Trauma and the Organization: Understanding and Addressing Secondary Trauma in a Trauma-Informed System

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Introduction

Working with traumatized clients impacts workers and organizations in complicated ways – both positive and negative. Secondary trauma, burnout, and compassion satisfaction are among the psychological responses reported by trauma workers. In this presentation, we explore the potential consequences of secondary trauma, burnout, and compassion satisfaction on client care, as well as the influence of organizational culture on worker wellness. To focus the discussion, we share preliminary findings from a recent survey conducted with domestic violence service providers in Texas and North Carolina. We also draw from workshop participants’ comments to help us explore the dynamics of these concepts within their own organizations.

The Organizational Context of Trauma Work

We think about the organization as the context for interactions between service providers and clients that lead to either healing or re-traumatization (see Diagram 1). We view the organization, service provider, and client as parts of an interconnected and mutually influencing system. When the relationships between service providers and clients with trauma histories are empowering and therapeutic, clients will experience healing. On the other hand, when the relationships between service providers and clients are coercive, triggering, or otherwise disempowering, clients may experience additional trauma within the service delivery setting (Harris & Fallot, 2001). While positive relationships between service providers and clients may be viewed as a cornerstone for healing, the organization plays a critical role in supporting or undermining these healing relationships. Indeed, organizational setting and culture strongly influence the nature of service provider-client interactions. For example, organizational policy dictates the types and amount of services a client may receive. Human service organizational culture has both visible and embedded features (Hasenfeld, 2010). Service providers are oriented and trained in organizational policies and procedures, but are also influenced by implicit cultural values that often determine
how narrowly or broadly policies and procedures are implemented. For example, organizations may have standard service criteria, but organizational culture may determine how much leeway service providers have or do not have in interpreting service guidelines. An organization with a flexible, responsive culture may allow service providers to function more autonomously than one with a rigid or bureaucratic orientation.

We recognize that organizational influences may not always be the overriding influence. The service providers’ skills and choices about how to function within the organization will also influence how the service is delivered. Service providers may choose to bend rules to act in the client’s best interest, or, conversely, may use their autonomy to be punitive. The client’s level of trauma, coping capacities, and supports clearly play a role in what services are needed and how receptive the client is to receiving the service.

In the following sections, we briefly review the impact of trauma on service providers and on the organization, and consider the possible impact on client services. We will draw on the responses of workshop participants to reinforce as well as extend the literature.
Impact on Service Providers

Trauma often affects how clients approach and experience potentially helpful services. Traumatized clients are often reluctant to engage, suspicious, vigilant, and may re-enact traumatic dynamics within their relationships (Pearlman & Saakvitne, 1995). In addition, they often present serious mental health and substance abuse issues, self-injury, and other complex problems (Harris & Fallot, 2001).

Working with traumatized clients and hearing traumatic material is inherently stressful (Coffey, Dugdill, & Tattersall, 2004; Lloyd, King, & Chenoweth, 2002). Service providers are also exposed to primary trauma in cases when clients or their partners are violent and threaten staff. Workshop participants reported numerous workplace challenges that increased their overall stress levels. These included:

- Difficulty leaving work behind at the end of the day/shift
- Lack of resources to do the work; i.e., expectation to do more with less, not enough time in the day
- Need for system change
- Struggling with service provider-client relationship dynamics; i.e., trying not to take over the client’s life, not being able to meet client expectations
- Exposure to secondary trauma, suicide, homicide, experiencing more trauma
- Feeling ineffective or powerless to help the client
- Not getting enough money
- Different philosophies between staff members, even in the same department

Exactly how these stressors impact service providers is an evolving question. Early conceptions of burnout were developed from a stress and strain model – the greater the stress, the more likely workers were to be worn out. Burnout was defined as “a prolonged response to chronic emotional and interpersonal stressors on the job...defined by the three dimensions of exhaustion, cynicism and inefficacy. . .” (Maslach, Schaufeli, & Leiter, 2001) with symptoms of guilt, avoidance or over-involvement with clients, poor boundaries, low energy, and/or depression.

There is considerable evidence that worker burnout occurs across both human service and other kinds of work. For example, Anderson found that 62% of experienced Child Protective Services (CPS) case workers surveyed exhibited signs of emotional exhaustion (Anderson, 2000). More recently, Siebert (2005) conducted a large randomized survey of social workers and found a current burnout rate of 39% and a lifetime rate of 75%.

