The Revelation of Organizational Trauma

William A. Kahn
Boston University

This article describes a process by which organizations and their units may experience trauma, which is revealed through dysfunctional patterns of individual, group, intergroup, and organizational behavior. I illustrate this process in the context of an action research project with a hospital's surgical unit whose presenting symptoms involved the inability of staff members to work together effectively. The article concludes with a discussion of principles of movement that enable group and organization members to create patterns that get them unstuck in how they work and function.

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"Stuckness" is inevitable in social systems. Indeed, the development of relationships, groups, and organizations is characterized by cycles of movement and stuckness (Smith & Berg, 1987). People routinely find themselves stuck, caught in patterns that frustrate them and their capacities to do what they wish to do. Social systems develop when people take risks—trusting others, making their selves vulnerable, raising difficult issues—that enable them to figure out what lies beneath their frustrating patterns and to act accordingly. This occurs over and again, as people move ahead and then press up against further limits in their relationships. These limits manifest differently in different social systems. In a marriage, one partner might keep pushing for more intimacy from the other. A group might find itself unable to let any of its members lead. An organization may be marked by constant battles between two divisions whose leaders cannot reconcile their differences. Each of these situations represents a choice point. People may remain caught in their ineffective patterns. Or they may explore the ground they find when they look beneath the issues underlying those patterns (Smith & Berg, 1987). When they continue choosing the latter, their relationships, groups, and organizations keep developing. They get stuck, and then they move, ad infinitum.

William A. Kahn is an associate professor in the Department of Organizational Behavior at the Boston University School of Management.

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In some organizations, as in some relationships and groups, movement does not occur. People remain caught within ineffective patterns of working and relating, with lots of activity and pressure but little forward movement. There are various ways to understand this. The history of an organization may prevent its members from changing how they go about their work. A founder's death might leave organization members unable or unwilling to disturb the status quo. An organization's culture may prevent its members from openly confronting ineffective structures, policies, or intergroup relations. Another's culture may emphasize blame and risk-avoidance, leaving members unable to examine difficult issues openly. Overly bureaucratic systems may prevent people from providing their leaders with candid assessments and information. Such factors may help to explain organizations that remain unalterably stuck.

My work with caregiving organizations suggests another source of stuckness. Caregiving organizations are institutions whose members directly provide for people who seek healing, growth, ministry, learning, or support of one kind or another. These organizations are unique because their stuckness is so often set or kept in motion by trauma of one sort or another. Trauma may be direct and acute, an episode that erupts within the organization and like an earthquake, strikes a target and radiates distress through the rest of the organization. It may be direct and chronic, as caregivers experience their own trauma in relations with care seekers. Or it may be vicarious, created by constant exposure to care seekers' traumas. In any of these forms, trauma seeps into caregiving organizations and affects not only those involved but the organizations as well. It becomes an underlying dis-ease that presents as organizational stuckness.

"A traumatic event," note Thompson and Kennedy (1987, p. 195), "is one in which the person is flooded with intense stimulation that he or she cannot control." Traumatic events often involve threats to life or bodily harm, or a close encounter with violence. People can be traumatized as well without being physically harmed or threatened by harm. The American Psychiatric Association definition reads as follows:

> The person has experienced an event outside the usual human experience that would be markedly distressing to almost anyone: a serious threat to his or her life or physical integrity; serious threat or harm to his children, spouse, or other close relatives or friends; sudden destruction of his home or community; or seeing another person seriously injured or killed in an accident or by physical violence. (American Psychiatric Association, 1994)

This definition encompasses several sources of trauma, each of which may affect caregiving-organization members.

The most obvious source of trauma in caregiving organizations is violent episodes that occur within their boundaries. A student stabs another at school. Gang members fight in a neighborhood social service agency. A social worker commits suicide in her office. A hospital patient dies in an accident on the floor or from a medication error. A clerical worker at a health clinic is assaulted by a patient off his medication. A minister is publicly accused of sexual abuse. A nurse is sexually threatened by a violent patient. Such episodes erupt within caregiving organizations and assault those who are at their epicenter and, inevitably, radiate out to other organization members.

Trauma in caregiving organizations may be cumulative and relatively more subtle. Teachers in an urban school are routinely verbally assaulted and threatened by their students. Child-care workers at a residential treatment center are kicked and spat on during the course of physical restraints. Nurses in an emergency room are verbally harassed by frustrated, frightened patients and their families. Residents working the psychiatric ward of a teaching hospital are confronted daily by unruly patients. Although none of these patterns may erupt in a traumatic event per se, their cumulative effects can, over time, induce traumatization within caregivers and other organization members. They may become shell-shocked by the constant assault. Like trauma victims, they may feel helpless and terrified over time rather than all of a sudden.

Trauma in caregiving organizations also may be vicarious. Secondary traumatic stress affects caregivers who work with others in emotional pain and "soak up" such pain themselves. Like soldiers who witness violence and death and develop battle fatigue, caregivers exposed to abuse and pain may develop compassion fatigue (Figley, 1995). Social workers and child-care workers who work with child-abuse victims may be traumatized by their intimate exposure to that abuse. Nurses, physicians, and support staff working a burn unit, pediatric cancer ward, or an AIDS facility may be traumatized by working so closely with the trauma of their patients and their families. Crisis workers, disaster relief workers, and emergency medical technicians who work the sites of natural disasters, terrorism, and large-scale accidents may be infected by the trauma of the victims. The toxicity of such secondary traumatic stress for caregivers matches that of post-traumatic stress for the trauma victims themselves.

