

TRAUMA: WHAT LURKS BENEATH THE SURFACE

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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

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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

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 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

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.

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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,

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).

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 rele-

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.nasddds.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)).

vant 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

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*

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.

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").

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 well-being.”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, acci-

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).

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).

dents, 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 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

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 DeCarlo 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. Kluff et al., *Treating the Traumatized Patient and Victims of Violence*, 86 NEW DIRECTIONS IN MENTAL HEALTH SERVS. 79 (2000)).

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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

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)).

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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 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,

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.*

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

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. HEALTH-CARE 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

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

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*

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

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 Inter-relatedness 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 Statisti-*

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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

cal 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.

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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).

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⁵⁶ Katz & Haldar, *supra* note 7, at 366; Shonkoff & Garner, *supra* note 35, at e236.

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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 Allostatis 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).

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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

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*

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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

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)).

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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.

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⁷⁰ Shonkoff et al., *supra* note 55.

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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).

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⁷² DAVID A. BINDER & SUSAN C. PRICE, LEGAL INTERVIEWING AND COUNSELING: A CLIENT-CENTERED APPROACH (1977).

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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,

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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-cl-

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).

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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)).

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

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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.

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

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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).

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⁸¹ *Id.* at 290.

⁸² *Id.* at 294; Jacobs, *supra* note 4, at 354 n.29. As much as the client’s views are influ-

ent 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

enced 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.

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“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. 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’ be-

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.

haviors.”⁸⁷ 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

⁸⁷ *Id.*

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?

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

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.

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

⁸⁹ Bryant, *supra* note 83, at 42.

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

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

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").

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

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.

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 re-

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). **R**

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). **R**

⁹⁸ Susan Bryant identifies these lawyering skills as part of building cross-cultural competence. See Bryant, *supra* note 83, at 41–42. **R**

⁹⁹ Katz & Haldar, *supra* note 7, at 370–72.

quires 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

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.*

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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

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-AttorneyClient-Relationships-and-Collaborations-1.pdf>.

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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

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*, SAMSHA, <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

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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

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

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.

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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

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.*

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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.

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.

1. *Philosophical Framework*

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

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.

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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

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.

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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*

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 decision-making. 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 rela-

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).

tionship. 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

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.

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.

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 ex-

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

plore 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

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).

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 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 envi-

¹⁵⁴ White-Domain, *supra* note 103.

¹⁵⁵ *Id.*

ronment 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

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 profes-

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 de-escalate 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

sional 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)).

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client who has experienced trauma.¹⁶⁴

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

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; Gillece, *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”).

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

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.

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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-in-

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).

formed 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

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).

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.

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 health-care 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.

