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CREATING COMPASSION AND CONNECTION IN THE WORK PLACE

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This article raises questions about what contributes to creating a compassionate work environment and sustaining connections that are meaningful in relation to clients and colleagues. Concepts including burnout, compassion fatigue, vicarious traumatization and countertransference are examined, with attention to how they complicate the establishment of a compassionate work place. Factors are discussed which further influence the work environment and inhibit the creation of the desired culture. Individual and institutional steps are then suggested that can be taken to establish a preferred work environment. In particular, practices are considered within the workplace that combat some of the undesirable symptoms, or that lead to the acknowledgment of contributions to a healthy environment and which foster human connections.

As I enjoyed a concert by the 60's band the Turtles, I was struck by the sense of connection and joy communicated throughout the concert by the two lead singers. I wondered what factors contributed to their appreciation for one another and what meaning they attach to their life work, spanning some forty years of collaboration.

The purpose of this paper is to first raise questions about what contributes to creating a compassionate work environment and sustaining connections that are meaningful in the mental health context. A case example will illustrate some of the common challenges in health care. Then, an examination of factors in our culture and our work settings that compli-

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cate or prevent the establishment of a compassionate work environment will be undertaken. In the second half of the paper individual and program steps will be proposed that can be taken to create compassion and sustain connections. Two guiding premises are offered for creating compassion and connection, followed by examples in an array of professional settings to illustrate these practices.

COMMON CHALLENGES IN HEALTH CARE: A CASE EXAMPLE

Coming down the corridor and onto our hospital unit I saw three or four security guards and an equal number of nurses, all wearing protective gloves and clustered at the nursing station near the high observation area. A flushed, perspiring nurse approached the psychiatrist I was with to check if the medical orders supported moving a particular patient to a high observation room against his will. The nurse noted that the teen was armed with some dining utensils and was threatening anyone who came near. The psychiatrist confirmed the propriety of the approach being taken and the nurse turned and left, too busy to process what was happening.

As I left work at the end of this day I had a mix of feelings: 1) relief that I was going home and didn't have to worry about this tense situation; 2) admiration for the staff and their quiet, effective handling of a potentially volatile predicament; and 3) curiosity if any of the staff involved would process the altercation. After all, there were still ten other patients to attend to on the shift, and by the time any of these individuals came to work the next day there would no doubt be other demands requiring their attention. It was quite impossible to know what leftover feelings they might harbor. Would anyone say "thanks," or "good job," or "are you okay?"

In the above example, we could substitute representatives of many other health care professions—therapists, physicians, psychologists, social workers, educators, child care workers. No doubt many therapists, whether in public agencies or private offices, could tell similar stories that produce sharp, powerful feelings and memories. Therapists can frequently relate to the sense of being inundated by the myriad of complex and volatile situations that clients present. Therapists must maintain their decorum when confronted by angry, disparaging, or desperate clients, who

are distressed about the service being provided or circumstances that seemingly defy resolution. Therapists must address the sequelae of a completed suicide. This may involve a meeting with the surviving family members, or a critical incident debriefing, or quiet reflection in one's own office. It may involve heeding a command to "say little" for fear of litigation.

I have anecdotal reports from several sources of well trained and experienced clinicians in private and public settings reducing their clinical practice in favor of ventures that will lessen the pressure and fatigue experienced when providing direct client care. Hospital social workers, psychologists, and psychiatrists speak about their disillusionment with the relentless volume of referrals requiring immediate attention. These demands in the face of desperate circumstances and limited support services can overwhelm even the most resilient emotional stalwart.

In our quietest moments we may acknowledge being fatigued, or despairing, about our capacity to make a difference. We may fantasize about an alternate vocation, or at least a more relaxed venue in which to practice our craft. Are we overwhelmed by our experience or are we able to reflect on the rhythms of our workplace and create a truly preferred environment?

THE RHYTHMS OF THE WORKPLACE

Our work environment constitutes a community that include our colleagues and clients. Although my experience is based on the inpatient hospital mental health culture which is hierarchical in nature, I believe the ideas presented here apply to many diverse settings and varying dynamics based on my conversations with other professionals in a wide array of professional settings. For purposes of this paper, I will use the term therapist generically, to refer to all professionals employed in the health care system, in whatever capacity. I will use the term client to refer to those individuals and families who are recipients of care, whether in a hospital, residential program, outpatient service or private practice. Do health care systems facilitate a sense of connection and community? Or are such efforts circumvented and handicapped by the nature of the work we are doing? What factors inhibit or contribute to these developments?

