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Shared Traumatic Reality and Boundary Theory: How Mental Health Professionals Cope With the Home/Work Conflict During Continuous Security Threats

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ABSTRACT

In a shared traumatic reality, mental health professionals and their clients are exposed to the same communal disaster. Both living and working in the same high-stress community can create a conflict between the professional's work and his or her private life. The author analyzed three focus groups consisting of 30 mental health professionals who worked with traumatized populations in a missile-stricken area in southern Israel. The professionals' experience was explored through the lens of boundary theory by examining the ways in which they created and maintained boundaries between the different domains of their lives. Findings demonstrated that these professionals presented a continuum of segmentation and integration of the domains as suggested by boundary theory, when both living and working in a highly stressed environment. The discussion deals with possible costs and benefits of the boundary theory continuum.

Introduction

Shared traumatic reality (STR) refers to a situation of disaster or collective trauma in which mental health professionals (therapists, social workers, etc.) live in the same stricken community as their clients (Baum, 2010; Dekel & Baum, 2010). In this particular situation, therapists are exposed to traumatic events on multiple levels: as private citizens, as members of a family, and, finally, as therapists who are exposed to trauma through the treatment of and intervention with their patients (Saakvitne, 2002).

The effect of large-scale shared trauma situations on mental health professionals has been assessed following events such as the September 11 attacks in 2001 (Tosone, 2006), Hurricane Katrina in 2005 (Faust, Black, Abrahams, Warner, & Bellando, 2008), and in the aftermath of events that have taken place in other parts of the world, such as the first Gulf War (Granot, 1992), the second Lebanon War

(Lev-Wiesel, Goldblatt, Eisikovits, & Admi, 2009), and suicide bombings in Israel (Shamai & Ron, 2009).

One central characteristic typifying STR are the blurred boundaries between one's personal/family life and one's work life (Baum, 2010; Lev-Wiesel et al., 2009; Shamai & Ron, 2009). The emergency situation often demands that the mental health professional conduct his or her work outside of the regular workplace and hours, which can lead to the undermining of physical and temporal work boundaries. For instance, interventions must be conducted in shelters in the aftermath of severe weather-related traumas (Rosser, 2008), or mental health professionals must leave home in the middle of a family gathering (Lev-Wiesel et al., 2009). In these situations, mental health professionals are often required to be available on an around-the-clock (Shamai, 2005).

Boundaries also expand when therapists are suddenly required to perform tasks that were never part of their job descriptions. Often they must tailor interventions to fit specific disasters or unfamiliar circumstances; these situations demand quick responses, creativity, and "thinking outside the box" (Rosser, 2008).

Boundaries between work life and private life are also blurred, as the existential threat in times of shared trauma hovers over not only the therapist's patients but also over his or her loved ones. As a result, thoughts and concerns about family are often present during work hours, while thoughts and concerns about patients are often present at home (Faust et al., 2008; Shamai, 2005).

Thus, one of the central STR aspects described in the literature is the reciprocal influence of the therapists' personal and professional domains and the need to cope with these two worlds simultaneously (Lavi, Nuttman-Shwartz, & Dekel, submitted for publication). Despite the centrality of this personal–professional boundary issue, none of the studies that address STR have used a theory as a basis, either to analyze or explain the data. The current study uses boundary theory as a roadmap for understanding the boundaries and coping methods of mental health professionals who for over a decade—along with their patients—have been the targets of missile fire in their southern Israel communities.

Boundary Theory

Boundary theory focuses on the ways in which people create, maintain, or change boundaries among the different domains in their lives, to simplify and classify the world around them (Ashforth, Kreiner, & Fugate, 2000). This theory grew out of organizations' and mental health professionals' need to reconstruct the relationship between work and family in a world where the boundaries between these domains were getting more flexible and less distinct, partly as a result of technological advances (Clark, 2000).

