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International Journal of Trauma Research and Practice

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Over the last 20 years, issues of trauma have become more visible in the mainstream consciousness. As military personnel come home from combat, natural disasters become more violent, and large scale terrorist attacks impact the United States, the everyday person has developed a more sophisticated understanding of the impact of trauma. While trauma professionals have long known the wide-ranging impact of trauma on the American public, until recently trauma has been seen as an individual “problem” that needs to be solved.

In recent national Adverse Childhood Experiences (ACE) surveys it has become clear that individuals with traumatic stress issues can no longer be considered exceptional – they have become the norm. Several states have reported that 40-60% of children have been impacted by trauma and, according to UNICEF, these figures are consistent throughout the world. Traumatic experiences are now the rule – the majority of children and adults in the United States have had some kind of trauma experience. This number may be larger if we include secondary exposure to trauma.

Trauma has become a major health, education, and economic issue in the U.S. We hope that this publication will be a call to action for trauma professionals and others working with trauma-impacted populations. To begin to address wide-ranging issues of trauma, we hope to not only incorporate papers from the field of trauma studies, but also from the fields of education, law, health care, and psychology. Through a combination of empirical research, case studies, and cutting edge work in the field, this journal is an attempt to disseminate information in an accessible way. We believe that by spreading a sophisticated understanding of traumatic stress issues and interventions, we can help educate about traumatic stress both within and outside the therapeutic community. Again, we issue a call to action for trauma professionals to share this vital work with the community at large.

This inaugural issue of the IJTRP focuses on the relationship between trauma, anger, and violence. Powell and Dubi in their paper, “Treating the Angry Brain”, look at the brain mechanisms involved in anger and also present research-based treatment options. The study of anger in the Minnesota prison system represents the best type of empirical research and clearly illustrates the need for long-term embedded research. The authors present a new direction for treating angry and violent individuals.

Also in this issue, both the articles by Byczate and Legget and by Norton, Woods, and Brown address the issue of secondary trauma. Individuals who counsel victims of violence and people involved in criminal trials involving violence are often secondarily impacted by that violence. Those on the front lines of trauma often do not clearly understand how they can be impacted by issues of violence. Bob Rhoton in his case study, “The Stalking Wife,” explores how to work with themes created by a history of repeated dysregulation in relationships.

IJTRP is prepared to place itself at the center of trauma research and practice to educate both the professional and lay community.
Minnesota AVP Anger Study
Terry Kayser, Laura Roberts, John Shuford, John Michaelis

Problem and Purpose of Study

There is a great need in America’s prisons for effective programming that can teach inmates how to resolve conflicts without violence (Saunders, 2006). The purpose of this study was to examine a popular program called Alternatives to Violence (AVP) that was designed to achieve the goal of teaching people, in this case, prison inmates, to solve conflicts with prosocial strategies rather than with fighting and violence. We reasoned that a key first step to teaching inmates to choose prosocial over violent strategies was to reduce feelings of anger that are often stimulated during conflict situations. Thus, the purpose of this study was to test whether inmates who participated in AVP exhibited reductions in feelings of and expression of anger.

Introduction

History of the program. The Alternatives to Violence Project began in 1975 at Green Haven Prison in upstate New York. It started mostly as lecture and role play and has evolved into the Full Emersion Experiential Training [FEET] design that it is today. There have been over 15,800 workshops completed in the U.S. alone impacting over 230,000 individuals, 85% in prisons. Last year in the U.S., there were 983 workshops in prisons with 15,085 participants in 27 states facilitated by 807 inmate and 598 outside volunteer facilitators in 94 prisons. AVP has spread around the world and has been used in Central Africa to heal from genocide, Latin America to heal from civil war, Australia to reduce bullying in schools and as a college course [150,000+ students have enrolled] in South Africa and Kenya to reduce and heal from violent conflict and in Russia to bring communities together. In fact, the Russian Ministry of Prisons requested a six-page article on AVP be written for its professional corrections journal; it was the only time a foreigner had had an article published in that journal. More recently in 2012, trainings were held in Afghanistan with women who wanted to prepare themselves for a male dominant government run by the Taliban.

Further, AVP and AVP facilitators have received the U.S. President’s “1000 Points of Light Award,” the “Order of Australia,” the International Association of Correctional Training Personnel’s “2004 Award of Excellence,” the Delaware Center for Justice’s “2011 Exemplar of Justice Award,” the 2012 Delaware Governors Outstanding Volunteer Program award, nomination for the Presidential Citizens Metal, and has been featured on NPR, the New York Times and Atlantic Monthly.

AVP is an 18-20 hour program, typically held over a three-day period with both the facilitators and the participants being volunteers. Some prisons and judges mandate inmates to take the program, and it does not change the impact of the workshops. The workshops are fun, engaging, connecting and transformational. Even those with a resentful and/or hostile attitude about taking the training soon forget their hostility and fully engage in the experience. Because of its impact on motivation, AVP has been used prior to or in conjunction with other programs to improve the impact of those programs.

The AVP training model has also been used to train governmental employees [teachers and social workers] and correctional staff in the USA and around the world, although not always on a volunteer basis. Of the 2,000 plus prison staff of the Philadelphia Prison System who were mandated to take the training [50% did not want to take the training and 25% were openly hostile], 70% said it was excellent and 27% said it was good in the post training evaluation, for a 97% positive evaluation. Even six months after the training with no other follow-up training or refresher program, 82% stated they were using the skills with co-workers [the focus of the training] and 71% were using them with superiors. Of special interest is that
even though the focus of the training was only on co-workers, 71% were using the skills with inmates and 84% were using them at home with their families. The importance of this last statistic is quite significant when considering the recent research findings that correctional personnel have an alarmingly high rate of PTSD [double that of Viet Nam and Iraq veterans], a significantly shorter life expectancy than other professions [58 years, on average], a high suicide rate [double that of police], major depressive disorder and many other health issues.

Description of the program. Many training models offer experiential skills training, but what sets AVP and the Full Emersion Experiential Training model apart is the creation of an emotional climate of safety based on honesty, respect and caring that is at the beginning of every workshop. This emotional climate of safety enables participants to effortlessly lower their barriers and defenses, opening them up to honestly see themselves, their behaviors and the consequences of their behaviors, as well as be receptive to new attitudes and interpersonal skills. As one inmate put it, “That we are all the same beneath all that life has given us to experience. That no matter what persona or mask we wear, we can be reached, loved, and healed. Only a group of this nature can provide us with the safe environment to remove this mask.”

One result of this is that participants take responsibility for their actions, as indicated by a letter from a prison psychologist about an inmate in her sex offenders group who had flatly stated that his encounter with another person “...was consensual sex,” and when he returned to the group after an AVP weekend, he admitted it was, in fact, rape. An individual’s charges or legal situation are never discussed in a workshop, so the facilitators would not have known the individual was in a sex offenders’ group. The individual took personal responsibility without ever having been asked to. It is part of the process of AVP, to take personal responsibility for our actions and our thoughts. This emotional climate of safety along with “transforming power” as an attitude changing element are part of every workshop, even though the other exercises and activities from the manuals are tailored to each situation. Transforming Power, as a core element, is that power within every person to change his/her attitude, which changes her/his outlook on self, others and life in general and thus, they as well as their relationships are transformed.

Qualitative evaluations of the program from corrections officials. Comments such as the following from corrections officials are common:

Your program has been a mainstay contributing to the lowering of violence in the Facility. Time and again, we have witnessed the effectiveness of the Alternatives to Violence Project through changed behavior of inmates, who might otherwise have committed violent acts which would have lengthened their period of incarceration. We have no substitute program; we must rely on you and your staff for this vital support. Philip Coombe, Jr., Superintendent, Eastern Correctional Facility, New York.

I saw AVP facilitate a dramatic reduction in the number of assaults between inmates in what had been a difficult maximum security unit. As the program continued to run and “graduate” more and more inmates, the overall climate improved to a point where the inmates were actually seeking out ways to positively affect their living environment. I’ve seen similar results in each of the prisons that have implemented AVP. There have never been any security breaches and the staff and inmate population alike respect the AVP volunteers. I’d highly recommend AVP to any correctional manager and especially to those experiencing a high level of inmate on inmate conflict. Stan Taylor, Commissioner Delaware DOC.

Comments from corrections officials about staff trainings:
It is generally thought to be the best training program that staff has participated in. The labor
unions are strong supporters of it and employee grievances have dropped to an all-time low.
Thank you for helping us change the culture at MCI. It is the best investment of resources
that we have ever made. Chris Money, Warden, Merion Correctional Institution, Ohio.

Words cannot express the value of the training you have conducted at the Academy. The
impact your training has had on my staff is remarkable. After the first training workshop,
there was a definite change in attitude and I saw a cohesive bond develop between many of
my staff. Your training addressed the Academy’s need to have our supervisors better en-
abled to motivate and lead line staff. I am constantly amazed at the transformation our staff
experiences during the training sessions. There is actually a paradigm shift from the rigid-
ity and inflexibility ingrained in Corrections, to the understanding and acceptance of the
value of community and teamwork. Craig Conway, Director, New Jersey Office of Training.

AVP participation and anger. Although AVP has a long history of effectiveness and many testimo-
nials from participants and officials, as well as research on recidivism, violent attitudes and behavior, it was
felt a study on the links between AVP participation and anger would be beneficial. We were looking for
data to support or refute the theory that AVP participation would bring about reductions in inmates’ feel-
ings of anger. Thus, AVP Minnesota engaged in such a study. We measured changes in the levels of anger
with the State–Trait Anger Expression Inventory–2 (STAXI–2) with inmate participants before and after the
Basic workshop, after the Advanced workshop, after the Training for Facilitators and a follow-up two years
later. The results of this study are presented in this paper.