In the 1990s, researchers began to examine the unique impact of trauma work and used the model of Post-Traumatic Stress to explain the stress and symptomology of helpers exposed to traumatic material in the workplace. These concepts included vicarious traumatization (Pearlman & McCann, 1997), and secondary trauma and compassion fatigue (Figley, 1995). All of these concepts share the assumption that the impact of traumatic material upon the service provider mimics what happens to those who are...
victims of primary trauma, although typically at a lower level of intensity. Symptoms vary and may include intrusive symptoms, such as flashbacks and nightmares, as well as numbing symptoms, such as depression and avoidance of clients.

Some research suggests that secondary traumatic responses are fairly common among exposed service providers. For example, Bride (2007) found that 70.2% of surveyed social workers had experienced at least one symptom of secondary trauma in the previous week and that 15.2% met the core criteria for a diagnosis of PTSD. Secondary trauma symptoms seem to increase with increased exposure to traumatized clients (Bober & Regehr, 2006; Chrestman, 1995; Kassam-Adams, 1994; Warren, Lee, & Saunders, 2003), although the evidence has not been consistent (Sabin-Farrell & Turpin, 2003).

Service providers’ risk for some symptoms may be greater than others. One research study found that counselors with increased exposure to traumatic material experienced higher levels of PTSD symptoms, but no significant changes in cognitive schema (Brady, Guy, Poelstra, & Brokaw, 1999). Therefore, service providers may experience certain types of distress, while their views and beliefs about the world may remain intact. Some researchers have found that service providers who have a personal history of trauma are more likely to experience difficulties (Schauben & Frazier, 1995; Pearlman & McIan, 1995), yet other research has not confirmed trauma history as a risk factor (Bober & Regehr, 2006). However, not all trauma histories are equal or affect individuals in the same manner. It may be that service providers with trauma histories who have had less opportunity to heal or have experienced more extensive or cumulative trauma may be at greater risk.

Trippany, Kress, and Wilcoxon (2004) have hypothesized an interactive relationship between burnout and secondary trauma/compassion fatigue. They argue that burnout is related to overload and develops over time, while compassion fatigue is related to specific traumatic cases and may emerge suddenly. Burnout symptoms are typically depressive, whereas symptoms of compassion fatigue may include both numbing and intrusive symptoms. Burnout may not lead to changes in fundamental beliefs as compassion fatigue does. However, both may result in physical, emotional, and behavioral symptoms and result in decline in quality of client care. Further, unrelieved compassion fatigue may lead to burnout.

The construct, compassion satisfaction, has emerged more recently to capture the positive aspects of trauma work. Service providers who experience compassion satisfaction are rewarded in their work by seeing clients heal, encountering client resilience, experiencing gratitude for their own life, learning how to handle life, feeling skilled, helpful, and hopeful about the healing process, as well as feeling connected to others (Stamm, 2005). Further qualitative work (Bell, 2003) indicates that service providers may employ strategies and resources that inoculate them from the worst symptoms of secondary trauma, including feeling competent about their coping, maintaining an objective motivation for their work, resolving their own personal traumas, drawing on early positive role models of coping, and having buffering personal beliefs. Our own recent research suggests that burnout, secondary traumatic stress, and
compassion satisfaction have unique relationships with worker and organizational characteristics (Kulkarni, Hartman, & Bell, in progress).

Interventions designed to reduce work stress, whether burnout or compassion fatigue, have primarily focused on individual self-care strategies (e.g., Lonne, 2003), such as exercise, meditation, healthy eating, increasing positive coping and time management skills, and engaging in supportive relationships, such as supervision. Interestingly, research exploring the associations between an array of individual coping strategies and work-related traumatic stress found no significant relationship between the therapists’ belief in the efficacy of certain coping activities (e.g., self-care activities, use of supervision, and leisure), the time that therapists actually engaged in the activities, and their traumatic stress scores (Bober & Regehr, 2006). Leiter and Maslach (2005) concluded after nearly 30 years of research that “burnout is not a problem of the people themselves, but of the social environment in which people work” (p. 18). Though individual self-care strategies may offer some benefit, these findings reinforce the importance of understanding and addressing organizational and workplace risk factors that lead to burnout and secondary traumatic stress.