Trauma affects individuals in powerful ways. Herman (1997) offers a compelling description of trauma victims. She writes that "traumatic reactions occur when action is of no avail. When neither resistance nor escape is possible, the human system of self-defense becomes overwhelmed and disorganized" (p. 34). Trauma victims relive the event yet are unable to master the feelings it aroused; they continue to feel terror, rage, and helplessness. They experience difficulty in maintaining close relationships. These symptoms often remain even while trauma events seemingly fade. "Traumatic symptoms," writes Herman, "have a tendency to become disconnected from their source and to take on a life of their own" (p. 34). When individuals develop effective therapeutic relationships marked by safety and boundaries, they can process their trauma and dismiss their symptoms as no longer vital for their continued functioning.

In this article, I suggest that trauma affects organizations as well as individuals. Caregiving organizations whose members have pronounced, ongoing difficulty in maintaining useful working relationships may be traumatized. Trauma can thus be collective; it can be a property of the organization itself or of specific units, not simply of individual members. When violent or traumatic episodes erupt in caregiving organizations, they dramatically affect those most proximate. Similarly, traumatized care seekers dramatically affect caregivers who work most closely with them. Such direct effects have indirect effects. Trauma radiates throughout caregiving organizations. As caregivers interact with one another, with administrators, and with staff, they communicate not simply information but emotional experiences. Other organization members experience vicariously that which was first borne by whoever is at the epicenter of traumatic episodes or accumulations.

Caregiving organizations, or their units, are thus repositories for trauma. If they are able to process the trauma, organizations and their members can integrate painful experiences into daily functioning without being disabled. If they are unable to process the trauma, it seeps into the organization itself. There it remains, disturbing the organization's functioning, like bodily waste that cannot be flushed out of the human system. The organization develops symptoms disconnected from the trauma itself. These act as social defenses (Jacques, 1974; Menzies, 1960) against the anxiety and the pain that the originating trauma triggers in the unconscious life of the organization. Like individual defenses against trauma, these social defenses assume lives of their own. Like individual defenses, they call attention to rather than suppress trauma.

In this article, I illustrate how an organizational unit became stuck in ineffective patterns that were unconsciously developed by its members to shield them from trauma. The illustration comes from an action research project that I completed with a hospital operating-room staff seeking to improve its work and working relations.

METHOD

Maple Hospital was located in Maple Heights, a middle-class, blue-collar city of 100,000. The community hospital had, over the years, lost a great many patients to the sprawling university hospital located 30 miles away. To compete, Maple had to create a number of specialized services and a reputation for outstanding care. It had to bring in physicians and their patients, who would bring insurers and money.

The hospital was perched high on a hill overlooking the city. Its physical plant was serviceable, in the way of an old high school, with worn linoleum floors, cranky elevators, and stucco walls. Built in the early 1900s, it was at one time the city's jewel. That time had long passed. In the Surgical Unit (SU), space was tight, not so much in the operating rooms but in the preoperative and postoperative areas where patients had little privacy, often separated by nothing more than a drawn curtain that did nothing to stop them from hearing the details of one another's procedures and conversations. Money was tight too, for the purchasing of new equipment that would entice surgeons practicing elsewhere and for hiring more staff.

Dr. Palmer, the new chief of surgery, asked me to help him understand why staff members had difficulty working together. (The names of the hospital and its staff are disguised.) "The unit has zero teamwork," Dr. Palmer said. "It's pretty much everyone for themselves. Everybody has his own agenda, often in conflict with one another. It's not about pulling together." He wanted to change how unit members worked together.

> This place is like the Wild, Wild West. They make up the rules as they go along and then change them to suit their fancy. They don't trust one another. It's a dysfunctional family. I've got surgeons venting in front of patients, berating staff, who retaliate by slowing down and being unaccommodating. I've got staff nurses who won't go out of their way to help new surgeons who represent new business. People here are just not collegial. Their first instinct is to blame.

Several weeks before our conversation, Dr. Palmer had asked staff members to complete a survey about their working conditions and relationships. He then notified

the unit that he had asked me to help them understand the results of that survey and its potential implications for unit functioning and changes. I then met separately with staff groups in the unit—nurses, technicians, surgeons, and administrators—to review the survey, discuss its implications, and ask them whether they would like me to conduct a more in-depth diagnosis of the unit's issues. Each group later reported to Dr. Palmer that they were willing to participate in such a process.

Over the course of the next several months, I conducted semistructured individual interviews with unit members, following the logic of organizational diagnosis (Alderfer, 1980). I interviewed 5 surgeons, 6 technicians, 12 nurses, the nurse manager, and the chiefs of surgery and anesthesiology for the unit. Interviews focused on members' experiences of their work, their roles, their relations within and across disciplines and hierarchies, and their ideas about how to create a better work environment. During that time, I observed nursing-staff meetings run by the nurse manager, surgeon meetings run by the chief of surgery, and an all-staff meeting. I also observed a surgical procedure conducted by Dr. Palmer, enabling me to watch the work of a cross-disciplinary surgical team.

