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COMPASSION FATIGUE

Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized

Edited by

Charles R. Figley, Ph.D.

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Preventing Compassion Fatigue: A Team Treatment Model

JAMES F. MUNROE, JONATHAN SHAY, LISA FISHER, CHRISTINE MAKARY, KATHRYN RAPPERPORT, and ROSE ZIMERING

Social support has been identified as a source of significant psychological benefit for trauma survivors (Keane, Scott, Chavoya, Lamparski, & Fairbanks, 1985), and a team approach can provide similar support for mental health professionals working with these clients. More important, a team also can provide, on a regular basis, active intervention in the prevention of secondary traumatization. The ideas presented here are derived primarily from work with Vietnam combat veterans, but our experience suggests that the concepts and practices have applicability to therapists working with other survivor populations. For therapists who do not have a team available, attention is paid to building preventive alliances.

Editor's Note: There are a number of outpatient treatment teams that work with traumatized people. In this chapter, such a team describes some important methods it has perfected for teams to work together to identify, prevent, and treat secondary traumatic stress disorder among team members and other colleagues. Similar to the other chapters in this volume, the authors suggest that secondary trauma in therapists parallels that of primary trauma, and the intensity and duration of their exposure to traumatized clients are seen as predictive of responses.

THE EXISTENCE OF SECONDARY TRAUMA

As the field of trauma has grown, it has become increasingly apparent that the effects of traumatic events go beyond those who directly experience them. Secondary trauma refers to effects in people who care for, or are involved with, those who have been directly traumatized. Solomon (1990) found that wives of Israeli veterans with post-traumatic stress disorder (PTSD) suffered from increased psychiatric symptomatology, somatic complaints, and loneliness. Others (Eth & Pynoos, 1985; Pynoos & Nader, 1988) noted that the symptoms that appear in traumatized children are contagious to nontraumatized children who play with them. Figley (1988) wrote about the "deleterious effects on family members exposed to a traumatized member," identifying them as "families of catastrophe," and Van der Ploeg and Kleijn (1989) identified the families of hostage victims as additional "victims in need of professional care." Utterback and Caldwell (1989) found that "debilitating symptoms may be seen in some friends, family members, or bystanders who did not experience the trauma per se." The effects of secondary trauma also have been described in family members who had not yet been born when the events occurred (Danieli, 1985; Figley, 1988; Milgram, 1990; Nagata, 1990).

The literature provides evidence that working with trauma survivors has debilitating effects on therapists. Some have described these effects as burnout (Doyle & Bauer, 1989), many have applied the concept of countertransference (Haley, 1974; Schwartz, 1984), and others have described the work as exhausting (Egendorf, Kadusin, Laufer, Rothbert, & Sloan, 1981) or challenging to the therapist's affect tolerance (Herman, 1988). McFarland (1986) notes that the emotional impact of disaster on research workers could interfere with their objectivity, and that these workers experienced a feeling of threat that "had little to do with their actual experience." Danieli (1984) notes that therapists dealing with Holocaust survivors reported "sharing the nightmares of the survivors they were treating." Langer (1987) identifies his experience of nightmares similar to those of his prisoner-of-war clients as "a kind of derivative neurosis." Herman (1988, 1992a) suggests that PTSD could be viewed as contagious, requiring precautions for the protection of therapists. Mollica (1988) states that therapists become infected with their clients' hopelessness, and McCann and Pearlman (1990) say that, through vicarious traumatization, "therapists may find themselves experiencing PTSD symptoms."

One of the best predictors of symptom development in traumatized individuals is the intensity and duration of exposure (Gleser, Green, &

Winget, 1981; Hartsough, 1988; Kolb, 1988), and several authors have posited a cumulative effect of traumatic experiences (Abse, 1984; Kolb, 1988; Scurfield, 1985). It seems reasonable to assume that these factors will be related to secondary trauma as well. Munroe (1991) studied therapists and found responses of intrusiveness and withdrawal that were significantly related to their exposure to combat PTSD clients. Therapists were not protected by age or experience. This study also demonstrated that these responses were distinct from burnout, as suggested by McCann and Pearlman (1990).

These findings imply that therapists dealing with PTSD are at risk with regard to secondary trauma, and this evidence further suggests an ethical duty to warn and prepare clinicians for what can be considered an occupational hazard. The question as to the level at which secondary trauma becomes an impairing therapist condition that compromises the quality of services to clients also must be raised. The ethical codes of all professional mental health workers require that corrective action be taken if a worker is impaired. Determining appropriate actions for preventing secondary trauma requires an understanding of how the therapist is traumatized.

