ORGANIZATIONAL STRESS AS A BARRIER TO TRAUMA-SENSITIVE CHANGE AND SYSTEM TRANSFORMATION

Sandra L. Bloom, M.D.
Associate Professor
Health Management & Policy
School of Public Health
Drexel University,
Philadelphia, PA 19102
Slb79@drexel.edu

www.cnvsj.org
www.sanctuaryweb.com

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Summary

For the last twenty years, the mental health system has undergone significant change and a great deal of loss as psychiatric hospitals and community mental health systems have decreased their scope of service or been lost entirely. These changes have resulted in a significantly heightened level of individual and organizational stress for the programs that continue to struggle to respond to the needs of adults and children who suffer from serious emotional difficulties. At the same time, knowledge about the traumatic etiology of many of these serious problems has been exploding and significant efforts are underway urging both public and private systems to become "trauma-informed". This paper explores the notion that organizations are living systems themselves and as such they manifest various degrees of health and dysfunction, analogous to those of individuals. Organizations like individuals are vulnerable to the impact of repetitive and/or chronic stress conditions, but since we do not recognize our systems as alive, we treat them as if they were machines, slaves to the whims of current political, social and economic forces. Becoming a truly trauma-informed system therefore requires a process of reconstitution within our organizations top to bottom. It is the job of the staff to become trauma-informed about the impact of past experiences on the evolution of the clients problems. But it is the shared responsibility of staff and administrators to become "trauma sensitive" to the ways in which past and present overwhelming experiences impact individual performance, leadership styles, and group performance. A system cannot be truly trauma-informed unless the system can create and sustain a process of understanding itself. A program cannot be safe for clients unless it is simultaneously safe for staff and safe for administrators. Lacking such a process and despite well-intentioned training efforts, there will be no true system transformation in systems that are now for the most part, "trauma organized" repeating, rather than healing, the injuries previously experienced by clients and staff. The author contends that applying concepts from trauma theory to organizational function can serve multiple purposes. While it provides the leaders and staff of the organization a framework for understanding the frequently dysfunctional adaptations they have made to chronic stress, it simultaneously serves to heighten their awareness of the ways in which exposure to chronic stress has impacted their clients and provides a window into the interaction between organizational dysfunction and individual dysfunction. Better identification of the true nature of the problems leads to better approaches to solve those problems. Interestingly, the world of business, at least as it is reflected in the organizational development literature, is far ahead of the social service world in applying group concepts to the workplace. This paper draws on the organizational development and communications literature, much of which has its roots in group dynamics and the therapeutic community, to help us remember and reintegrate knowledge that has been lost from our own systems.

Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation

Sandra L. Bloom, M.D.

Introduction: Restoring the Context to Psychiatry

A friend shared a quote with me from a former Provost of the University of Pennsylvania, Dr. Vartan Gregorian about system change. He remarked that *"In order to change a system you have to be either a loving critic or a critical lover".* In this paper I have taken that admonition to heart and applied it to the mental health system and the vastly interconnected social service system. For the last forty years I have been an employee, a student, a caregiver, a manager, a founder, a teacher, a writer, and a consultant in both the for-profit and non-profit spheres of the mental health system, and for the last decade I have consulted to many other components of the social service system. I love these systems and I admire the people who work in them. I am proud to spend my time working shoulder to shoulder with those who want to help others, and who believe that this world can be a much better place than it is.

But I am a critical lover. Over the last twenty-five years I have watched a disturbing series of events unfold within the social service network that for me constitutes largely a disintegration of many components of this system. The result of this disintegration is what many other people now are calling "a crisis" in service delivery. Certainly widespread economic forces like managed care have been a major determining factor in creating this crisis, but predatory financial behavior can only occur in an environment that is already philosophically and morally weakened.

When I began my work in psychiatry, I learned that there was an intimate and relationship between the individual who showed dysfunctional behavior of some sort, and the context within which they lived and breathed. This context extended in concentric, interactive and permeable circles around the individual outward and included family, community, nation, and world. I was taught that to help someone, it was important to understand their unique position within those concentric circles and the multiplicity of interacting influences that could be determining their behavior.

The broad term used to encompass these notions was "Social Psychiatry". With its roots in the Moral Treatment of the previous two centuries, Social Psychiatry connected individual problems to the larger social world and found sources for healing, not just within the individual but within the larger context of the community. The Community Mental Health

movement was one of the vital offshoots of this way of thinking as was the democratic therapeutic community. Underlying the notions of social psychiatry was a profound psychodynamic understanding of the complexity of the human mind. Symptoms could only be understood by comprehending the totality of the person and that totality included their individual conscious and unconscious mind and the ways in which we all participate in the group conscious and unconscious mind. Surfacing what could not be readily seen could best be done within a positive relational context and making conscious what is unconscious could help an individual – or a group – make different and less predictable choices.

Through this period and frequently outside of the state institutions, in private and nonprofit clinical settings, as long as the customer was the client, there was an incentive to find methods that would deliver effective therapeutic services to the clients. Clinicians began experimenting with innovative methods for achieving significant gains in a time frame less onerous than that of psychoanalysis. Innovation in what is still a young field of endeavor compared to the other fields of medicine, blossomed.

The fundamental practice of Social Psychiatry within institutional settings was the "therapeutic community" or "therapeutic milieu" (referring to the democratic therapeutic community, not the "concept" therapeutic communities that have been applied in many substance abuse programs in the U.S.). A therapeutic community is designed to address the issue of complexity within organizations and within each individual and the ways in which this shared complexity interacts. One of the founding principles of the therapeutic community is that of "social learning", meaning the creation of an environment where clients and staff are learning from each other all the time, and learning together as a group, how to solve the difficult problems presented by life, a "living learning environment" [1, 2].

An essential aspect of the therapeutic community is that of democratic participation, meaning that everyone – clients, staff, and managers – needs to have a say in the decisions that determine the nature and quality of their lives together. It is recognized that there are differences in power that inhere in all human relationships but power used abusively inevitably emerges as violence. Therefore to create a nonviolent environment – essential for healthy growth, development, and healing – it is necessary to actively manage the shifting distribution of power that exists within any community and to recognize the unconscious forces that exist within any group. Trust between members of a community is essential for a group to work as a unified whole. But human relationships are vulnerable to the betrayal of trust that occurs when conflict is not resolved, when communication breaks down, and when power is abused. The successful management of conflict requires an ever broadening level of emotional and moral intelligence, both of which are learned and practiced within the context of social and political relationships.

When my colleagues and I began the journey that would bring us to the development of the Sanctuary Model, we had all been bathed in this psychodynamic and systems view of psychiatric care. We had been exposed to a variety of schools of therapy and had come to the conclusion that all had something to offer and none knew "the truth", that the truth of an individual client emerged out of their own unique interactions with their history and the environment and that our mission was to facilitate their process of change that would lead to a different and better trajectory than the one they were on when they first came to us. This could only happen if we were taking care of each other, learning all the time, and modeling through our own life's work the possibility of change. As we worked together, over time, we began to recognize that the system we had created collectively was itself a living thing, greater than the sum of the parts that comprised it and subject to its own dynamics.

We learned that this living system we had created had the power to bring about change in our clients that could not be explained solely by our individual efforts but emerged out of this collective process we came to call “Creating Sanctuary”[3]. At the time, the field of traumatic stress studies was shedding a wide beam of light on the origins of most psychiatric disorder in what has become known as the adverse experiences of childhood [4]. The growing research focus on the nature and results of disrupted attachment and emotional intelligence was providing the underlying links between healing and the therapeutic relationship. Drawing upon all of this knowledge to inform treatment, our formerly “resistant” and “chronically mentally ill” clients began making significant changes in their lives that astonished us.

But we learned darker truths as well. The broad agenda of change required by Social Psychiatry has always been vulnerable to criticism largely because its focus of interest is so broad and necessitates not just medical action, but social, economic, and political action as well. Beginning thirty years ago a variety of pressures began to change the face of mental health service delivery so that in many ways it is unrecognizable today as the same system that existed three decades ago.

The growing interest in the biological and genetic causes of mental disorder began to dominate the psychiatric field. Various influences served to fuel deinstitutionalization resulting in the loss of many institutional settings for study and research and the shifting of twenty-four/seven care to short-term, intensely “medical model”, pharmaceutically-driven psychiatric care. Innovation in non-biological therapeutic methods within the mental health system virtually ceased when the customer ceased being the client and became instead the middle managers of insurance companies and the organizations they created or hired, a system known as “managed care”.

As these changes were occurring, my colleagues and I learned that like individual human beings, collective living systems are fragile, that they can be injured, traumatized, and destroyed. For ten years, each of us as individuals struggled to keep our system alive while larger forces than we had the power to control, assaulted the system until finally, we laid it to rest in 2001. In that time, however, we had learned a great deal about treating traumatized people, about the impact of stress on systems as a whole and on the individuals who work within them. After we closed our program, we began the process of introducing the fundamental tenets of the program to residential settings for children, domestic violence shelters, homeless shelters, group homes, outpatient settings, child protection services, acute care inpatient, and substance abuse programs.

What we have found in mental health and social service settings around the country is profoundly disturbing. In inpatient programs, state hospitals, day hospitals, residential treatment programs, outpatient settings, substance abuse treatment programs, group homes, shelters, and child protection services - something is dreadfully wrong. Something has happened to the post-World War II spirit of extraordinary hope and belief in progress in all human affairs, even among the most disordered in our society. The result is a cynicism and hopelessness about the clients our systems are supposed to serve.

As a result, over the last few decades, the problems within all of these systems have been accumulating and compounding insidiously. Clients present at the doors of mental health and social service programs seeking remedy for their problems but they often leave with few solutions and sometimes with even more difficulties than they brought with them. Staff in many treatment programs suffer physical and psychological injuries at alarming rates, become demoralized and hostile, and their counteraggressive responses to the

aggression in their clients create punitive environments. Leaders become variously perplexed, overwhelmed, ineffective, authoritarian, or avoidant as they struggle to satisfy the demands of their superiors, to control their subordinates, and to protect their clients. When professional staff and nonprofessionally trained staff gather together in an attempt to formulate an approach to complex problems they are not on the same page, they share no common theoretical framework that informs problem-solving. Without a shared way of understanding the problem, what passes as treatment is little more than labeling, the prescription of medication, and behavioral "management". When troubled clients fail to respond to these measures, they are labeled again, given more diagnoses and termed "resistant to treatment".

Meantime, the system grinds on, people go to work, workers do the best they can. They frequently change jobs searching for a better place to work while longtime -workers become profoundly demoralized And clients do not get the benefit they could and should be receiving. Managed care companies, recognizing the disarray, seek simple solutions by funding only "evidence-based practices" that selectively endorse only forms of interventions that meet medical standards of proof of efficacy, ignoring the reality that we know most forms of psychotherapeutic interventions are effective as long as several key factors are present [5]

As is always the case when individual financial gain supersedes social welfare, the public system has been the most profoundly affected by these changes. It is still possible for wealthy and middle class patients to seek out therapeutic interventions from knowledgeable and systems-informed therapists, but even for them, if they must be hospitalized, they are unlikely to have anything resembling the kinds of therapeutic experiences offered in years past, although the disassembling of the state hospital systems has also virtually guaranteed that no one will experience any form of inpatient care for more than a few days.

During this era of service systems degradation, there has simultaneously been the emergence of a different way of viewing very complex human problems. Trauma Theory brings context back to human services without denying the important of the biological discoveries of the last several decades. In many ways, Trauma Theory represents Social Psychiatry with a biological underpinning. There are currently significant national efforts directed at helping systems to become "trauma-informed" which is defined as care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and is informed by knowledge of the prevalence of these experiences in persons who receive mental health services. *Trauma Specific Services* are defined as promising and evidenced based best practices and services that directly address an individual's traumatic experience and sequalae and that facilitate effective recovery for trauma survivors [6, 7].

This paper explores the notion that mental health and social service organizations, like individuals, are living systems and that being alive, they are vulnerable to stress, particularly chronic and repetitive stress. Organizations, like individuals, can be traumatized and the result of traumatic experience can be as devastating for organizations as it is for individuals. And the outcome of a traumatic experience will be in part determined by the pre-traumatic level of organizational health and integrity. I believe that at this point, our social service network is functioning as a "trauma-organized system"[8] 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.

Just as the encroachment of trauma into the life of an individual client is an insidious process that turns the past into a nightmare, the present into a repetitive cycle of reenactment, and the future into a terminal illness, so too is the impact of chronic strain on an organization insidious. As seemingly logical reactions to difficult situations pile upon each other, no one is able to truly perceive the fundamentally skewed and post-traumatic basic assumptions upon which that logic is built. As an earthquake can cause the foundations of a building to become unstable, even while the building still stands, apparently intact, so too does chronic repetitive stress or sudden traumatic stress destabilize the cognitive and affective foundations of shared meaning that is necessary for a group to function and stay whole.

For the last few years I have been talking regularly to mixed groups of mental health and social service workers about these notions of organizational stress. Together they represent most of the treatment and service delivery sectors for children, adults and families. Unfailingly, people come up to me at the end of the talk and half-seriously, half-jokingly ask how it could be that I know so much about the place where *they* work. Their feedback combined with my own experience has convinced me that we must reform our systems, or as many people are recommending, "transform" them. But it is not sufficient to think that we can transform our systems to serve our clients without transforming the systems for the people who work within them. A program cannot be safe for clients if it is unsafe for the staff and the administrators.

Living systems are complex and adaptive and therefore, unlike machines, they can learn, they can grow, and they can change. System transformation efforts are underway in the mental health and social service domains, but it is important to give attention to the more "psychological" and "group dynamic" organizational barriers to such vital efforts that may be the key to whether or not trauma-informed change can be sustained. Truly transformative changes are inevitably anxiety provoking and therefore subject to the forces of resistance to change that are so typical of individuals, groups and systems. The study of nonlinear systems is providing us with a framework for thinking outside the box about transformative change and how we can weather the storms of change, minimize resistance, and make the leap into a new and better way of functioning, how we as individuals can promote the *self-organizing* capability that is a characteristic of all living systems. Ideas about a system as a *learning organization* provide a language and a practice for understanding and working within our systems as living things, instead of machines.

But most of the theory and research about organizational dynamics and the process of change is not to be found in the mental health literature or in most training programs. For that, we must look to the worlds of business, management, organizational development and communication and little of this knowledge seems to have found its way into clinical or social service settings in the last few decades.

The goal of this paper is a practical one: to provide the beginnings of a coherent framework for organizational staff and leaders to more effectively provide trauma-informed care for their clients by becoming *trauma-sensitive* themselves. This means becoming sensitive to the ways in which managers, staff, groups, and systems are impacted by individual and collective exposure to overwhelming stress. The goals are to improve clinical outcomes, increase staff satisfaction and health, increase leadership competence, and develop a technology for creating and sustaining healthier systems. It is my belief that only

in this way can the mental health system and its "sister" social service systems become enabled to make a more effective contribution to the overall health of the nation.

Accomplishing such far-reaching goals will require a shift in mental models - wide-reaching changes in basic assumptions that are the foundation of thought, feeling and behavior. Building upon the work of those involved in utilizing and researching trauma theory as well as organizational development theorists and practitioners, this paper will explore a different way of thinking about the systems that currently exist to treat traumatized, emotionally disturbed people and at least begin describing what needs to change in order to allow true system transformation to occur.

To do this, this paper will explore the ways in which organizations function as living systems (Part I) and review some of the previous work that has looked at what an unhealthy or declining organization looks like and what constitutes organizational stress (Part II). To fully understand the impact that the last decade and a half of system erosion has had, it will be necessary to briefly expand on the state of health of the mental health system and explore the notion of parallel process as applied to organizations. Part III will focus not just on individuals but on the many ways in which chronic stress and traumatic stress impact the individual and the organization Using the analogous concept of *"trauma-organized systems"* the paper will explore some of the ways in which organizations develop processes that run in parallel with the clients in their care. As a result organizations under repetitive stress can become crisis-oriented, unsafe, fragmented and amnestic, impoverished, authoritarian, abusive, disempowered, aggressive, chronically bereaved, and demoralized. In doing so they are likely to replicate rather than remedy, the problems of the clients who come into their care.

The final part of this paper is comprised of an introduction to the notions of creating, sustaining, and living *Sanctuary*™ , a nonlinear, complex, adaptive, self-organizing, trauma-sensitive method for learning to think about organizations as living beings, respecting the complexity and challenges of creating and maintaining healthy organizations that support the recovery, growth, development and evolution of healthy individuals. This paper, and the book that is in preparation that expand on it, are derived from twenty years of creating, sustaining, and finally closing a trauma-informed psychiatric acute care setting, and from the experience of introducing these concepts in a state hospital setting [3, 9, 10]. In the last decade, I – along with many other dedicated professionals working in various settings, in a number of states and several countries outside the U.S., have been developing methods to bring about organizational transformation in large and small residential treatment programs for children, group homes, acute adult psychiatric settings, substance abuse programs, homeless shelters, domestic violence shelters, outpatient settings, schools, child protection organizations, and whole communities [11-20][1] . In a collaborative effort with one of those settings, Andrus Children's Center, we have created a Sanctuary Leadership Development Institute to enable other programs to engage with us in this kind of a transformational process and to expand the support networks for people doing this important and demanding work [2]. So far, we only have one controlled study to back up our claims [21-23], but the rapid expansion of the Sanctuary Network should enable us to demonstrate - to more than ourselves, our clients, and their families - that organizational transformation and individual transformation are essential at every level of our social, political, and economic system.

[1] See www.sanctuaryweb.com for more information.
[2] See www.andruschildren.org for more information.

Part I: Organizations as Living Systems

The central position of this paper is that a mental health organization – acute care psychiatric unit, psychiatric hospital, residential program for children, group home, partial program, outpatient program, or the mental health system as a whole – is a living organism. Such a position may seem blindingly ridiculous to some and glaringly obvious to others because two different paradigms presently exist in the corporate world. The older paradigm that has dominated group life – and therefore individual existence – for at least the last two hundred years is a model that sees organizations as machines that operate more or less like clocks with interchangeable parts, lacking feelings, able to perform their function without conflict – regular, predictable, ordered and controlled. The newer model is that of organizations as alive, possessing the basic requirements of a living system [24, 25]. In the organizational development literature, the idea of the organization as alive is not a new one. As one investigator noted:

> *"The prevalence of life cycle and ecological models of change in organization science has produced several generations of theorists who think and write about organizations in terms of life metaphors. According to many accounts, organizations are born, grow up, age to adolescence and maturity, become set in their ways, and eventually die. Although organizations certainly are not alive in any meaningful biological sense, few people question the use of these metaphors in describing organizational life cycles.... Our metaphors strongly condition how we think about organizations. Theorists are preoccupied with when organizations are "born", what species they are (their forms), and when they have changed enough to be termed dead (p.52) [26].*

Although individualism has long dominated our philosophical premises, there is a growing body of evidence to suggest that groups are a basic form of social and cognitive organization that is essentially "hard-wired" into our species and that our 'group-self is the core component of our sense of personal identity (Cohen, Fidler, & Ettin, 1995). *Groupmind* is the word that has been used to describe the concept of a supra-individual nature and independence of the collective mind of a social group. The concept goes back at least to the German philosopher Hegel and Durkheim, but it was the social psychologist McDougall who became convinced that a society is more than the mere sum of the mental lives of its units and he concluded that "a complete knowledge of the units, if and in so far as they could be known as isolated units, would not enable us to deduce the nature of the life of the whole" (McDougall, 1920).

The current concept that holds the most theoretical and practical promise is that of complexity theory in which an organization is viewed as a complex adaptive system that is self-organizing [27]. In complexity theory, one way of understanding how collective phenomenon could arise and be different than the components that comprise it is through the concept of *emergence.* The simplest way of understanding emergence is that it occurs whenever the whole is greater than – or smarter than – the sum of the parts. It is about understanding how collective properties arise from the properties of parts and the

relationship between them [28]. As neuroscientist John Holland has written in his book on the topic, *"we are everywhere confronted with emergence in complex adaptive systems – ant colonies, networks of neurons, the immune system, the Internet, and the global economy, to name a few – where the behavior of the whole is much more complex than the behavior of the part (p.2)"* [29].

In the business world, unlike the social service sector, the new paradigm has been itself emerging in part due to the enormous pressures of globalization. Some strong proponents of this emerging point of view in the business world have claimed that "*the 20th century gave birth to a new species – the global corporation… a life form that can grow, evolve, and learn"*[30]. In this new paradigm, individual consciousness becomes even more – not less – important so that *"the key challenge is to apply inner knowledge, intuition, compassion and spirit to prosper in a period of constant and discontinuous change (p.6)"*[31]. As organizational development expert Peter Drucker notes, "*The organization is above all, social. It is people. Its purpose must therefore be to make the strengths of people effective and their weaknesses irrelevant. If fact, that is the one thing only the organization can do – the one reason why we have it and need to have it"*[32].

Some of the most useful explorations of organizations as collective and living organisms derive from the study of *organizational culture.* Organizational culture determines can be defined as a "pattern of shared basic assumptions that a group has learned as it solved its problems…and that has worked well enough to be considered valid and taught to new members" or "How we do things around here". Organizational culture matters because cultural elements determine strategy, goals, and modes of operating.[33]. Let's glance at the mental health system using first the lens of organization-as-machine and then the lens of organization as living system.

The Mental Health System as Machine

Society's charge to the mental health system is to take care of the "problem" of the mentally ill. Depending on the historical era, sometimes the emphasis shifts to rehabilitating, curing, or at least treating the mentally ill, and at other times the emphasis is on preventing the mentally ill from interfering with the smooth running of society. Whatever, the case, historically the mentally ill have been seen to jam the gears of industrial progress and put a drain on the system. They have been considered society's waste and those who labor in the industry designed to take them off society's hands are doing work that has sometimes been considered noble and infrequently heroic, but remains work that is largely undervalued, relatively low-paid and low status employment.

In the machine model of organizations, the identity and purpose of the organization-as-machine is imposed from outside, by its owners or representatives. Major decisions are made by those same owners or representatives and communicated downward to those who may be profoundly affected by those decisions but who play little if any role in making the decisions. A machine must be controllable by its operators and exerting control is the primary job of management in the model of organization-as-machine.

The issue of control is a primary component of the mental health system since the system itself is hired by the public to restrict and restrain behavior on the part of the mentally ill that is by definition "out of control". The definitions of what constitutes out-of-control behavior is itself strictly controlled by the intricate diagnostic labeling system of the

Diagnostic and Statistic Manual that allows entry into the mental health system and from which it is virtually impossible to extricate oneself once drawn into it.

Mental health organizations, like most current businesses and virtually all social service agencies, are strictly hierarchical in structure in order to exert top-down control over the employees whose job it is to control the patients in their care. In an era of dominance by biopsychiatry, the patients are expected to take medications that will control their symptoms. When the management hierarchy fails to adequately control its charges, some form of external authority must come in to "fix" the program machine. If it is the patient that needs to be fixed, a new medication will be prescribed. If it is the employee that needs fixing, the process will begin with their immediate supervisor. If it is the organization itself that is broken, then some regulatory body will step in to impose some sort of action intended to correct the problem.

Machines change only if someone changes them and mighty efforts have been and still are expended in trying to make the mental health system change. If you replace the headlamps in your car, you do not expect your car to complain about missing its familiar companions. Machines do not generally react to imposed change, except perhaps to operate more smoothly when repairs are made. The latest spate of changes in the mental health system have revolved around "cost savings" and "fiscal discipline" and "managed care" and the mental health system-as-machine should logically respond no differently than your car to significant infrastructure changes.

Human beings – in an organization-as-machine are simply parts of the machine. If the part wears out or breaks, it is to be replaced by a similar part to keep the machine operating. In this model, occurrences like layoffs, dramatic changes in trained professional staff to patient ratios, or therapist turnover should really have relatively little effect since other people-as-machines have been designated to fill in the holes left by others. Of course, the whole machine can break down and if that happens, it is the job of management to rebuild it. In some cases, the society comes to view the machine as obsolete and simply throws it away as has largely happened to our large state hospital systems and many other psychiatric settings as well. And machines do not learn – they can do no more than their individual parts allow them to do and experience has no effect other than to wear them out.

The Mental Health System as a Living System

A system is a set of interconnected elements that are *interdependent* so that changes in some elements or their relations produce changes in other parts of the system. A system is comprised of a set of components that work together for the overall objective of the whole [34, 35]. Unlike a machine - like your car, or your vacuum cleaner - a therapeutic environment is a living system – open, complex, and adaptive. It is comprised of the staff – at all levels, the clients, and their families. It is rooted within a mental health system that is a component of the social service system of a county and state, and all are set within a

country, a country that is embedded within a global civilization. The past history of that treatment program, like the histories of the individual children and staff, and the systems they are embedded within, continue to determine present behavior and in every moment, present behavior is playing a role in determining the future. All of these components – individual, group, organization, local government, national government, global influences, past, present and future – all are interacting with and impacting on each other in complicated ways, all of the time – that's what makes things so *complex*. It is this complexity that compels the usual oversimplification that occurs whenever an individual, or a group of individuals encounters the apparently overwhelming complexity of changing systems.

Living systems are *open systems* because they accept input from their environment, they use this input to create output, and they then act on the environment. Living systems are adaptive because they can *learn* and based on that learning, they can adapt to changes in their environment in order to survive. As a living system, the mental health system and every component of that system has an identity, a memory, and has created its own processes that resist changes imposed from above, but will evolve and change naturally if the circumstances are conducive to change.

Living systems are not entirely controllable by top down regulation. Like the human body, a living system functions through constant feedback loops, flows of information back and forth. In the body, there certainly are hierarchies but these hierarchies are "democratic hierarchies" – power distribution is circular [36]. Regulation comes through feedback mechanisms and changes constantly over time, adjusting and readjusting to internal circumstances that have been altered and reacting and adjusting to external changes in the environment. Information from below in the hierarchy has as much influence as control mechanisms higher in the hierarchy. (If you find this difficult to believe, just try focusing your own intellectual attention on something when even your little toe is throbbing with pain.) A living system evolves, regenerates, and self-organizes to adapt to changing circumstances. Living systems learn and use that new information to alter present and future behavior. A living system is constantly balancing and rebalancing to maintain homeostasis. And in a living system there is no such thing as "health" – health is a relative term. You cannot feed a living system and then leave it alone - it must be fed and maintained all the time.

Machines are owned by someone. They are property. But what about the question of ownership in living systems? Do relationships come with price tags? Is it morally acceptable to profit from someone else's suffering? As Peter Senge points out, *"most people in the world would regard the idea that one person owns another as fundamentally immoral. Is it no less problematic with regard to a company?"* (p.viii) [24]. Once financial gain or at least financial savings began to drive the mental health systems, decision making criteria changed. Decisions are and routinely have been made that have profoundly impacted service delivery in the mental health system with little meaningful concern for the systemic impact, the effects on employees, or on consumers. Nor have these interested parties had much input into those financial decisions. In the financial restructuring of managed care, radical changes were made in vital institutional aspects such as staffing, reporting requirements, and professional training demands with little consideration given to the impact on service delivery or on employee well-being. This happened largely because it was possible to make it happen. Despite the fact that the mental health system is a living system, it has been treated as if it were a machine owned by others who are free to manipulate the system in any way necessary to achieve greater gain or reduced cost.

But is it any wonder that we have stayed with a machine-model of living systems for so long? We are all familiar with machines – they are so much more manageable. And regardless of how complex, there is always an expert somewhere who can help us repair our machines when they break. In the organization-as-alive model we are confronted with an overwhelming complexity, a logic that frequently appears nonlogical and counterintuitive. This is because machines are linear – they do what we tell them to do and we can predict by what we put into them, what will come out. They are predictable and therefore they soothe our anxiety that is always aroused in situations of uncertainty. In contrast living systems are *nonlinear.* They frequently do not do as they are told, they are not predictable, and the more we try to exert control over them to get them to do what we want them to do, the more contrary and unpredictable – and stubborn - they appear to be. Being able to learn is one of the definitions of a healthy, self-organization system. In the next section we will review some information from the business world about what constitutes health and the loss of health in an organizational setting.

Organizational Health & Dysfunction

Although not always practiced, it is well-established in the world of business that healthy organizations provide measurable business advantages. It is also established that there is a strong relationship between the culture and people practices of organizations and the productivity and health of their people, a relationship so strong that investing in people is seen as a wise strategy for achieving and maintaining high levels of bottom-line business success [37].

The importance of creating a corporate culture that relies on mutual trust is recognized as critically important. *"The implementation of high performance or high commitment work systems requires … a serious commitment to doing things differently … It is almost impossible to successfully implement high performance or high commitment work practices in the absence of mutual trust and respect. But trust is missing in many employment relationships — and … the atmosphere in the work place is crucial. All work place practices and changes should be evaluated by a simple criterion: Do they convey and create trust, or do they signify distrust, and destroy trust and respect among people?"* [38].

This new paradigm for what constitutes a healthy organization – defined by more than financial profitability but consistent with that profitability – reflects a growing recognition that businesses are indeed alive and that corporate responsibility entails recognizing and responding to issues of ecological sustainability [31]. The most explicit description of this idea emerges through a widespread discussion in the business world of a "learning organization" which is an organization skilled at creating, acquiring and transferring knowledge and modifying its behavior to reflect new knowledge and insights [39].

Little has been done to imply insights about the *learning organization* to the mental health system or the social service system despite the fact that helping people to change – through learning – would seem to be the essential mission of all organizations concerned with the well-being of individuals and families. Discussion of many of the characteristics of a learning organization can be found in the pages ahead but for now let us just look at an abbreviated list of the common characteristics of the learning organization: 1) the presence of tension; 2) the presence of systems thinking; 3) a culture which facilitates learning [39].

These characteristics mirror longstanding insights of how to create healthy environments that derive from the therapeutic community literature, perhaps best described by one of its originators, Maxwell Jones when he discussed the concept of "social learning" as "*the little understood process of change which may* result from the interpersonal interaction, when some conflict or crisis is analyzed in a group situation, using whatever psychodynamic skills are available"(p.70) [2].

But because a system is alive it can become unhealthy just as our individual bodies can become ill. The illnesses that systems manifest can be acute and short-term, or chronic and long-term. Living systems can become self-destructive and suicidal and they can even die. Later we will look at the state of health of the mental health system. For now let's briefly review some ideas formulated over the last half century about the ways in which organizations can manifest dysfunction and disability.

Unhealthy Organizations

- As in the case with diagnoses of individual problems, more attention has been paid to defining what comprises an unhealthy organization than describing a healthy one. Some of the earliest explanations were psychodynamic in origins, from describing the organization as an environmental mother so that when an organization breaks down, the effects are not dissimilar to maternal breakdown: *"its containing function is destroyed. The safety provided by the external frame is replaced by a sense of danger, and primitive anxieties and defense mechanisms abound (p. 254)"* [40]. Erich Fromm described "socially patterned defects" wherein "the individual shares a defect with so many others that he is not aware of it as a defect, and his security is not threatened by the experience of being different, of being an outcast, as it were" (p. 15) [41].

Whether we refer to the "declining organization" [42] or the "neurotic organization"[43], the "snakepit organization" [44], the "addictive organization" [45], or "high fear organizations" [46], unhealthy organizations have a great deal in common. There is a general air of degradation and and a sense that everything is always falling apart and one must be very careful to make sure that it does not fall on you. There is a general lack of energy, low motivation and low morale among the people in the organization. Organizational goals and standards are not generally agreed upon by the employees, and frequently the stated goals are not consistent with what actually occurs, although this discrepancy is never directly confronted.

Standards tend to be low and norms are disrupted, unclearly stated, and unmonitored. There is a great deal of individual unhappiness, dissatisfaction and complaining, but the complaining is usually indirect and frequently takes the form of gossip or rumors that in a circular way tend to lead to more dissatisfaction. The environment is rife with conflicts but these are not dealt with directly and communication tends to be indirect, confused and ineffective. Memos or email frequently substitute from meaningful interpersonal communication. There is a long list of things that cannot be discussed because of the fear of negative repercussions, even if no one has ever actually witnessed such repercussions. The boss is never to be questioned at any level of the hierarchy and the hierarchy is fairly rigid. Decision-making is not shared and there is little feedback from below to above once decisions are made.

The atmosphere of routine boredom and unhappiness is interspersed with periods of crisis that creates intense feelings and allows people to momentarily work together for the common good, but this commonality is rapidly eroded with the return to business-as-usual, until the next crisis occurs. There is a repetitive, reoccurring pattern of behavior and the general attitude of the staff is that "nothing really changes here". Learning from the past does not appear to happen and there may be a loss of corporate memory for events that could be instructive, were they to be recalled. Change efforts are met with a passive resistance that tends to chase off competent leaders, leaving less confident and competent leadership in its wake. There is a lack of transparency and an air of secrecy, even about events that could easily be aired publicly and openly. Ultimately, this is an environment that leads to dishonesty and ethical deterioration.

Toxic Leaders

Such an unhealthy environment lends itself to the emergence of what have been described as "toxic leaders". Toxic leaders are subtly or overtly abusive, violating the basic standards of human respect, courtesy, and rights of the people who report to them. They tend to be power-hungry and appear to feed off of the use and abuse of the power they have. They play to people's basest fears, stifle criticism and teach followers never to question their judgment or actions. They lie to meet their own ends and tend to subvert processes of the system that are intended to generate a more honest and open environment. They compete with rather than nurture other leaders, including potential successors and tend to use divide-and-conquer strategies to set people against each other. Toxic leaders will not hesitate to identify scapegoats and then direct followers' aggression against the designated scapegoat rather than themselves. They frequently promote incompetence, corruption, and cronyism and exploit systems for personal gain [47].

The Mental Health System

Now, if we look at the mental health system as a whole living system and we keep in mind the work that has been done in looking at the characteristics of unhealthy organizations, what do we see? A dictionary describes a "siege mentality" as a shared feeling of helplessness, victimization and defensiveness that evolved from real sieges when an army attempted to capture a city, town or fortress by surrounding and blockading it. Today it refers to persecution feelings by anyone in the minority and is a phenomenon that is particularly common in business as a result of competition or downsizing [48].

Mental Health: A System Under Siege

The Known Burden on the System

According to the former Surgeon General of the United States, about one in five Americans experiences a mental disorder in the course of a year or 44 million people per

year. Approximately 15 percent of all adults who have a mental disorder in one year also experience a co-occurring substance (alcohol or other drug) use disorder, which complicates treatment [49].

About 10 percent of the U.S. adult population use mental health services in the health sector in any year, with another 5 percent seeking such services from social service agencies, schools, or religious or self-help groups. Approximately one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year, but only about 5 percent of all children experience what professionals term "extreme functional impairment" [49].

Yet critical gaps exist between those who need service and those who receive service. Given that 28 percent of the population has a diagnosable mental or substance abuse disorder and only 8 percent of adults both have a diagnosable disorder and use mental health services, one can conclude that less than one-third of adults with a diagnosable mental disorder receives treatment in one year. In short, a substantial *majority* of those with specific mental disorders do not receive treatment [49]. In the United States, mental disorders collectively account for more than 15 percent of the overall burden of disease from *all* causes and slightly more than the burden associated with all forms of cancer [50].

Adverse Childhood Experiences – The Ever Growing Burden

The health of the mental health system becomes even more important when we look at the recent "Adverse Childhood Experiences Study". This study, the largest of its kind to examine the health and social effects of adverse childhood experiences over the lifespan, included almost 18,000 participants. An adversity score or "ACEs" score was calculated by simply adding up the number of categories of exposure to a variety of childhood experiences including severe physical or emotional abuse; contact sexual abuse; severe neglect; living as a child with a household member who was: mentally ill, imprisoned, a substance abuser; or living with your mother who was being victimized by domestic violence; or parental separation / divorce.

Of this middle-class, largely Caucasian, and educated population, almost two-thirds of this the population had an ACEs score of one or more, while one in five was exposed to three or more categories of adverse childhood experience [51]. Two-thirds of the women in the study reported at least one childhood experience involving abuse, violence or family strife. The study showed that adverse childhood experiences are surprisingly common, although typically concealed and unrecognized and that ACEs still have a profound effect 50 years later, although now transformed from psychosocial experience into organic disease, social malfunction, and mental illness. There was a strong, graded relationship to adverse experiences in childhood and smoking, chronic obstructive pulmonary disease, hepatitis, heart disease, fractures, diabetes, obesity, alcoholism, IV drug use, depression and attempted suicide, teen pregnancy – including paternity, sexually transmitted diseases, occupational health and job performance. If you are a woman and have adverse childhood experiences your likelihood of being a victim of domestic violence is increased and if you are a man, your risk of being a domestic violence perpetrator is increased. The authors of the study concluded that adverse childhood experiences are the main determinant of the health and social well-being of the nation and that childhood adversity determines the likelihood of the ten most common causes of death in the United States [4].

As a nation we desperately need a healthy mental health system to respond to what amounts to a public health disaster. It needs to a system that can respond to injured children, adolescents, adults and families and able to engage in primary, secondary and tertiary prevention efforts. So how fit is our mental health system to respond to the overwhelming needs facing it?

An Already Burdened System Takes Many Hits

The mental health system has taken a real beating in the last two decades, a beating so severe that it can be considered a "system under siege". State and federal cutbacks and twenty-five years of reductions in the social service system are taking a toll on every aspect of the social network including mental health. Mental health had still not achieved parity with the physical health system by the time the incursion of managed care companies into the diagnosis and prescription of treatment began to severely limit care. This has had a demoralizing effect on many individual and organizational clinicians and has increased the amount of paperwork exponentially. Regulatory agencies have been tightening their hold over what organizations can and cannot do without necessarily fully considering the already existing constraints on the organizations. Consumers have become increasingly vocal about compromised care.

Funding changes have caused reductions in staffing patterns reduced staff training, reduced lengths of stay, and higher acuity of patients who come into care. Since every treatment program is interdependent with every other aspect of the social service system, anything that jeopardizes the function of one part, can negatively affect the other parts. Competition for labor has meant a decrease in the educational level of many of the staff hired in institutional settings. Lawsuits have not significantly diminished, nor has there been significant tort reform to save institutions from the ever-present fear of legal involvement. All of these stressors comprise the background "noise" of chronic stress that makes the reactions to acutely stressful situations magnified and unmanageable.

The Documented State of Crisis

An abundance of reports highlight the present dysfunction of the mental health system as a whole. According to multiple reports looking at the present state of the mental health system, separate health, mental health and substance abuse service delivery systems and funding sources, differences among clinicians in practice orientation and training, and various consumer concerns are just some of the barriers that must be overcome to deliver effective integrated care.

According to the President's New Freedom Commission on Mental Health, *"The mental health services system defies easy description…. Taken as a whole, the system is supposed to function in a coordinated manner; it is supposed to deliver the best possible treatments, services, and supports-but it often falls short".* [52]. As the Bazelon Center for Mental Health Law points out, *"Fragmented care remains the norm for individuals with serious mental disorders. The delivery systems for mental health, substance abuse and physical health care are separate, often with different financing arrangements and policy-setting"* [53].

The Consumer Movement

Who exactly *is* the customer for the mental health system? Public agencies and officials? Insurance companies or their surrogates, managed care companies? Employers who pay for the health care insurance? Or, the consumers themselves, those who suffer from emotional illnesses and seek treatment within the mental health system for those problems? The consumer and recovery moment are finally achieving a voice, fueled in part by the recognition of the extent of underlying exposure to trauma and violence in the population and by numerous recent accounts of abuse within the mental health system itself.

But in terms of moving the system itself, the consumer voice is still a small one. In part this is because - according to the Surgeon General's Report on mental health from 1999, among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability, as well as by age or gender or by the racial and cultural identity of those who have mental illness [49]. These are critically important goals for a healthier society, but also a tall order for people who have historically had almost no voice in determining the goals or methods of the system itself, who have little political power, and who are still significantly stigmatized by the larger culture.