Description of research instrument. The State–Trait Anger Expression Inventory–2 (STAXI–2) is a
57-item inventory which measures the following: (a) the intensity of anger as an emotional state (State An-
ger); (b) the disposition to experience angry feelings as a personality trait (Trait Anger); (c) the frequency
with which angry feelings are expressed inwardly and outwardly (Anger Expression); and (d) the frequency
with which anger is controlled inwardly and outwardly (Anger Control). The scales and subscales are:

State Anger. These three scales measure the intensity of anger being experienced at the time of test-
ing or at a time specified by the test administrator. The three scales are as follows:
1. State Anger Feelings: measures the intensity of angry feelings currently being experienced.
2. State Anger Expression Verbal: measures the extent to which the individual feels like expressing
   her/his anger verbally during the testing situation.
3. State Anger Expression Physical: measures the extent to which the individual feels like expressing
   his/her anger physically during the testing situation.

Trait Anger. These two scales measure the individual’s predisposition to become angry, with or
without provocation. The two scales are as follows:
1. Trait Anger Temperament: measures anger that is expressed quickly and with little provocation
   and has little to do with situational factors, e.g., someone described as an angry person or having a hot-
   headed tempermenat.
2. Trait Anger Reaction: measures the tendency to become angry when the individual is criticized,
given negative feedback or believes has been treated badly or unfairly. It does not matter if the events are
real, imagined or unintended; it is the person’s perception that is important.

Anger Expression. These three scales measure the tendency to express anger inwardly or outwardly.
The scales are as follows:
1. Anger Expression Index: measures the overall tendency to express anger outwardly toward other
people or inwardly toward self.

2. Anger Expression Out: measures how often angry feelings are expressed in verbally or physically aggressive behavior.

3. Anger Expression In: measures how often angry feelings are experienced but suppressed or turned inward.

*Anger Control.* These two scales measure the control of inward and outward expressions of anger (these scales are in reverse, the higher the better). The scales are as follows:

1. Anger Control Out: measures the expenditure of energy to monitor and control the physical or verbal expressions of anger.

2. Anger Control In: measures how often the individual attempts to relax, calm down and reduce angry feelings before they get out of control.

**Results**

*Question 1.* Did inmates show a drop in anger after taking a Basic workshop? Table 1 shows each pair of mean scores before and after the inmates participated in the Basic workshop. For example, SAF pre is the pretest score (before the Basic workshop) for State Anger Feelings; SAF post is the posttest score (after the Basic workshop) for State Anger Feelings. Table 1 also shows a drop in anger for State Anger Verbal Expression (SAV at pretest to SAV at posttest). Moreover, there was a drop in anger for State Anger Physical Expression (SAP at pretest to SAP at posttest). As shown on the table, scores tend to drop from pretest to posttest, indicating a drop in anger. This pattern was also observed for Trait Anger Temperament (TAT) and Trait Anger Reaction (TAR) and for Anger Expression Out (AXO) and Anger Expression In (AXI).

The Anger Control Out (ACO) and Anger Control In (ACI) scores went in the opposite direction from the other anger scores. They showed gains from pretest to posttest, which means the scores actually show an increase in outward and inward control. Not only did the anger drop, but the outward control increased, meaning participants learned to control their outward expression of anger toward others and internal controls increased, meaning they learned to calm themselves down.
Table 1

Paired Samples Statistics

<table>
<thead>
<tr>
<th>Pair</th>
<th>Subscale</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
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<td>SAF pre</td>
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<td>67</td>
<td>4.19</td>
</tr>
<tr>
<td></td>
<td>SAF post</td>
<td>6.70</td>
<td>67</td>
<td>2.94</td>
</tr>
<tr>
<td>Pair 2</td>
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<td>7.96</td>
<td>67</td>
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</tr>
<tr>
<td></td>
<td>SAV post</td>
<td>6.16</td>
<td>67</td>
<td>2.23</td>
</tr>
<tr>
<td>Pair 3</td>
<td>SAP pre</td>
<td>6.52</td>
<td>67</td>
<td>3.03</td>
</tr>
<tr>
<td></td>
<td>SAP post</td>
<td>5.36</td>
<td>67</td>
<td>1.45</td>
</tr>
<tr>
<td>Pair 4</td>
<td>TAT pre</td>
<td>7.60</td>
<td>67</td>
<td>2.91</td>
</tr>
<tr>
<td></td>
<td>TAT post</td>
<td>6.00</td>
<td>67</td>
<td>1.70</td>
</tr>
<tr>
<td>Pair 5</td>
<td>TAR pre</td>
<td>8.63</td>
<td>67</td>
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</tr>
<tr>
<td></td>
<td>TAR post</td>
<td>7.30</td>
<td>67</td>
<td>2.07</td>
</tr>
<tr>
<td>Pair 6</td>
<td>AXO pre</td>
<td>16.21</td>
<td>67</td>
<td>4.40</td>
</tr>
<tr>
<td></td>
<td>AXO post</td>
<td>15.10</td>
<td>67</td>
<td>3.87</td>
</tr>
<tr>
<td>Pair 7</td>
<td>AXI pre</td>
<td>18.61</td>
<td>67</td>
<td>4.64</td>
</tr>
<tr>
<td></td>
<td>AXI post</td>
<td>16.96</td>
<td>67</td>
<td>4.87</td>
</tr>
<tr>
<td>Pair 8</td>
<td>ACO pre</td>
<td>21.57</td>
<td>67</td>
<td>5.63</td>
</tr>
<tr>
<td></td>
<td>ACO post</td>
<td>24.64</td>
<td>67</td>
<td>5.52</td>
</tr>
<tr>
<td>Pair 9</td>
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<td>21.36</td>
<td>67</td>
<td>5.90</td>
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<tr>
<td></td>
<td>ACI post</td>
<td>24.70</td>
<td>67</td>
<td>6.04</td>
</tr>
<tr>
<td>Pair 10</td>
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<td>39.90</td>
<td>67</td>
<td>15.32</td>
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<tr>
<td></td>
<td>AXIndex post</td>
<td>30.72</td>
<td>67</td>
<td>16.54</td>
</tr>
</tbody>
</table>

**Question 2.** Was the change in anger from pretest to posttest (before and after taking the Basic workshop) a significant change? In order to answer this question, we conducted a series of paired t tests to answer the question. The results are given on Table 2. The p value or probability value in the right hand column shows whether the change was significant for each subscale. If the p value is less than .05, it is considered a significant effect. If the p value is greater than .05, it is considered a non-significant effect. With the exception of AXO, all effects were significant. AXO was very close to being significant.
Table 2

Subscale Significance Statistics

<table>
<thead>
<tr>
<th>Pre minus Post Basic</th>
<th>m</th>
<th>SD</th>
<th>t</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAF</td>
<td>1.87</td>
<td>4.72</td>
<td>3.24</td>
<td>66</td>
</tr>
<tr>
<td>SAV</td>
<td>1.79</td>
<td>3.91</td>
<td>3.75</td>
<td>66</td>
</tr>
<tr>
<td>SAP</td>
<td>1.16</td>
<td>2.77</td>
<td>3.44</td>
<td>66</td>
</tr>
<tr>
<td>TAT</td>
<td>1.60</td>
<td>2.33</td>
<td>5.61</td>
<td>66</td>
</tr>
<tr>
<td>TAR</td>
<td>1.33</td>
<td>2.81</td>
<td>3.86</td>
<td>66</td>
</tr>
<tr>
<td>AXO</td>
<td>1.10</td>
<td>4.61</td>
<td>1.96</td>
<td>66</td>
</tr>
<tr>
<td>AXI</td>
<td>1.66</td>
<td>4.61</td>
<td>2.94</td>
<td>66</td>
</tr>
<tr>
<td>ACO</td>
<td>-3.07</td>
<td>6.01</td>
<td>-4.19</td>
<td>66</td>
</tr>
<tr>
<td>ACI</td>
<td>-3.34</td>
<td>6.75</td>
<td>-4.05</td>
<td>66</td>
</tr>
<tr>
<td>AXIndex</td>
<td>9.18</td>
<td>16.48</td>
<td>4.56</td>
<td>66</td>
</tr>
</tbody>
</table>

**Question 3.** How large was the effect of the Basic workshop on anger? We addressed this question by first computing Cohen’s d statistics to gauge the effect of the Basic workshop. A d statistic less than .3 is considered small, between .3 and .5 moderate, and larger than .5 is a large effect. Table 3 shows that most effects were moderate in size with the exception of TAT, AXIndex, ACI, and ACO which had large changes and AXO change which had a small change. Note that the change for the anger control scales (ACI and ACO) were in the negative direction. This was because pretest scores were lower than post test scores. We computed Cohen’s d by subtracting posttest scores from pretest scores. Increases in the anger control scales mean the participants learned how to control outward expressions of anger and also learned to calm themselves down.
Table 3

Effect Sizes for STAXI Subscale Change Scores

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Effect Size</th>
<th>Cohen’s $d$ statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAF change</td>
<td>moderate</td>
<td>0.40</td>
</tr>
<tr>
<td>SAV change</td>
<td>moderate</td>
<td>0.46</td>
</tr>
<tr>
<td>SAP change</td>
<td>moderate</td>
<td>0.42</td>
</tr>
<tr>
<td>TAT change</td>
<td>large</td>
<td>0.69</td>
</tr>
<tr>
<td>TAR change</td>
<td>moderate</td>
<td>0.47</td>
</tr>
<tr>
<td>AXO change</td>
<td>small</td>
<td>0.24</td>
</tr>
<tr>
<td>AXI change</td>
<td>moderate</td>
<td>0.36</td>
</tr>
<tr>
<td>AXIndex change</td>
<td>large</td>
<td>0.56</td>
</tr>
<tr>
<td>ACI change</td>
<td>large</td>
<td>-0.51</td>
</tr>
<tr>
<td>ACO change</td>
<td>large</td>
<td>-0.50</td>
</tr>
</tbody>
</table>

Conclusion

All subscales showed change in the predicted direction and, with one exception, all subscale changes were significant. These findings provide support for the theory that the use of AVP can reduce anger and that, with regard to trait level anger, these changes persist over time. The one exception to the general conclusion pertained to the subscale: Anger Expression Out. This subscale showed a small change that was on the border of being significant.

