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SECONDARY TRAUMA: A TEAM APPROACH

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ABSTRACT: Bearing witness to trauma stories can evoke in clinicians the confusion and emotional turmoil their clients experience, known as secondary trauma. Given the complexities of trauma work, practitioners need help to clarify issues and feel more effective. The terror attacks of September 11, 2001 further compound the task, as therapists may themselves be feeling the impact of those events. Presented here is a team model for structured case discussion which can help workers identify and deal with their reactions to both client trauma stories and their own experiences. The model is explained and illustrated with examples, and the process by which it was piloted and evaluated is discussed.

KEY WORDS: secondary trauma; team case discussion; collegial responsibility.

INTRODUCTION

Trauma can be profoundly overwhelming to people's capacity to modulate their feelings and to organize their thinking (van der Kolk,

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1996). Both the original experience of trauma and its ongoing impact on affect and cognition can lead to feelings of ineffectiveness which may cause withdrawal from contact with other people who might be helpful (Symonds, 1975).

For the clinician, recognizing the destructive effects of a client's trauma both initially and over time can be similarly disturbing. The capacity to empathize, to feel with another person, is central to the process of psychotherapy (McCann & Pearlman, 1990). The therapist's ability and willingness to recognize and share the emotional experience of the other contributes to healing. However, as empathic engagement exposes us to the client's emotional distress, we feel the effects as well.

The impact of this process on the worker is referred to by several terms, primarily differentiating between effects which are considered normal and inevitable, such as "compassion fatigue" or "secondary traumatic stress" (Figley, 1995) or "vicarious traumatization" (Pearlman & Saakvitne, 1995) and effects which are considered more problematic, such as "secondary traumatic stress disorder" (Pearlman & Saakvitne, 1995) or countertransference (Figley, 1995). We use the term "secondary trauma" to refer to a particular range of potential reactions in a helping person engaging with a traumatized person and his/her story. For example,

> A woman reports running out of her office building on the morning of September 11, and through the streets after the first WTC building collapsed. She was surrounded by screams and sirens, by papers and ashes, and by what she feared were body parts. The worker had seen this collapse from her office window and had also heard similar stories twice this week. She is feeling overwhelmed by horror and sadness. Her empathic response, which was more readily available to the first two clients, is now numbing, and she finds herself withdrawing emotionally from this woman.

Like primary trauma reactions, secondary trauma may disturb the worker's ability to think clearly, to modulate emotions, to feel effective, or to maintain hope. Yet hope is an essential component of doing the work. If the clinician is overwhelmed, s/he may, like the client, feel inclined to withdraw from potential sources of support. Practitioners may react defensively, for example: by avoiding such cases; perhaps by denying their seriousness; or possibly by rationalizing their destructive impact. On the other hand, defensive reactions might take the form of over-involvement and rescue efforts that can undermine the client's potential strengths. These factors impinge on the worker's ability to sustain a hopeful and effective stance.

In the field of disaster relief work, it is a basic principle to provide care for first responders so they can sustain a response to people who are directly affected by a particular incident (Ehrenreich, 2001). As airplane passengers are advised, "if you are traveling with a person who needs help, adjust your own oxygen mask first." We asked, what does our staff need in order to sustain effective therapeutic work?

THE DEVELOPMENT OF A MODEL

The authors are senior clinicians who provide supervision and consultation on trauma cases at Jewish Board of Family and Children's Services (JBFCS), a large mental health and social service agency in New York City. Based on our experience with the challenges this work presents, we sought to address clinicians' needs as they parallel the needs of the clients.

Like clients, clinicians affected by secondary trauma need to talk about their experience and concerns in a safe context that is validating and non-judgmental, offers empathic connection, and supports clear thinking toward effective action. Beginning with the premise that supportive collegial groups can offer workers such a context to better understand both their own reactions and their traumatized clients (Rudolph & Stamm, 1999), we developed a model for conferencing trauma cases, called Clinical Risk Management Team (CRMT).

The CRMT model has two fundamental components. The first is a structured protocol for case discussion, which helps to organize and counterbalance the impact of trauma on complex cognition. Its aim is to support thorough and careful thinking that may be lost in the intensity and confusion of trauma stories. The second is a collegial team that provides a safe context in which to reflect on the work, offering support and connection to the clinician in response to the potentially isolating effects of trauma.