**Organizational Strategies**

After researching burnout for many years, Dr. Christina Maslach and her colleague, Dr. Michael Leiter, concluded that burnout is not a specific function of the person or the organization, but rather the fit between the service providers’ individual needs and what the job and workplace offers. This conceptualization helps us understand the different experiences co-workers can have while working in essentially the same work environment. In their book, “Banishing Burnout” (2005), Leiter and Maslach identified the following mismatches at work that can lead to burnout: workload (having too much or too little work); control (either feeling out of control or being micromanaged); reward (too little money or recognition or too little intrinsic interest in the work); community (either too little or too much closeness and communication between co-workers); fairness (sense that assignments and rewards are distributed equitably or experiencing disrespect and discrimination); and values (feeling either in sync or out of sync with the organizations’ mission and values). Notably, perceptions about workload, control, reward, community, fairness, and values within in their organization may vary among co-workers – it is the subjective experience of these workplace characteristics that makes a difference.

Our own research findings support the view that mismatches are important in understanding burnout, secondary traumatic stress, and compassion satisfaction. We surveyed 250 domestic violence service providers and found that after adjusting for numerous individual, organizational, and environmental factors: 1) time spent in leisure and perceptions of workload were significantly related to burnout; 2) hours spent per week with domestic violence (DV) victims and perceptions of workload were significantly related to secondary traumatic stress; and 3) time spent in research/policy, having an ethnically and racially diverse workplace, having community leadership that understands DV, and perceptions about the congruence in values between self and the
organization were significantly related to compassion satisfaction (Kulkarni, Hartman, & Bell, in progress). Thus, the factors that increase risk and protection for workers are slightly different for each of these constructs.

Although this organizational research is based on the perceptions of individual service providers, other researchers have developed theory that suggests that organizations also possess a culture that can be shaped by the collective trauma that individuals and the organization as a whole has experienced.

**Organizations and Trauma**

Organizational culture is co-created by all members of the organization and has characteristics that are experienced by all organizational members. It is expressed in both visible and embedded ways in terms of policies and procedures, as well as expectations and norms. Highly mission-driven organizations, such as agencies that address domestic violence and sexual assault, have unique strengths that tend to characterize their organizational culture. They are often value and expertise-based, client-centered, relationally oriented, and committed to social change (Vivian & Hormann, 2002).

Unfortunately, the organizational culture of such entities is susceptible to traumatization in a number of ways. Organizations may be born out of trauma by actually being created in response to a high profile tragedy or community crisis. The organization may also be traumatized by external events, such as the firing of an executive director or staff lay-offs. Finally, organizations may become traumatized due to cumulative exposure to clients’ trauma.

Such organizations often function on the cutting edge of societal values, at times isolating them from the community and sometimes placing them in conflict with the political status quo. These organizations often develop a specific organizational culture that allows them to fulfill their mission with limited resources, sometimes in a hostile political environment. These organizations would not survive without a fervent commitment to their mission. However, as with traumatized individuals, the strategies that organizations engage in for survival may also impede their ability to adapt and grow.

According to Vivian and Hormann (2002), these “shadow” aspects of organizational culture can include: closed boundaries to outside organizations, conflict avoidance, reluctance to make decisions, reactivity, and demoralization. A traumatized organization can become isolated, exclusive, and rigid. Group cohesion can lead to a merging of identities, with no individual responsibility. As a result, there can be a suppression of conflict and unclear boundaries among staff. Without consensus, decisions are put off. Commitment to clients can lead to over-functioning and unrealistic expectations for staff. The difficulties in achieving a social change mandate can lead to a sense of failure and internalized guilt. Stress becomes contagious in the tight-knit group, resulting in reactivity rather than deliberate and rational decision
making. Shadow elements are typically unacknowledged and sometimes unconscious qualities within the organization because they are often incongruent with the organization’s cherished identity.

Organizations seeking to implement trauma-informed care systems must consider the impact of trauma upon organizational culture and acknowledge potential shadow elements that may be operating. The organizational culture of a trauma-informed system is defined as one in which maximizes “safety, trustworthiness, choice, collaboration, and empowerment” for all staff members (Fallot & Harris, 2009). Thus, we asked workshop participants to help us consider how organizational shadow elements might serve as barriers for organizations on the path to trauma-informed service delivery and how barriers might be overcome in order to achieve a deeper level of change. Below we summarize some of their responses.

Participants identified additional organizational “shadow” barriers associated with “cultural issues,” how leadership develops, reduced productivity because of inability to achieve consensus, fear of conflict, and resistance to change. For example, a participant whose agency focuses on Latinos reported that in Latino culture relationships are “super important.” However, in her organization the shadow side of “caring about relationships” was expressed in staff’s reluctance to follow rules, or be individually accountable. These tendencies were defended by organizational members because to act otherwise was against the “culture.”