Communication and Information Transfer

And what about communication and information transfer, essential ingredients for any healthy system? Information is not easily shared among different components of the mental health system, much less with systems that interact with mental health. There is not a shared conceptual framework or language between components such as mental health, substance abuse, and physical healthcare [54]. Information systems, if they exist in other than a primitive form, vary between different settings and are not necessarily compatible with each other. To make matters worse, confidentiality laws and practices for mental health and substance abuse are more stringent than for physical health care. A study of three Medicaid behavioral health plans found that information-sharing between clinicians in different systems is hindered by differing confidentiality rules. Before records can be shared, individuals must sign a separate release authorizing their mental health or substance abuse caregivers to furnish information to their primary care physician. Some behavioral health clinicians simply do not ask for authorization nor do they discuss the advantages of sharing information with others who are involved in the consumer's care [53]. Particular problems arise when the client can block the flow of information between systems and the information turns out to be a secret that is vital for the providers to know – like a history of substance abuse. Additionally – and very importantly - state-of-the-art treatments, based on decades of research, are not being transferred from research to community settings [55].

Mirroring Disorder Instead of Treating Disorder

The combined implications of these experiences and reports are that the mental health system appears more determined by something the opposite of what is intended. In many ways the system itself appears to reflect the disordered minds of its patients rather than the solution to their problems. In their Interim Report for the President's New Freedom Commission on Mental Health, the conclusions were that

> *"Our review for this interim report leads us to the united belief that America's mental health service delivery system is in shambles. We have found that the system needs dramatic reform because it is incapable of efficiently delivering and financing effective treatments-such as medications, psychotherapies, and other services-that have taken decades to develop. Responsibility for these services is scattered among agencies, programs, and levels of government. There are so many programs operating under such different rules that it is often impossible for families and consumers to find the care that they urgently need. The efforts of countless skilled and caring professionals are frustrated by the system's fragmentation. As a result, too many Americans suffer needless disability, and millions of dollars are spent unproductively in a dysfunctional service system that cannot deliver the treatments that work so well"* [52].

Organizational Health? Not By Ignoring the Workforce

In the organizational development literature, the criteria used to define a healthy organization relate to the management of the people actually doing the work of the organization – team management, professional development, learning opportunities, shared decision making, a substantial rewards system, recognition for innovation and creativity, a high tolerance for different styles of thinking and ambiguity; respect for tensions between work and family demands; job sharing, parental leave, childcare, a specific corporate social agenda; job safety awareness; and change management – all are criteria not discussed in any of the recent national reports which are notably silent about the people who actually do the work in the mental health and social service systems.

Although a report from the National Mental Health Association addresses the lack of cultural diversity among mental health clinicians and notes the workforce crisis in mental health because *"faced with high stress and low paying jobs, many potential clinicians have turned away from the mental health service sector"*, little else is mentioned about what it truly takes to create and sustain health within an organization [56].

This lack of attention to the people who actually deliver the service that is the centrally stated mission of the mental health system is not surprising if we consider the working model of mental-health-system-as-machine. In such a model, the workers are simply pieces of the machinery and being such, their feelings, beliefs, and thoughts do not need to be considered, any more than you would consider the feelings, beliefs or thoughts of your refrigerator. All that matters is the behavior and if the behavior fails to meet the needs of the system, you replace the people and get new ones, just as you replace your old refrigerator. It is ironic that factories that make widgets, and companies that do financial planning pay more attention to the well-being of their employees than systems designed to deliver vital health, social welfare and mental health care services to human beings.

Signs of Arrested Development

Looked at from a developmental point of view, the mental health system represents an example of arrested organizational development attested to by the systemic fragmentation, lack of clear purpose and foreshortened vision of the future [57]. This failure of development is most poignantly recognizable within the institutional setting. Since the origins of the state systems in the nineteenth century, the course of institutional psychiatry has been plagued by a seemingly terminal repetition: a positive vision of healing, empowerment and recovery in all its complexity is washed away by ignorance, greed, and a social lack of commitment on the part of society as a whole. The small, treatment oriented programs with a high staff-to-patient ratio and a rich network of relationships that characterized Moral Treatment were supplanted by the huge bureaucratic institutions that came to be called "state hospitals" and we have been busy disassembling them for the past three decades. But rather than seeing that many people need and can benefit from twenty-four/seven care when it is done properly, we have substituted once again ignorance, greed and a social lack of commitment called "managed care" to slowly strangulate inpatient treatment in all of its forms, while laying all of the blame for systemic shortcoming on the mental health system for its own failures.

The latest enthusiasm is for "evidence-based practices" as the only form of service delivery that should be permitted. Although a rigorous concern about outcomes should be the basis of any form of treatment, the burden of expecting practitioners to only use double-blind, scientifically demonstrated treatment methods is short-sighted and absurd for many reasons, not the least of which is that we already know that therapy works – and no therapy seems to work better than any other. The simpler the problem, the simpler the approach may be. But likewise the more complex the problem, the greater the demand for complex approaches to healing and recovery. Complex approaches have been well-described already and well studied. According to those who have thoroughly reviewed the existing literature, successful outcomes hinge on four fundamental factors: 1) factors related to what the client brings to the situation (accounting for about 40% of outcome); 2) the therapeutic relationship (accounting for about 30% of outcome); 3) expectancy and placebo factors – also known as "hope" (accounting for about 15% of outcome), and 4) an explanatory system that guides healing rituals (accounting for the last 15% of outcome) [5]. This means that 60% of what accounts for whether or not a person responds to treatment hinges on the people delivering the treatment. If they develop a positive, warm, supportive and empathic relationship, support the development of hope that progress can be made, have a clear rationale for what they are doing that outlines a therapeutic map of recovery, and empower the client to help themselves, there is likely to be improvement.

This explains why the mental health system and all components of the social service system are in such straits and why so many workers within these systems have become profoundly demoralized. The very factors that appear to make the largest contribution to outcome are those most affected by the radical changes in mental health and social service institutions – relationship, hope, and therapeutic healing rituals. Little attention has been given to the impact of downsizing, increased workload, increases in job complexity, loss of role definition, frustrated career development, increased levels of risk, toxic organizational cultures, or severe ethical conflicts on the workforce within these systems.

To find a way of even thinking about how these components of workplace stress affect the central healing mission of our social service and mental health networks, we have

to turn to the world of business and finance where these subjects have been studied. The business community has been reckoning with the impact of chronic and recurrent stress on employees and on the system as a whole because of the negative impact on the bottom line of companies.

Part II: What Constitutes Workplace Stress?

Definitions, Scope & Costs

Like the various systems that comprise the human body, individual human beings and human systems seek *homeostasis* or balance and anything that causes *imbalance* gives rise to a requirement for resolution of that imbalance or restoration of the homeostasis [50]. This notion of imbalance is consistent with another observation that workplace stress is created by *uncertainty* that occurs in the work environment [58].

According to several of the most significant contributors to the study of organizational stress, stress is not a factor that resides in the individual or the environment; rather, it is embedded in an ongoing process that involves individuals transacting with their environments, making appraisals of those encounters, and attempting to cope with the issues that arise. It is this transactional characteristic that makes the stress concept so useful and consistent with thinking about the impact of a variety of factors on complex adaptive systems. But it also means that stress on individuals is likely to produce strain on the organization-as-a-whole and stress that the organization experiences - such as funding changes, loss of programming, downsizing, and mergers - are likely to strain individual coping skills.

The National Institute for Occupational Safety and Health (NIOSH) defines job stress as the *"harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker".* According to NIOSH, job stress has become a common and costly problem in the American workplace, leaving few workers untouched while 40% of workers report that their jobs are very or extremely stressful. According to NIOSH, one-fourth of employees view their jobs as the number one stressor in their lives; three-fourths of employees believe the worker has more on-the-job stress than a generation ago. Problems at work are more strongly associated with health complaints than are any other life stressor, more so than even financial problems or family problems [59].

There are many indicators of individual stress including: an increase in unexplained absences or sick leave, poor performance, poor time-keeping, increased consumption of alcohol, tobacco or caffeine, frequent headaches or backaches, withdrawal from social contact, poor judgment/indecisiveness, technical errors, constant tiredness or low energy, unusual displays of emotion [60]. The ways in which individuals respond to workplace strain is multiply determined by individual, job-specific, and organizational sources [50].

As for the cost of workplace stress, a writer for the Harvard Business Review has estimated that 60-90% of medical problems are associated with stress and one large insurance company estimates that 45% of corporate after tax profits are spent on health benefits [61]. But that only reflects a portion of the actual cost. A true analysis must include absenteeism, job turnover, replacement cost for employees who leave the job, accidents, workplace injuries (and in the worse cases, death), the long-term use of tobacco, alcohol

and drugs and the health consequences of those, to say nothing about the costs of quality control, administration, and customer service problems related to stress. According to a group called The American Institute of Stress, chronic stress adds over $300 billion each year to cover associated health care costs and absentee rates. That represents a cost of over $600 to every "stressed" worker without getting anything in return. Even worse the cost for health insurance of a single employee doubled over the last few years and is still rising [62]. The next section briefly reviews some of the findings about the impact of work stress on individuals and some of the sources of job-specific stress that are particularly relevant to the mental health environment – past history, downsizing, ethical conflicts.

Stress & Individual Health

A large body of research has accumulated about the impact of stress on the individual. In general, it has been found that stress has a negative relationship with psychological well-being [63], psychosomatic symptoms [64], mental health [65], attitudes toward role senders [66], commitment [67], job threat and anxiety [68], non-work satisfaction [69] and job involvement [70]).

A Massachusetts-based study dating back to 1972 showed the surest predictor of heart disease was job dissatisfaction [62]. A recent study conducted by LLuminari® found that 54 percent of workers leave work feeling fatigued. Ten percent of workers are too tired to enjoy their leisure time. The result is that one out of five workers is at risk for stress-related health problems. In addition to a threefold risk for heart and cardiovascular problems, stressed employees are two to three times more likely to suffer from anxiety, back pain, substance abuse, injuries, infections, cancers, and obesity [62].

And then, there is substance abuse. Alcoholism causes 500 million lost work days annually. Absenteeism among alcoholics or problem drinkers is 3.8 to 8.3 times greater than normal and up to 16 times greater among all employees with alcohol and other drug-related problems. Family members of alcoholics and substance users use ten times as much sick leave and have higher than average health care claims than family members of non alcoholic and substance using families. [62].

Sources of Stress

Bill Wilkerson, CEO of Global Business and Economic Roundtable on Addiction and Mental Health, conducted a survey to find the top ten workplace stressors. The top ten workplace stressors included: "the treadmill syndrome" where employees have too much or too little to do; random interruptions – telephone calls, walk-in visits, demands from supervisors; pervasive uncertainty as a result of organizational problems, unsatisfactorily explained and announced change; funding changes; mistrust, unfairness, and vicious office politics; unclear policies and no sense of direction in the organization; career and job ambiguity resulting in feelings of helplessness and lack of control; no feedback - good or bad; no appreciation; lack of communications up and down the chain of command leading to decreased performance and increased stress; lack of control as the greatest stressor in the workplace because employees feel that they have no control over their participation or the outcome of their work [61]. Although there seems to be no similar survey on mental

health organizations themselves, the similarities in employee complaints cannot be ignored. It is important to note that these sources of stress appear to have very little to do with the work itself. Instead, the main sources of stress on workers are the ways in which organizations operate and the nature of the relationships that people experience within the work setting.

Downsizing

Repeated downsizing has become a staple of the mental health world that has become virtually universal with negative consequences to morale, program development, innovation, training, supervision and virtually every aspect of mental health care. Since human beings are human beings and not replaceable parts of a machine, people suffer as a result of layoffs, and not just those who are laid off. Research on downsizing has shown an array of negative results and minimal positive results for organizations, confirming a decline in job satisfaction and organizational commitment among survivors as illustrated by one study that looked at downsizing in a large medical rehabilitation hospital [71]. Research, published in the February 2004 British Medical Journal, found that the risk for a worker having a heart attack and hospitalization doubled after downsizings, along with a number of other conditions and that the risk occurred at a higher incidence following rapid expansion as well [72].

One group of investigators described a "Survivors' Syndrome" and suggested that there are three stages survivors progress through after a layoff: a sense of anguish, brought on by change, heightened job insecurity and the loss of friends and companions; a neutral stage, a sort of healing time; and a time when survivors get a grip on themselves and become productive employees again [73]. Severe funding cutbacks in the mental health field have resulted in cutbacks in most mental health service providers and therefore the loss of jobs and key personnel. In the case of line workers, this often means the loss of someone upon whom you have depended for a sense of safety, not just for collegial relationships. In dealing with volatile, sometimes dangerous clients in situations that are highly emotionally charged, social support is likely to be the only attenuating factor that helps staff members manage difficult situations in a constructive way. When team members are laid-off or leave because of adverse work conditions, the vital network of social support is eroded.

The impact of these losses on teamwork, communication, and emotional management is frequently devastating to the total environment. As an example, recent newspapers reported that in Spokane, Washington, one-fifth of mental health workers in the non-profit sector were going to be laid-off [74]. The impact on the most vulnerable members of the community is likely to be devastating, but the impact on every member of the mental health sector that does not lose their job and must pick up the slack and therefore ration services will also be devastating. And despite the fact that there are far fewer people necessary to do the work, no individual will be held any less legally liable should someone fall through the cracks and suffer harm as a result. The emotional, physical, and professional toll that lawsuits take on the individual are well established since individuals are frequently held to be legally responsible for problems that are far more complex than the individual and instead involve the entire system [75].

Workload and Job Complexity

Research has demonstrated that there are many job-related sources of stress that are major contributors to stress-related problems. One is workload – both too heavy and too light a workload can be stressful. However, in the case of the mental health system, conditions leading to too light a workload are presently difficult to imagine. On the contrary, research in acute mental health settings has demonstrated that a lack of adequate staffing is the main stressor reported by qualified staff and qualified nurses reported significantly higher workload stress than unqualified staff. In one important study, approximately half of all nursing staff showed signs of high burnout in terms of emotional exhaustion [76].

Level of job complexity is known to be another source of stress and it is difficult to conceive of a subject more complex than trying to help someone recover from the long-term effects of multiple traumatic and abusive experiences in a limited period of time with radically reduced resources. Yet that is what virtually every mental health practitioner should be doing and this is notion is at the heart of the movement to make services "trauma-informed". This demand is particularly challenging for staff in children's programs, since the child is still developing and the outcome of treatment may – or may not – alter a child's destiny.

At the present time, the mental health system is at its lowest ebb since the 1950's prior to the community mental health movement. Large pieces of what was once a fairly well-integrated system have been eliminated or degraded leaving behind the state of crisis so well described in the reports mentioned above. As a result, the demand from federal and state authorities to become "trauma-informed" and thereby significantly increase their ability to respond to complex problems with complex responses is perceived by many systems – and the individuals within those systems - as an absurd, dangerous and unrealistic demand, putting further strain on a workload that is already overwhelming.

Role Definitions

One's role in an organization is also another potential source of job-specific stress. Role overload is determined by how many different roles a person has to fulfill. This factor is known to be stressful because it creates uncertainty about an individual's ability to perform adequately and is well established as a major correlate of job-related strain (Cooper, 1987). Ambiguity and role conflict as well as the burden of responsibility are other sources of role strain. As one expert put it, "*for some workers, responsibility for other people's lives and safety is a major source of psychological strain*" (p. 41)[50].

In mental health settings, the roles of professionally trained clinicians tend to be fairly well defined and certainly, trained professionals are well-aware of the burden of moral and legal responsibility they carry. It is at the level of the line staff that problems with role overload, role ambiguity and conflict, and the burden of role responsibility is most likely to surface and has not been well-studied, particularly in residential settings for children. Line staff are with their adult clients for eight to ten hour shifts at a time. Likewise, childcare workers are with the children to a much greater extent than any other professionals in the setting and each childcare worker – whose training is likely to have been minimal - must serve as parent-surrogate, educator, disciplinarian, caretaker, nurturer, and security guard – often within the space of a single shift. This level of extreme role ambiguity can be a

constant source of stress. Additionally, many line workers must work more than one job, or volunteer constantly for overtime in order to make ends meet at home, while working shift work is well-established as a significant workplace stressor [50].

There may be a poor fit between the personality of the individual and the role requirements but when jobs are scarce people may find themselves taking jobs in mental health settings without being fit for the role, without a prior understanding of the responsibilities that are going to be expected of them, and with unclear notions of the roles they will be expected to fill. In areas where there is fierce competition for qualified workers but limited resources to compete, organizations may hold on to employees who are minimally capable of responding to the complex roles demanded of them. Over time, the role of the mental health technician or childcare worker may become more clearly defined but the role definition becomes too simple to reflect the needs of these very troubled children and adults. In this way, systems may devolve a system that has line workers doing little except enforcing rules and meting out punishments, inadvertently sifting out anyone capable of the more complex role demands that should be fulfilled in order to help clients recover.

Relationships

Relationships at work, such as those with supervisors, colleagues, and subordinates are key ingredients to either attenuate stress or increase work stress. Negative interpersonal relationships and a lack of social support from others in the workplace have been established as significant stressors [50]. Stressors on the organizational level can produce changes in the bureaucratic structure that then negatively affect individuals when supervisors are stressed and take it out on workers, when colleagues leave, when there is inadequate time to resolve interpersonal conflicts, when subordinates blame supervisors for what are problems attributable to larger forces. All of these can contribute to an atmosphere that is not only stressful because of the failure of interpersonal relationships but because those relationships are the only source of buffering against the other difficulties inherent in mental health practice.

Interpersonal conflict is a serious source of job stress and has been demonstrated to interfere with job performance. Conflict can arise between a manager and a line worker when the manager communicates what the line worker perceives as mutually incompatible expectations such as “you must always treat the patients with kindness and respect” and “it is your responsibility to guarantee safety and order”. There may be conflicts between one’s own expectations and the values of the organization, “these children are sick and you need to understand their behavior”, and “these kids are just bad – they need more discipline”. Mental health settings are fundamentally rife with conflicts because that is the nature of the work – the clients end up in treatment because of intrapsychic and interpersonal conflicts they have not been able to resolve within the scope of their own resources. Managing conflict while creating and sustaining a healthy relational network is a critical component to helping people recover but this relational network is extremely vulnerable to the impact of workplace stress.

Career Development

Career development issues also play a substantial role in determining the way an individual manages other kinds of stressors in the environment. Job insecurity, perceived under-promotion, over-promotion, a general sense of lack of achievement are all established sources of workplace stress [50]. Studies have shown that managed care practices are having a significant impact on mental health practitioners' incomes, their level of fulfillment in their jobs, the nature of the practice in which they engage and their morale [77-81].

Level of Risk

A significant aspect of job stress is level of risk and it is the high degree of risk and the fear attendant on that risk that has been a significant contributor to why so many individuals and institutions in the mental health system have been reluctant to change established practices of seclusion and restraint and forced medication, even though these practices are so frequently associated with negative - sometimes disastrous - outcomes in the patients. In crisis environments the "constant state of arousal may be a special health risk [50].

Organizational Culture

Organizational culture is an astonishingly powerful force that affects all of us who function within organizational settings, all of the time, but it is also the most overlooked force because it works indirectly and frequently at the level of nonverbal communication. Perhaps the best example of how organizational culture works comes from David Geisler, a specialist in human resources and labor relations [82]. To illustrate the powerful nature of organizational culture in determining reality he uses the story of the five squirrels:

> Five squirrels are inside a cage. In the cage there is an acorn directly above a flight of stairs. There is also a hose that sprays ice-cold water. Soon, a squirrel goes to the stairs and starts to climb toward the acorn. As soon as the squirrel touches the stairs all the other squirrels are sprayed with cold water. Before too long, a second squirrel makes an attempt at the acorn by using the stairs. Again, all the other squirrels are sprayed with ice-cold water. In a short while, a third squirrel tries to climb the stairs to get the acorn. As before, all the other squirrels are again sprayed with ice-cold water. Finally a fourth and fifth squirrel attempt to ascend the stairs but are blocked by all the other squirrels.
>
> Now, one of the original squirrels is replaced by a new squirrel. Inside the cage, the acorn is still hanging above the stairs. But the hose that sprays ice-cold water has been removed. Before too long, the new squirrel moves to the stairs to climb them to retrieve the accord. To the new squirrel's surprise, the other squirrels attack him. Not intimidated easily, the new squirrel tries again and again he is attacked with even greater intensity by the other squirrels.
>
> Later another of the original squirrels is replaced by a new squirrel. So now there are three of the original squirrels, the first new squirrel and now the second new squirrel. The acorn is still there hanging and the hose is gone. The second new squirrel goes to the stairs and is attacked. The first new squirrel leads the attack.

This same pattern continues until the original squirrels are entirely replaced by new squirrels one at a time. Each time, the newest squirrel attempts to go after the acorn,he is attacked by the other squirrels. The replacement squirrels now have no idea why the acorn is so eagerly protected or why they participate in attacking each new squirrel – but if we could see them thinking it would be along the lines of, "That's they way we have always done thing around here" (p. 82)

From Geisler, D. (2005). "Meaning From Media: The Power of Organizational Culture." Organization Development Journal 23(1): 81-83.

As an example of the impact of organizational culture, researchers surveyed over 21,000 registered female nurses to prospectively examine the relationship between psychosocial work characteristics and changes in health related quality of life over a four year period. They looked at physical functioning, role limitations due to physical health problems, bodily pain, vitality, social functioning, role limitations due to emotional problems, and mental health. The study found that low job control, high job demands, and low work-related social support were associated with poor health status at baseline as well as greater functional declines over the four year follow up period. Examined in combination, women with low job control, high job demands, and low work-related social support had the greatest functional declines. The authors concluded that adverse psychosocial work conditions are important predictors of poor functional status and its decline over time [83].

Ethical Conflicts

Perhaps due to news reports that continue to uncover cases of unethical behavior in business organizations, there has been a growing interest among practitioners and researchers regarding differences in ethical values between employees and their organizations. A lack of congruence regarding the ethical values of employees and their organization is typically referred to as an ethical conflict. An ethical conflict pertains to situations in which an employee's personal ethics are not compatible with the organization's business ethics and hence the behavioral expectations and norms of the organization [84].

Many studies have examined the consequences of a lack of congruence between the personal characteristics of employees and the attributes of the organization at which they are employed [85]. This assumption has been supported by research demonstrating that a conflict between the characteristics of the employees and their organizations is related to job dissatisfaction, low organizational commitment, substandard job performance, job stress, and turnover [86, 87] Empirical investigations have explored conflicts between employees and their organizations on a variety of characteristics, including conflicts in values, attitudes, needs, and goals [88].

One way of understanding person-organization fit is to look at the congruence between organizational values and personal beliefs and preferences [89]. Maslach and Leiter (1997) developed a model of burnout that focuses on the mismatch between the employee and the job environment in terms of workload, control, reward, community, fairness and values. A mismatch in values occurs when the organization makes choices that are inconsistent with the employee's core values. The greater the mismatch between a

person's values and the organization's, the more burnout the person will experience [90, 91]. In one study, questionnaires from 161 business professionals were analyzed to investigate a proposed interaction between pressure to engage in unethical work activity and relativistic moral beliefs with respect to business professionals' organizational commitment and intentions to leave the organization. The results indicated that organizational commitment was lower and intention to leave was higher for professionals who felt pressured by their employer to engage in unethical work activity. The proposed interaction was also significant for organizational commitment demonstrating that organizational commitment was generally high, except for business professionals who felt pressured to engage in unethical behavior and did not adhere to a belief that ethics are relative [84]. In another study of the academic setting, the less a participant reported a match between his/her values and the university's, the more that person experienced burnout and the more that person increased time on non-work activities. Person-organization value congruence was also negatively related to intent to leave and job satisfaction [92].

Ethical conflicts are one of the most underestimated, but chronically unrelenting sources of stress in today's mental health treatment environment. Years ago, clinicians were warning that *"the managed care approach to provision of human services will dominate professional work for the near future and possibly beyond. This approach raises serious concerns about the capacity of professionals to work within the structure of managed care without encountering serious ethical and clinical conflicts"* (p. 47)[93].

Dr. Ivan Miller, writing for the National Coalition of Mental Health Professionals and Consumers, has pointed out the eleven most unethical managed care practices. These include: 1. Disregarding personal and medical privacy; 2. Using false advertising; 3. Using deceptive language - calling cost cutting "quality improvement" or gatekeepers "patient advocates"; 4. Violating traditional scientific ethics; 5. Practicing outside of a professional's area of competence as when utilization reviewers do not have the credentials or training necessary to confirm that they are competent to overrule and change the decisions of the treating professional; 6. Creating and intensifying conflicts of interest; 7. Keeping secrets about financial conflicts of interest; 8. Violating informed consent procedures; 9. Using "kickbacks" to keep patients away from specialists; 10. Squandering money entrusted to their care; 11. Disregarding information about harm to patients [94].

The takeover of managed care, particularly some that are for-profit companies, have placed professionals in untenable positions. In the highly managed mental health environments, one of the greatest sources of stress – although certainly not the only source – is the potential conflicts of interest that are intrinsic to many aspects of the system [79, 95]. Should the clinician promote the interests of the patients over all other interests, as is consistent with most professional codes of ethics? Should the clinician promote what is considered the "general social good" by rationing care? Should the clinician promote their own financial well-being which may be at the expense of the other interests [96]? If clinicians do not comply with the demands their organizations are forced to make by the dictates of managed care, they risk losing their jobs and their incomes. If they do comply, they may have to make decisions and engage in behavior that they inwardly believe compromises the level of care they offer to their clients. Should clinicians advocate for their clients with managed care companies even if there will potential acts of retribution [97]. Is it ethically wrong to give the client a wrong diagnosis if that is the only way to get them

services because of the diagnoses that managed care companies will and will not cover [78]?

For example, relationships with managed care companies can present professionals with significant ethical dilemmas over the issue of patient confidentiality as when the managed care company demands access to client records and or detailed information about intimate aspects of the client's history, presenting problem, course of treatment and documented outcomes as a condition of authorizing services [98].

Managed care policies may impinge on the practitioner's capacity to act on clinical knowledge appropriately because of multiple barriers to practice that are established in service of cost-cutting methods [93]. Entry into the system can only be achieved by applying a diagnostic label that is likely to become a part of the client's permanent record and therefore accessible to anyone who has access to the records from the point forward [93]. At least one study has demonstrated that intervention methods in a managed care environment are dictated not necessarily by what the practitioner believes the client needs but by limitations on the number of visits that are covered. Managed care requirements become a significant mediating factor in treatment planning and although clinicians feel strongly that the choices they must make are "unethical", they make them nonetheless. As the authors of the study note, *"widely accepted ethical principles may be rationalized in practice in regard to either what is in the best interest of the client, or perhaps, on the basis of the inherent 'unfairness' of the managed care system"* (p. 209*)* [98].

Besides purposely misdiagnosing clients, in order to be helpful to their clients, or prevent harm from being done, practitioners will often distort their activities and reports in such a way that the written information is relatively useless going forward. For instance, since decisions about hospital course may be made by reviewers who have little experience and are motivated to save money for the company, if a hospital employee reports that a previously suicidal patient is no longer suicidal, these will be grounds for immediate termination of benefits if the patient is not discharged. On the other hand, rarely is a patient truly suicidal one day and non-suicidal the next in any absolute or clinically viable sense, and yet charts will reflect this unlikely phenomenon simply because it is the only way to keep someone who is still quite dangerously fragile but not openly expressing suicidal ideation, in a hospital setting. Such a "catch-22" situation puts the clinician in a profound ethical and personal conflict. Is it more wrong to lie on the record and to the reviewer or risk being compelled to discharge a patient who is still not truly safe? Is it more wrong to put the financial stability of the hospital at risk or the financial stability of the patient if one tells the truth and the patient's benefits are terminated? As discussed by two social work academics, *When a clinician must lie or omit crucial information in order to ensure that appropriate services are provided, the secondary conflict is clearly one of a legal-ethical nature. The professional in such a situation must violate the principle of integrity in order to provide what is clinically necessary for the client" (p.47)* [93]

Inpatient providers may be faced with repetitive and frustrating dilemmas because they have so little control over decisions impacting their work. For inpatient services, Glen Gabbard points out that a big roadblock has been the existence of a "*largely mythical treatment model designed for a mythical psychiatric patient*" (p. 27), for whom rapid pharmacological stabilization is followed by discharge with no regard for the actual complexities of a person's problems, the psychodynamics of noncompliance and decompensation [99].

One investigator has expressed her concerns about the far-reaching implications this could have on clinicians as they adapt to the demands of managed care. She suggests that *"the meaning of managed care for this group of clinicians lies in the prospect of being gradually, unknowingly, and unwillingly reprofessionalized from critics into proponents simply by virtue of continuing to practice in a managed care context, and in losing a moral vision of good mental health treatment in the process"* [100].

Summing Up

So if we think of the mental health system as a stressed system, fully recognizing that chronic stress is having a negative impact on administrators, staff, and clients, then how do we fix the problem? It is, after all, such a very *big* problem. The life of a system is generally longer than the lives of the individuals who create and sustain the system. Not only is it comprised of dozens, even hundred of people, but it's time line stretches into the past, sometimes for a century or more.

It's not possible to solve a problem unless you have properly identified the problem and to do that, it's necessary to have a way of thinking about the problem that is a bit different than the frame you have used to previously think about the problem. Since it is being nationally recognized that understanding the multiplicity of ways in which trauma has impacted our clients is vital if we are to deliver adequate -services to them, what if we use trauma, or in this case, chronic stress as a metaphor for what happens to systems. Where might our thinking – and then our behavior – lead if we begin to see our systems as "trauma-organized", suffering the effects of severe and chronic stress without even recognizing that is what is happening? [8].

Part III of this paper looks at our systems through the lens of chronic stress. We will find that the organizational stress literature actually does mirror many of the findings we have come to recognize as post-traumatic in individuals. As a result, it becomes possible to describe parallel processes that result in the need to pay attention to healing at simultaneous levels – clients, staff, management, and institution-as-a-whole.

Part III: Parallel Processes: Trauma-Organized Systems

In the last few years the consumer-based recovery movement has made significant forward strides in improving the level of care delivered to people who present to the mental health system with emotional disturbances, especially those related to an underlying post-traumatic etiology [6, 7, 101]. However, helping victims of complex post-traumatic syndromes to recover is fraught with barriers, some of which arise secondary to the disorders themselves and some of which arise because existing treatment systems are ill-prepared to focus on helping people to recover from these disorders.

The concept of parallel process is a useful way of offering a coherent framework that can enable organizational leaders and staff to develop a way of thinking "outside the box" about what *has* happened and *is* happening to their treatment and service delivery systems, as well as to the world around them [102-106]. Identifying a problem is the first step in solving it. The notion of parallel process derives originally from psychoanalytic concepts related to transference and has traditionally been applied to the psychotherapy supervisory relationship in which the supervisory relationship may mirror much of what is going on in the relationship between therapist and client [107].

In their work with organizations, investigators have recognized that conflicts belonging at one location are often displaced and enacted elsewhere because of a parallelism between the conflicts at the place of origin and the place of expression. The concept of parallel process in studying the dynamics that unfolded between two consulting groups hired by the same client that mirrored what was happening in the client's organization [108, 109]. Other authors have used the notion of parallel process to illustrate this largely unconscious individual and group interaction [110, 111]. An even older conceptualization of this process derives from the original sociological studies of mental institutions in the 1950's describing "collective disturbance", a phenomenon that will be described in more detail later in the paper. As Smith 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 …. Parallel processes can be set in motion in many ways, and once initiated leave no one immune from their influence. They can move from one level of a system to another, changing form along the way. For example, two vice presidents competing for resources may suppress their hostility toward each other and agree to collaborate interpersonally, but each may pass directives to her or his subordinates that induce them to fight with those of the other vice president. Thus, what began as a struggle among executives for resources become expressed by lower-ranking groups in battles over compliance with cost-cutting measure* (p.13) [112]

It is the contention of this paper that parallel processes are at play that interfere significantly with the ability of the mental health system to address the actual needs of trauma survivors, specifically and people with mental health and substance abuse

problems, in general. Instead, because of complex interactions between traumatized clients, stressed staff, pressured organizations, and a social and economic environment that is frequently hostile to the aims of recovery, our systems frequently recapitulate the very experiences that have proven to be so toxic for the people we are supposed to treat.

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 stress of trying to cope with a flawed mental model that is the present underpinning of the mental health system. When this happens, it sets up an interactive dynamic that creates what are sometimes uncannily parallel processes. 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 recovery from the pain 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.

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 some form of behavior that is 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 *helplessness* may drive them to exert methods of control that become pathological. They are chronically *hyperaroused* and although they try to *control* their bodies and their minds, they are often ineffective. They may have significant *memory problems* and may be chronically dissociating their memories and/or these feelings, even under minor stress. They are likely therefore to have *fragmented* mental functions. The clients are likely never to have learned very good *communication* skills, nor are can they easily engage in *conflict management* because they have such problems with emotional management. They feel *overwhelmed, confused* and *depressed* and have *poor self-esteem.* Their problems have emerged in the context of disrupted attachment and they do not know how to make and sustain healthy *relationships* nor do they know how to *grieve* for all that has been lost. Instead they tend to be revictimized or victimize others and in doing so, 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 humiliating confrontations. They feel *helpless* in the face of the enormity of the problems confronting them in the form of their clients, 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 tend to backfire and they become *hopeless* about the capacity for 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.

And how are these parallel processes manifest in organizational culture? Under these circumstances, the organization becomes unsafe for everyone in it. Emotional intelligence decreases and organizational emotions, including anger, fear, and loss are poorly managed or denied. The crisis-driven nature of the hyperaroused system interferes with organizational learning. When the organization stops learning it becomes increasingly helpless in the face of what appear to be overwhelming and hopelessly incurable problems. Radical changes in reimbursement and regulation force radical changes in staff, positions, and role descriptions. People and programs depart and the organization begins to suffer from the consequences of organizational amnesia. Communication networks breakdown and error correction essentially stops and instead errors begin to systemically compound. Leaders respond to the perceived crises by becoming more controlling, more hierarchical, more punitive. In an effort to mobilize group action, leaders silence dissent which further diminishes active participation and essentially ends innovative risk-taking. As participatory processes are scaled back, decision making and problem solving processes are deeply ravaged. As a result, decisions tend to be oversimplified and may create more problems than they solve, despite the leaders' best efforts. Staff respond to the control measures by various forms of aggressive and passive-aggressive acting-out. Interpersonal conflicts escalate and are not resolved, further sabotaging communication. Systemic function becomes ever more fragmented and stagnant. Ethical conflicts abound, organizational values are eroded, hypocrisy is denied. If this process is not stopped, the organization steadily declines and may, in the way organizations can, die sometimes by dying through closure, sometimes by committing organizational suicide, and sometimes by continuing to function but representing a permanent failure of mission and purpose.

In the mental health and social service literature, there is very little recognition of the ways in which these forces are playing themselves out across our horizons. Caught in the grip of monumental assaults upon the systems, few people have had the time or energy to step back and begin to look at the system-as-a-whole through a trauma-informed lens. The rest of this paper explores this territory, drawing upon what turns out to be a wealth of theory and research in the area of organizational development, usually applied to the for-profit, business sector.

A. Chronic Stressors – Hostile Environment – Collective Trauma

Thesis: The mental health system and virtually every component of it, as well as the other social service components that interactively serve the mental health system have been and continue to be under conditions of chronic stress, individually and collectively experiencing 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.

> *For decades, state mental health systems have been burdened with ineffective service-delivery programs and stagnant bureaucracies. Their operations have become rote, spurred to change only by crises. Combined with ever-increasing fiscal pressures, this situation has precluded innovation and kept most systems from incorporating the new and more effective interventions developed in recent years. As a result, patched-up state mental health systems have all but disintegrated, falling ever farther from the ideal of accessible, effective services that promote meaningful community membership, p.5.*
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> Disintegrating Systems: The State of States' Public Mental Health System
> A Report by the Bazelon Center for Mental Health Law, 2001

"The public mental health system is in shambles"

From a letter to President Bush from the President's New Freedom Commission on Mental Health, 2002

"The overall infrastructure is under stress, and access to all levels of behavioral health care is affected."
Challenges Facing Behavioral Health Care:
The Pressures on Essential Behavioral Healthcare Services.
A Report by the National Association of Psychiatric Health Systems, 2003

Collective Trauma

As we have seen, organizations have culture and organizational culture helps to determine the health and well-being of the individual worker. Organizational culture arises out of the history, memory, experiences and formal structures and personnel of the organization. As organizational research has demonstrated, uncertainty is a main contributor to the perception of stress, and there is nothing so uncertain in corporate life as organizational change. As one author from the world of business has noted *"the combination of economic scarcity, the recession of the late 1980s and early 1990s, the widening gap between demand and resources in public services such as health and*

education, and the rampant influence of technological change has produced a deeply uncertain organizational world which affects not just organizations in their entirety but groups and individuals at all levels of the organizational matrix", p. 253 [40]. The literature clearly demonstrates that the combination of uncertainty and the likelihood of change, both favorable and unfavorable change, produces stress and, ultimately, affects perceptions and judgments, interpersonal relationships, and the dynamics of the business combination itself [113]. In the mental health field for the last two decades, change has been steady and certain only in its tendency to be unfavorable to the practice of the mental health professions.

On a psychological level what happens in a crisis? Psychodynamically-oriented investigators who have looked at the human social organization and institutional development have pointed out one underlying and largely unconscious motivation beneath organizational function and that is the containment of anxiety. Human beings are particularly vulnerable to overwhelming fears of disintegration, nothingness, annihilation, disorder, chaos, loss and underlying all – death. We organize our social institutions to accomplish specific tasks and functions, but we also utilize our institutions to collectively protect us against being overwhelmed with the anxiety that underlies human existence. We are, after all, the only animal that knowingly must anticipate our own death. The collective result of this natural inclination to contain anxiety becomes a problem when institutional events occur that produce great uncertainty, particularly those events that are associated with death or the fear of death. Under these conditions, containing anxiety may become more important than rationally responding to the crisis, although because of our relative ignorance and denial about our unconscious collective lives, this is likely to be denied and rationalized. As a result, organizations may engage in thought processes and actions that may serve to contain anxiety but that are ultimately destructive to organizational purpose [114-116].

Just as individuals respond to acute stress and chronic stress in variable ways, so too can organizations experience the effects of both acute and chronic stressors. The focus of this paper is more on the impact of chronic and unrelenting stress and repetitive crisis than on the reactions of organizations to acute incidents. One of the terms applied to this difference when speaking of individuals is the use of terminology like "complex post-traumatic stress" in an attempt to emphasize the very complicated outcomes that can derive from recurrent severely stressful situations over time.

In the case of whole organizations, the concept of "collective trauma" is a useful one. Referring to the impact of disasters, Kai Erikson has described 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) [117].

The impact of dramatic changes in mental health care funding and operations can be thought of as a collective trauma to the mental health system as a whole, directly impacting the organizational culture of every component of the mental health system and the system

as a collective. Since every organization has its own culture, each culture can be traumatized. Patient deaths and injuries – from natural causes, accidents, and most particularly suicide and deaths while in restraints; staff deaths or injuries; loss of leaders; lawsuits; downsizing – all may be overwhelming not just for the individuals involved but for overall organizational function.

Chronic Stressors

The effects of stress in organizations and within whole systems are cumulative. A series of small, unrelated, stress-inducing incidents can add up to a mountain of stress in the eyes of people that work there and receive services within these settings. Therefore, there is no such thing as minor and major stress; minor stress can multiply into often unresolvable dilemmas [73]. Like a client who has been repeatedly abused by their family, the mental health system had never achieved parity with the physical health system before the onslaught of managed care and federal and state cutbacks radically changed the face of health care delivery, rapidly bringing the system to the point of crisis that have been ably described in a number of national reports.

As former American Psychiatric Association President, Applebaum pointed out, the genesis of the current crisis in the mental health care system is inadequate payment for care [118]. Between 1987 and 1997, the current insurance system had cut mental health and substance abuse benefits by more than 50% (Hay Group Study, 1987-1997). In reviewing claims from large employers responsible for 1.7 million covered lives, researchers have found that behavioral health spending dropped from 7.2% of total private health insurance spending in 1992 to 5.1% of total spending in 1999 (primarily because of a dramatic decrease in hospital treatment due to shorter lengths of stay and reduced probability of admission). In fact, as overall health spending **increased** by 15.7%, mental health and substance abuse spending **decreased** by 17.4% during this period [119].