As shown in Figure 1, the State Anger score, or level of anger at the time of taking the inventory, showed a moderate reduction after taking the Basic and Advanced workshops, but subsequent to that, rebounded by the time of the two-year follow-up. This increase over time may be explained because of the toxic environment inmates live in and correctional staff work in, which tends to wear down one's resistance. As an indicator of the level of toxicity in the prison environment, it should be noted that research shows 34% of correctional officers have PTSD, 34% experience Major Depression Disorder\textsuperscript{10} and they have a suicide rate double that of police.\textsuperscript{11} The toxic environment is wearing on both inmates and staff.
The Trait Anger score is the most important of the subscales, because it indicates a more permanent change in the individual's predisposition to anger. Figure 1 also shows the Trait Anger score showed a large, significant reduction ($p < .0005$) and remained low at the two-year follow-up. The trait score dropped from 20 to 15. In comparison, the norming score for the test was 18.4, which is a typical trait anger level for people outside the prison community. Thus, the pre-AVP trait score started well above the trait anger level for the non-incarcerated community. After AVP participation, trait anger dropped significantly and remained low at the two-year follow-up. This is especially notable given that the inmates were still living in a toxic environment. Also, the Anger Expression Index, which measures an individual's tendency to express his/her anger outwardly toward other people, or inwardly toward himself/herself, showed a large and significant reduction ($p < .0005$). Further, the two Anger Control scores, which relate to coping skills, showed large improvement ($p < .0005$). These scores indicate a long lasting positive change in attitude and coping skills.

These results support findings in other studies on AVP, which show that AVP is linked to reductions in violent attitudes, inappropriate behaviors, and recidivism. Thus, AVP should be given serious consideration by corrections officers seeking to bring about improvement among inmates who have anger problems. Moreover, corrections officers should consider implementing AVP with inmates who have a pattern of resolving conflicts by using violence.

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Footnotes


References


Female Therapists’ Experiences of Burnout While Providing Treatment for Domestic Violence

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Abstract

American women receive multiple messages regarding appropriate gendered roles in Western culture. Many of these messages encourage self-sacrifice in which women adapt more passive, care-taking roles. Female mental health clinicians are not immune to these messages which may impact their susceptibility to burnout. The current research examines the experiences of female mental health professionals in a small mental health agency. Specifically examined were participants’ experiences of burnout, support, self-care, and struggle related to working with a clinical population with high trauma. Two in-depth interviews and four hours of observations of staff at the agency were completed. The major themes identified were: personal stressors, work related stressors, self-care coping strategies, experience of burnout, and supervision. Sub-categories that emerged were: social support, stressors related to clients, stressors related to relationship with co-workers, and stressors related to relationship with Executive Director and with policy. Phenomenological analysis of observation data provided triangulation of interactions among office staff, and interactions among therapists. Clinical, research and agency implications were explored with recommendations for supervisors and agency development provided.
Introduction

Mental health professionals often encounter the symptoms associated with burnout. Burnout is comprised of exhaustion, cynicism and a decreased sense of self-efficacy (Lambert & Lawson, 2012; Maslach, 2003). A prolonged period of inadequate resources and excessive demands creates the environment for burnout (Lambert & Myers, 2011; Lambert & Lawson, 2012). Women in the counseling profession are at a unique risk for burnout due to societal pressure to fulfill the demands of their profession, families, and communities.

American women receive multiple messages delivered by parents, teachers, and other well-meaning individuals regarding their deportment and appropriate roles in society (Maccoby, 1990, as cited in Hibbard & Buhrmester, 1998). Girls receive messages early in life that shape their concept of feminine roles. These messages encourage women to adopt nurturing and passive roles. Adoption of these roles, such as self-sacrifice and pleasing others, may come at a high cost (Ruble, Greulich, Pomerantz, & Gochberg, 1993; as cited in Dedovic, Wadiwalla, Engert, & Pruessner, 2009). Dedovic and colleagues described the higher levels of stress in response to these demands. Many women believe they must competently complete every task that is asked of them, whether or not they have the necessary resources to meet all of the demands. The belief emerges that the well-being of everyone else comes first. Women fear that focusing on self-care when faced with other societal expectations would be judged as selfishness or indifference (Baila, 1990). Women feel pressure to excel in their roles at home, at work, and in their relationships. Although in the United States, women are becoming a larger segment of the workforce and gaining independence, these conflicting messages influence the ways they view themselves and their responsibilities (Mensinger, Bonifazi, & LaRosa, 2007).

Female mental health professionals are also susceptible to such societal messages and the subsequent effects. They are in the unique position of working within these gender roles and in a profession that is becoming more feminized. Diamond (2011) explained that men began departing the profession due to lack of status and power to find better paying jobs which opened these positions to women. The flight of men was not only due to dwindling resources, but also increased managed care demands to take on more clients in less time. Therapists must focus on productivity and job performance even though the inherent description of therapy is to be genuine, caring, and empathic. The emphasis to be congruent and present with each client, and to create effective therapeutic relationships, conflicts with the increased demands on therapists’ time and energy. Women have assimilated the message that increased demands necessitate increased self-sacrifice. Female therapists feel they must fulfill the demands of expanding caseloads and pressures of their personal lives, often resulting in decreased attention to self-care. The pressure to meet conflicting demands leads to a lack of healthy boundary setting further jeopardizing personal well-being.

Regardless of gender, the prevalence of burnout among therapists is a serious issue (Jenaro, Flores, & Arias, 2007). Although it is desirable to aim to achieve in one’s career, the minimizing and devaluing of one’s personal needs and care comes at a high cost. This experience can manifest into therapists feeling
helpless, lonely, anxious, and depressed while negatively impacting the care they are able to provide for their clients (Conrad & Kellar-Guenther, 2006). Individuals experiencing burnout feel cynical, emotionally and physically exhausted, and less effective (Maslach, 2003). When therapists were asked to describe colleagues who they believed were experiencing burnout, Ericson-Lidman and Strandberg (2007) found five themes including: (a) struggling to manage alone, (b) showing self-sacrifice, (c) struggling to achieve unattainable goals, (d) becoming distanced and isolated, and (e) showing signs of falling apart. This is often the consequence of the lack of resources and increasing demands over a long period of time (Lawson & Myers, 2011). While therapists may be able to foster self-care for their clients, they may be less able to recognize that need in themselves and to implement coping strategies. When addressing burnout, therapists tend to focus on the use of individual coping strategies. Healthy coping and self-care strategies often include active participation in supervision, balance between work and personal life, and utilization of stress management methods such as relaxation (Lambert & Lawson, 2012). This implies that those who feel traumatized or burned out may not balance life and work adequately and may not make effective use of leisure time, self-care, or supervision. A structural approach may provide an additional solution (Kahn, 1993) through more social support to assist those who do not recognize burnout in themselves (Ericson-Lidman & Strandberg, 2007).

Increased structural support may be beneficial in agencies dealing primarily with trauma. Female therapists who do not receive adequate support may be at increased risk for secondary or vicarious trauma when working with clients (Sprang, Clark, & Whitt-Wosley, 2007). When prolonged exposure to trauma occurs without individual self-care and structural support, therapist burnout is a likely result. When these therapists have also experienced personal trauma, they are more likely to experience compassion fatigue, which impairs their ability to provide adequate care to clients (Figley, 2002). With the multiple negative effects from these experiences, it is vital for the mental health profession to gain a better understanding of ways to decrease burnout and increase the use of supportive strategies (Lawson & Myers, 2011).

The purpose of this study was to gain a better understanding of how female therapists experience burnout, and to identify factors associated with increased feelings of support (or lack thereof) within a small community mental health agency. In this exploratory study, the researchers set out to discover how female mental health professionals manage the multiple stressors and pressures they encounter in their lives. Data were collected via two in-depth interviews and four hours of observations that focused on not only the individuals in the agency but also the effect of the agency on the individuals.

Methods

Participants

The agency in which both the interviews and observations took place was chosen due to its size and population served. The agency is a small not for profit community mental health agency in the Midwest that primarily works with lower income clients and clients who are involved with domestic violence situations. The agency had a total of five full-time therapists, two part-time therapists, and (at the time of the study) one Master’s level intern. The services offered at the agency include individual, couples, and family counseling (including services for domestic violence victims) and group therapy for domestic violence offenders.

