma-informed lawyering, inter-professional collaborations create norms that allow lawyers to consult with social workers about how to discuss issues with clients, make referrals for therapeutic interventions, and gain additional insights about trauma.

Likewise, social workers can learn from lawyers to screen for legal issues, and refer clients to lawyers both for advice about preventing legal crises from arising and to address existing legal needs such as in the case of Ms. A. Such inter-professional partnerships allow lawyers and social workers to learn from each other about the manifestations of trauma in specific cases, and to provide resources to each other to ensure that the service delivery is consistent and trauma-informed. Moreover, collaboration between lawyers and social workers *245 facilitates inter-professional problem solving such as the comprehensive safety plan developed for the client living with her abusive partner and concerned about the safety of her daughter.¹⁷⁹

Finally, empirical research should be undertaken to measure the benefits of incorporating a trauma-informed approach to lawyering. While trauma-informed lawyering improves the experience for clients, particularly for those clients affected by trauma, empirical research documenting such client outcomes as increased client satisfaction, client retention, reduced overall stress and anxiety, increased lawyer empathy,¹⁸⁰ increased trust of the lawyer,¹⁸¹ and improved health outcomes¹⁸² would promote a more universal implementation of the practice and potentially generate sources of funding for providers.

Footnotes

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1 To preserve the client's anonymity and privacy, I do not use the client's name or real initial. In addition, the narrative, while inspired by the experiences of one client, combines the experiences of several different clients with some facts that are fictitious. While clinical scholarship commonly uses clients' stories to enrich the dialogue about theoretical concepts, some scholars have rightly questioned whether the client should have a role in deciding whether, and how, their narrative should be told. *See, e.g.*, Binny Miller, *Telling Stories about Cases and Clients: The Ethics of Narrative*, 14 GEO. J. LEGAL ETHICS 1 (2000); Nina Tarr, *Clients' and Students' Stories: Avoiding Exploitation and Complying with the Law to Produce Scholarship with Integrity*, 5 CLINICAL L. REV. 271, 273-75, 306-08 (1998) (questioning whether it is exploitative for clinicians to use client stories to advance their scholarship, and balancing respect for client dignity, autonomy, and privacy with maintaining ability to produce scholarship that has integrity). I chose not to seek the client's consent to tell any of the client-inspired stories in this article because I did not want to risk causing the client psychological harm by initiating a conversation about personal experiences they may not want to discuss, and which they never referred to as "traumatic" to me. I try to maintain the integrity of the experiences as much as possible while changing enough of the facts to not tell the "real" story of any client.

2 MD. ATTY'S RULES OF PROF'L CONDUCT r. 2.1 (MD. BAR ASS'N 2016).

3 Robert Dinerstein et al., *Legal Interviewing and Counseling: An Introduction*, 10 CLINICAL L. REV. 281, 290 (2003).

4 *Id.* at 294; Michelle S. Jacobs, *People from the Footnotes: The Missing Element in Client-Centered Counseling*, 27 GOLDEN GATE U.L. REV. 345, 354 n.29 (1997). As much as the client's views are influenced by many factors, so, too, are the lawyer's views. Much has been written about the need for lawyers to be aware and critical of their own values that they bring to the lawyer-client relationship, as well as about the assumptions they hold about their clients' views, values, and influences. *See id.* at 361 n.73; Dinerstein et al., *supra* note 3, at 301.

5 Most individuals seeking public behavioral health and other services, such as homeless and domestic violence services, have histories of physical and sexual abuse and other types of trauma-inducing experiences. These experiences often lead to mental health and co-occurring disorders such as chronic health conditions, substance abuse, eating disorders, and HIV/AIDS, as well as contact with the criminal justice system. *See Ask the Expert Welcomes Dr. Joan Gillece*, THE HOMELESS HUB (2001), <http://homelesshub.ca/resource/ask-expert-welcomes-dr-joan-gillece>; *Trauma Informed Care*, NAT'L ASS'N ST. DIRECTORS DEVELOPMENTAL DISABILITIES SERVS., <http://www.nasddd.org/resource-library/behavioral-challenges/mental-health-treatment/trauma-informed-care/>.

6 KATHRYN COLLINS ET AL., UNDERSTANDING THE IMPACT OF TRAUMA AND URBAN POVERTY ON FAMILY SYSTEMS: RISKS, RESILIENCE AND INTERVENTIONS 22 (2010) (citing Thema Bryant-Davis, *Healing Requires Recognition: The Case for Race-Based Traumatic Stress*, 35 COUNSELING PSYCHOLOGIST 135 (2007)).

7 Sarah Katz & Deeya Haldar, *The Pedagogy of Trauma-Informed Lawyering*, 22 CLINICAL L. REV. 359, 361 (2016).

8 *See, e.g.*, Patricia Van Horn & Betsy McAlister Groves, *Children Exposed to Domestic Violence: Making Trauma-Informed Custody and Visitation Decisions*, 57 JUV. & FAM. CT. J. 51 (2006).

9 *See, e.g.*, Lynette Parker, *Increasing Law Students' Effectiveness When Representing Traumatized Clients: A Case Study of the Katherine & George Alexander Community Law Center*, 21 GEO. IMMIGR. L.J. 163 (2007); Ingrid Loreen, *Therapeutic Jurisprudence & the Law School Asylum Clinic*, 17 ST. THOMAS L. REV. 835, 845 (2005).

10 *See, e.g.*, Sarah Mourer, *Study, Support, and Save: Teaching Sensitivity in the Law School Death Penalty Clinic*, 7 U. MIAMI L. REV. 357 (2013).

11 *See, e.g.*, EVA J. KLAIN ET AL., IMPLEMENTING TRAUMA-INFORMED PRACTICES IN CHILD WELFARE (2013); U.S. DEP'T OF JUST., REPORT OF THE ATTORNEY GENERAL'S NATIONAL TASK FORCE ON

CHILDREN EXPOSED TO VIOLENCE (2012); CARLY B. DIERKHISING ET AL., TRAUMA-INFORMED JUVENILE JUSTICE ROUNDTABLE: CURRENT ISSUES AND DIRECTIONS IN CREATING TRAUMA-INFORMED JUVENILE JUSTICE SYSTEMS (2013); Carolyn S. Salisbury, *From Violence and Victimization to Voice and Validation: Incorporating Therapeutic Jurisprudence in a Children's Law Clinic*, 17 ST. THOMAS L. REV. 623 (2005); Renee DeBoard-Lucas et al., *16 Trauma-Informed, Evidence-Based Recommendations for Advocates Working with Children Exposed to Intimate Partner Violence*, 32 CHILD L. PRAC. 136 (2013); Barbara Ryan et al., *Protecting and Supporting Children in the Child Welfare System and the Juvenile Court*, 37 JUV. & FAM. CT. J. 61 (2006).

12 Karen Sloan's article, *Law Clinics Answer the Call*, notes that students in veterans' law clinics at UCLA and the John Marshall Law School take a "trauma-informed" approach in working with clients who may suffer from post-traumatic stress disorder (PTSD) or brain injuries. Karen Sloan, *Law Clinics Answer the Call*, NAT'L L.J., July 3, 2015, at 3. See also Evan R. Seamone, *The Veterans' Lawyer as Counselor: Using Therapeutic Jurisprudence to Enhance Client Counseling for Combat Veterans with Posttraumatic Stress Disorder*, 202 MIL. L. REV. 185 (2009).