In part these decreases reflect major shifts in inpatient spending which was 48% of total behavioral health spending in 1992 but by 1999 it was only 18%. From 1992 to 2000, the number of state mental hospitals declined by 29%, private psychiatric hospitals declined by 38%, and general hospital units declined by 14% [119]. This reduction in facilities and beds has had widespread reverberations including substantial increases in admissions to the remaining hospitals. According to a survey of members of the National Association of Psychiatric Health Systems (NAPHS), admissions per facility on average have increased 11% (from 2,113 in 2000 to 2,354 in 2001). Occupancy rates have also substantially increased over the past few years. Based on the NAPHS survey, occupancy rose from 69.2% in 2000 to 74.1% in 2001 — a 7% increase in occupancy rates in one year. In 1996 occupancy rates were 55.6%, compared to 74.1% in 2001. In addition, 25% of the respondents to the survey had occupancy rates greater than 88% in 2001 [119].

Shorter lengths of stay, increased occupancy, and increased admissions means great savings and profitability for the companies managing the benefits but for the staff working in these settings it is a prescription for a wide variety of individual and organizational dysfunctions. The impact of this dysfunction spreads throughout the system and does not just affect the inpatient care programs. For example, inpatient teams do not have time to gather a client's history or even establish a relationship of sufficient length to gain the level of trust necessary for someone to reveal the kinds of intimate information that are required in order to make an accurate assessment. Inpatient programs become little more than

“holding tanks” for the most severely ill patients while medication is rapidly and frequently injudiciously adjusted. Outpatient providers are then left to fend for themselves when the patients are sent back to them in little better condition than when they were admitted, having received little information from the overextended inpatient staff as to what to expect or how to proceed.

While the number of mental health organizations providing 24-hour services (hospital inpatient and residential treatment) more than doubled in the United States over the 28-year period between 1970 and 1998, the number of psychiatric beds provided by these organizations decreased by half, from 524,878 in 1970 to 261,903 in 1998. The corresponding bed rates per 100,000 civilian population dropped proportionately more in the same period from 264 to 97. Beds in state mental hospitals accounted for most of this precipitous drop, with their number representing only 24 percent of all psychiatric beds in 1998, compared to almost 80 percent in 1970 [120].

One of the results of this precipitous drop in state mental hospital beds, as every urban dweller can attest, is the rise in the number of mentally ill homeless people frequenting shelters and simply living on the streets, subject to repeated victimization and exposure to violence [121-123]. And it is emergency room mental health crisis workers and staff in inpatient settings who must refuse admission or force these destitute and deranged souls back onto the streets, not the bureaucrats or legislators who have made the structural decisions that have led to this crisis of care.

The shift away from inpatient treatment was not compensated for by partial hospital programs. Many have closed or limited the number of patients they can accept. While 82.5% of respondents to the National Association of Psychiatric Health Systems’ *Annual Survey* offered partial hospitalization services in 2000, in 2001 only 66.7% of respondents offered this level of care. Fewer partial hospital slots exist as facilities have struggled with administrative costs due to Medicare regulations, fewer payors for partial hospital services, and managed care organizations’ pressure to look to lower-cost alternatives. While the number of facilities offering partial hospitalization programs has shrunk, those that remain have seen substantial increases in their admissions and visits [119].

Nor have outpatient programs been able to meet the needs. As a report from the Bazelon Center for Mental Health Law pointed out, *“the squeeze on state mental health systems is resulting in fewer and fewer services in the community… most communities in nearly all states lack the necessary continuum of appropriate care”. P.5* [124].

And as multiple investigators have pointed out, the services for children are in even worse disarray than those for adults, with children stuck for days and even months in emergency rooms waiting residential programs [124]. According to a report requested by Senators Waxman and Collins, about 15,000 children with mental illnesses were improperly incarcerated in detention centers in 2003 because of a lack of access to treatment, and 7% of all children in detention centers remain incarcerated because of a lack of access to treatment. In addition, the report found that 117 detention centers incarcerated children with mental illnesses younger than age 11. The report also found that 66% of detention centers said they incarcerated children with mental illnesses "because there was no place else for them to go," Some witnesses who testified at the hearing said that children with mental illnesses often are incarcerated in detention centers because their parents do not have access to treatment in schools or lack health coverage for such treatment [125].

In observing the fact that spending for mental health care had declined as a percentage of overall health spending throughout the 1990’s, former Surgeon General

Satcher, noted that although some of the decline in resources for mental health relative to total health care could have been due to improvements in efficiency, he concluded that it also could reflect increasing reliance on other (non-mental health) public human services and increased barriers to service access a conclusion which has been born out by subsequent reports [126].

Even the most dedicated mental health people and programs cannot function providing free service. As one astute observer pointed out, *"So poorly are psychiatrists, clinics and hospitals compensated for the treatment they render that relying on insurance payments for patients' care is often literally a losing proposition"* The response has been the closure of psychiatric inpatient units, service cutbacks at clinics and an inability of psychiatrists and other mental health professionals to support their practice with insurance payments. The existing problems have been vastly compounded by the utilization-review practices of the managed care industry and taken together, the result is "*a critical inability of patients to access needed psychiatric care"* [118]. Adding to the burden is that current incentives both within and outside managed care generally do not encourage an emphasis on quality of care [126].

Workforce Issues

The incursion of managed care has created seismic changes in public and private practice settings. Reflecting the general trend of shrinking inpatient hospital utilization, the numbers of social workers in hospitals fell from 19.2 percent to 11.3 percent. This decline in social work employment in hospitals represents a long-term decline since 1989, when 20.8 percent of social workers were in hospitals [120]. The numbers, however, do not accurately reflect what has been lost. In mental health and social service systems, social workers traditionally have played a linking role with other service providers, serving in many settings as the official or unofficial communication channels, the “glue” in the systems. The result of the decline in social work roles has been not just a decline in direct service, but the increased fragmentation of an already fragmented service delivery system [54].

Over the past two decades, the rate of growth in the number of clinically trained psychiatrists has decreased and in fact the number of psychiatric residents has remained relatively constant since 1990. There has, however, been significant growth in the number of international medical graduates entering psychiatric residencies [120]. Again, the numbers do not tell the human story. Psychiatrists, previously trained in a wide variety of modalities, and frequently experienced in running a multidisciplinary team, no longer have the time – and in many cases, the training – to provide leadership within inpatient or outpatient settings. Psychiatric shortages in many areas of the country create situations where patients cannot be properly medicated and where there is a decreasing systemic knowledge base about the complex interactions between mind, body, and social adjustment.

Among all disciplines that provide mental health care to children, there is a striking trend toward the use of professionals who lack specialty training in child mental health. The bulk of psychotherapy – such as it is - and behavioral therapy is provided by social workers. Most prescriptions for psychotropic medication for children are written by pediatricians and family physicians, not psychiatrists. Child psychiatrists are in exceedingly short supply. The federal Bureau of Health Professions projects that just to maintain the current utilization rates of psychiatric care, and considering that currently most children who need care do not

get it, by 2020 the nation will need 12,624 child and adolescent psychiatrists but is expected to only have 8,312 [127].

Lack of Innovation and Stagnation

> *We do not tell cancer patients to come back if and when their disease has metastasized. But we turn mental health clients away and tell them to return when their symptoms are so severe and persistent that they cannot meet their own needs, p.19.*

Disintegrating Systems:
The State of States' Public Mental Health System
A Report by the Bazelon Center for Mental Health Law, 2001

Although an extensive research base has been documenting the enormous implications of previous exposure to trauma, violence and abuse to the physical, emotional, and social health of the nation for over twenty-five years, only now is the issue of trauma being addressed by both the private and public health systems, and that largely due to the insistence of the consumer recovery movement and some very diligent and persistent mental health providers and administrators [6, 7, 128]. Most mental health programs and substance abuse programs are still only minimally addressing the issue of trauma and public systems are only now receiving pressure to become trauma-informed. Although, there are other reasons for resistance to incorporating the issue of trauma, particularly because it is so fundamentally disturbing to the underlying mental models upon which mental health practice is based, the most obvious cause for this resistance is the lack of innovation and creativity that is typical of both stressed individuals and stressed systems.

The mental health system as a whole and each individual element of that system have had all they could manage to simply contend with the enormity of the changes they have undergone. The capacity to innovate, experiment, evaluate innovations, and tolerate the uncertainty of trying new things is simply not possible under the conditions described by this paper. Worse yet, innovation that was burgeoning in the private psychiatric system in the 1990's was virtually completely eliminated by the managed care environment. Dozens of programs specializing in the treatment of trauma were created in the early 1990's and almost all were closed by the beginning of the new century – not because of a lack of clients seeking services but because the loss of beds and the tightening of budgets meant that beds could be filled with far less expense by eliminating all specialty care [129]. More recently, many isolated examples exist of exemplary programs but as the Bazelon Center report illustrates, these are rarely brought to scale and made available to significant numbers of people in need. These successful programs, often funded with demonstration dollars for limited periods, are overshadowed by the disintegration of the system as a whole [124].

Hostile Environment

The present woeful state of the mental health system cannot be attributed to a lack of knowledge, research, or evidence. In an extensive review, Hubble, Duncan and Miller

have pointed out that many varieties of therapy are very effective and for most people who seek therapy, positive results are evident in a relatively short period of time [5]. Instead, it reflects a lack of political and social will to address the impact of mental illness in all its form, on the health and well-being of the nation. When it comes to physical illness, there is no comparable denial. So what is it about emotional problems that create such chronic – and self-destructive – inequities?

As Luhrmann has pointed out *"Psychiatry is inevitably entangled with our deepest moral concerns: what makes a person human, what it means to suffer, what it means to be a good and caring person"* (p.23) [130]. No grand conspiracy theory is necessary to posit that it is no coincidence that just as the mental health field began to seriously address the issue of violence, abuse and maltreatment, research, training, innovation and treatment were vastly cutback or eliminated altogether in many private and public settings. Foucault [131], the radical psychiatrist of the 60's [132], and many of the social psychiatrists from that era and beyond [3], have recognized the connection between emotional disturbance and social disturbance.

> *"Many of the children and adults who end up repeatedly or chronically institutionalized are a product of a society that refuses to face up to and both rationally and adequately deal with its chronic problems: racism, sexism, poverty, child maltreatment, community violence, and domestic violence… The hospital is landed in a situation where it tries to help an individual on behalf of society which really just wants to be rid of him. This is a no-win situation for the hospital and its staff",* p.27 [133].

Addressing the traumatic origins of most emotional disturbance means changing our mental model of what it means to be human, particularly when that humanness leads to some kind of problematic behavior or deviance. Deviance refers to *"any behavior or attribute for which an individual is regarded as objectionable in a particular social system. . . anything that violates prevailing norms"* [134]. For as long as there have been historical records, human deviance has been viewed as either sin, crime, or sickness [135]. The essential conflict between madness as moral failure and madness as disease goes at least as far back as the Greeks and has never been resolved [136]. Psychiatry is the profession that is socially assigned to deal with a certain class of "deviants" - the mentally ill. As a major social institution and therefore supporter of the status quo, the psychiatric profession has always had an underlying conflict, forever arguing over the etiologic foundation of the disorders that come under its purview [130]. Those inclining toward biological predisposition have always been in conflict with those who place a stronger emphasis on social and environmental factors as the sources of psychiatric dysfunction. And it is in psychiatric care that the largest discrepancies in care occur attributable to race and socioeconomic class.

A social worker, newly hired in a mental health program discussed how she believes the system promotes mental illness. She talked about a middle-aged woman, diagnosed with chronic schizophrenia who was a high utilizer of psychiatric services – inpatient mobile crisis, and outpatient. When the patient has decompensated in the past it has been precipitated by a relationship stressor. She also has a history of a many past traumatic experiences. She cannot work, and is completely dependent on the public system but she is able to

reconstitute if she receives concrete support. Apparently, an administrator in the county mental health system, pressured to figure out how to make yet another cut-back in the budget, decided that she was calling for help too frequently so the intensive case manager was instructed to stop answering her phone calls and instead the patient was instructed to go to the psychiatric emergency room. Naturally, this course of action increased both her ER visits and her inpatient hospital stays.

The social worker went on to say, "*Our system appears to be training people to be chronic patient, to be dependent, to not even contemplate functioning better or, getting back to work*. *The main provider of services to the public sector told them me that we should be wary of taking public sector patients because they destroy property and dirty the waiting room. And they will never come for treatment and they will never keep their follow-up appointments*. *I didn't listen to him, we do take public sector patients and as long as they think they are benefiting they come to their appointments like anyone else*. *There is no expectation that these people are really people – but only that they are sick – no expectation that they could recover at all".*

Postulating that traumatic origins lie behind most psychiatric dysfunction reconnects all kinds of behavioral disorders to the social context within which these behavioral problems arise. To take seriously the notion of intervention and prevention in the realm of mental illness, a society must take on the issue of systemic violence, abuse, child maltreatment, domestic violence, poverty, racism, gender inequality. Within a trauma-informed framework, the underlying mental model for understanding dysfunction shifts from that of "sickness" or "badness" to that of injury and is therefore likely to arouse resistance from top to bottom. At an individual staff level the implications of trauma theory are bound to raise anxiety within the institutional setting as the staff become less able to use their usual defenses to protect themselves from the contagious affect surrounding the traumatic past. In addition, many of them will be themselves trauma survivors and may have unresolved issues that have brought them into the field in the first place. This breakdown of barriers between "us" and "them" can cause massive personal anxiety when beginning to address the patients' past traumatic history triggers reminder in the staff of similar things that happened to them. As one author has noted, *"Talking to patients is dangerous because it threatens to puncture the barrier that keeps sanity and madness in their proper places",* (p. 605) [137].

Isabel Menzies, building on the work of Jacques, described the ways in which mental health systems create "social defense systems". She described how systems develop specific and static protective mechanisms to protect against the anxiety that is inevitably associated with change. The defense mechanisms she describes sound uncannily like those that we see in victims of trauma - depersonalization, denial, detachment, denial of feelings, ritualized task-performance, redistribution of responsibility and irresponsibility, idealization, avoidance of change.

This social defense system plays itself out at every level within the institution. For example, in the nursing staff in a hospital who:

> *"develop some form of relationship that locates madness in the patient and sanity in themselves, with a barrier to prevent contamination. Such an arrangement allows the nurses to stay in the situation without feeling that their minds are being damaged. It justifies the use of control by the nurses, entitles patients to care and refuge, and is a virtual guarantee that they will continue to be thought ill and therefore will not be sent outside*", (p. 604) [137],

This social defense system can be seen operating in psychiatrists who spend more time deciding on the diagnosis that most adequately fits the DSM-IV-R and then based on the diagnosis, prescribing the "proper" medication, then they spend actually talking to the patient. It is also operating in the institution as a whole, when that institution provides services that are called "treatment" but which are more accurately designed to control or "manage" the individual patient on behalf of the society. The conflict between "controlling" the mentally ill for the sake of society and helping the mentally ill by empathizing with and empowering them to make positive change is a source of chronic conflict. And this conflict is a source of chronic, unspoken, unrealized stress for everyone working within virtually any mental health institution. It is also major barrier to the goals of the consumer-recovery movement [138]. As long as the mental health system is responsible for the legal and social containment of mental illness, it will be exceedingly difficult and perpetually stressful for the staff of institutions to offer the kind of care sought by many advocates of the recovery movement.

Over time and as a result of collusive interaction and unconscious agreement between members of an organization, this agreement becomes a systematized part of reality which new members must deal with as they come into the system [recall the story of the five squirrels]. These defensive maneuvers become group norms, similar to the way the same defensive maneuvers become norms in the lives of our individual patients and then are passed on from one generation of group participants to the next. Upon entering the system each new member must become acculturated to the established norms if he or she is to succeed. In such a way, an original group creates a group reality which then becomes institutionalized for every subsequent group [139]This aspect of the "groupmind" becomes quite resistant to change, rooted in a past that is forgotten, now simply the "way things are" [140].

Taking the idea of systemic conflict to even deeper realms, a German professor of Political and Administrative Science has explored the idea of "successful failure" when an organization or social sector continues to be funded, albeit inadequately, despite its apparent failure to solve the fundamental problem it has been created to service.

> "*One prerequisite of continuous resource mobilization despite low performance is that the principals at both levels (board and public) are interested in failure rather than in achievement of the organization they are in charge of….Second, another prerequisite of continuous resource mobilization despite low performance is that the principals at both levels prefer not being confronted with dilemmas that the organization has to cope with. Consider the organization's job being something terrible, disgusting, or just puzzling. Again, the mere remoteness from public attention may facilitate forgetting about those job"*. (p. 99-100) [141].

He notes that the probability of successful failure increases if: organizations find themselves in a peripheral position outside the dominant spheres of the public and private sector [*the mental health system has yet to achieve parity within health care*]; those providing resources to the organization are interested in failure rather than in achievement [*there are no performance standards that insist that the patients have made significant change*]; those providing resources to the organization prefer not to be confronted with dilemmas the organization has to cope with [*it is currently politically incorrect to focus on poverty, racism, child maltreatment as the etiology of mental illness*] ; plausible ideologies are available that protect the organization against the "inappropriate" application of efficiency and accountability standards thus mitigating the cognitive dissonance caused by the gap between poor performance and the standards of organizational efficiency and accountability [*biological models of mental illness*]; demand for ignorance is satisfied, which stabilizes the illusion of the compatibility of organizational performance and the standards of organizational efficiency and accountability. *"Why delegate [particularly pressing problems] to an institutional segment whose resource dependency, governing structure, and ideology imply weak rather than strong performance? … we may assume the public at large to be interested in weak rather than strong organizational structures when coping rather than problem solving is requested",* p. 103 [141].

These very deep individual, organizational, and systemic conflicts about what mental illness really is and how to deal with it are chronic, underlying and largely hidden sources of chronic stress within every component of the mental health system. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of State Mental Health Program Directors (NASMHPD) are two federally-funded organizations that are taking seriously the issue of system *transformation* defining this as *"a complex, revolutionary, and continuous process, demands fundamental changes in the organizational structures and systems through which products are developed and services are delivered" [142].* Consistent with the Biblical proverb, "physician, heal thyself", developing an understanding of traumatic stress via the lens of organizational dysfunction may help accelerate that process. However, at a macro level, the present social and political environment has never in recent years, been quite so averse to addressing these systemic structures and the impact they have on individual and family problems, particularly if the source of these problems can be located in "family values" that support patriarchy, authoritarianism, physical punishment, and obedience to someone else's will. Such values set the stage for the abusive use of power so characteristic of family and community violence.

B. Lack of Basic Safety

Thesis: 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 physical safety, abusive behavior on the part of managers and/or staff, and a pervasive mistrust of the organization. Additionally, there is no safety from without as typified by a constant fear of funding cuts, loss of workforce, and compromised services leading to public and legal accusations and lawsuits. A perceived lack of safety erodes trust which is the basis for positive social relationships.

The Risks of Working in Mental Health

"Fear can make people lash out and transform normally reasonable people into bullies and tyrants... Fear spreads like a virus and encourages corporate abuse to thrive in the policies, structures and operations of a business", p. 7 [143]

L. Wright, 1996
Corporate Abuse: How "Lean and Mean" Robs People and Profits

Although workplace homicides attract more attention, the vast majority of workplace violence consists of non-fatal assaults. The Bureau of Labor Statistics data shows that in 2000, 48 percent of all non-fatal injuries from occupational assaults and violent acts occurred in health care and social services. Most of these occurred in hospitals, nursing and personal care facilities, and residential care services. Nurses, aides, orderlies and attendants suffered the most non-fatal assaults resulting in injury. Injury rates also reveal that health care and social service workers are at high risk of violent assault at work. Bureau of Labor Statistics rates measure the number of events per 10,000 full-time workers—in this case, assaults resulting in injury. In 2000, health service workers overall had an incidence rate of 9.3 for injuries resulting from assaults and violent acts. The rate for social service workers was 15, and for nursing and personal care facility workers, 25. This compares to an overall private sector injury rate of 2. [144]

It is not surprising then, that after law enforcement, persons employed in the mental health sector have the highest rates of all occupations of being victimized while at work or on duty. In fact, between 1993 and 1999 the rates of workplace violence for all occupational categories fell, and all the declines were statistically significant *except* for mental health. Even law enforcement victimization showed a greater decline (55%) then the decline in mental health (28%). In 1999, for every 1000 people employed in law enforcement, 74 were injured while for every 1000 people employed in mental health, 46 were injured. The next highest rate is retail sales in which the rate was 14 per thousand people hired, and for teaching the rate was 12 per thousand. Professional (social worker/psychiatrist) and custodial care providers in the mental health care field were victimized while working or on duty at similar rates (68 and 69 per 1,000, respectively) — but at rates *more than 3 times* those in the medical field. Workers in the mental health field

and teachers were the only occupations more likely to be victimized by someone they knew than by a stranger [145]

Erosion of Trust

Threat does not just arrive in the form of physical intimidation, but can come from a number of sources and in a variety of forms. Fear can be conveyed through the actual experience of people in an organization – what has happened directly to a person or what they have directly observed in the present or the past. Then there are the stories about other people's experiences that rapidly circulate within any organization, and are especially likely to be taken seriously if the person conveying the experience is liked or trusted and when the trustworthiness of the organization is already in question. Threat may also be conveyed via the negative assumptions about other people's behavior and intentions about what has happened that reside within the company and fuel many self-fulfilling prophecies. And then all change is potentially threatening, but externally imposed change is the most threatening – and it has been largely externally imposed change that has characterized the mental health system [46].

It has been clear to organizational development investigators that trust in the workplace is key to productivity and ultimate to the lifespan of the organization [24]. The fundamental problem with creating atmospheres of threat and mistrust is that the more complex the work demands, the greater the necessity for collaboration and integration and therefore the more likely that a system of teamwork will evolve to address complexity. In fact, in the business world, "Fortune's 100 Best Companies to Work For" are more likely to have cultures in which trust flourishes, and have half the turnover rate (12.6% vs. 26%) and nearly twice the applications for employment of companies not on the list [146].

The list of behaviors that can trigger mistrust in staff is a long one and includes both verbal and nonverbal behavior. Silence, glaring eye contact, abruptness, snubbing, insults, public humiliation, blaming, discrediting, aggressive and controlling behavior, overtly threatening behavior, yelling and shouting, public humiliation, angry outbursts, secretive decision making, indirect communication, lack of responsiveness to input, mixed messages, aloofness, unethical conduct all can be experienced as abusive managerial or supervisory behavior [46]. According to Bill Wilkerson, CEO of Global Business and Economic Roundtable on Addiction and Mental Health, mistrust, unfairness and vicious office politics are among the top ten workplace stressors [61].

> For over thirty years an inpatient program had been dominated by a tyrannical nurse manager who had completely controlled the staff, the patients, and even the psychiatrists. His word was law and no one interfered or contradicted his dictates because of their fear of his abusive response. His boss had so much on his plate and was so disinterested in the psychiatric service, that he had given the nurse manager free rein to do whatever he saw fit. The nurse manager could

hire as many staff members as he wanted. He was unpredictable in his rule-setting and very controlling. He publicly humiliated staff and was verbally abusive and demeaning to staff and patients. But he was seen by his superiors as "running a tight ship" and was repeatedly rewarded. As a result, the staff had learned that independent thinking was dangerous and many of bullying the patients as they were bullied. When he finally left the organization, the new nurse manager found it necessary ultimately to hire what was essentially an entirely new staff because the existing staff were highly mistrustful of any change, carried a level of mistrust for the new nurse manager that she could not overcome, and resisted every positive change she attempted to institute.

Workplaces that are experienced as fundamentally unsafe – physically and emotionally dangerous, untrustworthy environments - are experienced collectively as dangerous as well. When a large number of people collectively experience fear, difficult-to-resolve and even dangerous strategic dilemmas arise that contain within them the potential for violence [147]. The tendency of a staff to escalate coercive control measures in psychiatric settings is likely to occur whenever they fear for their own safety or the safety of their colleagues, and when they do not trust the organizational structures and norms to contain potential or real violence.

C. Loss of Emotional Management

Thesis: Atmospheres of recurrent or constant crisis 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. Atmospheres of chronic crisis and fear contribute negatively to poor services.

Organizational Emotions

The idea of organization emotional life is not a comfortable one in most of the literature, largely because there has been a "myth of rationality", a generally held belief that organizational behavior can best be explained in rational cognitive terms [50]. But stress models are fundamentally about emotional reactions and so the emotional nature of organizational behavior can no longer be ignored. In fact, one group of investigators have argued that *"emotions are among the primary determinants of behavior at work …. And profoundly influence both the social climate and the productivity of companies and organizations"* (p. 154) [148].

How does an organization "manage" emotional states? It does so through the normal problem-solving, decision making, and conflict resolution methods that must exist for any organization to operate effectively. The more complex the work demands, the greater the necessity for collaboration and integration and therefore the more likely that a system of teamwork will evolve. For a team to function properly there must be a certain level of trust among team members who must all share in the establishment of satisfactory group norms. These are the norms that enable the group to: tolerate the normal amount of anxiety that exists among people working on a task; tolerate uncertainty long enough for creative problem solutions to emerge; promote balanced and integrated decision making so that all essential points of view are synthesized; contain and resolve the inevitable conflicts that arise between members of a group; and complete its tasks [103]

Although most organizations within our society function in a fundamentally hierarchical, top-down manner, in a calm, healthy, well-functioning system there is a certain amount of natural democratic process that occurs in the day-to-day operations of solving group problems, making decisions in teams, and resolving conflict among members of the organization. In fact research has demonstrated that self-managed teams with decentralized decision making abilities are among the most important practices for high performance in the current business climate [38].

Organizational Crisis and Fear

In organizations under stress, however, this healthier level of function is likely to be sacrificed in service of facing the emergency. Organizations under stress can manifest traits similar to stressed individuals. As anyone knows who has worked in a setting facing some kind of threat, everyone's attention becomes riveted on the latest rumor and little productive work is accomplished. Because human beings are "hard-wired" for social interaction, a

threat to our social group can be experienced as a dangerous threat to our individual survival and can evoke powerful responses.

What is a crisis? A crisis is a condition where a system is required or expected to handle a situation for which existing resources, procedures, policies, structures, or mechanisms are inadequate [149]. It describes a situation that threatens high priority goals and which suddenly occurs with little response time available [150]. In a crisis, the things that people are used to doing and comfortable doing, are not working and the stage is set for the possibility of disaster or new learning.

An organizational crisis will be sensed by everyone in the sphere of influence of the organization almost instantaneously regardless of how strenuously leaders attempt to contain the spread of information. Emotional contagion –without cognitive input – occurs within one-twentieth of a second and although employees of an organization may not know what the problem is, they will indeed know that there is a problem [151]. Tension literally fills the air. Within minutes or hours of a particularly disturbing piece of gossip, news, or crisis, everyone in an organization will be in an alarm state with all that goes along with that, including compromised thought processes[152] .

Organizations respond to crisis in observable ways. When a crisis hits, most managers want to do the right thing. But one of the things that makes a crisis a crisis is that no one really knows what to do for certain, yet everyone expects the organizational leaders to know what to do. Different leaders will respond in different ways but this is often the time when a charismatic leader exerts the most influence either by creating a different frame of meaning for followers, by linking followers' needs to important values and purposes, through articulation of vision and goals, or by taking actions to deal with the crisis and then moving to new interpretive schemes or theories of action to justify the actions [149].

At such a time, every person throughout the system is under stress, so everyone's ability to think complexly will be relatively compromised. Stress increases a person's vigilance towards gathering information, but it can also overly simplify and perceptively distort what we see or hear. Negative cues are usually magnified and positive cues are diminished or ignored altogether. Furthermore, the stress of an event is determined by the amount and degrees of change involved, not whether this change is good or bad [73]. Under these conditions, command and control hierarchies usually become reinforced and serve to contain some of the collective anxiety generated by the crisis. Command hierarchies can respond more rapidly and mobilize action to defend against further damage. In times of danger, powerful group forces are marshaled and attachment to the group radically increases. Everyone in the organization is vulnerable to the risks the organization faces as a whole – everyone feels vulnerable [153].

Hospital beds around the country have been so decreased that many hospitals are under significant community pressure to admit anyone who requires hospitalization, even if they must exceed their normal bed capacity. One hospital

began using a crisis code – an amber alert – indicating that the hospital has exceeded its capacity, are now taking on more than they can manage, and that the "no divert" system is in effect. When this occurs, everyone's computer screen flashes orange and announcements are made, causing a repetitive sense of crisis, even though there is nothing anyone can do about it. In reality, when the "amber alert" goes off, the staff are already managing the overload, the patients are fine, and order is present even when they have to add extra beds to the rooms or the hallways.

But when crisis unrelentingly piles upon crisis - frequently because leaders leave, burnout, are fired, or fail - an organizational adjustment to chronic crisis occurs. Chronic fear states in the individual often have a decidedly negative impact on the quality of cognitive processes, decision making abilities, and emotional management capacities of the person. Impaired thought processes tend to escalate rather than reduce, existing problems so that crisis compounds crisis without the individual recognizing the patterns of repetition that are now determining his or her life decisions.

In similar ways, significant problems arise in organizations when the crisis state is prolonged or repetitive, problems not dissimilar to those we witness in individuals under chronic stress. Organizations can become chronically hyperaroused, functioning in crisis mode, unable to process one difficult experience before another crisis has emerged. The chronic nature of a stressed atmosphere tends to produce a generalized increased level of tension, irritability, short-tempers and even abusive behavior. The urgency to act in order to relieve this tension compromises decision making because we are unable to weigh and balance multiple options, arrive at compromises, and consider long-term consequences of our actions under stress. Decision-making in such organizations tends to deteriorate with increased numbers of poor and impulsive decisions, compromised problem-solving mechanisms, and overly rigid and dichotomous thinking and behavior.

Organizations under stress may engage in a problematic emotional management process that interferes with the exercise of good cognitive skills, known as "group think". The social psychologist, Janis looked at how groups make decisions, particularly under conditions of stress. He reviewed studies of infantry platoons, air crews, and disaster control teams and felt that this work confirmed what social psychologists had shown on experiments in normal college students, that stress produces a heightened need for affiliation, leading to increased dependency on one's group. The increase in group cohesiveness, though good for morale and stress tolerance, could produce a process he saw as a disease that could infect otherwise healthy groups rendering them inefficient, unproductive, and sometimes disastrous. He observed that certain conditions give rise to a group phenomenon in which the members try so hard to agree with each other that they commit serious errors that could easily have been avoided. An assumed consensus emerges while all members hurry to converge and ignore important divergences. Counterarguments are rationalized away and dissent is seen as unnecessary. As this convergence occurs, all group members share in the sense of invulnerability and strength conveyed by the group, while the decisions made are often actually disastrous. At least temporarily, the group experiences a reduction in anxiety, an increase in self-satisfaction, and a sense of assured purpose. But in the long run, this kind of thinking leads to decisions that spell disaster. Later, the individual members of the group find it difficult to accept that their individual wills were so affected by the group [154].

In a crisis unit, or an acute care inpatient setting, groupthink is easily observable. Staff members are under stress to admit patients, diagnose them, stabilize them and get them out on the streets again. Under such conditions, the staff is likely to develop a high level of cohesiveness which helps them handle the stress more adequately, but the result may be that the group is so intent on supporting each other that the group members never engage in meaningful, task-related conflict surrounding the diagnosis or the treatment of the patients.

Another significant group emotional management technique that is particularly important under conditions of chronic stress is conformity. Another social psychologist, Solomon Ash, demonstrated that when pressure to conform is at work, a person changes his opinion not because he actually believes something different but because it's less stressful to change his opinion than to challenge the group. In his experiments, subjects said what they really thought most of the time, but 70% of subjects changed their real opinions at least once and 33% went along with the group half the time [155]. If a psychiatric setting is dominated by norms that, for instance, assert that biological treatments are the only "real" medicine that a patient needs, or that the only way to deal with aggressive patients is to put them into four-point restraints, or that "bad" children just need more discipline, then many staff members will conform to these norms even if they do not agree because they are reluctant to challenge the group norms.

- Specialists in the corporate world have looked at the impact of chronic fear on an organization. Just as exposure to chronic fear undermines the ability of individuals to deal with their emotional states and to cognitively perform at peak levels, chronic fear disables organizations as well. Lawsuits, labor unrest, the formation of unions and strikes are typical signs of a high-fear environment. A lack of innovation, turf battles, social splitting, irresponsibility, bad decisions, low morale, absenteeism, widespread dissatisfaction, and high turnover are all symptoms of chronic fear-based workplaces [46]. *"In all these instances, the hidden factor may be an absence of group cohesion and commitment and the presence of unbearable tensions which create particular stresses for the individual. In these circumstances, the workplace is experienced as unsupportive, threatening to the emotional and physical well-being of the employee. At its worst, the workplace becomes a paranoid-schizoid environment, a nightmare existence",* p. 250 [40].
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D. Dissociation, Amnesia and Fragmentation of Function

Thesis: Communication networks tend to break down under stress and as this occurs, organizational learning is negatively impacted, organizational memory is lost, organizational amnesia affects function, and service delivery becomes increasingly fragmented.

Barriers to Organizational Learning

"If an organization is to learn anything, then the distribution of its memory, the accuracy of that memory, and the conditions under which that memory is treated as a constraint become crucial characteristics of organizing", p.206.

Karl E. Weick, 1979
The Social Psychology of Organizing
Reading, MA: Addison-Wesley

Much talk is made these days of organizational learning but what exactly is that? The concept implies that organizational learning is both a cognitive and social process; that it involves capturing, storing and diffusing knowledge within the organization. It is the product of certain organizational arrangements and decisions and it often involves reassessing fundamental assumptions and values. Organizational learning begins with learning at the individual level and then involves diffusing the knowledge generated to other parts of the organization. The end result of organizational learning is organizational adaptation and value creation [156].

What is the "value creation" in the clinical world? Unlike the business sector, the value in mental health services is not as easy to measure since it relates to human performance over a long trajectory. Enormous value is lost to a society by the toll that mental illness takes on the individual and social economy. Clinical services have value if they improve an individual, family or group level of function. According to a 1999 report from the Surgeon General, the direct cost of mental illness and substance abuse per year is $81.6 billion and the indirect costs that include lost productivity account for another $76.6 billion and that is in 1990 dollars. Eighty percent of the indirect cost comes out in disability payments. And these numbers do not yet take into account the enormous economic costs over the lifespan of exposing children to adversity [see earlier discussion of Adverse Childhood Experiences Study). The mental health system – as a learning organization - should be able to reduce that toll, ultimately in measurable ways.

Another way of understanding how organizations learn is by using a framework that involves four processes of learning: intuiting, interpreting, integrating, and institutionalizing. Intuiting occurs when an individual recognizes a pattern or possibility in a situation and shares this intuition with the organization. Through a process of interpretation, the intuition is discussed and refined through a social activity involving the group, producing a convergence of meaning. Integration involves the development of shared understand and coherent collective action that helps develop a new understanding of how to adapt so that learning takes place at the group level and is linked to the organizational level.

Institutionalizing occurs when the learning becomes embedded in systems, structure, procedures and organizational culture [157] .

Extensive research on corporate knowledge concludes that “knowledge exists in two forms: explicit knowledge, which is easily codified and shared asynchronously, and tacit knowledge, which is experiential, intuitive and communicated most effectively in face-to-face encounters”. Explicit knowledge can be articulated with formal language. It is that which can be recorded and stored. Tacit knowledge is that knowledge which is used to interpret the information. It is more difficult to articulate with language and lies in the values, beliefs and perspectives of the system [156, 158].

According to some investigators, there is a widespread failure to capture tacit knowledge because Western culture has come to value results-the output of the work process-far above the process itself, to emphasize things over relationships [159]. In the mental health world, tacit knowledge has often been referred to as clinical “wisdom” or “intuition”. Although frequently widely agreed upon, clinical wisdom is difficult to test, and is therefore vulnerable to the present demand for “evidence-based” practices. In the current environment, information that does not have “evidence” – meaning a sufficient number of double-blind, controlled studies - is more likely than ever to be discounted as meaningless and this determines what gets funded. But in the effort to provide methods of helping people that have been shown to be effective, we are in danger of retaining only explicit knowledge and losing the equally valuable tacit knowledge within the mental health system as a whole.

Tacit, intuitive, experiential knowledge about the inner working of the human mind has historically been interpreted, integrated and ultimately institutionalized within mental health organizations through the sharing of information among a clinical team and in supervisory sessions. In what were frequently prolonged and extensive discussions focused on the many lenses through which that information could be interpreted, organizations as a whole and subgroups within the organization, could synthesize explicit and tacit information into a working model of the whole human being. Not only was the biological interpretive lens valued, but so too was the psychodynamic, the family systems, the behavioral, the creative, and the existential and spiritual lenses. Biological hypotheses are easier to test, more likely to get funded with research dollars, encouraged by big pharmaceutical corporations, and viewed as less costly so that for the last several decades, the explicit knowledge that has been generated from biological research has come to dominate the treatment environment to such an extent, that in many environments it is all anyone talks about. As a result, a full understanding of the human being labeled as the patient, a human being living within and interacting with his or her personal, social, political, and economic environment becomes meaningless and important knowledge is lost to the system.

Visiting an acute care adult psychiatric inpatient unit one day, a consultant sat in on “rounds”. The head psychiatrist – wearing what is now the ever-present white coat – was clearly in charge of the discussion in the meeting. The conversation about every patient consisted of four fundamental questions: the date of

admission, the medications the person was on, recent events (in abbreviated form and mostly about drug effects), and the proposed date of discharge. When the consultant heard of the recent suicide attempt and the decision to diagnose a formerly healthy and high-functioning young woman with major depressive disorder, she broke into the rapidly moving meeting and asked if anything had happened to the woman in the past year that could explain this deterioration. Silence broke out in the room and the obviously irritated psychiatrist looked at the social worker in charge of the case who, paging through the patient's history, reported that yes, the young woman had been raped the year before. Not only was the past history seemingly irrelevant to the clinical team but upon further probing, the team was unable to even formulate how the previous rape and the depressive episode might be related much less what role the staff could or should be playing in addressing the past traumatic experience. Without meaningful clinical exchange, organizational learning had, for the most part, come to a halt and team meetings had deteriorated into relatively meaningless ritualistic behaviors.

Individuals create certain ways of knowing, or schemas, that serve to reduce uncertainty. Organizations, too, are said to create interpretive schemes or frames of reference to filter information that is considered within an organization. These organizational-level schema may then block, obscure, simplify or misrepresent some of the information that organization must process and remember [160]. The diagnostic system created by the American Psychiatric Association is an extremely influential filtering system for the mental health professions. The Diagnostic and Statistic Manual has become a method for reducing – or at least trying to reduce – the uncertainty that has always accompanied "madness".

Using the ancient method of giving a name to what we most fear, we give madness names and descriptions and believe therefore that it is less frightening and more manageable. However, staff members, particularly line staff who are not trained to understand that these are only oversimplified and reductionistic descriptive labels for which we have no agreed upon etiology – begin to reduce the patients to the diagnoses they carry. Unless patients are willing to pay out of pocket, the only way they can enter the mental health system is to get a diagnosis. The diagnosis then carefully filters what can and cannot be discussed, understood and shared. The diagnosis implies expected behavior consistent with that diagnosis. Because our minds are set to see what we expect, the diagnosis cues a staff member to expect certain behaviors, provides an explanatory framework for that behavior, and thus minimizes curiosity about what the behavior may actually mean. Being social creatures, and thus vulnerable to being influenced by other people's expectations, the patients respond with the expected behavior. In this way a diagnosis easily becomes a self-fulfilling prophecy.

So powerful are the suggestive effects of diagnosis, in fact, that in the early 1970's David Rosenhan experimentally demonstrated that labeling can create a false reality. In an article originally published in *Science* [161], eight pseudopatients - a psychology grad students, three psychologists, a pediatrician, a psychiatrist, a painter, and a housewife - agreed to be experimental subjects and gained secret admission to twelve different hospitals. Those who were mental health professionals said they were in other occupations and they used pseudonyms to hide their identity. The pseudopatients' single complaint was

that they had been “hearing voices” that were unclear, but sounded like “empty”, “hollow”, and “thud”. Beyond alleging the symptoms of hearing voices and falsifying name, vocation, and employment, no further alterations of the pseudopatients’ person, history, or circumstances was made. None of their histories or current behavior – other than the report of hearing voices – was seriously pathological in any way.