I analyzed interviews, observations, and my own experiences in the unit to generate various categories of members' behaviors, perceptions, and experiences. These themes were used to develop a feedback report. I delivered the same report orally in separate meetings with the administrative group, nursing staff, surgeons, and technicians. Its primary themes appear below.

RESULTS

The SU was at a particularly difficult point in its history. Patient volume was low. The unit was understaffed. Personnel had left and not been replaced, leaving the remaining nurses and technicians overworked and the operating rooms underutilized. It was difficult to increase patient volume, given the focus on cost-cutting measures that reduced customers for all hospitals. Patients had more choices and were attracted to competitors with good facilities and management. The Maple Hospital SU was struggling for its survival.

The Loss of Task

Rather than pulling together to work with their leaders to create a unit to which surgeons and patients wanted to come, SU members pulled apart from one another. The unit was marked by subgroups unrelated to the task of attracting and retaining patients, surgeons, and staff. Such subgroups included nurses and surgeons who supported or opposed the nurse manager; nurses who worked in the preoperative or postoperative wings; nurses who supported or opposed the union; and veteran surgeons who supported or opposed Dr. Palmer's emphasis on customer satisfaction. The SU also functioned on the basis of overly personal relationships. People made decisions (e.g., nurse managers' scheduling of cases and shifts, surgeons' requests for specific nurses) and reacted to one another (e.g., feedback or requests for assistance) on the basis of the his-

tory of their personal relationships with one another rather than on their given tasks. Many SU personnel, physicians and staff alike, were focused on their own agendas. They sought control of their incomes, schedules, territories, and job descriptions and protected themselves from others, to the exclusion of their ability to collectively join around their work tasks.

Various unit members had in previous years suggested various mechanisms to improve the unit's functioning, to little avail. They had requested from hospital administration help in acquiring additional resources, most particularly personnel who would ease the burden on existing nurses, technicians, and other staff and enable the opening of more operating rooms. They had attempted to create new systems for coordinating patient flow, replenishing supplies and equipment, and more generally, supporting and holding people accountable for effective job performance. They also generated attempts to replace individuals in nursing leadership, staff, or physician roles who were unable or unwilling to work effectively toward creating a unit capable of attracting and retaining physicians, patients, referring primary care providers, and nursing and technical staff. These attempts had failed. The SU had lacked the capacity to utilize problem-solving mechanisms or communication forums in which personnel could have meaningful dialogue that led to concerted action. Leaders and members had not been able to pursue a common vision for creating a thriving unit.

Lightning Rod

During the organizational diagnosis, the nurse manager, Barbara Nash, emerged as a lightning rod attracting the heat and light of the unit's energy. Barbara had worked at the hospital for almost 30 years, the last 12 as SU nurse manager. She ran the unit's daily operations: She scheduled surgeries, assigned shifts, hired and trained nurses and technicians, maintained the unit budget, and worked with the chief of surgery to insure smooth relations between her staff and the surgeons. She had a great deal of power, over both her staff—whom she hired, fired, scheduled, and managed—and the surgeons—by scheduling their regular operating times and their "add-ons," emergent cases that required surgery within a day.

In the interviews, people kept circling back to Barbara as if she occupied a central zone they must constantly traverse. Many perceived her as playing favorites with nurses and surgeons. She rewarded nurses she liked, they said, with desirable shifts and hours, while treating others disrespectfully. "She treats some nurses like children," said one, "even calling them dodo. And she yells at them in front of others." Surgeons reported that Barbara rewarded those she liked with desirable schedules, quick add-ons, and good nurses. "She makes some surgeons' lives miserable," one said. "It's selective suffering," said another. "She knows how to work the system, and no one has the balls to get her out. She's called a senior surgeon an asshole to his face and Dr. Palmer one behind his back." I am told many stories about her rudeness. Barbara also had her defenders, who saw her as a victim of sorts, blamed by surgeons who disliked the paperwork or safety procedures that she enforced or by prounion nurses for whom she represented hospital administration.

Barbara framed her leadership differently. "I'm not going to please people," she said. "It's part of the job." She blamed the divisions in the unit on the unions. "It's hard to motivate the staff, because they're entitled, saying 'it's not my job.' Some of us fight that, and others resent it." Barbara believed that some of the surgeons resented her because she was a stickler for the procedures that ensured safety. "I make sure that patients go safely through the system. The physicians just want to get the job done, and don't spend enough time with the patients." She believed that she was forced into various battles, against nurses swayed by the union or surgeons who placed their own convenience above the safety of their patients. She saw herself as the guardian of the hospital and its patients. She wished for a less embattled unit but was unaware of how her own style—of favoring allies and punishing enemies—helped draw the very battle lines that prevented people from working easily as a unit.

