ORGANIZATIONAL STRESS AS A BARRIER TO TRAUMA-INFORMED SERVICE DELIVERY

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"The public mental health system is in shambles"
Dr. M. F. Hogan, October 29, 2002
Chairman's Cover Letter for the Interim Report
President's New Freedom Commission on Mental Health

INTRODUCTION

Frequently we think of service delivery in some abstract way, as if human emotions and human life experiences play little if any role in that "delivery" of services. The words themselves give rise to images of help being sent through a mail slot or dropped down the chimney like the legendary stork carrying a new baby. But clearly that is a rationalization we use, perhaps to protect our discourse from the messiness of all-too-human emotions.

In reality, services are delivered by people and the people who deliver these services are at any point in time, experiencing stressful events in their own lives, and a majority of them – given large epidemiological studies- will experience at least one traumatic event in their lifetime. It is the contention of this chapter that as a result of widespread exposure to acute and chronic stressors, there are organizational processes that run in parallel to the destructive processes that so influence the lives of the clients that these organizations serve. These parallel processes in individual organizations then interfere significantly with the ability of the current mental health system to address the actual needs of women with mental health and substance abuse problems, most of whom are likely to have also been exposed to childhood adversity and adult trauma (Bloom, 2002; Edwards, Holden, Felitti, & Anda, 2003; Goodman, Rosenberg, Mueser, & Drake, 1997; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

This chapter will discuss the dynamics of organizational stress using a paradigm derived from the study of traumatized and chronically stressed individuals and from the organizational development literature largely focused on the business community (Bloom, 1997; Bloom, 2006). The chapter will conclude with ideas about the implications of this paradigm for changes in service delivery to vulnerable populations.

TRAUMA-ORGANIZED SYSTEMS

We know from epidemiological studies, like the Adverse Experiences Study, that it is likely that large segments of the population will have had significant encounters with maltreatment, dysfunction, loss and violence as children and as adults (Felitti et al., 1998). As an illustration of this, in a recent training experience that involved staff members from residential programs for children, juvenile justice programs, community-based workers, public health professionals, and other clinicians working in the mental health care industry, participants did an anonymous activity calculating the group Adverse Childhood Experiences Score. Out of 78 people working in these social services, 33 had experienced psychological abuse at the hands of parents, 24 had been physically abused by parents, 22 had been sexually abused by someone as children, 33 had been emotionally neglected, 8 had been physically neglected, 32 had lived as a child with a household member who was a substance abuser, 29 had experience parental separation, 20 of them witnessed domestic violence directed at their mothers, and 14 of them had lived with a household member who was imprisoned.

These are the very same vulnerable human beings who come together to form organizations. As human beings combine their collective conscious – and unconscious – energies, a complex adaptive system emerges that has its own unique and often perplexing characteristics that cannot be understood or explained by understanding the individuals who comprise that organization (Senge, 1990). Organizations, like individuals, are vulnerable to the impact of repetitive or chronic stress and are vulnerable to the traumatic experiences that occur to and within institutions. When an individual becomes part of a group, his or her identity is expanded to include a group identity, and as a result, there is an on-going and interactive challenge of productively managing stress between the individuals within the organization and within an organization-as-a-whole (Carr, 2001; Ettin, Fidler, & Cohen, 1995).

Although there is an extensive body of knowledge in the organizational development and business management literature about the impact of stress on individuals and organizations, this impact has not yet been well described in the literature pertaining to social service or mental health service delivery (Bloom, 2006). Yet the sources of stress within organizations that serve the health, mental health, and social service needs of women are extensive. Numerous reports have declared that the system is now in a state of chronic crisis (Appelbaum, 2002; Bazelon Center for Mental Health Law, 2001; President's New Freedom Commission on Mental Health, 2003). The summarized version of these reports claims that, *"the overall infrastructure is under stress, and access to all levels of behavioral health care is affected"* (p.4) (National Association of Psychiatric Health Systems, 2003).

Just as the lives of people exposed to repetitive and chronic trauma, abuse, and maltreatment become organized around the traumatic experience, so too can entire systems become organized around the recurrent and severe stresses that accompany delivering services to women especially when there still exists vast social denial about the post-traumatic origins of so many mental health, substance abuse, and social problems (Bentovim, 1992). As a result complex interactions that we refer to as "parallel processes" often occur between traumatized clients, stressed staff, frustrated administrators and pressured

organizations that result in service delivery that often recapitulates the very experiences that have proven to be so toxic for the people we are supposed to treat.

PARALLEL PROCESS

The idea of parallel process has its origin in the psychoanalytic concept of transference and was developed conceptually by Searles in 1955 when he noted that the *"relationship between patient and therapist is often reflected in the relationship between therapist and supervisor"* (p. 135) (Searles, 1955). At a group level, the ideas of "collective disturbance" – a specific form of parallel process - were first explored by early sociological studies of mental hospitals (Caudill, 1958; Stanton & Schwartz, 1954). Since then, it has become more widely recognized that conflicts belonging at one location in a system are often displaced and enacted elsewhere because of a parallelism between the conflicts at the place of origin and the place of expression. As one investigator described it, "*When two or more systems – whether these consist of individuals, groups, or organizations – have significant relationships with one another, they tend to develop similar affects, cognition, and behaviors, which are defined as parallel processes* (p.13) (Smith, Simmons, & Thames, 1989).