THE NATURE OF SECONDARY TRAUMA

It seems reasonable to assume that the process of secondary trauma is similar to that of primary trauma, and that existing theoretical models can shed light on that process. Erikson (1963, 1967) has described the capacity for basic trust as the human's first developmental achievement in the social world, the foundation upon which all subsequent developmental accomplishments rest. He describes the child as receiving from the parents "a firm sense of personal trustworthiness within the trusted framework of their community's lifestyle." The parents also communicate "a deep, almost somatic conviction that there is meaning to what they are doing," and a belief in "Fate's store of good intentions." Traumatic events that shatter trust can be seen in key concepts related to trauma, such as shattered assumptions (Janoff-Bulman, 1992), disrupted schemas (McCann & Pearlman, 1991), a lost sense of invulnerability (Lifton, 1979), and loss of community (Erikson, 1976; Lifton, 1979).

An event can be defined as traumatic to the degree to which it violates the sense of basic trust. Behavior is then altered to be functional in a world that is based on an expectation of exploitation rather than a sense of basic trust (Munroe, 1991; Munroe, Fisher, Shay, Wattenberg,

Makary, Keefe, Cooks, & Rapperport, 1990a). In clinical work, secondary trauma involves a violation of the therapist's sense of basic trust, where the therapist's assumptions are undermined or shattered. As assumptions are undermined, the behavior of the therapist is likely to be altered as well. Secondary trauma occurs not only by being exposed to the clients' trauma material (McCann & Pearlman, 1990), but also by being engaged to participate in reenactments of the themes and relationships inherent in the clients' trauma.

THE PREVENTION MODEL

Like direct trauma, then, secondary trauma violates trust, severs connections to community, and destroys meaning. Thus a treatment team can serve as a community to prevent secondary trauma in therapists. The primary function of the team is to identify and alter trauma engagement patterns. The therapist who is engaged is often not aware that he or she is being engaged. But even the therapist who is aware of being engaged may find it extremely difficult to find a way out. Like the survivor whose world view has been narrowed by trauma, the therapist's perception becomes narrowed by secondary trauma. The therapist who is engaged behaves within the patterns generated by the client, and sees few options for relating in other ways. The team supplies those other options through discussion with the therapist or direct involvement in the case. The treatment team that expects secondary trauma on a regular basis is in a unique position to recognize emotional and behavioral responses of therapists that signal engagement. The team can support or confront the engaged therapist as necessary.

As a therapist is being engaged in client reenactments, the team also maintains relationship patterns that provide support and promote trust. These nonexploitative relationships serve as a counterpart to the isolating effects of secondary trauma. A trusting community, or team, also values its members and attends to their well-being, which is a direct challenge to the trauma world view.

Although therapists may belong to communities outside their workplaces, the most effective place for a preventive community is the work site where secondary traumatization takes place. The greater the exposure to trauma clients, the greater will be the need for a treatment team. The program described here illustrates the functioning of such a team. The concepts and practices of the team, however, can be applied to other client populations and treatment situations where teams are not readily available.

THE VETERANS' IMPROVEMENT PROGRAM

The Veterans' Improvement Program (VIP) offers long-term intensive outpatient treatment, centered on group therapy within a milieu and supported by a behavioral point system to maintain good standing in the therapeutic community. Veterans participate in several group therapies a week, and most engage in pharmacotherapy and individual psychotherapy. There is also an emphasis on family involvement, including family therapy. Additional therapy modalities and special events are employed as the opportunity arises. Each veteran has therapeutic relationships with various members of the team, and efforts are made to consolidate all therapy within the program.

The Client Population

The program provides treatment for Vietnam combat veterans diagnosed with PTSD. Most have severe trauma histories, such as multiple combat tours, and many have additional trauma histories from both before and after their military service. A smaller section of the program directly addresses childhood physical and sexual abuse. Herman (1992a, 1992b) argues that the current diagnosis of PTSD is derived from a single circumscribed traumatic event, and describes a complex form of PTSD that involves prolonged, repeated trauma under conditions of captivity. These veterans fit Herman's description well in that they suffer from the severe, disabling, and often life-threatening sequelae of prolonged, repeated trauma under conditions from which escape was impossible. This is further complicated because the role of combat veteran includes being a perpetrator as well as a victim of violence. Veterans referred to the program are severely disabled in most aspects of their daily lives and are frequently seen as poor treatment candidates who are disruptive to programs. Working with such a population presents a high risk of secondary trauma.

The Treatment Team

The team consists of six primary members who devote varying degrees of their time to the program. Members include a full-time clinical director from the psychology service, a half-time psychiatry resident, a quarter-time psychiatrist, a quarter-time clinical psychologist, and a three-quarter-time master's-level counselor. The assistant chief of the psychology service is also an active team member, but with limited time. Each team member has professional contacts with other survivor popu-

lations in addition to those in the program. The team members have different levels and types of training, as well as different ideas about and approaches to the treatment of trauma. Team members also have differing roles within the power structures and hierarchies of the institutional setting. At any given time, three to six psychology interns or trainees also are part of the team. Over the past 11 years, we have developed the team model in response to the treatment needs of the population and the psychological survival needs of the staff. We hold three tenets regarding the team's functioning and secondary trauma.