Barbara was clearly a divisive force in the unit, whose members rallied for or against but not around her as a respected leader. She was unable to instill teamwork and collegiality in the unit. Yet she had remained as the nurse manager. There were a number of immediate possible reasons. She kept costs low and within tight budgets. Her boss, the recently fired vice president of nursing, had protected her, based on her defense of the patients (against the surgeons) and the administration (against the unionized nurses). The administrators also were busy elsewhere, given the pressing financial and strategic issues facing the hospital.

None of these explanations, however, addressed why the hospital administration wanted an SU marked by conflict and dissension. Maple Hospital, like most organizations, had a thriving grapevine, and the various senior administrators during the last decade had certainly heard the stories about Barbara's leadership. They must have known as well that there were other nurse managers quite able to work within tight budgets and still enable staff and physicians to work as a team, even in unionized environments. And too, they must have known that the potential costs of conflict among SU staff could be catastrophic: A misinterpreted word here or a shrug of the shoulder there and the wrong dosage or drug or X ray would go unchecked, with real consequences for patients. In spite of such potential consequences, Barbara remained the unit's nurse manager. This kept the unit's conflicts in place in spite of the damage to the SU. It was as if Barbara was a key part of some sort of defense mechanism for the hospital or the SU. Yet what were they defending against?

Cataclysm

During the interviews, surgeons and nurses referred to a particular surgical error in the Maple SU. Some referred to it in passing, obliquely, while for others, it occupied a central place. Five years earlier, a surgeon had badly botched an operation, removing the wrong internal organ. There were various versions of the story. One version blamed the surgeon. "The appropriate diagnostic information was on the chart, and there was verification in the room," Barbara said. "But the surgeon just took over and made an assumption." Another version blamed Barbara herself, noting that she had not required the surgeon to follow standard operating procedures, such as having X rays

and charts in the room, because he was one of her favorites. The surgeon himself told me, "It was a screw up of a whole bunch of things." He listed them:

> The patient was already in the room but none of the films were. I didn't know I could access them there. I had the patient confused in my mind with another patient. It had been seven or eight weeks since I had seen the patient. I didn't have access to my own notes. And I was rushed to get out of the room by other doctors.

He portrayed himself as out of the loop, hurriedly operating in the dark.

The patient survived, the lawsuit was quietly settled, and the surgeon and his assistant, after being suspended and put on probation, still practiced at Maple. There were state and national investigations. Maple Hospital was required to develop and implement an action plan based on a thorough analysis of what had gone wrong. The event was picked up first by the local newspaper, which ran a number of articles on the error, and then nationally. Suddenly, Maple Hospital was notorious. It became a lightning rod for people's terror about being defenseless on an operating table and having someone make an awful mistake that was at once ludicrous and preventable. The press fed the terror. A surgeon noted, "The newspapers made it sound moronic, as if the surgeons were just stupid. The operation had some degree of difficulty. Yes, it was clearly a bad mistake. But the press portrayed them as bloodthirsty savages." "They were treated like criminals," said another surgeon of his colleagues. "They were at the wrong place at the wrong time."

The Maple SU surgeons and staff felt unfairly singled out. "Look," a senior physician said, "this kind of thing, or errors of equally bad culpability, happens all the time at lots of hospitals. It's just not reported at most places." Medical errors are typically handled internally, with reviews, action plans, and sanctions. "Who called the paper?" the assisting surgeon said, still aggrieved at the betrayal 5 years later. "We felt like they were bullying the weak local community hospital," reported a nurse. The unit as a whole felt victimized. The publicity left the SU staff reeling.

They also were left with no place to turn. Unit members were told by hospital administrators not to talk about the event. There was no public discussion. "We discussed it at grand rounds a month later," recalled one surgeon. "No one," a nurse said, "came and talked with us, said this is okay, it happens other places, we'll get through it. We were told to keep quiet. We were even threatened by the management." Another said, "No one ever came up and said, you've had a tough time, asked how we're doing. It was all about confidentiality, don't say a word to anyone about anything. Don't talk in the elevator and at lunch where people can hear you." The embattled administrators, trying to control media coverage, public perceptions, and potential lawsuits, demanded silence from the staff. SU members did not even speak openly with one another.

Although there was no sustained, public discussion of the event and what it meant in the life of the SU, its emotional traces lived within different individuals. Barbara cried during several conversations about the event. Several surgeons said they were furious, 5 years after the fact, with their colleagues or Barbara or the administration. A nurse and a surgeon reported recurring nightmares about mistakes and danger; one

continued to be treated for depression triggered by the event. These individual cases pointed to how emotions from the event—sadness, guilt, rage, depression—remained alive in the unit, located within individuals.

The Aftermath

The event also remained alive within the SU culture. Surgeons were required to personally conduct patient histories and physicals on the day of surgery rather than rely on previous reports. The consent process involved multiple permission slips, insurance forms, and nonmedical office visits. Nurses checked surgeons' preoperation plans, verifying correct procedures, and insuring that they knew which operation was to be performed. This altered greatly the traditional power relationship between surgeons and nurses. Nurses reviewed surgeons' procedures and plans and were obliged to halt operations if specified procedures had not been followed.