Boundary theory defines three kinds of boundaries. The physical domain focuses on the location where the activities take place. The temporal boundary relates to time (i.e., when the activities occur). Finally, the psychological domain focuses on

which rules, or patterns of behavior, thinking, and emotions, are appropriate within each domain (Clark, 2000; Kossek & Lautsch, 2012).

This theory suggests that three central factors contribute to the conflict between the domains: boundary characteristics, role identity, and organizational climate (Clark, 2000; Kossek & Lautsch, 2012; Tosone, Nuttman-Shwartz, & Stephens, 2012). Flexibility—which explores how much a boundary can expand in order to meet the demands of the other domain—is one central boundary characteristic. For example, a university professor has a great deal of flexibility as many of his or her tasks (writing, grading) can be put aside if necessary when another role demands his or her attention (Kossek & Lautsch, 2012). Another central boundary characteristic is permeability, or how much the boundary can enable spillover from one domain into the other. Permeability can be experienced as an intrusion or disturbance, such as negative emotions from work that arise at home after a difficult or depressing meeting (Kreiner, Hollensbe, & Sheep, 2009). Permeability can also, however, fuel positive experiences. A nurse describes how she used teamwork skills she learned on the job at home with her family in order to improve their ability to work together as a family unit (Clark, 2000).

Role identity refers to the construction of the self in a role (e.g., the paternal role in the family or the managerial role at work) and the determination of which features of that role are essential (Ashforth et al., 2000). Some people can identify more with one domain's role, while others are comfortable inhabiting several roles simultaneously (Kossek & Lautsch, 2012). High identification can affect the degree of the person's influence on what occurs in this domain and on his autonomy in managing the boundaries (Clark, 2000).

Organizational climate also plays a central role in the conflict and its management. Kossek and Lautsch (2012) describe organizational climate in this context as a continuum going from standardized to customized. This continuum refers to how much freedom workers have in choosing their own boundary management style and how much they are expected to adjust to standard organizational norms. Clark (2000) talks about "boundary keepers" (e.g., managers at work) and their sensitivity to individuals' other domains: for example, the degree to which they treat the worker as a whole person and not just as an employee. High standardization or low sensitivity can increase the tension and the conflict between the domains and vice versa. Matthews, Barnes-Farrell, and Bulger (2010) found that respondents who felt that their organizations were supportive of their family life reported a greater ability and willingness to be flexible about the work boundary.

In addition to these three factors, the coping patterns one uses also make a contribution to the conflict's intensity. Boundary theory suggests that coping patterns exist on a continuum whose two poles are segmentation and integration, each representing an opposite approach to the work-life balance (Ashforth et al., 2000; Nippert-Eng, 1996). Segmentation is defined as the degree to which aspects of each domain (e.g., thoughts, concerns) are kept separate from one another, cognitively, physically, or behaviorally (Ashforth et al., 2000; Nippert-Eng, 1996). For example, people who lean toward segmentation might keep separate e-mail accounts and avoid

work calls when at home (Kossek & Lautsch, 2012). Integration, by contrast, represents the merging and blending of various aspects of work and home (Ashforth et al.; Nippert-Eng) and might be exemplified by a therapist who exchanges text messages with his or her colleagues or clients during family hours (Kossek & Lautsch).

Examples of boundary theory can be applied to home–work situations such as employees who use telecommuting (and therefore can do some of their work from home) (Bulger, Matthews, & Hoffman, 2007; Kossek, Lautsch, & Eaton, 2006), community professionals such as priests (Kreiner et al., 2009) who are almost never "off-duty," or members of the workforce who are employed in a broad range of industries and at various occupational levels (Matthews et al., 2010). However, boundary theory has never been applied to extreme situations, such as those marked by a continuous security threat in which individuals are exposed to continuous life-threatening situations in both their professional and personal lives.

This article describes an STR in southern Israel. Since 2001, the southern region of Israel, and particularly the Gaza area, has been the target of Qassam missile attacks. In such continuous and recurrent situations, there is a need to deal not only with the physical and emotional damage in the immediate aftermath of the attack but also with the long-term stress evoked by the threat that is constantly looming (Braun-Lewensohn, Celestin-Westreich, Celestin, Verté, & Ponjaert-Kristoffersen, 2009).