This largely unconscious process sets up an interactive dynamic with results that are uncanny and disturbing. The clients bring their past history of traumatic experience into the mental health and social service sectors, consciously aware of certain specific goals but unconsciously struggling to defend against the pain, terror and loss of the past. They are greeted by individual service providers, subject to their own personal life experiences, who are more-or-less deeply embedded in entire systems that are under significant stress. Given what we know about exposure to childhood adversity and other forms of traumatic experience, the majority of service providers have experiences in their background that may be quite similar to the life histories of their clients, and that similarity may be more-or-less recognized and worked through.

PARALLEL PROCESSES BETWEEN CLIENTS AND STAFF

For many institutions the end result of this complex, interactive, and largely unconscious process is that the clients – children and adults – enter our systems of care, feeling *unsafe* and often engaging in behaviors that are dangerous to themselves or others. They are likely to have difficulty managing *anger* and *aggression*. They may feel *hopeless* and act *helpless*, even when they can make choices that will effectively change their situations, while at the same time this chronic *learned helplessness* may drive them to exert methods of control that become pathological. They are likely to be chronically *hyperaroused* and although they try to *control* their bodies and their minds, the methods used – such as substance use - are often problematic. They may have significant *memory problems* and may be chronically dissociating their memories and/or feelings, even under minor stress. They are likely therefore to have *fragmented* mental functions. These clients are not likely to have learned very good *communication* skills, nor can they easily engage in *conflict management* because of chronic difficulties with emotional management. They often feel *overwhelmed, confused* and *depressed* and have *poor self-esteem.* Their problems have emerged in the context of disrupted attachment and they may not know

how to make and sustain healthy *relationships* nor is it likely that they know how to *grieve* for all that has been lost. Instead they have an increased vulnerability to revictimization of the victimization of others and in doing so, may repetitively *reenact* their past terror and loss.

Likewise, in chronically stressed organizations, individual staff members - many of whom have a past history of exposure to traumatic and abusive experiences – do not feel particularly *safe* with their clients, with management, or even with each other. They are chronically frustrated and *angry* and their feelings may be vented on the clients and emerge as escalations in punitive measures and *counteraggressive* behavior. They feel *helpless* in the face of the enormity of the problems confronting them, their own individual problems, and the pressures for better performance from management. As they become increasingly stressed, the measures they take to "treat" the clients may backfire and they become *hopeless* about the capacity of either the clients or the organization to change. The escalating levels of uncertainty, danger and threat that seem to originate on the one hand from the clients, and on the other hand from "the system" create in the staff a chronic level of *hyperarousal* as the environment becomes increasingly crisis-oriented. Members of the staff who are most disturbed by the hyperarousal and rising levels of anxiety, institute more *control* measures resulting in an increase in aggression, counter-aggression, dependence on both physical and biological restraints, and punitive measures directed at clients and each other. Key team members, colleagues, and friends leave the setting and take with them key aspects of the *memory* of what worked and what did not work and team *learning* becomes impaired. *Communication* breaks down between staff members, interpersonal *conflicts* increase and are not resolved. Team functioning becomes increasingly *fragmented*. As this happens, staff members are likely to feel *overwhelmed*, *confused*, and *depressed*, while emotional exhaustion, cynicism, and a *loss of personal effectiveness* lead to demoralization and burnout.

PARALLEL PROCESSES AT THE ORGANIZATIONAL LEVEL

The staff members of service organizations are frequently caught between the demands of the system and the needs of the clients. Unable to see beyond the crises that present each day, staff members are apt to lose continuity between the past and the present, while lacking the energy and enthusiasm to plan for the future. It is not unusual to hear bewildered mental health professionals and other social service employees wonder how it is possible that their organizations can be so dysfunctional when taken individually, most of their colleagues seem reasonable, caring and committed. Efforts to create change often appear to confound the very process of change, and as that happens, staff demoralization escalates. It is possible then to see the parallel processes just described at a whole-organizational level.

Over the past few decades, a large body of knowledge has been accumulating about organizational function at a conscious and an unconscious level – mostly in the world of business. Although many mental health organizations have been significantly stressed by the willy-nilly application of business models to service professions, the transfer of knowledge about the organization-as-a-whole has not penetrated the social services. In an abbreviated way, the remainder of this chapter aims at beginning to rectify that

imbalance, at least in putting a new spin on defining what those problems are. As we have learned from our traumatized clients, recovery begins with a new understanding of the problem.

THE ORGANIZATIONAL IMPACT OF CHRONIC STRESS

CHRONIC STRESSORS & COLLECTIVE TRAUMA

The mental health system and virtually every other social service component that interacts with the mental health system have been and continue to be under conditions of chronic stress. Many systems have individually and collectively experienced repetitive trauma, and are functioning within an overall social and political environment that is complacent about, if not overtly hostile to, the aims of recovery. It is a "system under siege".