13 Katz & Halder, *supra* note 7, at 361-62.

14 While this paper focuses on urban poverty, it should be noted that people living in rural poverty also experience trauma that affects their behavior and has been linked to negative outcomes. See, e.g., Terri N. Sullivan et al., *Relation Between Witnessing Violence and Drug Use Initiation Among Rural Adolescents: Parental Monitoring and Family Support as Protective Factors*, 33 J. CLINICAL CHILD & ADOLESCENT PSYCHOL. 488, 490, 495 (2004) (finding in a sample of sixth-grade students from "fairly poor, predominantly agricultural communities" that "[w]itnessing violence predicted subsequent initiation of cigarette, beer and wine, liquor, and advanced alcohol use"); Carole E. Kaufman et al., *Stress, Trauma, and Risky Sexual Behaviour Among American Indians in Young Adulthood*, 6 CULTURE, HEALTH & SEXUALITY 301, 304, 311, 312 (2004) (finding in a representative sample that American Indian women aged 17 to 25 years old living in the Northern Plains who experienced a trauma had an increased probability of having multiple casual sexual partners); Jane Leserman et al., *How Trauma, Recent Stressful Events, and PTSD Affect Functional Health Status and Health Utilization in HIV-Infected Patients in the South*, 67 PSYCHOSOMATIC MED. 500, 501-02, 505 (2005) (finding that, among a sample of low-income HIV patients in the rural Southeast: "more trauma was related to worse health-related physical functioning (e.g., interference with walking and lifting), role functioning (limitations on work and activities), pain, and cognitive functioning (difficulty with reasoning, thinking, and concentrating). Total lifetime trauma, as well as sexual or physical abuse history, was shown to increase the risk of disability and health care utilization during the past 9 months"); Matthew J. Taylor et al., *Negative Affect, Delinquency, and Alcohol Use Among Rural and Urban African-American Adolescents: A Brief Report*, 22 J. CHILD & ADOLESCENT SUBSTANCE ABUSE 69, 77 (2013) (finding that negative affect was positively related to alcohol use in rural adolescents and that this relationship was mediated by delinquency; noting that other researchers have suggested that "community and individual stressors" result in negative affect and that the negative affect-delinquency relationship may be linked to "environmental and community stressors").

15 *Trauma & Violence*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Sept. 15, 2015), <https://www.samhsa.gov/trauma-violence>.

16 *Post Traumatic Stress Disorder Fact Sheet*, SIDRAN INST., <https://www.sidran.org/resources/for-survivors-and-loved-ones/post-traumatic-stress-disorder-fact-sheet/> (last visited Aug. 2, 2017).

17 COLLINS ET AL., *supra* note 6, at 1, 22. See also *FITT Model: Impact on the Adult: Summary*, FAM.-INFORMED TRAUMA TREATMENT CTR., <http://fittcenter.umaryland.edu/portals/0/Model/adult-parental-response.html> (last visited Aug. 2, 2017).

18 *Trauma*, SAMHSA-HRSA CTR. FOR INTEGRATED HEALTH SOLUTIONS, <https://www.integration.samhsa.gov/clinical-practice/trauma> (last visited Aug. 2, 2017).

19 SAMHSA'S TRAUMA & JUSTICE STRATEGIC INITIATIVE, SAMSHA'S CONCEPT OF TRAUMA AND GUIDANCE FOR A TRAUMA-INFORMED APPROACH 8 (July 2014).

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- 20 *Id.* See also AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-5) 265 (5th ed. 2013) (including a new diagnostic category of Trauma and Stressor-Related Disorders).
- 21 MD. COALITION OF FAMS. & FAM. INFORMED TRAUMA TREATMENT CTR., TRAUMA AND THE FAMILY: LISTENING AND LEARNING FROM FAMILIES AFFECTED BY PSYCHOLOGICAL TRAUMA 1 (Sept. 2010).
- 22 COLLINS ET AL., *supra* note 6, at 22 (citing Thema Bryant-Davis, *Healing Requires Recognition: The Case for Race-Based Traumatic Stress*, 35 COUNSELING PSYCHOLOGIST 135 (2007)).
- 23 *Id.* (citing Ibrahim Aref Kira, *Taxonomy of Trauma and Trauma Assessment*, 7 TRAUMATOLOGY 73 (2001)); Katz & Haldar, *supra* note 7, at 364-65 (citing KATHRYN COLLINS ET AL., UNDERSTANDING THE IMPACT OF TRAUMA AND URBAN POVERTY ON FAMILY SYSTEMS: RISKS, RESILIENCE AND INTERVENTIONS 22 (2010)).
- 24 COLLINS ET AL., *supra* note 6, at 22 (citing Martha E. Wadsworth, & Catherine De-Carlo Santiago, *Risk and Resiliency Processes in Ethnically Diverse Families in Poverty*, 22 J. FAM. PSYCHOL. 399 (2008)).
- 25 MD. COALITION OF FAMS. & FAM. INFORMED TRAUMA TREATMENT CTR., *supra* note 21.
- 26 *Id.*
- 27 Katz & Haldar, *supra* note 7, at 366-67 (citing Richard R. Kluft et al., *Treating the Traumatized Patient and Victims of Violence*, 86 NEW DIRECTIONS IN MENTAL HEALTH SERVS. 79 (2000)).
- 28 COLLINS ET AL., *supra* note 6, at 1, 2 (citing the AM. PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-4) (4th ed. text rev. 2000)); SAMHSA'S TRAUMA & JUSTICE STRATEGIC INITIATIVE, *supra* note 19. In focus groups with families impacted by trauma, some families reported benefitting from the support of family members, while others reported that the stress and burdens caused by trauma made them feel alone and isolated because other people “don't know what it is like to be in my shoes.” See MD. COALITION OF FAMS. & FAM. INFORMED TRAUMA TREATMENT CTR., *supra* note 21.
- 29 SAMHSA'S TRAUMA & JUSTICE STRATEGIC INITIATIVE, *supra* note 19. See also Katz & Haldar, *supra* note 7, at 359, 367.
- 30 MD. COALITION OF FAMS. & FAM. INFORMED TRAUMA TREATMENT CTR., *supra* note 21.
- 31 BESSEL VAN DER KOLK, THE BODY KEEPS THE SCORE 2-3 (2014).
- 32 Victor Carrion, *Understanding the Effects of Early Life Stress on Brain Development*, in INTERVENTIONS FOR CHILDREN EXPOSED TO VIOLENCE 45, 49 (Alicia F. Lieberman & Robert DeMartino eds., 2006)(citing AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-4) 428-29 (4th ed.1994). See also Julian Ford et al., *Clinical Significance of a Proposed Developmental Trauma Disorder Diagnosis: Results of an International Survey of Clinicians*, 74 J. CLINICAL PSYCHIATRY 841, 841 (2013)(citing JUDITH HERMAN, TRAUMA AND RECOVERY: THE AFTERMATH OF VIOLENCE - FROM DOMESTIC TO POLITICAL TERROR (1992)); Katz & Haldar, *supra* note 7, at 364 (quoting *Trauma*, AM. PSYCHOL. ASS'N, <http://www.apa.org/topics/trauma/>).
- 33 JUDITH HERMAN, TRAUMA AND RECOVERY: THE AFTERMATH OF VIOLENCE - FROM DOMESTIC TO POLITICAL TERROR, 88-95 (1992); Katz & Haldar, *supra* note 7, at 359, 366-67 (citing Sandra L. Bloom, *The Grief that Dare Not Speak Its Name Part I: Dealing with the Ravages of Childhood Abuse*, 2 PSYCHOTHERAPY REV. 408, 408-09 (2000)).
- 34 VAN DER KOLK, *supra* note 31, at 1.