The first tenet is the acceptance of the reality of secondary trauma, including an understanding and expectation that each team member will be affected by the work we do with traumatized veterans on an ongoing basis. This is not an issue that is ever resolved, and no team member is assumed to have any immunity or special status with regard to being affected. It is assumed that on any given day or with any given case, each team member will vary in the degree to which he or she is affected.

The second tenet is that these therapist responses be regarded as a natural and valuable process rather than as a deficiency on the part of team members. Such responses of team members to any given client or situation are assumed to be significant clinical information. This is especially true where therapist responses are different or contradictory. It is also assumed that therapist responses such as vague feelings or dreams are personally valid and clinically relevant.

The third tenet of team functioning is the assumption that each team member can be an accurate observer of how other team members are personally responding to secondary trauma, and how such responses influence treatment interventions. Team members not only have permission to verbalize these observations, but also have the responsibility to do so. This assumption means that the observations or opinions of any team member concerning any other team member have validity regardless of differences in training, discipline, power, or institutional role. Team members must learn to trust and listen to one another.

Therapist Background

It is not necessary to assume any prior unresolved conflicts in the personality of the therapist for him or her to be affected by the processes of secondary traumatization. The therapist, like the client, however, does not exist in a vacuum. He or she may have conflicts that are amplified by the work, or may have a trauma history of his or her own. A trauma history is not be seen as a detriment to the thera-

pist's ability to function or as a susceptibility to secondary trauma. A therapist who has worked through his or her own healing process has a distinct advantage in understanding the client and being able to model healing. If there is an unacknowledged trauma history, however, it appears that the processes of secondary traumatization exacerbate responses. Trauma therapists require an ongoing process of monitoring their responses. The question of why the therapist chooses to do trauma work is pertinent because the therapist is a participant and always has patterns of his or her own.

COMMUNITY AS PREVENTION OF SECONDARY TRAUMA

Erikson's concept of basic trust is employed above to understand the effects of trauma, but it is also useful for conceptualizing a prevention model. Healing from trauma, or, in this case, preventing secondary trauma, involves strengthening social networks. The team functions as a social network for the therapist and provides a community in which the secondary trauma experience can be worked through. This is accomplished through validation of feelings and provision of valued relationships.

A community absorbs the traumatic experience of an individual by diffusing its effects among many people and demonstrating that the survivor's feelings are understood. Absorbing can be seen at a wake, where people come together to mourn the loss of someone cared for and to support those closest to the deceased. The wake validates the feelings of those directly traumatized, through others who express or demonstrate similar feelings. The survivors are also actively included in the social network of those who attend. Similarly, the team can validate the feelings of the therapist as he or she is exposed to trauma material or reenactments.

The community that validates the survivor and continues to include him or her as a valued member provides roles and relationship patterns that are not repetitions of the trauma. A team that validates the therapist's responses to secondary trauma can continue to include that therapist in professional healing relationships. A community that organizes and rebuilds after a disaster provides valued roles for its members. Such efforts can strengthen community trust and reaffirm for the traumatized individual "a deep, an almost somatic conviction that there is a meaning to what they are doing" (Erikson, 1967). The team provides a complementary function that enables the therapist to maintain the valued role of a healer.

FAMILY FUNCTIONS OF THE TEAM

The therapist's role as a healer caring for a client is in some ways similar to the role of a parent caring for a child. When one parent is a primary caregiver, the other plays a complementary role. For the therapist who is a primary caregiver for a client, the team can fulfill the complementary role. In his book on raising a psychologically healthy child, Winnicott (1964) identified three different ways in which the complement to the primary caregiver is valuable:

1. Helping the primary caregiver feel well cared for and providing a sense of social security and hope for the future.
2. Supporting the authority of the primary caregiver while allowing for splits that do not destroy anyone concerned.
3. Enriching the life of the one receiving care through the personal qualities, ideals, knowledge, and liveliness of the other.

Each of these benefits can also be gained from a supportive team. The dependence of the primary caregiver on others for their personal qualities not only provides a great deal of support for the therapist, but also models and invites a variety of healthy patterns of engagement. The sense that others will provide additional enrichment relieves the primary caregiver of the pressure to be more than is humanly possible, expands his or her role options, and allows him or her to be more comfortable with "not knowing."

In *A Good Enough Parent*, Bettleheim (1988) emphasizes the importance of a team approach, as well as the importance of just being good enough. He discourages efforts to become perfect, along with expectations that others be perfect. "Perfection is not within the grasp of ordinary human beings. Efforts to attain it typically interfere with that lenient response to the imperfections of others...which alone makes good human relations possible." Bettleheim focuses on the benefits to the one receiving care, but he also recognizes the difficulty of providing care in an environment in which caregivers are not supported, and are often blamed for any bad outcome associated with their work. When working with a population that tends to act out, the lack of support for therapists can be especially devastating. The complementary and supportive functions of the team become increasingly important as the engagement pressures of secondary trauma accumulate.