The sources of this chronic stress are wide-ranging and multiple and include things like (in no specific order) excessive paperwork; increased demands for productivity that ignore the client's demands for time and empathic regard; competition for workers, undereducated workers, inadequate time for supervision, case consultation, and collaboration; constant ethical conflicts resulting from the needs of clients as they conflict with the requirements of a managed environment; adapting to new technology; staff turnover; downsizing leading to everything from loss of basic safety to the loss of friendship patterns, peer support, and organizational memory; confusion about the underlying premises of the mental health system – diagnoses, nature vs. nurture, mind/body dichotomy, stabilization vs. recovery. And then there are the traumatic events that can accompany working with a very vulnerable population of people in less than ideal times: suicides, homicides, client injuries, staff injuries, scandals, media attacks, lawsuits.

The mental health system taken as a whole has undergone such radical change in the past several decades that it is possible to consider the use of terms like "collective trauma" and "collective disaster" to describe the results. Kai Erikson has used both of these terms in his poignant descriptions of communities that have been struck by natural and man-made disasters. He sees collective trauma as *"a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality. The collective trauma works its way slowly and even insidiously into the awareness of those who suffer from it, so it does not have the quality of suddenness normally associated with 'trauma'. But it is a form of shock all the same, a gradual realization that the community no longer exists as an effective source of support and that an important part of the self has disappeared… 'I' continue to exist, though damaged and maybe even permanently changed. 'You' continue to exist, though distant and hard to relate to. But 'we' no longer exist as a connected pair or as linked cells in a larger communal body"* (p.233) (Erikson, 1994).

LACK OF BASIC SAFETY

As a result of these combinations of acute and chronic stress, in many helping organizations, neither the staff nor the administrators feel particularly safe with their clients or even with each other. This lack of safety may present as a lack of basic physical safety. After law enforcement, persons employed in the mental health sector have the highest rates of all occupations of being physically victimized while at work or on duty. Nonfatal assaults occur nearly four times more often in health care than in all private sector industries combined (Clements, DeRanieri, Clark, Manno, & Kuhn, 2005). The Department of Justice's (DOJ) National Crime Victimization Survey for 1993 to 1999 lists average annual rates of non-fatal violent crime by occupation. The average annual rate for non-fatal violent crime for all occupations is 12.6 per 1,000 workers. But the average annual rate for mental health professionals is 68.2; and for mental health custodial workers it is 69 (Occupational Safety and Health Administration, 2004). Despite this, over 70 percent of United States workplaces do not have a formal program or policy that addresses workplace violence (Bureau of Labor Statistics, 2006).

According to OSHA, the actual number of incidents is probably much higher than reported because incidents of violence are likely to be underreported, largely because of the persistent perception within the health care industry that assaults are part of the job (Occupational Safety and Health Administration, 2004). Underreporting may reflect a lack of institutional reporting policies, employee beliefs that reporting will not benefit them or employee fears that employers may deem assaults the result of employee negligence or poor job performance.

As bad as the statistics on physical violence are, they do not reflect the other forms of violence that mental health and social service workers are routinely exposed to. Mental health environments are not immune to bullying, harassment, and other forms of psychological violence. Emotional abuse is defined by the World Health Organization as "the intentional use of power, including threat of physical force, against another person or group that can result in harm to physical, mental, spiritual, moral or social development and includes verbal abuse, bullying/mobbing, harassment, and threats (World Health Organization, 2002). According to a recent workplace study, approximately 35% to 50% of U.S. workers experience one negative act at least weekly in any 6 to 12 month period, and nearly 30% experience at least two types of negativity frequently (Lutgen-Sandvik, Tracy, & Alberts, 2007). In another survey, 44% of American workers said they have worked for a supervisor or employer who they consider abusive, while over half have been the victim of, or heard about supervisors/employers behaving abusively by making sarcastic jokes/teasing remarks, rudely interrupting, publicly criticizing, giving dirty looks to, or yelling at subordinates, or ignoring them as if they were invisible (Employment Law Alliance, 2007).

These behaviors and attitudes create an erosion of trust among people within the organization and toward the organization as a whole{Kramer, 1999 #16280}. Trust is the basis for all positive social relationships. The erosion of trust in the workplace has become a major barrier to instituting trauma-informed care and significantly interferes with the provision of adequate health and mental health care to women. In failing to ask about the clients' trauma histories, failing to incorporate the information into ongoing treatment planning the traumatic experiences of the clients are denied and/or "forgotten". In

failing to recognize that most of the staff have also been subjected to childhood adversity and may have significant difficulties managing their own emotions and reactions that get triggered in the therapeutic environment, organizational managers inadvertently support the on-going denial of the traumatic origins of their clients' problems. Workers do not trust that responding to the past traumatic experience in clients, and empowering them to make decisions for themselves, will enable the workers to feel safe. At the same time, administrators cannot trust that the decisions they make about the well-being of their institutions will be respected by their superiors or by funding sources.

LOSS OF EMOTIONAL MANAGEMENT

Organizations manage emotions through regular and productive meetings, retreats and an atmosphere of participatory management, all of which are likely to cease or productively occur under the influence of chronic stress. At the organizational level, the failure to cope with workplace emotions and conflict may promote a situation that covertly supports substance abuse, harassment, bullying and sexual misconduct in the workplace. As one group of investigators put it, *"affect permeates organizations…. Affective processes (more commonly known as emotions) create and sustain work motivation. They lurk behind political behavior; they animate our decisions; they are essential to leadership. Strong affective feelings are present at any time we confront work issues that matter to us and our organizational performance"(p. 36)* (Barsade & Gibson, 2007)*.