Two female Master’s level therapists working full time at the community mental health agency were interviewed; all seven therapists, one intern, and two front desk office staff were observed. The therapists worked primarily with domestic violence issues, both with female victims and male perpetrators in both individual and group settings. Of the participants who were interviewed, one had been employed by the agency for approximately nine years, and served in a supervisory capacity. The other therapist had only
worked fulltime at the agency for six months, but had also worked part-time at the agency for the previous two years. The remaining therapists who were observed were Master’s level clinicians who worked full time and one part time intern from a Clinical Mental Health program. As they did not consent to interviews, no other demographic data were collected on them. Support staff worked full time responding to telephone calls, handling appointments, filing documents, and notifying clinicians of arrivals.

**Measures**

Eleven questions were developed based on a literature review of the topics of burnout and vicarious trauma. These questions were used to investigate the experiences of the two therapists interviewed. Sample questions include “What is your overall stress level?” and “What methods of coping do you feel help you to avoid feeling burned out?” The questions are attached in the appendix.

**Procedure**

The therapists were informed how the information would be used when they were solicited for the study. The participants consented to the interview and allowed the head researcher to take written notes of their responses. Both interviews lasted for approximately 90 minutes. The Executive Director of the agency agreed to allow four hours for the observations. Observation was discussed in the staff meeting so all employees were informed and allowed to decline participation if they so desired. All employees consented to the observations. The observations took place over four periods, two in the evening, and two in the morning. The Executive Director requested that observers sit at the front desk area. This ensured clients’ confidentiality while providing the observer with insight into how the support staff interacted, and what the therapists would say when they were at the front desk area.

**Results**

**Interviews**

The interviews were transcribed and the data were coded and examined across questions. Five major themes emerged, including: personal stressors, work related stressors, self-care coping strategies, experience of burnout, and supervision. Within these five major themes were sub-categories including: social support, stressors related to clients, stressors related to relationship with co-workers, and stressors related to relationship with Executive Director and with policy.

The personal stressors theme included those that were not work related, but that affected the participants’ experiences of burnout and self-care. The interviewees discussed how personal factors had hindered their ability to care for themselves and increased their overall stress level. Examples of some personal stressors mentioned included involvement in a long distance relationship, home life, financial stress, travel time, and trying to move. One of the interviewees stated, “Financial strain and wanting to move has been affecting my stress level recently. I want to have babies and I do not want to have them here. This stress can distract me when I am here at the office.” This statement also demonstrates the presence of the discrepancy that many women experience between wanting to start a family while maintaining a career.

Work related stressors included stress that was directly related to the experiences at the interviewees’ current job (work related stress to clients, to coworkers, and to the Executive Director and the Agency). General work related stress included position specific stressors. For example, the Head Therapist at the agency is in charge of most of the programmatic responsibility including organization of outreach programming in different schools and grant writing. This therapist discussed how this added responsibility increased her stress level due to the difficulty balancing task responsibilities.

The sub-category of stress related to clients included the unique stressors and challenges faced by the
interviewees working with domestic violence clients. The interviewees both agreed that working with clients with domestic violence concerns adds another layer of stress to community mental health work. One interviewee discussed her struggles working with male perpetrators, stating, “I have to remember that the men are human and this can be difficult after working with victims for so long. I sometimes wonder if I am even teaching them anything. It gets difficult after you see the same men returning over and over.” Additional stress is related to working with female victims, as illustrated in the statement, “Having to tell a woman that if she stays in her current relationship she will probably die and actually fear that this is true is very stressful. I know there is only so much I can do, but when they don't come back I can't help but worry that this fear came true.” Both of the interviewees described similar experiences related to these unique stressors and yet were not aware of specific self-care strategies for working with this population or knowledge of vicarious trauma of clinicians or compassion fatigue.

Although the majority of responses about co-workers were positive—identifying them as essential support—some noteworthy examples emerged in which co-workers were identified as an additional stressor. The therapists discussed how certain co-workers were not supportive. They expressed that some co-workers would expect others to know what they were thinking and feeling without open discussion. Interviewees stated that the co-workers who behaved this way had already left the agency. No mention was made about whether this behavior may have been a manifestation of burnout.

The subcategory work stress related to the Executive Director and policy was one of the most substantial categories. The majority of the responses were related to the impact the Executive Director and the policies of the agency had on stress level, although this differed depending on the interviewee. The Head Therapist discussed how important having support from the Executive Director and the Agency was for her stress level: “I feel 100% supported by the agency and the Executive Director. She and I are close friends. If I didn't feel agency support I couldn't do this type of work, it would be too stressful.” This statement demonstrated how the Head Therapist's experience had been a positive one, although she could see how without this support her stress would increase.

The description provided by the other interviewee was quite different. Although she did recognize the impact that the Executive Director and the agency had on her stress level, she did not feel supported at all. She stated,

There is no support here, I am often verbally abused by the Executive Director and yelled at. I don't like being talked down to and there is a lot of fake compassion around this agency. The agency does not care what I go through personally or actually promote this open sharing. We work with serious trauma but unless you're the best friend of the boss, good luck getting support. It becomes the opposite, you end up just keeping to yourself, and not talking, which adds stress.

The theme of self-care strategies describes the different ways in which the interviewees attempted to care for themselves and counter the effects of burnout. This theme included a general description of self-care strategies with one subcategory of social support. The interviewees were not able to provide any
specific strategies they used for self-care related to treating victims and perpetrators of domestic violence.
Although researchers state the importance of having additional self-care strategies (Lawson & Myers, 2011; Stamm, 1999), it did not appear that this was something emphasized at the agency. Some general self-care strategies reported included deep breathing, self-talk, remembering the reason one entered the field, reading, and trying to focus on future goals that are not work-related. Both interviewees could name different methods of self-care but both complained of not having enough time to use many of these coping strategies.

One self-care strategy that came up frequently in the interviews was the importance of social support. This subcategory highlights the experiences of the interviewees related to friends, family, and professional support. The interviewees discussed having significant others in their life who listened to their stressors. They appeared to use this experience as a way of venting their stress and getting validation that they sometimes did not receive at their work place. Significant others may provide a sense of validation for individuals outside of the clinical arena that they may generalize to the workplace. The importance of supportive co-workers was also discussed within this subcategory. Both interviewees discussed the importance of being able to talk to their co-workers about their work-related stress and receive feedback and validation of their experiences. The level of support received from co-workers seems to have mitigated at least some of the work related stress these participants experienced. Without it, they reported their level of stress would have been higher.

Both interviewees described being currently in a state of burnout or having experienced it at one point in time while working at the agency. The major theme experience of burnout was used to describe the different ways that these individuals felt and endured the symptoms of burnout. The interviewees discussed feeling like they were “stuck in a rut”; although they knew what to do to make themselves feel better, they did not have the time or the energy to do it. One interviewee stated,

I have been becoming increasingly anxious. I feel that if I do not leave this agency soon, I will probably have to be put on medication or something. I have been having stress-related muscle spasms, acid reflux, and just a general sense of not wanting to do anything while at work. I mean if everyone else is slacking and I am constantly being verbally abused by my boss, how can they expect me to do great work with my clients or even get all the paper work done?

The experience of burnout was described in a broader sense than that found in most formal definitions of burnout and appeared to be a personal feeling that varied between the interviewees. One interviewee discussed how working with domestic violence perpetrators has changed her sense of humor and how currently “nothing shocks me”. Both interviewees discussed how working with this population had probably affected them more negatively than they realized.

The last major theme, experiences with supervision, describes how supervision either helped or hindered them in their struggles against burnout. Both interviewees described the necessity of having a caring and compassionate supervisor to counter burnout, but they did not agree whether their supervision met this criterion, even though both were supervised by the Executive Director. One interviewee stated, "Supervision can be helpful to gain new perspectives and hear different ways of thinking. I really enjoy the supervision I get from the Executive Director. I just wish in group supervision there was more time.” The other interviewee stated, “I think supervision is very important. I just don't get that individual time here and I think I really suffer because of this. I have had great supervisors in the past that talked openly about self-care and were validating. I don't get that here.” It would appear that the relationship with the supervisor is critical to mediate the relationship with support and stress level.
Both interviewees highlighted the significant impact that the support or lack thereof from the Executive Director and/or the Agency made on their stress levels. It was noteworthy that one therapist who felt she did not have support from the Agency or Executive Director, chose to isolate herself, which seems similar to the behaviors of co-workers who had since left the agency. This may lend more support to the theory that one of the reasons past therapists had left the agency was this increased stress and lack of support.

**Observations**

Four major themes emerged out of phenomenological analysis of data collected during observations. These included physical description of the agency, description of the employees, interactions among office staff, and interactions among therapists. Under the theme of physical description of the agency, three subcategories were created to describe the waiting room, the offices, and the front office/kitchen area. Another subcategory was created under the theme of therapists interaction; this subcategory was labeled venting frustrations about head therapist. For the current purpose of the study, only the themes regarding interactions will be discussed in-depth.

The theme of interaction among office staff included all observed interactions. There were few observed occasions where the office staff interacted; it seemed that the office staff tended to keep to themselves. Of note was the fact that the office staff with greater seniority expected others to take on more office duties, answer the phone, checking in clients, notifying therapists of clients arrival; they also made more personal phone calls during office hours. The senior staff also appeared to expect junior staff to multitask, and to complete special projects for them while also responsible for answering the phones. Although there was not a formal hierarchy of office staff at the agency, it appeared the staff adhered to one.

The theme interactions among therapists also included a subcategory of interactions that involved voicing frustrations about the head therapist. When the therapists were not voicing their frustrations, their interactions were terse. The two Master’s level therapists gave salutations in the hall but did not interact directly with the Head Therapist and seldom with the Executive Director. On occasions when the Executive Director was observed interacting with the Master's level therapists, it was to ask one of the therapists a favor. These interactions were completed very quickly with each therapist agreeing to help, finding a time this could occur, and ending the interaction. These interactions may be contributing to a hierarchical management structure as well as a lack of collegiality among therapists and the Executive Director.