This situation increases the demands on mental health professionals in both the work and family domains. In the work domain, the ongoing and continuous emergency nature of the situation demands that the therapist—who is responsible for multiple trauma victims—remain at work long after regularly scheduled hours and invest an enormous amount of emotional resources. In the family domain, most of these therapists live in close proximity to their patients and also are continuously being exposed to missile attacks; like their patients, the professionals and their families are therefore exposed to an ongoing and continuous threat on their lives. Moreover, this situation has lasted continuously for longer than 14 years. In light of these complex challenges, we wanted to further explore how mental health professionals navigate these two worlds and to describe the various ways they do so.

Method

Participants

Thirty mental health professionals (five men and 25 women) participated in the groups. Participants ranged from 30 to 60 years of age and were trained in a variety of helping professions: 18 social workers (60%), six psychologists (20%), and six art, animal, and movement therapists (20%). Given the variety of professions among the participants, all will be addressed from this point forward as trauma workers, because they were all working with traumatized individuals (Cohen & Collens, 2013). The duration of their employment in the region ranged from 1 month to 20 years, although most had been employed in the field for longer than 5 years.

All of the trauma workers were parents of children ranging in age from infants to adolescents. A few (3%) were also parents to grown children who were married and had families of their own. More than 75% of the participants (23) lived in the region. They were employed by three agencies: two regional resilience centers (12 participants in one center and nine in the other) and one municipal social service agency (nine participants).

Procedures

Data were collected in three semistructured, in-depth focus group interviews, each of which lasted around 2 hours. The groups ranged in size from nine to 12 participants (Brotherson, 1994). The researchers prepared a manual with several questions and issues regarding the continuous threat to which participants were exposed, and after the participants introduced themselves, the manual was used similarly in all three groups. Participants were encouraged to talk about their experiences of living and working within the same community. Specifically, the participants were asked to share a memory about what it was like to be a professional in their community within recent years, to speak about their children and family, and to share ideas about what they found helpful during times of stress. The group interview was conducted in Hebrew, tape recorded, and later transcribed and translated into English. Two interviewers led the groups interchangeably: one had lived and worked outside of the conflict zone, and the second had lived outside of the area but worked regularly within the conflict zone over the previous 8 years. The interviewers were careful to ensure that all of the interviewees had an opportunity to express themselves to a reasonable extent.

Ethical Considerations

The review board of the Sderot Resilience Center—which includes the center's director, the head psychologist, and a senior staff member (an art therapist who is also a member of the center's intake board)—approved the research. The researchers then approached the directors of each of the three participating centers, presented the study's aims and the central issues proposed for the focus groups, and obtained their cooperation. Each of the center directors then presented the study's aims to the trauma workers and asked them if they would be interested in taking part in the study. Following this stage, the researchers met with the focus group staff members and explained the general aims of the research and once again emphasized that participation was voluntary. After having received a brief explanation of the general aims of the research, all of the participants voluntarily provided verbal consent to participate in the study. It should be noted that none of the participants were financially compensated for their participation. The participants' names and identifying details in all the reports were changed so as to maintain confidentiality. The results of the study were later shared with the participants during follow-up meetings at

each center a few months after the initial focus group. During these meetings, the authors presented their findings, and the participants were invited to respond.

Data Analysis

Content analysis was conducted as follows. First, recordings were transcribed. Each researcher read the transcripts of the three groups. After identifying the participants' voices, they examined the main units of meaning in each individual's narrative in each group (Patton, 1990). Finally, each of the researchers integrated the units into main themes after careful examination and reexamination of the texts. Subsequently, the authors compared their individual analyses. They discussed differences and looked for areas of agreement. The comparison related both to the content of the themes and interpretations of their meaning. The researchers derived similar interpretations of most of the themes. A few themes were identified by only one researcher. In such cases, the researchers engaged in an open discussion and determined whether the theme would be considered new or whether it would be incorporated into other preexisting themes.