SPLITTING

Splitting is probably familiar to anyone who has worked with severely traumatized clients, although it is usually identified as symptomatic of borderlines (Kernberg, 1975). Gabbard (1989) summarized numerous views on splitting and described both intrapsychic and interpersonal splitting in borderlines. The interpersonal component includes projective identification in which the staff members treating a client unconsciously identify with the client's issues and begin to feel or behave accordingly (Ogden, 1979). Stanton and Schwartz (1954) describe the intensity of staff and client involvement in splits as pathological excitement. Splitting is directly relevant to secondary trauma in that splits involve interactive situations in which engagement patterns are acted out. Splits are important to the trauma therapist because of the intense personal involvement generated. Staff members become direct participants in engagement patterns as the splits unfold.

A split is the presence of an unacknowledged disagreement, negative emotion, or adverse value judgment among staff members that is amplified by clients. These often occur along lines of existing staff tensions, such as differences in theoretical orientation, discipline, experience, age, sex, race, or power. Any staff team will have conflicts that are accidently discovered or actively exploited by clients. If sufficient conflict does not exist, trauma clients may attempt to engineer them because splits are functional to survival in at least two ways.

The primary function of a split for the survivor is that it tests the trustworthiness of the community—or, in this case, the treatment team. Because trauma survivors do not trust, by definition, they will not accept a community without convincing evidence of trustworthiness. (They may sometimes blindly overtrust in a test that is bound to fail and prove untrustworthiness.) Survivors can generate splits by giving conflicting information to different staff members or by singling out certain staff members as good or bad. Staff members can become enmeshed in these splits, and amplify and stimulate them as well. Splits generate a parallel process of mistrust that can be initiated or exacerbated from either side. Splits also test the trustworthiness of the community of clients and staff by involving those outside, such as clinic administrators or family members of the clients.

The secondary function of a split is that if the tested community proves to be untrustworthy as expected, the survivor can exploit the side in the split that is most functional to serving his or her own immediate needs. When the world is perceived as hostile and untrustworthy, attending to one's own basic needs becomes necessary for survival.

Exploiting a split to meet one's needs is a survival tactic that people who have been traumatized seem to learn well.

Splits generated or amplified by clients are based on the patterns of relating that embody their trauma experience and world view. Splits become a stage for the reenactment of the themes of the trauma. A disagreement between an administrator and a therapist may replicate for a veteran the experience of a rear-echelon command to a field officer who has more knowledge of the immediate combat conditions. Does the field commander trust the wisdom of the higher command? Does the higher command listen to the field officer's input? Will the soldier live or die as a result of how authorities handle the situation? For a veteran, a split within the team may replicate the indecision of leaders during a firefight that resulted in comrades' being killed or wounded. Splits can be terrifying threats to the very existence of survivors, and their responses can generate intense countertransference in therapists. Community decisions may be more influenced by conflicts between individuals or subgroups than by the well-being of community members. Survivors are keenly aware of splits because their own well-being depends on how splits influence decisions. A split on a treatment team may be perceived by a survivor who depends on that team as a direct threat to his or her existence. The most dangerous characteristic of a split is its covert or unacknowledged nature, because it cannot be directly addressed or resolved. A split that is overt loses a great deal of its destructive power in that it can be openly discussed, and its influence on decisions can be minimized. The survivors' amplification approach serves either to speed the process to a disastrous conclusion or to force it into the open.

Attempted split amplification by survivors will frequently take the form of overt challenges to treatment plans, rules, or authority of any kind. The competence or integrity of a staff member may be challenged. These provocations can easily disrupt the treatment team's ability to attend to the business of prevention or treatment. Such behaviors by clients, frequently seen as symptoms or acting out, may be viewed as tests of the trustworthiness of a community.

Therapists who are involved in splits are being secondarily traumatized by being actively engaged as participants in reenactments of the survivors' traumatic experiences. Their sense of trust in the professional community is being undermined in the process. Therapists end up more isolated and their collective resources are depleted. The prevention of secondary trauma associated with splits lies in the ability to acknowledge them and deal openly with them. This requires a good deal of trust and communication among treatment team members. The goal in prevention is not to avoid or resolve splits completely, but to be able to

struggle with them openly. The effectiveness of a team in struggling through splits is that those members who are less engaged can identify the splits and recognize how treatment decisions are influenced by them. Team members diffuse splits by taking on involved roles in which they do not take sides in the conflict.

The ability to acknowledge and deal with splits also allows survivors to begin to trust the community. If splits or attempted splits can be seen as tests of trust, a unique opportunity is available to work directly on influencing the survivors' world view. Working through splits requires that team members relate in cooperative rather than exploitative ways, and therefore model trusting relationships for survivors. The prevention of secondary trauma from splits coincides with the effective treatment of survivors.

PATTERNS OF TRAUMA ENGAGEMENT

Splits, reenactments, challenges, parallel processes, transference, and countertransference all relate to the patterns of engagement that embody the trauma experience. Each individual's patterns of engagement will be unique to his or her traumatic experience. Recognizing the client's patterns can be an avenue to identifying the specific aspects of trauma that need to be addressed in treatment. More important, with regard to secondary trauma, the therapist can recognize and use the patterns to determine how he or she is being engaged to reenact the trauma theme. Awareness can help minimize the effects of secondary trauma by affording the therapist more control and insight into the process.