Exposure to recurrent, systemic violence and chronic stress creates an atmosphere of recurrent or constant crisis which severely constrain the ability of staff to: involve all levels of staff in decision making processes; constructively confront problems; engage in complex problem-solving; or even talk to each other. Team meetings become ritualized, severely attenuated, or cancelled altogether. Under the pressures for increased productivity, informal conversations diminish. Atmospheres of chronic stress and fear contribute negatively to poor services. Organizations that are crisis-driven become hypersensitive to even minor threats and if there are a sufficient number of crises, may become chronically *hyperaroused.*

Under these circumstances, it is not unusual for staff members within caregiving systems to become counter-aggressive, failing to de-escalate and instead escalating tension within their clients. This results in more injuries to staff and clients, and increases in the use of coercive practices leading to further decreases in safety and increases in the level of fear in the environment.

DISSOCIATION, AMNESIA AND FRAGMENTATION OF FUNCTION

Organizational learning is both a cognitive and a social process that involves capturing, storing and diffusing knowledge within the organization. Organizational learning results in organizational adaptation to changing environments (Othman & Hashim, 2004). Organizational learning depends on a constant flow of information but under conditions of chronic stress, communication networks tend to break down. As

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people are laid off, key employees leave and long-time leaders retire or move on. Explicit knowledge may be retained because it is in tangible form – policies, paperwork, records. But the critically important implicit knowledge – that which is experiential, intuitive, and that is most effectively communicated in face-to-face encounters - is lost (Conklin, 2001; Crossen, Lane, & White, 1999; Lahaie, 2005; Othman & Hashim, 2004). In this way, organizational memory is lost, organizational amnesia affects function, and service delivery becomes increasingly fragmented.

Like clients who have a dissociative disorder, such chronically stressed systems of care engage in faulty and inadequate problem-solving under stress, usually reverting to old ways of doing things, even if old ways no longer work and therefore they are unable to adapt well to changing circumstances. Without a shared memory and lacking a systematic shared theoretical framework, organizations begin to look more and more dissociative as the "right hand" knows less and less about what the "left hand" is doing. *"When a company loses its medium and long-term memory, it repeats its past mistakes, fails to learn from past successes and often forfeits its identity… Hard-won and expensively acquired organizational memory walks out the door every time an employee retires, quits, or is downsized", p. 35* (Kransdorrf, 1997).

In mental health and social service organizations today, identity confusion in organizations is evident in the recurrent conflicts between theory and practice, various professional groups, management and workers, clients and staff. These conflicts represents a failure to "get on the same page", to engage in processes that increase the likelihood of synthesis, convergence, integration and creative emergence. *"Even though organizations do not have a biological existence, they can still act in ways that suggest they have forgotten key lessons previously learned. Lessons learned and knowledge previously generated are sometimes lost and forgotten", p.273* (Othman & Hashim, 2004).

Systematic Error

When organizational amnesia and multiple breakdowns in the communication networks occur so too do the feedback loops that are necessary for consistent and timely error correction (Kanter & Stein, 1992). This is particularly noticeable when a repetitive crisis occurs. Under stress, the communication network within care-giving organizations tends to break down. Formal lines of communication become more rigid and convey less information, while the slack is picked up by the grapevine which may – or may not – convey accurate information.

Stressed organizations frequently respond to a fear of impending chaos by becoming more structured. Unfortunately, an increase in structure can easily lead to a system that is too rigid and inflexible. When this occurs, rule-making and rule-enforcement become substitutes for process discussions resulting in fixed expectations and consequences that punish clients for the problems that bring them into treatment in the first place and that punish staff for errors that should create opportunities for organizational learning. Organizational boundaries may become so rigid and over-structured that no useful feedback information gets utilized at all.

Alternately, stressed organizations can become so befuddled about boundaries that they do not have clear role definitions or expectations for behavior. As a result interpersonal and intra-organization boundaries become confused and overly permeable and this diffuse permeability may lead to a significant increase in interpersonal conflict.

INCREASED AUTHORITARIANISM

As communication breaks down, errors compound and the situation feels increasingly out of control, organizational leaders attempt to correct the problems but in doing so, frequently adopt measures that are both controlling and authoritarian (Kanter & Stein, 1992; Weick, 2001). Authoritarian responses to crises can be extremely helpful, as the group pulls together to respond to the direction of a single leader in charge. However, chronic authoritarian responses minimize the critical thinking of everyone lower in the hierarchy and diminish the possibility of organizational learning (Altemeyer, 1996). Under these circumstances, workplace bullying is likely to increase at all levels. In the worst cases, authoritarian leaders may become petty tyrants (Ashforth, 1994). As mentioned earlier, over 44% of American workers report that they have worked for a supervisor or employer who they consider abusive and repetitive crises can turn otherwise fair and participatory leaders into potential abusers (Employment Law Alliance, 2007).