Findings

All of the participants in the study spoke of the complex encounter that takes place between work and home in an STR. This is a conflict well known to these trauma workers as they have coped with more than a decade of being exposed to and threatened by missile attacks in both their personal and professional lives. The trauma workers described various ways in which they handled their home–work boundaries.

Segmentation of the Work and Home Domains

One strategy used by some to help cope with the intensity of the conflict was segmentation. According to boundary theory, in this strategy the trauma workers disconnected home and work by constructing rigid boundaries with little flexibility between domains. In analyzing the data, we discovered that there are several ways to create segmentation: placing physical boundaries between domains, actively choosing one domain over another, the construction of rigid identities, and total avoidance.

One way to segment is by making the conscious decision to place physical borders between the domains. This type of segmentation was manifested in some therapists' decision not to live in the affected area or to leave the area due to the situation. The trauma workers who chose this option explained that this act of physical segmentation gave them the feeling that their families were safe and thus enabled them to do their work.

An additional way of keeping the domains separate was by trying to narrow the work range so as to limit the amount of overlap between the work and the personal

life. For instance, a participant who had a young child described how she consciously chose not to take children on as her clients, in order to create a border between her personal life and her professional work.

In these two cases, the trauma workers segmented the domains by placing borders around them. In the following cases, they gave priority to one domain over the other. Given the conflicting demands of each of their worlds, and the life-threatening nature of their situation, the decisions they made were intense, high pressured, and often reflected the conflicts they confronted.

For instance, a participant was on her way home from work when she heard that the roads were closing due to a direct missile hit on a bus. Her son was with her in the car, and she understood that if she were to drive him home she would not be able to get back to work. After playing out a number of scenarios in her head, she came to a decision: "My son is more important than my professional responsibilities," and she drove him home.

Choosing family over work in a shared traumatic situation is not at all an obvious choice, according to the participants' stories, and sometimes they had to assert their right to prioritize family needs in the face of workplace demands. One participant who moved with her family out of the targeted area during a period of heightened escalation is an example:

> There was an increasing amount of pressure from the psychiatrist at my workplace for me to come back to work since my clients were waiting for me there. And I said, "I can't." And it was a very, very strong conflict, and it was very hard to do it …. This occurred at the beginning of my career, and there was a very clear statement from both my supervisor and my place of work that I needed to come back, but in the end I resisted the pressure and put my kids first. I felt that this was the proper thing to do, and I said to my supervisor, "I can't …." Perhaps it was difficult for the people at work to understand my situation, that I had nowhere to leave my kids, and if I did not feel that my kids were safe, I could not be there for other people.

Some therapists chose the work domain over the home domain due to pressure from their bosses—a choice that led to feelings of internal conflict. One was a therapist whose 90-year-old father called to say that his kibbutz was on fire after having been struck by missiles:

> Wow, he's so agitated. He's alone, and no one's with him. I should have told them that I was leaving, that the meeting was over, but I didn't. Instead, I went outside for a second and took a deep breath. Then I came back inside and said, "Okay, let's continue." They asked what had happened and I told them that the kibbutz was on fire. They said, "Okay, let's get back to business, let's continue the meeting." There was no empathy, nothing. That's all it was: Come on, come back to the meeting, let's get on with it.

At times the participants experienced an internal conflict when choosing between home and work and explained the rationale for their choice. Some of the trauma workers chose the work domain over the home domain, despite the price that they and their families had to pay. Several made this choice due to their sense of commitment and identification with their patients; for example, one of the religious workers chose to leave her family on the Sabbath eve in order to take care of missile attack

casualties and was proud to explain her decision to her family. Another participant, having been asked by her frightened daughter not to go back to the hazardous area, said:

> "This is my job, dear, I have to go." She was sobbing, and I drove off anyway.

Therapists who adopted this coping method were consistently engaged in an inner dialog between their work and family personas. Sometimes their choice of one domain over the other fit their central identity, reducing the conflict. Other times, the conflict intensified for them and the therapists had to decide whether to stand up and fight against workplace demands, paying the price for their decision, or to surrender to the pressure and pay a personal price.