Another participant described the shadow aspects of leadership in her mission-driven organization. In this case, individuals are propelled into organizational leadership when they or someone they love becomes a victim. Such a leader may not have the leadership skills that the organization requires, and the fact that his or her identity is so tied to the organization makes it challenging for them to leave that position. In this situation, everyone feels helpless, as there is no leadership.

Another participant described her agency’s attempts to balance feminist values about consensus with the accomplishment of tasks and goals in a timely manner. She stated: “we were not afraid of conflict, but talked things out too much.” In order to deal with this shadow, the organization eventually set up a true hierarchy, but allowed for consensus decision-making within the hierarchy.

A participating executive director described her organization’s efforts to constructively engage in conflict. Every Friday afternoon, staff has a designated session for conflict resolution and problem solving (CRAPS). Staff members reserve problems for the set aside time for conflict resolution. A lot of the staff also attended conflict resolution training. The introduction of these new skills changed the organizational culture by helping staff to be less fearful of conflict and more skillful in managing it.

Another participant identified the challenges of working in a multi-sited organization – each site with its own supervisory and management culture. The organization struggled to coalesce around an overarching mission while honoring the culture of each site. In
another example, participants described different professional philosophies contributing to organizational shadow elements.

Participants also mentioned resistance to change as a general barrier to innovation. One participant noted that staff members who identified problems were often rewarded by being charged with creating solutions and sometimes confronted with resistance and retaliation from co-workers uncomfortable with change. This dynamic resulted in staff reluctance to identify problems.

Participants also noted that reframing an issue could help an organization to move forward. As one participant offered, “When my organization began to look at commitment to work and our over-functioning in terms of amount of work we were requiring as a form of self-inflicted violence it began to change the culture.” Thus, despite the barriers to change that organizational shadows may create, some organizations are finding successful strategies to overcome barriers. These strategies reflected those identified in the literature, including: 1) naming the problem through acknowledgment of organizational shadow elements and the impact of trauma upon the organization; 2) promoting openness and healthy external relationships that bring information and energy into the organization; and 3) developing systems and structures to deal with tension, conflict, pressure, and stress for those who work for the organization (Hormann & Vivian, 2005).

**Organizational Prevention of Secondary Trauma**

In a trauma-informed service delivery system, the organization is committed to creating and maintaining a healthy work environment that is attentive to the effects of vicarious trauma (Pearlman & Saakvitne, 1995; Harris & Fallot, 2001). In 2003, we reviewed and highlighted organizational strategies designed to prevent secondary traumatization among service providers (Bell, Kulkarni, & Dalton, 2003). We identified seven key recommendations. First, the organizational culture should acknowledge both positive and negative impacts associated with working with trauma survivors. Second, to prevent burnout, service providers require a reasonable workload and, whenever possible, a workload that is diverse. A diverse workload can mitigate some of the risk service providers experience when they are continually exposed to traumatic material. Allowing staff members to explore varied professional interests and develop new skills in prevention, policy, and advocacy can be helpful, as well as balancing client caseloads in ways that are sensitive to worker stress. Third, service providers need a safe, comfortable, and private work environment that is secure for both staff and their clients. It may be helpful to allow staff members to personalize their spaces and bring objects from home, such as family photographs or objects from nature, which can help ground staff members and allow them to reconnect with non-traumatizing aspects of the world. Fourth, staff members greatly benefit from training, such as this conference, that provides specific information about the needs of trauma survivors and the potential impact of trauma on service providers. Having a framework for understanding personal and client reactions to trauma normalizes these responses, offers a non-blaming language, and provides additional resources for coping. Fifth, service providers often
need to break down the isolation associated with trauma through group support, whether offered from colleagues, supervision and/or therapy groups, or family and friends. Sixth, supervision should focus not only on work-related tasks and skills, but also provide a supportive, non-judgmental relationship for supervisees to express the range of reactions they may have to working with traumatic material. Finally, service providers who work with trauma survivors need encouragement and resources for self-care, including health insurance that provides access to mental health counseling, as well as opportunities for physical activity and healthy lifestyle. An organization’s investment in these resources may pay dividends in terms of reducing costly staff turnover and maintaining quality client care.