The protocol will be presented, with explanations and examples, followed by discussion of how the team works, the piloting process, and the rationale for our approach.

THE WRITTEN PROTOCOL

CLINICAL RISK MANAGEMENT TEAM, Protocol Outline (45 minutes)

I. Case Presentation (10 minutes)

II. Trauma Issues (6 minutes)
III. Exploration of Various Perspectives of the Case (6 minutes)
IV. Checklist of Issues (5 minutes)
V. Worker's Feelings About the Case (7 minutes)
VI. Case Conceptualization (6 minutes)
VII. Worker's Reactions to the Team Process (5 minutes)

CLINICAL RISK MANAGEMENT TEAM COMPLETE PROTOCOL
(45 minutes)

I. Case Presentation (10 minutes)
–Worker begins with "my concern in this case is that I . . ."
–Case summary that is brief, clear, and focused.
–Identify client strengths and coping abilities.
–Identify what is going well in case.
–Brief period for clarifying questions.

II. Trauma Issues (6 minutes)

Explore worker's understanding of how the problem/symptoms are an expression of the person's having experienced trauma (e.g. flashbacks, dissociation, numbing, hyperarousal, affect dysregulation).

Consider ways to talk with the client about how the problem/symptoms are an expression of his /her having experienced trauma.

III. Exploration of Various Perspectives of the Case (6 minutes)
(Worker does not participate in this part of the discussion.)
–Give voice to different aspects of the client's ambivalence.
–Take the position of different people within the case.
–Use experiential exercises and/or role play as appropriate.

IV. Checklist of Issues (5 minutes)
Identify whether and in what way these apply.
–are there people in danger? actual/potential
–is a report to Child Protective Services warranted, and what are implications?
–what health/medical factors? e.g. assessment and care of injury
–what relevant cultural factors? (gender, race, religion, ethnicity, class) e.g. traditional modes of discipline, prohibitions against telling family secrets, how shame is expressed
–what additional family resources? e.g. extended kinship

– what additional community resources? e.g. hotline, shelter, justice system, order of protection, church/synagogue

V. Worker's Feelings About the Case (7 minutes)
Discussion of worker's ongoing feelings about case and how these relate to the work.
Responses from colleagues to what worker has presented.

VI. Case Conceptualization (6 minutes)
(Worker does not participate in this part of the discussion.)
Each speaker gives case conceptualization as a rationale for specific treatment recommendations, including additional or alternate modalities, e.g. group, family.

VII. Worker's Reactions to the Team Process (5 minutes)
Which suggestions are usable and/or useful and which are not.

Case Presentation (I)

Worker begins with his/her concern about the case.

By beginning in this way, the worker focuses the team on what s/he feels s/he needs and therefore guides the discussion. This is an example of parallel process, echoing for the worker the premise that an environment in which the client exercises control and sets his/her own pace is a cornerstone of safety in the work (Herman, 1992).

The client's trauma reaction is understood to be an effect of injury rather than an expression of pathology (Van der Kolk, 1996; Bloom, 1999). Similarly, in the CRMT process the worker's presenting concern is received as the worker's response to trauma in the case rather than as an expression of the worker's own underlying issues. The worker is attuned to the client, the team members are expected to be empathically sensitive to the presenting colleague.

> John was at a loss with a particular family. The seven-year-old girl had been sexually abused and mother was angry at the daughter, blaming her for being seductive. John knew that mother was herself an incest survivor and also had been in a series of abusive relationships. There were so many serious issues affecting this family that it was hard for John to believe he could be helpful. He presented this feeling of helplessness to the team as the issue he most wanted help with.

Case summary that is brief, clear, and focused.

The use of time limits throughout the protocol is meant to help organize the considerable amount of material one often finds in trauma cases, which can feel overwhelming. The request for a brief summary is intended to help the worker to focus, prioritize, and partialize, and therefore to feel more in control in an oftentimes chaotic situation.

> Claudia presented a multi-problem and complicated case. The family's dysfunction was extensive and their resources meager. Claudia felt overwhelmed and flooded with details about their various needs and did not know what to focus on first. She protested that presenting a brief summary would only scratch the surface. However, when she pressed herself to do so as called for in the protocol, she began to gain clarity, to feel in control and able to prioritize, and she became less anxious.