The majority of the interactions observed between the therapists were related to venting frustrations about the head therapist. In one observed interaction, two Master’s level therapists discussed an event that occurred earlier in the day related to the head therapist refusal to work her two required nights. The therapists discussed their frustrations, feelings of blame, and pressure to cover these hours. The therapists had this conversation in the front desk area in front of the reception staff and appeared to be relieved after sharing their frustrations with one another. In another interaction the same two Master’s level therapists discussed their frustrations with the Head Therapist's failure to assist in running the groups that she was scheduled to conduct. In this interaction, one of the therapists vented her frustrations while the other one provided validation for this experience. It appeared this interaction helped the frustrated therapist to feel that her feelings were warranted.

**Discussion**

The level of desensitization among other symptoms reported and observed indicates the need for a more structural approach to counteract burnout among female trauma-focused therapists. The multiple demands placed upon these women by their jobs, their families, and their communities were perceived as
daunting to the point that both felt burnt out. There were disparities between job descriptions (e.g., the number of night groups required or caseload) and the experiences of the therapists (being asked to take on extra groups or clients). The level of desensitization expressed by and observed in the clinical and office staff at this community mental health agency demonstrates not only the need for adequate self-care, but also for structural support to address burnout.

One way to provide structural support is for colleagues at all levels of a mental health agency to hold each other accountable for how their level of burnout affects each other, and ultimately the clients they serve. When agencies emphasize productivity at the expense of productiveness, vicious cycles of helplessness, isolation, and hostility emerge (Conrad & Kellar-Guenther, 2006). As these feelings remain unaddressed, female therapists struggle to meet goals they feel unreachable, sacrificing emotional and physical well-being in a solitary existence in which they are overwhelmed. As burnout sets in, individuals often need social support to assist them in recognizing the symptoms and take steps to address them (Ericson-Lidman, & Strandberg, 2007). Ultimately, this experience left unaddressed impacts the standard of care provided to clients (Conrad & Kellar-Guenther, 2006).

Implications

Clinical: Agencies need to establish policies to provide adequate support through clinical supervision and a healthy dialogue with clinicians about their work and needs. Establishing a structure for feedback from clinicians about their experiences in supervision, as well as their perceptions of their workload is very important. If directors are unaware of the level of stress and burnout experienced by their therapy staff, they will more likely be faced with therapist turnover. Including social support and interactions during work hours may be a great way to improve workplace atmosphere. For example, celebration of birthdays or life events can be affirming and create positive feelings.

Another avenue of policy support could be through agency participation in community events. Race for the Cure teams or booths at the County Fair could reinforce the Agency’s work uniting staff in a common cause. Another clinical implication is the need for supervisors to focus on personalization skills, including therapists’ experiences in therapy and therapists’ implementation of self-care. Supervisors must provide support for taking time for self-care. It also is important that supervisors and administrators maintain an open line of communication to maintain adequate working conditions and collegiality within an agency. This will add authenticity to reminders for self-care. Furthermore, therapists working with family trauma need to ensure that they remain aware of the extent to which their work with domestic violence populations affects their level of sensitivity and health. As they become desensitized to the trauma of the population with whom they work, their sense of active presence and unconditional positive regard may become hindered. They may also begin to start viewing relationships in general in a negative manner, feeling that abuse is common and violence is a norm. This belief may cause mental health workers to start distancing themselves from their friends and family at a time when they may need this support the most.

It is important for female therapists working with male perpetrators to remain genuine and congruent in session. Negative stereotypes may be developed or reinforced due to the experience of burnout (Lauber, Nordt, Braunschweig, & Rossler, 2006). Lauber et
al. explained that perception of social disturbance and dangerousness were two of the factors implicit in stereotypes. Women working with power and control issues may easily make the connection of these concepts, reinforcing negative attitudes. Lauber and colleagues in their Swiss study called for a change in attitude among mental health professionals. Addressing these issues in professional education and quality clinical supervision are paramount.

Administrators need to become more sensitive to gender expectations given the multiple messages that women receive from society. Supervisors are in a position of power that enable them to protect employees from work overload that would be detrimental to their own self-care. They are in a unique position to become aware of and recognize symptoms of burnout before it negatively affects the therapist in their personal or professional responsibilities. Supervisors may need additional training in how to intervene with impaired clinicians.

Research: The themes identified in this study may help guide future researchers’ efforts to understand better the experience of mental health professionals. Although the themes were developed based on the responses of two interviewees, they still provide insight for identification of more specific questions or survey development. In addition, the themes in this particular study were found after interviewing female clinicians. Exploring whether gender differences indeed do exist in the experience of burnout and vicarious trauma would be an important future step.

Future research is also needed to address whether gender makes a difference in the experience of compassion fatigue. The importance of quality relationships, both collegial and supervisory, among women who are trauma therapists deserves exploration as well.

Finally, researchers are encouraged to explore the impact of agency policy on the burnout and resilience of the clinicians employed. Disconnects between required performance and actual performance (e.g., the night groups that were required, or client quotas) may contribute to negative attitudes and burnout.

It seems that counselor training needs to shift focus from awareness of vicarious trauma and burnout to creating safer working conditions for mental health professionals with emphasis given to structural support. Increased emphasis on prevention of burnout rather than treatment of symptoms will benefit the profession.

**Conclusion**

The researchers set out to explore how female therapists experience burnout working in a small community agency and to identify factors that contributed to increased feelings of support. After interviewing two therapists and observing seven therapists and agency staff, the researchers found five major themes (personal stressors, work-related stressors, self-care coping strategies, experience of burnout, and supervision); five subcategories (social support, stressors related to clients, stressors related to relationship with co-workers, stressors related to relationship with Supervisor [Executive Director], and stressors related to Agency policy); and four observation themes (physical description of the Agency, description of the employees, interactions among office staff, and interactions among the therapists).

An important conclusion is that the quality and strength of relationships often mediated burnout. Specific attention must be given to the development and maintenance of the supervisory alliance and to fostering an atmosphere of support and collegiality among staff. When this occurs, female therapists will be able to express feeling overwhelmed and ask for assistance when they need it.

The implementation of Agency policy by the Executive Director was constraining to the therapists when it came to self-care. They knew they were over-extended and over-worked but felt they had no op-
tion when asked to assume extra duties. Supervisors and directors must ask for feedback from supervisees, empowering them to express their concerns. Through this preliminary research, the authors encourage mental health professionals to stop looking at burnout as an individual problem and start recognizing systematic, structural, and cultural differences.

References


**Appendix**

**Interview Questions**

1. Tell me about your personal view on whether this agency provides adequate support for you? Examples?
2. Tell me about your personal view on support received from your co-workers
3. What are the unique stressors related to working with individuals involved in domestic violence situations?
4. What methods of coping do you feel help you to avoid feeling burned out?
5. What is your overall stress level? Personal stress? Work related stress?
6. Have your ever felt burned out and if so how did you manage this experience?
7. What coping skills that you utilize do you believe are unique to working with clients with have experienced trauma?
8. How is the supervision you receive helpful? How is it not helpful?
9. How often are issues such as self care and vicarious trauma discussed in your agency? With co-workers? In supervision?
10. How much information do you personally know about burn out and vicarious trauma?
11. What factors do you believe are unique to your experience due to your gender?
Treating the Angry Brain

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“Anger management problem” is a familiar term to many clinicians. The phrase is commonly applied to individuals seeking treatment for impulsivity, mood disorders, criminal offenses, or frequent acts of violence (Eckhardt, Samper, & Murphy, 2008). Some of these individuals defer the blame for their actions to others. “They made me do it. They pushed my buttons.” Other individuals claim their actions were outside of anyone’s control. “I don’t know why I did it, it just happened.” The individual may blame family, clinicians providing treatment or people in authority such as the police or a supervisor at work (Gascon et al., 2012). “I wasn’t doing anything wrong, they just arrested me. I don’t think there’s anything wrong with me. I’m here because you say I have to be.”

For most individuals anger dissipates within moments. However, many individuals have experienced a lifetime of anger (Watt & Howells, 2010). They may have experienced significant trauma, verbal, physical, or sexual abuse, neglect, or bullying as a child. Anger may have begun as a purposeful and typical response to protect oneself. As the individual matured, he or she may have continued to express anger for self protection and as a means to retain some level of power. By the time they reach adulthood, the individual may have developed a pattern of anger and physical aggression impacting most or all areas of their lives (Gomez, 2010).

These individuals have trained their brains by continuous repetition to think, feel, and verbally state responses that maintain or lead to increased anger (Pally, 2007). For example, clients recounting stories will often state, without realizing, that they verbally pushed someone into giving them an aggressive response before physically fighting. Unsurprising, these individuals may not have experience communicating in non-aggressive ways. They also may be defensive of their right to be angry, reluctant to continue treatment, or need continual treatment during their lifespan (Gascon et al., 2012).

Cognitive behavioral therapy is a frequent treatment method for anger management issues (Heseltine, Howells, & Day, 2010). Unfortunately, clinicians often become frustrated treating a population that becomes angry at the therapy process or stops attending treatment (Gascon et al., 2012). In an attempt to provide better treatment outcomes, researchers have been exploring how the human brain relates to anger management (Denson, Pederson, Ronquillo, & Nandy, 2009).