Some of the particpants experienced a rigid form of segmentation where they experienced a significant gap between their "home identity" and their "work identity." While they functioned properly at work, they allowed themselves to feel fear and even not to function at home:

> When you are at work, you do not allow yourself to fall apart. Perhaps this was what protected me. It gave me strength … my breakdowns were at home. The breakdown didn't happen here, at work. At home I panic when I hear the alarms sounding, and when I run to the shelter. My husband doesn't understand how I function at work, while at home I am so afraid. Here, at work, I can manage on my own. I have no choice.

This kind of segmentation led the therapist to avoid reality and to not take care of or protect himself or herself at home:

> Then I walked home, and I couldn't do anything. I just lay down on the sofa and said: *I have to relax a bit, that's what will help me*. Then the missiles started falling and they didn't stop. Over the course of the next two hours there were maybe 20 missiles, but I didn't move from my couch. I was in this *How do I keep the missiles away from my mind?* mode, just lying on the sofa doing relaxation exercises.

In these two examples, there is an acknowledgment of the existence of both worlds, accompanied by different behaviors enacted in each. In both places, the participants desired to gain some control over the conflict between the two domains. In the following examples, however, there is extreme segmentation, up to the point of unawareness of the other world. The trauma workers describe situations in which they focus only on their work tasks. They do not acknowledge or remember the existence of their family members or their needs. One of the participants received a call from work instructing her to go to a school that had been hit by a missile. Only after she completed her work there did she realize that the school she had run to was actually her son's school and that she had not thought about or checked on him. Another participant forgot about her family altogether when dealing with a situation in which someone from her community had been killed by a missile:

> I never thought about that. I only thought about treating the people who were in need of my help at the moment. My dad who lived 200 meters away said that when he went out of the house he saw the smoke and he didn't know what was happening with me … at the same time it did not occur to me to let my parents know we were okay.

The intensity of their distress led some of the therapists to disconnect the two domains from one another to protect their family members. For others, it seems the aim of the disconnection was to protect themselves by preserving their ability to function and/or by preventing themselves from knowing about the dangers facing them and their families. What is clear in all of these descriptions is that the therapists could not perceive and handle both domains simultaneously and needed to use various levels of segmentation.

Integration of the Work and Home Domains

At the other end of the continuum is the integration pattern. In this strategy, the workers integrated home and work by constructing flexible boundaries between the home and work domains; in some cases, it was difficult to say where the professional's personal life began and ended. These workers spoke of experiencing intrusive thoughts, a merging of identities, being both a trauma worker and a survivor, and integrating their personal and professional domains. This merging manifested itself in the way participants told their stories and in the content and feelings that emerged in their narratives. The constant worry about their families led to intrusive personal thoughts during therapy sessions with patients in cases of STR:

> It was mixed up … It's not that I bring my own experiences into the therapeutic sessions without any restraint, but I can't say that I don't sometimes think about my daughters during the treatment of a patient, or that I don't have flashbacks regarding a patient while at home. I can't really separate these things.

At times, the merging of the worlds led to a merging of the identities. When the participants were telling their stories, it was not always clear to the listener who they were talking about: themselves as parents or as therapists. The next anecdote exemplifies the merged identity of a mother as a trauma worker who simultaneously inhabited both her professional and personal roles:

> I'm driving to work. I'm supposed to meet a patient at eight whose daughter died in a missile attack. So I give a ride to my two kids and a friend of theirs from the neighborhood. While we're driving, my daughter says, "Mom, Mom!" Her friend has started panicking and shaking because her father texted her that a siren has sounded. We haven't heard the siren because it is winter and the car windows are closed. I know that this girl is in therapy, and my kids also know she's anxious. My daughter tells me to pull the car over and give the girl breathing exercises. But I can't pull over because we're in the middle of the road. So my daughter says, "Okay, okay, you continue driving, and I'll do the breathing exercises with her."