Identify client strengths and coping abilities.

All clients have strengths and coping abilities. In trauma cases, distress and disorganization are so much in the forefront that strengths can be lost to awareness. Therefore, specifically identifying them is a useful reminder.

> Steve talked about a poverty-stricken couple in which the husband was psychotic, although stabilized on medication. Their only child had been sexually abused by an uncle who was a chronic substance abuser. Steve was at a loss as to what he could do for this family due to their many deficits and problems of daily living. A member of the team saw strengths in this couple's loyalty to each other and their daughter. Hearing her observations enabled Steve to recognize aspects of their story he had overlooked and therefore to feel more hopeful that therapy could be effective.

Identify what is going well in the case.

Similar to client strengths, addressing what is going well in the case is a reminder of the worker's strengths.

> To continue with Steve's case, Steve was now able to see the couple's commitment to treatment in how they never missed a session, to note that there were mutual positive feelings between them and him, and to hear that the parents were motivated to help their daughter recover.

Trauma Issues (II)

Identifying the client's feelings and behavior as symptoms of trauma provides for a common orientation and a more accurate diagno-

sis and helps to make sense of what might appear to be a disorganized array of dysfunction.

> Karen was working with a woman who was detached, labile, and periodically explosive. This behavior was diagnosed as Borderline Personality Disorder. The client also presented a history of multiple childhood traumas. Recognizing the client's instability as a reaction to her traumatic life story enabled Karen to view the client with more understanding and address her needs in a more effective way.

> One week after 9/11, a 32-year-old woman writer met with Joan, the intake worker, in a highly agitated state. She cried and reported sleeping and eating problems, and nightmares. While she had not directly experienced the attacks, she had been interviewing families and ground zero workers, especially at the morgue. Hearing their trauma stories had stimulated her own nightmares, in which she actually saw the scenes which had been described to her. Joan was so overwhelmed by the severity of the client's emotions and detailed stories that she feared the client would harm herself, although this had not been said. The team helped Joan recall her own nightmares and to recognize both her own post-trauma reactions and her secondary trauma in relation to the client. As Joan understood these issues she felt less frightened herself and was then able to help the client to calm down, to sleep and eat, and to write her stories.

Exploration of Various Perspectives of the Case (III)

Notably, in this section of the protocol the presenting worker does not play an active role in the discussion. This structural intervention enables the worker to listen to suggestions without being on the spot to respond, a part of the team rather than a direct recipient of comments. We were introduced to this idea by colleagues at JBFCS (personal communication, A. van Dalen & P. Nitzburg, 1995). Team members raise questions, make observations, and offer suggestions to the group as a whole, fostering a sense of shared ownership of the work in the entire team. Exploring various aspects of the case broadens the perspective and can elicit dynamics and interactions not thus far considered.

> Eleanor presented the case of a twelve year old girl who reported her stepfather had sexually molested her. He had been ordered out of the home and, because of their drug use, both he and mother were court-ordered to drug treatment programs. The worker's presenting concern was, "can this family become a safe place for this child?" The family's polarizing style in this and other situations complicated finding an answer. In this part of the CRMT process, members of the team took the roles of different family members and

> the worker. Rather than directly seeking to answer the worker's question, the act of giving voice to each of the family members involved allowed the question itself to become a way to understand and connect with them.

Checklist of Issues IV

This section serves to alert the worker to additional case considerations needing attention. Any relevant issue identified here can be pursued further outside of the CRMT meeting.

Worker's Feelings About the Case V

In all therapeutic work feelings can be aroused in the practitioner, but with the intensity of trauma treatment they may be especially disturbing. Many clinicians have documented these effects. As Geller has stated, "...these feelings, left unattended, can result in mistakes in treatment that can seriously hamper the work" (1992, p. 245). On the other hand, recognizing and understanding them can help to clarify the work.

> Maria was treating an adult survivor of childhood sexual abuse. Caught in symptomatic re-experiencing, the client told the graphic details of her story again and again. Maria asked the team for help with her guilt about her lack of empathy as she emotionally withdrew from this client who was obviously distressed. The team helped Maria to recognize the painful impact the horrible story had on her and to understand her withdrawal as another aspect of the PTSD symptoms, i.e. numbing and avoidance. This process highlighted the fact that Maria was, in fact, extremely empathic to the client and that both of them were being overwhelmed by the way the story was being told.