IMPORTANT CONCEPTS: TERMS OF REFERENCE

Several concepts—vicarious traumatization (Pearlman & Saakvitne, 1995), compassion fatigue (Figley, 1995), burnout (Freudenberger, 1975) and countertransference (Masterson, 1993; Johansen, 1993)—can be considered as consequences of the work we do. These notions can be thought of as symptoms that emerge in mental health workers and work cultures. They influence relationships that emerge toward the self, between people and with respect to values and professional goals that evolve in the work environment. As a result, the therapist's experience of these phenomena may inhibit the development of a compassionate work culture.

There are generally accepted definitions for these concepts. Burnout is a state of physical, emotional, and mental exhaustion caused by long term involvement in an emotionally demanding situation (Pines & Aronson, 1988). But burnout among therapists who are working with victims of trauma and the continual exposure to emotionally wrenching experiences leads to responses that develop along a somewhat different pathway than the generic definition (McCann & Pearlman, 1990). Vicarious traumatization (Pearlman & Saakvitne, 1995) is a process through which the therapist's inner experience is negatively transformed through empathetic engagement with the clients' trauma material. The authors note that while there are rewards in doing trauma therapy, the concept of vicarious traumatization focuses specifically on the negative aspects of the transformation. The therapist's responses tend to mirror responses from an individual suffering from post-traumatic stress disorder related to their specific victimization (Pearlman & Saakvitne, 1995). Helplessness and confusion are characteristic of the responses to this emotional contagion. Compassion fatigue results from the cumulative effect of the work (Figley, 1995). As the phrase suggests, compassion can be depleted and fatigue sets in. Empathy (Rogers, 1980) is a major resource in the helping professions. Like any precious quality, it can be depleted if attention is not paid to replenishing it. Countertransference is written about extensively in the mental health literature (Graybar & Leonard, 2005; Dalenberg, 2004; Sarles, 1994). Generally, it refers to the affective responses of the therapist to the client, as well as the defenses employed by the therapist in response to their interactions in therapy (Kernberg, 1965). Countertransference can facilitate or inhibit empathy.

These concepts, though hard to distinguish between, seem generally connected to one another. Figley (Figley, 1995) acknowledges what he now

calls compassion fatigue he initially thought of as a form of burnout. Figley uses the terms compassion fatigue and secondary stress disorder interchangeably. Pearlman and Saakvitne (Pearlman & Saakvitne, 1995) focus on the terms countertransference and vicarious traumatization in their text. Sussman (1995) edits a text of articles examining the perils of psychotherapeutic practice from the standpoint of almost thirty practitioners. In fact, each of these authors (Figley, Pearlman & Saakvitne, and Sussman) mentions the work and concepts of one another as they talk about their own understanding of these phenomena.

There is a phenomenon of being vicariously traumatized as you sit with and listen to another human's sufferings. We can reach a saturation point with our compassion in the context of too many wrenching stories of sadness and seemingly impossible life circumstances . . . compassion fatigue. These phenomena can combine to leave us emotionally and psychologically unavailable to do more . . . burn out. The contagion effect of being witness to trauma can overwhelm the therapist emotionally (Herman, 1992) and is referred to in Herman's text as "traumatic countertransference" or "vicarious traumatization." The therapist has the task of understanding and containing their adverse reactions to the therapeutic process. The danger is that our experiences, if unchecked, may lead to pejorative conclusions about ourselves and others and contribute to the development of a hostile work milieu.

Using our case example, if you interviewed the involved staff some might describe their response as consistent with one or another of these several concepts. Paradoxically, others may say that "none of these concepts apply." These factors are hard to measure specifically or uniformly. For example, if any of the staff were involved in a series of confrontations in short order, or had been off work with injuries resulting from a situation of patient confrontation, or grew up in a violent home, they might be less tolerant in the moment. Would we attribute these perceptions to vicarious trauma, or burnout, or countertransference? Would we view an unaffected staff member as healthier, or in denial? Ultimately, these phenomena and our responses to them can inhibit or facilitate the creation of a compassionate work place.