In this high-stress moment, the participant's daughter requested that she stop the car and function as a therapist so as to calm her friend. In that moment, the trauma worker experienced an integration of two roles—she was simultaneously a mother driving her children and an expert in anxiety management.

As this situation was ongoing and lengthy, the therapists themselves were often exposed to direct missile hits and attacks. Therefore, they quickly went from being

trauma workers to being trauma survivors as well. This concrete merging of worlds sometimes led to a fuller understanding of patients' experiences: "I worked in Erez all those years," said one therapist. "My house was damaged. I am both a terror victim and a post-trauma therapist."

The following examples describe more fully the awareness of the integration and the continuous movement between the domains. There is also recognition that professionals are human beings with fears and limitations and that a professional who personally experiences a situation can gain deeper insights into it than one who never did:

> We can't erase our existence as people when we're treating others. Just because we're therapists doesn't mean that we're less sensitive or less scared. I don't separate the two. I don't know how to. Whatever happens to me will happen, and that's part of the treatment, whether I analyze it or not. It's part of the interaction between me and the patients. I'm not a hero, nor are they.

This integration is also expressed in the participants' insights about the complexity and contribution of the STR:

> The complexity lies in the fact that I feel enriched in both places. Living in this stressful situation as both a mental health professional and a mother of young children has indeed enriched me both at work and at home.

Recognizing the STR situation and its inherent costs and potential benefits simultaneously enables participants to integrate their work and family worlds and to live in greater peace. It enables them to move between these two worlds without needing to disconnect from one or the other or needing to weld them together.

Discussion

This study investigated trauma workers' coping strategies in an STR. In accordance with the STR literature, the issue of the conflict between professional and personal worlds was found to be central for participants, and some even mentioned it as an additional area of coping, beyond coping with the traumatic reality itself (Faust et al., 2008; Lev-Wiesel et al., 2009; Shamai, 2005). Although the existing STR literature frequently describes the resultant conflict, coping patterns have not previously been conceptualized. For this purpose we used boundary theory, which draws a continuum of segmentation–integration coping patterns (Nippert-Eng, 1996).

Segmentation is characterized by a disconnection between worlds. One way to account for the emergence of this coping method is the domination of one domain over the other during a specific moment (for example, during a mass casualty event involving patients or, conversely, when direct harm befalls the trauma worker or his or her family) prevents one from having to encounter the other domain. Another explanation relates to the difficulty in dealing with the conflict itself, described by some of the participants as impossible. The conflict is so threatening that the worker prefers drawing rigid boundaries between the domains, allegedly living each

moment in only one domain, with the hope of preventing a conflict from arising between them.

The findings of this study dovetail neatly with existing research on the continuum within boundary theory (Nippert-Eng, 1996; Bulger et al., 2007). This study revealed different levels of segmentation, inflexibility of boundaries, and workers' awareness of their segmentation pattern. At one end of the segmentation continuum was the worker who knowingly chose to narrow her practice in order to distance the domains from each other. At the other end of the continuum was the worker who disconnected the worlds by not realizing she was actually at her son's school, as well as the worker who described the split between functioning at work and total dysfunction at home. At these extremes, the segmentation pattern resembles the mental defense mechanism of peri-traumatic dissociation, defined as psychologically removing one's self during or immediately following the events of a trauma (Lev-Wiesel et al., 2009).

Some of the professionals who practiced segmentation found themselves needing to make a choice between home and work, and opting to actively segment the domains (Bulger et al., 2007). Boundary literature describes segmentation as low flexibility and permeability or strong boundaries between the domains (Clark, 2000; Kossek & Lautsch, 2012), definitions that are compatible with participant descriptions of putting aside family matters when at work and vice-versa. Segmentation of domains is a coping mechanism consistent with boundary theory and can positively contribute to reducing the conflict and its negative implications (Kreiner, 2006; Matthews et al., 2010). However, segmentation that is so extreme as to result in avoidance is a phenomenon that is not considered by boundary theory, and it raises questions about the price one pays for using this mechanism. For example, a trauma worker who is high-functioning at work but collapses at home is clearly exhausting too many of his or her resources in the workplace.