IMPAIRED COGNITION AND SILENCING OF DISSENT

As decision-making becomes increasingly non-participatory and problem solving more reactive an increasing number of short-sighted policy decisions are made that appear to compound existing problems. Organizational democratic processes are eroded and accompanying this loss is an escalating inability to deal with complexity. Dissent is silenced leading to simplistic decisions and lowered morale (Kassing, 1997; Morrison & Milliken, 2000).

Chronically stressed systems are more likely to make poor judgments, particularly when dissent is silenced and alternative points of view cannot be properly aired (Mellers, Schwartz, & Cooke, 1998). Whenever participatory processes are minimized or eliminated, organizational thought processes are likely to become oversimplified, extremist and reactive. As stress increases and participatory processes are eliminated, both individual and group decision making are likely to become progressively compromised (Sunstein, 2003).

IMPOVERISHED RELATIONSHIPS

In an organization where lines of communication are broken and people are becoming afraid of each other, interpersonal conflicts increase and are not resolved because the system lacks adequate conflict resolution skills. Under these circumstances, unresolved and pre-existing interpersonal, intradepartmental and interdepartmental conflicts are likely to increase. Measures that should be taken to adequately manage and dissolve those conflicts do not occur. There is an inverse relationship between interpersonal conflict in the workplace and the ability to engage in constructive conflict over specific tasks. The greater the interpersonal conflict, the less likely it is that members of the organization will be

able to engage in the kind of conflict that leads to creative and innovative approaches to new problems. At the same time, interorganizational conflicts are likely to increase. The organizational conflict culture becomes rigid and inflexible; hierarchies become more fixed with one conflict management style dominating the rest (Amason, 1996; Jehn, 1995; Jehn, Northcraft, & Neale, 1999).

The chronic failure of communication and conflict resolution in the system may emerge as a "collective disturbance" which flows down from the original source of unspoken conflict and manifests in problematic behavior, first in the staff and later in the clients. In organizations, "collective disturbance" represents the separation of cognitive and emotional content of an experience (Caudill, 1958; Stanton & Schwartz, 1954). Problems cannot be honestly, openly and safely discussed. Secrets exist at many levels, or at least an air of secrecy and a lack of transparency is felt by everyone. Little differentiation is made between privacy and secrecy, so secrets may be kept while privacy is invaded. Conflicts at the level of the administration or the staff are then unconsciously projected upon the clients who act-out the emotional elements of the conflict. Meanwhile, no one understands or grapples with the cognitive content. In this way, an acute collective disturbance easily becomes a chronic unresolved conflict and a source of further stress.

Organizations that cannot surface, explore, resolve and transform conflict cannot learn from experience and are likely to make the same mistakes over and over instead. *"Call it escalation of commitment, organizational defensiveness, learning disability – or even more bluntly – executive blindness. It is a phenomenon of behavior in organizations that has been widely recognized. Organizational members become committed to a pattern of behavior. They escalate their commitment to that pattern out of self-justification. In a desire to avoid embarrassment and threat, few if any challenges are made to the wisdom and viability of these behaviors. They persist even when rapid and fundamental shifts in the competitive environment render these patterns of behavior obsolete and destructive to the well-being of the organization", p.642* (Beer & Spector, 1993).

DISEMPOWERMENT & HELPLESSNESS

As the organization becomes more hierarchical and autocratic there is a progressive and simultaneous isolation of leaders and a "dumbing down" of staff, with an accompanying "learned helplessness" and loss of critical thinking skills.

Chronically threatened organizations become extremely risk avoidant in trying to control clients' risky behavior and in doing so may virtually eliminate the expectation that clients' need to take risks in order to change. Since all change involves risk, the more risk-avoidance the environment, the less likely it is that anything – including the clients – will change.

While this depleting spiral is operating the staff in chronically stressed systems may become increasingly helpless about the possibility of change in their clients, themselves, or their systems. When challenged to empower themselves and "be the change you want to see", they may helplessly wait for someone else to "tell them what to do" (McGrath, 1994).

INCREASED AGGRESSION

Stressed systems may fail to see the larger issues that are clouding vision and impairing performance and instead attempt to address problems using a system of rewards and punishment that do not address the core issues. Staff respond to the perceived punitive measures and the escalation of conflict by acting-out and engaging in a wide variety of passive-aggressive behaviors. Rumors fly and nasty forms of gossip increase as does absenteeism, poor performance, errors and counter-aggression (Baker & Jones, 1996)

UNRESOLVED GRIEF

Caregiving organizations under stress may become oblivious to the most obvious question, "Is what we are doing working?". Instead, quality assurance issues will focus on the more mundane aspects of the environment, like completed paperwork and adequate fire alarms, while neglecting the most vital aspects of quality care – catalyzing positive change in clients, staff, and the living system as a whole. Meanwhile, a chronic organizational disaster is unfolding. Kai Erikson has defined a "chronic disaster" as one that:

> *"gathers force slowly and insidiously, creeping around one's defenses rather than smashing through them. People are unable to mobilize their normal defenses against the threat, sometimes because they have elected consciously or unconsciously to ignore it, sometimes because they have been misinformed about it, and sometimes because they cannot do anything to avoid it in any case" (p.21). In individuals this manifests as "a numbness of spirit, a susceptibility to anxiety and rage and depression, a sense of helplessness, an inability to concentrate, a loss of various motor skills, a heightened apprehension about the physical and social environment, a preoccupation with death, a retreat into dependency, and a general loss of ego functions" (p.21)* (Erikson, 1994).