Immediately upon admission – and they were all readily admitted – the pseudopatients ceased simulating any symptoms of abnormality. In some cases there was some nervousness over being admitted so easily to a psychiatric unit, but other than that they behaved as they would behave normally. Each pseudopatient was told that there was no foreknowledge of when they would be discharged – that they would have to get out of the hospital by their own devices, essentially by convincing the staff that they were sane. They were paragons of cooperation and were not disruptive in any way. But despite their show of sanity, the pseudopatients were never detected. In all but one case they were admitted with a diagnosis of schizophrenia and discharged with a diagnosis of schizophrenia in remission. The average length of stay was nineteen days, although the length of hospitalization varied from 7 to 52 days. Visitors and other patients were frequently able to recognize that the pseudopatient was not ill at all, but the staff could not. *“As far as I can determine, diagnoses were in no way affected by the relative health of the circumstances of a pseudopatient’s life. Rather, the reverse occurred; the perception of his circumstances was shaped entirely by the diagnosis… Having once been labeled schizophrenic, there is nothing the pseudopatient can do to overcome the tag. The tag profoundly colors others’ perceptions of him and his behavior… The facts of the case were unintentionally distorted by the staff to achieve consistency with a popular theory of the dynamics of a schizophrenic reaction.* p. 60-61 [162].

In another experiment, Temerlin took a normal, healthy man, recorded an interview with him, and then played the audio interview to psychiatrists, clinical psychologists, and graduate students in clinical psychology. Just before listening to the interview, the experimental group heard a professional person with high prestige who was acting as a confederate in the study, say that the individual to be diagnosed was *“a very interesting man because he looked neurotic but actually was quite psychotic”*. The control group did not hear this suggestion. No control subject ever diagnosed psychosis while 60% of the psychiatrists, 28% of the psychologists and 11% of the graduate students diagnosed this normal man as psychotic after hearing the suggestion of the expert [163].

If these studies were replicated today would the results be the same? I can only speculate but I suspect that although it would be for harder for the pseudo patients in the first study to be admitted to a hospital, they would still be likely to be labeled as psychotic and as their diagnoses accompanied them they would find it extremely difficult to shed the diagnosis. And once the diagnosis is in place and unquestioned – as it rarely is in highly stressed environments – it is likely to become self-fulfilling as each subsequent professional believes the assumed expertise and accuracy reflected in the patient’s chart and treats the patient accordingly. If the patient is diagnosed not as psychotic, but as having a personality disorder, the course of treatment is unlikely to a pretty one. Because personality disorders are so loaded with connotations not of sickness but of badness, people carrying the diagnosis of borderline personality disorder, or antisocial personality disorder for examples are likely to be shunned, seen as “manipulative” and “attention seeking”, repeatedly rejected and avoided regardless of the legitimacy of their complaints.

The sociologist, Thomas Scheff described this labeling process years ago but his work and the work of those like him, is little discussed today because it is inconvenient and because it leads to an increase in uncertainty that cannot be tolerated, particularly in a stressed environment [164-166]. The information that has been most systematically screened out via this mechanism is the impact of previous traumatic experience on the evolution of so many diagnostic categories. The traumatic origins of what is perhaps a majority of behavioral dysfunction, is enormously threatening to this hugely embracing categorization system that the mental health profession has adopted to feel more secure in a shifting world.

Trauma restores context to what has increasingly become a decontextualized meaning framework in mental health practice. If the origins of so much dysfunction are to be found in the adverse experiences of childhood that a majority of Americans apparently experience [4], then what exactly is the role of the mental health professional? What should mental health institutions focus their efforts upon? Can we stay comfortably settled in our offices or is advocacy for fundamental change a moral necessity? What exactly do all the diagnostic categories mean when someone diagnosed with post-traumatic stress disorder is six times more likely to be diagnosed with another psychiatric disorder and eight times more likely to be diagnosed with three or more psychiatric disorders [167-169]?

These are disturbing questions for an institution under the best of circumstances but virtually impossible questions for a system-under-siege to answer. So, for the most part, the issue of trauma is simply screened out organizationally and systemically. With every new war, disaster, terrorist act it bubbles to the surface again and then as each day distanced from the latest trauma occurs, the knowledge fades away, or within the context of this discussion, is socially dissociated. Lacking the time, energy, or knowledge base to use intuition, re-interpret behavior, or integrate new knowledge, the reality of the traumatic origins of mental illness go unaddressed. And the patient, frequently diagnosed with chronic depression, borderline personality or some other “axis II’ disorder is labeled, everyone in the system colludes to support the reality and meaningfulness of the label in determining future behavior and outcomes, and the patient’s more fundamental – and treatable – trauma conditions go untreated.

Organizational Memory & Organizational Amnesia

For learning to occur, organizations must have memory. Some modern philosophers believe that all memories are formed and organized within a collective context. According to them, society provides the framework for beliefs, behaviors, and the recollections of both individual and groups [170]. Later, present circumstances affect what events are remembered as significant. Much of the recording and recalling of memories occurs through social discussion. This shared cohesiveness of memories is part of what defines a culture over time. Shared language also helps a society organize and assimilate memories and eventually, forget about the events. Recent authors in the world of organizational development, braving the shoals of being accused of anthropomorphism have gone into some detail about the definitions and workings of organizational memory.

Organizational memory refers to stored information from an organization’s history that can be brought to bear on present decisions. This information is stored as a consequence of implementing decisions to which they refer, by individual recollections, and

through shared interpretations [160]. Like individual memory functions, organizational memory is distributed, not concentrated in one place or domain.

But where in an organization is memory stored? One postulate is that there are five "storage bins" that comprise the structure of memory within an organization [171]. The first storage bin includes the recollections that individuals have of what has transpired in and about the organization. This information is embodied within the individual in the form of actual memories and in belief systems, causal maps, assumptions and values. Individuals also keep written records and files of things that occur in the workplace that also serve as memory storage components. In the mental health system, the staff members within the organization comprise the first storage bin. The files they keep, their notes in the patient charts all represent forms of this kind of memory storage.

Organizational culture represents the second memory storage bin. Organizational culture structures the way future situations will be dealt with by the organization. The learned cultural information is stored in a variety of ways including language, symbols, stories, and the grapevine. Every mental health organization has a unique culture and the older the organization, the more likely it is that the established organizational culture will exert a strong effect on individual members as they join the organization.

The third form of storage is embedded in the transformations that occur in organizations. Transformation occurs in a psychiatric hospital between the patient at admission and the patient at discharge, or between the new staff member and the experienced staff member. Patient or staff member, people rapidly learn the standard operating procedure of the organization – the role they are to play, the way they are to play it, what is expected of them under different circumstances – and these procedures provide a frame of reference grounded in the past history that constrains innovation and that often become self-fulfilling prophecies [160, 171].

Organizational structures become the fourth form of memory storage. Individual roles of each person within the organization provide a repository in which organizational memories can be stored. The role labels form the social expectations and these social expectations link individual enactment with collective rules – the formal and informal codifications of "correct" behavior, what is to be controlled and who is to be in control. The ways in which the organization is structured then come to reflect the institutionalized myths of the organization and/or the society as a whole. The organization's memory then serves to legitimate those myths [160]. In the mental health system, particularly in hospital settings, roles have historically been clearly delineated, sorted into an established medical hierarchy of authority.

The fifth memory storage bin is represented by the actual physical structure or workplace ecology of an organization. Physical space often reflects values, beliefs, assumptions and culture of the organization and is known to powerfully influence employees' workplace experience. A mental health or social service facility that has no room large enough to gather the entire community conveys the lack of value it places on community. Dingy, ugly, dirty, colorless settings convey attitudes toward both clients and staff. In hospitals, barriers that separate staff from patients define lines of authority and social expectations.

Finally, external archives are another, more external form of organizational memory storage. Reports, books, personal accounts, other people's reminiscences all can be part of this external archival memory. In the mental health sector, much of the original material on the practice of therapeutic community is out-of-print. One of the first things to be closed

under budget constraints are specialized libraries that were accessible to students and psychiatric residents right in the environments within which they were working. Patient charts have simultaneously increased in relatively useless documentation while decreasing in meaningful information. Now they are likely to be only the barest representation of the people they purport to describe.

Organizational memory is vital if organizations are to learn. But organizational memory appears to be vulnerable to some of the same circumstances that affect individual memory. Critical events and organizational failure change us and change our organizations, but without memory we lose the context. Studies have shown that institutions do have memory and that once interaction patterns have been disrupted these patterns can be transmitted through an organization so that one "generation" unconsciously passes on to the next, norms that alter the system and every member of the system [remember the five squirrels again]. But without a conscious memory of events also being passed on, organizational members in the present cannot make adequate judgments about whether the strategy, policy, or norm is still appropriate and useful in the present [172].

Corporate amnesia has been defined as a loss of organizational memory [173]. Analogous to the division in individual memory between verbal, explicit and situational implicit memory, literature in the corporate world refers to explicit and implicit or "tacit" corporate memory, the latter referring to vital, organizationally-specific knowledge that is cumulative, slow to diffuse, and rooted in the human beings who comprise the organization in contrast with the explicit corporate memory which is embodied in written documents, policies and procedures.

One investigator studied a variety of companies and showed that organizations kept repeating their mistakes and blunders for two main reasons: they had either lost their corporate memory and were incapable of recalling their corporate history, also known as "time-based" memory loss; or they were unable to communicate lessons from one part of the organization to another part in a timely manner – "space-based" memory loss [156, 173]. "Time-based" memory loss occurs when learning that has taken place fails to be encoded and documented and thus knowledge is lost over time; while "space-based" amnesia occurs when learning, even when encoded and documented, fails to be shared or diffused [156]. Presumably, organizational amnesia can also result from impairments in any of the five "storage bins" as well – individual recollections, organizational culture, organizational transformation and structure, physical space and physical archives.

Organizational amnesia can result from break down in any of the four stages of learning: intuition, interpretation, integration, and institutionalization [156]. There may be no mechanism for intuitive knowledge of the individual to be transferred to the organization, or individual intuition may be looked down on, effectively silencing individuals resulting in time-based memory loss. Tacit knowledge – often in the form of skills or corporate wisdom - is much more difficult to transfer than explicit knowledge so that much that goes on at a tacit level may not be transferred to other parts of the organization and cause "space-based" memory loss. Integration and institutionalization may help the organization retain explicit information gained over time, but the tacit information is more easily lost. When this happens rules may replace norms as guides for the group. Additionally, presumed causal relationships may be in error, but may become institutionalized, while accurate causal relationships are ignored. Selective perception and attribution also come into play, as individuals and groups systematically ignore information that does not fit into established schemas.

Corporate amnesia becomes a tangible problem to be reckoned with when there is a loss of collective experience and accumulated skills through the trauma of excessive downsizing and layoffs [174]. It is now generally recognized that corporate layoffs can have devastating effects not just on individual but on corporate health as well, even producing what has been termed "survivor sickness" in the business world [175, 176]. Corporate memory loss at any level in the organization is significant. However some investigators believe that when it happens at the senior team level it has the greatest impact. Senior team members hold the strategic piece of the organization and a sense of the intended vision for the future direction. There are fewer members at this level and they hold more power. Therefore decisions made have a greater global impact throughout the organization. They are responsible to maintain the integrity of the organization and that loss can impact not only the organization, but the community it serves as well [158].

It is the valuable tacit memory that is profoundly disturbed by the loss of personnel in downsizing. According to investigators in the field, the average length of a U.S. employee's tenure with any given company is approximately five years. *"The dramatic shift in the nature of employment toward short-term tenure is among the biggest damaging influences on productivity and competitiveness in companies today. That's because short-term tenure translates into short-term organizational memory. And 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* [177].

Organizations must reckon with past failures and the fragmentation of meaning and purpose that accompanies these failures, much like individuals. Organizations can distort or entirely forget the past – or important parts of the past - just like individuals do, and the more traumatic the past the more likely it is that organization will push some memories out of conscious awareness. Changing leaders, even changing the entire staff does not erase the organizational memory, nor does it excavate and provide decent burial for the skeletons in the organizational closet. As one author puts it, *"Pain is a fact of organizational life. Companies will merge, bosses will make unrealistic demands, people will lose their jobs. The pain that accompanies events like these isn't in itself toxic; rather, it's how that pain is handled throughout the organization that determines whether its long-term effects are positive or negative"p.12* [178].

Organizational Amnesia and the Mental Health System

The movement to eliminate hospital beds, combined with the excesses of managed care has resulted in the dramatic loss of a variety of resources in the mental health field but in the long-term the most devastating loss may be that of organizational memory. This loss of memory produces an institutional Alzheimer's syndrome that radically affects every level of function.

What are factors that repeatedly cause this loss of knowledge in the mental health system? There are several challenges to effective organizational memory that can be addressed: (1) informal organizational knowledge, being tacit and intuitive, like a wild animal, resists capture; (2) the usual approach to organizational memory by keeping files and preserving documents, fails to preserve context and for many reasons may cease to provide accurate records of past events; and (3) under some circumstances, knowledge

loses its relevance, and thus its value, over time; (4) the current litigious environment may create an economic incentive for "organizational amnesia" [159]; (5) the institution may have experienced a traumatic experience that is organizationally dissociated; (6) the subject matter of memory may demand such major organizational change that it simply must be "forgotten or because it places the institution in conflict with the larger society.

Informal organizational knowledge is lost when individuals, particularly long-time professionals, leave the organization and do not pass on hard-earned knowledge to new employees. Much of the tacit memory in institutions is passed on through the mechanism of organizational culture, "the way we do things around here". Culture is massively affected by lay-offs, program closures, leadership changes. The transformations that used to occur in hospital settings and even partial and outpatient settings may no longer occur because treatment is so attenuated and thus the knowledge of how both patients and staff change over time may be lost. Organizational structure tends to be more lasting, but the structure and function may cease to inform each other so that the structure itself becomes meaningless, repetitive and hollow because the tacit information formerly embedded in clinical wisdom that has now left the system, no longer informs the structure. Even the knowledge that seems embedded "in the walls" of the institution is lost when the physical structures themselves are torn down, or when the entire program moves to a new – and frequently diminished – locale.

The program in a residential treatment program for children was highly structured around behavior management. Children lost points for an almost infinite variety of infractions and the decisions about consequences remained largely in the hands of childcare workers who were indoctrinated into the system by other childcare workers. The staff members who had previously started the behavior management system as an almost revolutionary way to address difficult problems that had not been responsive to psychodynamic forms of treatment had long since retired or gone on to other positions. Without a guiding and integrated theoretical framework, the behavior management system had come to bear absolutely no relationship to the child's history and was performed as a relatively meaningless ritual. A similar behavior management plan was set out for every child who came into care. If the child continued to be disobedient to the rules no one on the staff stopped to inquire about the intended consequences of the child's behavioral plan and how it fit into an overall recovery process for the child. There was no discussion about the meaning behind the child's behavior. Childcare workers were taught to believe that their job was to manage behavior through this system and were led to believe that they did not need to know anything about the child's previous experience in order to successfully achieve this. Without a conceptual framework or strategy to fall back upon, staff members frequently simply "dosed" the children with more behavioral consequences that did not work to actually change behavior.

Organizational memory is kept within the files and records of the institutions. But the actual physical archive of a patient's file becomes essentially meaningless when the record-keeping is based on satisfying the demands of what is frequently seen as an oppressive, arbitrary and capricious process of justifying admission.

On an acute care inpatient unit, the case manager or psychiatrist may have to call the managed care company every day to get permission to keep a patient in the hospital. Unless they can demonstrate concretely that the patient needs what the insurance company defines as hospital level care – usually requiring an imminent threat to life – the hospital stay is likely to be denied. Although human beings rarely change dramatically overnight, the hospital charts indicated that radical and dramatic change frequently did in fact happen within hours. According to the chart, a patient would continue to be suicidal for days and then seemingly miraculously be ready for discharge, or a psychotic patient's voices would suddenly disappear. In fact, patients were improving at the pace at which patients have always improved, but reality could not be truthfully explained in the chart without damaging consequences. Additionally, staff were taught never to write anything positive about changes the patient was making until the end of the stay because these comments could be used to justify and mandate discharge, even if the improvement was still quite fragile from the point of view of the clinician. As a result of these and other adaptations to adversity made by hospital staff, over time, even the physical archives of a patient's progress have become corrupted and can no longer be considered an accurate portrayal of what actually happened in the treatment process.

Knowledge loses its relevance when it is no longer valued by the organization as a whole. *"Even though organizations do not have a biological existence, they can still act in ways that suggest they have forgotten key lessons previous learned. Lessons learned and knowledge previously generated are sometimes lost and forgotten, p.273* [156]. If an administrative system is emphatically concerned about reducing costs, or reducing hospital stays, and pays only lip-service to clinical care, it is not long before knowledge that relates to clinical care is lost simply because it is no longer considered relevant to what employees perceive as the real organizational mission, even if the stated mission says something else.

The loss of organizational memory can be witnessed in many settings where the staff – even professionally trained staff – seem unable to formulate anything but the most rudimentary ideas about human motivations, drives, and problems. Losing the history of the patient is a common occurrence in many settings today. As if they were journalists instead of clinicians, staff carefully record the "who". "what", "where", and "when of their patient's lives but may never get to the "why". The meaning in the message is lost as communication within an organization breaks down and organizational memory becomes increasingly impaired. The patient's history is not conveyed to other members of the treatment team resulting in space-based memory loss, and the patient's history is not carried through time, a situation particularly applicable now to the longer-term treatment of disturbed children, resulting in time-based memory loss.

A multidisciplinary team of a residential treatment program were meeting regularly to create significant change within their organization. Children often stayed in this program for several months, and sometimes years. In a discussion about a particularly difficult little girl who had already been in the institution for over two years, the social worker mentioned that this was a child who had been sexually abused. A childcare worker who worked in the cottage with this girl piped up indignantly, "How is it possible that I have worked with this child for the last year and a half and no one ever mentioned that she had been sexually abused?" This caused the entire team to step back and look at the many ways in which they repeatedly lose the children's histories in the day-to-day struggle to control behavior.

Similarly, as staff and leaders leave an institution, the memory of organizational events, like the histories of the patients, becomes like a cheesecloth that is filled with holes. Parts of the institutional memory are kept in consciousness but because it is only part, the result may be a serious distortion of the past.

An outpatient organization with a variety of different programs decided to work on better integrating their overall system. To serve this goal, the consultant urged the group to review their long history. One of the conflicts that surfaced was a generalized but nonspecific fear and suspicion of the financial department in the organization that seemed to make no sense in terms of present operations. The consultant asked the most long-term members of the organization to form an inner circle to talk about the past and the other members of the group sat in a wider circle around them. What surfaced was a part of their history that many people in the room knew nothing about. Thirty years before there had been a financial crisis that almost caused this venerable institution to shut its doors. Financial specialists – one of whom was still running the department – were called in to attempt to rescue the situation. At the time, everyone felt enormous pressure but particularly the newly hired financial people. The organizational grapevine warned everyone about "staying away from finance" and some personal vignettes about short-tempered responses from the people in finance reinforced this warning. Although the situation had long since righted itself, the "word on the street" was still "stay away from finance". The current leader had known nothing about this piece of the history so had not been able to do anything to correct the misapprehension that targeted one lonely – and isolated – department until this fragment of organizational memory was retrieved.

Lawsuits are known to be extremely stressful and in some cases, traumatic for many of the people involved in the proceedings. There may be an unconscious and conscious bias toward only remembering experiences that support the defense of the suit and this may encourage organizational amnesia. Instructions given by lawyers at the time a professional

or an organization encounters a potential lawsuit may unwittingly encourage forgetting especially when all talking or writing about the events is discouraged [179]. And it is also likely that events that led to litigation have been traumatic to the staff involved, not just the person who has been in some way injured.

A consultant was talking to a group of staff members of a psychiatric until and one woman was notably withdrawn and silent, contributing nothing to the group discussion, sitting herself behind and away from the other members of the group. The consultant had already learned that the program had experienced a suicide on the unit two years before and the date of this meeting had happened to fall on the two-year anniversary of the death. If the date had been arranged deliberately, it was an unconscious move on the part of the administrative assistant who had arranged that date with the consultant and who was surprised later to learn of the coincidence.

At the time of the patient's death, on the advice of hospital attorneys, little was said about the suicide to anyone but the immediate staff who had been involved and the entire issue was kept closely under wraps, largely because of legal concerns. But despite the fact that these concerns were ultimately unfounded, the staff had never been debriefed about the death and it was immediately clear that it was a living memory for the staff members present in the room with the consultant – and a puzzle for those who were hired after the incident.

The consultant shared his own experience with a suicide on a psychiatric unit – always an extremely traumatic occurrence – and when he had finished, for the first time the withdrawn staff member tearfully spoke up, "I now know more about your patient and the circumstances surrounding it, than I know about the person who died here, even though I was here that night". The consultant was later told that this was the first time the staff member had revealed any emotion about the incident and the first time she had been willing to emotionally engage with her colleagues at all since the suicide.

The result of organizational amnesia may be a deafening silence about vital but troubling information, not dissimilar to the deafening silence that surrounds family secrets like incest or domestic violence. There is reason to believe that maintaining silence about disturbing collective events may have the counter effect of making the memory even more potent in its continuing influence on the individuals within the organization as well as the organization as a whole much as silent traumatic memories continue to haunt traumatized individuals and families [180].

A social service organization had endured three leadership changes in two years. The internal situation was becoming increasingly chaotic and the Board of Directors requested an evaluation from an external agency. The report obtained through many personal interviews with the staff, was largely negative, probably more to make the point for funding sources that there was great need, then that the authors wanted to criticize the staff. Unfortunately, however, the leader at the time, herself just making the transition, chose to keep the findings of the report

secret from the staff but based much of her change policy upon the report. She was an authoritarian leader and the changes she made were perceived as insulting, unfair, and cruel by the staff. She only lasted in her leadership position for two years. When the organization again changed directors, a consultant was brought in to help with the reorganization that was obviously needed. In the interim, the level of service delivery had radically slipped, staff morale had plummeted, and the organizational reputation was sliding progressively downward. After a number of meetings with a multidisciplinary team, the issue of this elusive report now five years old, finally surfaced, Fortunately the current director managed to find a copy of the report buried in the organizational files. Once the "secret" report was exposed to the staff, put into context, and emotionally and cognitively worked through, the organization could begin the healing process so necessary for it to recover its former level of function and status in the community.

Previously hard-earned knowledge may be lost and then rediscovered as if new. We are currently in a climate where seclusion and restraint are being actively discouraged and even prohibited, due in part to the activism of mental health consumers and the deaths of patients while in restraings. However, the cycling of the curbing of restraint followed by the escalation of coercion has been a pattern that has repeated over time, going at least back to the birth of Moral Treatment in the late 18th century. Reformers come in, demonstrate that psychiatric care, even of the most violent, can be delivered without violence in environments conducive to healing and as long as the reformers are active, this proves to be largely true. But then the knowledge gradually slips away again.

A psychiatrist experienced in operating inpatient settings using milieu therapy, assumed leadership of an inpatient unit that had been in existence for decades. Although the level of restraining people was relatively low compared to many current settings, the staff denied any knowledge of what "milieu therapy" actually is. They actively resisted the suggestions of the new psychiatrist to change their current practices in line with milieu treatment, openly stating that the psychiatrist had herself invented the "milieu" ideas and the staff viewed her suggestions as the impositions of radical new ideas that could never work. And then one day one of the older nurses brought in an old nursing book from the 1940's. The staff were shocked to see clear definitions and explanations of "milieu therapy", not as the new psychiatrist's radical ideas, but as previously established and accepted nursing practice. It was clear that at some point in time, milieu therapy knowledge had been embedded in the practice of the unit program since the "footprints" were still visible, hidden in some of the policies on the unit that supported non-coercive treatment. But the theory and practice of those policies had been cut-off from the context, much like post-traumatic fragments of experience are cut-off from the total context of a person's experience. The psychiatric unit as a whole had become amnestic for entire bodies of previously gained knowledge and experience and was unable to access those memories and incorporate that experience into on-going practice.

Mental health and social service organizations can be traumatized in many ways – layoffs, closures, loss of funding, patient deaths, staff deaths, staff injuries, other acts of violence. And it may not be possible to traumatize an institution without producing defects in organizational memory. In traumatized individuals, memory problems follow two main patterns – too little or too much. After a traumatic experience, individuals may develop amnesia for the worst aspects of an experience, while at the same time; fragments of the traumatic memory may continue to intrude into consciousness at inappropriate times. Either way, the trauma may radically interfere with current information processing, decision-making, problem solving, and life choices.

Historically, the reality of traumatic experience in the lives of psychiatric patients has been recurrently "unknowable" by the mental health system. As Judith Herman has pointed out, "*the study of psychological trauma has a curious history – one of episodic amnesia. Periods of active investigation have alternated with periods of oblivion. Repeatedly in the past century, similar lines of inquiry have been taken up and abruptly abandoned, only to be rediscovered much later. Classic documents of fifty or one hundred years ago often read like contemporary works. Though the field has in fact an abundant and rich tradition, it has been periodically forgotten and must be periodically reclaimed* (p.7)[181].

Dr. Herman and others have pointed out that the study of traumatic stress must occur within political and social contexts that give voice to the disempowered and the disenfranchised. The reality of traumatic amnesia in individual trauma survivors has repeatedly left us with a cultural amnesia – a gap in the societal narrative that could fully round out the reality of those traumatic events. The reluctance of victims to dredge up memories of a past trauma and thereby become triggered into states resembling the initial horrors has been paired with a social reluctance on the part of witnesses to listen to those stories and to bear witness to the terrors of the past accompanied by an unwillingness on the part of those in power to take responsibility for the perpetration of acts of violence or the failure to protect citizens from those acts [182]. This social amnesia is particularly great when the trauma has occurred to an oppressed or marginalized social group – women, children, minorities – and the mentally ill. And importantly, the course of development transiting from traumatic event through post-traumatic reactions to symptomatic behaviors can span decades and travel through a variety of intervening variables each of which can negatively or positively impact on the ultimate course. As a result it has been easy for both survivors and witnesses to lose the thread of cause and effect relationships and this always serves the interests of the perpetrators who are rarely held accountable for their acts [152].

E. Systematic Error

Thesis: 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. This is particularly noticeable when a crisis occurs.

> *Organizations are built, maintained, and activated through the medium of communication. If that communication is misunderstood, the existence of the organization itself becomes more tenuous, p. 136.*
>
> K. E. Weick, 2001
> *Making Sense of the Organization*

Patterns of Miscommunication

How many ways are there for communication to go wrong, even under normal circumstances? Let's just say that one person, A needs to convey information to another person, B. The message is conveyed by A in a language they both, presumably understand and then B decodes the message and puts it into context – makes sense out of it. Of course, what happens when the way A uses the words do not convey the same information to B as was meant? Or what if A's nonverbal information contradicts the verbal message being sent? Or what if A's message does not say precisely what he intends to say? Then, as for B, when the message arrives, "noise" may interfere with B hearing the message accurately. Or B might reject the information as not being that important, or something he or she doesn't want to hear. B may misinterpret the information. Even if all goes well and accurately in the communication between A and B, the feedback loop from B to A may clear up many of the communication problems or it might just make things worse. As a result there communication pathologies can take a number of forms [183].

Miscommunication within systems can occur for a variety of reasons: channels may be inadequate for the volume of information that is entering them – they may be too few, too narrow, or too slow. In mental health organizations, clinical communication networks have traditionally been defined by team meeting structures as well as the informal sharing of information that occurs between people in relatively confined spaces. As time pressures have increased, both informal and formal communication systems have been eroded with staff members in acute settings having little time at all to communicate the valuable informal information and team structures being limited to only the most vital information delivery. With little time or incentive to chart data about the context of the patient's life, the patient file may have relatively little value and be too narrow in form to be of much use. The time delay of information between various shifts or components of the system may increase the likelihood of miscommunication so that a day later, the staff is just beginning to respond to events that have occurred the day or days before. As communication has become more dependent on the technology of computers and email, technological difficulties may also interfere with the direct and immediate conveyance of important information.

Pathologies of information flow can happen when excessive or improper filtering of useful data or the inadequate filtering of useless or erroneous data occurs. For example, when the traumatic roots of mental disorders is ignored and forgotten, and when knowledge of milieu management is lost, then it is likely that information vital to the patients' recovery will be systematically filtered out of the flow of information and judged as irrelevant to the immediate concerns. The loss of psychodynamic and systems perspective means that far-ranging information about context and meaning will be eliminated from discussion and often replaced by or even swamped by erroneous or irrelevant information about details of behavior that do not necessarily lead anyone anywhere.

Communication Under Stress

Crises are never totally secret – all stakeholders in an organization are likely to feel the anxiety and uncertainty in the environment, even if they know relatively little about what is happening. Informal networks of communication – rumors, gossip – are likely to increase under these conditions as formal networks withhold information. But it is during times of crisis that leaders most need to get feedback, adjust actions accordingly, rather than wall themselves off or "shoot the messenters" who bring bad news. By definition, in a crisis things are out of control and there are no easy and obvious solutions to the problems. Constant feedback becomes more critical because of the high degree of uncertainly about ongoing actions taken to address the crisis. Organizations that already have poor communication structures are more likely to handle crises poorly [184].

As stress increases, perception narrows, more contextual information is lost, and circumstances deteriorate to more extreme levels before they are noticed, all of which leads to more puzzlement, less meaning, and more perceived complexity. Communication is necessary to detect error and crises tend to create vertical communication structures when, in fact, lateral structures are often more appropriate for detection and diagnosis of crisis. In any crisis situation, there is a high probability that false hypotheses will develop and persist. It is largely through open exchange of messages, independent verification, and redundancy of communication channels that the existence of false hypothesis are likely to be detected. Therefore in a crisis there is a premium on accuracy in interpersonal communication [185]. Research has shown that organizations are exceedingly complex systems that can easily drift toward disaster unless they maintain resources that enable them to learn from unusual events in their routine functioning. When communication breaks down, this learning does not occur [186].

Instead of increasing interpersonal communications, people in crisis are likely to resort to the excessive use of one-way forms of communication. Under stress, the supervisory structure tends to focus on the delivery of one-way, top-down information flow largely characterized by new control measures about what staff and patients can and cannot do. Feedback loops erode under such circumstances and morale starts to decline as the measures that are communicated do not alleviate the stress or successfully resolve the crisis.

> The staff of an inpatient unit were under considerable stress due to staff reductions and leadership changes after years of a controlling, and sometimes abusive leader. A woman was admitted with suicidal ideation and a number of

serious medical problems. She had managed to get away from her abusive partner but in doing so had lost her job and had no place to live. The staff perceived the patient as needy and dependent and took an immediate dislike to her. There was little discussion about the nature of her problems. Shift to shift, day to day, the word was that she was too needy and should be discharged. Little time was spent talking to her and the belief system about her took on a life of it's own. The patient then began having escalating symptoms of psychosis and only then did she get attention from the staff. Her medical problems - that were previously attributed to attention-seeking behavior - worsened and more medical attention was obtained for her. Meanwhile, the staff kept talking about how she really did not deserve to be in the hospital and should be discharged. Only when the psychiatrist was able to get the woman's entire story and share it with the staff were they able to see this patient as deserving of care. He was able to frame her neediness as post-traumatic and pointed out to the staff how much the woman needed to be empowered to take care of her own medical problems that formerly had been under the charge of her abusive husband. Once the patient began being heard, her psychotic symptoms resolved without antipsychotic medications and all of her symptoms improved enough to support discharge.

Groups are especially prone to "groupthink" under conditions of stress and this type of group information processing can have devastating effects [154, 187, 188]. When this is happening members lose their ability to evaluate ideas critically because of perceived group pressure for conformity. Organizational members may develop illusions of group invulnerability and beliefs that everything the members of the group does is - and can only be - correct and will steadfastly disconfirm any evidence to the contrary, while pressuring any dissenting members to cease their dissent.

When professionals acquire more complex responses so that they can sense and manage more complex environments, they do not become more complex all at once. Instead, they develop their complexity serially and gradually. Under pressure, those responses acquired more recently and practiced less often, unravel sooner than those acquired earlier, which have become more habitual. When some or all of these communication pathologies are already in play, small events can lead to potentially disastrous outcomes. Organizational theorists have observed that when important routines are interrupted, when pressures leads people to fall back on what they learned first and most fully, when coordinated actions breaks down, and when communication exchanges become confusing, more errors occur, error detection is decreased, errors pile upon and amplify each other. Complex and complex collective responses are all more vulnerable to this kind of disruption than are older, simpler, more overlearned, cultural and individual responses (Weick, 2001).

In chronically stressed organizations, it may be the constant "noise" of interruptions that decrease the efficiency of complex thought processes and effective communication. According to Mandler's theory of stress, autonomic activity is triggered by interruption which he defines as *"any event, external or internal to the individual, that prevents completion of some action, thought sequence or processing structure*", p. 92 [189]. Both actions and thoughts can be interrupted, either when an expected event fails to occur or an unexpected event occurs. Crises, by definition, involve interruptions in actions and thoughts.

Another source of systematic error resides in the hierarchical nature of most organizations that is exacerbated by stress. When people are fearful of the response of the person above them in a hierarchy they are likely to do things to communicate in ways that will minimize the negative response from their superior but which may significantly distort the message [190]. They do this in a variety of ways: by gatekeeping and thereby filtering some information in and other information out; by summarizing; by changing emphasis within a message; by actually withholding information, and by changing the nature of information [191] .

The way this plays out in the typical mental health organization is that as stress increases and communication networks erode, the more complex team organizing strategies to deal with the complicated problems surrounding an emerging crisis with a patient, another staff member, or the organization as a whole are eliminated. The administrators at the top are likely to know the least about solving the problems at the bottom, and yet everyone turns to them expecting them to solve the problem. As a result the staff and administrators are likely to resort to simple, punitive, draconian and restrictive methods of intervention more characteristic of their own childhood experiences than any rational theoretical, psychologically-informed complex solutions to complex problems. Since these responses arise from regressive responses, they may not be entirely rationale and are likely to be ineffective. But because of the nature of group regression, it is difficult for the group to admit its own irrational responses and therefore self-correcting mechanisms are not likely to readily occur and systematic error is likely to be the result.

Toby was an 8-year old with lots of problems that worsened around bedtime. As the staff of a residential program were getting the children ready for bed, Toby's behavior problems would escalate. This took the form of moving her bedroom furniture all over the room – every night. The staff – increasingly stressed by this child - would try to get her to stop, but their interactions would inevitably result in the child being restrained and then she would be awake for hours, scared, angry, upset. When the staff complained to the administrator, he made a general rule – for everyone - that bedroom furniture could no longer be moved, and even went so far as to explicitly state the rightful position of each piece of furniture in the room. Since this over-simplified and irrelevant response did not actually serve to do anything except make the administrator feel like he had done something, the child continued to repeat the same sequence very night. Finally the staff and the administrator decided to more carefully and thoughtfully review her case. In allowing for more complex information sequencing, they realized that this sexually abused little girl was simply trying to blockade herself in her room every night to keep herself safe from anyone who might want to molest her again. Armed with this recognition the staff decided on a far more complex series of actions – they got her bunk-beds and arranged for her to "win" a very large stuffed dog to sleep in the bed with her. She no longer needed restraint at night.

F. Increased Authoritarianism

Thesis: As communication breaks down, errors compound and the situation feels increasingly out of control, organizational leaders become more controlling and authoritarian, instituting ever more punitive measures in an attempt to forestall what they perceive as impending chaos. Under these circumstances, workplace bullying is likely to increase at all levels and organizations may become vulnerable to petty tyrants.

> *Compared with others, authoritarians have not spent much time examining evidence, thinking critically, reaching independent conclusions, and seeing whether their conclusions mesh with the other things they believe. Instead, they have largely accepted what they were told by the authorities in their lives (p. 93).*
>
> Bob Altemeyer,
> *The Authoritarian Specter [192]*

An Adaptive Evolutionary Response to Crisis

At present, most organizations and institutions in our society are more hierarchical and bureaucractic than democratic. Investigators in the field have pointed out the strong tendency within organizations to gravitate toward hierarchical modes of structuring themselves [193]. In the early part of the twentieth century, Michels described "the iron law of oligarchy" saying that as organizations grow larger and become more complex, increased specialization occurs along with the need for more expert leadership and when this happens participation in organizational decision making declines. He was pessimistic about the possibility of success for any democratic experiment [194].

A strong tendency toward hierarchical control has been noticed, even in organizations that claim to be democratic. It has even been argued that management resists free speech more stubbornly than any other concession to employees [195] and this has been substantiated by a review of court decisions pertaining to freedom of speech in the workplace revealing a general assumption *"that conflict and dissent are always bad and no good can come from them; a concept that flies in the face of modern thought on organizational conflict and free speech"* (p.260) [196].

When a crisis occurs, centralization of control is significantly increased with leaders tightening reins, concentrating power at the top, and minimizing participatory decision making [184]. Even where there are strong beliefs in the "democratic way of life", there is always a tendency in institutions, and in the larger containing society, to regress to simple, hierarchical models of authority as a way of preserving a sense of security and stability. This is not just a phenomenon of leadership – in times of great uncertainty, everyone in the institution colludes to collectively bring into being authoritarian organizations as a time-honored method for providing at least the illusion of greater certainty and therefore a diminution of anxiety [114].

From an evolutionary standpoint, this makes a great deal of sense. Terror Management Theory has experimentally shown that reminding people of their own mortality enhances and strengthens their existing world view, religious beliefs, group identifications, and their tendency to cling to a charismatic leader [116]. When danger is real and present, effective leaders take charge and give commands that are obeyed by obedient followers, thus harnessing and directing the combined power of many individuals in service of group survival. Fear-provoking circumstances within an organization are contagious. Within a group, emotional contagion occurs almost instantly and predictable group responses are likely to emerge automatically [151]. Threatened groups tend to increase intra-group attachment bonds with each other, and are more likely to be drawn to leaders who appear confident, take control and are willing to tell other people what to do. Longstanding interpersonal conflicts seem to evaporate and everyone pulls together toward the common goal of group survival producing an exhilarating and even intoxicating state of unity, oneness and a willingness to sacrifice one's own well-being for the sake of the group. This is a survival strategy ensuring that in a state of crisis decisions can be made quickly and efficiently thus better ensuring survival of the group, even while individuals may be sacrificed.

Under crisis conditions, the strong exercise of authority by leaders coupled with obedience to authority by followers may be life-saving. In a group confronted by new, unique and dangerous conditions, if someone in a position of authority - or someone with the confidence to assume authority - gives orders that may help us to survive, we are likely to automatically and obediently respond. But, when a state of crisis is prolonged, repetitive, or chronic there is a price to be paid. The tendency to develop increasingly authoritarian structures over time is particularly troublesome for organizations.

Chronic crisis results in organizational climates that promote authoritarian behavior and this behavior serves to reinforce existing hierarchies and create new ones. Under stress, leaders are likely to feel less comfortable in delegating responsibility to others and in trusting their subordinates with tough assignments when there is a great deal at stake. Instead, they are likely to make more decisions for people and become central to more approvals; this in turn builds a more expensive hierarchy and bureaucracy [46]. Communication exchanges change and become more formalized and top-down. Command hierarchies becomes less flexible, power becomes more centralized, people below stop communicating openly and as a result, important information is lost from the system. "*It is the increased salience of formal structure that transforms open communication among equals into stylized communications between unequals. Communication dominated by hierarchy activates a different mindset regarding what is and is not communicated and different dynamics regarding who initiates on whom. In situations where there is a clear hierarchy, it is likely that attempts to create interaction among equals is more complex, less well learned, and dropped more quickly in favor of hierarchical communication when stress increases"*, p. 138 [185].