- 35 Jack P. Shonkoff & Andrew S. Garner, *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, 129 TECH. REP.: AM. ACAD. PEDIATRICS e232, e236 (2012).
- 36 See generally Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACEs) Study*, 14 AM. J. PREVENTATIVE MED. 245 (1998). Seven categories of ACEs were identified in a questionnaire completed by approximately 9,500 adults at a large HMO in Southern California. The seven categories included psychological abuse; physical abuse; sexual abuse; violence against mother; living with household members who were substance abusers; living with household members who were mentally ill or suicidal; and living with household members who were ever imprisoned. *Id.*
- 37 *About the CDC - Kaiser ACE Study*, CTR. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/violenceprevention/acestudy/about.html> (last visited July 18, 2017).
- 38 *Id.*
- 39 Johanna K.P. Greeson et al., *Traumatic Childhood Experiences in the 21st Century: Broadening and Building on the ACE Studies with Data from the National Child Traumatic Stress Network*, 29 J. INTERPERSONAL VIOLENCE 536, 539 (2014).
- 40 COLLINS ET AL., *supra* note 6, at 22 (citing Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*, 14 AM. J. PREVENTATIVE MED. 245 (1998)); Christopher M. Layne et al., *Cumulative Trauma Exposure and High Risk Behavior in Adolescence: Findings from the National Traumatic Stress Network Core Data Set*, 6 PSYCHOL. TRAUMA: THEORY, RES., PRAC., & POL'Y S40, S41 (2014).
- 41 Karen T. Putnam et al., *Synergistic Childhood Adversities and Complex Adult Psychopathology*, 26 J. TRAUMATIC STRESS 435 (2013). See also Frank Putman et al., *Opportunities to Change the Outcomes of Traumatized Children*, CHILDHOOD ADVERSITIES NARRATIVE (CAN) (2015), http://childstudycenter.yale.edu/fcpb/approach/evidence/CAN_Narrative_4-8-15-Ryan-Final_216922_123098_31225.pdf.
- 42 Richard C. Christensen et al., *Homeless, Mentally Ill, and Addicted*, 16 J. HEALTHCARE FOR THE POOR & UNDERSERVED 615, 617-18 (2005) (finding high rates of sexual and physical abuse in homeless adults with co-occurring substance abuse and serious mental health disorders); Rachel K. Jewkes et al., *Associations Between Childhood Adversity and Depression, Substance Abuse and HIV & HSV2 Incident Infections in Rural South African Youth*, 34 CHILD ABUSE NEGL. 833, 840 (2010) (South African study finding childhood exposure to emotional, physical, and sexual abuse increased the risk of HIV in adulthood); Rebecca Vivrette & Kate Wasserman, Presentation, Baltimore Mental Health Outreach for Mothers (BMOMs) Survey Initial Report (Mar. 4, 2015) (on file with author) (reporting on a 2015 survey of 285 pregnant women or mothers of children under five years old in seventeen low-income neighborhoods in Baltimore City finding that one in five women endorsed all eight ACEs, with 92% reporting exposure to community violence, 56% reporting exposure to domestic violence, 11% reporting exposure to sexual assault, and 60% reporting having experienced four or more ACEs). See also Bessel van der Kolk, *Developmental Trauma Disorder*, 35 PSYCHIATRIC ANNALS 401, 402 (2005) (stating adults who experienced childhood trauma have significant use of medical, correctional, social, and mental health services, and make up almost the entire criminal justice population in the United States).
- 43 CRICKET BARRAZOTTO, LIFE DON'T HAVE TO END (2013).
- 44 *Id.* at 72.
- 45 *Id.* at 29-33.
- 46 *Id.* at 81.
- 47 Katz & Haldar, *supra* note 7, at 365.

- 48 Marylene Cloitre et al., *A Developmental Approach to Complex PTSD: Childhood and Adult Cumulative Trauma as Predictors of Symptom Complexity*, 22 J. TRAUMATIC STRESS 399, 406 (2009); Bradley C. Stolbach et al., *Complex Trauma Exposure and Symptoms in Urban Traumatized Children: A Preliminary Test of Proposed Criteria for Developmental Trauma Disorder*, 26 J. TRAUMATIC STRESS 483, 484 (2013) (citing Bessel van der Kolk et al., *Proposal to Include a Developmental Trauma Disorder Diagnosis for Children and Adolescents in DSM-V* (2009) (unpublished manuscript to the National Child Traumatic Stress Network Developmental Trauma Disorder Taskforce)); Judith Herman, *Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma*, 5 J. TRAUMATIC STRESS 377, 379-80 (1992); Bessel van der Kolk, *Developmental Trauma Disorder*, 35 PSYCHIATRIC ANNALS 401, 402-03 (2005).
- 49 Shonkoff & Garner, *supra* note 35.
- 50 Cloitre et al., *supra* note 48, at 406. *See also* Ford, *supra* note 32, at 847.
- 51 Studies show that “[i]ndividuals who experience a single trauma in childhood are likely to have experienced several types of adversity, with some studies suggesting that 81% to 98% of adults who report one adverse childhood experience report at least one additional experience”; another study demonstrates that 86% of children who had experienced any type of sexual victimization and 77% of children who had experienced physical abuse by a caregiver had experienced four or more types of victimization the preceding year. Bradley C. Stolbach et al., *supra* note 48, at 483 (citing Maxia Dong et al., *The Interrelatedness of Multiple Forms of Childhood Abuse, Neglect, and Household Dysfunction*, 28 CHILD ABUSE & NEGLECT 771 (2004); R.C. Kessler, *Posttraumatic Stress Disorder: The Burden to the Individual and to Society*, 61 J. CLINICAL PSYCHIATRY 4 (2000); David Finkelhor, *Re-Victimization Patterns in a National Longitudinal Sample of Children and Youth*, 31 CHILD ABUSE & NEGLECT 479 (2007)).
- 52 Indeed, Layne and his co-authors found that the 14,088 participants in their 2014 study, who were clients at agencies associated with the National Traumatic Stress Network, had histories of exposure to an average of more than four different types of trauma during childhood and adolescence. The most commonly reported traumatic events were traumatic loss, bereavement, separation, and various types of intrafamilial trauma. Layne et al., *supra* note 40, at S44. *See also* Ernestine Briggs, *Links Between Child and Adolescent Trauma Exposure and Service Use Histories in a National Clinic-Referred Sample*, 5 PSYCHOL. TRAUMA: THEORY, RES., PRAC., & POL’Y 101, 102 (2013).
- 53 For this reason, in 2009, Bessel van der Kolk and other researchers proposed a new developmental trauma disorder to include in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) to capture the complex symptoms present in chronically traumatized children. Many children who have experienced a traumatic event meet some, but not all, of the required criteria for the current PTSD diagnosis, and researchers believe that a new developmentally-based diagnosis is needed to qualify them for treatment. To date, the proposed new developmental trauma disorder has not been adopted by the American Psychiatric Association. Stolbach et al., *supra* note 48 (citing Bessel van der Kolk et al., *Proposal to Include a Developmental Trauma Disorder Diagnosis for Children and Adolescents in DSM-V* (2009) (unpublished manuscript to the National Child Traumatic Stress Network Developmental Trauma Disorder Taskforce)). *See also* Shonkoff & Garner, *supra* note 35, at e234, e239 (citing reports from the Center on the Developing Child at Harvard University); Greeson et al., *supra* note 39, at 538; Carrion, *supra* note 32, at 47.
- 54 Shonkoff & Garner, *supra* note 35, at e233; Layne et al., *supra* note 40, at S41.
- 55 Children chronically exposed to early life stress exhibit larger amygdala. *See* Shonkoff & Garner, *supra* note 35, at e236. *See also* Jack Shonkoff et al., *Neuroscience, Molecular Biology, and the Childhood Roots of Health Disparities*, 301 JAMA 2252, 2254 (2009); Robert F. Anda et al., *The Enduring Effects of Abuse and Related Adverse Experiences in Childhood*, 256 EUR. ARCHIVES PSYCHIATRY & CLINICAL NEUROSCI. 174, 180-81 (2006).
- 56 Katz & Haldar, *supra* note 7, at 366; Shonkoff & Garner, *supra* note 35, at e236.
- 57 Carrion, *supra* note 32, at 58 (citing the results of the “Brain Development in PTSD” study at the Stanford University Early Life Stress Research Program as finding higher cortisol levels in groups of children presenting with PTSD symptoms than in the control group).