Exploiter/Exploited

Perhaps the most basic pattern in trauma perpetrated by humans is the theme of exploiter and exploited, which is also experienced as perpetrator and victim. The therapist is frequently accused of being "just like all the others" who abused the survivor, or an intern is accused of "only wanting to learn from us." Efforts to help the client talk about traumatic events in a session may be interpreted as the therapist's attempt to retraumatize the client. If the therapist changes approaches, the client may then accuse him or her of denying the reality of the client's experience. The client may also put the therapist in the position of the exploited by missing or rescheduling appointments or by demanding letters to avert some crisis. The client may call at night or during weekends and vacations, or save highly charged material for the last five minutes of a session. He or she may try

to get the therapist to intervene in situations that are outside the boundaries of therapy, such as talking to a landlord to whom the client owes back rent. In either role, exploiter or exploited, the therapist has confirmed the theme that relationships are based on exploitation.

Allies/Enemies

Another, closely related pattern that is common among combat veterans is that of allies and enemies. In this pattern, the veteran essentially forces the therapist to choose between these roles. The veteran will usually communicate some variation of the idea that if the therapist is not completely with him, then he or she must be completely against him. These are the only options. Therapists are not usually comfortable in the position of enemy when they are trying to help a client. Discomfort with the enemy role can result in the therapist's not challenging or disagreeing with the client, even when he or she should, to avoid being identified as an enemy. A therapist can just as easily be derailed by being cast as an ally. The ally is in the position of the idealized therapist in which the therapist is the only one who understands. The idealized therapist is on a pedestal, and it is tempting to dilute the difficulties of therapy in order to stay on the pedestal. The enemy position clearly replicates the combat situation, but the ally position does the same, since the alliance is against some enemy. The war goes on.

Aggressor/Aggressee

Closely related is the aggressor and aggressee pattern. This pattern is prominent in those who have experienced a world based on violence and intimidation. They attempt to influence the therapist through direct intimidation or threats, although actual physical violence may be rare. It is more significant that everyday transactions are framed in the context of threats, either overt or veiled. We would hope that it is even more rare that the therapist takes a role involving physical violence and intimidation, but it is easy to become accustomed to the survivor's style and therapists might fail to challenge clients' threats to themselves or others. For example, a veteran who reports getting his way in a store by threatening a clerk and notices that this elicits a chuckle from the therapist, will draw the conclusion that the therapist agrees that the world is a hostile environment in which violence is necessary. The survivor may frequently present the therapist with "what if" situations and ask how the therapist would handle things. These are usually violent situations that reflect experiences of the client. They are designed to get the thera-

pist to agree that the situation calls for violence, and any answer to the forced situation will probably result in the therapist's getting caught in one of those uncomfortable dilemmas.

Rescuer/Rescuee

A most important, and potentially dangerous, pattern is that of rescuer and rescuee. Therapists are particularly prone to becoming caught in this pattern because of their desire to help. Relationships with clients are often begun as a result of some crisis or emergency, and the therapist is immediately cast in the role of rescuer. The danger is that crisis may become the only basis of the relationship. The client who shows up only in crisis, then disengages from treatment, has established a pattern that will negate any therapeutic change. The need to be rescued and the related behavior of the rescuer confirm each time that the world is a hostile place. The role of rescuee is particularly dangerous because of the need of escalating emergencies to mobilize rescuers. It can lead to risky and suicidal behavior. The rescue pattern replicates many of the situations of combat, and the relationships surrounding rescues become a substitute for intimacy. The intensity of a rescue creates a strong bond between the parties, but it is one that fades as soon as the crisis passes. Many survivors have established families or relationships that are crisis-bound, in that they need a crisis for them to pull together, and then they drift apart until the next crisis. Such relationships are based on a contract of, "If you love me, you will rescue me, and I will prove I love you by rescuing you." The therapist who is engaged in a pattern of rescue is subverting the establishment of relationships based on trust. The client may quickly respond to any situation in which a rescue operation can be performed for a therapist. Such opportunities may arise out of splits when the client tries to come to the therapist's aid. Being rescued, of course, replicates the rescue theme, and the therapist should realize that it is time to address this openly.

An important variation of the rescue theme is the Lone Ranger pattern. This is seen in therapists and is a parallel of the John Wayne pattern for combat veterans. The Lone Ranger therapist is enlisted to fight the bad guys, single-handedly, for the good of the client. This is an attractive image in our culture, but it should be noted that the Lone Ranger is fighting a hostile world, and that he is not part of a community, but is alone. The Lone Ranger therapist may be verbalizing appropriate therapy, but he or she is modeling a traumatized world view. (The legend of the Lone Ranger is significant in that he was the sole survivor of company of rangers who were massacred. It is not surprising that a

traumatized world view is modeled.) Being part of a team is a very useful protection against becoming a lone ranger, but the attraction of the role is powerful. Any therapist who works alone, or frequently feels alone in therapy, may be easily engaged in this pattern. Any therapist who thinks that he or she can recognize and respond to engagements without the input of others is at risk of being a lone ranger.