Friends and colleagues leave or are laid off, leaders depart, programs close or are greatly diminished, and clients do not respond to interventions in satisfactory ways. Everyone in the system experiences losses that no one is permitted to fully address. When leaders fail to pay attention to the effects of these losses on their subordinates, they convey the attitude that there is nothing to be gained by working through loss – so no one does. As a result, loss is compounded upon loss, further contributing to the atmosphere of demoralization and depression (Jeffreys, 2005).

Chronically stressed organizations tend to have significantly lowered abilities for creative change and instead, to mirror the clients' reenactment behavior by reenacting failed treatment strategies and policies that do not work while remaining unaware of the repetitive nature of their interventions. In a system, constant reenactment is a sign of unresolved grief (Bloom, 2007a). The result may be failure of the purported organizational mission.

LOSS OF MEANING & DEMORALIZATION

In chronically stressed organizations, staff often become progressively hopeless, helpless and demoralized about the work they are doing and the possibility of seeing significant change in the clients, failing to recognize that much of their hopelessness and helplessness is related not to the clients but to the larger systems within which they are all embedded. Chronically stressed organizations may be controlled top-to-

bottom by people who are "burned out" – emotionally exhausted, cynical about their clients, doubting any personal efficacy (Angerer, 2003; Cordes & Dougherty, 1993). Over time, leaders and staff lose sight of the essential purpose of their work together and derive less and less satisfaction and meaning from the work. This foreshortened sense of future in organizations presents as a loss of vision, of true purpose, of hope that the organization and all of the staff together can play a significant role in helping people to recover.

IMPLICATIONS FOR MENTAL HEALTH SERVICES

Judging from the extent of exposure to childhood adversity, it is no longer acceptable to believe we can consign some special treatment programs to the alleviation of trauma-related problems. Every service agency, every educational institution, and every workplace needs to be trauma-informed and trauma-sensitive. It must be possible for injured women and children to enter any mental health or social service environment and have experiences that are potentially healing, rather than experiences that compound their injuries as so often happens today.

As has been detailed in the previous pages, the results of these complex and interactive series of stress-related problems plaguing our service delivery systems and negatively impacting the treatment of women and children can readily be compared to the complex problems of chronically maltreated clients. At this point, our social service network is largely functioning as a "trauma-organized system"(Bentovim, 1992) still largely unaware of the multiple ways in which its adaptation to chronic stress has created a state of dysfunction that in some cases virtually prohibits the recovery of the individual clients who are the source of its underlying and original mission, and damages many of the people who work within it. If you have read this chapter and recognize some or all of the ways your own organization is functioning, how can you help be an agent of positive change?

It is useful to think about parallel processes of recovery because in reality, we cannot stop the systems from functioning in order to fix what is broken. The flow of clients who need services has not and will not stop in any world that we can realistically anticipate today. So we have to mend our broken systems at the same time that we are providing services to the people who need them. As daunting a process as this may seem, it is consistent with both the recovery movement and the drive for trauma-informed care. What needs to be added is a heightened awareness of the interconnected, living nature of all of our systems and a recognition that significant changes in one part of the corporate "body" can only occur if the whole body changes as well.

The total-systems approach that we have designed to help organizations reverse the stress-related trends described in this chapter is called "The Sanctuary Model". Based on more than twenty years of experience in responding to the needs of traumatized individuals, Sanctuary® is a repackaging of an enormous amount of tacit clinical wisdom that has been slowly draining out of the mental health system and its "sister" social service systems, while integrating within it the new trauma-informed knowledge that is so vital if we are to make progress in improving women's health.

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The Sanctuary Model expands the idea of "trauma-informed" care to include the individual staff members of our systems of care as well as each organization and the system-as-a-whole. It is based on the parallel process notion that analogous relationships exist between each organizational level and that therefore the maximum gain and the potential for true transformation lies in instituting individual and systemic change simultaneously.

It is not a trauma intervention by itself, or a trauma-specific treatment. It represents the necessary framework of the "house" – the roof, the ceiling, and the frame – within which must be built an array of treatment methods, approaches, policies and procedures that represent the rooms of the "house" and the "furniture" in the rooms. Like the homes we live in, every program must have its own unique identity, its own character and personality, its own methods for accomplishing its mission. But every program – being alive – must bear the characteristics of living systems.

Sanctuary is what can emerge when groups of people come together, create community, engage in authentic behavior, share common values and a common language and make seven specific cultural commitments: Commitment to Nonviolence, Commitment to Emotional Intelligence, Commitment to Social Learning, Commitment to Open Communication, Commitment to Democracy, Commitment to Social Responsibility and Commitment to Growth and Change (Bloom, 2005, 2007b).

In Sanctuary we are endeavoring to describe what it means for a system to be alive, growing, changing, learning, and even reproducing. As a Sanctuary Network of programs, we are together discovering the day-to-day "technology" that is necessary to maximize systemic health[1]. The only way to effectively remove barriers to trauma-informed care delivered to individual trauma survivors is to become "trauma-sensitive" to the ways in which managers, staff, groups, and systems are impacted by individual and collective exposure to overwhelming stress. Ultimately, the goals of the Sanctuary Model are to improve clinical outcomes, increase staff satisfaction and health, increase leadership competence, and develop a technology for creating and sustaining healthier systems.