- 58 Shonkoff & Garner, *supra* note 35, at e235 (citing Bruce S. McEwen, *Stressed or Stressed Out: What is the Difference?* 30 J. PSYCHIATRY & NEUROSCI. 315 (2005)); Bruce S. McEwen & Teresa Seeman, *Protective and Damaging Effects of Mediators of Stress: Elaborating and Testing the Concepts of Allostasis and Allostatic Load*, 896 ANNALS N.Y. ACAD. SCI. 30, 41-42 (1999); Bruce S. McEwen, *Protective and Damaging Effects of Stress Mediators*, 338 NEW ENG. J. MED. 171, 175-76 (1998).
- 59 Shonkoff & Garner, *supra* note 35, at e236-e237.
- 60 *Id.* at e235 (citing Jack P. Shonkoff, *Building a New Biodevelopmental Framework to Guide the Future of Early Childhood Policy*, 81 CHILD DEV. 357 (2010)); NAT'L SCI. COUNCIL ON THE DEVELOPING CHILD, EXCESSIVE STRESS DISRUPTS THE ARCHITECTURE OF THE DEVELOPING BRAIN: WORKING PAPER NO. 3 (2014).
- 61 Shonkoff & Garner, *supra* note 35, at e236.
- 62 *Id.*
- 63 Cloitre et al., *supra* note 48, at 400.
- 64 Ford, *supra* note 32, at 841 (citing Wendy D'Andrea et al., *Understanding Interpersonal Trauma in Children: Why We Need a Developmentally Appropriate Trauma Diagnosis*, 82 AM. J. ORTHOPSYCHIATRY 187 (2012)).
- 65 Cloitre et al., *supra* note 48, at 400. *See also* van der Kolk, *supra* note 42, at 404.
- 66 Kaisa Haatainen et al., *Gender Differences in the Association of Adult Hopelessness with Adverse Childhood Experiences*, 38 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 12, 15-16 (2003).
- 67 COLLINS ET AL., *supra* note 6, at 22 (citing JOHN BRIERE & CATHERINE SCOTT, PRINCIPLES OF TRAUMA THERAPY (2006)).
- 68 Kathleen M. Connors, Presentation, Interdisciplinary Discussion: Impact of Trauma on Families (Apr. 7, 2016) (on file with author) (citing Robert S. Pynoos et al., *Issues in the Developmental Neurobiology of Traumatic Stress*, 821 ANNALS N.Y. ACAD. SCI. 176 (1997)).
- 69 COLLINS ET AL., *supra* note 6, at 1.
- 70 Shonkoff et al., *supra* note 55.
- 71 HERMAN, *supra* note 33, at 110; Cloitre et al., *supra* note 48, at 400 (proposing a new DSM-IV diagnosis of Complex PTSD to capture the symptoms that result from childhood trauma such as the self-regulatory disturbances uniquely associated with repeated childhood adverse experiences). *See also* Shonkoff & Garner, *supra* note 35, at e236-e237; van der Kolk, *supra* note 42, at 404; Shonkoff et al., *supra* note 55; Sophia Miryam Schussler-Fiorenza Rose, *Adverse Childhood Experiences, Disability and Health-Risk Behaviors*, 26 POPULATION HEALTH MATTERS (2013).
- 72 DAVID A. BINDER & SUSAN C. PRICE, LEGAL INTERVIEWING AND COUNSELING: A CLIENT-CENTERED APPROACH (1977).
- 73 DAVID A. BINDER, PAUL BERGMAN & SUSAN C. PRICE, LAWYERS AS COUNSELORS: A CLIENT CENTERED APPROACH (1991); Katz & Haldar, *supra* note 7, at 375; Jacobs, *supra* note 4, at 350 (citing Robert Dinerstein, *Client-Centered Counseling: Reappraisal and Refinement*, 32 ARIZ. L. REV. 501, 504 n.15 (1990), stating ninety-four law schools have adopted the Binder, Bergman & Price text). While client-centered lawyering is commonly discussed in the context of client interviewing and counseling, as Stephen Ellmann, Robert Dinerstein, Isabelle Gunning, Katherine Kruse, and Ann Shalleck point out in their textbook, the lawyer-client relationship extends beyond these discrete lawyering activities. Client interviewing and counseling are, in practice, “interwoven parts of the whole project of creating a lawyer-client relationship. ...” and occur throughout the course of an attorney-client relationship. *See* STEPHEN ELLMANN ET AL., LAWYERS AND CLIENTS: CRITICAL ISSUES IN INTERVIEWING AND

COUNSELING 2 (2009); Dinerstein et al., *supra* note 3, at 290. *See also* Don Gifford, *The Synthesis of Legal Counseling and Negotiation Models: Preserving Client-Centered Advocacy in the Negotiation Context*, 34 UCLA L. REV. 811 (1987).

74 The client-centered therapist must: (1) have unconditional positive regard for the client, (2) possess acceptance or empathic understanding, and (3) identify with the attitudes and feelings they share with the client. *See* Robert D. Dinerstein, *Client-Centered Counseling: Reappraisal and Refinement*, 32 ARIZ. L. REV. 501, 538 (1990) (citing CARL ROGERS, CLIENT-CENTERED THERAPY: ITS CURRENT PRACTICE, IMPLICATIONS AND THEORY 9 (1951); Carl Rogers, *A Theory of Therapy, Personality, and Interpersonal Relationships, as Developed in the Client-Centered Framework*, in PSYCHOLOGY: A STUDY OF A SCIENCE, STUDY I CONCEPTUAL AND SYSTEMATIC, VOLUME 3 FORMULATION OF THE PERSON AND THE SOCIAL CONTEXT 185 (Sigmund Koch ed., 1959)).

75 Dinerstein, *supra* note 74, at 525.

76 *Id.* at 512-17, 547.

77 *Id.* at 507.

78 *Id.* at 543, 584. *See also* Dinerstein et al., *supra* note 3, at 291-92; Jacobs, *supra* note 4, at 350.