COMPLICATING FACTORS

The factors below can impede the development of a compassionate, connected work place.

Dominant Cultural Factors

Dominant cultural factors that impinge on the work environment in North America include lack of time (Menzies, 2005), competition to "get ahead" (Connelly, 1996; Waters & Saunders, 1996) and our shift toward "instant gratification" (Junker-Kenny & Tomka, 1999). We are not just witnessing, but participating in, fundamental shifts in our culture. Yet, not everything of human value can be judged on the basis of efficiency, cost efficacy, and marketing slogans (Sykes-Wylie, 1997).

In all areas of North American society, there seems to be a constant reminder that if we are not up to it, there are always people waiting to take over. However, being lured into competition with one another is not demonstrably in the interest of our communities (Coombs, 2001; Segal, 1999; Sennett, 2003). Yet, cutbacks, downsizing and this competitive culture can prompt us to situate ourselves as adversaries toward our colleagues. An effort to find a more compassionate way of relating can therefore seem oddly out of sync with such a dominant culture, even as "humanizing medical training" is one step identified by the American Medical Association for long-term prevention for the impaired physician (Dickstein & Elkes, 1986).

Mental Health Culture

The mental health culture in the United States and Canada can stress competition, as well as efficiency, cost-effective results (Pipal, 1995; McWilliams, 2005) and an armor that admits to no fatigue or weakness. It may be those individuals who thrive on taking on more and working longer hours (Grosch & Olsen, 1995) who are rewarded psychologically, while those who set personal limits lose favor.

The managed care (Donavan, Steinberg, & Sabin, 1994) approach which is so prevalent in modern health care emphasizes efficiency and verifiable treatment outcomes (Hoyt & Friedman, 1990). The complexity and seeming intransigence of some of the issues and circumstances that bring the client to the therapist challenge the tenets of managed care, in my opinion. The emphasis on rapid and accurate assessment, then discharge to a community program for follow-up (although none may exist due to their own cutbacks and downsizing) is a frequently troubling solution to complex illnesses and intractable social circumstances.

The power of the biological perspective in mental health (Madanes, 1999) with an emphasis on medication as the treatment of choice for a host of mental difficulties is predominant (Duncan, Miller, & Sparks, 2000). Providing information or medicines to a patient and family does not necessarily mean that they will comprehend or accept what is being said. Anger and desperation can be the response of clients seeking a cure to what ails them.

Along with a shift to expert assessment is a shift to specific treatment strategies developed according to an aggregate of symptoms and character traits grouped in various categories in manuals and diagnostic resources such as the DSM-IV (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 4th ed. 1994). Thus there is a growing emphasis on mastering and utilizing some manual-approaches (Yalom, 2002) while disregarding the value of traditional therapies that emphasize an interpersonal relationship (Anderson, 1997; Kaufhold, 2001) and attributes such as empathy, positive regard, and congruence (Rogers & Stevens, 1967).

Therapist Experience Factor

Life is changed irrevocably for those who must grapple with illness. Feelings that a client may experience with an emerging illness are frequently raw and intense. These include: despair, hopelessness, anger, and even rage at life's circumstances. It is the therapist's challenge to shepherd the individual and family through their initial experience of profound loss and grief to a manageable adjustment to whatever life has brought to them. The therapist is also changed by their exposure to the suffering (Tick, 1995), trauma (Solomon et al., 1992), and pain of others.

Individuals don't simply suffer a break, recover and move on in their lives. Periods or episodes of connection, then disconnection, inform client's lives as they experience their illness. This can prompt the fatigued or overwhelmed therapist to lose touch with their compassion for the client's experience, even to question their career (Palumbro, 2000). Therapists may interpret the client's responses as resistance or pre-contemplation (Prochaska, Norcross, & DiClemente, 1994) and rationalize that the client is not ready to be in treatment.

Additionally, no sooner does the therapist complete the process of working through these feelings with one client than they arise again as the thera-

pist meets a new client. The therapist's challenge is to be aware of their feelings and responses and to process them, not to deny or avoid them (Treadway, 1998).