Case Conceptualization VI

As in Section III "Exploration of Various Perspectives of the Case," the presenting worker does not play an active role in this part of the discussion, allowing the worker temporarily to step out of the position of responsibility for the case and instead to listen to suggestions as part of a collaborative team effort. Suggestions are offered with supporting rationale, as team members share responsibility for thinking through the work.

Worker's Reactions to the Team Process VII

At this point in the protocol, the presenting worker gives feedback about the discussion itself; in particular, about what suggestions made

by the team seem useful and not useful. In addition to dealing with practitioners' concerns about the work, the team discussion is intended as an instrument of self-care. Feedback on the discussion tells the team whether or not the worker's needs were met. In particular, eliciting what has NOT been useful to the worker serves to support honest communication within the team, thereby reinforcing the principle of safety (Bloom, 1997).

> Laura felt the suggestions of the team did not adequately address her concerns. The team had focused on an aspect of the case of which she was well aware and in which she felt competent. Her stating that she did not feel sufficiently helped led the team to return to her presenting question at a subsequent meeting. This process also promoted an atmosphere of safety, because of the freedom to give honest feedback without negative consequence.

ROLE FUNCTIONS

The CRMT model calls for some specific role functions. One person takes the role of leader, another is timekeeper, while a third is the presenter of the case. These roles may shift or remain stable from one meeting to another, or even from one case presentation to another. Taking different roles helps team members to share responsibility and control of the process.

DESCRIPTION OF PILOTING PROCESS

JBFCS is a very large mental health and social service agency with a diverse network of programs serving people of varied religious, ethnic, and economic backgrounds. Several pilot settings were used, each with its own unique demands. Two were community–based preventive programs, offering counseling to families with children at risk of abuse or neglect, while others were outpatient mental health clinics treating adults and children. Although somewhat different structurally, they all have in common a client base composed of ethnically diverse families with multiple stressors. Clients have experienced violence within their communities and families, against children and adult partners, sexual abuse, substance abuse, chronic mental illness. Many suffer from posttraumatic stress reactions to various life events including the terror attacks of September 11, 2001.

By piloting the CRMT in different settings, we hoped to ensure that the model could be widely applied. We expected that following the piloting process, each setting would tailor the model to meet its particular needs. During the pilot phase, all settings followed the protocol for case discussion during a schedule of regular, ongoing meetings, generally weekly or biweekly, and generally for six to eight meetings. In each setting, the staff became the team. The team was composed of all levels of clinical staff who worked in that setting, and generally consisted of primary clinicians, supervisors, program directors, consulting psychiatrists, and social work interns. The inclusion of all clinical staff was deliberate and a salient feature in developing a sense of shared responsibility and teamwork. In this context, each person's perspective was of equal value, despite differences in role and status present in other aspects of their work. Staff members took turns volunteering to present cases, so that each person generally had an opportunity to be both a presenter and a member of the collegial group.

As noted, the presenting worker's reactions to the team discussion is an essential component of the model. In addition, we elicited feedback on the effectiveness of the model in each pilot setting, using a short questionnaire that asked for reactions to the model as a whole (e.g. was team format helpful, what would make you likely to continue or discontinue use) and to specific components (e.g. re time frame, re beginning with worker's concern). The questionnaire was presented midway through the piloting sessions with each team to stimulate discussion and modify as needed, and again at the end.

Responses indicated the team model served to create a safe environment in which workers felt able to express their feelings and reactions to their cases. This level of expression enabled a fuller understanding of the issues within each particular case and elicited support from co-workers. In turn, that support directly impacted the work by helping practitioners recognize and manage emotional reactions within the case and think them through to effective interventions.

> Annette was treating surviving siblings whose mother was incarcerated for having caused the death of one of her children. The mother's worker at the prison was pressing for the remaining children to visit. The severity of the abuse made this a high–profile case reported on in the media. This combination of fatal abuse and public attention made the case particularly stressful for Annette. She wanted to cooperate with the other worker but felt the children were not yet ready to see their mother. The team discussion helped Annette to recognize how she felt caught between the needs of the children, her own secondary trauma reactions, and the wishes of the mother's worker. This bind impaired Annette's judgment and

her morale. Recognizing the bind she was in enabled Annette to rethink her stance with the mother's worker. Further, identifying her own reactions enabled her to separate her feelings from the needs of the children and to develop a plan for ongoing collegial support with this case.