Impact of Work Stress on Clients

In summary, over the past thirty years, concerns about the impact of trauma and stress on service providers have grown. A compelling body of research has confirmed the impact of trauma and more general work stress on human service providers. This work stress has a large human and economic impact in terms of decreased job satisfaction, collaboration, and motivation (Coffey, Dugdill, & Tattersall, 2004; Gellis, 2002; Jaskyte, 2003; Lambert, Pasupuleti, Cluse-Tolar, Jennings, & Baker, 2006); increased staff turnover (Mor Barak, Nissly, & Levin, 2001; Nissly, Mor Barak, & Levin, 2005) and stress-related absences and disabilities (Schaufeli, Leiter, & Maslach, 2009).

To date, there has been very little research on the impact of work stress on job performance or client outcomes (Schaufeli, Leiter, & Maslach, 2009). Making a stronger empirical connection between the stress of service providers and client outcomes will provide a more powerful rationale for organizational investments to reduce workplace stress, especially trauma-related stress, in these hard financial times. This research is challenging in its complexity and will be expensive to conduct. However, findings from previous research suggest some interesting directions to explore (Kulkarni, Bell, & Rhodes, in press; Kulkarni, Bell, & Wylie, 2010).

For example, utilizing focus group data from national domestic violence hotline and domestic violence survivors, we identified and explored key characteristics that both groups associated with high quality services. Both groups emphasized the importance of services that provided empathy, supported empowerment, individualized care, and maintained ethical boundaries between service providers and clients (Kulkarni, Bell, & Rhodes, 2011). Significantly, these qualities tend to reflect the soft services that staff members provide. In addition, these service qualities reflect those relational aspects of service delivery that are most negatively affected by trauma.

Primary barriers to quality care were also identified in this study. These included: inadequate organizational resources, staff burn-out, lack of training, and poor integration with other community resources. At times, a particularly problematic dynamic emerged in the form of adversarial relationships between clients seeking services and service providers who viewed their jobs as “screening out” or “gate-keeping.” This dynamic noted by advocates and survivors emerges in a context of scarce
service resources. Unfortunately, such a dynamic has the effect of pitting advocates against survivors and reducing their ability to effectively advocate together for increased resources and services.

We created a hypothetical case scenario in order to help workshop participants more concretely explore the dilemmas that organizations face and capture the solutions they enacted. Below we share the case scenario, as well as key points from the discussion.

Case Scenario: Shelter A is a 40 bed shelter that serves a community of 500,000. With limited numbers of beds, the shelter is overcrowded, and staff must frequently turn down requests for shelter. The staff gets frustrated with having to intervene with disputes between residents. Because of financial difficulties, the shelter relies on volunteers for key shifts, and therefore “rules” are inconsistently reinforced. As a board member, you are tired of hearing negative things in the community.

You believe you have some dedicated staff members, but they are burning out and your services are far from trauma-informed. How will you go about creating change?

Participants identified the following recommendations in response to this case scenario.

- Have “trauma champions” – people who have attended trainings who can inspire others in the organization, keep the flame alive, and help move the agency in the direction you want
- Ask both staff and clients what they need – gather data and assess the situation
- Conduct community outreach and education about mission. Create a shared agenda between staff and clients.
- Reach out to other people and organizations in the community – invest in those relationships so that you can trust and rely on them to assist clients and to help you grow resources.
- Assess whether there are too many rules. Most advocates don’t get into the work to be rule enforcers. Determine the key requirements of the shelter and let go of details.
- Have a volunteer coordinator ensure that the rules and expectations are clear for all staff and volunteers.
- Appreciate that listening to callers and helping them problem-solve is a service. Don’t just say “there is no room at the shelter” and hang up. Even if you can’t provide the concrete service, you can at least be a link to other people who care about his person.

In summary, participants viewed the case scenario as realistic and connected to some of the challenges they faced in their own communities. Participants approached the case systemically and generated a number of useful suggestions about how to address the corrosive impact of secondary trauma upon clients, staff members, and the organization itself.
Next Steps

Research, as well as the practice experience of workshop participants, indicates that working with trauma survivors can be stressful and have both positive and negative impacts on service providers. While most prevention strategies focus on individual approaches, there is growing evidence that preventing such stress is most effectively done on an organizational level. There is a need for more evidence-based programs that address secondary trauma and research into the mechanisms of their effectiveness. Finally, research that examines the impact of service provider stress on the quality of client services is important in helping us to develop more effective trauma-informed systems of care.
References