RESPONSES TO WORKPLACE PRESSURES

An article in the *Canadian Journal of Psychiatry* examined stress leave in emergency medical service personnel (Regehr, Goldberg, Glancy, & Knott, 2002). A main conclusion of this review was that the primary factor in identifying those individuals who would take stress leave from their job had to do with personality. A number of pejorative descriptors were used to describe individual personality factors of people who tended to seek relief via stress leave. There was little attention in the study to changes in our society, or cutbacks in resources or any of the numerous other factors that could contribute to overwhelming the individual worker. This attitude of denigrating the worker and attributing vulnerability solely to personality factors inhibits our discussion of other factors that can contribute to the individual's incapacitation.

Individuals who gravitate toward the "helping professions" usually see themselves as helpers (Sussman, 1995), and gain personal esteem from this. The daily assault to one's frame of reference and identity as a therapist can have a cumulative effect (Pearlman & Saakvitne, 1995). A cycle of enthusiasm, to frustration and burnout can occur when therapists are feeling overwhelmed by multiple problems and a lack of resources and support (Rojano, 2004).

When therapists are not conscious of stressors the risk is that they will take them out on others (Treadway, 1998). These others may be family and they may be colleagues (Chessick, 1971; Merklin & Little, 1962). Worse yet, they may be clients (Mehlman & Glickauf-Hughes, 1994). Therapists can develop elaborate defenses to protect their identity (Lerner, 1995). Therapists can begin to feel and interact as clients do (Bohen, 2000). The sustained energy required to understand and process the client's actions in a therapeutic manner is challenging.

There may also be a tendency for us to tolerate harm done to our peers in the pursuit of our own interests (Coombs, 2001; Lerner, 1995). The rationale for such behavior may include advancement, self-protection, or survival. We are all diminished by such developments. The entire thera-

peutic community must be encouraged to become aware of not just their own experience but sensitized to the perspective of their colleagues (Lederberg, 1998).

SEEDING WORKPLACE COMPASSION AND CONNECTION

The focus on the above concepts and factors is intended to emphasize that unexamined interactions and patterns that emerge and become ingrained in our personal lives and our work cultures may lead to less compassion and connection in the workplace. There are steps that can be taken by therapists and organizations to create and facilitate a preferred work environment.

Individual Steps

1) There are voluminous resources regarding the importance of self-care, from physical, mental, emotional, and spiritual standpoints. The main texts referenced herein, including Figley, Pearlman & Saakvitne, and Sussman, all address self-care. There is considerable variability among individuals both in terms of preferred coping strategies and the relative efficacy of their coping efforts (Muldary, 1983). Accordingly, a sustained discussion of self-care ideas will not be undertaken in this article. Individuals and groups in an agency or program can review, personally and collectively, initiatives and activities that promote self-care.

2) We can commit to ethical practices in relationship to one another (White, 1997; Kaufhold, 2001; Anderson, 2001; Gergen, 2001; Sykes-Wylie, 1994). Such a commitment requires that we spend time talking about what constitutes ethical and fair practices. In a dominant culture that glorifies self-serving pursuits and sets therapists against one another in the persistent valuing of competitive practices, collaboration and connection may be casualties of the inevitable tensions that arise. It is a challenge to make a commitment to ethical practice.

This is not merely an abstract idea or a platitude that therapists will support in words but neglect in action. I think that this is a universal human challenge, to integrate personal ambition with our shared participation in a community. This challenge transcends generations. In fact, the early days of the American Revolution are described as "a magic time when virtuous

values flourished . . . private interests were surrendered to public ideals, and Washington himself stepped forward to embody the self-sacrificing spirit of '76" (Ellis, 2004, p. 168). The invitation to examine personal interest in the context of what is for the greater good of the work environment, and attempting to balance the two, is possible.

Raising this idea risks real tensions as therapists create a personal work regimen within the context of the communal work environment. These may include organizing advantageous work conditions for one therapist at the expense of another. There may be competition over scarce resources, such as access to hospital beds or community programs. The desire for career advancement or professional recognition can lead to less-than-harmonious collegial relationships.

To acknowledge that these tensions exist may prompt a rebuke. Therapists may take umbrage with the idea that an examination of ethical practices might be warranted. This does not erase the idea that these are complicated notions to contend with and all of us can err on the side of personal gain. A deliberate effort to examine these tensions and create some solutions to them can be achieved via a spirit of openness about what constitutes ethical practice in our interactions with one another. Yet, to enter into such a dialogue risks interrupting the status quo.