Nurses were thus set up to protect the patients from the surgeons. The surgeons resented the implication. They chafed over presurgical procedures. "Barbara's fucking rules make it hard to get our cases done," one said. A less outraged surgeon noted, "Doctors don't like redundancy, and don't think that the physicals are necessarily outdated after a week or a month. They resisted, tossing charts back to the nurses or shouting at them." Nurses had little sympathy. "They created this mess," one said. "If we have to close the OR because we're too strict and doing things right, so be it." They too resented the situation, for they had not only to police reluctant surgeons but also to deal with anxious patients, who said things to them like, "Don't take off the wrong leg, okay?" Both the nurses and the surgeons were stuck with identities they neither liked nor felt they deserved.

They were stuck as well with their resentment and anger. SU members had no place to discharge these emotions, which were triggered by the surgical error. Barbara Nash exacerbated rather than relieved these feelings by contributing to an atmosphere of blame and divisiveness. Indeed, she was a key part of the unit's social defenses against the anxiety set in motion by the surgical error 5 years earlier. The social defenses depended on unit members remaining constantly upset and angry. They were thus less available to feel sadness, guilt, loss, and vulnerability, which inevitably would have been part of their normal experiences of the event. As long as they were mad at one another they did not have to do the more difficult work of addressing the pain from their collective trauma. Barbara Nash helped by fracturing the unit, leaving members constantly upset.

The SU was thus marked by a defense mechanism that prevented the excavation and cleansing of its wound. Barbara and her favoritism were simply a component of that mechanism. So was the ongoing blame and resentment that had sprung up around the safety procedures. And so too was the culture of self-protection, rather than collegiality, that marked the unit. Each of these prevented SU members from working as a team. Each was a defense against the possibility that they would get close enough to share their experiences of the event (cf. Menzies, 1960). The unit organized itself around a defense against the expression of emotions that had been suppressed for 5 years.

But the incident also remained alive in the unit, after a fashion. Like a finger pressing insistently on a wound, Barbara Nash maintained the pain from the incident. She tried to locate the pain in the surgeons. Her focus on compliance with safety rules was right, and the surgeons knew that. But her belittling of them, publicly and to her nurses, was a constant reminder of the event for the whole unit. It was also a punishment to the surgeons, enabling unit members to believe that justice was being served. This too was part of the social defense system. As long as staff members accepted that the surgeons had been at fault and were being punished, they would not have to talk about their own experiences and feelings during and after the event. Without such real expression, however, members were reduced to acting out their emotions. These emotions were kept alive for the last 5 years because they could not be fully buried; they were like disturbed ghosts that could not rest until what unsettled them was addressed, after which they could fade into the past where they belonged. The SU was haunted.

Exorcism

The unit sought an exorcism, a way to rid itself of the emotions remaining beneath the surface of members' relationships with one another. Yet they could neither confront those emotions directly nor examine their experiences and perceptions of the surgical error with one another. Instead, they found a scapegoat, someone on whom they could place blame, guilt, and anger and then expel from their midst. They chose Barbara. The process by which they expelled her involved me and the feedback report. During or after each feedback meeting, staff members invariably narrowed in on Barbara. "Why don't you focus more clearly on Barbara Nash as the problem?" asked one surgeon. "[The report] seems pretty indirect to me." He was indignant, disappointed that I did not assert what was obvious to him, that she was the root of the unit's problems, which would disappear with her leaving. In each meeting, I emphasized that Barbara was but one component of the issue; this fell, too often, on deaf ears. Some nodded, but the voices calling for her removal sounded most loudly.

The hospital CEO had been pressuring Dr. Palmer to dismiss Barbara for several months. He had been putting the CEO off until the feedback report, wanting both the external validation and the political cover it would offer with unit nurses and physicians. He also had been waiting for the hospital management team to get in place. "We can't wait any longer," he said after the initial feedback meeting. "We're losing credibility, with the nurses, with outsiders. We can't wait for a Nursing VP to get hired." He pointed to the copy of my report. "And we have some outside leverage now that will help us make the argument. The staff now can't just say that I had it out for her."

I was the outside leverage. I am ambivalent about this. On one hand, the organizational diagnosis indicated that Barbara was indeed a powerful obstacle to a more functional unit. She helped maintain the unit's defenses against working through the traumatic event and its aftermath. On the other hand, she was cast into that role by others—administrators, surgeons, nurses—and served, albeit unconsciously, on behalf of their defense against the experience of trauma. She auditioned for and captured the role, keeping at it at the expense of the unit. Yet she was cast there as well, kept there by others who wished her to remain in place even as they inveighed against her behavior.

I met with Dr. Palmer and the CEO to discuss the implications of the report for the unit. They were both eager to fire Barbara Nash. I did not want them to believe this was the only fix. They wished to quickly move through this process and get rid of her. They operated, so to speak, on the surgical model of healing: Isolate the offending growth or disease from other parts of the organism, cut it out, sew up the body, and move on. They were excited about this, speaking fast, making plans, readying themselves for the operation. I tried to interrupt their preparations. I cautioned them about scapegoating Barbara. They nodded but it mattered little; they were too taken with their diagnosis of Barbara as the primary problem in the unit. Several weeks later, Dr. Palmer summoned Barbara Nash to his office and offered her the choice to resign or to be fired. She resigned, taking 4 months of paid leave. Dr. Palmer was pleased, particularly after having discovered that there was little in her personnel file, in terms of performance reviews and disciplinary actions, to provide a paper trail justifying her dismissal. Previous senior administrators had ignored the complaints and issues surrounding the SU and its nurse manager. After putting out the gag order on the unit, they had left it in place by the simple act of keeping Barbara just as she was. In leaving her there—an act of omission, rather than commission—they had silenced the unit to protect the rest of the hospital.