There are many variations on these patterns, and probably many others that need to be identified. Although engaging in these patterns may challenge the therapist's sense of trust, on some level, this may be the only way to begin a relationship with someone who has been traumatized to the point that he or she has no other basis on which to relate.

PATTERNS OF COOPERATION AND TRUST

For the therapist who is engaged in having his or her world view challenged and trust undermined, the effects of secondary trauma may soon follow. Engagement in the patterns will also produce an increasing amount of affect in the therapist, with alternate periods of numbing and withdrawal. The primary functions of the team in addressing secondary trauma are (1) validating the affect, (2) identifying the trauma patterns, and (3) proposing healthy alternative patterns that restore trust.

The generation of healthy alternative patterns will be specific to the situation, but some general approaches can be identified. The therapist must be keenly sensitive to ensuring that relationships with clients are cooperative, not exploitative. Nonexploitative relationships should involve looking out for the best interests of both parties and including others in the work. It is not unusual for therapists to allow themselves to be abused in small ways for some perceived good of the client. These situations can be openly identified so that either party has an option to refuse his or her role. Ally and enemy roles are most easily defused by direct and open communication. When a client identifies an enemy to a therapist, the therapist can suggest that they both talk to the enemy. Even if the client declines, the therapist can go ahead with establishing a cooperative relationship with the identified enemy in full view of the client.

Aggressive relationships are best diffused by including others in the community who are not directly threatened. Rescue relationships are replaced by prediction and planning as a regular and ongoing part of treatment. Crisis defusing is an approach in which the team works with the client to anticipate and plan for the crisis cycle so that rescues are minimized. Using the input of the team is the best overall way to identify healthy patterns that do not replicate the trauma.

It is important to note that clients are aware of the process of secondary traumatization. They will screen the amount of material they bring to the session to protect the therapist from becoming disabled (Munroe, Makary, & Rappaport, 1990). The team not only provides a healing environment for the therapists, but relieves the client of the burden of protecting the therapist. It is not uncommon for clients to ask the therapist if he or she is enlisting the support of the team when the content of sessions becomes intense. If a survivor knows that the therapist has support, he or she can attend to therapy rather than concentrate on being the therapist's rescuer.

Clients may be much less aware of the patterns since these embody basic assumptions that have been established through the experience of trauma. For them, this is simply the way the world is. The team addresses patterns in two ways. It can assist any team member to realize what patterns are operating, and it can offer suggestions to alter the therapist's responses. The team can also directly involve other therapists who have varying relationships with the client. Multiple therapists offer multiple patterns that provide alternative world views to the client. Even if the client resists all of these, the therapist has modeled a pattern of trust in a community by enlisting the team while disengaging from the client's pattern. Enlisting the team not only helps the therapist, but is a powerful intervention to demonstrate trust to the client. The power of such a move by the therapist may lie in the action taken. Trauma clients attend to what therapists do, not necessarily to what they say.

Survivors often have been exploited by words as a part of their trauma, and though words are a comfortable medium for therapists, clients may respond more to their behaviors. The therapist who uses the team as a trusted community when faced with secondary trauma behaviorally demonstrates a coping process. The team is a preventive environment for therapists, who can generate a parallel process for the clients.

EXAMPLES

The following examples illustrate some of the processes of secondary traumatization. Each involves patterns of engagement in clinical work. Several patterns may be operating simultaneously, and the reader is invited to note patterns in addition to those identified. Any one of the patterns exemplified could be disruptive for a therapist, but the accumulation of such exposure increases the likelihood that the therapist will begin to show the effects of secondary trauma.

The Rescuer

Therapist A had been client X's individual therapist for several years. They had established close ties and client X had said that he really trusted and counted on this therapist. Increasingly over the past several years, client X had called therapist A when on drinking binges. At these times, he threatened suicide. These were not idle threats, as he had made several serious suicide attempts.

The most recent call came one morning before a staff meeting. The therapist asked another team member to cover a group because he had to go out and find client X, who had told him that he had a gun and that life was no longer worth living. Therapist A left before the team member could respond.

When therapist A returned to a team meeting that afternoon, he was confronted by the team about his rescue mission. He angrily replied, "I was out saving a man's life. What were you doing?" The team then asked him to describe more of his feelings. He said he felt alone and responsible for this client. The team pointed out that the therapist's feelings and behaviors mirrored some of the client's experience in Vietnam, and that he was reinforcing rather than changing the client's behavior. The team was then able to work out emergency plans. Other team members took on increased responsibility for the client. A plan in which the police and the hospital would be notified was drawn up. Finally, the client was asked to meet with the team and was informed of the new procedures and of how the team would respond.