Perhaps a measure of the health of a work culture is the willingness to bring ethical practice to life by a commitment to the discussion that can unfold, a conscientious acceptance of personal accountability for one's actions and a desire to contribute to the shared dialogue where collaboration is honored and there is a collective sense of pride and contribution to the culture that evolves. Such steps involve an acknowledgement of, and commitment to, shared purposes. They are also consistent with the therapeutic principle of facilitating the client's exploration of their emotional and psychological state, and relationships.

3) How many individuals incorporate their values and contributions in the work place in the form of a mission statement? Some examples are the annual evaluation (Silimperi, Veldhuyzen van Zanten, & Miller-Franco, 2004) or goal setting that is common in organizations (Lombardi, 1988) and professional disciplines. This process is an opportunity to reflect on and share our personal purposes and intentions with one another.

At times, such a practice can seem tedious, as a necessary exercise to maintain one's professional certification. As such, the annual evaluation, including goal setting, can seem like an academic exercise, not actually brought to life in daily practice. Can this annual review become more

dynamic, galvanizing the therapist's sense of mission or meaning in their work?

If the work culture emphasizes the importance of this process of annual review and creates ways for therapists to share their respective missions as part of a community, that might encourage a renewed sense of vigor and meaning about the work. This is one of the ways in which connections are naturally formed—as therapists come together and in sharing their visions and interests realize that they are talking to a kindred spirit. Such a conscientious effort can enhance the sense of camaraderie and shared purposes in the work community.

Institutional Steps

1. Standards of practice that we are all familiar with may be casualties of the competing pressures we experience. Vaguely formulated treatment goals can contribute to therapists and clients feeling disillusioned or like failures (Spira, 1996). Responding to daily crises may cause our focus to drift. The practice of recalling and sharpening the original treatment goals and the proposed action plan can reduce this risk. It can also serve as a reminder to therapists about the purpose of their interaction with the client, potentially invigorating the treatment team.

2. Regular staff meetings can be utilized for collective self-examination (Syme, 1987). The combination of rapid pace, acuity, and expectation that a hospital or treatment agency can be all things to all people can contribute to a mandate drift. Reflection on the direction of the program and whether or not the program mandate is being met can guard against this drift.

Staff meetings can also be utilized for more informal, regular debriefing and processing of emotionally-laden experiences. For example, in the case example cited, there is an opportunity for therapists directly involved to talk about their experience in the volatile situation. This could be a source of support and confirmation for the therapists that they are not alone with whatever they are feeling as a result of the incident. Utilizing staff meetings to process feelings and address issues other than those related to clinical care can contribute to an atmosphere where therapists routinely process emotional material in an open manner.

This idea is utilized in many agencies and private practices in relation to critical incident debriefing. For example, a suicide of a client will prompt a critical incident debriefing for all therapists and community representatives involved in the case. However, anecdotal feedback follow-

ing such debriefings suggests that many therapists require more than the one session that is commonly employed to satisfactorily make sense of their feelings and reflections stemming from a completed suicide. Yet, these same therapists are reluctant to pursue further discussion openly for fear of how they will be perceived. The suggestion that an individual therapist seeks individual counseling following a critical incident risks promoting isolation for the therapist and may be less effective than providing a forum in which the therapeutic community can continue to examine their reactions to the death. Therapists counsel their clients not to carry their emotional pain alone. The same holds for the community of therapists.

3. Is effective supervision/consultation in place? Such supervision may be formal and hierarchical or it may involve a peer group (Counselman & Weber, 2004). It may be more palatable when thought of as mentoring. Recently, the concept of life coach (Williams & Davis, 2002) has emerged. However it is conceptualized, the commitment to being open about our work, being prepared to examine our efforts and to share our practices during the course of consultation can facilitate collaboration, thereby contributing to the development of a compassionate workplace. This requires that we be less well-defended psychologically. It demands a rigorous commitment to accountability.