DISCUSSION

Good therapists trace patterns of emotion to their sources. They look for underlying springs, some hole or wound in the individual from which the emotion originates. It is, often enough, some earlier trauma that went untreated. Children are emotionally and physically abused; siblings, parents, and lovers die; catastrophic accidents happen. Such traumas spawn sadness, rage, shame, guilt, and hurt. These emotions require direct expression. They need to be honored, talked about as if they mattered, until people understand what they mean. If there is no place for this, people bury their emotions. They disconnect them from the traumas, which get forgotten or remembered in ways that may seem curiously dispassionate.

But trauma-induced emotions cannot be buried deeply enough. Like toxic waste, they seep out. People unconsciously bootleg them into their current experiences. They unconsciously seek out and create situations that enable them to express buried emotions. They continue to do so until the original traumas are excavated and worked with in their proper context. Until that happens, the emotions take up a great deal of space in people's internal lives. The emotions and the events that spawned them are outsized, not yet placed in proper perspective.

Organizational units operate similarly. A combat unit gets ambushed and loses half its members. A small business goes bankrupt. An employee brings a gun and kills several colleagues before taking his own life. A beloved leader dies. A surgeon operates on the wrong organ, and the local newspaper finds out. A priest sexually abuses boys, and the church hierarchy engages in a cover-up. These traumas affect the group, although they hit some individuals harder or differently than others. The groups then contain the array of emotions triggered by the event: shock and disbelief; guilt, about

not preventing the event, and shame, that it occurred at all; sadness and depression about loss; rage, at whatever or whoever seemed to cause the event. If people have places to talk about these emotions in the aftermath of the trauma they shared, the emotions are expressed and, over time, fade. If not, they lay pooled beneath the surface of people's interactions and seep out everywhere.

It is in exactly this process that organizations, and their members, often break down and become stuck. Organization members may try to repress emotions loosened by traumatic events, but it is not possible to imprison them indefinitely. Silence in organizations—the inability to publicly speak the truth of one's experience—is corrosive. It creates cultures of rumor and cover-up. People spend time trying to figure out both the truth and how to disguise it, which takes them away from looking closely at what happened and how to ensure it does not happen again. They cannot learn or heal. The corrosion weakens the system. Organizations slow, finally halt, their members stunned by unexpected disasters or paralyzed by chronic conditions that wear them down emotionally.

The Maple SU fit this pattern. Members were stuck in dysfunctional patterns of relating and working. These patterns were shaped by the surgical error, whose memory they seemingly buried but which lived on in how people dealt with one another. Staff members' distancing from and frustration with one another helped defend them against the anxiety of what might happen if they came together and explored their experiences of the surgical error: rage, shame, blame, guilt, sadness. At the same time, members rationally understood that the unit needed some intervention, given the current state of relationships. They thus colluded to scapegoat the nurse manager. She was extruded from the system. This fit with the unit's implicit underlying model of how organisms are fixed: Diseased parts are isolated and surgically removed, leaving organisms to right themselves and recover.

Dr. Palmer and other staff members believed that this solved the unit's problems. An interim nurse manager was hired. The staff liked her. She created transparently fair systems for surgeons and nurses. Dr. Palmer reported that morale was high, noting, "The unit doesn't have people blaming one another as they once did." He and the interim nurse manger replaced 50% of the nurses and technicians. He also met regularly with the nurses every month or so to share information and listen to concerns. Over the year, the SU had a few episodes of potential medical errors being caught at the last moment, one serious and the others less so. Dr. Palmer reported they were handled well: reported, investigated, learned from, and dealt with. If true, this represented a move away from the old culture of blame.

On the face of it, the surgical model of identifying and removing "diseased" people seemingly solved the unit's issues. This goes directly against the therapeutic model underlying the notion of organizational trauma, which holds that unless underlying trauma is worked through, people and organizations cannot be fully resolved and functional. How can these be reconciled? There are several possibilities. First, removing both the scapegoat and half the staff may indeed have interrupted the social defenses, as the people carrying the memory of the trauma were extruded. They became casualties, taking with them their pain like untreated trauma victims, possibly leaving the remaining staff able to create new ways of relating.

Second, and more likely, the extrusions changed the surface but not the depth of the unit's work relationships. Indeed, once the interim nurse manager was replaced with the new permanent nurse manager, problems began to develop between her and a vocal cadre of nurses and surgeons involving issues of staff assignments. The unit also began to coalesce around its anger toward a senior technician who was perceived as sloppy in her work setting up for surgeries. The technician was not confronted nor was her performance reviewed systematically. Each of these cases suggests the unit's ongoing capacity to focus on specific individuals as the cause of upset (i.e., to scapegoat) rather than on the larger underlying issues in the unit as a whole.