79 Dinerstein, *supra* note 74, at 585.

80 Dinerstein et al., *supra* note 3, at 290, 299 (stating the lawyer must understand that the client's views may be shaped by their connections to other people and communities such as family, friends and neighborhood, as well as communities of racial, ethnic, or national identity).

81 *Id.* at 290.

82 *Id.* at 294; Jacobs, *supra* note 4, at 354 n.29. As much as the client's views are influenced by many factors, so, too, are the lawyer's views. Significant scholarship has discussed the need for the lawyer to be aware and critical of their own values that they bring to the lawyer-client relationship, as well as about the assumptions they hold about their clients' views, values, and influences. *See* Dinerstein et al., *supra* note 3, at 301; Jacobs, *supra* note 4, 361 n.73.

83 Susan Bryant identifies these lawyering skills as part of building cross-cultural competence. *See* Susan Bryant, *The Five Habits: Building Cross-Cultural Competence*, 8 CLINICAL L. REV. 33, 41-42 (2001).

84 Connors, *supra* note 68.

85 Bryant, *supra* note 83, at 43 (noting potential misperceptions between the lawyer and client based on cultural misinterpretations); Jacobs, *supra* note 4, at 380, 386 n.163.

86 Bryant, *supra* note 83, at 70-71.

87 *Id.*

88 Inasmuch as a paramount goal of the lawyer-client relationship is to help the client resolve problems in a way that reflects the client's unique values, goals and priorities, the lawyer must understand and respect the many influences in the client's world that can impact the way they view the world, their view of their own situation, and the choices they have. Dinerstein et al., *supra* note 3, at 292.

89 Bryant, *supra* note 83, at 42.

90 Dinerstein et al., *supra* note 3, at 292.

91 BARRAZOTTO, *supra* note 43.

- 92 Bryant, *supra* note 83, at 44 (noting that students sometimes describe clients who organize information differently than the students or the legal system as “wandering all over the place”).
- 93 *Id.* at 43.
- 94 Communication problems between the lawyer and the client have been described in the context of cross-cultural lawyering as well. Indeed, in her article, *The Five Habits: Building Cross-Cultural Competence*, Susan Bryant, in describing Habit Four, which focuses on cross-cultural communication, shares an interaction between a lawyer and an eight-year-old client, who is the subject of a child neglect proceeding. In their first meeting, the lawyer uses a standard script to explain the proceeding and, thinking of the many children who blame themselves for neglect proceedings against their parents, the lawyer explains that neglect proceedings are brought by the state against the parents and not against the child. The child was “subdued and reticent to talk other than saying, ‘I did not do anything wrong.’” Later, after a court proceeding, the child asked the lawyer why there were no police in the courtroom. The child told the lawyer that they thought you only get a lawyer if you have done something wrong, and that everyone they knew who had a lawyer went to jail. To maximize accurate and genuine communication between the lawyer and the client, Professor Bryant encourages “culturally sensitive exchanges with clients” by varying the lawyer’s communication strategies in place of scripts, asking open-ended questions that call for narrative responses and engaging in “attentive listening” to the child’s story and voice, and paying particular attention to developing trust and rapport at the beginning of the interview. Bryant, *supra* note 83, at 72-75 (citing Gay Gellhorn, *Law and Language: An Empirically-Based Model for Opening Moments of Client Interview*, 4 CLINICAL L. REV. 321, 335 (1998)).
- 95 Bryant, *supra* note 83, at 41-42 (identifying the same aspects of the attorney-client interaction as implicated when lawyers and clients come from different cultures).
- 96 *Id.*; Jacobs, *supra* note 4, at 361 n.73.
- 97 Culture has been broadly defined as “the logic by which we give order to the world” and has been recognized as shaping attitudes, values, and norms of behavior. Bryant, *supra* note 83, at 40 (citing RAYMONDE CARROLL, CULTURAL MISUNDERSTANDINGS: THE FRENCH-AMERICAN EXPERIENCE 2 (1988)). See generally Jacobs, *supra* note 4; Katherine R. Kruse, *Fortress in the Sand: The Plural Values of Client-Centered Representation*, 12 CLINICAL L. REV. 369, 388-90 (2006).
- 98 Susan Bryant identifies these lawyering skills as part of building cross-cultural competence. See Bryant, *supra* note 83, at 41-42.
- 99 Katz & Haldar, *supra* note 7, at 370-72.
- 100 See, e.g., V. Pualani Enos & Lois H. Kanter, *Who’s Listening? Introducing Students to Client-Centered, Client-Empowering, and Multidisciplinary Problem-Solving in a Clinical Setting*, 9 CLINICAL L. REV. 83, 84, 87-88 (2002); Dinerstein et al., *supra* note 3, at 308-09 (citing Robert D. Dinerstein, *Client-Centered Counseling: Reappraisal and Refinement*, 32 ARIZ. L. REV. 501 (1990); Stephen Ellmann, *Lawyers and Clients*, 34 UCLA L. REV. 717 (1987); Alex J. Hurder, *Negotiating the Lawyer-Client Relationship: A Search for Equality and Collaboration*, 44 BUFFALO L. REV. 71 (1996); Jacobs, *supra* note 4; Robert F. Cochran, Jr. et al., *Symposium, Client Counseling and Moral Responsibility*, 30 PEPP. L. REV. 591 (2003)).
- 101 Given the client-centered approach to representation’s roots in psychology, a practice philosophy grounded in behavioral health logically enhances the framework. Client-centered representation is based on a nondirective counseling model developed by psychologist Carl Rogers that posits that the client is capable of making all decisions for themselves, and should, therefore, take an active role in their counseling. See Gifford, *supra* note 73, 817-18.
- 102 Bruce J. Winick, *Therapeutic Jurisprudence and Problem Solving Courts*, 30 FORDHAM URB. L.J. 1055, 1063 (2012) (citing PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HELPING PROFESSION (Dennis P. Stolle et al. eds., 2000); Symposium, *Therapeutic Jurisprudence and Preventive Law: Transforming Legal Practice and Education*, 5 PSYCHOL. PUB. POL’Y & L. 793 (1999)).