4. Each of the above steps involves personal responsibility, but must be supported by a commitment at the leadership level of the program or agency in order to extend beyond small pockets to be alive across the whole culture. Balancing administrative, corporate, staff, and consumer interests is an enormous challenge for the leadership of a program or agency. This leadership has influence on the tenor of the work environment (Kernberg, 1984) and the commitment to espoused principles of the particular agency. It may seem obvious that sound leadership is a sine qua non of a healthy program. Yet, anecdotal reports suggest that a leadership vacuum can be surprisingly common for a variety of reasons which, nonetheless, leave the program or therapists in some jeopardy.

5. Just as with the individual therapist, the vitality of the program may be enhanced by the examination and articulation of its mission statement. A collective dialogue about the program mission meets the standard of keeping quality improvement on the minds of staff members (Pane, 2004). Involving all staff in developing a strategic plan and tracking the implementation of goals and objectives also meets best practice recommendations (Yeager, 2004) and increases the likelihood of success.

Again, this is not suggested as an academic exercise, but rather as a conscientious practice of bringing to life the mission of a program via shared dialogue and commitment by therapists who make up the work community. Putting these ideas into practice on a daily basis is the challenge, as it is with the client who moves from insight to action in their effort to change.

6. Notions introduced by Michael White related to making "a commitment to identifying and addressing the real effects or the consequences of one's actions in the lives of others" (White 1996, p. 150) can be applied to our relationships with colleagues just as much as to our interactions with clients. This notion is closely related to the emphasis on ethical practice. The focus is more precisely on our interactions with one another and the relationships that will evolve, separate from ethical practices and work conditions that can emerge from contract conditions of work and institutional policies. Efforts to achieve a consensus with respect to how we are going to treat one another will contribute to the creation of a preferred work environment (White, 1997; Sykes-Wylie, 1994). The more open dialogue about our practices and relationships with one another, as opposed to behind-the-scenes, sub-group discussions, can promote a sense of community and allow therapists to have the experience of contributing to the preferred culture.

GUIDING PRINCIPLES OF ENHANCING CONNECTIONS

There are two guiding principles I will offer to enhance connections and contribute to a compassionate work environment. The first guiding principle is making a conscious and deliberate effort to discuss the mission statement of the organization in concert with the mission statements of individual staff members in order to support a more coherent and compassionate work environment. The process of sharing values, purposes, and objectives, by discussing the respective mission statements, could enhance the sense of shared goals and community. A dynamic and sustained dialogue about our collective purposes and intentions as part of the work culture could satisfy the search for meaning that is a part of the human condition (Frankl, 1984).

As with the provision of excellent clinical care (Taffel, 1995), it is in the examination of our shared purposes, as well as the everyday details of how we interact with one another, that we make a difference in the kind of work

culture we create. Such practices could enhance social support at work, which can reduce job stress (Browner, 1987) and provide a sense of being cared about by others, a factor in counteracting burnout (Cronin-Stubbs & Rooks, 1985).

The second guiding principle involves extending the idea of acknowledging and honoring therapists' contributions more formally and routinely. Attention to our influences on one another and contributions to the culture of the work place might be protective against feeling devalued or marginalized. This approach is consistent with ideas expressed in the development of outsider witness groups, reflecting teams and definitional ceremony (White, 1999; Dulwich Centre Publications Conference Collective, 1999). For example, what if at the outset of a staff gathering we spent a few minutes turning to our colleague and speaking to them directly about one aspect of their work or character that we've been influenced by, that we appreciate about them or that inspires us in our own work. This can occur as a go-round at the outset of a meeting, with each person present speaking in turn to the person to their right or to their left, until all in the room have been included. Would the practice of speaking about our respective contributions to, and influences on one another, serve to renew and energize us, as well as lay the foundations for attending to one another in a manner that weaves a richer tapestry to our work culture?

A variation of this idea could be employed in the case example noted at the outset by utilizing a formal, written letter of appreciation to those staff involved in a challenging situation. In another predicament, involving police and hospital security attending at a therapy room when a client was threatening to jump from an upper floor window, the therapist and program manager sent a letter of appreciation to the involved staff and copied it to their respective managers. One manager responded in writing with their own appreciation for their service being recognized and commented on the "thankless" nature of much of their work in the hospital. The ripple effect was striking of acknowledging appreciations for the efforts of all concerned.

PRACTICAL EXAMPLES

The following are examples of efforts undertaken to contribute toward the creation of a compassionate work environment where there is a sense of connection. At times the described practices have been utilized in an

effort to diminish the deleterious symptoms described earlier in this article. At other times they have been intended to establish or enhance a compassionate culture and strengthen collegial connections.

