Is Trauma Research Unethical?

"I can think of no research area where emotions and ethics are more important than in traumatology, especially when we study the catastrophic affective reactions people have to social catastrophes such as national and family violence, where the ethical structures of a social group seem to be shattered." –Judith G. Armstrong (1996)

In the last 15 years, trauma research has experienced a small boom in the number of studies that have been conducted (Walker, Newman, Koss, and Bernstein, 1997; Newman, Walker, and Gefland, 1999). Similar to the rest of research psychology, tension exists between traumatologists' differing goals of beneficence: the conflict between a commitment to a greater good (i.e., those who will benefit from the added knowledge gained from trauma studies) and a commitment to study participants' well-being. While there have been recent advances in legal protections of study participants, ethical principles of "do no harm" to participants' remain vague and un-operationalized (e.g., APA, 2002). With this escalation in trauma research activity, there has been increasing pressures from Institutional Review Boards led trauma researchers to become more self-conscious about their adherence to this principle of no-harm (Newman, Walker, and Gefland, 1999).

Early anecdotal impressions worried the trauma research community about the possible deleterious impact on trauma populations (DuMont and Stermac, 1996; Templeton, 1993), and led investigators to wonder whether trauma populations should be granted a "vulnerable population" status (Templeton, 1993; Levine, 2004). The result was a small but growing empirical literature that scrutinized trauma studies and studied participant post-study psychological reactions. These studies have sought to answer two questions. First, do participants suffer due to their participation in this research? Second, do trauma populations need extra protections due an inherent vulnerability? In the following paper, I will review

relevant empirical studies to explore these important ethical questions, and apply these findings to my current work in Dr. Nnamdi Pole's Post-Traumatic Stress Disorders Laboratory.

Issue 1: Are trauma subjects being harmed?

In the empirical studies examining possible harm on participants, harm was operationalized. "Harm" was measured by whether participants regretted their participation, and/or would these participants have participated had they known what their subjective experience would be during the research process (e.g., Walker, Newman, Koss, and Bernstein, 1997). Participants were also often asked if they experienced un-expected distress during the study, and/or whether there were benefits to their participation in the study (e.g., Walker, Newman, Koss, and Bernstein, 1997).

Previous empirical research unequivocally demonstrates that trauma survivors are not harmed (e.g., Walker, Newman, Koss, and Bernstein, 1997; Newman, Walker, and Gefland, 1999; Griffin, Resick, Waldrop, and Mechanic, 2003). Two studies are very indicative of the findings across the studies. First, Walker, Newman, Koss, and Bernstein (1997) randomly sampled female participants after receiving a comprehensive questionnaire measuring distress and previous history of victimization (neglect, sexual, physical, and emotional abuse), found that among 330 participants 76% indicated that they would have still participated in the study if they had known in advance what the experience was going to be like for them and only 5% said they would not. More over, 25 % said they actually felt benefited from the experience versus 13% that said they would not. Those 13% expressed that the protocol had been more upsetting than anticipated. Interestingly, only 1.2% (n=4) reported that they were unexpectedly distressed and would not still complete the survey again had they known what the experience would be like for them. The difference between those who were more upset than anticipated was higher scores of

distress and exposure on the original protocol, however no other group seemed to be correlated based on distress or exposure.

In a similar study by Griffin, Resick, Waldrop, and Mechanic (2003) with domestic violence, rape, and physical assault survivors (total n= 430) between 2 weeks and 6 months after the last traumatic event, examining participant reaction to trauma assessment procedures, participants were also very positive about their participation in the study. This is true even for those that participated during the normally acute phase after their traumatic event (within 10 days post-trauma). For the physical assault and rape survivors, only 5% reported that they might not be willing or definitely would not be willing to participate in a similar assessment. In this sample, those participants that were highly symptomatic did not report differently from those that were not symptomatic. In the domestic violence sample, 98% of the participants indicated a willingness to participate in a similar study, regardless of the fact that 42% experienced very strong emotions during the research process. There were no significant differences in responses based on severity of symptomology.

Newman and Kaloupek (2004) conducted a literature review and found that across studies that examined the impact of trauma research on participants, participants reported the following benefits: medical and mental health services, empowerment, learning and insight into their own trauma experience and history, greater acceptance and normalization of trauma-related reactions, breaking the silence in an accepting setting, altruism, kinships with others, feeling worthwhile by participating, receiving favorable attention by researcher, and finally the material compensation for participating. These outcomes across studies demonstrate that trauma research most often does not cause harm, but provided an almost brief, therapeutic intervention.

Issue 2: Police Subjects as a Vulnerable Population?