The centralization of authority means that those at the top of the hierarchy will be far more influential than those at the bottom, and yet better solutions to the existing problems may actually lie in the hands of those with less authority. "*There is a tendency to centralize control during a crisis period, to manage with tighter reins and more power concentrated at the top. The need for fast decisions may preclude participative processes. But this is risky. Centralization may transfer control to inappropriate people; if top managers had the ability to take corrective action, there might have been no crisis in the first place"*, p. 243 [184]. In

this way, *"the same process that produces the error in the first place, also shapes the context so that the error will fan out with unpredictable consequences",* p. 140 [185]. Lipman-Blumen has studied the dynamics of leadership and has recognized that *"Crises can create circumstances that prompt some leaders, even in democratic societies, to move beyond merely strong leadership to unwarranted authoritarianism. In tumultuous times, toxic leaders' predilection for authoritarianism fits neatly with their anxious followers' heightened insecurity..... Set adrift in threatening and unfamiliar seas, most of us willingly surrender our freedom to any authoritarian captain"*(p.99-100) [47].

In mental health and social service delivery, crisis situations typically are instances in which a client's life, health, safety, or well-being is seriously endangered. In these circumstances, both uncertainty and risk are high, and the penalties (consequences) for errors in decision making are severe--factors that greatly increase practitioner stress [197]. In situations of chronic crisis, leadership positions are likely to keep or attract people with strong authoritarian tendencies in their personality makeup, while more democratic leaders will find such situations unsatisfying and even toxic. As this occurs in the mental health system, there may be a progressive isolation of leaders, who tend to become more autocratic over time, a dumbing-down of staff, less participation of staff in decision making processes, and a loss of critical judgment throughout the organization. Everyone knows that something is happening that is all wrong, but no one feels able to halt the descent that is occurring. As time goes on and the situation feels increasingly out of control, organizational leaders are likely to respond by becoming even more controlling, instituting ever more punitive measures in an attempt to forestall what appears to be a slacking off of staff and an increase in disciplinary problems, all signaling impending chaos. Helplessness begins to permeate the system so that staff become helpless in the face of their clients, clients feel helpless to help themselves or each other, administrators helplessly perceive that their best efforts are ineffective. As we will see, in our ever more complex world, the tried-and-true evolutionary adaptation to crisis can easily backfire because of the untoward effects of centralization of authority and authoritarian states of mind.

A 25 year old male patient was admitted to a psychiatric service in a psychotic state. He made no attempt to hurt anyone, but he was impulsive in his actions, made quick, darting motions which started people, and at one point jumped over the nursing station to get cigarettes when the nurses had not responded rapidly enough to suit him. The police had brought him to the hospital and the staff assumed that he was a lawbreaker and a bad character. He had destroyed some property at home but had no history of physically hurting anyone. Nonetheless, he was immediately perceived as a "bad egg". When he jumped over the nursing station, it was perceived as a direct threat and the staff tried to restrain him. At this point, no one had yet taken the time to try to actually talk to the man. He obviously did not understand why people were trying to pin him, and he ran to his room and slammed the door. He had made no threats but the staff were concerned about what he might be doing and they heard him tearing things up. A male staff member demanded that he come out of his room. When but he did not respond the staff called security who then called in local police who prepared to physically go through the door. Twenty armed police men with SWAT gear (and a police dog), took a circular electric saw and put a hole in the door to get him out. He had indeed, damaged the room, but had not hurt himself or anyone else. He

was put him in restraints and medicated. Although the patient still had not assaulted or threatened anyone, and everyone recognized that he was psychotic, members of the staff wanted to file criminal charges against him. One policeman did in fact take it upon himself to file assault charges against the patient, despite the fact that there was no assault, just – if anything – disobedience to authority. The patient responded dramatically to structured support and medications and calmed down, but when he was discharged he had to go to court to face criminal charges.

The Inherent Problem of Authoritarianism

The nature of people who were recognized as highly authoritarian was studied in the late 1940's after Hitler's totalitarian regime had caused such enormous global suffering. In the work of Adorno, Sanford and others, nine interrelated personality dispositions indicated an authoritarian personality. These included: Conventionalism (a tendency to accept and obey social conventions and rules; Submission (an exaggerated emotional need to submit to authority); Aggression (aggression towards individuals or groups disliked by authorities, particularly those who threaten traditional values); Destruction and Cynicism (generalized hostility); Power and Toughness (identification with those in power); Superstition and Stereotypy (a tendency to shift responsibility to outside forces beyond one's control and a tendency to think in rigid categories); Anti-intraception (rejection of the subjective, imaginative and aesthetic); Projectivity (a tendency to transfer internal problems to the external world and to believe in the existence of evil); and Sex (exaggerated concerns with respect to sexual activity) [198, 199].

In his seminal experiments immediately after World War II, psychologist Stanley Milgram wanted to understand how so many otherwise reasonable people could have willingly participated in the Holocaust. What he found was startling and disturbing. In the experimental setting, sixty-five percent of his experimental subjects would obey an authority and administer shocks to another person even when the victim cried in pain, even when he claimed heart trouble, even when he pleaded to be freed. When assured by apparently legitimate authority that there was good cause for the experiment, they overrode their own sensory impressions, empathic responses and ethical concerns and automatically obeyed authority without questioning the grounds on which this authority is based or the goals of established authority. In his conclusion, Milgram warned, *"A substantial proportion of people do what they are told to do, irrespective of the content of the act and without limitations of conscience, so long as they perceive that the command comes from a legitimate authority"*[200].

Building on the work of Adorno, Milgram, Erich Fromm and others, Robert Altemeyer has been studying authoritarian behavior – particularly right-wing-authoritarian behavior - for the last twenty-five years and his work illuminates the central cognitive problems in authoritarian behavior that pose significant challenges when people high in these traits become employed in the mental health and social service systems [192].

Altemeyer has reduced the nine personality dispositions to three fundamental and interrelated characteristics: *Authoritarian submission* described as a high degree of submission to the authorities who are perceived to be established and legitimate in the society in which one lives; *Authoritarian aggression* which is a general aggressiveness,

directed against various persons, that is perceived to be sanctioned by established authorities; and *Conventionalism* determined by a high degree of adherence to the social conventions that are perceived to be endorsed by society and its established authorities.

People who are high in authoritarian submission generally accept the statements and actions of established authorities and believe that those authorities should be trusted and deserve both obedience and respect, by virtue of their positions. They place narrow limits on other people's rights to criticize authority figures and tend to assume that critics of those authority figures are always wrong. Criticism of established authority is viewed as divisive and even destructive and motivated by little except a desire to cause trouble. For such people, when authority figures break the law, they have an inherent right to do so, even if the rest of us cannot.

Those who are high in authoritarian aggression are predisposed to control other people through the use of punishment and they advocate for physical punishment in childhood and beyond. They deplore any form of leniency toward people who diverge from established authority and advocate capital punishment. Unconventional people and anyone considered to be socially deviant are believed to pose a threat to the social order and therefore aggression toward them is justified, particularly when condoned by authority figures.

Conventionalism indicates a strong acceptance of and commitment to the traditional social norms of one's society. Anything that is based on long-standing tradition and custom and that maintains the beliefs, teachings, and services in their traditional form is preferred. Such people reject the idea that people should derive their own moral beliefs to meet the needs of today because moral standards have already been established by authority figures of the past and should be obeyed without question. This requires endorsing traditional family structure within which women are subservient to men and "keep their place" and the only proper marriages are between men and women. Other ways of doing things are simply wrong and potentially dangerous.

But for all the social problems connected to extreme authoritarian behavior, it is the impact on mental functioning and the behavior that follows associated with authoritarianism that has the most bearing for the functioning of the mental health system. In investigating the cognitive behavior of authoritarianism, Altemeyer found that authoritarians do not spend much time examining evidence, thinking critically, reaching independent conclusions, or seeing whether their conclusions mesh with other things they believe. They largely accept what authority figures have told them is true and have difficulty identifying falsehoods on their own. They copy other people's opinions without critically evaluating them if those opinions come from someone with established authority and as a result they end up believing a number of contradictory things without even being able to see the contradiction. They do not mentally reverse situations and put themselves in "the other person's shoes". They examine ideas less than other people and tend to surround themselves with people who agree with them and do not contradict them. They show a "hefty double standard" when testing whether something is true or not: if evidence supports what they believe they accept it unquestioningly as truth; if evidence fails to support what they believe they tend to throw out the evidence. Since they tend not to be able to think for themselves, they are vulnerable to mistaken judgments and can be astonishingly gullible when an insincere communicator bears the trappings of authority [192].

The inability to think critically, synthetically, and diversely is an enormous handicap in trying to assist those with complex physical, psychological, social and moral difficulties

secondary to exposure to repetitive stress, trauma, and violence. If authoritarian leaders assume key administrative positions within mental health organizations the result is likely to be highly detrimental to true trauma-informed change because they will be unwilling to shift away from what are now "traditional" explanations of emotional problems embodied in the Diagnostic and Statistical Manual. They are likely to insist on a centralized and traditional hierarchy, discourage true staff participation, be unable to facilitate team treatment, punish dissent, and surround themselves with people who will agree with their view of the world. Authoritarian leadership is likely to encourage the same leadership style throughout the organization. As a result, the organizational norms for all staff are likely to endorse punitive behavior, empathic failure, and traditional methods for managing difficult situations. It is hard to imagine a situation more detrimental to long-lasting, positive change in the lives of trauma survivors. As for the staff, when authoritarian behavior comes to dominate a situation, the result can also be devastating. Unchecked authoritarians can become bullies at any organizational level but when they are given power, they can become "petty tyrants".

Bullying in the Workplace

Workplace bullying has been defined as "*repeated and persistent negative acts towards one or more individual(s) which involve a perceived power imbalance and create a hostile work environment* [201] or "*the repeated, malicious, health-endangering mistreatment of one employee (the Target) by one or more employees. The mistreatment is psychological violence, a mix of verbal and strategic assaults to prevent the Target from performing work well. It is illegitimate conduct in that it prevents work getting done. Thus, an employer's legitimate business interests are not met (p.3)* [202]. Einarson points out that it is "*the systematic persecution of a colleague, a subordinate or a superior, which if continued, may cause severe social, psychological and psychosomatic problems for the victim* [203].

Bullying behaviors may include social isolation or the silent treatment, rumors, attacking the victim's private life or attitudes, excessive criticism or monitoring of work, withholding information or depriving responsibility and verbal aggression. They may include changing work tasks or making them difficult to perform, personal attacks on the person's private life by ridicule, insults, gossip; verbally humiliating workers in public, and threats of violence [203]. The main difference between "normal" conflict and bullying is not necessarily what and how it is done, but rather the frequency and longevity of what is done.

Increased fear and authoritarian behavior combined with a breakdown in communication is likely to lead to an increase in workplace bullying and gives license to those employees who are already prone to engage in bullying behavior to continue and escalate their negative behavior towards others. Bullying has been show to be associated with higher turnover, increased absenteeism, and decreased commitment and productivity. It has been reported to result in lower levels of job satisfaction, psychosomatic symptoms, and physical illness as well [201]. Research has shown that workplace bullying is commonplace in many different organizations and professions including health care and mental health care settings. In one large survey, 8.6% of respondents experienced ongoing bullying and non-sexual harassment at work during the six months prior to the survey [203]. There are no similar figures available for U.S. health care settings but in a survey of 217,000 National Health Service staff in the United Kingdom, 10% of those surveyed had been bullied and harassed by colleagues in the 12 months to March 2005. This figure rose to

37% when abuse from patients or their relatives was included. Additionally, 1% had been physically assaulted by fellow employees, 42% of these workers across the UK would not report incidences of bullying in the workplace; 39% of UK managers say they have been bullied in the past three years; and 70% of managers believe misuse of power or position is the number one form of bullying [204]

Organizational factors are clearly important in the emergence, maintenance, prevention and response to bullying behavior. Thirty years ago Brodsky studied over a thousand cases of work harassment in the U.S. and concluded that for harassment to occur there must be elements in the organizational culture that permit or reward such behavior [205]. Bullying will only occur if the offender believes he has the overt or more usually covert support from superiors for his or her behavior. Organizational tolerance for, or lack of sanctions against bullying serves to give implicit permission for the bullying to continue. Aggressive or predatory behavior that starts on a one-to-one level can end up splitting an organization into opposing camps. Conditions that serve as enabling structures and processes that make it possible for bullying to occur include power imbalances between the victim and perpetrator, low perceived costs of bullying from the point of view of the perpetrator, and dissatisfaction and frustration in the workplace.

One of the obstacles in dealing with bullying in the workplace is that the organization frequently treats the victim, not the perpetrator as the problem, tending to accept the prejudices of the offenders and blaming the victim for their own misfortune [203]. One investigator has pointed out four key factors that are prominent in eliciting bullying behavior at work 1) deficiencies in work design; 2) deficiencies in leadership behavior; 3) a socially exposed position of the victim; 4) low moral standards in the organization [206].

Petty Tyranny

•

Under what is arguably the worst conditions, an organizational leader, predisposed to authoritarian behavior and acquiring power, may evolve into what has been described as a “petty tyrant” [207]. A petty tyrant is someone who arbitrarily and in a small-minded way, exercises absolute power oppressively or brutally. Petty tyrants believe certain things about their employees, a set of beliefs that have been termed Theory X - that the average person dislikes work, lacks ambition, avoids responsibility, prefers direction, and is resistant to change [208]. They do this in definable ways. They use their authority in ways that are unfair and that reinforce their own position or provide personal gain. They play favorites. They belittle subordinates and humiliate them in front of others. They lack consideration and tend to be aloof, cold, and unapproachable. They force their own point of view on others and demand that things be done their way. They discourage participation of others and discourage initiative. They are likely to be critical and punitive toward subordinates for no apparent reason.

Although few organizations openly condone such arbitrary and abusive use of authority, the organizational norms may facilitate the emergence of petty tyranny, particularly in “total institutions” such as prisons or mental hospitals. In one well-known study, investigators simulated a prison environment and randomly assigned subjects to the role of either guard or prisoner. During the 6-day simulation, the experimenters found that the guards began--and quickly escalated--harassing and degrading the prisoners "*even after most prisoners had ceased resisting and prisoner deterioration had become visibly obvious to them*" (p. 92), and appeared to experience this sense of power as "*exhilarating*" (p. 94)

[209]. The effect of power over others can become so intoxicating that (1) power becomes an end it itself, (2) the powerholder develops an exalted sense of self-worth, (3) power is used increasingly for personal rather than organizational purposes, and (4) the powerholder devalues the worth of others [210]. In a mental institution, Nurse Ratchett in the movie, *One Flew Over the Cuckoo's Nest,* most vividly illustrates the development of a petty tyrant.

Fitting Leadership Style to the Situation

There is a role for neither petty tyrants nor bullies in the mental health environment. However, there is no "one best" leadership style for decision making, leading, and motivating. It is the "situational approach" that offers leaders the most useful framework for leadership. Leadership styles can vary depending on basically two factors: the *quality of the decision,* meaning the extent to which the decision will affect important group processes, and *acceptance of the decision,* or the degree of commitment of employees needed for its implementation. This theory suggests that when the decision will affect few members of the group and little commitment from others is required, the leader should use an autocratic style. But when the decision is likely to affect many people and can only be implemented if employees buy in to the decision and carry out the implementation, then leaders should use a participative style[211]. Effective leaders know how to match styles to situations and get things done. Ineffective leaders do not. In effective leaders are likely to employ only one dominant style and then use that style in all situations. They are therefore ineffective in addressing the real complexities of the modern work environment.

G. Impaired Cognition and Silencing Of Dissent

Thesis: 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 simplification of decisions and lowered morale.

> *Conformity can lead individuals and societies in unfortunate and even catastrophic directions. The most serious danger is that by following others we fail to disclose what we actually know and believe. Our silence deprives society of important information… Those who dissent and who reject the pressures imposed by others, perform valuable social functions, frequently at their own expense (p.v).*
>
> Cass R. Sunstein
> *Why Societies Need Dissent [212]*

> *The more it knows how to nurture and use the rich diversity of individual views and capabilities within it, the more wise (and democratic) a society will be. It will resist small-minded leadership and even the dictatorship of the majority. It will cherish dissent as a wise individual cherishes doubt - as a door to deeper understanding*.
>
> Tom Atlee
> *Deep Democracy and Community Wisdom,[213]*

Effective Decision Making

What defines "good" decision making abilities? To begin, people *learn* to make effective decisions – the skills are not innate. Since making good decisions is a skill, it is possible to evaluate what goes into building those skills. The best decisions are likely to come out of a process rather than "just happening" which are unfortunately, the kinds of decisions we are most likely to make under stress. Effective decision makers define as specifically as possible the decision that needs to be made and decide whether they are really the ones to be making that decision. Faced with a decision, good decision makers search for alternatives; rely on multiple sources of information not just expert opinion; consider short and long-term consequences of each possible decision; carefully weigh the pros and cons of each alternative; are sensitive to and aware of the influence of group process on decision making; listen to and integrate information from intuition and "gut"feelings; draw upon both positive and negative past experience; and are aware of their own short-comings, vulnerabilities, and blind spots that may influence the decision making process.

This process of effective decision making is characterized by thoughtfulness and information informed by emotion and intuition. It is careful, methodical and well-reasoned. It

is also difficult and demanding and the greater the complexity of the situation or the decision that needs to be made, the greater the demand on the individual. If is for this reason that repetitive and routine decisions are expediently managed by authoritarian systems of control while complex decisions require a very different approach.

Decision making may be profoundly affected by emotion. Positive emotion increases creative problem-solving and facilitates the integration of information while negative emotion produces a narrowing of attention and a failure to search for new alternatives. People who are in pleasant moods tend to deliberate longer, use more information, and reexamine more information than others. People in aroused or unpleasant moods tend to take more risks, employ simpler decision strategies and form more polarized judgments [214].

But this analysis of decision making focuses on the individual decision maker. At the workplace, individual decisions certainly must be made very day, but even individual decisions must be made in the context of "the group" – whatever that group happens to be. What do we know then, about the process of decision making when many factors must be taken into account, when many people must participate in the decisions, and when decisions that are made may have significant and lasting consequences?

Participation and Decision Making

In the world of business, there has long been discussion about the advantages and disadvantages of encouraging, creating and supporting ways in which larger number of people in the workplace can participate in making decisions about workplace issues that affect them. Lack of participation in the decision-making process, lack of effective consultation and communication, office politics, and lack of a sense of belonging have all been identified as potential organizational stressors for workers, while increased opportunity to participate has been repeatedly associated with greater overall job satisfaction, higher levels of emotional commitment to the organization, and an increased sense of well-being [50].

To some extent, the need to participate in influenced by education – the more professionally developed the workforce, the greater their desire to participate in decisions that affect their job [36]. However, relatively few people have actually had the opportunity to practice the skills required to encourage, support and sustain active participation. Despite that fact that here in the United States we grow up in what is presumed to be a democracy, in reality most people learn that authority is not to be questioned – at home, at school, in the military, and at work.

In truth, regardless of the work that people are doing, it has to be organized, and the typical form of organization is that of the hierarchy. For the most part, hierarchies are assumed to be necessarily autocratic – the higher level tells the next lower level what to do and they do it. *"This assumption explains why most of the organizations and institutions, even government agencies, in a democratic society are managed autocratically. It is argued that they need hierarchy to organize work, and that hierarchy is necessarily autocratic. Those who are bothered by the irony of this try to soften hierarchical autocracy by decentralizing some of the decision making"* (p.115) [36]. Hierarchy is often also equated with bureaucracy, defined by the famous sociologist Max Weber as "a fixed division of labor among participants, a hierarchy of offices, a set of general rules which govern performance, a separation of personal from official property, and rights, selection of personnel on the

basis of technical qualifications and employment viewed as a career by participants" (p. 12) [215]

Whatever their educational background, human beings are adversely affected by helplessness and become more motivated, creative, committed, and engaged *if* they are included in decisions that affect them. Worker participation has been described as comprising *"organizational structures and processes designed to empower and enable employees to identify with organizational goals and to collaborate as control agents in activities that exceed minimum coordination of efforts normally expected at work"* (p.357) [216].

Generally speaking, participatory processes engage workers at all levels in a greater variety of activities and offer them more knowledge about the organization than they would otherwise have had. Participation changes organizational communication, and often alters beliefs and values, decision making, and problem-solving methods. Participation must enter the real life of the organization, where work gets done and evaluated, what is paid attention to, how problems are appraised, what is compensated, and who gets promoted [217]. Where participation is really happening we should see greater amounts of communication – *"more people talking to more people about more things more of the time"* (p.358) [216]. We should see frequent and complex interactions between and among people as the desire for coordination increases. We should see greater information richness and greater commitment to the execution of decisions and analysis of the results of those decisions. The results of expanding participation and making it a vital part of the fulfillment of organizational mission can reap significant rewards:*"I often work with a design team composed of a cross section of representatives from all levels and functions of the organizational unit..... The people who serve on the design team will be changed as a result of their participation in the process. They are transformed by the experience. They learn to think about the organization in new ways, to speak out when they have an opinion, to deal with conflict within the team, to survive battles with management, to communicate with their peers, to be creative, to read, to make presentations, to write, to participate. In a word, they become citizens. Active, powerful, well-informed, conscientious citizens bent on improving the system in which they live and work"* (p. 44) [218]

Unfortunately, "empowerment" can become simply a catch-word like anything else. "We already tried empowerment here but it didn't work", one executive confessed to a consultant. "Not the E word again!" another client moaned, "We're sick of it." (p.240-241) [217]. But resistance to participation is more likely to be related to a lack of preparation than a fixed desire not to participate. Since people generally have relatively few experiences with actively participating in making organizational decisions, they are likely to lack the basic skills and the self-confidence to voice their opinions, offer dissenting opinions or engage in conflict. If they have been exposed to fear-based organizations, they are likely to worry that the invitation to participate is simply a guise of some sort, and that managers cannot be trusted. They are then likely to sit silently or refuse to come to meetings for fear that they will say or do the wrong things that will get them into trouble. As one investigator observes, *"We do a terrible job of preparing people to participate in change and of preparing our supervisors to help people participate. .... We continue to limit workforce participation to relatively trivial issues because we view them as unable to take part in more meaningfully discussions. We view participation as a gimmick to increase their satisfaction and motivation, rather than as a potent force to enhance organizational survival".* (p. 43) [218].

Besides a failure to prepare people for the challenging work of true participation, participatory schemes can become corrupted in a number of ways. A dominant group can take over control and dominate the discussion. This results in the appearance of participation without the substance. Or participation may be very narrowly defined so that it has no real impact on the way an organization actually functions but simply comforts managers that they are creating a more "democratic" work environment.

But sham participation is likely to give way to true participation for those organizations who hope to be successful in a globally challenging environment. As one observer points out, *"Sick of it or not, empowerment of workers will change the form of every organization in the twenty-first century. Empowerment is not a fad that failed. It is a core idea of the future that forces antiquated organizational forms to adjust to both societal change and the expansion of workers' attitudes. Better-educated workers will reject nineteenth-century authoritarianism on the job as they have rejected it in so many other aspects of their lives"* (p.240-241) [217]. Recently, successful organizations have been urged to change the way they do things in order to cope with a globally challenging economic environment. According to experts, they need to become: more knowledge intensive, radically decentralized, participative, adaptive, flexible, efficient, and responsive to rapid change [216]

But are these same ideas relevant to the mental health care and social service environments? It is relatively easy to make the simple argument that when lives – not just the bottom line – are at stake, these principles become even more important. Given the challenging physical, emotional, social, and ethical problems that confront most helpers and caregivers today, creating more participatory systems is critical. The difficulties our clients have are simply too complex to be addressed by the stagnant, bureaucratic, and autocratic environments that are so typical of the non-profit world and in the private, for-profit sector of the health care environment, the search for profitability in a financially constrained environment, makes it necessary to apply both internal and external pressures that advocate for good patient care.

But ensuring better participatory systems and therefore relying on less individual decision making judgment means that we must become aware of the dynamics of group decision making and the forces that can affect those kinds of decisions. This means understanding the mechanisms of group polarization, social loafing, conformity, and groupthink.

Group Decision Making

When participatory schemes result in groups making decisions rather than individuals, things do not necessarily get easier, but the forces at work may be different. One theme that runs through much of the research on group decision making is that basic processes in groups can lead to both good and poor performance. Apparently the same processes that can produce poor individual performance can also produce poor group performance [219].

Social Influence

The classic studies of social influence were done by Solomon Asch half a century ago. Asch showed that when a person's private judgment was unlike the judgments expressed by

other people, the person would abandon his own judgment, even when his judgment was correct. However, this influence could be attenuated by even one other person who sided with the person. With just that much support, the person could stick to his own position.

Social Loafing

Social loafing occurs when someone in a group takes the opportunity to "free-ride" on other group members' efforts and is unwilling to do the work that other people in the group are doing. This effect appears to be stronger in people who are strongly individualistic or who see themselves as better than other people. The effect is minimized by strong group cohesion or anticipated punishment for poor performance, while the effect is strengthened when the cost of task performance to the social loafer is increased and when conditions in some way reduce the individual's sense of responsibility to the group [219].

Group Polarization

Group polarization has been found in hundreds of studies involving over a dozen countries, including the United States, France, Germany, and Afghanistan. In countless cases, like-minded people, after discussions with their peers, tend to end up thinking a more extreme version of what they thought before they started to talk (p.112) [212]. When the majority of a group initially leans toward one position – even when that position is extreme - their consensus tends to influence others in the group that hold a more moderate position and then the whole group moves toward the extreme position [220]. People respond to the arguments made by other people and when a number of people are predisposed in one direction, the entire group will become skewed toward that predisposition. Those who hold a minority position often silence themselves or otherwise have disproportionately little weight in group deliberations. The result can be *hidden profiles* – important information that is not shared within the group. Group members often have information but do not discuss it. The result is to produce inferior decisions [212].

Additionally, people with extreme views tend to have more confidence that they are right and as people gain confidence they become more extreme in their beliefs. By contrast, those who lack confidence and are unsure what they should think tend to moderate their views. The result is that increased confidence can increase extremism as well. This is particularly likely to happen if the person exuding confidence about his point of view also has high status in the group. Other people are likely to keep quiet about their reservations, simply because of their desire not to incur the disfavor of the high status speaker. Indeed, they might silence themselves simply because they do not want to cause internal tension. Seeing their views corroborated and uncontradicted, the first speakers then becomes even more confident still, and hence more extreme. Groups that are highly bonded through affectional ties may be particularly susceptible to polarization because the tendencies are so strong to agree with each other. All these effects, however, are invisible to the participants, so as other people continue to reinforce the extreme position, confidence grows based on further agreement, not necessarily because evidence has actually been presented that supports the conclusions that are being reached.

Over time, group polarization can have very detrimental effects on an organization because those with more moderate opinions stop contributing or leave the group altogether and as a result, extreme positions may come to dominate the organizational climate.

It is interesting to consider the influence of biological psychiatry in this light. Faced with the profound uncertainties of human existence and the complex social realities that

have such an impact on our patient's lives, how comforting it is to be utterly confident about the function of neurotransmitters and the drugs designed to affect them. How easy it is to become contemptuous of those who minimize or even question the utility of such treatments. Did the virtual takeover of psychiatry by biological psychiatrists and the accompanying displacement of most psychodynamically-oriented psychiatrists have everything to do with "truth" and "best practices"? Or could it be a recent example of group polarization in mental health practice?

Decision Making Under Stress

Under stress, individual performance changes and all of these group processes will be exacerbated. Stress tends to increase performance quantity while decreasing quality. Attention becomes narrowed to include only the most vital task features. Information processing becomes simplified [219]. Under stressful conditions, decision makers are likely to experience what has been termed *decisional conflict* referring to the simultaneous tendencies within a person to accept and to reject a given course of action. Prominent signs of this are hesitation, vacillation, feelings of uncertainty, and signs of psychological distress [188]. All of these are threats to self-esteem and threaten the aura associated with leaders and the centralization of authority that typically occur in a group under stress. As a result, decision makers are likely to display premature closure by terminating a decisional dilemma without generating all the possible alternatives and consequences of the decision. To add to the problem, under stress the cognitive function of decision makers is not likely to be at its best but instead is typified by a narrowing of focus, attention only to threat, and increasing cognitive rigidity. These deficiencies result in a premature narrowing of alternatives, overlooking long-term consequences, inefficient searching for information, erroneous assessment of expected outcomes, and oversimplified decision rules that fail to take account of the full range of values implied by the choice being made [154]. In this way the gap between effective decision making and impaired decision making is likely to widen.

Investigators reviewed many different situations of decisional conflict, and noticed five basic patterns of coping with stress generated by people who have vital choice to make: 1) *unconflicted inertia* – when the decision maker complacently decides to continue whatever he or she has been doing, ignoring information about associated risks; 2) *unconflicted change* – when the decision maker uncritically adopts whichever new course of action is most strongly recommended, without making contingency plans and without psychologically preparing for setbacks; 3) *defensive avoidance* – when the decision maker evades the conflict by procrastinating, by shifting responsibility to someone else, or by constructing wishful rationalizations that bolster the least objectionable alternative, minimizing the expected unfavorable consequences and remaining selectively inattentive to corrective information; 4) *hypervigilance* – when the decision maker, in a panic state, searches frantically for a way out of the dilemma, rapidly shifts back and for the between alternatives, and impulsively seizes upon a hastily contrived solution that seems to promise immediate relief, overlooking the full range of consequences of the choice because of emotional excitement, repetitive thinking, and cognitive constriction (manifested by reduction in immediate memory span and by simplistic ideas); 5) *Vigilance* – when the decision maker searches painstakingly for relevant information, assimilates information in an unbiased manner, and appraises alternatives carefully before making a choice [154].

Looked at from the point of view of critical decisions, it is clear that *vigilance* is the approach least likely to lead to problematic decisions. Apparently, the best defense against stress is recognizing that stress is likely to affect performance. In a study of flight crew performance, the one item that discriminated most clearly between outstanding performance and average performance among airplane pilots was whether or not they admitted that their decision making ability was negatively influenced by stress. Outstanding pilots – contrasted with below average pilots – realized that their abilities could change under stress and because they realized this, they appeared to be more receptive to inputs from others [185].

What happens to decision makers who later regret their decision? They are likely to suffer from strong and distressing feelings of post-decisional regret which may further interfere with the ability to curtail losses or to make new decisions that will enable recovery from the setback. Post-decisional regret entails intense emotional distress – anxiety, rage, guilt – which then creates a higher level of stress and can give rise to psychosomatic symptoms as well [154]. All five decisional patterns are available to every individual, although every individual may have a marked preference for one or another coping pattern. The coping pattern will largely be determined by three conditions: awareness of serious risks associated with whatever alternative is chosen; hope of finding a better alternative; belief that there is adequate time in which to seek out information and to deliberate before a decision is required.

If we look at how groups respond to stress, groups adapt to stress at first and the increase in stress may actually increase performance. But then as stress increases, group performance begins to degrade as has individual performance [219]. Stressful group work conditions tend to increase the "need for closure" – the desire for definite, nonambiguous solutions – within the group. Groups under stress exhibit a strong desire for uniformity of opinion or preference and are likely therefore to exert influence on anyone who diverges from this uniformity of opinion. Pressures to conform to the will of the most powerful and persuasive members of the group intensify. As a result, stress tends to result in a "closing of the group mind" described as an aversion to unpopular options, an acceptance of authoritarian leadership and existing groups norms [219].

As a result of these pronounced tendencies under stress, one organizational consultant has emphasized that *"given the tendency for communication among equals to turn hierarchical under stress, it would appear necessary that those at the top of the hierarchy explicitly legitimate and model equal participation if they are to override the salience of hierarchy"* (p. 142) [185].

In organizations, as systemic stress increases and authority becomes more centralized, organizational decision making processes are likely to change as well. We like to believe that important decisions are made rationally and unemotionally – and under normal conditions this may indeed by the case. But under stressful conditions, emotions are likely to play a much more important role in a decision making process that may already be compromised by inadequate access to all needed information. Stressful conditions do not just originate from actual life threat – particularly within organizations. Instead, stress is generated by feared losses, worrying about unknown consequences that may negatively impact on the work environment, concern about self-esteem, and conflicting values.

The Importance of Dissent

Given the pressures within a group that may push for conformity it may take a great deal of courage to dissent, but given these same pressures, it is vital that individuals use their own perceptions when they see something they believe to be problematic within an organization. Dissent can be defined as expressing disagreement or giving voice to contradictory opinions about organizational practices and policies [221]. Dissent can be triggered by a number of circumstances, but research has shown that the most common dissenting accounts were related to perceived unjust treatment, organizational change and the implementation of those changes, decision making, inefficient work practices and processes, roles and responsibilities, use and availability of resources, unethical practices, performance evaluations, and dangerous circumstances involving self, co-workers or clients [222]

Investigators looking at the process of dissent in the workplace have pointed out a number of existing variables that determine what is meant by dissent and what conditions promote or discourage someone from expressing their dissenting voice. Employees express dissent in response to individual, relational, group and organization influences and decide to voice their opinions after considering how they will be perceived by other people and whether or not there is likely to be retaliation for expressing contrary opinions [221].

There are a variety of ways in which people voice their dissent within the workplace. *Articulated dissent* occurs when employees believe they will be perceived as constructive and that there will not be any retaliation for voicing their opinions. It involves expressing dissent within organizations to audiences that can effectively influence organizational policy or positions. Articulated dissent involves expressing dissent directly and openly to management.

Antagonistic dissent occurs when employees believe they will be perceived as adversarial but also feel they have some safeguard against retaliation. For reasons like seniority, expertise, family relationships, or personal friendships, antagonistic dissenters believe they have a degree of immunity against retaliation. They tend to dissent primarily about issues that have some personal advantage for them and they express this dissent to someone they think has the means to influence their concerns in their favor.

Displaced dissent entails disagreeing without directly or confronting or challenging anyone is a position of authority. Instead, dissenters voice their opinions to either external audiences such as family, neighbors, friends, or strangers or to internal audiences, like co-workers who have no power to really do anything. This variety of dissent tends to occur when employees believe that their opinions will be viewed as adversarial and are likely to lead to retaliation [221].

Creating environments that support direct and open dissent are important for a number of reasons. Worker satisfaction is increased when employees feel their can freely voice their opinions and be heard. Participation appears to increase satisfaction and commitment. Workers sense whether dissent is acceptable in the organizational culture and then determine their reactions based on their perceptions [221, 223]. But most importantly perhaps, dissent serves as corrective feedback within an organization that can avert disaster. But to be useful it must be direct, and therefore the conditions that promote dissent within an organizational culture must be conducive to free speech without retaliation.

Silencing of Dissent

As useful as dissent is, it has rarely been welcomed in the workplace. There is empirical data that employees often feel compelled to remain silent in the face of concerns or problems – a phenomenon that has been termed *organizational silence* [224]. In one study that interviewed employees from 22 organizations throughout the U.S., 70% indicated that they felt afraid to speak up about issues or problems that they encountered at work. The "undiscussables" covered a wide range of areas including decision-making, procedures, managerial incompetence, pay inequity, organizational inefficiencies, and poor organizational performance [46].

The silencing of dissent is arguably even less welcome in environments characterized by chronic stress. One investigator who characterized organizational expression as "*an enduring problem of fundamental tension between the individual and the collective*" (p. 127), noted that such tension tends to be resolved in favor of organizational interests [225].

For managers, particularly under stressful conditions, dissent may be seen as a threat to unified action. As a result escalating control measures are used to repress any dissent that is felt to be dangerous to the unity of what has become focused organizational purpose, seemingly connected to survival threats. This encourages a narrowing of input from the world outside the organization. It also encourages the development of split-off and rivalrous dissenting subgroups within the organization who may passive-aggressively, or openly subvert organizational goals. As group cohesion begins to wane, leaders may experience the relaxing of control measure as a threat to organizational purpose and safety. They may therefore attempt to mobilize increasing projection onto a designated external enemy who serves a useful purpose in activating increased group cohesion while actively suppressing dissent internally. But the suppression of the dissenting minority voice has negative consequences. As dissent is silenced, vital information flow is impeded. As a result the quality of problem analysis and decision making deteriorates further. If this cycle is not stopped and the organization allowed opportunity to recuperate, the result may be an organization that becomes as rigid, repetitious and ultimately destructive and even suicidal as do so many chronically stressed individuals [152].

H. Impoverished Relationships

Thesis: Unresolved interpersonal, intradepartmental and interdepartmental conflicts increase and are not resolved. 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.

> *The presences of tension and conflict seem to be essential characteristics of the learning organization. The tension and conflict will be evidenced by questioning, inquiry, disequilibrium, and a challenging of the status quo* (p. 30).
>
> Luthans, Rubach, and Marsnik
> *Going Beyond Total Quality* [39].

Ah, conflict – can't live with it, can't live without it. As sociologist Randall Collins has pointed out, human beings are both sociable and conflict-prone [226]. Conflict provides us with the drama of life. A movie, television drama, or novel without conflict is a bore and life without conflict – even organizational life - is dull, flat, and stagnant.

But conflict in the workplace can be, as one author put it, "good, bad or ugly" and in part, good or bad or ugly will be determined by the impact of stress [227]. Under conditions of acute stress, conflicts will be submerged as individuals, groups, and the organization as a whole struggle to cope with the emergency, rallying strong group pressures to produce unified group action. But under conditions of chronic and repetitive stress, old conflicts are likely to emerge again – with a vengeance – and new conflicts are likely to develop as time constraints make it difficult for the normal mechanisms of conflict management to be utilized. In this section we will look at the nature of conflict, the different kinds of conflict, the relationship between conflict and emotional intelligence, the impact of conflict, and what happens to conflict under the impact of chronic stress.

The mental health and social service literature is notable for its apparent lack of interest in the issue of conflict management in our workplace settings, though perhaps no other settings could be more prone to conflict, nor could successful conflict management be more important, since conflict is at the heart of emotional and relational difficulties. And yet, as one social worker in a children's residential treatment program pointed out, *"how can we possibly expect the children to resolve their conflicts when we cannot resolve the conflicts among us – and they see that every day"*. The ways in which staff conflict affect service delivery are rarely mentioned, nor do most programs appear to have formal conflict management strategies that work consistently and effectively among and between various components of the organizations. So it is necessary, once again, to turn to the business literature to find a framework for understanding the issue of workplace conflict. In this section we will look at the nature of conflict, the different kinds of conflict, the relationship between conflict and emotional intelligence, the impact of conflict, and what happens to conflicting parties under the impact of chronic stress.

The Nature of Conflict

Conflict or disagreement is characterized by discord of action, feeling, or effect. A simple way of understanding conflict is that it arises when two or more individuals view a situation from different frames of reference and demand mutually exclusive outcomes [228]. Another simple definition is that conflict is a process in which one party perceives that its interests are being opposed or negatively affected by another party [229]. For many people the word conflict immediately generates a 'mental collision' a perception that a quarrel, a fight, or a battle, a competition or struggle is occurring. Under these circumstances, people's reaction to this conflict usually reflects their feelings of stress and creates both cognitive and physiological effects [230].

Because conflict is always with us, conflict has been a topic of enormous interest in the world of business and finance. Conflict, of course, is the bedrock of all forms of therapy, and yet relatively little has been written about conflict and conflict management in the mental health system itself. This is despite the fact that virtually every mental health and social service setting is rife with conflict because we are human beings and human beings engage in conflict routinely, and because there are fundamental aspects of these settings that breed conflict: differences in personality traits, race, age, gender, ethnicity – the various forms of diversity that affect every setting - but also differences in professional background, ideological framework, values, goals, and basic underlying beliefs about the clients and the role staff members are to play in the clients' lives. These sources of conflict – largely unexamined – have always been with us but have been exacerbated by the influence of the enormous changes that have impacted all of our caregiving systems.

Conflict is an interactive process manifested in incompatibility, disagreement, or dissonance within or between social entities, i.e. between and among individuals, groups, and organizations. Conflict is most likely to occur when any of the following conditions are in play: 1) a party is required to engage in an activity that is incongruent with his/her or their needs or interests; 2) a party holds behavioral preferences, the satisfaction of which is incompatible with another person's or group's preferences; 3) a party wants some mutually desirable resource that is in short supply so that there is competition for that resource; 4) a party possesses attitudes, values, skills, goals, beliefs that strongly influence that party's behavior but are perceived to be exclusive of the attitudes, values, skills, goals, beliefs of someone else; 5) two parties have partially exclusive behavioral preferences regarding their joint action' 6) two parties are interdependent in the performance of functions or activities [211].