Early in the pilot process, workers consistently found it difficult to begin with a single concern, since it was often the multi–problem, overwhelming quality of the case which led them to choose to present it to the team. Over time, usually three or four sessions, they came to see this beginning as an essential feature which helped them focus and feel in control.

We also found that some programs preferred to focus on one case for 45 to 60 minutes and to use any remaining time to revisit a previously presented case for follow-up, while others used their time more rigorously, presenting two cases of 45 minutes each.

Upon completion of the pilot process, each setting incorporated some aspects of the model into their ongoing clinical review program. The outline itself has been modified and adapted to meet the needs of various settings. For example, the time allowed for various sections has been adjusted, such as shortened to fit time constraints or lengthened to allow for more participation. Despite the variations, in all settings the protocol moved staff in the direction of a collaborative effort where feelings and interventions were shared. The use of a highly structured outline for case discussion combined with team involvement enabled practitioners to feel understood, supported, and able to return to the work with renewed energy and focus.

RATIONALE

Traumatized clients often have difficulty with self-regulation which may be expressed in problematic behaviors such as fights, substance abuse, and self-harm (van der Kolk, 1996). These behaviors can pose potential risks to the clients which may require a combination of techniques, such as crisis intervention, case management, and advocacy as well as clinical interventions. The name Clinical Risk Management Team addresses this fact. These cases may be time-consuming as well as emotionally demanding, evoking strong feelings in workers. Grappling with both the client's needs and one's own reactions can disrupt the work. Clinicians in distress may be less able to maintain a focus within the case, may be less clear and consistent, and less attuned to shifts in client participation in the work. The adverse

effects for clients may range from missed appointments to increased crises and emergency hospitalizations; for staff, the effects may be burnout and frustration (Figley, 1995).

For the clinician, the traumatic experience can be the empathic engagement with the client, the therapist's bearing witness to the client's story. This may be in addition to any personal trauma history, including the terror attacks of September 11 and subsequent threats such as anthrax and other environmental dangers. In contrast to the traditional model of an individual practitioner working alone with each case, we sought a team approach which engages co-workers as a resource and source of support for the primary therapist.

THE TEAM FORMAT

The practitioner working alone with these cases can develop a distorted perspective as a result of secondary trauma. For example, when the client is not changing quickly enough, as by remaining in a destructive relationship, the worker may feel frustrated, ineffective, and hopeless. In contrast, reviewing the work with a team of peers who are not as immersed in the case can provide needed support and help to refocus. A new perspective resulting from team input provides the potential for restoring hope.

> Jackie was treating a ten-year-old child referred for acting-up in school. It was discovered that the mother had been abused and the abuser was still in the home. Jackie began to work with the mother, who said she wanted to leave the relationship and in sessions would make plans to do so, but never followed through and always gave her partner another chance. Jackie was both frustrated and worried for the mother, having had a number of cases where abused women were not able or willing to protect themselves and leave. She felt as ineffective with both child and mother as mother seemed to Jackie to be. In the CRMT meeting, members pointed out the client's strengths and the small but real efforts she was making to leave. The team helped Jackie feel less anxious by developing with mother a safety plan whether or not she remained with her partner. Feeling more effective, Jackie was then able to stop pressuring her client.

The CRMT model focuses primarily on the presenting worker's concern in the case. Countertransference and case issues other than those presented by the worker are noted and can be discussed at another time in supervision or another format. The team is directed to assume a

collegial responsibility along with the therapist for managing the case. According to Catherall, this can include encouragement, advice, correcting distortions, and reframing (1999). In the CRMT model, the worker is encouraged to discuss openly his/her concerns and feelings.

The model highlights the presenting worker's reaction as a way to understand the case better. Because the team members understand and accept that treating trauma affects workers, they can normalize for the presenter the experience of feelings such as revulsion, horror, anger, and a wish to withdraw from the client. As with clients, normalization is relieving and can make for more objectivity and less inclination for the worker to act on these feelings. The team can also help the worker clarify his/her observations in a non-judgmental atmosphere. When the worker shares the client's story with colleagues who respond with empathy and hope, the worker's traumatic reaction is often ameliorated. This frees the worker to resume offering empathy and hope to the client in a similar way.