For further the discussion, the reader should have a basic understanding of brain components. The cerebral cortex is the largest part of the brain. It is responsible for higher brain functioning such as cognition and action. It consists of the frontal lobe, parietal lobe, occipital lobe, and temporal lobe. The cerebral cortex is divided into two halves: the left and right hemisphere. The left hemisphere is associated with logic abilities. The right hemisphere is associated with arts and the creativity (Yeo et al., 2011). The neocortex, a component of the cerebral cortex, is a six layered structure found only in mammals. It is responsible for higher information processing (Rakic, 2009).

Deeper in the brain, the cerebellum is smaller and evolutionarily older than the cerebral cortex. It is responsible for coordinating movement and balance. The limbic system resides deep within the cerebrum and evolved earlier than the cerebellum. It contains the thalamus, hypothalamus, amygdala, and hippocampus (Rajmohan & Mohandas, 2007). The thalamus is responsible for relaying sensory and motor signals to the cerebral cortex. The hypothalamus is responsible for metabolic processes. The hippocampus is responsible for transferring short term to long term memory. It is also important for processing emotional
reactions, including anger and fear (Immordino & Singh, 2013).

Readers may be familiar with the term “fight or flight.” When confronted with potential danger, the hippocampus activates the amygdala which results in increased emotional processing (Lin et al., 2010). The amygdala sends projections to the hypothalamus which in turn activates the sympathetic nervous system and adrenal-cortex. The sympathetic nervous system affects our body through our nerves, while the adrenal cortex affects our bodies through hormones and neuro-chemicals (Bruno, 2011). As a result, our heart rate and blood pressure increase, our blood glucose levels increase, our muscles tense, blood transfers from our skin to essential muscle groups, and our pupils dilate so that we can see as much light as possible. Non-essential tasks, such as digestion, stop to allow energy to be diverted in more necessary areas. As a result, our bodies are primed to either become either physically aggressive to defend ourselves or to run away from danger, depending upon our emotional response (Bruno, 2011).

The neo-cortex, which is responsible for sensory perception, spatial reasoning, and language, cannot process conscious thought fast enough to counter the emotional reaction resulting from activation of the amygdala. As a result, we respond first from emotion instead of reason (Goleman, 1995). For further discussion, the amygdale can produce an emotional response such as fear or anger in as little as 1-50 milliseconds. By comparison, the conscious processing in the neo-cortex can take 500-600 milliseconds (Cozolino, 2008).

This theorem may explain why some individuals claim they react before they have time to think. This viewpoint illustrates a negative perspective of our ability to control our emotions. Fortunately, we can learn to express healthier emotional reactions, regardless of the brain's incredible influence.

Treatment

Counselors utilizing traditional therapies have focused on cognitive techniques to inhibit the input from the amygdala, the part of our brain that processes anger and other emotions. Therapist utilizing cognitive techniques view unwanted emotions as obstructions to positive mental health that should be suppressed (Del Vechio & O'Leary, 2004). By ignoring or inhibiting anger, clinicians are missing the opportunity to address the trauma that originally resulted in anger and subsequent expressions of aggression. Clinicians should instead focus on addressing the original trauma and re-conditioning individuals from trauma based responses. Along with managing emotions, clients need to be able to incorporate past traumatic experiences and make new meanings of their lives (Lanius et al., 2010).

Exposure interventions such as Brainspotting and Eye Movement Desensitization and Reprocessing (EMDR) are being utilized to stimulate the amygdale, the part of the brain responsible for processing anger and re-writing anger circuitry (Corrigan & Grand, 2013; Shapiro, 2013). Francine Shapiro, developer of EMDR, believes that traumatic experiences overwhelm cognitive functioning and coping mechanisms. Memories of traumatic events are stored inappropriately in isolated areas of memory. A clinician
utilizing EMDR techniques assists clients in recalling traumatic memories and negative cognitions. Techniques involve the client recalling the traumatic memory or associated feeling while undertaking lateral eye movement and bilateral stimulation. Lateral eye movement typically involves the client following a pointer or a machine with his or her eyes until he or she no longer reports intense negative feelings associated with the traumatic or subsequent memories (Shapiro, 2013).

Brainspotting is similar to EMDR in some ways (Terrell, 2009). The central concept of Brainspotting is that traumatic memories can be accessed by finding an eye position that allows the individual to access the part of the brain where trauma is stored. A clinician using Brainspotting would have a client mentally focus on a significant negative feeling or traumatic situation. The client would then visually focus his or her attention on a pointer being held by a clinician. A clinician moves the pointer in various directions until the client reports access to the memory or feeling or by the clinician denoting eye movements characteristic of emotional access. The client then holds the visual focus on the pointer while thinking of the traumatic situation and experiencing auditory bilateral stimulation (Terrell, 2009).

With EMDR and Brainspotting, the client repeats the process until he or she no longer feels anger or other upsetting emotions in relation to the memory or life situations (Grand, 2013; Shapiro, 2012). A part of the EMDR process involves the clinicians checking in with the client regularly and using a rating scale to obtain a sense of the client's level of emotion in relation to trauma or situations (Shapiro, 2012). Brainspotting differs in that clients are allowed to focus as long as they need to. The amygdala and cortex can formulate new neural pathways when the client doesn't have to break concentration and speak with the clinician (Grand, 2013).

Many clients feel initial success with both therapies. It may be necessary for some client's undertaking either therapy to have multiple sessions before reporting significant results (Grand, 2013). Clients who report multiple, or complex trauma, may need to receive treatments for each individual trauma or brain spot. Clients who feel anger or other negative emotions in a variety of situations may need to be trained to apply the process when alone in the event they are not with the clinician. Clients will continue to restructure neural pathways and diminish emotional responses with continued practice (Grand, 2013).

References


Secondary Trauma in Forensic Settings: Effects on Court Personnel, Jurists, Jurors, and Correctional Officers

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Overview of Secondary Trauma

There is no single authoritative definition of secondary trauma; however, there is general consensus among traumatologists that indirect exposure (i.e. listening to stories about trauma or caring for a person suffering from trauma) to overwhelming events can cause the same symptoms of helplessness and horror as seen in those who directly experience trauma. Symptoms of traumatic stress have been observed and described for centuries and are the foundation of modern theories of secondary stress. The Iliad and Odyssey narrate the persistent horrors of war (Shay, 1994; 2002). Neurologists studied the phenomenon of hysteria in the 19th century (Goetz, 1987). Physicians at the front lines described shell shock in WWI (Myers, 1940), and war neurosis in WWII (Kardiner, 1947). In the 1970’s, the Vietnam war disgorged thousands of abjectly incapacitated veterans who were plagued by severe symptoms that were not well known or understood. Social scientists responded to this post-war condition, and also to the similar symptoms seen in victims of rape and domestic violence. In 1980, the DSMIII included the first diagnosis of posttraumatic stress disorder (PTSD). This edition emphasized the cause of traumatic stress symptoms—events that were experienced with “intense fear, terror, and/or helplessness,” that were “outside the range of usual human experience,” and “would be markedly distressing to almost anyone” (APA, 1980).

Research into post-traumatic conditions following the Vietnam war did not subside, and interdisciplinary interest in the subject remained high. Informed by a growing body of data, the authors of the DSMIIIIR shifted their attention from cause to effect, and revised the diagnostic criteria of PTSD to include three categories of symptoms: intrusion, avoidance, and arousal (APA, 1987). By the 1990’s, enough data had been generated to allow researchers and clinicians to move from description to prescription regarding traumatic stress. Moreover, clinicians, researchers and other practitioners began to notice that not only individuals who sustained direct trauma developed symptoms; helpers, family members, and others also became symptomatic (McCann & Pearlman, 1990).

Trauma researcher Charles Figley pursued this theme. In his text, “Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those who Treat the Traumatized”, he describes how health care providers could become “traumatized by concern” (Figley, 1995, p. 5). Recognition of the secondary effects of trauma was a defining advancement in the field of traumatology, and lead to the hypothesis that a much broader population of individuals could be at risk for secondary traumatic stress than at first was thought. Increased knowledge about the infectiousness of anxiety and trauma supported the notion that numerous professionals outside the mental health field suffered from the secondary symptoms of traumatic stress. Figley and his progeny edified the communicable effect of trauma from patient to doctor, victim to caretaker, disenfranchised to advocate. Cumulative research
illuminated the mysterious and elusive symptoms experienced by helping professionals. Systematic inquiry into what was initially referred to variously as vicarious trauma, secondary trauma and compassion fatigue, revealed that practitioners, both individually and in groups, often minimized or denied their symptoms, or simply were overcome and had to leave their professions. They tended to compare their distress with that of those who experienced primary trauma. Studies of compassion fatigue lead to exploration of an increasingly larger population consisting of individuals who, by virtue of their exposure to traumatic material, felt extreme fear, horror, and helplessness, and developed symptoms of posttraumatic stress.

**Secondary trauma: effect on judges and lawyers**

In 1995, before Figley published his seminal work, Lee Norton, a forensic social worker, met with Charles Figley to discuss the relevance of his work for lawyers, paralegals and other legal personnel. The potential for this population to experience secondary trauma had not yet been explored. In October of 1995, Norton introduced the concept of compassion fatigue to the legal field through a series of seminars at the Kentucky Department of Public Advocacy, Trial Practice Institute, whose participants consisted of attorneys, paralegals, investigators and support staff. All participants completed the Compassion Fatigue Self Test, consisting of questions about personal and work satisfaction. Although there was a high endorsement of stress-related symptoms, including alcohol and recreational drug use, somatic complaints, depression, problems with sleep and diet, chronic fatigue, anhedonia, resentment toward co-workers and clients, feelings of emptiness and isolation, and problems in personal relationships, the notion that the nature and demands of the work could correlate to the mental, emotional and physical symptoms was overwhelmingly rejected by participants. Norton continued her efforts to bring the evolving knowledge of secondary trauma into the legal profession but with little success. It was not until 2003 that a preliminary study on secondary trauma and burnout in attorneys was conducted by Levin (2003).