Other workers in the field of conflict management have identified the potentials for conflicts that exist in five different levels when teams are working together: 1) individual group members; 2) content of the issue; 3) interaction or psychosocial level; 4) method level; 5) external relations level [231].

At the level of the individual group members, people experience a variety of intrapsychological tensions and conflicts and are likely to express them within interpersonal work contexts. These tensions, colored by an individual's past experiences, beliefs, and values, may alter the person's perceptions, feelings, and behavior. The Adverse Childhood Experiences Study and a growing body of research indicate that regardless of the setting, a majority of workers within that setting are likely to have experienced childhood adversity themselves [see earlier discussion of Adverse Childhood Experiences Study]. Unlike other less emotionally stimulating workplaces, mental health and social service settings are likely

to trigger whatever unresolved memories or emotions are leftover from the workers' past lives and may lead to a variety of interpersonal conflicts with clients, their families, other staff members, and management. These effects are likely to be particularly potent whenever someone's safety is jeopardized. The more unsafe the treatment or service delivery environment is, the more likely that these intrapsychic and individual conflicts will play themselves out in the environment - with detrimental results.

Conflict over the content of task-related issues can be very useful, but emotion inevitably accompanies conflict and the "heat" of a conflict over issues can spill over into interpersonal conflict rather easily. Without good conflict management skills in the group, task-related conflict can lead to misunderstanding, miscommunication, and increased team dysfunction.

In many teams that have been working together for some time, roles are clearly delineated: one person is the arguer, one person is the creative one, and another individual is passive, while still another tries to settle disputes. Psychosocial conflict arises when a group member feels pressure from the group to assume a role which they do not want or for which they do not feel prepared or when the group constrains someone from changing their assigned role when they wish to do so. In many mental health settings, role is determined by professional training and the rather rigid hierarchy so typical of the medical model. Psychosocial conflicts may arise when changes are suggested that encourage greater participation in decision making of staff members who are lower in the command hierarchy, and especially when structures are created that encourage more participation of clients.

Methods chosen for decision making, problem solving, and simply getting work done may also be the cause of conflict. The more complexly interdependent a system is, the more likely it is that a change in one area will produce reverberating changes throughout the system – and change creates conflict. Leaders – pressured by time and demands for decisions from above – may use methods of problem solving that are not participatory, even though their decision may be the right decision to make and the one that would have come from a participatory process anyhow. But the method chosen – autocratic decision making – may end up creating more conflict – and therefore more problems, than a more participatory process would have created.

And then, always, there is the issue of conflict between one component of a system, like a team, and other teams or components within the organization and conflicts between the organization-as-a-whole and other components of the wider system. It is not unusual in institutional settings to have conflicts between different shifts and different professional groups. And there are usually conflicts between institutions, state regulatory agencies, and funding sources.

But these very rational definitions of conflict leave out the most troubling aspect of all conflict situations – distressing emotions. To be in conflict is to be emotionally activated. In fact, human conflict does not exist in the absence of emotions and dealing successfully with conflict requires the development of both individual and organizational emotional intelligence [232].

Conflict , Emotional Intelligence and Collective Disturbance

Conflict evokes emotion and conflict in the workplace has largely been seen as bad or dysfunctional, an interference with the smooth running of any operation, similar to the ways in which emotions at work have tended to be downplayed, considered irrational and

counterproductive. To be in conflict is to be in an emotionally charged situation. There probably is no such thing as a purely intellectual conflict. Human emotions and thought are too hard-wired together. Effectively managing conflict in the workplace requires the development of emotional intelligence in individuals within the organization and in the organization-as-a-whole.

Emotional intelligence has been defined as "*the ability to perceive accurately, appraise, and express emotions; to access and/or generate feelings when they facilitate thought; the ability to understand emotions and emotional knowledge; and the ability to regulate emotions so as to promote emotional and intellectual growth"* [233]. Later this definition was amended as "*an ability to recognize the meanings of emotions and their relationships, and to reason and problem-solve on the basis of them. Emotional intelligence is involved in the capacity to perceive emotions, assimilate emotion-related feelings, understand the information of those emotions, and manage them"* (p. 267) [234]. In research findings, emotional intelligence has been associated with: success at work, career advancement, superior leadership behavior, effective team leadership and team performance, better physical and psychological well-being, higher in-role job performance. The dimensions of emotional intelligence most related to the workplace environment have been defined as four clusters of social competencies: self-awareness, self-management, social awareness and social skills [235]. All of these competencies can be seen as necessary for good conflict resolution skills.

When people or groups are in conflict, it is never a purely intellectual affair. Our cognitive processes are always being affected by our emotions and when we are in conflict situations, levels of emotional arousal rise significantly for a variety of reasons, some of which are individual and some of which – like emotional contagion- are a product of the group [151]. When conflicts are resolved in a group, the emotion of the group converges. Hope appears to be associated with positive emotions in a group, and likewise, hope is one of the key factors in psychotherapeutic healing [5]. Groups higher in positive emotions will be associated with higher performance on tasks, although this effect seems to work best when groups periodically experience negative emotions that then must be converted into more positive emotions. Fear in a group appears to be associated with negative emotions and in terms of task performance, there is empirical evidence that at least some fear is an essential ingredient, while high levels of fear leads to impaired decision-making.[236].

So, emotion and conflict go hand-in-hand and are complexly interrelated. Emotional arousal can cause conflict, can be the product of conflict, can result from the resolution of conflict [236]. In fact, emotional arousal is what keeps conflicts in play, and it is conflict that propels change. Research has shown that the higher the level of emotional intelligence, the better able employees can manage stress and the higher their organizational commitment [237].

The level of emotional intelligence in an organization is likely to determine how rapidly and effectively a group manages a common but largely unconscious phenomenon known as "collective disturbance". In sociological studies of the mental hospital and the democratic therapeutic community dating back to the 1950's, it became clear to researchers that individual patients who became the focus of attention on a psychiatric unit were those who were the subject of unexpressed staff conflict and that as soon as the staff conflict was surfaced, the individual patients' behavior improved. Similarly, collective disturbances involving several patients or an entire unit could be traced to conflicts originating near the top of the institutional hierarchy and the intensity of emotional

interpersonal conflict could be followed down through the staff and into the patient community. These originating conflicts usually seemed to revolve around disagreements between the priorities of institutional purposes or incompatibility between a given purpose and some institutional need. The signs of an impending collective crisis were abundant: errors in technique, doors left unlocked, messages forgotten, increased absenteeism frequently due to functional illness, staff preoccupation with problems of or with other staff, increased withdrawal by key staff members, increased sense of helplessness, breakdown in communication, missing or canceling meetings, inability to make decisions and finally, a sense that "something bad is going to happen". If the evolving crisis was not attended to and resolved, violence on the part of several, although not all, patients would be the result [238, 239]. If the managers and staff members were able to confront their own unspoken conflicts they could prevent or at least terminate a collective disturbance and in doing so, reduce the level of violence within the therapeutic community.

The sequence of balance of forces that developed in the hospital was related to the state of transition from a diagnostic to a psychodynamic treatment program. In the months preceding the outbreak of the collective disturbance, the senior staff members were engaged in trying to define their own roles, in determining therapeutic policy, and in finding ways to formalize the routines of the hospital so that these would serve to implement therapeutic goals. The (psychiatric) residents tended to see therapeutic problems in terms of their individual patients and were opposed to formalized routine. Such disagreement placed the nurses in confusion about their responsibilities and what were the rules to be followed. In line with the effort at transition, a new activities program headed by a professional group worker, was started on the wards.

This new program was felt as a threat by the occupational therapist and as another area of confusion in routine by the nurses. This unsettled state among the staff was reflected in the patients in a lack of certainty about what were correct and permitted actions. These questions of disagreement among role groups tend to remain covert and were not openly discussed at such expected points as the daily administrative conference. Such disagreements were, however, very often implicit in the discussion of plans for individual patients, who then became the vehicle through which differences of opinion were expressed.

Some two months before the collective disturbance, the observations clearly indicate that the various role groups had attempted to ease the difficulty of the situation by a process of <u>mutual withdrawal</u> in which each role group concentrated on the tasks which it felt were most sharply defined for its members and limited its interaction with other role groups to 'neutral' activities. The mutual withdrawal could be demonstrated at every organizational level: senior staff had given up insistence on certain administrative matters and had withdrawn from daily routine of decision making; psychiatric residents had restricted their focus to their own patients and reduced their interest in the general work of the hospital; nurses had decreased their communication at the administrative conferences and had increased the formalization of their routines; group activities worker had remained isolated from the other staff role groups; the patients had increased their intra-group relations and assumed a greater degree of independence in the planning of their daily activities.

What appeared to have happened was that an adjustive process of defense against the stresses of change and reorganization in the hospital policy was taking place <u>within</u> each group and looked at from the point of view of each separate group was reduced by

the defenses used; but, looked at from the point of view of the hospital system as a whole, stress was increased, because all groups were still part of the hospital. *In* such a state of mutual withdrawal, cognitive communication had been disrupted, while affective communication was still going on, although the members of various groups were not aware of precisely why they seemed to be sharing certain feelings.

The second type of balance of forces which occurred was initiated by the peak of acute difficulties and may be called the period of open collective disturbance. Just prior to the open collective disturbance two key members of the patient group were discharged, and this resulted in a fragmentation of the group structure on the ward. At the same time, two patients who were very upsetting to the patient group were admitted. The patients could not, at this point, reform adequate companionable groups, and, in various ways, appealed to the staff for greater control over their activities. Because of the state of mutual withdrawal, the patients' attempts at communication did not get through in a meaningful way to the staff, and the open collective disturbance ensued.

During the open collective disturbance, the patients were unable to maintain a state of relative equilibrium in the face of events on the ward, and the integration of the patient group was shattered. Following the outbreak of open disturbance on the ward, the staff were at first bewildered and then were divided in their efforts to help the patients… a situation was created in which the residents identified themselves with the patients, and the nurses with the senior physicians.

This forms the third type in the sequence of structural balances – and may be called a paired role group response which was taking place in a social field that was seriously split apart. During this time, cognitive communication was somewhat better between the role groups which were paired with each other, but the two sets of pairs were not in communication on a cognitive basis – indeed, there was active resistance to this type of communication, as when the psychiatric residents withheld information from the administrative conferences.

Affective communication, however, in the sense of emotional discharge, continued to spread throughout all role groups in the hospital system as it had done during the preceding periods of mutual withdrawal and open collective disturbance.

Two other matters of importance can be seen: (1) the expression of disagreement indirectly through the medium of the individual patient; and (2) the concentration on the 'defiance and rebellion' within the patient group, without bringing out the possibility of similar feelings present among the residents and nurses. Such an unstable balance of forces could not persist and, after several weeks, the discrepancies between the procedures followed by the psychiatric residents in granting privileges to patients and the general policy of the hospital on this matter were 'discovered'.

This led to several conferences in which the real disagreements between the various staff role groups were openly discussed, and the operation of the hospital returned to a more stable equilibrium. This process of restitution comprises the fourth type in the sequence of balance of forces. In subsequent conferences a great many further topics were discussed. These included: (1) the difficulties the resident staff had in presenting their cases to the senior staff; (2) the senior staff's supervision of the therapy done by the residents; (3) the whole area of the administrative management of patients and its effect upon therapeutic progress; (4) the financial situation of the patient and the meaning of this both therapeutically and administratively; and (5) the practical and emotional needs of ward personnel and residents which had to be satisfied in order for them to function effectively in the hospital.

During all four phases of the collective disturbance outlined in this chapter, affective communication between the various role groups was maintained, but the lines of cognitive communication were at first broken, then re-formed rather strangely in the

period of paired role group response, and only finally re-established during the period of restitution.

Thus the covert emotional structure of the hospital was operative throughout the three-months' cycle that included the acute period of the open collective disturbance, but the spread of emotions in the system was not supported by the effective operation of the overt social structure, which was fractured and twisted in many ways before it returned to normalcy. This research also demonstrated that behavior could be understood in terms of how patients and staff adjusted to the social 'system' of the hospital, not just in terms of individual illness or personality.

It became obvious that to bring about change in people, it might be necessary to understand and change the social organization of the ward or hospital. The process referred to here as a collective disturbance is not necessarily bad, and, in fact, much good can come of it. A hospital (or any other organization for work) which did not have some rhythm in its activities would not be a good hospital, it would be a dead one. The opposite is also obviously true – the ups and downs in everyday life can reach too great proportions for adequate functioning. In between a state of extreme oscillation and one of dead calm there is much to be learned from such processes and many ways in which they can be put to use for truly therapeutic ends. Another student of the therapeutic community, Rapaport (1956)…indicates that "these tension states need not be seen as antitherapeutic and therefore categorically to be avoided. On the contrary, they may have therapeutic value". He proposes the term 'sociotherapy" for the activities associated with the didactic, beneficial resolution of these tension states. Concerning this he says: "The resolution of a hidden staff conflict might alleviate a patient's disturbance and thus be beneficial but it would only become sociotherapeutic if it were done to the accompaniment of an analysis of the patterned personal significance of the development and alleviation of discordant relationships for those concerned.

The conclusion would appear to be that rather than attempting to do away with the processes that make up a collective disturbance (at bottom an impossible task because of the nature of both staff and patients as human beings), what is needed is the development of methods for studying the covert emotional structure in its relation to the overt social structure with the goal of first coming to some understanding and then perhaps bringing about changes in both.

This classic description of a collective disturbance is taken from William Caudill's 1958 book, The Psychiatric Hospital as a Small Society [239]

Last year was the first year in a while that a principal returned to [an inner city high school] for a second year. Over a three year period, the school went through a number of principals, some in the same year, and in the year I am describing, half the staff from last year were fired and half were new staff. Not only does this school have major staff and administration changes each year, but a number of the teachers who are there either have little control of the classroom or let the students leave and run the hall. With the lack of consistency and confusion, fights are frequent between peers, and the In School Suspension room is usually as crowded as a classroom. Ironically, the one place inner-city parents should be able to feel their children would be safe is school, but schools have turned into war zones. The sad reality is that while the world may see these teenagers as troubled, the problem is way deeper. The problem is not troubled children but rather a troubled system that has been affected by collective disturbance

due to an educational system built on inequity, where some kids are worthy, and others due to their class status and/or color of their skin are unworthy. When a school has a significant number of staff that are either burned-out, do not care, and/or do care but feel powerless to change a system, collective disturbance is nothing out of the ordinary. One thing I have learned working with urban adolescents is that they are able to read people well. They can see through phoniness. They know the teachers who expect them to succeed and the ones who do not. They can also tell the difference between genuine care compared to judgment and lack of real care.

- **Lisa, Second Year Social Work Student.**

Last year, I worked as a part-time case manager for a residential treatment home for children aged infancy to 8 years old who were in foster care. The tension and "war of words" that was prevalent between the different groups got to the point that staff members were fired and others left in protest. The children started rebelling in the home and at school because their basic needs were not being fully met. Staff members devoted much of their time and energy to gossiping and negative thoughts. Within a month of me joining the agency, I was able to pick up on the tension and stress between the different groups. The houseparents, who were the primary caretakers of the children, felt unsupported and unappreciated by the support staff and administration. Despite the minimal time spent around the children, the administration still made the majority of the decisions. The administration felt the houseparents did not do enough. Support staff was viewed by the houseparents as being on the side of the administration, though the members of the support staff distrusted both the houseparents and the administration. It got to the point that the houseparents would not reveal all the information and observations they had made throughout the night and meetings were seldom attended by all staff members. I remember distinctly several meetings in which upwards of 3-4 staff members would fail to show! All were in violation of basic safety rights. How much this agency would have benefited from self-reflection and group work.

- **Kevin, Second Year Social Work Student**

Different Kinds of Conflict

If organizations are viewed as machines, then conflict is viewed as an evil that must be eliminated because it creates disorder in an otherwise supposedly orderly world. When this kind of philosophical position is in play, conflict is viewed as a problem of poor design or inadequate structure that must be corrected through more elaborate job descriptions, or greater exercise of authority, or through the active suppression of or passive avoidance of conflict. But organizations that must respond creatively to complex problems and that must change rapidly to accommodate changing circumstances must have the ability to successfully manage and even promote conflict or they will stagnate. Conflict creates opportunities for organizational and individual learning and must be harnessed in service of the collective goals. But not all conflict is the same [227].

Research evidence indicates that emotional conflict – also known as relationship conflict, social-emotional conflicts or affect conflict - impedes group performance by limiting the ability of individuals and groups to process information and to think well [240-243]. It also diminishes group loyalty, team commitment, intent to stay at the organization, and job satisfaction because of escalation in levels of stress and anxiety [211, 240-242, 244]. High levels of personal conflict are associated with bad performance – if people are fighting because of personal animus they are less likely to accomplish their tasks. There is another lesson from the empirical literature: that group members should neither like each other too much, if too much liking squelches dissent, and they should not like each other too little, if too little liking creates personal tension [212].As one researcher states it, *"relationship conflicts interfere with task-related effort because members focus on reducing threats, increasing power, and attempting to build cohesion rather than working on task.... The conflict causes members to be negative, irritable, suspicious, and resentful* (pp.531-532) [244]. The bottom line is that if people in a group do not like each other and spend their time in personal conflict, the group as a whole will perform badly.

High levels of personal conflict are associated with bad performance; if people are fighting because of personal animus, they are less likely to accomplish their tasks. Conflict over process is generally harmful as well – a finding that makes sense in light of the risk that if people argue over process, they will spend less time doing what they are supposed to do [245].

Substantive conflict also known as task-related conflicted happens when two or more organizational members disagree on their task, or disagree on the recognition and solution to a particular problem. Research indicates that a moderate level of substantive conflict is good for an organization or a team because it stimulates discussion and debate and urges a group on to a higher level of performance [211, 246]. Groups that report task-oriented conflict generally have higher performance because there is more likely to be the sharing of various viewpoints and alternative solutions [241, 242, 246-248]. This is particularly true for groups performing tasks that were not routine and that required complex problem-solutions. Groups that report substantive conflict are also able to make better decisions than those that do not because substantive conflict encourages greater understanding of the issues and that leads to better decisions [240, 249-252].

When the underlying tasks are complex and call for a degree of creativity, dissenting views and a measure of conflict about how to perform those tasks lead to better outcomes [241, 242]. For effective performance of given tasks, diversity of information appears to be the crucial variable [242]. Jehn found that if group members impose pressure toward agreement, they will *"squelch the creativity needed to complete nonroutine tasks effectively, because members will focus on building consensus rather than entertaining new ideas"* (p. 260) [241]. Diversity can operate along many different dimensions. – geography, race, age, gender, ethnicity, values, information [212]

Groups that report substantive task-related conflict are also able to make better decisions than those that do not because substantive conflict encourages greater understanding of the issues and that leads to better decisions [240, 249-252]. Groups perform well if they allow open discussion and hence foster conflict about the substance of the task. New insights often result from the exchange of perspectives within groups [253].

Sharing values in a group matters as well because although diversity about opinions enhances outcome, diversity about basic values can produce unproductive conflicts. For a team to have high morale (higher satisfaction, intent to remain, and commitment), or to

perceive itself as effective, it should be composed of participants with shared values [242]. Jehn summarizes her findings this way "*For a team to be effective, members should have high information diversity and low value diversity. For a team to be efficient members should have low value diversity. For a team to have high morale (higher satisfaction, intent to remain, and commitment) or to perceive itself as effective, it should be composed of participants with low value diversity".* (p. 758) [245].

It appears that the story of Goldilocks and the Three Bears most suits the issue of substantive conflict because there is an amount of organizational conflict that is "just right" – not too much and not too little, as long as it is of the right kind of conflict. The inherent difficulty is that the two dimensions of conflict – emotional/interpersonal and substantive or task-related – are positively correlated. When substantive conflicts increase, emotional conflict is likely to increase as well [254].

Organizational conflict – or defensive routines as Argyris calls it – consists of procedures, policies, practices, and actions that prevent employees from having to experience embarrassment or threat. This *"makes it highly likely that individuals, groups, intergroups, and organizations will not detect and correct errors that are embarrassing and threatening because the fundamental rules are 1) bypass the errors and act as if they were not being done,2) make the bypass undiscussable, 3) make its undiscussability undiscussable* (p.43) [211, 255].

Conflict Management Strategies

There is a difference between *conflict resolution* and *conflict management.* Similar to the idea of emotional management, conflict management does not imply that conflicts should be avoided, reduced or even terminated. Instead, it suggests that conflicts must be properly managed so that the dysfunctional impact of conflict is minimized while the constructive functions of conflict are maximized to produce greater organizational effectiveness [211]. But different people have different strategies for handling conflict. Some people face conflict directly and focus on problem-solving, collaborating, and integrating various points of view. Others tend to be "peace makers" who try to minimize conflict, smooth the waters, and will yield to others. A third group try to maximize their own outcomes at the expense of others through domination, control, competing and forcing. A fourth group try to avoid conflict altogether by withdrawing, refusing to engage, or not taking action [256]. Different people use different strategies at different times and part of emotional intelligence is being able to be flexible and apply the right strategy at the most appropriate moment.

There are signs that indicate whether or not conflict management strategies are adequate to the needs of the organization. Some indicators that conflict management strategies are insufficient include: organizational conflicts that run on for years without really changing; a general attitude that conflict-laden problems will never be resolved or even addressed; a predominance of private complaining with little attempt to fix the problem; staff who show little interest in working on common goals but spend significant time and energy protecting themselves or their own interest – or just whining and complaining. These are frequently signs of some pathological organizational strategies that have led to this outcome including non-action, administrative "orbiting", secrecy and a law & order approach.

In non-action, conflict is simply ignored or denied with the end result of a significant escalation of conflict. In administrative orbiting, managers put people off by telling them that "we are dealing with the problem" but in reality the problem never gets addressed. Management may in fact produce many stalls including "we are collecting more data", "we are documenting performance", "we cancelled that meeting", "we have called in a consultant". Another way of avoiding conflict is through secrecy and both managers and employees can utilize this approach. Although secrecy may work in the short term to keep people from knowing what is happening, in group settings secrets have a way of inevitably leaking out through the grapevine and when that happens, conflict is escalated even further. Yet another way of not addressing conflict directly is through invoking a "law and order" strategy, by leaning on people to repress the outward manifestation of conflict which does little except to drive the conflict underground where it can grow in destructive power [227].

Conflict management strategies involve: 1) recognition of the types of conflict that may have negative effects on individual and group performance and therefore must be reduced; 2) recognition of the types of conflict that can have positive effects on individual and group performance and thus should be generated or maintained; and 3) teaching individuals different styles for managing different conflicts so that they have a wider repertoire of skills to draw upon [211].

Conflict management strategies must meet some important criteria: 1) they must be designed to enhance organizational learning by enhancing critical and innovative thinking. This involves proper diagnosis and intervention of the correct problem; 2) they must be designed to satisfy the needs and expectations of all of the stakeholders while achieving a balance among them – and this involves figuring out who all the stakeholders are and solving the right problem; and 3) they must involve ethical decision making [211]. As one organizational consultant has remarked, *"if we can't define a problem so that it leads to ethical actions that benefit humankind, then either we haven't defined or are currently unable to define the problem properly"* (p. 148) [257].

To meet these criteria effectively conflict management cannot simply focus on individual conflict but must look to the ways in which conflict is – or is not – managed within the organizational culture. A successful strategy must minimize emotional conflicts at various levels within the organization, while promoting a moderate level of substantive, task-related conflict. It should also teach people to use different kinds of conflict management styles to fit varying circumstances.

Many of the existing conflict resolution strategies such as dispute resolution, negotiation and bargaining, mediation and arbitration can be very useful in minimizing emotional conflict but they do not necessitate significant change in the organization. Finding and maintaining the right level of task-related conflict, however, is likely to require shifts in fundamental organizational approaches toward double-loop kinds of learning (see below) [211].

Conflict Management Under Stress

When stress is acute - as when an organizational crisis occurs – interpersonal conflict is likely to be submerged in the interests of the group. Human beings tend to "circle the wagons" under conditions of acute stress and mobilize powerful group forces to deal with the crisis. Individual and group conflict and competitive strivings that normally exist between people are always a threat to rapid, unified action during a crisis. Efforts must be

made to minimize the normal tensions, conflicts and aggressive behaviors that inevitably arise in any group. Leadership emerges within the group and frequently, an external enemy is targeted that helps to mobilize in-group bonds. The external enemy becomes the object upon whom the group can project all its own negative emotions and desires in service of group cohesion. Blame for the crisis is sought, and the search commences for an external enemy or scapegoat who will shoulder this blame. The more externalized the blame can be, the more the blaming behavior will increase group cohesion as internal conflict is projected externally. The greater the consistency between this psychosocial need and actual events, the easier it becomes to define friend and foe. The greater the perceived differences between “us” and “them”, the greater the ease in labeling the enemy and doing whatever it takes to defend “us” [102, 103]. Under these circumstances, in mental health settings, there are times when the patient becomes “the enemy”, particularly when the behavior of a patient has resulted in staff injury, or when an individual staff member or the institution itself is threatened with a lawsuit, newspaper exposure, or some other public embarrassment.

Chronic stress has a very different impact on workers. As work related stressors increase, employees develop negative perceptions of their co-workers and the organization as a whole and this may precipitate serious decreases in job performance. Negative interpersonal relationships and the absence of support from colleagues and superiors is a major stressor for many workers. Social support in the form of group cohesion, interpersonal trust, and liking for a supervisor is associated with decreased levels of perceived job strain and better health. On the other hand unsupportive or inconsiderate behavior from a supervisor appears to contribute significantly to job strain [258, 259]. Although the direct effect of social support on stress has been extensively researched, it is only recently that focus has been directed at examining the interaction of social support with a "buffering effect." which suggests that the relationship between stress and outcomes is dependent upon the amount of social support available. For example, coworker support had a more pervasive buffering effect than did support from either supervisor or from one's non-work context [260].

Under stress, lacking social support and unable to see the larger system influences that are at work, people become frustrated and angry with their co-workers, supervisors and managers who they can see and as a result interpersonal conflicts increase and this leads to further decreases in collective efficacy [261]. Hierarchical structures concentrate power and in these circumstances, power can easily come to be used abusively and in a way that perpetuates rather than attenuates the concentration of power. Transparency disappears and secrecy increases under this influence. Communication networks become compromised as those in power become more punishing, and the likelihood of error is increased as a result. In such a situation, conflicts tend to remain unresolved and tension – and resentment – mount under the surface of everyday group functioning. Interpersonal conflicts that were suppressed during the initial crisis return, often with a vengeance, but conflict resolution mechanisms, if ever in place, deteriorate under stress. Helplessness, passivity, and passive-aggressive behaviors on the part of the underlings in the hierarchy increase while leaders become increasingly controlling and punitive. In this way the organization becomes ever more radically split, with different parts of the organization assuming the role of managing and/or expressing different emotions that are then subsequently suppressed [103]. Such conditions as these make an organization ripe for collective disturbance that

may go unresolved and unrecognized, while policy changes are made that insure the underlying conflicts will remain out of conscious group awareness.

Conflict and Organizational Learning

Conflict is a necessary component of a learning environment because conflict is a necessary component of learning. Conflict spurs motivation and the desire for change. Organizational development researchers have defined organizational learning as "detection and correction of error" and have described two types – single-loop learning and double-loop learning. [262]. In single loop learning a problem is recognized, diagnosed and addressed without changing the underlying policies, assumptions and goals. In double-loop learning the recognition, diagnosis and intervention requires changes in the underlying policies, assumptions, and goals.

This latter form of learning is what is necessary to address the astonishingly complex problems of adults, children, and families who enter treatment environments and present challenging problems for staff members whose goal it is to help them. Trauma-informed learning is double-loop learning. Mental health and social service workers have to change paradigms of thinking and behaving in order to meet the goals of recovery that trauma-informed change necessitates.

But all too often, this kind of shift in underlying paradigm is inhibited by defensive reasoning on the part of organizational members because they so fear complaints of errors in judgment or incompetence that they will not take the risk of making a mistake and learning from it [211]. As one group of investigators have pointed out,

> *"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) [263].

When organizations cannot deal directly with conflict using methods that utilize good conflict management skills, the organization cannot learn from its own mistakes and error is likely to become systemic. Employees are likely to develop escalating negative feelings about the organization that include loss of trust or pride in the organization resulting in diminished dedication and commitment; increase in political or self-protective behavior; contemplated or real job transfers; petty revenge or sabotage; lack of any extra effort; making and hiding mistakes or failing to meet deadlines or budgets; loss of effective problem solving, work on wrong priorities, poor methods; loss of creativity, motivation, and risk taking; negative feelings about oneself, loss of self-esteem, self-criticism; negative emotions of anger, frustration, depression, disappointment, disillusionment and tension; deepening cultures of cynicism (p. 111-116) [46].

I. Disempowerment & Helplessness

Thesis; 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. The organization and the individuals in it become highly risk-avoidant.

> *Widespread interest in empowerment comes at a time when global competition and organizational change have stimulated a need for employees who can take initiative, embrace risk, stimulate innovation, and cope with high uncertainty (p.1448).*
>
> Gretchen Spreitzer
> *Psychological Empowerment in the Workplace [264]*

Culture is important because it acts as a buffer and supportive system for its members and provides members with a stock of knowledge about the way things work and a set of meanings that makes sense of that work. Collective trauma tests that stock of knowledge and if the organizational culture cannot answer that test of explanation to its members, then the members are left disempowered, helpless, and unable to make sense out of their experience [265]. This is an apt description, applicable to all of the mental health professions who have rallied little organized protest to the devastating impacts of the changes that have occurred, whether those changes have resulted in significantly diminished services to their clients or significantly diminished incomes and job satisfaction for themselves.

Learned Helplessness

Learned helplessness was first defined as a concept in the early 1960's when Overmier and Seligman began doing experiments on the reaction of animals to shock. The basic idea was that a perceived lack of control over one's environment leads to future inaction. Seligman suggested that human beings, born in a state of total helplessness, gradually develop a sense of control as the child learns that his intentions direct his voluntary movements and that he/she also has an impact on the people around him[266]. Under the right circumstances a child comes to believe that his or her actions will predictably affect outcomes and increasingly develops a sense of mastery and self-efficacy.

Learned helplessness is a phenomenon containing three components: contingency, cognition, and behavior. Contingency addresses the relative uncontrollability of the situation. Cognition refers to the attributions that people make regarding their situation or surroundings of which they are a part. Behavior allows individuals to decide whether they will give up or proceed with the obstacle set before them [267]. Helplessness is more likely to result from situations where failure is uncontrollable. And no matter what one does, it leads to a negative outcome. Trauma, by definition, requires a devastating experience of helplessness.

Learned helplessness has been used as an explanation for the ways in which people learn to cope with repetitive trauma and as a model for depression. Later, the model was expanded to describe some people's pessimistic explanatory style in which individuals attribute negative events to internal or stable causes over which they believe they have no control, and people with this style are said to be more likely to develop a helpless response in the face of new challenges. Although over the years there has been a great deal of discussion and debate over the exact mechanism of learned helplessness, it has been applied to a wide cross section of people from test-taking students to disruptive children and their mothers [268].

Studies of learned helplessness in humans have shown that exposure to recurrent unsolvable problems can undermine performance on a subsequent test task. In terms of the original theory, these deficits result from a reduction in a person's expectancy of control. Upon recurrent failure to solve a problem, people may develop the expectation that nothing they do will affect the outcome and may transfer this expectation to other tasks. As a result, they may put less effort into subsequent tasks and consequently show performance deficits. Research has consistently shown that people who attribute failure to internal/ stable/global causes perform worse in a new task than people who make an external/ unstable/specific attibution [269, 270].

Learned helplessness at work has been defined as a debilitating cognitive state in which individuals often possess the skills and abilities necessary to perform their jobs, but exhibit suboptimal or poor performance because they attribute prior failures to causes which they cannot change, even though success may be possible in the current environment [271]. When applied to the mental health system it is possible to see parallels between the helpless responses of the clients and the helpless responses of the staff and managers who serve them. Historically, our systems of care have not focused on empowering clients to make their own decisions but have instead created "expert" cultures within which the client is chronically dependent for help on a medical model that places expertise solely in the hands of caregivers. Helpless passive or passive-aggressive dependency is likely to be the result. Visit many mental health care, health care, or social service environments today and you will see the same behavior mirrored in the staff.

In a controlling, non-participatory environment exercising top-down management, every subsequent lower level of employee is likely to become progressively disempowered. This organizationally-induced helplessness has been described as the antithesis of empowerment [272]. After years, decades, and even generations of controlling management styles, reversing this sense of disempowerment can be extremely difficult, particularly under conditions of chronic, unrelenting organizational stress.

All workers bring to the workplace environment various personal dispositional factors such as optimism or pessimism – seeing the glass as half empty, or half full. The Big Five personality factors that have been shown to positively influence performance include: extroversion, emotional stability, agreeableness, conscientiousness and openness to experience. These factors are likely to influence the way workers do their job and the results they get. Individuals then attribute cause for the outcomes they get. When the cause is obvious, this factor plays less of a role but when the cause is ambiguous, people tend to fall into their own habitual way of explaining bad events that befall them. Learned helplessness is associated with a style that is stable – happens all the time – and internal – "it's because there is something wrong with me"[273]. In other research this "external locus of control" –

believing that you are a pawn at the mercy of external forces – contrasts with an "internal locus of control" where you believe you are in control of your own behavior [271].

And then there are significant situational factors that may influence performance level. People regularly subjected to role conflict, role overload, and role ambiguity along with a pervasive sense of helplessness may feel prevented from asking for help, getting clarification, and receiving support. Tasks may be ambiguous or poorly defined. Feedback may be nonexistent or be so distant from the actual behavior that it is meaningless. Success may be very difficult to assess and may be only distantly related to day-to-day actions on the part of the worker [273]. In many mental health situations, roles are very ambiguous, particularly for institutional line workers and their tasks are frequently ill-defined. Although they are supposed to help clients "recover", what this means is unclear, while they are likely to be punished if they fail to "control" the clients. Feedback for the ways in which they convey empathic regard for the clients may be minimal, while feedback for the ways in which they do not make the clients follow the rules may be rapid, punishing and pervasive. And in virtually all mental health and social service environments, there are great distances between what individuals do on a day-to-day basis and long-term outcomes. In this way, providing these services bear a closer similarity to parenting than to most other kinds of jobs.

In an organization, employees may engage in specific behaviors that contribute to organizational helplessness. They may stop striving for high levels of achievement because they harbor a fundamental belief that no matter what they do, they will not make a significant difference. Other people become passive, failing to seek out any new or innovative ways of approaching a problem and resisting anyone else's suggestions as impossible. Some become passive-aggressive, sticking to the letter of the rules – and doing nothing above and beyond those rules. Many will not make decisions, even when urged to do so because they are afraid of negative consequences [274].

Research has demonstrated that employees of centralized, bureaucratic organizations that rely on formal rules and policies often experience feelings of alienation, frustration and helplessness [275]. Not being able to control work methods, performance evaluations, decision making all contribute to the sense of helplessness within an organization and the less participation an employee has, the more this is likely to be the case. As one investigator stated, "*Aspects of the organizational environment such as traditional appraisal systems, flawed reward systems, poor leadership, counterproductive personnel policies, and inappropriate organizational structure are all said to lead to feelings of helplessness on the part of organizational members. If organizationally induced helplessness results in lowered feelings of performance efficacy, both for new tasks and those currently being performed by these members, strategies to decrease and even reverse these feelings are critical"*(p.408) [276].

Given the argument made in this paper for the critical shortcomings in the mental health and social service system, it is easy to see where the issue of learned helplessness fits in. It is visible everywhere. In the mental health system, the systematic takeover by managed care, the pressures of deinstitutionalization, the desacralization of psychotherapeutic healing, and the increased medicalization of service delivery have represented an uncontrollable series of events to everyone within the system [277]. Individual personality differences not withstanding, it appears that the system-as-a-whole has responded with an inability to protect itself, suffering blow after blow with little if any protest. The impact on clients, however, has been recognizable. Many mental health

organizations promote further helplessness in their workers through fundamental flaws in structure and process and then the staff of these organizations encounters the complex problems presented by their clients as insolvable problems that simply frustrate them further. Helpless to protect themselves, feeling embattled, hopeless and helpless, the staff and management often engage in risky risk avoidance – risk management policies that may virtually prevent therapeutic change.

Risky Risk Avoidance

The notion of risk comes from the French, risqué which at the turn of the nineteenth century referred to a wager between individuals taking account of the probability of losses and gains (Beck 1992). In its present usage, risk has been defined as "*the project of a degree of uncertainty about the future on to the external world"* (p.5) [278]. Between 1967 and 1991, the number of articles published about "risk" went from 1000 article in the first five year period, to 80.000 in the last five year period reviewed, suggesting to the investigator that medical practice specifically, and Western society in general have become preoccupied with minimizing risk, just at a point in time when the risk of so many major threats to human health are lower than at any other point in history. One author calls this a "risk epidemic" and relates it to the growing belief that we can – and should – control all the risks to our safety, to our health, to our existence [279]. Others have pointed out that we live in a "risk society" [280, 281].

This kind of attitude has never existed before and we can attribute it to the combination of discoveries in science and the ability of computers to meet enormous statistical challenges and calculate all kinds of relationship among variables. Unlike our forebears who carried a reasonably fatalistic attitude toward our inevitable demise, a prevalent social attitude – backed up by many legal proceedings – is that people can identify and eliminate risk factors through proper "risk management" and can thereby prevent disease and ….. death [279, 282]. What unfortunately accompanies this notion is the linkage of risk factors with causal hypotheses. And if knowing someone is at risk leads to a supposed cause for a problem that medical professionals are assigned to treat, then failure to control supposedly high-risk situations leads to malpractice claims and rising expectations of health care – and mental health care.

Nowhere is the problem of risk assessment, risk management, and risk avoidance more evident than in the delivery of mental health services. To assess risk it is necessary to classify risk – and in mental health this means classifying people into various forms of mental disturbance. This would not be so problematic if, as in pneumonia or heart disease, we were able to take a blood test or a radiology study of some sort, and scientifically diagnose a problem. But psychiatry is not a science based on data but on the subjective determination of more-or-less skilled and experienced clinicians. As pointed out by the author of the Study Guide to DSM-IV, "*the diagnoses in DSM-IV are like ready-made suits that come in a variety of standard styles and sizes. They fit many patients well, others adequately, and some barely at all. The clinician's task, like the clothier's, is to fit individuals with specific characteristics into standard, predefined categories…The art of diagnosis depends on the clinician's ability to find and fix the patient into the appropriate diagnostic category even if he or she has atypical signs and symptoms* (p.175-176 quoting Fauman, 1994) [283].

A significant problem with this approach is that the diagnostic label defines reality – even when the person does not actually fit the label very well at all. Although mental illness has and still does exist, each new version of the Diagnostic and Statistical Manual has expanded the number of categories that are considered to be mental disorders until virtually everyone could be seen as having some symptoms typical of some disorder that may or may not be causing some form of debilitation. Given that every kind of behavior can fit into this nosology, individual choice is largely superseded by a definition of medical disorder and since mental health professionals are presumed to be expert at providing the remedy for the mental versions of medical disorders, then mental health professionals become responsible for preventing the problems related to – or caused by – the individuals bearing these diagnoses. And if problems still occur, even though these diagnosed individuals are under the care of medical experts, then the medical experts can be held responsible for the failures in "treatment".

This becomes a particularly pressing issue when people in certain kinds of diagnostic categories do harm to themselves or harm to others. Relatively few mental health professionals will quibble over the responsibility they carry when treating someone who is acutely psychotic, manic, or psychotically depressed. But what about the "liminal" disorders – the people who carry diagnoses of personality disorders? [284]. Sometimes recognized as "sick", other times as "bad", these patients are notoriously at high-risk for harmful and destructive behavior and yet they are generally considered to be neither legally insane nor incompetent. Nonetheless, a significant amount of time, resources and energy in all mental health practices is spent on trying to figure out how to assess and manage the risks these individuals pose because the ever-present danger is that they will act destructively in some way and that the mental health professional and his or her system will be held liable for the patient's conduct.