The team culture recognizes that secondary trauma can include countertransference (Figley, 1995). While countertransference refers to unconscious components within the therapist and is generally considered problematic, secondary trauma can refer as well to conscious emotional responses. The CRMT model emphasizes the stance that these responses are natural elements in the process of the ongoing work. Consequently, being open and able to express troublesome feelings in reaction to clients' issues is accepted and valued by the team, thus alleviating potential stigma and isolation.

In sum, the CRMT model offers staff the support of their co-workers in a structured, case-focused way. This provides the context for staff to maintain their attention, work competently, avoid burn–out, and deal with their own secondary trauma. Acknowledging and dealing with the effects of trauma becomes part of the task for everyone working with these cases.

ONGOING CONCERNS

The team process calls upon colleagues to offer each other safety and empathy as well as help to understand the case from a trauma perspective and to plan interventions. However, the degree of staff openness to the CRMT process was very much related to the pre-existing culture of the particular program. We encountered some situations in which staff did not feel safe enough to use this process because of long–standing problems with trust. In one setting, the CRMT meetings created an opportunity for staff concerns regarding openness to surface.

This staff went on to identify and address these concerns in another forum before returning to the CRMT process. As Catherall notes (1999), the professional group may vary in its readiness to facilitate healing.

For a worker to reveal feelings of distress about the work in some settings could open the clinician to potential criticism in a judgmental atmosphere. This might affect choices about which staff to include in the team, such as to exclude supervisors or directors with authority over line staff. We would caution against this. If there are problems of safety within the team, excluding certain staff only perpetuates the situation. Instead, the team creates an opportunity for these issues to be identified and dealt with appropriately in order to move toward the creation of a safer work environment.

From the outset, we were concerned about whether a setting would continue to use the CRMT model after the pilot phase, when the consultants had gone. In view of organizational pressures for productivity and other constraints, would this process be seen as a luxury or as a necessary structure for dealing effectively with these cases? The follow–up we received both at the end of the piloting process and several months later indicates that the time and attention given to the CRMT has enhanced the ability to work with many of these very difficult cases. In fact, the safe environment created by the team experience is restorative, renewing hope for staff that they are not alone in the work and that they can do the work effectively.

As noted, our role in this process was as outside consultants to the various programs. This raised questions for us as to advantages and disadvantages of an outside consultant as opposed to a leader from the staff itself. An outsider might not know the culture and history of the setting, possibly making trust more difficult, or offering suggestions which are not feasible. On the other hand, this lack of history might activate staff to articulate issues previously unspoken. Outside consultants can present a fresh perspective precisely because they are not immersed in the culture. These are choices to be made by the participants in each setting.

CONCLUSION

Clinicians need help to deal with secondary trauma in order to manage their own feelings, think clearly, and engage with clients effectively. Although our experience has been largely with cases of family violence, and more recently with the events of September 11, the model can be used for all cases of trauma. The CRMT model has evolved

through a process of piloting in different settings within JBFCS and in several outside settings at professional conferences.

As noted, we chose to include all staff, from direct line to consulting psychiatrist when possible, because of our belief that the input of any staff person who has ongoing contact with the client can be useful. In some settings, such as a milieu program, the team might be expanded to include other staff as well. Each setting determines the team composition suitable for its needs.

The CRMT model is worker–focused and specifically designed for a hands–on discussion of cases rather than for didactic learning about trauma. The discussion, nonetheless, often does provide an educational function, as when raising various assessment and treatment suggestions.

The supportive team experience presented here may be less accessible for an individual practitioner in private practice. One possible solution is for such a worker to develop a peer group where a collaborative context could replicate the CRMT model. In piloting the model outside the agency, we have found that even clinicians who do not work together can become engaged to form a team with each other rather readily if a level of trust and safety is established. While a naturally existing team may be preferable and a team with ongoing connections may provide deeper and more comprehensive support, neither is absolutely essential.

In our experience, the CRMT process enables staff to express their feelings about trauma cases in an atmosphere that is validating, normalizing, and safe. When enhanced by structure and support of colleagues, clinicians are able to work more effectively with traumatized clients.

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