When the client, intoxicated and suicidal, again called the therapist, the new plan was carried out. The call was a test of the rescue role and the new plan. The team then joined the hospital in insisting on inpatient alcohol treatment. The drinking, and suicide–rescue pattern, eventually stopped. The therapist reported feelings of relief, support, and empowerment.

Allies and Enemies

When the program was threatened with cutbacks that made effective operation very difficult, the veterans were furious that the government was treating them unfairly again. Several team members reacted by becoming angry at and suspicious of all authority. They felt that no one outside the team could be trusted, and several plans for the team members to join with the veterans to fight the system were suggested. Some of the team members, however, began to express concern about this suspiciousness and identification. It was pointed out that the team was behaving as if the administration were an enemy. The team reevaluated

its position. When the team returned to a more therapeutic stance, the veterans took the lead and successfully and peacefully advocated for the program's continuation.

Therapist Response to Trauma Material

Therapist B, a female clinician in a mental health clinic, found that her caseload increasingly included women who had been traumatized by rape or domestic battering. Over time, she began to feel uneasy when walking in unattended parking lots or in her neighborhood at dusk. She became jittery when alone at night in her apartment. After several weeks of being nervous, she accepted a new female client, who reported the details of a recent brutal rape by an acquaintance.

Afterwards, therapist B began to withdraw from friends, skipped late-afternoon meetings in order to avoid going home after dark, and had difficulty sleeping, which resulted in occasional tardiness at work. When the team questioned her meeting attendance, she denied any problems.

Soon, therapist B consistently refused to accept new male clients, and the team recognized her behavior as indicative of a problem. The team members asked her if she were getting enough support for her work and encouraged her to talk about her feelings as associated with trauma work. One team member discussed his own experience of nightmares following sessions with a client. Through these discussions, necessary adjustments were made to her caseload, matters surrounding her own physical safety were discussed, and her reaction prompted a series of discussions about support for the effects of trauma work for all team members. Therapist B now feels less isolated and participates more in staff meetings.

A Split

Therapist C, a female team member, was the target of a sarcastic comment by one of the veterans in the program in the presence of other veterans. She interpreted the comment seriously and felt that the veteran was trying to intimidate her. When she brought her concerns before the team, a clear difference of opinion emerged. Two team members held the position that "you have to be tough to work with tough clients" and nonchalantly dismissed the issue. Other team members felt that this was a serious issue, which also had been raised by interns, who saw several veterans as being aggressive. One team member suggested that the team needed to examine how intimidation was endorsed and supported in the community's culture. The issue was still unresolved by the end of the meeting.

Therapist C felt that the two team members had challenged her competence to do trauma work because she was not tough enough. She was fearful of her safety with the client who had threatened her, but she said nothing because she did not want to risk further embarrassment. Therapist C felt very angry at the team members who dismissed the issue. (Fortunately, this split did not divide along lines of gender, professional discipline, race, or experience.)

Several days later, two team members from opposite sides of the issue were coleading a group. Friction was increasing in the group, and threatening remarks were directed toward the team member who had spoken against intimidation by patients in the program. After the group session, this team member became angry and berated the coleader for not trying to defuse the situation. The team explored this issue and recognized that toleration of the aggressiveness of combat veterans could be seen as promoting the behavior. The "get tough" attitude of some team members was identified as an engagement in a survivor pattern. One member connected the threat in the group to the comment made to therapist C, to which the team had not responded. Therapist C was able to express her feeling of being victimized by the other two team members, as well as by the veteran.

The team met with the veterans who had been threatening and identified their behavior as an inappropriate way of getting needs met. The team also took responsibility for any behavior or lack of behavior that may have condoned intimidation. The question of how both staff members and clients condone aggressiveness was then discussed openly in all of the group meetings. Intimidating behavior decreased, and both staff members and veterans expressed feelings of increased safety.

TEAM LIMITATIONS

The potential benefits that team participation can afford to therapists in preventing secondary trauma are numerous. These benefits promote strong feelings of loyalty to the team and solidarity among its members. These same positive forces, however, may become limitations, and, on occasion, have resulted in negative consequences. Team cohesiveness may lead to an unspoken desire for unanimity. The term *groupthink* has been used in social psychology's study of small-group behavior to illustrate the deterioration of function that may arise from in-group pressures (Janis, 1972). The team is susceptible to in-group pressure as the nature and intensity of the work fluctuate. Dangers include the development of stereotyped views of other groups, self-censorship of deviations

from group consensus, and the exclusion of information or persons not in accord with the group consensus.

The stereotypic response may be seen in a view that administration is insensitive or unresponsive to requests from the team. This can set up an "us against them" mentality that precludes accepting administrative behavior that goes against the stereotype. (This mentality provides a foundation in cultivating a split.)

An example of self-censorship on our team was noted when one member found herself surprised when she could not justify to a colleague outside of the team why she chose to continue seeing a patient despite his repeated no-shows and her own clinical guideline of three no-shows resulting in referral to another clinician. She was influenced by an unspoken team consensus that the veteran deserved another chance.