Several investigators reviewing the issue of risk management have noted that the behavior generally focused upon as risky is selective and narrow. Never is there a thorough investigation of the risks to the patient of risk management or of the risk to the clinician of not resorting to the DSM-IV diagnostic system [283]. In reality, an over-emphasis on risk management is likely to lead to "treatment" environments within which real treatment is impossible because the possibility for the individual actually taking risks and thereby engaging in the process of change is so minimized that stagnation occurs. And it is impossible – unless there is some source of private funding – to even enter the systems of care without having a diagnosis. And relatively little attention is paid to the risk of using psychotropic medications in spite of a large body of evidence supporting the established dangers of many of these medications [285].

In many settings, the confusion is profound and frequently results in restrictive, controlling mental health settings that at times may minimize the risk of some forms of danger but also minimize the possibility that anything will change. The underlying mental model that holds up the mental health system is a fundamental part of the problem. As long as troubled and troubling people are either "sick" or "bad" (or both), the definitions of what constitutes sickness and the legal wrangling surrounding these definitions will inevitably continue. A model that views most psychological dysfunction as a sign of "injury" can lead to very different premises upon which to make sounder judgments [3]. Regardless of how divergent their point of view, injured people – as long as their basic cognitive functions are intact - are seen as having agency and as individuals who are responsible for their own choices. Risky risk avoidance happens when mental health organizations become so risk

avoidant that they inhibit therapeutic change and instead insist on trying to “control behavior”. The only way we can control someone else’s behavior is to completely restrict their freedom and when we do that we also eliminate their capacity to make the choice to change.

J. Increased Aggression

Thesis; Staff respond to the perceived punitive measures instituted by leaders and the escalation of conflict by acting-out and passive-aggressive behaviors. Rumors fly and nasty forms of gossip increase.

"I heard it through the grapevine,
Not much longer would you be mine.
Oh I heard it through the grapevine,
Oh and I'm just about to lose my mind"
Marvin Gay

Punishment in the Workplace

Punishment has been defined as the presentation of an aversive event or the removal of a positive event following a response which decreases the frequency of that response [286]. Although failures to perform and other disciplinary problems are common occurrences in the workplace, the typical response to such problems is instituting some kind of punitive measures. This is particularly likely to occur as institutional stress increases, workload intensifies, employee frustration rises, interpersonal conflict escalates, and leaders become more desperate to achieve rapid and positive responses to a changing environment. As one investigator summed it up, "*decreased worker performance led to increased punitive and autocratic leader behavior",* p.135 [287]

Stressful times are difficult for employees and as interpersonal conflict increases, it is likely that workers will express their anger, frustration and resentment in a variety of ways that have a negative effect on work performance. When changes are rapid, there is likely to be a clear statement of new principles. But when change is gradual and slow – as has been the case in the mental health and social service sectors - there may be no real clarity of intention and managers adjust to the changes by interpreting the changes individually and idiosyncratically. Frequently, bureaucracy is substituted for participatory agreement on necessary changes, and the more an organization grows in size and complexity, the more likely this is to happen [288]. Research has demonstrated that the lower performance gets, the more punitive leaders become and that very possibly just when leaders need to be instituting positive reinforcing behaviors to promote positive change, they instead become increasingly punitive [287]. But is punishment effective?

In studies that look at the impact of punishment there appear to be key variables that determine the effectiveness of punishment. The first is timing. An aversive stimulus can be introduced at different times – while the negative behavior is occurring, immediately after the behavior, or some time after the behavior. According to the research, the sooner the aversive event is delivered the more likely it is to be effective [289]. This is one significant contributor to why punishment usually fails be very effective in most organizational contexts and certainly in those related to social services – rarely does the problematic behavior and the consequences of that behavior occur close together in time. Because of other factors that are likely to be in play - in-group loyalty, distrust of supervisors, distrust of the system, bureaucratic inefficiency - there are likely to be protracted time periods between infractions

and response. By the time the employee actually experiences the punishment, so much time has elapsed that he or she is likely to perceive the response as unfair and even abusive instead of an appropriate and even helpful corrective response.

Another fairly well-demonstrated proposition is that moderate levels of punishment are more effective than low or high intensity levels [289] [289]. But how do we define low, medium, and high intensity? This is likely to be individually variable and if the match between person and punishment is not correct, it is likely to lead to adverse outcomes rather than a change in positive behavior.

Another variable is the relationship to the punishing agent and this reflects research taken directly from work with children. Warm and affectionate parents achieve greater effectiveness with punishment than cold and unaffectionate parents but it is unclear whether this is a result of the punishment or the withdrawal of affection. The implication for organizations is that punishment is likely to be most effective when administered by warm and friendly supervisors [289].

The effects of punishment also depend on the schedule of punishment. In laboratory experiments, punishment is most effective if administered on a continuous schedule after each negative behavior. In at least one study, absenteeism decreased when employees received punishment every time they were absent compared to those who received punishment for the same behavior intermittently. To be effective in administering punishments, managers must be consistent over time, punishing the same behavior each time it occurs; consistent across employees; and every manager must be consistent with every other manager. But this demand for consistency may interfere with the individual reasons for problematic behavior and if a manager always must be viewed by others as both fair and equitable, an individual approach must be entirely eliminated [289]. These demands for consistency are virtually impossible across a large, complex, frequently under-staffed and poorly funded organization.

The effects of punishment – at least on children – are improved when children are offered clear, unambiguous reasons explaining why the punishment occurred and what the future consequences will be if it recurs. This kind of reasoning may make late-timed punishment and low-intensity punishments more effective than they would otherwise be. Effectiveness of punishments are also greatly enhanced when there are clear alternative responses that are available to people [289].

There is another key recognition that must be taken into account, particularly when we focus on punishment within the context of a caregiving organization. The rate of exposure to adverse childhood experiences (ACEs) is likely to be extremely high within these settings – in the clients and in the staff. As mentioned previously in the discussion of the ACE's Study, as far as we know now, only a third of adults – at best – have an ACEs score of 0. This being the case, we can assume that many workers in the human services will have been victimized at some point in their own lives and are likely to get triggered by the reenactments of the children or adults who enter their treatment environments. They are vulnerable to becoming drawn into reenactment scenarios with the clients and with each other that may lead to the breakdown of discipline and a wide variety of behavioral problems.

Knowing this changes the responsibility of the supervisory system and the organization as a whole. How can we expect to see change in our clients if we remain as resistant to change as they frequently are? How can treatment be successful if we continue to unwittingly reenact our own early childhood scarring experiences through our own

negative behavior punitive responses toward them? People who have been unfairly treated and punished as children are likely to response to punishment in the present as further evidence of a fundamental injustice that they have been exposed to since childhood, while at the same time setting themselves up to be punished over and over again. For them, untimely, harsh, non-relational punitive systems are likely to be further damaging.

Manager's perceptions of their fair punishment practices have been shown to be associated with their belief that the subordinate knew that the behavior was wrong and expected to be punished [286]. But managers hold a variety of beliefs about their employees and may attribute far more conscious awareness about the wrongness of the behavior than is warranted. This is particularly true when supervisors have far more professional training than the people they supervise. It is difficult to imaginatively go back in time and remember what we once did *not* know. Supervisors may mistake ignorance for a conscious and deliberate decision to engage in wrongful behavior.

Additionally, employees who through their misbehavior are reenacting some earlier and largely unconscious conflict are unlikely to be able to describe the role this played in their behavior which is likely to be compulsive in nature. But even so they may still respond quite negatively to what is internally experienced as an unfair response that they do not really understand. They may be unable to take full responsibility for their actions simply because they do not truly have control over their own behavior. For them, the early experiences of injustice may have been fundamentally traumatizing, and further experiences with perceived injustice may compound existing problems and lead to even more aggression. This is particularly likely to happen when managers' punishment decisions are based not on constructive, forward-looking dialogue with the problematic employee but instead is motivated by a desire to "make an example" of him or her. When this is happening, it is likely that the same staff members are then reenacting these punishing scenarios with the clients who may have very similar backgrounds.

The ideas that most people have about punishment originate in their early experiences of childhood and the definitions that parents give to children. There is a frequent confounding of notions of punishment – sometimes applying to the idea of achieving justice and retribution which is a "past orientation", and at other times being applied instrumentally as a way of changing or modifying behavior which is a "future orientation" [289]. In the laboratory these two fundamental ideas about punishment may be easy to separate. In the practical application of punishment in the complex situation that defines an organization, these two concepts may easily appear simultaneously and interactively. Since "getting even" is likely to produce unethical behavior in the workplace, while aiming at changing behavior may have no untoward ethical implications, when they are intertwined the result is likely to produce negative consequences. These are particularly problematic scenarios for organizations that treat troubled children or adults because the ways in which organizations respond to employees may mirror the damage originally done to the clients and by doing so set up parallel processes that create toxic environments within which healing cannot take place.

Managers may have other reasons for punishing an individual besides trying to actually bring about a change in the behavior within that person. They may be very concerned about the other employees in the environment and use the punishment as an example setting experience to reinforce behavioral standards, making an example of the violator, and thus maintaining that the organization is a place where people "get what they deserve". Effective disciplinary action can, in fact, result in important learning for everyone

in the organization but managers do not always think about whether the employees are learning what they want them to learn, no more than the employees consider whether the children or adults in their care are learning what they want them to be learning. If the employees see punishment administered unfairly, inappropriately severely, non-contingently, without cause, in an untimely way, with a disregard for privacy or constructive suggestions for improvement they are likely to see the manager involved, and the system as a whole, as unfair and untrustworthy [286]. Such an environment promotes secret-keeping, cliques, and mutual protectiveness and as a result, conduct can go wildly wrong before management even is aware of the problem.

Studies over many years have demonstrated that leader reward behavior generally correlated positively with performance in employees. In fact, the relationship between reward behavior and subordinate performance is much stronger than the relationship between punitive behavior and performance [287]. In one series of studies, punitive behavior had no correlation with performance for professional and technical groups and in administrative and service groups, punishment was *inversely* correlated with performance [287]. In many other studies, punitive behavior on the part of supervisors was associated with lower productivity, higher turnover, and aggressive feelings on the part of employees [290].

Disciplinary actions taken to correct workplace problems are frequently operationalized long after the events have actually taken place, do not necessarily take into account individual differences that could account for the failures in discipline, are vulnerable to the exercise of favoritism by managers, and are often viewed as unfair and capriciously applied by workers. As the psychological distance grows between an employee and management, arbitrary punishments are likely to emerge to cope with workplace problems. Many of these interventions designed to punish the employee often compound the problem by seeming to punish innocent people – if an employee is suspended, demoted, or fired the result is more work for everyone else.

It has been demonstrated that in the workplace, punishment of infractions only works under certain conditions. As one early investigator put it, *"Experience indicates that even severe punishment achieves nothing to redirect behavior into more desirable channels, at least in the large majority of cases… the troubles experienced in our [workplace] seem more consistent with the hypothesis that, in adults, punishment generally produces many undesirable – and few if any, desirable – results* (p. 65) [288].

Moral Development and the Ethical Organization

Recently, some ethics researchers are taking the issue of reward and punishment in the workplace a step further and it is work that has immediate implications for treatment as well. Using Kohlberg's stages of moral development, they propose that the heavy reliance on rewards and punishments fosters low levels of moral reasoning and in the long-term contributes to unethical behavior. In exploring why some employees behave unethically, although there are admittedly some "bad apples", in general management researchers conclude that corporations elicit, inculcate, or even encourage unethical behavior by employees [291].

According to these ethics researchers, organizations, like individuals, have stages of moral development. Kohlberg divided the progression of moral reasoning into six stages. Stages I and 2 he called "pre-conventional" usually achieved in elementary school, Stage 1

is represented by obedience and punishment, Stage 2 as individualism, instrumentalism and exchange. Stages 3 and 4 he called 'conventional" and typify most of the people in society, Stage 3 representing "good boy or girl", while Stage 4 emphasizes law and order. For Stage 5 and Stage 6 he used the term "post-conventional" and claimed that relatively few members of society reach this level of moral development. Stage 5 is represented by the social contract and Stage 6 by principled conscience [292].

Organizations that are operating at Kohlberg's lowest levels of moral reasoning have specific design mechanisms that shift employees' focus from ethical behavior toward stakeholders, to acting in ways that generate rewards or avoid punishments. Performance appraisal systems usually assess behaviors that contribute to profitability or achievement of the organization's strategy and goals and may lower employees' moral reasoning by focusing their attention on behaviors that result in rewards and avoid punishment, regardless of whether it is ethical behavior or not. Reward and punishment systems may create workplaces that are low in trust, in which people feel controlled and are not encouraged to learn, progress, or consider ethical positions. Size matters as well – large organizations in which an employee only has a small part of a task may discourage moral reasoning because they have little role in decision making and because they are simply a small cog in a very large wheel. Access to information may be denied some people and therefore their reasoning cannot be complete because they lack sufficient information to make complex judgments. Codes of ethics may focus on nothing but adhering to rules and regulations which encourage Stage 4 moral reasoning [291].

Leaders may model a low level of moral reasoning and research has supported that a group's moral reasoning decreased when the group leader operated at a low level of moral reasoning [291]. It is clear that employees make more effort to understand and follow top management's ethical values and guidelines if the organization rewards people who follow desired ethical practices and punishes or sanctions those who fail to behave ethically [293]. Unfortunately, according to young managers who were interviewed, very few companies embodied values consistent they hoped to live by [294]. Gaps may actually exist between a manager's level of moral reasoning and the organization's level of moral reasoning and this may put the manager in conflict with the organization's system of rewards and punishment [295]. According to some investigators, research suggests that reward and punishments systems may sometimes reward unethical behavior and punish ethical behavior.

Communities socialize employees and make them aware of their relationship with and responsibilities to each other and the larger society, not just as self-interested individuals. Heavy reliance on a system of rewards and punishments assumes that employees will only work on this basis, that they cannot be counted on to "do the right thing". In more corrupt institutions the system of rewards and punishments implies that employees can be counted on - with sufficient incentives - to do the *wrong* thing. Organizations that are designed with many layers of bureaucracy, with rigid control systems, complex sets of ever-expanding rules and regulations, limited access to information and compliance systems all signal an employee that they cannot be counted on and are not responsible for moral reasoning. When firms react to wrongdoing, or perceived wrongdoing with a tightening of controls, increased suspicion and supervision, more rules and regulations they simply reinforce these notions without ever considering what the employees are really learning [291]. Some commentators are urging that organizations must be designed and operated as ethical communities. According to them, it is clear that *"firms are typically designed for the few individuals who might behave unethically and take advantage*

of the organization rather than for the majority of employees who can be trusted to conduct themselves responsibly and ethically… When we view a corporation as a community – or more specifically, as an ethical community - we begin to focus on how the organization shapes and develops the character of employees working within it (p.362-363) [291].

In the private mental health and social service sector, where profit has to be made, and in the non-profit sector where the bottom-line is also increasingly the standard by which performance is judged, service employees may find themselves in serious ethical conflicts quite frequently. Demands to cut services, cut the number of sessions, see a fixed number of people within an unreasonable amount of time, get people in and out of service despite enormous obstacles, may all put enormous pressure on professionals who are accustomed to having the client as the central focus, not the amount of income the organization is making. Under these circumstances, they are likely to experience punishments directed at performance requirements as a direct challenge to their moral reasoning that is likely to be based on an entirely different set of principles.

Workplace Aggression

Investigators have recognized that there are many ways that employees can express aggression. The most obvious – and the most feared – is active, violent aggression against clients, co-workers, and managers. For the most part, policies and procedures are in place in most workplaces to address the issue of physical violence and much has been written about safety policies in the workplace. In mental health and social service settings, steps have been taken to protect clients from injury at the hands of staff. The recent national emphasis on reducing seclusion and restraint is instrumental in reducing staff-client injury.

But every episode of violence has a history. Violent physical or sexual assault always emerges within a context and can usually be traced to various forms of less appreciated forms of violence that may occur routinely within an organization. Dirty looks, defacing property, stealing, hiding needed resources, interrupting others, obscene gestures, cursing, yelling, threats, insults, sarcasm, the silent treatment, "damning with faint praise", arbitrary and capricious decisions, ignoring input, unfair performance evaluations, showing up late for meetings, causing others to delay actions, spreading rumors, back-stabbing, belittling, failing to transmit information, failing to deny false rumors, failing to warn of potential danger – all of these actions on the part of management, staff and clients are forms of aggression which can terminate in the emergence of violence [296]. But even if that is not the outcome, these kinds of behaviors can have devastating effects on individuals and the organization-as-a-whole.

The characteristics of disruptive employees have been described in colorful terms [297]. For example, The Autocrat is someone who wants everything done in a certain way and allows co-workers little input or authority in decision-making. The Rebel is someone who rebels against every rule and boundary, and although often exceptionally competent, eventually gets into trouble by alienating people in high places. The Aggressor is a person who turns everything into a win-lose battle, is fiercely competitive even when competition is destructive, and has difficulty working with a team. The Criticizer is the person who is insensitive to other's feelings, and excuses hurtful criticism by saying, "but I am just telling the truth" or "this is just the way I see things". The Procrastinator is always assuring people that tasks will be accomplished but who has to wait for the right mood to strike him/her to actually get the task done. The Perfectionist is one who drags on projects and misses

deadlines because everything has to be "just so" and the task never appears to be just right. The Backstabber bonds with co-workers and then betrays their trust for their own personal self-interest. The Objector has objections about everything, even the most straightforward of decisions. The Busybody becomes over-involved with other people and frequently does not recognize other people's boundaries. The Politician may rally the support of co-workers in an attempt to undermine established authority.

It is clear from a large research base that employees need to have their basic psychological needs met in order to feel satisfied at work. These include autonomy – having choice, voice, and initiative; competence – being seen as effective and challenged; relatedness – being connected to others and belonging to the group. When these conditions are met, workers are likely to have greater self-motivation and better adjustment..[298]. These necessary elements for job satisfaction run in parallel to the necessary elements for therapeutic change as well [5]. Any work environment that thwarts satisfaction of any of these three needs undermine self-motivation, performance, and wellness for staff and for the clients [299]. All of the behaviors listed above undermine autonomy, competence and relatedness in interacting and complex ways. Setting aside individual problematic characteristics, there are a number of known catalysts for producing anger at work that then decrease productivity and block teamwork. These include: general harassment – sexual or otherwise; favoritism of one employee over another; insensitivity by managers; depersonalization of the contemporary workplace; unfair performance appraisals; lack of resources; lack of adequate training; lack of teamwork; withdrawal of earned benefits; lack of or violation of trust; poor communication; absentee bosses [297]. A sure sign of an increase in aggression in the workplace is an escalation of vicious gossip and unsubstantiated rumor. Let's review here what we know about gossip and rumors and the ways in which both can be a manifestation of an increasingly unhealthy, stressed environment.

I Heard It Through the Grapevine – Rumors and Gossip at Work

In his song, famous with the over-fifty set, Marvin Gaye moaned that he *"heard it through the grapevine, Not much longer would you be mine. Oh I heard it through the grapevine, Oh and I'm just about to lose my mind"*. The traditional organization grapevine, is often the first way that employees hear bad news and when rumors fly about it certainly can feel like "I am about to lose my mind" if you are a worker in an environment loaded with unanswered questions about what is going on at work.

The notion of "the grapevine" apparently originated during the Civil War when telegraph lines were strung from tree to tree resembling grapevines, but the messages transmitted often were garbled, and these distorted messages were said to "come from the grapevine". One study contended that 70% of all organizational communication comes through this system of informal communication and several national surveys found that employees used the grapevine as a communication source more than any other vehicle [300]. Not only that, but the grapevine has been shown to communicate information far more rapidly than formal systems of communication. The result is that the grapevine has communicated information to employees before managers have even begun the process of activating the formal system of communication. Estimates of accuracy of the information transmitted on the grapevine range from 75-90%, but that 10-25% of inaccurate information can cause an organization a great deal of trouble.[300].

Within every organization there is a formal and an informal communication network and the amount of information going through these two channels is frequently inversely proportional – the less people are informed about what is happening by management, the more likely it is that uncertainty and anxiety will mount and the informal communication network – "the grapevine" – will buzz with sometimes accurate, but frequently distorted or inaccurate information. Studies have shown that employees are most likely to rely on the grapevine when issues are perceived as important but ambiguous, when they are threatened, stressed, or insecure, when there is impending change, and when they feel that management is not communicating [300]. As one investigator put it, *"Rumor defines a thin line between impression and reality"* (p. 14) [301].

The commonly accepted understanding of rumor is that it is talk that is unsubstantiated by authority or evidence [302]. Rumors represent hypotheses about how the world works and are therefore attempts to make sense out of uncertain situations [301]. Four different types of rumors have been described as: 1) the pipe dream expressing what those circulating the rumor hope will happen; 2) the anxiety rumor which is driven by fear and unease and often represents the 'worst-case scenario'; 3) the anticipation rumor which is usually precipitated by ambiguous situations where people are not sure what to expect; 4) the malicious or aggressive rumor which is motivated by an intention to harm others [303].

Rumors fill in the gap where facts are absent. Rumors frequently represent at least a 'kernel' of truth. Rumors are most likely to occur when something is happening that is particularly relevant to people's existence but they do not feel they actually have control over events. This is why rumors are particularly likely to escalate when some organizational change is taking place. This is particularly true when the change itself challenges established beliefs or practice, but before the change has actually taken place and demonstrates the nature of the new reality. In contrast with gossip, the primary role of the rumor is to help people cope with uncertainty [302].

Gossip comes from the combination of God and sibb that was used to refer to the sponsorship of a child at its baptism and evolved into "godparent". One of the functions, then of the original gossip was to convey the news of the birth to people who were not present. By Elizabethan times the term had been expanded from the context of family relationships to individual relationships more generally and had begun to acquire negative connotations [303]. Traditionally gossip has been defined as idle chatter, chitchat, or the evil tongue [304].

In the workplace setting, gossip has been defined as, "*the process of informally communicating value-laden information about members of a social setting"* (p.25) [305] or "*informal and evaluative talk in an organization, usually among no more than a few individuals, about another member of that organization who is not present"* (p.429) [304]. The basis of a rumor is unsubstantiated information. Gossip need not have anything to do with fact. Gossip typically occurs in a context of privacy and intimacy, and tends to be chatty and conversational unlike rumors which tend to spread universally and carry a sense of urgency. Rumors are underpinned by a desire for meaning or clarification to cope with uncertainty, while gossip is primarily stimulated by ego and status needs in a social context [301, 302]. Although gossip can be cruel and malicious, not all gossip is negative. It may promote social bonding and serve as another important route of communication. The function of gossip has been described in a number of ways. Gossip may be an attempt by an individual to broadcast a judgment to a wider group, to achieve personal gain in a play for more power of some sort; as a form of social trading; as a source of entertainment. Gossip

in groups is seen as a process by which groups maintain themselves by conveying the values of the group and a standard for comparison with others. Gossip may be used by a group as a way of sanctioning anyone that does not comply with the group norms [305].

In looking at gossip within an organization, most efforts have been made to suggest that managers should eliminate gossip which implies that managers *can* eliminate gossip. Therein lies the problem as one investigator has noted, *"gossip plays a vital role in group formation, regulation and perpetuation, so the removal of gossip from any social setting is not feasible unless there is a complete ban on all forms of communication"* (p. 32) [305]. Instead, managers may be able to appreciate that gossip can perform some useful purposes – the communication of rules and values; the diffusion of organizational tradition and history; the strengthening of interpersonal relationships; as a way of providing influence for those who have little voice in the organization; and as a vehicle for change [305].

So although gossip occurs in virtually every group and workplace setting, in times of uncertainty and chronic stress – usually a time of increased interpersonal conflict - negative gossip is likely to increase. In a work setting, negative gossip enhances the gossiper's coercive power over the recipient of the gossip and the more accurate the gossip, the greater their power [304]. The grapevine becomes poisonous when dysfunctional relational styles learned in the troubled family are brought into and played out in the workplace, as when bosses engage in gossiping and backbiting in order to maintain control, power and security [306]. Managers may gossip with subordinates about other employees or clients and play one employee off against another. The supervisor may make disparaging comments about one employee to another. All of this lends itself to the promotion of a toxic environment.

K. Unresolved Grief

Thesis: Staff, leaders, and programs depart. Neighboring systems close. Standards of care deteriorate and quality assurance standards are lowered in an attempt to deny or hide this deterioration.

> *"In the norms of the world of work, all losses become disenfranchised, because emotions and feelings are discounted, discouraged, and disallowed... Even mourning as it relates to death is severely constrained by narrowly defined policies that govern acceptable behaviors"* (p.92).
>
> Stein, A.J. and H.R. Winokuer,
> *Monday Mourning: Managing Employee Grief*,

Organizational Trauma, Grief and Change

An organization, or an entire system, can be traumatized by acute events or by chronic conditions. 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) [117]*

Deaths by suicide or homicide are acutely traumatic, particularly to a mental health or social service setting where the fear of recriminations for a failure to anticipate or prevent the deaths may be a major component of the event as it is experienced by the members of the organization. Sudden firings or other departures of key personnel may be experienced as organizationally traumatic, as may the sudden death of a leader or otherwise influential employee.

The effects of downsizing, mergers, hostile takeovers, cuts in program funding, changes in roles, increased and burdensome demands of insurance companies all may be experienced as examples of more "chronic disasters" that insidiously impact and change a system. The losses associated with organizational change are significant and impact the lives of the individuals within the organization as well as the organization-as-a-whole.

When individuals become a member of an organization, the individual surrenders some of his or her own individuality in service of the organization. As a result, losses to the

organization are likely to be experienced individually as well as collectively [307]. For the same reason, failures of the organization to live up to whatever internalized ideal the individual has for the way that organization should function, is likely to be experienced individually and collectively as a betrayal of trust, a loss of certainty and security, a disheartening collapse of meaning and purpose. As workers in this field have determined, "*the relationship between employee and organization are: deep-seated; largely unconscious; intimately connected to the development of identity; and have emotional content"* (p. 429) [307]. Because of this connectedness between individual and collective identity, and because all change involves loss, organizational change and grieving tend to go hand-in-hand [307].

The result of this identification is strongly felt when interpersonal bonds are broken as a result of downsizing, which has been called *"a pervasive form of organizational suicide".* According to previous research, 80% of the organizations studied that were involved in downsizing suffered morale problems. People feel insecure and their organizational commitment is decreased. They fear taking any risks and thus innovation is dampened. They have to work harder for the same pay or frequently, pay cuts. Anger over the loss of colleagues may lead to grieving with possibly a false sense of hope that the lost co-worker will eventually come back or will be rehired. The emotional toll is high on everyone [73]. As one executive reported, *"while layoffs may provide a short-term boost to profits, over the long run downsizing begins a cycle in which companies falter because of loss of talent and a decay of morale that constrain economic performance for years afterwards* (p.32) [308].

It is clear that the ways in which grief, loss, and termination are handled have a significant impact on employee attitudes. There is evidence that when employees are given permission to grieve for the "end of what was", the readjustment to new conditions is likely to be less problematic [309]. The stages of mourning have been applied to organizational change as a useful way of understanding what has been perceived as resistance to change. At first the change is denied or rejected and people cling to the "lost object". Then they adopt an air of resignation, work through despair, and finally come to accept the loss, while eventually adapting to life as it has changed. When the losses are traumatic, when they are disenfranchised, or when they are stigmatized, the process of successful grieving is not likely to be completed. This can have as many negative outcomes for an organization as unresolved loss has for the individual [310].

Disenfranchised Grief

Disenfranchised grief has been defined as grief that is deemed as inappropriate, that cannot be publicly acknowledged, openly mourned, and socially supported and which is thereby refused the conditions for normal resolution through the work of grieving. Examples of disenfranchised grief include examples such as when someone has been involved in what is considered an illicit affair and the lover dies, or in many cases, when a homosexual partner dies [311]. The term has been extended to apply to the workplace in general, serving to indicate that any loss becomes disenfranchised if we are not allowed to express grief in the one place where most of our waking hours during the week are spent – on the job. This is particularly important since at any point in time, 16% of the workforce experiences a personal loss within a given year. Grieving in the workplace represents decreased individual productivity and anything that inhibits the grieving process and thus

causes the mourning period to be lengthened, more severe, or entirely postponed, is likely to negatively impact the organization. Nonetheless, little attention has been paid to this issue [312].

Grieving in the workplace has been actively discouraged. Typically, the amount of grieving in the workplace that is "allowed" is determined by the perceived closeness of the relationship. On the average, organizations give employees about three days off to grieve for the death of a loved one and after that time they are expected to get back to work and resume normal activity. And the amount of allowable grief may be determined by the person's role in the organization. Leaders are expected to go on working as if nothing had happened in their private lives. People who deal with life and death issues all the time are expected to keep tight control in their workplace and this of course includes physicians, nurses, and social workers [312]. Perinatal deaths or the deaths of the elderly are often easily dismissed. Grieving over the loss of someone who is still alive but is no longer the same person they once were may be minimized. Losses that are a result of abortion, Sudden Infant Death Syndrome, suicide, homicide, AIDS, or "preventable" accidents may be stigmatized [312].

The problem, of course, is that grief often refuses to comply with the organizational timetable. Grieving is not linear and does not decrease steadily over time. The more normal grief is inhibited and the longer the grieving process is postponed, the more likely it is to become problematic and even pathological. When this happens and performance is affected, corrective measures are often directed at the symptom rather than the cause and the individual may become increasingly alienated from the organization [312].

Unresolved grief can result in an idealization of what has been lost that interferes with adaptation to a new reality. Individual employees and entire organizations may distort memories of the past as individuals can. Organizations may selectively omit disagreeable facts, may exaggerate or embellish positive deeds, may deny the truth and engage in what has been termed "organizational nostalgia" for a golden past that is highly selective and idealized and when compared to the present state of affairs, surpassingly better. It is a world that is irretrievably lost, with all of the sense of inexpressible grief associated with such loss and the present is always comparably poorer, less sustaining, less fruitful, less promising. In this way the organizational past – whether accurately remembered or not – can continue to exert a powerful influence on the present. The failure to grieve for the loss of a leader may make it difficult or impossible for a new leader to be accepted by the group. In fact, one author has noted that "*Nostalgia is not a way of coming to terms with the past (as mourning or grief are) but an attempt to come to terms with the present"* p. 132 [313] [104]. And reenactment is a way of "never saying goodbye".

Systemic Reenactment

The great American poet, W. H. Auden, has pointed out the importance of enactment in human functioning, *"Human beings are by nature actors, who cannot become something until first they have pretended to be it. They are therefore to be divided, not into the hypocritical and the sincere, but into the sane, who know they are acting, and mad who do not. We constitute ourselves through our actions*" (as quoted in Driver, 1991) [314]. We were actors long before we were talkers in our evolutionary history, and enactment remains a nonverbal form of communication with others of our kind.

Traumatized individuals frequently are subject to "traumatic reenactment", a compulsive reliving of a traumatic past that is not recognized as repetitive and yet which frequently leads to revictimization experiences. Reenactment is a sign of grief that is not resolved and instead the trauma and the losses associated with it is experienced over and over relentlessly. An organization that cannot change, that cannot work through losses and move on will, like an individual, develop patterns of reenactment, repeating past strategies over and over without recognizing that these strategies may no longer be effective. This can easily lead to organizational patterns that become overtly abusive. Corporate abuse comes in many forms including discrimination, demotion without cause, withholding of resources, financial manipulation, overwork, harassment, systematic humiliation, and arbitrary dismissal [315]. With every repetition there is further deterioration in functioning. Knowledge about this failing is available but it tends to be felt before it is cognitively appreciated, but without the capacity to put words to feelings, a great deal of deterioration may occur before the repetitive and destructive patterns are recognized. Healthier and potentially healing individuals enter the organization but are rapidly extruded as they fail to adjust to the reenactment role that is being demanded of them. Less autonomous individuals may also enter the organization and are drawn into the reenactment pattern. In this way, one autocratic and abusive leader leaves or is thrown out only to be succeeded by another, while those who have been involved in the hiring process remain bewildered by this outcome [104].

Reenactment patterns are especially likely to occur when events in the past have resulted in behavior that arouses shame or guilt in the organization's representatives. Shame and guilt for past misdeeds are especially difficult for individuals and organizations to work through. The way an organization talks to itself is via communication between various "voices" of the organization. If these voices are silenced or ignored, communication breaks down and is more likely to be acted-out through impulse ridden and destructive behavior [104].

Human beings historically have used ritual and social support to work through the process of loss toward recovery. Scheff has defined ritual as the *"potentially distanced reenactment of situations of emotional distress that are virtually universal in a given culture"* [316]. Indigenous healing groups deal with the experience of suffering, misery, and healing through staged reenactments of the traumatic experience and a reenactment of the great myths of the tribe. The healing ceremony is almost always a public and collective procedure involving family, tribe, and members of a special healing society. In tribal cultures these ceremonies are often quite large and may involve the entire social group. They are publicly open and often egalitarian, reflecting the traditional ethos of foraging societies. They tend to be repetitive and ongoing, occurring often throughout the year. The participants in the group use techniques designed to greatly increase the level of emotional arousal and alter consciousness. In such states, the participants are permitted the leeway to say or do things that under normal social conditions would be prohibited. In most healing groups, the healed are expected to become healers. The reliving of the traumatogenic situation occurs in precise detail, and the pain is integrated into a meaningful whole by giving it a meaning in a larger mythical system. There is a relabeling of the complaint, a reduction in fear through the ability to maintain some degree of control while social relations and subjective experience are brought into harmony [140, 316-318]

For human beings, grieving clearly is a social experience. It would appear, that on an evolutionary basis we are set for reenactment behavior and that this behavior has important

signal importance to our social support network. The nonverbal brain of the traumatized person signals through gesture, facial expression, tone of voice, and behavior, that something is amiss, that there is some rift in the social fabric that connects the individual to the social group, a rift that must be healed. The behavior of the individual triggers a ritual response in the group in order to help the individual tell the story, re-experience the affect, transform the meaning of the event, and reintegrate into the whole, while simultaneously the group can learn from the experience of the individual. The amount of social support that is offered is often enormous, with an entire tribe participating in escorting the injured party back into the fold through any means necessary to do so [140].

But in the workplace - although employees may indeed be constantly reliving the losses they have experienced - there is likely to be little time or attention given to the need to provide individual employees the sustained social support they require, Nor is it likely that a stressed organization will pay attention to the losses it sustains and allow any natural ritualized forms of working through organizational loss to unfold. The mental health system has sustained enormous losses over the past decade as leaders and staff have left, programs have been dissolved, communication networks destroyed, and meaning systems abandoned. Yet there has been little discussion of the unrelenting signs of unresolved grief that now plagues the system. Instead what remain visible are abundant signs of organizations in decline.

Organizational Decline

According to a worker who wrote about the issue of organizational decline forty years ago, organizations attempt to anticipate and adapt to environmental changes but the larger, more rapid, and harder to predict the changes are, the more difficult it is for the organization to adapt. This failure to adapt then leads to organizational decline and possibly, dissolution. "*Decline begins when an organization fails to anticipate or recognize and effectively respond to any deterioration in organizational performance that threatens long-term survival"* (p.94) [319].

One of the most pronounced effects of decline is to increase stress and under stressful conditions, managers frequently do the opposite of what they need to do to reverse decline: relying on proven programs, seeking less counsel from subordinates, concentrating on ways to improve efficiency, and shunning innovative solutions. Their causal explanations for what is causing the problem dictate their response alternatives and their causal explanations are likely to be incorrect or inadequate because the causes are frequently so complex. Just when people need to be pulling together, interpersonal and intraorganizational conflict increases and becomes difficult to resolve and thus goal-setting, communication, and leader-subordinate relationships decline [320].

Critical events and organizational failure change us and change our organizations, but without memory we lose the context. Some modern philosophers believe that all memories are formed and organized within a collective context. According to them, society provides the framework for beliefs, behaviors, and the recollections of both [170]. Later, present circumstances affect what events are remembered as significant. Much of the recording and recalling of memories occurs through social discussion. This shared cohesiveness of memories is part of what defines a culture over time. Shared language also helps a society organize and assimilate memories and eventually, forget about the events. Similarly, there is reason to believe that maintaining silence about disturbing collective

events may have the counter effect of making the memory even more potent in its continuing influence on the organization or society much as silent traumatic memories continue to haunt individuals [104] [180].

Studies have shown that institutions, like individuals, have memory and that once interaction patterns have been disrupted these patterns can be transmitted through an organization so that one "generation" unconsciously passes on to the next, norms that alter the system and every member of the system. But without a conscious memory of events also being passed on, organizational members in the present cannot make adequate judgments about whether the strategy, policy, or norm is still appropriate and useful in the present [172]. This process can be an extraordinary resistance to healthy organizational change [104]. Organizational decline is said to be caused by a dysfunction in organizational learning and organizational learning is seriously impaired by failures of organizational memory as discussed earlier. Regression may occur so that previous levels of achievement, knowledge, training, and service delivery are no longer remember and appear to play little if any role in the organizational culture.

A psychiatrist who had worked for years in inpatient settings in the early 1990's decided to move from outpatient work back into inpatient work because private practice had become so lonely and he wanted to work with a team again. He was appalled and disheartened by the changes that had occurred in the inpatient program where he had previously worked, despite the fact that some of the same people he knew as social workers and members of the nursing staff were still working there. He first noticed that the physical condition of the program had radically altered. The place was dark and dingy. The carpets were stained and the furniture was battered and dirty. Regardless of what the cleaning staff did, the place never really looked clean. Many of the patients were dressed in hospital gowns, rather than street clothes. Likewise, some of the other psychiatrists insisted on wearing white coats and all that was missing was a stethoscope around their neck to convey the medical nature of the program. The unit, previously unlocked was now carefully locked and off-duty policemen were often called in to manage "security" problems, sometimes wearing their weapons. The staff had come to view a patient restraint as a form of treatment and congratulated themselves when a restraint went well – and they had frequent opportunities to exercise their skills.

The psychiatrist was also disturbed by the nature of the patient information in the charts. Apparently, because of the excessive regulation instituted by the combined forces of managed care and increased risk management, the charts had become, as he put it "dumbed down" to such an extent that they were largely worthless in providing any useful clinical information about the client. That is not to say that the charts were empty of paper. In fact, if anything the charts had expanded in size but not in meaningfulness. What he found was a great deal of detailed reporting about exactly what the patient said, detailed charting of their bathroom and dietary habits, particularly when they were on some kind of special monitoring. What was lacking was any assessment or synthesis of what the information meant. There was no case formulation, no evidence of a thought process, no true clinical assessment.

And he found that the staff appeared unable to *think*, and instead just wanted him to tell them what to do, give them a set of directions, point them in

the direction of a manual they could use. He recalled picking up one chart in which a nurse had noted that there was a client – a "frequent flyer" – meaning a patient who had been in and out of the hospital many times. The nurse had written a note that the patient was threatening to kill himself by jumping into traffic. Nowhere had she drawn upon her own knowledge of the patient and his past history to note that he was a known heroin addict who had previously not followed through on treatment recommendations and was probably drug-seeking, using suicidal ideation as his ticket into inpatient treatment and the hope that he could find someone to give him narcotics.

On another chart, there were careful recordings about what a woman said about her compulsion to self-mutilate. In the social service history there was brief mention that this woman had been repeatedly sexually abused as a child. But nowhere was any connection made between the sexual abuse and the self-mutilation, nor was there any formulation that the two problems could be related. For the psychiatrist, these examples and many other experiences helped him to recognize how previous standards of care had deteriorated dramatically, although none of these negative changes were reflected in existing standards of quality assurance. The unit had just passed JCAH and state inspections with flying colors. He attributed this "dumbing down" of the whole process of treatment as signs of unresolved grief in a system that had numbed itself to the anger, sadness, shame, and despair associated with downsizing, loss of resources, and loss of status.

He said, "*I feel like I have gone into a time warp and am back in the early 1950's before the ideas of milieu treatment had permeated the system. It is a terrible thing to see the extent of regression that has occurred in our field and no one seems to be willing to talk about it. They don't even seem to notice. But this unit still passes all the inspections – what in the world are these regulatory agencies calling quality care at this point!?".*

Many dysfunctional behaviors characterize organizational decline. Increases in conflict, secrecy, scapegoating, self-protective behaviors, loss of leader credibility, rigidity, turnover, decreases in morale, diminished innovation, lowered participation, nonprioritized cuts, and reduced long-term planning are common problems associated with periods of decline [321]. All of these behaviors can be seen as inhibitors of organizational learning and adaptation – both necessary if the decline is to be reversed [322].