- 103 Rachel White-Domain, a lawyer with the National Center on Domestic Violence, Trauma and Mental Health, views the need to take more time with clients who have experienced trauma as an accommodation that allows the client to access legal services they may otherwise be unable to access. *See* Rachel White-Domain, Webinar, *Trauma-Informed Legal Advocacy: An Introduction*, NAT'L CTR. ON DOMESTIC VIOLENCE, TRAUMA & MENTAL HEALTH (Feb. 25, 2016), <http://www.nationalcenterdvtraumamh.org/trainingta/trauma-informed-legal-advocacy-tila-project/> (under the heading "TILA Webinars" click on "Webinar Recording: Trauma-Informed Legal Advocacy: An Introduction").
- 104 *Id.*
- 105 E-mail from client to author (Apr. 8, 2016) (on file with author). Mr. W. is one of the people who share his story in *Life Don't Have to End*. He never shared any of his life experiences with us nor did we ask. (I changed Mr. W.'s last name initial to protect his privacy). *See* BARRAZOTTO, *supra* note 43.
- 106 Trainings for legal service providers are becoming increasingly common, particularly for lawyers representing adults and children whose traumatic experiences are substantively relevant to the representation. For example, the Maryland State Bar Association held a day of service in March 2017 that included trauma-informed advocacy training focused on assisting military veterans. In 2016, End Violence Against Women International hosted a two-part webinar titled, *The Neurobiology of Sexual Assault* presented by James W. Hooper and advertised by organizations such as the D.C. Lawyers Project. *See* *Serving Those Who Served Us: A Day of Legal Training & Service for Maryland's Veterans*, MD. ST. BAR ASS'N LEADERSHIP ACAD. (Mar. 30, 2017), http://www.msba.org/Events/Committee_Events/LeaderAcad033017.aspx; Dr. James Hopper, Webinar, *Neurobiology of Sexual Assault, END VIOLENCE AGAINST WOMEN* (Sept. 2016), <http://www.evawintl.org/WebinarArchive.aspx> (click on "Full Description" links under the heading "Neurobiology of Sexual Assault 2-Part Webinar Series" to access slides and handouts). The D.C. Volunteer Lawyers Project provides legal representation to domestic violence victims and at-risk children in civil protection and family law cases in Washington, D.C. D.C. VOLUNTEER LAWYERS PROJECT, <http://www.dcvlp.org/> (last visited Aug. 2, 2017). *See also* White-Domain, *supra* note 103; Katz & Haldar, *supra* note 7, at 370 (referencing resources for lawyers practicing in areas such as juvenile justice and delinquency, child welfare, family law, and domestic violence); ABA, Webinar, Practice Recommendations for Trauma-Informed Legal Services (July 2013), http://www.americanbar.org/content/dam/aba/administrative/child_law/5C_Patten%20Kraemer_Practice%20Recommendations%20for%20Trauma%20Informed%20Legal%20Services.authcheckdam.pdf (last visited July 19, 2017); Mercedes V. Lorduy et al., Presentation, A Trauma Informed Approach to Attorney Client Relationships and Collaborations: Strategies for Divorce, Custody, Protection Orders and Immigration Cases, NAT'L IMMIGRANT WOMEN'S ADVOC. PROJECT, AM. U. WASH. C.L. (July 29, 2015), <http://library.niwap.org/wp-content/uploads/Powerpoint-Trauma-Informed-Approach-to-Attorney-Client-Relationships-and-Collaborations-1.pdf>.
- 107 *See* Kevin Huckshorn & Janice L. Lebel, *Trauma Informed Care*, in MODERN COMMUNITY MENTAL HEALTH: AN INTERDISCIPLINARY APPROACH 62 (Kenneth Yeager et al. eds., 2013). *See also* *About NCTIC*, SAMHSA, <http://www.samhsa.gov/nctic/about> (last visited July 31, 2017) (describing the mission of the National Center for Trauma-Informed Care (NCTIC) as "offer[ing] consultation and technical assistance, education and outreach, and resources to support a broad range of service systems, including systems providing mental health and substance abuse services, housing and homelessness services, HIV services, peer and family organizations, child welfare, criminal justice, and education." *Id.*; *Trauma Informed Care Series IHV Clinical Providers* MIDATL. AIDS EDUC. & TRAINING CTR., <https://www.maaetc.org/events/view/9568> (last visited July 31, 2017) (detailing a Trauma Informed Care Case Conference applying an interdisciplinary approach to trauma-informed care presented and discussed through a case).
- 108 For example, SAMHSA defines a trauma-informed approach as one in which a program, organization, or system "(1) realizes the widespread impact of trauma and understands potential paths for recovery, (2) recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system, (3) responds by fully integrating knowledge about trauma into policies, procedures, and practices, and (4) seeks to actively resist re-traumatization." *Trauma-Informed Approach and Trauma-Specific Interventions*, SAMHSA, <http://www.samhsa.gov/nctic/trauma-interventions>. *See also* Katz & Haldar, *supra* note 7, at 369 (citing SAMHSA's definition of trauma-informed practice as "acknowledging the prevalence and impact of trauma and attempt[ing] to create a sense of safety for all participants, whether or not they have a trauma-related diagnosis"). The National Child Traumatic Stress

Network (NCTSN) defines trauma-informed practice as including: (1) routine screenings for trauma exposure and related symptoms; (2) culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms; (3) resources available to children, families, and providers on trauma exposure, its impact, and treatment; (4) efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma; (5) addressing parent and caregiver trauma and its impact on the family system; (6) emphasizing continuity of care and collaboration across child-service systems; and (7) maintaining an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience. Dierkhising et al., *supra* note 11, at 2. Sarah Katz and Deeya Haldar reference the Sanctuary Model created by psychiatrist Sandra Bloom that proposes seven characteristics of a trauma-informed organization: (1) a culture of nonviolence, (2) a culture of emotional intelligence, (3) a culture of social learning, (4) a culture of shared governance, (5) a culture of open communication, (6) a culture of social responsibility, (7) a culture of growth and change. Katz & Haldar, *supra* note 7, at 370, n.60. According to Roger FalLOT and Maxine Harris, the five primary principles of trauma-informed practice are: (1) safety (including ensuring both physical and emotional safety), (2) trust (maximizing trustworthiness, making tasks clear, clarifying roles, establishing appropriate boundaries, and being predictable); (3) choice (prioritizing consumer choice and control); (4) collaboration (sharing power with clients); and (5) empowerment (prioritizing empowerment and skill building). Roger FalLOT & Maxine Harris, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*, 2.2 COMMUNITY CONNECTIONS 3 (2009), <https://www.healthcare.uiowa.edu/icmh/documents/CCTIC-Self-AssessmentandPlanningProtocol0709.pdf>. See also Elizabeth K. Hopper et al., *Shelter from the Storm: Trauma-Informed Care in Homelessness Services*, 3 OPEN HEALTH SERVS. & POL'Y J. 80, 81-82, 93 (2010) (reviewing the basic principles of trauma-informed care proposed by various workgroups, organizations, expert panels, and researchers, and concluding that each source presented a different definition of trauma-informed care).

109 See Tina Champagne & Nan Stromberg, *Sensory Approach in Inpatient Psychiatric Settings: Innovative Alternatives to Seclusion & Restraint*, 42 J. PSYCHOL. NURSING 34 (2004); Janice L. LeBel & Tina Champagne, *Integrating Sensory and Trauma-Informed Interventions: A Massachusetts State Initiative, Part 2*, 33 MENTAL HEALTH SPECIAL INT. SEC. Q. 1 (2010); Hopper et al., *supra* note 108.

110 *About NCTIC*, *supra* note 107.

111 Hopper et al., *supra* note 108, at 82.

112 *Id.* at 81.

113 *Id.* at 81-82.

114 SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., TRAUMA-INFORMED CARE IN BEHAVIORAL HEALTH SERVS.: QUICK GUIDE FOR CLINICIANS 7 (2014).

115 Katz & Haldar, *supra* note 7, at 369-90 (citing SANDRA L. BLOOM & BRIAN FARRAGHER, RESTORING SANCTUARY: A NEW OPERATING SYSTEM FOR TRAUMA-INFORMED SYSTEMS OF CARE 1, 7-9 (2013)).

116 *About NCTIC*, *supra* note 107.

117 Hopper et al., *supra* note 108, at 81.

118 Katz & Haldar, *supra* note 7, at 369 (citing Denise E. Elliott et al., *Trauma Informed or Trauma Denied: Principles and Implementation of Trauma-Informed Services for Women*, 33 J. COMMUNITY PSYCHOL. 461, 462 (2005)). See also Lori Beyer et al., Presentation at Taking on Trauma in Our Lives and Service Systems: A National Summit and Listening Session, *Creating Cultures of Trauma-Informed Care* (2011).

