Manual for Good Practice and Management in Trauma Centres

Structural Aspects of Work Related Stress - Care for Caregivers

Christian Pross
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The International Rehabilitation Council for Torture Victims (IRCT) is an independent, international health professional organisation, which promotes and supports the rehabilitation of torture victims and works for the prevention of torture worldwide. The vision of the IRCT is a world that values and accepts shared responsibility for the eradication of torture.

The views expressed herein are those of the author and can therefore in no way be taken to reflect the official opinion of the IRCT.

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Introduction

Psychotrauma is a fairly new field. In the past twenty years many trauma centres have emerged all over the world. They were mostly built outside traditional structures of health care as grass roots organisations and in the founding years all the participants rolled up their sleeves to start building the organisation with a lot of idealism and enthusiasm. Unfortunately, in the zeal of the pioneer phase structural issues are often neglected. Basics which are standard in ordinary health care institutions were often missing: regular case conferences, record keeping, fixed working hours, a service schedule that shows who is doing what at what time, time management, fixed channels for exchange of information, regular internal on-going training, statutes and internal rules of procedure, job descriptions, regular management appraisals of staff, clearly entitled leadership, management training for leaders, transparent lines of decision-making. Everybody does his job as well as he can, however the absence of these basics can cause a lot of friction, double work, disorientation, confusion and frustration.

This manual in Part I addresses the basic ingredients of a healthy organisation that supports survivors of torture and political violence: qualification and selection of caregivers, qualifications of leaders, treatment philosophy and team cooperation, organisational issues, the role of a board, care for care givers and supervision. The basic line of thought is that transparent, well maintained procedures and a good account of management and staff will have a strong positive effect not only on the quality of the work, but on the beneficiaries as well, which is the key task of centres.

A more in-depth scientifically based analysis of the ways in which organisational, therapeutic and personal issues can be sources of work related stress is presented in part II. This manual takes into account the results of scientific studies and is based on the author's experience as caregiver, director of a centre, IRCT council and executive committee member, clinical supervisor and organisational consultant.

'He' is used throughout the document in the interest of readability for both genders.

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Part I - Good Practice

1. Qualification of caregivers

Empathy and solidarity with victims of torture is a vital assumption for this work. People who are only looking for a job to make a living with no dedication and motivation from the heart are not suitable candidates. Yet a bleeding heart alone is no qualification by itself. Many centres for torture survivors have been built by survivors themselves. It is only natural and human that those who suffered will be most motivated to help their fellow victims. Their personal experience is a strong motive and driving force for this work. They have a particular sensitivity and deep understanding for their clients, who frequently and justly complain about the ignorance and lack of empathy of "normal" people. On the other hand, survivor-caregivers risk getting enmeshed and over-identified with clients, losing professional objectivity and transmitting their own trauma to the clients and colleagues. This risk is only mitigated unless they have worked through their personal history in some kind of self-awareness process while in therapeutic training and are able to distance themselves from the trauma of their clients.

In many centres there is a lack of psychotherapists. Much of the therapeutic work is done by lay people and volunteers. Some of the staff is only medically, and not psychologically, trained. Yet there are simple and easy-to-learn methods of psychotherapy that include self-awareness(1) in their training curriculum: e.g. transactional analysis(2) and dynamic therapy according to Horowitz(3) to name only two. Most psychotherapeutic methods and techniques are basically Western oriented and have to be adapted to the culture, context and education level of caregivers and clients – just to name a couple of examples: narrative exposure therapy(4) and psycho-educative work(5). In countries where centres exist there may be other original or traditional helping and therapeutic methods like testimony therapy developed in Chile during the dictatorship(6,7), therapeutic storytelling developed in oriental cultures(8), or traditional healing methods(9). Above all group therapy approaches have proven to be effective(10-12). For therapeutic training one does not necessarily need an academic degree in medicine or psychology. It can be learned by people with other professional backgrounds like social workers, nurses, physiotherapists and teachers.

It is difficult – if not impossible – to find out whether an applicant for this work is qualified and suitable after one interview. The best credentials, training certificates, a gapless perfect professional career do not necessarily tell you whether a person is a good caregiver. Therefore a probation period of at least half a year should be part of the labour contract.