Successful or Permanent Failure

As has been pointed out earlier in discussing organizations as living systems, *"theorists are preoccupied with when organizations are "born", what species they are (their forms), and when they have changed enough to be termed dead"* (p.52) [26]. Organizational death can be more difficult to define than biological death. It may come when an organization ceases to operate, when it loses its corporate identity, when it loses the capacity to govern itself, or it experiences any combination of these situations. An organization may die when it successfully merges with another organization, so that organizational death may not be equated with failure [26].

On the other hand, some organizations seem to be "permanently failing", yet continue to operate for years on end [323]. And many of these can be considered "successful failures" meaning that *"the objective is to keep a troubling issue out of the public eye and create the illusion that something is being done"* [141]. It is this kind of "successful" and "permanent" failure that best defines large components of the existing mental health and social service system. The mentally ill, the poor, the homeless all bring up distasteful reminders of what is wrong in our present social system and arouse anxiety about life's uncertainties.

It is this unseen but real "successful" failure that most confounds people who dedicate their lives to the mental health and social service professions. When young professionals first enter the helping professions, they are motivated by a desire to serve, a willingness to sacrifice financial gain for the satisfactions they assume to be found in helping other people get well, seeing people change, and bettering the lives of suffering humanity. What they frequently find instead are bureaucratic systems designed to "control the behavior" of children and adults rather than systems designed to facilitate healing and empowerment.

Kai Erikson sums up what that can feel like to the people involved *"the mortar bonding human communities together is made up at least in part of trust and respect and decency and, in moments of crisis, of charity and concern. It is profoundly disturbing to people when these expectations are not met, no matter how well protected they thought they were by the outer crust of cynicism our century seems to have developed in us all....The real problem in the long run is that the inhumanity people experience comes to be seen as a natural feature of human life rather than as the bad manners of a particular corporation. They think their eyes are being opened to a larger and profoundly unsettling truth: that human institutions cannot be relied upon* (p. 239) [117]

L. Loss of Meaning & Demoralization

Thesis: 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. When this is occurring, staff feel increasingly angry, demoralized, helpless and hopeless about the people they are working to serve: they become. "burned out".

Burnout

The most commonly accepted version of burnout is comprised of three components: 1) *emotional exhaustion* – a lack of energy and a feeling that one's emotional resources are used up; 2) *depersonalization* (also known as cynicism) – marked by the treatment of clients as objects rather than people; detachment and callousness toward clients, cynicism toward clients, co-workers and the organization; 3) *diminished personal accomplishment* – tendency to evaluate oneself negatively [324].

The burnout concept began being actively discussed and evaluated in the late 1970's and 1980's but initially was viewed as a problem of particular individuals. Now, it is becoming increasingly clear that burnout is not a problem of individuals but of the environments within which people work Burnout occurs in 'normal' people who have no previous history of psychopathology. Recent research has also differentiated burnout, which is related to work content, from depression which is multifaceted. It is also clear that burnout negatively impacts effectiveness and work performance [325].

Burnout has a negative effect on worker performance including: absenteeism, job turnover, low productivity, overall effectiveness, decreased job satisfaction, and reduced commitment to the job [326]. Some research has also indicated that burnout may also have a negative effect on people's home life as well. And burnout has been associated with heart attacks, chronic fatigue, insomnia, dizziness, nausea, allergies, breathing difficulties, skin problems, muscle aches, menstrual difficulties, swollen glands, sore throat, recurrent flu, infections, colds, headaches, digestive problems and back pain. The Japanese even have a word, *karoshi,* for sudden death that results from overwork [325].

Researchers have begun to investigate the organizational components that contribute to burnout. Building on the established three-component partition of burnout - emotional exhaustion, depersonalization, and diminished personal accomplishment - a group of investigators have been looking at North American companies and organizations around the world. They describe phases of burnout as an organization becomes increasingly compromised and the quality of life in those organizations deteriorates: Job involvement and all facets of job satisfaction decrease. Turnover increases as more people develop an intention to leave and many actually do depart. Group cohesion decreases while physical and emotional symptoms increase generally. Features of family life deteriorate and performance indicators fall, while the costs of medical insurance rise significantly. The authors claim that *"so many people fall in advanced phases that the term 'pandemic' seems no overstatement: Phases VI, VII, and VIII contain 41.8% of all respondents in public-sector work sites in Canada, 44.1% in the U.S. sites, and 60% in the 10 available global public-sector work sites"*(p.61) [327]. Six problematic work domains have been described:

work overload, lack of control, insufficient reward, breakdown of community, absence of fairness, and conflicting values [325]

It is of interest to note that although there are numerous references to the effect burnout has on mental health professionals in published articles over the last five years, most come from England, Wales, Australia, Japan, Canada, Ireland. China, Sweden, Norway, Greece, the Netherlands, and very few from the United States, despite the enormity of the changes that have impacted mental health care here and the crisis in mental health care that has frequently been cited.

Factors That Lead to Burnout

Work Overload. Due to restructuring and downsizing, work is more intense, more complex, and more demanding of time. To compensate people are working longer hours with greater effort. They are being asked to fill in multiple roles in organizations and engage in 'multitasking'. What that means is that one person is likely to be doing the job that used to be filled by two or three people. Additionally, to make ends meet, many people are compelled to work more than one job [325].

Lack of control. Many organizations have policies that inhibit individual problem solving or participation in decision making and this promotes burnout. Worker's health and productivity suffer dramatically when high demand is combined with low control [325]

Insufficient reward. Money, prestige, and security are some of the rewards received from a job. But people also want job satisfaction and with the decrease in teamwork, problem solving and creativity that makes work rewarding, job satisfaction plummets. As stress increases and authority becomes more centralized, workplaces become more polarized. Relationships deteriorate, social support wanes and this contributes to emotional exhaustion [325].

Breakdown of community, High rates of turnover destroy community within the workplace. People are less connected to each other and teamwork has suffered. *"The loss of community is evident in greater conflict among people, less mutual support and respect, and a growing sense of isolation"* (p. 49) [90].

Absence of fairness. The key elements to a fair workplace are trust, openness and respect and when a community fails, trust, openness and respect go out the window. When all that matters is short-term gain, employees know that they cannot trust their managers to operate in any way other than in their own self-interest [325]. This becomes a general social attitude that even gets played out in non-profit and social service settings where profit-making is not even possible.

Conflicting values. In the corporate sector, the driving need for profits and short-term gain frequently compromises values [325]. In the nonprofit sector, the emphasis on the bottom line may be just as demanding, but more carefully hidden from view

Conflicting Values for Mental Health Professionals

An important review of research studies has demonstrated that no therapy technique is better than any other but that they all work. As a result, investigators have been distilling the necessary elements that go into a good outcome [5]. There are four [5, 328-330]. The

first is related to what the client brings into the setting: how severe their problems are (related to chronicity and complexity of symptoms), their degree of motivation, their capacity to relate, their ego strength, their psychological mindedness and their ability to identify a focal problem. This is said to account for 40% of treatment outcome.

The second common therapeutic element is the therapeutic relationship. It is clear from decades of research that client improvement depends on the nature of the therapeutic relationship. The therapeutic alliance is one best characterized by the establishment of accurate empathy, positive regard, non-possessive warmth, and genuineness. This factor is said to account for 30% of client improvement.

The third common factor is expectancy or placebo effects that are said to account for 15% of client improvement. Basically, this is about restoring hope. This is incredibly important for very disturbed children and adults because by the time they get to treatment settings, they are likely to have given up hope that anything about them or their lives can substantially change. It is important to enhance positive expectations about getting over one's problems and feeling better. That means treatment must be focused on the future, particularly on the person's ability to overcome what has happened to them in the past.

The fourth common factor that all successful therapies have in common is an explanatory system that guides healing rituals. The notion of traumatic stress provides this rationale, offering an explanation for the individual's difficulties while putting those problems within a much larger context of meaning.

What this work concludes is what therapists have known all along – it's the *relationship.* But managed care has most impacted on the quality and nature of exactly this – the therapeutic relationship. Patients are being limited to less and less treatment and steered toward short-term, often drug-related forms of intervention. Privacy has almost entirely disappeared, despite increased regulations that do little but sabotage communication, and confidentiality can no longer be assured. In most cases neither the client nor the therapist know whether or not their relationship will be able to run its course or will be prematurely terminated by an agent on the telephone who has never met or even spoken to the client. Dependability and continuity, in many cases, is no longer assured [331]. These factors, among others, can create significant ethical conflict for mental health workers as they struggle to fulfill their professional responsibilities and survive in a challenging economic climate.

The Result

Ultimately, if this destructive sequence that has been described is not arrested, the organization begins to look and act in uncannily similar ways to the traumatized clients it is supposed to be helping. Only half tongue-in-cheek I call this, ORGANIZATIONAL COMPLEX STRESS SYNDROME.

We now know a great deal about what clients with complex, trauma-related problems require in order to recover. Perhaps as organizations struggle to become more helpful to their clients by becoming trauma-informed, this metaphor can provide us with guidelines for a "trauma-sensitive" method of simultaneous system recovery, applicable to all of the health, mental health, and social service systems that are designed to assist people who struggle with life's difficult journey.

In the final section, we will summarize the findings and suggest some implications for a creating, sustaining, and living Sanctuary® – a Parallel Process of Recovery.

Part IV: Sanctuary: A Parallel Process of Recovery

It must be remembered that there is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than the creation of a new system…. The hesitation arises…. From the general skepticism of mankind which does not really believe in an Innovation until experience proves its value.

Niccolo Machiavelli, *The Prince, (p.15)[332]*

Summing Up Parallel Processes

As has been detailed in the previous page, the results of these complex and interactive series of stress-related problems plaguing our service delivery systems 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"[8] 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.

To summarize:

Chronic Stress – Collective Trauma

- INDIVIDUAL: Clients have been exposed to chronic stressors and significant experiences of childhood adversity.
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  - ORGANIZATIONAL: Our helping systems are now chronically stressed. The mental health system, particularly, has experienced radical downsizing and collective systemic trauma.
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Lack of Basic Safety

- INDIVIDUAL: Clients have been repetitively exposed to danger and now have difficulty keeping themselves safe – sometimes physically safe, and even more commonly, psychologically, socially, and morally safe.
- ORGANIZATIONAL: Not only are our systems of care frequently unsafe for the clients but they may be unsafe for our staff and administrators as well – sometimes physically unsafe, but even more commonly psychologically, socially, and morally safe.
- INDIVIDUAL: Despite the fact that clients' backgrounds are filled with repetitive, often unrelenting stress, trauma, and pain, they are reluctant to talk about the most traumatic aspects of their past and in many case, have amnesia for the worst aspects of their experience.
- ORGANIZATIONAL: Our systems reflect the clients' dissociative problems by failing to ask about the clients' trauma histories, or failing to incorporate the information into ongoing treatment planning, and by 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.
- INDIVIDUAL: Clients who have been repetitively hurt within the context of close, interpersonal relationships, frequently have difficulty discerning who can be trusted and who cannot. Failures of trust characterize their interpersonal history.
- ORGANIZATIONAL: Erosion of trust in the workplace has become a major barrier to instituting trauma-informed care. 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. 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.
- INDIVIDUAL: The greater the exposure to childhood adversity, the more likely it is that clients will have physical problems secondary to that exposure and they may have great difficulties – for a number of reasons – providing proper self-care for themselves.
- ORGANIZATIONAL: A lack of organizational physical self-care can be seen in broken, ugly, dreary physical structures that need paint, new furnishings, new carpets, colorful paintings.

Lack of Emotional Management

- INDIVIDUAL: As a result of the exposure to chronic stress, clients are frequently chronically hyperaroused, responding to even minor stressors as major stressors.

- ORGANIZATIONAL: Our caregiving systems are crisis-driven, hypersensitive to even minor threats.

- INDIVIDUAL: One of the responses to chronic hyperarousal in our clients is an increase in aggression toward self and/or others.

- ORGANIZATIONAL: Our caregiving systems respond with counteraggression, together producing more injuries to staff and clients and more coercive measures, escalating the lack of safety and the level of fear in the environment for everyone.

- INDIVIDUAL: Repetitively traumatized clients have significant difficulties managing distressing emotions.

- ORGANIZATIONAL: Organizations manage emotions through regular and productive meetings, retreats and an atmosphere of participatory management, all of which ceases to regularly or productively occur under the influence of chronic stress.

- INDIVIDUAL: Clients may have adopted substance or behavioral addictions in order to cope with distressing emotions. As a result, drug and alcohol abuse; sexual acting-out, promiscuity and addiction all may be a part of the clinical picture.

- ORGANIZATIONAL: At the organizational level, the failure to cope with workplace emotions and conflict may promote a situation that covertly supports substance abuse and sexual misconduct in the workplace.

Dissociation, Amnesia, Fragmentation of Function

- INDIVIDUAL: Clients have fragmented mental functions because of traumatic dissociation and amnesia, learning problems, and reenactment.

- ORGANIZATIONAL: Service delivery becomes increasingly fragmented under stress as communication breaks down, organizational amnesia increases, and learning from mistakes grounds to a halt.

- INDIVIDUAL: Clients who are raised in situations of significant family adversity may not learn how to work through problems, partly because they cannot manage the intense emotions that one must tolerate to do adequate problem-solving.

- ORGANIZATIONAL: Chronically stressed systems of care engage in faulty and inadequate problem-solving under stress, usually reverting to old ways of doing things, even if they old ways no longer work.

- INDIVIDUAL: Under recurrently traumatizing conditions, it is difficult to maintain a clear and healthy sense of identity. As a result, clients often appear to be contradictory: they often do not act on what they think, or their actions contradict what they say. Their strongly held moral beliefs may not consistently guide their actions.

- ORGANIZATIONAL: Identity confusion in organizations is evident in the recurrent conflicts between theory and practice, various professional groups, management and workers, clients and staff. It all represents a failure to "get on the same page", to engage in processes that increase the likelihood of synthesis, convergence, and emergence

Systematic Error

- INDIVIDUAL: Clients frequently lack good communication skills and have difficulty in being both direct and diplomatic. As a result, their communication style may be indirect and covert and may end up creating more problems than it solves.

- ORGANIZATIONAL: Under stress, the communication network within caregiving 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.

- INDIVIDUAL: Having experienced repetitive violation of physical and psychological boundaries, the clients frequently violate other people's boundaries, fail to protect their own, or have such rigid boundaries that they cannot ask for help, allow help to reach them, or extend themselves to connect to others, in other words, their boundaries do not necessary let the right information in and do not operate sufficiently to screen out bad information.

- ORGANIZATIONAL: Stressed organizations frequently substitute rules for process resulting in fixed expectations and consequences that punish clients for the problems that bring them into treatment in the first place. Or, organizations can become so confused about boundaries that they do not have clear role definitions. As a result interpersonal and intra-organization boundaries become confused and overly permeable. Or organizational boundaries may be so rigid that no useful information gets in at all.

- INDIVIDUAL: Clients exposed to recurrent threat and the violation of boundaries may find themselves unable to protect themselves from revictimization, unable to mobilize necessary resources to keep danger out of their lives.

- ORGANIZATIONAL: Chronically threatened caregiving environments have been unable to mobilize any coordinated defense enabling them to protect staff, their organizations, or the ability to provide the care for clients that they recognize as necessary.

Increased Authoritarianism

- INDIVIDUAL: To be effective in the world, each of us must develop a response to external authority and a sense of internal authority that helps us both comply with authority and exert our own authority. Clients who have grown up in abusive relationships are likely to have difficulty with both domains. They may be overly obedient to authority and fail to develop critical thinking, or they may be unwilling to comply with any authority and end up plunging themselves into many unnecessary situations of conflict and punishment. They also are likely to have difficulties in exerting their own authority by being able to take control of situations by leading, not through bullying or passivity.

- ORGANIZATIONAL: Chronic stressors in systems take a significant toll on formal leaders who may not have learned how to apply different leadership styles commensurate with different demands. Under stress, leaders are likely to resort to the style they are most comfortable with and for some this may be authoritarianism which minimizes the critical thinking of everyone lower in the hierarchy and diminishes the possibility of organizational learning. In the worst case, authoritarian leaders may become petty tyrants. For others the leadership style may be laissez-faire, for others passive-resistance or just passive acceptance. Under these conditions, when leaders fail to lead, informal power will be used – and sometimes abused – to fill the leadership vacuum by others lower in the hierarchy.

Impaired Cognition and Silencing of Dissent

- INDIVIDUAL: As chronic stress increases and permeates every aspect of a client's life, the internal psychological environment – sometimes reflected in the external environment – becomes increasingly more disordered, contradictory, and chaotic.

- ORGANIZATIONAL: Likewise, chronic stress can produce disorder, hypocrisy and chaos in workplace environments.

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- INDIVIDUAL: Because of deficits in emotional management and problem-solving, clients often are in situations where they make very poor judgments and make bad decisions about what they should do.

- ORGANIZATIONAL: Chronically stressed systems likewise make poor judgments, particularly when they silence dissent, refuse to listen to alternative points of view, and minimize or eliminate participatory processes. As stress increases and participatory processes are eliminated, both individual and group decision making are likely to become progressively compromised.

Impoverishment of Relationships

- INDIVIDUAL: When clients try to communicate but fail to convey the information they seek to convey, the interpersonal relationships they have tend to become increasing compromised as misunderstanding piles upon misunderstanding. Since they are unlikely to have good conflict resolution skills, distressing emotion mounts and conflicts are not resolved.

- ORGANIZATIONAL: Likewise, 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. This 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.

- INDIVIDUAL: Because of the nature of the traumatic wounds, clients frequently lack words for feelings. Words, representing the conscious content of an experience, become separated from feelings, the affective content of an experience, and the emotional content tends to get acted-out or re-enacted in present relationships.

- ORGANIZATIONAL: In organizations, "collective disturbance" represents this separation of cognitive and emotional content of an experience. 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 then are unconsciously projected upon the clients who then act-out the affective element of the conflict while no one understands or grapples with the cognitive content.

- INDIVIDUAL: All forms of therapy focus on the resolution of internal and external conflicts. Resolving conflicts is a fundamental way we learn from our experience.

- ORGANIZATIONAL: 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.

Disempowerment & Helplessness

- INDIVIDUAL: Clients exposed to repetitive and unrelenting stress may become chronically helpless, failing to make changes that are indeed within their power to make.
- ORGANIZATIONAL: In a similar way, 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".
- INDIVIDUAL: Clients, desperate for relief of distress, often engage in behavior that puts them in situations of unnecessary risk, but are simultaneously afraid to take risks that could lead to positive and constructive change.
- ORGANIZATIONAL: 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 – and so do the staff within any organization that hopes to promote change.

Increased Aggression

- INDIVIDUAL: Failing and understanding of the nature and extent of their psychological injuries, clients will often direct their aggression inwardly in the form of self-destructive behavior, our outwardly in the form of some kind of violence.
- ORGANIZATIONAL: 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 and that may be perceived as aggressive responses and may evoke counteraggression in response.
- INDIVIDUAL: Lacking adequate adult role models, clients frequently lack the ability to control their impulses and to impose self-discipline. As a result, when in a caregiving environment, they are likely to become more stressed, and impulse control problems may increase.
- ORGANIZATIONAL: The parallel– and interactive - process reflecting this problem occurs when stressed staff act-out through absenteeism, poor performance, errors and counteraggression.

- INDIVIDUAL: Since violence can take many forms, clients may be able to control physical forms of violence but may engage in psychologically or socially tormenting themselves and/or others.

- ORGANIZATIONAL: More psychological forms of violence in an organization may emerge as an increase in vicious gossip and malicious rumors.

Unresolved Grief

- INDIVIDUAL: Given the "cloaking" nature of previous trauma and the nonverbal level at which many symptoms operate, outside of the limits of conscious awareness, many chronically stressed clients do not see the role they are playing in the development of their on-going difficulties and are unable to get on a self-correcting course.

- ORGANIZATIONAL: Likewise, 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.

- INDIVIDUAL: Clients who have been exposed to maltreatment in childhood are unlikely to be able to recognize their successes, often have poor self-esteem, and may repeatedly subject themselves to shame, guilt, and punishment for real or imagined failures.

- ORGANIZATIONAL: Organizations have difficulty paying attention to their successes, thus capturing and rewarding what they do well. Far more attention is routinely given to shortcomings and failures, then doing a job well.

- INDIVIDUAL: Repetitively traumatized clients have sustained a series of losses for which they have never been able to adequately grieve because the losses are stigmatized or disenfranchised and because they do not have sufficient emotional management skills to endure the overwhelming nature of grief. Unresolved grief manifests in a number of ways typical of chronic trauma disorders including chronic depression and suicidality, chronic pain, addictive disorders, hopelessness, and helplessness.

- ORGANIZATIONAL: 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. The lack of attention from above that the effects of these losses are having below conveys 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.

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- INDIVIDUAL: A common problem for chronically traumatized clients is their tendency to compulsively repeat an experience from the past that has not been fully incorporated into the full narrative of people's experience. This is commonly termed "traumatic reenactment" and in a treatment environment offers both a dilemma and an opportunity for change that can be seized by teams that know how to be catalysts for positive change. In a client, constant reenactment is a sign of unresolved grief.
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  - ORGANIZATIONAL: Chronically stressed organizations tend have significantly lowered abilities for creative change and instead, tend to mirror the clients' reenactment behavior by reenacting failed treatment strategies 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. The result may be the development of successful failure or permanent failure of the purported organizational mission.

Loss of Meaning & Demoralization

- INDIVIDUAL: Clients often seek- or are sent – to receive care when they are at their most helpless, when they have lost faith in the possibility of recovery.
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  - ORGANIZATIONAL: 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.
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- INDIVIDUAL: Chronically traumatized clients are likely to experience depression, physical exhaustion, cynicism about the possibility of positive change, and bottomed-out self-esteem.
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  - ORGANIZATIONAL: 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.
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- INDIVIDUAL: Clients who have been repetitively traumatized are likely to experience a fore-shortened sense of future and become hopeless about a positive vision of the future, instead living moment-to-moment without hope.
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  - ORGANIZATIONAL: 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.
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Summing Up Parallel Processes of Recovery

At this point in time, there is little we can do immediately about many of the chronic stressors plaguing the mental health and social service systems. The only solution to these problems is organized, coordinated and mutual activism on the part of people who use these services and those who work within these sectors. Judging from the state of fragmentation, in-fighting, and apathy of many organizations that represent these sectors, this may be some time yet in coming. So in the meantime, if you have read this paper 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. Let's briefly summarize what a parallel process of recovery needs to include.

Recovery from Chronic Stress and Collective Trauma

- INDIVIDUAL HEALING: Knowledge is power and clients need a different framework to understand what has happened to them, a different mental model for viewing reality. Effective problem-solving relies on accurate problem definition. This makes universal trauma assessment a vital component of good care. An intensive psychoeducational program that teaches clients about the effects of overwhelming experience on their ability to manage emotions and stay safe in the world, think clearly, regulate aggression, work through grief, and plan for the future becomes a keystone for good treatment.

  ORGANIZATIONAL HEALING: The ability to respond to chronic stress and collective trauma is significantly improved if a group of people can pull together and move in the same direction. The only real buffer against overwhelming stress is social support. But to achieve unified action on a consistent basis, people have to be on the same "page". Getting on the same page, despite the diversity of experiences, education, culture, ethnicity, gender and age in every setting requires universal training in psychobiology; therapeutic relationships; individual, group and organizational dynamics; attachment theory; trauma theory; and knowledge creation.

Commitment to Basic Safety

- INDIVIDUAL HEALING: Clients need to agree on a definition of what safety is and make a wholehearted commitment to acquiring the safety skills that will begin the process of healing. This requires an understanding of the physical, psychological, social and moral

elements that go into creating a truly safe lifestyle. The development of individual safety plans and a shared language for safety is a critical aspect of this domain of recovery. As safety skills are developed, the individual clients can move at their own pace in developing the other skills necessary to work through previous traumatic experiences, using safety towards self and others as a guidepost in how to pace the tasks of recovery. While the psychological work is being started it is critical to also pay attention to the ways in which chronic stress has jeopardized the health and safety of the body and clients need to develop a good self-care plan to restore physical health as well as psychological health.

ORGANIZATIONAL HEALING: Organizations-as-a-whole and every individual working within the organization must make a wholehearted commitment to nonviolence – physical, psychological, social and moral safety. Every staff member needs to develop a safety plan for staying safe, even under stress. The traumatic origins of the clients' histories must be kept in the forefront of treatment planning and day-to-day interactions and discussions. Organizations must also attend to the disturbing effects this attention to trauma may evoke in staff members and create the social supports necessary to contain these experiences. This includes taking concrete steps to build a sense of community and shared social responsibility in staff and clients together. Since building and sustaining trust is such an important aspect of developing health relationships, previous breaches of trust between management and staff, members of staff, and staff and clients must be addressed in a constructive way that provides community members with opportunities to restore relationships. The physical plant reflects the attitudes people have toward each other and the work they are doing together so the environment must be assessed, not just for physical safety concerns but for psychological, social and moral safety as well.

Development of Emotional Management Skills

- INDIVIDUAL HEALING: The first step in managing chronic hyperarousal is to recognize it, so part of the psychoeducational program is helping clients to recognize the signs of chronic hyperarousal and how to begin developing skills for managing the problem more effectively. The inhibition of destructive methods for managing emotions - i.e. substance abuse, self-mutilating behavior, compulsive sexual behavior - is a vital step in learning how to more effectively manage distressing emotions, but clients must have substitute behaviors that can help them achieve abstinence goals successfully. A wide variety of cognitive-behavioral tools are helpful in teaching clients these skills. Psychopharmacological interventions may be helpful in reducing the extreme startle responses and others symptoms related to hyperarousal. Becoming more aware of the connections between external stimuli, internal arousal and aggressive behavior is the beginning of developing better control over those impulses. Developing words for feelings and integrating thoughts with feelings are some of the markers along the way to developing higher levels of emotional intelligence. Community meetings, group therapies, psychoeducational groups all assist in the process of developing a higher level of emotional intelligence.

ORGANIZATIONAL HEALING: There is no avoiding the need for time, time, and time. Organizational healing *cannot* occur without devoting time and resources to allowing management and staff to reconnect with the organizational history, losses, and mission. Leadership must make a clear and non-negotiable commitment to reducing every kind of violence within the organization, including the counter-aggression that masquerades as "treatment" and results in physical and psychological injuries to staff and clients, as well as social and moral injuries to the therapeutic community as a whole. To do this, however, it is not enough to tell staff to simply stop whatever behavior is problematic. Management must recognize the legitimate fears that are aroused by this kind of work and find ways to support and sustain significant change while still affording the staff a sense of safety and mastery that is reflected in the way the staff consistently treats the clients and each other. This requires sufficient conversation, discussion and dialogue so that all members of the community have a voice, and learn together how to manage intense and distressing emotions that are inevitably aroused in helping injured people to heal from their injuries. Secret relationships or destructive behaviors in the past or the present, on the part of anyone, must be brought to light, aired, and breaches in trust repaired. Meetings must be guided by the notion of constantly creating a learning organization that demands a ever-increasing level of emotional intelligence.

Reintegration of Function

- INDIVIDUAL HEALING: In order to overcome a tendency to spontaneously dissociate under stress, clients must learn grounding techniques that help them learn how to stay focused in the present and soothe themselves. They are likely to needs specific, trauma-resolution techniques to minimize the occurrence of post-traumatic intrusive experiences like flashbacks and nightmares and to overcome post-traumatic amnesia and/or emotional numbing. Cognitive-behavioral techniques can help to address the deficits in problem-solving and emotional management that are secondary to the developmental insults they have experienced. Corrective emotional and relational experiences, as well as many kinds of peer and community interventions that reinforce self-mastery can help clients develop better self-esteem and a less fragmented sense of identity.

  ORGANIZATIONAL HEALING: Getting everyone on the same theoretical "page" makes meaningful dialogue and planning more possible because everyone is "speaking the same language". This reduces the fragmentation that is so currently symptomatic of our helping systems. Recovering lost knowledge is vitally important but can be difficult once significant numbers of people have left an organization, taking with them the tacit wisdom they carry about the system, about former ways of working together, and about therapeutic wisdom that has been lost from the system. Nonetheless, with time and effort most systems are able to recapture and honor their lost history which enables them to make new attempts to incorporate what was valuable from the past into the needs and constraints of the present.

Opening Up Communication

- INDIVIDUAL HEALING: In the context of individual and group experiences, clients can learn how to communicate their thoughts and feelings directly, honestly, and kindly. In the context of corrective emotional and relational experiences with staff and peers, they can learn about how to respect their own boundaries, protect themselves, and respect other people's boundaries, while remaining open enough to relate to others. In the context of community they can learn how to ask for help and how to offer help to others. They become able to mobilize sufficient resources and awareness to keep themselves out of dangerous situations and thus avoid revictimization.

  ORGANIZATIONAL HEALING: Managers recognize that communication along the grapevine will never disappear, but they can make efforts to make information that travels the grapevine more accurate and less malicious by providing abundant and accurate information to people, as early as possible. Managers set an example for open communication and staff can observe in practice that there are few subjects that are "undiscussable". Managers and staff make efforts to insure that the system remains flexible and responsive to individual needs, while still guaranteeing fair treatment for everyone in the system. They do this by focusing less on making new rules for every new situation and instead commit themselves to engaging in processes that examine, assess, and evolve adequate responses to complex individual and group situations. In this way, the organization remains open to new information- to learning – and it can readily and spontaneously engage in processes of information sharing and knowledge creation that allow it to mobilize complex responses, even in emergency situations.

Redefining Authority Relationships

- INDIVIDUAL HEALING: Within the context of a community, clients learn how to be fairer to themselves and others, how to use their own personal power to become personally empowered and take control of their lives, while not abusing the power they have and seeking to control others. Clients learn to "speak truth to power" without putting themselves in harm's way. In this way they learn to use their own internal authority constructively and develop more successful and socially astute ways for dealing with external authorities.

  ORGANIZATIONAL HEALING: Organizational leaders discourage authoritarian structures and teach the skills necessary for responsible, more democratic participatory structures. After assessing one's own leadership style, managers and supervisors make efforts to develop different styles of leadership to match different situations. There are many different ways of describing ideal leadership attributes but one that most adequately fits the social service and mental health sectors is called "authentic leadership" The four basic dimensions of authenticity include self-awareness; balanced processing of information that considers the perspectives of others and is free from distortions, denials or ignorance; relational transparency, and behavior that is aligned with one's values, needs and preferences [333]. Authentic leaders choose authentic behaviors even when strong external pressures and incentives exist to act inauthentically. Their

authenticity is a response to internal desires to behave with integrity, not to societal pressures to conform to certain standards [334].

Improved Problem-Solving and the Welcoming of Dissent

- INDIVIDUAL HEALING: As clients begin to give up self-destructive habits, develop better emotional management skills, and begin to rely instead on constructive social support, cognitive processing improves and judgments become sounder. Order evolves out of previous chaos and clients' lives become less turbulent, more structured, and safer. Clients learn to look before they leap and in this way, stay out of many troubling and potentially dangerous situations. They learn the difference between aggression and assertiveness and are able to voice their own opinions, dissent from the majority opinion, negotiate, compromise and agree to disagree. Their problem-solving becomes far more complex and they are able to anticipate difficulties before they arise.

  ORGANIZATIONAL HEALING: Organizational learning improves as routine participatory processes are put into place. The increased diversity of opinions requires more thoughtful and meaningful conversations and debates over tasks. Consensus is sought because it is seen as demanding the most complex, although challenging, group decision making abilities. Dissent from the majority opinion is actively solicited and encouraged in order to minimize groupthink, conformity, and group polarization effects. Even under stress, the organizational norm is to deliberately maintain the same participatory processes that are effective under less stressful conditions.

Cultivation of Relationships

- INDIVIDUAL HEALING: Since re-establishing the capacity to trust is recognized as a vital element in healing, individuals are challenged to develop new relationship skills that allow meaningful and safe explorations. Through various forms of therapeutic encounters in individual psychodynamic and cognitive behavioral interventions, in creative expressive therapies, and in peer support and community contexts, clients learn conflict resolution techniques that enable them to give words for feelings. They learn how to recognize the dynamics of reenactment behaviors in their own lives and in the lives of other people. They learn to see every conflict as an opportunity to learn and to practice new skills.

  ORGANIZATIONAL HEALING: There is a general recognition that it is the responsibility of every member of the organization to resolve interpersonal conflict in service of the greater good. The organization adopts methods that enable members to utilize clear guidelines in the routine resolution and transformation of conflict. There is also a general understanding that groups function on both conscious and unconscious levels and therefore the organization is able to recognize and respond to collective disturbance as *collective,* not individual, disturbance. Transparency exists at all levels and although all members of the organization respect individual privacy, there is a universal awareness that secrets spell trouble for the safety and well-being of the organization.

Empowerment and Mastery

- INDIVIDUAL HEALING: After years of deprivation, abuse, and trauma clients learn that the only way out of chronic victimization is to overcome their learned helplessness and exert control over their own destructive behavior. They are able to look ahead and see a number of daily choices that they must make for themselves, choices that either result in them being "part of the problem or part of the solution". They stop taking unnecessary and dangerous risks, but start taking risks to change that are actually more frightening and less predictable than their previous engagement in danger, at least initially. Social support through staff and peers supports their growing mastery skills.

  ORGANIZATIONAL HEALING: Staff members realize that the only time that people - and systems - are incapable of change is when they are already dead. They recognize that their previous cynicism and helplessness about the possibility of individual and organizational change was actually a refusal on their part to take charge of their work lives and to become "part of the solution instead of part of the problem". They realize that only when each one of them follows Ghandi's prescription to "becomes the change you want to see" will the organization be fully empowered to bring about change. They also recognize that change always involves risk and that although through careful processes of collaboration, knowledge creation, integration, and synthesis they can minimize the risks, life and people always remain ultimately unpredictable and life offers few guarantees.

Nonviolence and Social Responsibility

- INDIVIDUAL HEALING: Although anger, frustration and the desire to retaliate are natural human emotions, clients who have been repetitively injured learn that they must harness the energy generated by these powerful emotions and transform them into something that serves both themselves and others. Dr. Herman has called this the development of a "survivor mission" [181]. Clients move toward seeking a higher level of integrity and engage in a search for meaning that helps them transcend their own individual wounds and see themselves as part of a larger historical movement for human rights.

  ORGANIZATIONAL HEALING: Organizations recognize that a fixed system of rewards and punishments may inadvertently keep organizational members functioning at a lower moral level of development than is demanded by an organization seeking authenticity. As a result, the organization takes very seriously any rupture in the organizational fabric caused by individual or group dysfunction, but deals with it through a process that guarantees physical, psychological, social and moral safety to the best of its abilities. Individuals recognize they are role models for others, that they must "walk the talk" if the organization is to truly enable transformative change.

Griefwork

- INDIVIDUAL HEALING: After developing skills to manage distressing emotions and the ability to sustain safety, even in the face of stress, clients recognize the need to mourn

for all that has been lost, both tangible and intangible losses [335]. The work of grief often ends the tendency to engage in compulsive reenactments of the past as the past is given a full voice and the blank spaces in the person's biographical narrative are filled in.

ORGANIZATIONAL HEALING: In reviewing their own past, staff members recall all of the losses that have been experienced over the last two decades and honor what has been lost in the process. In working through the loss of what has been, organizational members become capable of reconsidering what is and what still carries on despite the changes that have occurred. Members are able to review the ways in which the organization has been failing to motivate change and has instead been repeating failed strategies while at the same time developing methods for honoring successes. The system begins to ask itself repeatedly, "is what we are doing working? Are we bringing about change in our clients and ourselves?"

Hope and Restored Meaning

- INDIVIDUAL HEALING: Through the development of better emotional management, self-soothing, problem-solving, and relational skills clients who entered treatment demoralized and hopeless begin to unfold for themselves a new map of the future. The chronic feelings of depression and helplessness have lifted and they can see how much they have grown and changed. They are know that the road ahead is unlikely to be consistently smooth, and they are prepared for signs of relapse, but they also know they can never return to what has been – they have moved on. Their injuries may have left them with some – or extensive – lingering effects, but they no longer see themselves as crippled victims but as survivors whose lives mean something. They count.

  ORGANIZATIONAL HEALING: Through processes of participation and engagement, staff and management have co-evolved a vision of where they want to go together into the future. They fully recognize that the organization they are co-creating with their clients will never be perfect but they understand that it is up to each and every one of them to keep it alive, to work toward authenticity and integrity together. They have put in place hiring, training and orientation systems that introduce new members of the community to the organizational norms and expectations. They continue to embody their growing knowledge base in written archives and daily practice. They are "Creating Sanctuary" together.

The Sanctuary Model

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 people to enter any environment and have experiences that are potentially healing, rather than experiences that compound their injuries as so often happens today.

As mental health professionals, as social service workers, in the end, what is our mission? Is it simply to contain society's mentally wounded and prevent them from doing

further harm? Is the mission, "recovery" as the consumer movement urges? Our helping systems have several important social roles. Yes, we must reduce harm where we can by helping people commit to nonviolence, by increasing emotional and moral intelligence, by improving relationships, and by being catalysts for the journey of recovery. We must create systems where emotionally injured people are offered realistic opportunities to achieve their maximum level of function.

But our role is larger than that. It is clear that there is no subset of traumatized people for whom we can build new structures, new institutions that will more adequately suit their needs. The world is a traumatized place and underlying what we now consider "normal" society are basic assumptions, beliefs, policies and behavior that if not transformed, are certain to doom the entire species – and very possibly all living things – to utter annihilation. Like it or not, the coming years will determine whether or not reason can harness our biological urges with sufficient power to curb the self-destructiveness that threatens our very survival. System transformation urged upon the mental health system, therefore, is not just about the mental health system. Since mental health encompasses the whole realm of what it means to be a human being, transforming the mental health system may create a proving ground for much wider system transformation.

The total-systems approach outlined in this paper is called "The Sanctuary Model. 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 the overall health and well-being of the nation. This 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 the 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 carry the characteristics of living systems.

So perhaps a better metaphor is the body. Each of us has a head, and a heart, arms and legs and eyes and all the other parts, but we are not any of those parts – we are each of us bigger than the sum of our parts. We are emergent. We organize all the work we do together, from looking at our own system, to managing our individual stress responses, to treatment planning, goal-setting and our daily interactions with clients using the map of recovery we call "S.E.L.F." – an acronym representing the four key domains of recovery: Safety, Emotions, Loss, and Future. This paper has extensively explored the parallel process notions relevant to Safety, Emotions, and Loss, so to finish this journey for now, consider Future. Chronically traumatized people are described as having a foreshortened sense of future. There have been many accounts, for example, of urban youth, raised in neighborhoods where shootings are a daily occurrence, who when interviewed express the sentiment that completing high school is irrelevant to them because they do not believe they will live past their teenage years anyhow.

This foreshortened sense of future represents a failure of the imaginative capacities. Imagination is what propels us through our lives. Our daily work schedule is an act of imagination. We anticipate and plan because we imagine ourselves into our lives. But for many people who have experienced repetitive terror, pain, and horror, opening the door to imagination only lets in monsters. So they shut those doors and seal them tightly. The end result is that they must live in the present moment, haunted by the past, and unable to plan for the future. Thus they live without hope. Healing requires opening those doors, unsealing the amazing human imaginative power that determines what comes next. Healing requires beginning to hope for something better and then working to make that hope come alive.

Chronically stressed organizations also stop imagining a better future for themselves. They live only in the present, coping with each new stress using the strategies of the past, without planning, anticipation, or hope. Creating Sanctuary is about opening up that capacity to imagine a better future, to move in the direction of creating the kinds of environments that we dream about instead of settling for the ones we have.

Sanctuary is what can emerge when groups of people come together, create community, engage in authentic behavior, share common values 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.

In Sanctuary we are endeavoring to describe what it means for a system to be alive, growing, changing, learning, and even reproducing. We are together discovering the day-to-day "technology" that is necessary to maximize systemic health. I believe that the only way to 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.

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