REFERENCES

Altemeyer, B. (1996). *The Authoritarian Specter*. Cambridge, Mass. ; London: Harvard University Press.

Amason, A. C. (1996). Distinguishing the effects of functional and dysfunctional conflict on strategic decision making: Resolving a paradox for top management teams, *Academy of Management Journal* (Vol. 39, pp. 123-148).

Angerer, J. M. (2003). Job burnout. *Journal of Employment Counseling, 40*(3), 98.

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[1] See www.sanctuaryweb.com

Bloom, S. L. (2010). *Organizational Stress as a Barrier to Trauma-Informed Service Delivery.* Becker, M. and Levin, B. A Public Health Perspective of Women's Mental Health, New York: Springer (pp.295-311).

Appelbaum, P. S. (2002). Starving in the Midst of Plenty: The Mental Health Care Crisis in America. *Psychiatric Services, 53*(10), 1247-1248.

Ashforth, B. (1994). Petty Tyranny in Organizations. *Human Relations, 47*(7), 755-778.

Baker, J. S., & Jones, M. A. (1996). The poison grapevine: How destructive are gossip and rumor i. *Human Resource Development Quarterly, 7*(1), 75.

Barsade, S. G., & Gibson, D. E. (2007). Why does affect matter in organizations? *Academy of Management Perspectives, 21*(1), 36-59.

Bazelon Center for Mental Health Law. (2001). *Disintegrating Systems: The State of States' Public Mental Health Systems*: Bazelon Center for Mental Health Law.

Beer, M., & Spector, B. (1993). Organizational diagnosis: Its role in organizational learning. *Journal of Counseling and Development, 71*(642-650).

Bentovim, A. (1992). *Trauma-Organized Systems: Physical and Sexual Abuse in Families*. London: Karnac Books.

Bloom, S. L. (1997). *Creating Sanctuary: Toward the Evolution of Sane Societies*. New York: Routledge.

Bloom, S. L. (2002). *The PVS Disaster: Poverty, Violence and Substance Abuse in the Lives of Women and Children. A Literature Review*. Philadelphia, PA: Women's Law Project.

Bloom, S. L. (2005). The Sanctuary Model of Organizational Change for Children's Residential Treatment. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations, 26*(1), 65-81.

Bloom, S. L. (2006). *Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation, White Paper for the National Technical Assistance Center for State Mental Health Planning (NTAC), National Association of State Mental Health Program Directors*. http://www.nasmhpd.org/publications.cfm.

Bloom, S. L. (2007a). Loss in human service organizations. In A. L. Vargas & S. L. Bloom (Eds.), *Loss, Hurt and Hope: The Complex Issues of Bereavement and Trauma in Children* (pp. 142-206). Newcastle, UK: Cambridge Scholars Publishing.

Bloom, S. L. (2007b). The Sanctuary Model of Trauma-Informed Organizational Change. *The Source: The National Abandoned Infants Assistance Resource Center., 16*(1), 12-14, 16.

Bureau of Labor Statistics. (2006). *News - Survey of Workplace Violence Prevention, 2005* (http://www.bls.gov/iif/oshwc/osnr0026.pdf ed. Vol. October 27). Washington, D. C.: United States Department of Labor.

Carr, A. (2001). Understanding emotion and emotionality in a process of change. *Journal of Organizational Change Management, 14*(5), 421-434.

Caudill, W. (1958). *The Psychiatric Hospital as a Small Society*. Cambridge, MA: Harvard University Press.

Bloom, S. L. (2010). *Organizational Stress as a Barrier to Trauma-Informed Service Delivery.* Becker, M. and Levin, B. A Public Health Perspective of Women's Mental Health, New York: Springer (pp.295-311).

Clements, P. T., DeRanieri, J. T., Clark, K., Manno, M. S., & Kuhn, D. W. (2005). Workplace Violence and Corporate Policy for Health Care Settings. *Nursing Economics, 23*(3), 119-124.

Conklin, J. E. (2001). *Designing organizational memory: Preserving Intellectual Assets in a Knowledge Economy, http://www.touchstone.com/tr/whitepapers.html*. Washington, D.C.: Touchstone Consulting.

Cordes, C. L., & Dougherty, T. W. (1993). A review and an integration of research on job burnout. *Academy of Management. The Academy of Management Review, 18*(4), 621.

Crossen, M. M., Lane, H. W., & White, R. E. (1999). An organizational learning framework: From intuition to institution. *Academy of Management Review, 24*(3), 522-537.

Edwards, V. J., Holden, G. W., Felitti, V. J., & Anda, R. F. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: results from the Adverse Childhood Experiences Study. *American Journal of Psychiatry, 160*(8), 1453-1460.

Employment Law Alliance. (2007). *Nearly 45% Of U.S. Workers Say They've Worked For An Abusive Boss*. Employment Law Alliance. Retrieved, 2007, from the World Wide Web: http://www.employmentlawalliance.com/node/1810

Erikson, K. (1994). *A new species of trouble: The human experience of modern disasters*. New York: W.W. Norton.