The American Psychological Association Ethical Code (2002) provides special protections for those populations deems as particularly vulnerable, such as children and pregnant mothers. Should trauma populations be considered vulnerable populations and be granted greater protection in the research process? Is the trauma population a vulnerable population?

Informed consent is especially salient for many concerned researchers (Levine, 2004; Newman, Walker, and Gefland, 1999). There is concern whether traumatized individuals, especially in the acute phase following a traumatic event, are able to give truly informed consent given their high levels of distress (Levine, 2004). For informed consent to be given, participants would need to really be able to foresee the distress that participation in the research process may entail (Collogan, Tuma, Dolan-Sewell, Borja, & Fleischman, 2004). For instances, some worry that individuals might not recognize that their particular distress and symptomology may increase (e.g., intrusive symptoms) due to their participation in a trauma study (Newman, Walker, and Gefland, 1999). There is always a question as to whether traumatized individuals' decisional capacity is compromised by the traumatic events; however, there is no empirical research to substantiate this concern (Collogan, Tuma, Dolan-Sewell, Borja, & Fleischman, 2004). Griffin, Resick, Waldrop, and Mechanic (2003) mention that some researchers are concerned that traumatized individuals may be too fragile for measures that remind them of their trauma histories and these individuals may be unable to decline participation due to their past experiences with victimization. However, given the empirical data collected regarding participant post-study reactions, it does not appear that participants shared those sentiments.

Applicability to our study.

We are studying retired Michigan law enforcement officers and seek to understand the relationship between traumatic events, occupational stressors, psychophysiology, coping, social

support, functioning, work place environment, trauma history, and psychopathology in these men that had been exposed to over an extended period of time. Because exposure to a traumatic event is a selection criterion, we are prepared to encounter Post-Traumatic Stress Disorder (PTSD) among our participants. Our research protocol involves an exhaustive booklet of measures examining the above-mentioned variables, a space to describe the critical incident, and the opportunity to discuss the consequence of emotional distress. During an in-person interview, we collect psycho-physiological data as we ask the retirees to re-tell their critical incidence experience in detail, play startling sounds for them, and finally show them a series of video clips that include neutral and police-related, violent scenes.

The findings of no harm to participants in the literature was very reassuring, and contextualized for me the reasons we have the practices we do in our lab when we work with participants. We recruit participants through newspaper ads and word-of-mouth, which limits coercion. We prepare participants before giving them measures and collecting psycho-physiological data that they may feel distress at certain points in the process. We allow participants the opportunity to fill out measures at their home at their own pace. We give participants a list of mental health, clinical resources so they can pursue services to support them around any issues or distress that may arise during the course of the survey. We repeatedly check-in with them throughout the data collection process, and after the protocol. We offer no coercion to participate, and actually offer a relatively low monetary compensation for participation (merely $50). None of their benefits are contingent on their participation. They can choose to drop out at any time, and they will still receive compensation even if they choose to withdraw data or not submit their measures. Dr. Pole always makes himself very available to speak with participants throughout the process, and actually conducts all the clinical interviews

himself. The empirical researches reviewed for this paper seem to suggest that these methods are in fact ways of possibly minimizing harm to participants, and increasing gains. A finding that was very applicable to my work was Walker et al.'s (1997) finding that the PTSD symptomatic group rated the portion of the protocol with psycho-physiological measures the more distressing and difficult than the other participants. It demonstrates to me that participants may need extra emotional support following this portion of the data collection.

Implications for field.

The larger implications of these research findings are slightly more ambiguous than the findings themselves. While it is now clear that many trauma research protocols do not in fact cause harm, the field is still left without guidance on future research, or the research standards that could (and perhaps should) exist to ensure positive outcomes. Raftery (1997) points out that the trauma field has relatively neglected developing a field specific code of ethics; the International Society of Traumatic Stress Studies, the primary professional organization for trauma researchers and clinicians, has yet to discuss and publish a code of ethics for the trauma field. Future research can help educate the field on what such an ethical code should include to ensure continued positive and beneficial post-study responses in participants.

Future research should help differentiate the factors that promote or detract from participant satisfaction. Future research should compare protocols and methods to help guide the field in determining ways to ensure positive experiences for participants. It would be helpful if all studies incorporated an assessment of participant experience to provide feedback to both that particular researcher but also future research designs. For instance, does debriefing after the study or follow up a few weeks after participation support positive experiences for participants? Does gender match or ethnic of interviewer impacts participant satisfaction? What specifically

brings benefits to participants versus merely not harming participants? These are all questions that would be beneficial to further explore.

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