Third, and related, it may simply be too soon to tell whether the unit has indeed resolved its underlying issues. The extrusion of Barbara and other staff members did little to alter its underlying capacities for managing traumatic experiences. The theory underpinning this article suggests that SU is not on safe ground. SU members and hospital leaders have not demonstrated the capacity to deal with the store of feelings that a serious medical error would release. They had not learned to talk in the midst of trauma, as they struggled with feelings of blame, rage, sadness, and guilt. They had not learned to refuse the gag order that inevitably gets issued at such times.

This is difficult work. It requires people and units to avoid the seduction of the surgical model and the quick solutions it promises. It also requires consultants, at the outset, to be clear—clearer than I was with the SU, whose implicit surgical model of organizational change overwhelmed our work together—about the demands of the therapeutic model on which they will operate if confronted with underlying organizational trauma. This issue needs to be addressed during the entry process as part of the contract between members and those who seek to help them.

The therapeutic model is demanding. It may be understood in terms of three principles of movement identified by Smith and Berg (1987) to enable organization members to get unstuck in how they work and function. These principles parallel those that Herman (1997) describes as vital to recovery from trauma.

Move Toward Anxiety

One principle suggests the importance of moving toward rather than away from the anxiety associated with any event or issue. In the Maple Hospital SU, this means that members would have collectively explored their experiences of the surgical error soon after it occurred. They would have expressed their anger, sadness, and guilt. They would have talked of how the error had occurred and of the changes that they would have to make in how they worked together and communicated to safeguard against future errors. To do this, staff members inevitably would have to have difficult conversations with one another and address issues that made them anxious. These issues might have included, for example, the arrogance of surgeons unable to admit that they do not fully remember particular patients; the learned helplessness of nurses, choosing not to speak up when they believe things are going wrong; and members' sense of abandonment and betrayal by hospital administrators. Unit members chose not to publicly address these issues; instead, they constructed defenses against the anxiety associated with those issues.

Moving toward anxiety requires people to tolerate difficult feelings long enough to reflect on them (Halton, 1994). This, in turn, usually requires group and organizational contexts that support such reflection (Kahn, 2001). Such contexts are hard to come by, given the pull toward denial and repression in organizations whose members are subjected to anxiety and painful affect. A certain amount of self-deception may be useful in such settings, enabling people to continue working with care seekers who have been abused, have little prospects for meaningful lives, are seriously ill, or are dying (Vaillant, 1993). It can be dysfunctional as well, when preventing people from reflecting on and speaking of trauma. Trauma researchers refer to the "conspiracy of silence" in describing "no talk" rules that impede people's speaking of their traumas to others (Beaton & Murphy, 1995). Baranowsky (2002, p. 156) describes the silencing response as "guiding the caregiver to redirect, shutdown, minimize, or neglect the traumatic material brought by another to the caregiver." This may occur in caregivers' relations to care seekers or with one another. Often enough, it is both.

Movements toward anxiety are crucial for caregiving organizations and units that are stuck, in the way that they are for individuals who have experienced trauma. In both instances, people need to do what Herman (1997) refers to as reconstructing the narrative. Traumatized individuals must tell the stories of their traumas. The narrative includes the events as well as the person's responses and the responses of others. Facts and emotions must be expressed. After many repetitions, notes Herman (1997, p. 195), "the time comes when the trauma no longer commands the central place" in the person's life. The individual no longer needs continued efforts at adaptation, completion, and triumph—the compulsion to repeat the trauma, in ways small or large, to master it or the emotions it released. Rather, it can be expressed and thus integrated into one's daily life.

In a similar fashion, caregiving-organization members whose units are stuck in some fundamental way must reconstruct their narratives. They must speak of that which haunts them—an event, a series of episodes, or the daily, cumulative assault of their work. They must talk of their experiences. They must share the emotions triggered by their experiences. In so doing, they will be able to integrate their experiences into their daily lives. They will come to some resolution, such that the triggering events or issues assume proportionate rather than disproportionate places in their psychic lives. If not, like the SU, they may be locked within defensive routines that keep alive trauma and its attendant emotions without the hope of resolution.

Recognize and Reclaim Projections

A second principle of movement focuses on group and organization members' recognizing how they project onto others to define themselves. The premise here is that splitting and projection, while defending individuals from anxiety, leaves their social systems stuck (Jacques, 1974; Menzies, 1960). Movement cannot occur unless people are able to explore the full range of their own experiences and emotions. Consider, for example, a marriage in which one partner has split and projected onto the other his need for closeness, and the other, in return, has done the same with her need for distance (Scarf, 1995). Their marriage is stuck within a pattern whereby one partner is

constantly seeking more from the other, who rejects her. This pattern enables them, together, to regulate and constrain intimacy within the marriage. There can, however, be no movement: Neither the partners nor the marriage itself will grow so long as they cannot together explore their own desires for both intimacy and distance.