Ettin, M. F., Fidler, J. W., & Cohen, B. D. (Eds.). (1995). *Group Process and Political Dynamics*. Madison, CT: International Universities Press.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med, 14*(4), 245-258.

Goodman, L. A., Rosenberg, S. D., Mueser, K. T., & Drake, R. E. (1997). Physical and sexual assault history in women with serious mental illness: prevalence, correlates, treatment, and future research directions. *Schizophr Bull, 23*(4), 685-696.

Harvey, P., Martinko, M. J., & Gardner, W. L. (2006). Promoting Authentic Behavior in Organizations: An Attributional Perspective. *Journal of Leadership & Organizational Studies, 12*(3), 1.

Jeffreys, J. S. (2005). *Coping with Workplace Grief: Dealing with Loss, Trauma, and Change, Revised Edition*. Boston, MA: Thomson Course Technology.

Jehn, K. A. (1995). A multimethod examination of the benefits and detriments of intragroup conflict. *Administrative Science Quarterly, 40*(2), 256.

Jehn, K. A., Northcraft, G. B., & Neale, M. A. (1999). Why differences make a difference: A field study of diversity, conflict, and performance in workgroups. *Administrative Science Quarterly, 44*(4), 741.

Bloom, S. L. (2010). *Organizational Stress as a Barrier to Trauma-Informed Service Delivery.* Becker, M. and Levin, B. A Public Health Perspective of Women's Mental Health, New York: Springer (pp.295-311).

Kanter, R. M., & Stein, B. A. (1992). *The Challenge of Organizational Change: How Companies Experience It and Leaders Guide It*. New York: The Free Press.

Kassing, J. W. (1997). Articulating, antagonizing, and displacing: A model of employee dissent. *Communication Studies, 48*(4), 311.

Kernis, M. H. (2003). Toward a Conceptualization of Optimal Self-Esteem. *Psychological Inquiry, 14*(1), 1-26.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Arch Gen Psychiatry, 52*(12), 1048-1060.

Kransdorrf, A. (1997). Fight organizational memory lapse. *Workforce, 76*(9), 34-39.

Lahaie, D. (2005). The impact of corporate memory loss: What happens when a senior executive leaves? *Leadership in Health Services, 18*(3), xxxv-xlvii.

Lutgen-Sandvik, P., Tracy, S. J., & Alberts, J. K. (2007). Burned by Bullying in the American Workplace: Prevalence, Perception, Degree and Impact. *Journal of Management Studies, 44*(6), 837-862.

McGrath, R. (1994). Organizationally induced helplessness: The antithesis of employment. *Quality Progress, April*, 89-92.

Mellers, B. A., Schwartz, A., & Cooke, A. D. J. (1998). Judgment and decision making. *Annual Review of Psychology, 49*, 447.

Morrison, E. W., & Milliken, F. J. (2000). Organizational silence: A barrier to change and development in a pluralistic world. *The Academy of Management Review, 25*(4), 706.

National Association of Psychiatric Health Systems. (2003). *Challenges Facing Behavioral Health Care: The Pressures on Essential Behavioral Healthcare Services*. Washington, D.C.: National Association of Psychiatric Health Systems.

Occupational Safety and Health Administration. (2004). *Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers*. Washington, D.C.: United States Department of Labor.

Othman, R., & Hashim, N. A. (2004). Typologizing organizational amnesia. *The Learning Organization, 11*(2/3), 273-284.

Pekrun, R., & Frese, M. (1992). Emotions in work and achievement. *International Review of Industrial and Organizational Psychology, 7*, 153-200.

President's New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America.* Rockville, MD: New Freedom Commission on Mental Health.

Searles, H. (1955). The informational value fo the supervisor's emotional experience. *Psychiatry, 18*, 135-146.

Senge, P. (1990). *The Fifth Discipline: The Art and Practice fo the Learning Organization*. New York: Doubleday.

Bloom, S. L. (2010). *Organizational Stress as a Barrier to Trauma-Informed Service Delivery.* Becker, M. and Levin, B. A Public Health Perspective of Women's Mental Health, New York: Springer (pp.295-311).

Smith, K. K., Simmons, V. M., & Thames, T. B. (1989). "Fix the Women": An intervention into an organizational conflict based on parallel process thinking. *The Journal of Applied Behavioral Science, 25*(1), 11-29.

Stanton, A. H., & Schwartz, M. S. (1954). *The Mental Hospital: A Study of Institutional Participation in Psychiatric Illness and Treatment*. New York: Basic Books.

Sunstein, C. R. (2003). *Why Societies Need Dissent*. Cambridge, MA: Harvard University Press.

Weick, K. E. (2001). *Making Sense of the Organization*. Malden, MA: Blackwell.

World Health Organization. (2002). *Framework Guidelines for Addressing Workplace Violence in the Health Sector*. Geneva, Switzerland: International Labour Office.

Bloom, S. L. (2010). *Organizational Stress as a Barrier to Trauma-Informed Service Delivery.* Becker, M. and Levin, B. A Public Health Perspective of Women's Mental Health, New York: Springer (pp.295-311).