The strongest and most important asset and working tool of a caregiver/therapist is his personality, because he serves as a role model to the client, and because the therapeutic relationship is first and foremost a human relationship. So beyond one's professional skills and experience it is important to look at a candidate's character: is he warm-hearted, sensitive, empathetic, solid, and balanced? Does he have resources in his personal life, a normal life outside work, a sense of humour, capacity to rest and relax, does he value pleasure? Workaholics, fanatics and narcissists who centre their lives around work and need it to feed their big ego can often impress their peers by enormous

dedication, zeal and achievements in advocacy and politics, yet they usually prove not to be good caregivers, one of the reasons being that they do not take good care of themselves.

Similar scrutiny should be applied in recruiting volunteers. The good will of a volunteer who is prepared to work for no salary is fair enough. But will he be of an added value to the organisation? What skills does he have? Does he match with the team? Sometimes volunteers can be more of a burden to the organisation than a gain. Volunteers should also get a contract in which their duties are defined.

In some cultures it is common to recruit family members and friends for positions because they are family. This can work if they are legitimately qualified for the job and don't take advantage of their kinship. Nevertheless it always carries the risk of nepotism and corruption. It can harm the team spirit and work motivation when, for example, a staff member who turns out not to be qualified for the job maintains the position because he is the relative of the director. A director has to be just and treat everybody equally, keeping always in mind that the first responsibility of a centre is to provide appropriate care to survivors. In the hypothetical case of this relative's malfunctioning, the director's hands will be tied and he will be placed in an awkward position of dual loyalty.

2. Qualification of leaders

Natural born leaders are very rare. People working in the health and human rights field usually do not have management skills, yet this can be learned in special training. A trauma centre needs a clearly authorized leadership. There should be a clinical director in charge of client services and an administrative director in charge of finances and organisational issues. Leadership requires some elementary properties like talent for listening, modesty, level-headedness, maturity, life experience, stability, persistence, assertiveness and wisdom. All these properties resemble those of a good father and mother, so the style of leadership should follow the good parenting principle. Leading a trauma centre is a special challenge because one serves as a projection screen for all the negative and destructive energy that comes along with this work and which the leader has to contain. A good leader carries his role without blurring functional hierarchy, is prepared to endure "bad-boss" projections and carry through unpopular decisions. At the same time, he must encourage creative ideas and initiatives from staff, let others grow and blossom instead of seeing them as competitors, not abuse his power, and work with transparency to staff and accountability to the board. The leader must monitor staff members' performance and do regular appraisals with them. He should work with reinforcement and praise but must also be capable of telling somebody who turns out not to be qualified to undergo additional training or look for another job. It is impossible to carry all these challenges and responsibilities alone. "It is lonely at the top" is a common complaint one hears from leaders. Indeed they cannot share the problems connected with their role with staff, they cannot be everybody's darling and it is asking too much from them to expect them to always have a big heart and understand everybody's problems and complaints. They have their boundaries like every human being and they have to respect those boundaries. Therefore they need peer group exchanges and

consultation with other leaders and regular coaching by an independent external leadership coach.

The leader is an important role model for the team of caregivers as well as for clients. A chaotic undisciplined leader will foster chaos and sloppiness among staff. A choleric leader who cannot control his anger will spread fear and intimidation instead of containing it. A workaholic self-sacrificing leader who does not take good care of himself will not encourage care for caregivers among staff see e.g. Kets de Vries (13). The leader must also serve as conflict resolution moderator. If he is part of the problem, the board or an external mediator must take this role.

3. Treatment philosophy, healing environment and team cooperation

There should be an agreement on admission procedures and a common treatment philosophy: a set of standardised diagnostic tools such as trauma questionnaires, a formula for taking histories – medical, psychological, family, social and trauma history; an agreement on what interventions will be applied in what situations. Medical and therapeutic records should be kept carefully. New admissions and the therapeutic process of clients should be discussed in regular weekly interdisciplinary case conferences. This can be done like a round in a hospital ward where all clients/patients are presented every time, or it can be in the style of a more focused conference where only a few – for example the most difficult or urgent – cases at a given moment are discussed in depth. Topics of the case conference should include the case concept, diagnostic findings, the client's social situation, stresses and possible resources, the discussion of treatment methods such as crisis intervention, counselling, short-term or long-term treatment, social, psychiatric or psychotherapeutic treatment, physiotherapy, group therapy, family or community interventions(14,15). Furthermore, the number of explorative sessions for a new patient, regular appraisals of the therapeutic process and the anticipated end of therapy should be discussed. For survivors of torture, social and existential needs are often the most urgent ones. So social support in finding a job, housing, building a social network, getting asylum in the host country, nursery and school education for children, psycho-education, stabilising, trust-building etc. may have priority and be more appropriate in the beginning than trauma focused therapy. However, these advocacy activities should be combined with other supportive psychotherapeutic interventions(12).