The same holds true for groups and organizations. When individuals make unrecognized projections they lock one another in roles that constrain movement. In the Maple Hospital SU, members split off their angry, vengeful emotions and projected them onto Barbara Nash. Many unit members were angry with the surgeon who had botched the operation and with the arrogance of the surgeons more generally. These members, many of them nurses who thought of themselves as caring and compassionate, implicitly reinforced their nurse manager for treating the surgeons disrespectfully and enforcing rules that constrained the surgeons' power. While grumbling about her favoritism, they did not complain so publicly to hospital administrators that her power over the surgeons would be threatened. They were thus able to maintain both the belittling and punishment of the surgeons and the image of themselves as compassionate and caring. Barbara Nash was angry and demeaning on behalf of the whole unit.

I suggest that this sort of process is a traumatic reaction at the unit level. Trauma disrupts people's relations with others (Herman, 1997). Individuals who have been traumatized turn away from most others, their basic sense of trust violated. They heal when they are able to restore that sense of trust through attachments with others who prove themselves trustworthy. In the context of those relationships, survivors integrate the range of their reactions—guilt, anger, sadness, and the like—and come to an understanding of their complete experiences. Similarly, when a unit is traumatized, episodically or cumulatively, members' sense of basic trust is violated. Members cannot easily hold on to all parts of their emotional experiences—hope, anger, disappointment, sadness, guilt—and thus cast one another into roles that enable those dimensions to exist within the unit as a whole. Units thus fracture. This makes it difficult for unit members to collectively absorb traumatic experiences and integrate their different dimensions. "The group as a whole," writes Herman, "has a capacity to bear and integrate traumatic experience that is greater than that of any individual member" (p. 216). When individuals are cast out of that group and into covert roles, underlying traumas remain locked in place.

Leaders Facilitate Explorations

The third principle of movement focuses on the role of leaders as facilitators of people's explorations of underlying tensions, issues, and events. Movement occurs when unit members reclaim emotions and reactions that have been split off and when they immerse themselves in and explore the polarities of their experiences (Smith & Berg, 1987). This is a difficult process. It requires safety, basic trust, and support. It requires leadership. Maple Hospital's SU lacked such leadership in the months and years following the surgical event. The hospital administration, chief of surgery, and nurse manager were unable or unwilling at the time of the event to convene SU members and facilitate their reflections. Their successors too did not help SU members examine the disturbances in their unit that arose from the traumatic incident. Dr. Palmer's efforts to

"fix" the unit focused on isolating and excising the most prominent of its observable symptoms of dysfunction. This is leadership of a certain kind, focused more on decisive action than on excavating buried disturbances.

In working through trauma, the role of the leader is akin to that of an attachment figure: a trustworthy, secure base on whom others can rely (Kahn, 1995, 1998). This role is made complicated by the fact that leaders must be attachment figures for units, not simply for individuals within them. The distinction is crucial. Barbara Nash may well have served as an attachment figure for some nurses who prospered because of her favoritism. They may have come to her for support, career advice and problem solving. She did not, however, serve the unit as a whole in such ways. She focused on problematic individuals—the offending surgeon, nurses out of favor, and the like—rather than on the unit's problems, which were related to communication, cliques, and a culture of disrespect. "Leaders," writes Catherall (1995, p. 239) in a discussion of institutions dealing with trauma, "must recognize group dynamics, create regular opportunities for groups to meet and talk about . . . traumatic stress, and define and approach issues as group problems, not as individuals' problems."

When leaders are able to serve as attachment figures for their units, they are more likely to create the conditions of safety defined as necessary for trauma victims to reconstruct their story and restore their connections to their communities. Often enough, it is therapists who serve this role for trauma victims. Good therapists bear witness to what occurred, foster insight and empathic connections, and work with the inevitable transference and countertransference that arises within the healing relationship (Herman, 1997). This offers a model of sorts for leaders in caregiving organizations whose members are stuck in ineffective patterns. While not therapists per se, these leaders or the consultants with whom they partner can similarly help excavate and bear witness to that which troubles unit members beneath the surface of their work lives. Not to do so exacerbates the trauma itself: It is an ongoing betrayal by those in authority that continues to disrupt members' sense of basic trust (Shay, 1994).

These principles of movement can be useful in working through the stuck patterns in which caregiving organization members may be trapped. With enough attention, these patterns may be understood as the artifacts of untreated trauma. Traumatic episodes or accumulations occur as a matter of course in caregiving organizations. If they are acknowledged as such, members may move through the process of resolving them—through narrative, witnessing, and insight. If they are not acknowledged, they are unceremoniously buried. Events occur, and without public comment, sink beneath the surface of organizational life.

Trauma brings loss of basic trust, attachments, identity, illusions of immortality, relationships. Loss must be grieved. Grieving allows people full range of expressions and experiences in relation to that which they lost. They come to terms with that loss, placing it within some appropriate context, and are able to move on. "The moment comes," notes Herman (1997, p. 195), "when the story is a memory like other memories, and it begins to fade as memories do. It occurs to the survivor that perhaps the trauma is not the most important, or even the most interesting part of her life story." When grief remains incomplete, trauma continues to attract energy. People cannot move away from it: They are held there by their sense of incompleteness. "Unresolved

or incomplete mourning," writes Robert Jay Lifton (1980, p. 124), "results in stasis or entrapment in the traumatic process." In such instances, people and their units cannot let go of that which wounded them. They remain trapped in incomplete mourning.

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