In-service Program Promotes Colleague Connection

An in-service workshop was offered on the implications of compassion fatigue and vicarious traumatization by one program to the mental health community. By preparing and being involved in the in-service, participants experienced a great deal of professional stimulation. This stimulation was replicated in the audience (of about 100) who engaged in a lively discussion during the dialogue portion of the in-service. A stress survey that was completed by a majority of the participants indicated that many were experiencing high levels of stress at work. Several therapists spoke of colleagues on stress leave—in each instance to the surprise of other staff. In the feedback that followed the in-service the staff of at least three other programs stated their plan to address some of the implications of this subject, including how to facilitate a greater awareness among staff of stress and how to combat these symptoms.

Participants in the in-service discussed the mission of the host program, as well as ways they could acknowledge and support colleagues on a daily basis. Case examples similar to the one described at the outset of this article, involving aggression or demeaning characterizations of therapists, were addressed more openly following this in-service. Therapists anecdotally reported a significant after-life to their positive experience of the in-service and that they also experienced a stronger sense of connection to colleagues.

Interviewing Staff Examines Personal and Program Mission

An interview of two or three therapists during a staff meeting, with other staff serving as an audience, has been employed. The focus of such an interview can be open-ended or specific. For example, this is one way to introduce examination of the mission of the program. Once the initial therapists have been interviewed regarding what stands out to them about the work culture in recent months, or their sense of how they are meeting their personal goals, the audience can be interviewed about their responses and impressions. Anecdotal feedback following such an exercise has been posi-

tive. Therapists have also noted that such an exercise is good practice for serving as a reflecting team member in therapy sessions.

A Reflecting Team Confronts Disharmony

In another situation where there were strongly divergent and divisive opinions on a therapy team about a clinical case, an interview of a small therapist group with a reflecting team drawn from the same program staff was utilized to address the contentions and disharmony that had emerged. Utilizing a reflecting team process within the therapy team created sufficient space to allow therapists to reflect collectively on the process that had unfolded and to examine how they would prefer to address such differences differently in the future. Therapists involved agreed that the demarcations and hurt feelings regarding the sides taken in the specific case were nullified and there was an increased sense of connection to one another.

A Witness Audience Reduces Program Tension

A program situation where a group of vocal adolescents were disparaging the collective efforts of therapists used a variation on the outsider-witness group. This involved having the teens serve as the witness audience behind a one-way mirror while the therapist group was interviewed about their work, their values, their respective commitment to the program, and their reactions to the conflict that was unfolding with their clients. A community meeting had already been held to resolve the dilemma, with negative results. Time was spent in preparation for the interview among the therapists and with the adolescent client group. (The adolescents were all familiar with some aspects of observation and reflections as a result of their program participation in a psychotherapy group). In the second phase of the interview with the adolescents they spoke about their new appreciation for the dilemmas experienced by the treatment staff. The outcome included a significant decrease in the tension between therapy staff and the client group in this particular instance. Of note, the involved therapists each also stated a willingness to participate in any such future exercise.

In each example, the reservations initially noted by therapists about vulnerability were overcome as a result of participating in the process.

A sense of stronger connection to colleagues was reported, as was a sense of pride regarding the willingness to participate in an exercise intended to reduce tension, create mutual understanding, and replicate the expectations that therapists have of clients for participating in their treatment.

CONCLUSION

Therapists are routinely stretched in their efforts to attend to client needs. This hinders reflection on the social pressures of the work culture. Scores of therapists will speak in smaller groups about the impact of these pressures and their desire for more open dialogue among colleagues about the impact of the myriad experiences inherent in the work culture. It is not easy to step back from these pressures to first reflect, then to open our minds and hearts to one another. The intention in this paper is to sharpen our attention to daily details that therapists can participate in to create compassion and connection in the work place.

It is a constant challenge to keep the principles of our training in the helping professions in front of us. Are we living our professional lives in the manner we intended and in a manner which is consistent with our values and purposes in this life? Many therapists seek an increased opportunity to make the connections so necessary to the creation of a compassionate work environment. It is in these connections with our clientele and with each other that we will bring the greatest benefits to our clientele, and ultimately find our solace.

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