Usually several persons work with a client: the doctor, the psychologist, the social worker, the nurse, the lawyer, etc. They must keep each other up to date; the right hand must know what the left one is doing. In order to assure appropriate exchange of relevant information diligent record keeping is important. Another approach is regular communication and exchange of information among caregivers through informal and formal channels. Team players will be much more effective and much more rewarding to work with than lone warriors and rescuers.

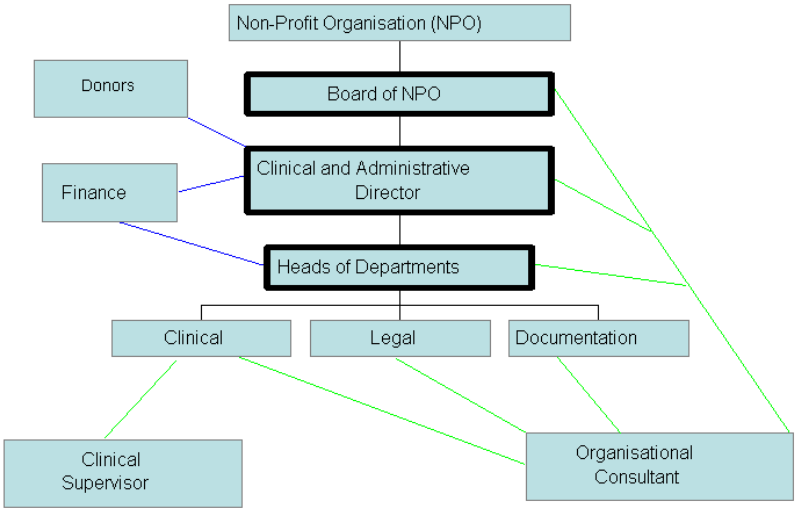
The atmosphere and the interior of a centre should have a welcoming, friendly healing character. A run down, shabby place usually is a sign of a chaotic, negligent and careless working style. Also, with limited resources and simple means such as paintings on the

wall, curtains in friendly colors, tidy rooms, toys for children in the reception hall, one can create an environment where clients and staff feel comfortable. The same goes for the style of communication: it is not what you say but "how" you say it. It starts with the person answering the phone and the receptionist in the admission. Does the client feel he is welcome or a nuisance? The same goes for the tone among staff: is there a culture of mutual respect, attentiveness and tolerance or a culture of competition, envy and intrigue?(16)

4. Organisational issues

In pioneering organisations rules and operating procedures are often considered a nuisance or a necessary evil. They carry the stain of alienated bureaucracy. Yet if they are shaped according to the needs and the tasks of a centre and created on a consensus basis they make life easier, they save time and energy, and they facilitate cooperation and communication. Statutes define the aims, the mission and the target groups of the centre. Bylaws define how they are accomplished in daily work. These, for example, set the daily working hours, a service schedule, who is doing what at what time, as well as some of the items mentioned above like the standards of record keeping, etc. Job descriptions as well as standardised labour contracts should be made for every staff member, to document clearly what his tasks are. It is useful to make an organisational chart of the centre (see Figure 1) which highlights the hierarchy, who is accountable to whom, who decides on what, how labour should be divided, who is responsible and in charge of what, what are the decision lines, what are the channels of information and communication. Responsibilities of volunteers should be clearly defined in differentiation from those of permanent employees.

Figure 1 - Sample of organisational chart



In some cultures it may be uncommon to put agreements and rules in writing. The problem is that oral agreements tend to be forgotten, or may be remembered differently by various participants, so that after a while nobody remembers what exactly was agreed upon and there is nothing to refer to in case of lack of discipline or disagreement over violation of rules. Furthermore, time management may differ across cultures and meeting hours and service schedules may be handled more flexibly. Yet this often causes frustration and friction. It is a waste of time and resources (i.e. money) when a team of caregivers cannot start working because it has to sit around waiting for latecomers to show up at a team meeting or a case conference.

As clinicians often are not familiar with budgeting and administrative issues, the centre should employ an administrative director or – if resources are not available – at least an accountant.