119 Hopper et al., *supra* note 108, at 81-82.

120 *Id.* at 82.

121 *Homelessness Programs and Resources*, SAMHSA, <http://homeless.samhsa.gov/resource/ask-the-expert-welcomes-dr-joan-gillece-50951.aspx> (last visited Aug. 2, 2017); Joan Gillece, Presentation, *Understanding the*

Effects of Trauma on the Lives of Those We Serve Developing Trauma Informed Systems of Care (PowerPoint), <http://www.nasddd.org/resource-library/behavioral-challenges/mental-health-treatment/trauma-informed-care/understanding-the-effects-of-trauma-on-the-lives-of-those-we-serve-developi/> (last visited Aug. 2, 2017).

122 Hopper et al., *supra* note 108, at 81.

123 *Id.* at 82.

124 *Id.*

125 Talia Kraemer & Eliza Patten, *Establishing a Trauma-Informed Lawyer-Client Relationship (Part One)*, 33 ABA CHILD L. PRACT. 193, 198 (2014) (discussing the public health approach of “universal precaution”). While the focus of this article is the influence of trauma on the lawyer-client relationship, the lawyer's understanding of trauma and its effects can improve physical and mental health outcomes for the client as well. A positive lawyer-client relationship can not only alleviate stress for the client but also provide physical benefits. For example, in the HIV Legal Clinic, clients often feel anxious and stressed as a result of a legal problem and, as a result, may not have the mental focus to take their medicine every day as prescribed or go to medical appointments. Medical adherence is critical not only to the client's individual wellness but also to reducing the transmission of HIV within the community (because an individual is at significantly lower risk of transmitting HIV if they are virally suppressed). Clients have also shared that their medical conditions have worsened as a result of their stress. For example, Ms. A., the client whose narrative opens this article, endured numerous emergency hospitalizations due to flare-ups of her acute pancreatitis in the months following her job termination. Student attorneys represented another client in a Social Security matter who was hospitalized for ten days to treat high blood pressure resulting from the stress of awaiting a long overdue decision from Social Security about the reinstatement of her disability benefits.

126 White-Domain, *supra* note 103.

127 *About NCTIC*, *supra* note 107.

128 RELIAS LEARNING, 5 KEY ELEMENTS TO TRAUMA-INFORMED CARE, WHITE PAPER 4 (2016).

129 Meade Eggleston, Dir., Veterans Psychol. Clinic at the Univ. of Balt., Presentation on Trauma-Informed Care for Veterans (Mar. 30, 2017) (on file with author) (quoting Tonier Cain, a Team Leader with SAMHSA's National Center for Trauma-Informed Care).

130 Key aspects of a trauma-informed approach include: (1) realizing the wide-spread presence and impact of trauma; (2) recognizing signs and symptoms of trauma-related behavior; (3) responding by integrating knowledge about trauma into policies, procedures, and practices; and (4) resisting re-traumatization when interacting with clients and providing services. Eggleston, *supra* note 129 (citing SAMHSA's National GAINS Center for Behavioral Health and Justice and SAMHSA's National Center on Trauma-Informed Care).

131 The consideration of trauma as a possible explanation for the client's behavior expands the habit of “parallel universes” set forth by Susan Bryant. Bryant, *supra* note 83, at 70-72. Katz and Haldar also suggest that law students be trained to recognize that what a client may be describing, or the behavior the client may be exhibiting, may be indicative of trauma. *See* Katz & Haldar, *supra* note 7, 382-83.

132 Trauma-informed care requires that everyone working in an office be trained about trauma, not only the individual lawyer. Because the client interacts with other people in the office, including the office receptionist, the lawyer's colleague who answered a shared phone line and others, it is important that the client's experiences foster trust and feelings of safety. Katz & Haldar, *supra* note 7, at 369 (citing Denise E. Elliott et al., *Trauma Informed or Trauma Denied: Principles and Implementation of Trauma-Informed Services for Women*, 33 J. COMMUNITY PSYCHOL. 461, 462 (2005)). *See also* Beyer et al., *supra* note 118.

133 *See* examples of trauma-informed practice training opportunities, *supra* note 106 and accompanying text.

- 134 Kathleen Connors has over thirty years of experience as a clinical social worker working with traumatized children and their families. Connors is an instructor at the University of Maryland School of Medicine, Department of Psychiatry, Project Director of the Family Informed Trauma Treatment Center (through a SAMHSA-funded grant), and Program Director of the Taghi Modarressi Center for Infant Study.
- 135 Dinerstein et al., *supra* note 3, at 296.
- 136 Bryant, *supra* note 83, at 41.
- 137 See SAMHSA'S GAINS CENTER FOR BEHAVIORAL HEALTH & JUSTICE TRANSFORMATION, <http://gainscenter.samhsa.gov/> (last visited Aug. 2, 2017). The GAINS Center provides technical assistance to several of SAMHSA's justice-related grant programs and to the field, including trauma-informed response trainings, strategic planning workshops, and policy academies. See also SAMHSA'S NATIONAL CENTER ON TRAUMA-INFORMED CARE (NCTIC) & ALTERNATIVES TO SECLUSION AND RESTRAINT, <https://www.samhsa.gov/nctic> (last visited Aug. 2, 2017). NCTIC provides training, consultation, and other technical assistance to courts, jails, prisons, and other justice system partners.
- 138 Kraemer & Patten, *supra* note 125; Talia Kraemer & Eliza Patten, Presentation, Presentation, Practice Recommendations for Trauma-Informed Legal Services (2013) (Power Point), https://www.americanbar.org/content/dam/aba/administrative/child_law/5C_Patten%20Kraemer_Practice%20Recommendations%20for%20Trauma%20Informed%20Legal%20Services.authcheckdam.pdf. Talia Kraemer and Eliza Patten are lawyers at Legal Services for Children in San Francisco, which provides free legal services to vulnerable youth in guardianship, foster care, immigration, and school discipline cases. See LEGAL SERVICES FOR CHILDREN, www.lsc-sf.org (last visited July 31, 2017).
- 139 Katz & Haldar, *supra* note 7, at 387 (citing Judy I. Eidelson, *Post-Traumatic Stress Disorders: Representing Traumatized Clients*, PHILA. BAR ASS'N FAM. L. SEC. CLE (2013)).
- 140 *Id.* at 389.
- 141 White-Domain, *supra* note 103.
- 142 *Id.*
- 143 *Id.* (cautioning that the lawyer must find the balance between providing too much information that could be overwhelming versus providing enough information to minimize surprises); Kraemer & Patten, *supra* note 125.
- 144 See Katz & Haldar, *supra* note 7, at 392 n.149.
- 145 Kraemer & Patten, *supra* note 125.
- 146 Habit Four of Susan Bryant's five habits for building cross-cultural competencies involves paying conscious attention to the process of communication to ensure that accurate and genuine communication is occurring. To do this, Professor Bryant cautions against “scripting” parts of the interviewing such as explaining confidentiality, building rapport, and explaining the legal system and process. Instead, Professor Bryant suggests using a variety of communication styles to replace scripts. Bryant, *supra* note 83, at 73.
- 147 Kraemer & Patten, *supra* note 125.
- 148 Katz & Haldar, *supra* note 7, at 388-89; Hopper et al., *supra* note 108, at 84-85.
- 149 Kraemer & Patten, *supra* note 125.
- 150 Sloan, *supra* note 12.