Team discussions of treatment interventions or solutions to problems frequently may be generated by alternatives that have worked previously. Persons with minority opinions or special knowledge may be discounted because of a subtle threat to group conformity. Although a team may outwardly value and ask for alternative opinions, there may exist a subtle and covert pressure to maintain unanimity. We have sometimes tested new members of the team in a pattern similar to how veterans test us, and we took very seriously a reference to the team as a cult. It is possible for an entire team to be engaged in a trauma pattern.

Team decisions may be slower and more cumbersome to reach than those made by an individual, but they are more effective in that they are less likely to be sabotaged or miscommunicated. There are times, however, when decisions may be made without the full team. This can easily lead to difficulties if the information is not adequately communicated and discussed as soon as possible.

PREVENTIVE TEAM PRACTICES

The ideas and concepts presented in this chapter are not specific to the program in which they were developed. The prevention of secondary trauma is dependent on the practices of the treatment team rather than the treatment setting, the program model, or the theoretical orientation. The practices described below rest on three primary assumptions: (1) no therapist is immune to the effects of secondary trauma, (2) prevention of secondary trauma lies in membership on a team, and (3) the higher the intensity of exposure to trauma work, the greater is the need for a team. Some basic structure is necessary for the team to enact the practices.

The existence of a community requires a minimum of three people so that alliances can be made, broken, and reformed within the ongoing unit. A team requires the minimum addition of a third party to the therapist–client dyad. The third party is another therapist who can observe and intervene in the engagements that occur. An optimal size might be five to eight team members, but the minimum requirement is that all members are in regular communication.

Our team meetings take two and a half hours a week to cover all administrative and clinical issues, including treatment planning with clients present at the team meeting. Our program is structured around the time when team meetings can take place, but the number or lengths of meetings are not of primary importance. Team meetings need to be regular, and all members must be able to attend. If this is taken seriously, part-time and temporary team members can be accommodated. The functioning of a team does not depend on the content of the program, the style of therapy, the treatment modalities, or the theoretical approach of the staff.

The practices are not considered rules that must be followed, but ideals to keep striving to meet. The goal is continually to keep the struggle of maintaining a functioning team alive, rather than to arrive at some fixed way of operating. The reader is encouraged to integrate the practices that follow into his or her own prevention plan.

Team members regularly pose questions about secondary traumatization that include: (1) How are team members being engaged? (2) How do they feel about it? (3) What will we do about it?

Therapist self-care is expected, and the team reminds members of this if they neglect this responsibility. Chapter 9 in this volume provides excellent information to enable therapists to meet this obligation. The team is not expected to fulfill all the supervisory and preventive needs of the therapist. Overwork is discouraged.

The feelings of team members are considered important. These include countertransference feeling around trauma material, feelings toward clients, and feelings aroused among team members. The last are essential to uncovering splits.

Team members give each other permission to, and accept the responsibility to, comment on behaviors and decisions that are relevant to treatment and secondary trauma. It is expected that this process will become extremely uncomfortable at times. Identifying engagements may require confrontation and courage. Splits contain highly emotional issues that must be faced when the nature of the split is acknowledged. The team must provide a safe environment in which to do this.

Each team member is respected in that all members are willing to be influenced by other members. It is assumed that any member's suggestions

have merit unless proved otherwise. Members can also bring up their own dreams and hunches as relevant. This respect is extended to other treatment providers as well. Other treatment providers can be included on the team temporarily, or their team can be joined in any given client situation.

The team does not grant privileges to some members to speak and others to be silent. Members with different degrees, training, or power are encouraged to struggle with each other. The weight of ideas is not determined by who presents them. Inequalities in speaking privileges allow splits to go unacknowledged.

Information on treatment or secondary trauma is shared, and confidentiality is seen as resting within the team. The therapeutic alliance is to the team rather than to an individual. More than one team member is always actively working with a client, and cotherapists are used whenever possible. Functional roles among team members are intentionally blurred and traded from time to time. Authority is considered to reside in the team rather than in any single individual, and the team as a whole operates as openly as possible. These practices maximize the possibility of a third party's being able to recognize a pattern of engagement.

Unique skills and abilities of members are recognized and utilized. Members are expected and encouraged to have outside interests and commitments. These promote regular disengagement from trauma patterns.

Diversity of thought is valued, and the team does not require agreement with regard to theories, models, techniques, or schools of thought. Different approaches may provide different ways to establish healthy relationship patterns.

Working with trauma can be an intensely disturbing experience. A sense of humor and playfulness are considered useful coping mechanisms for the team as a whole.

CONCLUSIONS

These practices identify approaches for the prevention of secondary trauma. Many of these practices can be viewed as simply good communication, but they become necessities when trying to identify and alter engagement patterns. Not all therapists will be comfortable operating in these ways, and some will be very difficult to reach when they are engaged in trauma patterns. Implementation of these practices may be met with resistance and denial; however, if no one is immune to secondary trauma, then active prevention should be the concern of all therapists working with survivors. A team that can continually refocus itself on prevention can produce more effective and longer lasting therapists.

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