Levin's (2003) study, conducted at the Pace Women’s Justice Center, compared the levels of secondary trauma in mental health providers and social services’ workers with attorneys representing domestic violence victims and criminal defendants. He found that that the attorneys suffered significantly higher levels of secondary trauma than the mental health professionals. The differences appeared to be attributable to several factors, including the attorneys’ higher case loads, lack of education about the effects of working with traumatized populations, and lack of support in the form of multidisciplinary consultation.

Also in 2003, Jaffe et al., engaged in a preliminary exploration of secondary trauma in judges who served in criminal, domestic relations and juvenile courts. Of the 105 judges surveyed, 63% endorsed one or more symptoms consistent with secondary trauma. Additionally, this study found that women jurists reported more symptoms than men, as did all jurists who had seven or more years of experience. Thus, the data from this study suggest that women who have practiced seven or more years are more vulnerable to the effects of secondary traumatic stress than men who have practiced less than seven years.

Jaffe et al. (2003) suggested several factors that may contribute to their findings. First, in most instances, eligibility to hold the position of judge requires that the candidates have been through law school. Unlike many fields, such as medicine and mental health, which employ pedagogy emphasizing collaboration, consultation, and an interdisciplinary approach to their practice, law schools tend to emphasize a more competitive model of teaching. The legal model results in greater isolation both in law school and in practice. As a whole, lawyers are not taught or encouraged to routinely work in teams where they can garner support in developing their cases, and express some of the concerns and anxiety that any given case can cause. This climate of isolation is especially prominent in state and federal public defender and prosecution agencies, whose lack of resources create additional stress; absent co-counsel and support staff, attor-
neys are faced with examining very disturbing evidence and facts without any means of working through the effects of such difficult experiences.

Judges face similar obstacles to identifying and managing the effects of secondary trauma. This begins with their inviolate pledge to maintain impartiality in all cases. They labor in autonomous work environment, with few outlets for reflecting upon their own feelings and impressions about the facts and circumstances of their cases. Perhaps more so than attorneys, judges are required to defend “Lady Justice,” who holds a sword in one hand and a scale in the other. She wears a blindfold so that justice can be meted out objectively. Though a noble aspiration, it unfortunately does not take into account the great emotional sacrifice this requires of mere mortals.

**Trauma in the courtroom: jurists, attorneys and court personnel**

Even further from reach are definitive conclusions about the effects of exposure to traumatic material on attorneys, judges and court personnel. However, the raw material for research is readily available. Lawyers, judges and court personnel regularly face distressing experiences in the course of carrying out their jobs. Among these are:

- hearing repeated, detailed testimony about beatings, muggings, burglaries, rapes, child neglect and abuse–mental, physical and sexual–loss of livelihood, permanent mental and physical disabilities through work and other accidents, and countless other perverse acts of premeditated brutality
- exposure to graphic depictions of the results of criminal acts and tragic accidents due to negligence, including autopsy photos, security camera or civilian videos of crimes, accidents and natural disasters; (i.e., 911 tapes, detailed and remorseless confessions about heinous crimes)
- hearing and seeing the unmitigated pain and suffering of individuals who have experienced catastrophic loss of life, possessions, and station in life, while being prevented by the rules of court to console, express empathy or in any way try to mitigate unspeakable human anguish
- hostility toward any and sometimes all court personnel by various groups, such as activists, protestors, and others whose vociferous opinions, whether or not based in fact, are harsh, critical, and demeaning
- the strict rules of privacy and confidentiality that limit the ability for members of the legal system to metabolize, make meaning of and get closure on what they have seen and heard.

In most instances, conditions caused by chronic exposure to trauma do not resolve without effective intervention. This invariably involves “telling the story” to at least one caring person. Until recently, members of the legal profession have been a neglected segment regarding susceptibility to secondary trauma. Much more attention needs to be given to these “invisible victims” who unknowingly expose themselves to increasing levels of mental, emotional and physical stress, and whose signs and symptoms go unacknowledged and unaddressed.

**Secondary trauma in correctional officers**

While there has been consistent interest in the effects of incarceration on inmates and their families, the literature has very little to say about the effects on correctional officers of working in prisons, and is mute on the topic of primary and secondary trauma in correctional officers. This subject is increasingly salient because of the rapidly growing prison population in the U.S. and burgeoning research into a broad
spectrum of traumatic stress disorders. The rise in the prison population, heterogeneity of inmates and diversity of their problems, has resulted in less educated and experienced prison personnel, working in more unpredictable, high-risk settings, for less pay with less job security and higher turnover. These factors leave correctional officers and other prison personnel more vulnerable to primary and secondary trauma, burnout, and compassion fatigue, all of which can significantly undermine professional effectiveness and personal satisfaction. Strict operating procedures and advances in protective equipment serve as safeguards against threats to physical safety of guards; vicarious trauma, on the other hand, is pervasive and, because it is a new concept in the corrections profession, there are virtually no measures in place to prevent or treat it.

Because prisons are designed with maximum transparency (as a means to monitor inmates at all times), correctional officers are exposed to trauma as a function of the way prisons are constructed and operated. While increased visibility can reduce anxiety by affording greater awareness and predictability, it exposes guards to extremely personal and intimate activities (including inmates using the toilet, masturb器, and having sex with each other). Guards also witness inmates decompensate out of confusion, anxiety, and sheer terror. Many prisoners, especially the young with cognitive deficits or those who suffer from mental illness, have very few resources with which to cope in an unknown, hostile environment where they are isolated from friends, family, and other sources of support. Guards must make decisions about when and how to defuse situations that could escalate or affect other inmates.

Perhaps even more distressing is the demand to predict, intervene in, and observe the effects of violence. Guards and other prison personnel must remain keenly vigilant to the emotional climate and temperature of the inmate population and, if an individual or group assault begins, must intervene at varying degrees of risk to themselves to stop the violence and restore order. The repeated release of flight or fight hormones associated with the perception of danger can create a pattern that is not turned off once the immediate situation is resolved. Indeed, individuals who work in conditions of high potential danger tend to more readily generate chemicals, such as adrenaline which keep the body in a state of readiness and creates a "paucity of language and a propensity to act" (Bloom, 1997). This hyper-vigilance can bleed into personal relationships, causing tension, constriction, reactivity, and problems with communication and conflict resolution.

An even more onerous and insidious burden carried by correctional officers involves bearing witness to abject human despair. A large proportion of the inmate population is mentally and cognitively impaired, and their lives are bereft of the most rudimentary building blocks of competence and confidence. As a group, they possess low verbal and problem solving skills, and very low funds of common knowledge, and many suffer from brain deficits, learning disabilities, and lack of education. Most come from dysfunctional, and impoverished families with multigenerational histories of mental illness, and drug and alcohol de-
dependence. Over half the prison population has a documented history of mental illness (BOJ, 2006), and many more are ill but have not been diagnosed or treated. Inmates suffer from nightmares, panic attacks, delusions and hallucinations. They have a high incident of post-traumatic stress disorder, personality disorders, and mood disorders. These factors lead to physical and sexual assaults, and bullying, intimidation and terrorizing, the results of which guards witness and are left with to address. Many inmates engage in self-harm, including burning and cutting themselves, and some attempt suicide. Most prisons lack adequate mental health care, and very few prisons provide rehabilitation or vocational education. This leaves correctional officers with the greatest degree of contact with untreated inmates. For this reason they are exposed to a continual source of secondary stress.

There has been no systematic study of the incident and effects of secondary traumatic stress in correctional officers; however, a few efforts have been made to examine the effects of prison work on guards and their families, and these provide a basis from which to begin to study secondary trauma in this population. Crawley (2002) conducted a two-year ethnographic study of prison guards in England. Using open- and closed-ended survey questions, combined with interviews of guards and their families, she was able to gain insight to the unintended effects of prison work. Among her findings were that correctional officers changed in the ways they perceived danger, developed rigid external structure to reduce internal anxiety, became desensitized to emotional stimuli, and brought their coping mechanisms and prison culture into their homes.

Brown and Benningfield (2008) found similar results in a study of guards who work in general population versus those who work on death rows in the United States. Of all respondents surveyed: 63% endorsed feeling “burned out” or stressed by their work and 67% endorsed feeling frustrated and angry by their work. Of those with experience on death row, as well as regular units; 82% said that death row is different from the general population followed by statements such as “it is too quiet, eerie, depressing,” “there is a scary silence,” everyone knows they are there to die.” Respondents who work on death row described conditions as being “more alert and security conscious”: “there is pressure to take care of each other—to pay attention and keep each other safe.” They described increased pressure to follow procedures precisely, because failure to do so could result in harm to oneself or co-workers. At the same time, the quiet, controlled environment with increased security requirements reduced anxiety in guards about their safety.

Like Crawley (2002), Brown and Benningfield (2008) found that the nature of the work of guards requires them to be supremely concerned with safety, and that safety is best ensured through stringent rules and operating procedures. In addition, both studies indicate that guards must steel themselves to the emotional distress of others, and blunt their own emotions to the effects of witnessing violence and mental illness.