- 151 Katz & Haldar, *supra* note 7, at 388-89; White-Domain, *supra* note 103.
- 152 While limited resources may necessitate high caseloads, empirical evidence measuring positive outcomes to clients based on trauma-informed lawyering may provide support for grant funding to hire additional staff and permit reduced caseloads.
- 153 See *Average Wait Time Until Hearing Held Report*, SOC. SEC. ADMIN., http://www.ssa.gov/appeals/DataSets/01_NetStat_Report.html (last visited July 31, 2017).
- 154 White-Domain, *supra* note 103.
- 155 *Id.*
- 156 Sloan, *supra* note 12.
- 157 White-Domain, *supra* note 103.
- 158 Eggleston, *supra* note 129.
- 159 ELLMANN ET AL., *supra* note 73; Dinerstein et al., *supra* note 3.
- 160 Dinerstein et al., *supra* note 3, at 294.
- 161 *Id.* at 303. The lawyer must consider the implications that involving a support person in a client meeting may have on preserving client confidences both under rules of professional ethics and the evidentiary attorney-client privilege. The lawyer must not assume that the client's decision to involve a support person in a meeting means that the client consents to the lawyer's disclosure of information in the presence of that person. MD. ATTY'S RULES OF PROF'L CONDUCT r. 1.6 (MD. BAR ASS'N 2016) (preventing the lawyer from disclosing information relating to the representation of the client without the client's informed consent unless the disclosure is impliedly authorized to carry out the representation). In addition to the ethical obligation to protect client information, the lawyer must consider discussing with the client how the presence of a third party could destroy the client's ability to claim the attorney-client privilege if the legal matter ends up being litigated. See, e.g., Gregory Sisk & Pamela Abbate, *The Dynamic Attorney-Client Privilege*, 23 GEO. J. LEGAL ETHICS 201, 233-234 (2010) (the communication between the client and the lawyer must have been made in confidence for the attorney-client privilege to attach).
- 162 White-Domain, *supra* note 103; Eggleston, *supra* note 129 (recommending being thoughtful about language and avoiding punitive and disrespectful language).
- 163 Katz & Haldar, *supra* note 7 (citing Judy I. Eidelson, *Post-Traumatic Stress Disorders: Representing Traumatized Clients*, PHILA. BAR ASS'N FAM. L. SEC. CLE (2013)).
- 164 See Hopper et al., *supra* note 108, at 81-82; Katz & Haldar, *supra* note 7, at 369; Kraemer & Patten, *supra* note 125; White-Domain, *supra* note 103; Gillice, *supra* note 121; *Homelessness Programs and Resources*, *supra* note 121.
- 165 Katz & Haldar, *supra* note 7 (citing Judy I. Eidelson, *Post-Traumatic Stress Disorders: Representing Traumatized Clients*, PHILA. BAR ASS'N FAM. L. SEC. CLE (2013)).
- 166 White-Domain, *supra* note 103.
- 167 NAT'L CHILD TRAUMATIC STRESS NETWORK, WHAT'S SHARING POWER GOT TO DO WITH IT? (2016).
- 168 Katz & Haldar, *supra* note 7, at 387; Kraemer & Patten, *supra* note 125; Hopper et al., *supra* note 108, at 82 (stating that "because control is often taken away in traumatic situations, and because homelessness itself is disempowering, trauma-informed homeless services emphasize the importance of choice for consumers").
- 169 White-Domain, *supra* note 103.

- 170 Previous scholarship has discussed the value of storytelling and the importance of allowing the client to determine their narrative. *See, e.g.*, Lucie E. White, *Subordination, Rhetorical Survival Skills, and Sunday Shoes: Notes on the Hearing of Mrs. G.*, 38 BUFF. L. REV. 1, 46-52 (1990). *See also* Bryant, *supra* note 83, at 47 n.49 (discussing an immigration case in which the lawyers changed their strategy for presenting evidence of persecution because the client viewed evidence of injury to an area of her body to be private).
- 171 Kraemer & Patten, *supra* note 125.
- 172 Client e-mail (June 27, 2017) (on file with author).
- 173 Kraemer & Patten, *supra* note 125.
- 174 Katz & Haldar, *supra* note 7, at 387; Hopper et al., *supra* note 108, at 94.
- 175 Several studies have found that participants do not experience significant distress when asked about the trauma and even appreciate the chance to talk about it openly. *See, e.g.*, Katie M. Edwards et al., *College Women's Reactions to Sexual Assault Research Participation: Is It Distressing?*, 33 PSYCHOL. WOMEN Q. 225 (2009); Anne P. Deprince & Jennifer J. Freyd, *Costs and Benefits of Being Asked About Trauma History*, 3 J. TRAUMA PRAC. 23 (2006).
- 176 Meeting with Kathleen M. Connors, Instructor at the University of Maryland School of Medicine, Department of Psychiatry, Project Director of the Family Informed Trauma Treatment Center, and Program Director of the Taghi Modarressi Center for Infant Study (Nov. 10, 2014) (notes on file with author).
- 177 In 2013, SAMHSA released *Essential Components of Trauma-Informed Judicial Practice*. In the draft guidelines, SAMHSA sets forth common examples of courtroom communication or courtroom procedures, notes how a trauma survivor might hear or perceive them, and suggests another, more trauma-informed approach. As one example, when a judge asks, “Did you take your pills today?” the client may feel, “I’m a failure. I’m a bad person. No one cares how the drugs make me feel.” A trauma-informed approach would be for the judge to ask, “Are the medications your doctor prescribed working well for you?” ESSENTIAL COMPONENTS OF TRAUMA-INFORMED JUDICIAL PRACTICE, SAMHSA 4 (2013).
- 178 *See, e.g.*, *Trauma Informed Care System*, NAT’L COUNCIL JUV. & FAM. CT. JUDGES, <https://www.ncjfcj.org/our-work/trauma-informed-system-care> (last visited July 31, 2017) (listing the ten key principles juvenile court judges should know about trauma); *Trauma Informed Court Approaches for Mental Health Court Trainers*, JUST. CTR.: COUNCIL ST. GOV’T, <https://csgjusticecenter.org/courts/webinars/trauma-informed-court-approaches-for-mental-health-court-curriculum-trainers/> (last visited July 31, 2017).
- 179 Professionals involved in interdisciplinary conversations must act in compliance with rules restricting disclosure of client information including HIPAA’s Privacy Rule, *see, e.g.*, HHS’S SUMMARY OF THE HIPAA PRIVACY RULE, <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html> (last visited Jan. 14, 2018) (limiting the healthcare provider’s ability to share protected information), and professional ethics. MD. ATTY’S RULES OF PROF’L CONDUCT r. 1.6 (MD. BAR ASS’N 2016) (preventing the lawyer from disclosing information relating to the representation of the client without the client’s informed consent unless the disclosure is impliedly authorized to carry out the representation).
- 180 Katz & Haldar, *supra* note 7, at 376-77.
- 181 Dinerstein, *supra* note 74, at 546-56 (noting many of these same benefits from a client-centered approach to lawyering).
- 182 Based on my experience representing clients living with HIV and other medical conditions, I have seen numerous clients experience aggravated symptoms and medical complications triggered by their increased stress and anxiety. By making the legal process more accessible to clients through a trauma-informed approach, clients would experience reduced stress and anxiety and, as a result, experience improved health outcomes. *See* Kraemer & Patten, *supra* note 125 and accompanying text.

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