At the other end of the continuum is the integration domain. In this pattern, some of the narratives described a merging of home and work identities: the trauma worker identity merging with the trauma survivor identity, or the mother identity merging with the supporting therapist identity. Other examples of merging are when thoughts and feelings from one domain intrude on the other. Descriptions compatible with this pattern appear in the STR literature in the context of blurred boundaries (Faust et al., 2008; Lev-Wiesel et al., 2009; Shamai, 2005). Some professionals offered a more conscious awareness of the conflict and feelings regarding its complexity and recognized that their ability to "merge" enabled an encounter between the domains. This pattern seems to reflect a healthy way of coping, and it more closely resembles the integration pattern as described in the boundary literature, wherein the worker is able to move more freely between the domains (Matthews et al., 2010).

Yet most of the findings on the integration pattern reflected the workers' *insights*, not their actions. It is reasonable to assume that integration is easier to accomplish in situations that are less threatening than STR, where the demands of the two domains are more extensive and integration would require greater mental resources.

The current study's findings highlight the important role played by the organizational climate. As in other STR studies (Ron & Shamai, 2011; Tosone, Minami, Bettmann, & Jasperson, 2010), participants emphasized the importance of both practical and emotional support provided by supervisors in terms of managing the conflict between personal and professional domains. Conversely, an inhospitable organizational climate only increased the difficulties confronted by workers as they strove to cope with overlapping domains.

These findings are in line with Kossek and Lautsch (2012), who suggested that a customized organizational climate—one that enables the worker to choose his or her own boundary management style—would contribute to a decrease in conflict. Kreiner (2006) also assumed that congruence between personal and organizational preferences for boundary management style would contribute to a decrease in conflict.

The narratives in the current study were diverse in relation to the level of control the workers felt they had of their management of boundaries. An individual's perceived control over boundary management style was found to contribute directly to his/her conflict degree and to be a moderating factor between boundary management style and conflict implications (Kossek & Lautch, 2012). Kossek and Lautch explain that workers who feel they can manage the work-home interaction will experience a decrease in conflict because the psychological feeling of control constitutes a resource and enables them to perceive of themselves as capable of dealing with both home and work demands.

The current study has several limitations. As mentioned, the use of focus groups may have curbed participants' willingness to openly discuss personal and professional difficulties, leading to a perhaps only partial revealing of their feelings. Alternatively, the focus group space may have provided a therapeutic means to normalize therapists' reactions (Kitzinger, 1995).

Other limitations include the fact that this study took into account only the personal point of view of the workers; further studies must include additional family members and their perceptions of their parents' and spouses' ways of handling the conflict. Future studies should also explore how and whether the professionals' partners and children affected their chosen coping strategies, as studies have found that partners and children can play a role in the psychological detachment from work (Hahn & Dormann, 2013).

The study investigated the participants at only one time point, after many of them had already lived in a shared traumatic reality for 10 years. Hence, it is important to conduct a longitudinal study, which would investigate long-term changes and development in professional functioning. It would be worth looking at whether coping strategies differ depending on how long the participant has lived in the region, as well as the associations of these strategies and the long-term adjustment and functioning of these workers. Finally, in this study gender difference was not considered due to the limited numbers of male participants. As studies have found differences in spillover effects between genders, it would be important to see whether these results

would manifest themselves within this sample as well (Rupert & Kent, 2007; Rupert, Stevanovic, Tuminello Hartman, Bryant, & Miller, 2012).

The contribution of this study is twofold. It provides a theoretical framework for the STR literature, to be used to consistently document the complexity of the situation. And it enriches boundary theory by applying it to extreme (i.e., life-and-death) conflict situations. This study raises questions and provides food for thought regarding the implications of the boundary theory continuum in continuously threatening situations for trauma workers and mental health professionals in general.

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