What is known about the spectrum of traumatic stress disorders, along with research in related topics and populations, provides a basis for understanding how correctional officers may be vulnerable to the secondary effects of trauma. Long-term exposure to violence, cognitive impairment, and mental illness, in a stark, isolated environment with little or no opportunity to reflect, debrief, or find mutual support, can lead to an increase in hypervigilance, and a preoccupation with danger, security, structure, and regimens, as well as a generalized tendency to suspect the intentions of others, and to perceive danger where it does not exist. This may manifest as guards finding it difficult to leave their sense of danger and the emotionally dysregulated and severe environment in which they work at the door when they leave each day. Instead, it appears that they, like first responders, law enforcement officers, and some members of the military, may unwittingly develop defense mechanisms and coping strategies that bleed into their personal lives and take a toll on their mental and physical health. The subject of secondary stress reactions in correctional offi-
cers is deserving of a thorough examination with special attention to symptoms, preventive measures, and treatment.

Conclusion

The study of psychological trauma is still in its infancy. Even less is known about its progeny, including secondary and tertiary trauma and compassion fatigue. There are no uniformly accepted definitions of any of these terms. Moreover, the effects of working with trauma victims have primarily been studied in first responders, and mental health practitioners. Only very recently has there been research into other fields, such as law enforcement and law, both of which are at very high risk for secondary trauma. However, research is moving rapidly, with promising outcomes. The half-life on the knowledge base of psychological trauma is five years or less. This is likely to diminish as the related fields of psychology, psychiatry, neurobiology, and medicine combine their efforts and share knowledge to develop a broader understanding of the many variables that contribute to traumatic stress conditions, and the means of treating them quickly and effectively.

References


From the Trenches: Experiences from our Fellow Practitioners

The Stalking Wife

Robert Rhoton, Psy.D.

The following case demonstrates how a dysregulated sympathetic nervous system can interfere with perceptions, behaviors and relationships. When the threat response system of the body is repeatedly activated then behavioral adaptations can occur that seem pathologically like anger and control issues. It must be remembered that the human nervous system is unconscious (blind) to rationality when activated in perceived threat, and drives people to the instincts for survival and movement? Threat unconsciously conditions instinctive muscular and behavioral reactions below the level of conscious awareness. If this state of perceived threat is pervasive, repetitive, and intense or a combination of such, the human social engagement system can become compromised. This compromised social engagement system can adversely impact secure attachment and relationships by increasing volatility, aggression, and the creation of an unhealthy relational architecture in the lives of individuals and families.

Presenting Situation

A 28-year-old Hispanic woman, married, mother of three children 9, 7, and 4 years of age was self-referred for treatment due to her husband threatening to leave her. She had been stalking him at work, going through his phone and appointment book looking for evidence that he was being unfaithful. She was very anxious and expressed being depressed as well as overwhelmed much of the time with the relationship with her husband. She was firmly convinced that he was having an affair, and was actively trying to catch him in the act. It was not an unusual occurrence for the wife to call her husband 18-20 times a day, make unexpected drop-in visits to his employment, or to follow him when he was involved with any afterhours work, church, or social activities, such as playing basketball with some of his male friends.

Family life for this woman had been relatively stable; she was raised in the same home from the time she was brought home from the hospital until she married. She met her husband when she was a senior in high school and he was a junior in college. They married a few months after she graduated high school. Since the birth of their second child the wife had become increasingly discontent with the relationship and the husband and wife were both frustrated.

The client reported that she had an ideal childhood; she and all of her cousins grew up on the same block and there were always family activities with other family members to look forward to hanging out with. By the client’s account, her father’s three brothers and two sisters lived on the same block and between the six families boasted 31 cousins. She mentioned that there had been a history of incest, but it wasn't any “big deal”. It appeared to be a common family occurrence for the cousins to have highly erotic and sexualized relationships. The incest reported by the client was always cousin to cousin, and did not include the parents or aunts and uncles of the children.

References


As an adult she is highly active in a Christian denomination, as is her husband and children. Religion is about rigid performance of dogma and that anything that is not compliant to the faith is a cause of distress to her personally, and is interpreted as sin. She reveres a number of older women whom she feels are extremely pious and have near perfect lives and finds herself weak and ineffectual by comparison.

The following format is based on Ricky Greenwald’s (2005) case conceptualization structure.

Developmental history

- Weekly family dinners, big events each week for Sunday dinner.
- Paternal grandparents moved in when she was 3 years of age.
- Eroticized by cousins from 4-17 years.
- Sexual activity common between cousins.
- Mother and aunts were very strict and religious, all the cousins went to church every Sunday and other times during the week.
- Mom very critical of daughters, and full of praise for her sons.
- Father tended to ignore anything from school that was less than 100%.
- Father was attentive to sons (client had 3 brothers and 1 sister). Client felt that she was never as good as the boys.
- High performance expectations in school and strong shaming around failures to perform well.
- Mother very critical of dress and manners, she was never supposed to leave her room without makeup and being completely dressed.
- Family used alcohol for special occasions, but most use was when the men or older cousins sat together on weekend evenings and chatted. Never remembers either of her parents or aunts and uncles being drunk.
- In middle school molested by the father of a friend at a girl’s night sleep over. According to client this was the first really unwanted and scary sexual experience she had.
- Parents did not let her date until she was a senior in high school. They did not trust others outside of the family and thought the schools were just going to ruin their children with all the social aspects unrelated to academics.
- Received a full ride scholarship to college and parents talked her out of it, telling her she should get married, that was more important.
  - Married the August after graduation from high school.
  - Parents very critical of her working even before she got pregnant with her first child.

Schemas/Cognitions

- About the Self:
  a. That her value was as an object to be possessed.
  b. That she was never as good as one of her brothers or cousins.
  c. That she should be in a relationship.
  d. That she should love and protect her family.
  e. She needed to constantly monitoring of others trying to discern what they are feeling.
  f. She needed to be responsible for calming the situation when others are in distress, wants intense emotions to be quickly calmed or avoided.
g. Must be liked and approved of by others.
h. If she isn’t perfect at a thing she is a total loser.

• About significant relationships:
  a. Value in a relationship is tied to being desirable.
  b. That women are supposed to make a family work.
  c. Relationships are always tied to a cost (price tag).

• About the world:
  a. Women are always less than men.
  b. Women have to carry the burden of family and smile and be happy about it.
  c. Men will always take advantage of women.

Fears
• That she will never truly be loved.
• That she might not be good enough to be loved.
• That when she begins to lose her looks or desirability that she won’t be able to keep a relationship.
• That her own children will discover how imperfect she is.
• That her girls will grow up to be just like her.
• Of being criticized.
• Of being rejected by those important to her.
• That men will always gravitate to the most attractive and desirable woman.

Drives
• Guarantee her relationship with her husband is secure.
• That she maintains her looks.
• That no one discover how week and imperfect she is.
• That she never be hurt by rejection and criticism.

Themes
• Do anything to feel relationally safe.
• Make certain that those close to her still love her.
• Demand constant proof of desirability and validation or attractiveness.
• Desirability is proof of love, without desirability there is no love.

The summary above was derived after the three sessions. Themes tend to unify and make sense of the behavior that is often presented as problematic. However if those who are working with a client can attach interventions to the themes, then it is easier for the client to enact change. Themes are reflective of the energy being deployed by the individual as adaption strategies that emerge out of the personal history of that individual. Once the themes were established and tested through conversation with the client, it is frequently easier to get movement in therapy.

How the theme was used
The purpose of this case study is to illustrate the effectiveness of acting in accord with the theme or themes of a client. Themes are seldom rational, but are reasonable based on the life experiences of the individual and how they have personally and uniquely adapted to those experiences. To use the metaphor of a movie, often therapists get caught up in the complex plot structure of a person’s trouble and will miss the theme that unifies and makes sense of the plot.

In the case of this client, she had convinced herself that her husband must certainly be unfaithful,
and if he had not done so yet was only a moment away from doing so. This was her belief even though there was no evidence that it was true, and she knew no evidence existed because she had been desperately searching for it for nearly 20 months. This certainly was primarily based on the reduction in what she perceived as her husband’s desire to be with her intimately. When exploring the client perceptions, it distilled to “he doesn’t initiate sexual relationships as often as he should” which for her should have been daily if not more often. This was the primary evidence of her husband’s infidelity, because he must be having sex with someone else, since he isn’t seeking her out very often. When the current frequency was explored, she was embarrassed to admit it was only three to four times a week.

While the client’s view was not rational, it was reasonable for her life experiences. She had a very rigid view of love and sexuality.

The initial intervention that made therapy possible

She had identified several women who she thought were nearly perfect, women that she had idealized for having “perfect” marriages and families. After three sessions of collecting information and understanding the client’s rigidity, it seemed that approaching this client thematically made the most sense. She was asked if she would be willing to seek the wisdom of the women that she respected. She was, and the challenge was given to ask each of them what they felt was normal sexual activity with their husbands, and if it wasn’t as often as she thought it should be, what else their husband’s did to show love to their wives. She sought out five women and met with each and asked. The results of which stunned her. Many of them would go longer than a month and some even longer between sexual activity, and she came back with a list of actions many of which her husband already did for her. This altered her prospective and viewing of the situation much more effectively than trying to work the client through these things in therapy.

Addressing this single theme opened the door to moving into cognitive behavioral work around perceptions, beliefs and the trauma she had experienced. The largest issue actually turned out to be the grief and loss of her strongly held belief of what a tremendously loving and wonderful family she came from, and acceptance that every family has costs and benefits to belonging, and that her family had contributed to her perceptions and beliefs that created discord in her life.

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