5. Board and patron

A trauma centre should have a board that represents the legal body of the organisation, be it a foundation, a charity or a non-profit association. The board should ideally consist of independent experts from various backgrounds – medicine, academia, law, finance, business, politics, arts, media etc., who usually work on a voluntary basis. They should be influential people, figureheads who have a standing in society, and who can thus give the centre moral and political support. This is particularly important in countries with a repressive regime where such board members can protect a centre against threats and assaults from state authorities. Board members should have no stakes in the company to avoid conflict of interest, i.e. no mixing and fusing of roles and levels such as director or staff members serving simultaneously on the board. The board appoints and dismisses the director, monitors and controls the performance of staff and director, approves budget and controls spending. It also must serve as a conflict moderator in case a conflict cannot be handled on the staff's and director's level. Experience in many pioneer organisations shows that failure to overcome dysfunction, tension and conflict is due to a missing or a malfunctioning board.

In some countries it is uncommon to have a board and it is difficult to find independent experts who are prepared to sacrifice time and energy for this kind of voluntary commitment. In this case some kind of patron, an experienced external professional – possibly from abroad - may be able to support and protect the organisation.

6. Care for caregivers

This issue has often been neglected in the founding years of centres. Working with torture survivors carries a high risk of burnout and compassion fatigue. Much of work related stress stems from ambiguous task elements described above. Stress in workers will be reduced tremendously if the above mentioned organisational problems are tackled. But also in a healthy organisation one needs a counterbalance to the hard challenges of this work - in every team there is a mixture of constructive and destructive elements. Leaders and peers should have an eye on colleagues who show signs of

overwork and exhaustion. It is vital to preserve and foster a normal life outside work where one can relax and regenerate. It is necessary to shield the private sphere of life, one's children and family from hard and burdensome work-related topics. Colleagues working late hours and during weekends, taking work home, not taking their full vacation, neglecting friends, family and hobbies, colleagues who are obsessed and never stop talking about the work should make the alarm bells ring. It is important to arrange facilities at an organisational level like taking a break from client or advocacy work for a while, e.g. by taking "mental health days", a sabbatical, doing research, teaching, publishing, participating in ongoing professional training, rotating into other fields for a while, or reducing working hours to a part-time job. This can create distance, space and time for processing and reflecting.

In their private lives, caregivers usually have a whole range of resources for self-care and protective coping strategies that leaders should encourage (see Table 3). The Human Rights Foundation of Turkey identifies the inability to find time for external socialising and not being able to develop an identity beyond the work as a factor for burnout. They recommend caregivers to work part-time and take good care of themselves: i.e. sleep well, have a well balanced diet, participate in sports, consume less caffeine and participate in social activities. Last but not least they advocate ongoing supervision, which helps to clearly define the role between caregiver and torture survivor and to monitor processes of identification, transference and countertransference.(17)

Supervision is in fact a key element of self-care because it helps caregivers from drowning in work, losing their professional distance and getting too enmeshed. A care for caregivers program matching the specific culture and needs of staff should be designed and laid down in the statutes(18).

Caregivers should be aware of the fact that they serve as a role model for their clients. Survivors of torture are striving to reclaim some normalcy in their lives, to regain the capacity to celebrate, laugh, love and find pleasure in life as a counterpart to the darkness of their traumatic experience. If the centre is a dry, gray, humourless place and the professionals working there abstain from the pleasures of normal life and sacrifice all their time and energy only for the struggle against evil, they will not encourage their patients in this striving.

7. Supervision

Listening to tales of torture is a challenge that no caregiver can or should carry on his or her shoulders alone. It needs to be shared with others: with colleagues on a daily basis and from time to time with an external clinical supervisor. Clinical supervision is nowadays considered standard in medical, psychiatric and psychosocial care. What is clinical supervision? Supervising in the original Anglo-Saxon sense of the word means monitoring, controlling, directing and is associated with the function of a leader. A clinical supervisor is not a director, not an executive but an external consultant, usually an experienced therapist, who advises and helps caregivers (the supervisees) to improve the quality of their work. Supervision facilitates the development of persons and organisations, looks at personal interactive and organisational aspects and helps improve

communication and cooperation in a team of caregivers. It is a shared reflection on problems arising during therapy and teamwork and it is a joint search for solutions. Supervision is not instruction, training and education of a supervisee by a supervisor.

Individual supervision

The setting is one-to-one. One supervisor and one supervisee, or a couple of supervisees such as a social worker and a psychologist who look after the same client. The supervisee presents his case, and a problem he is seeking advice for from a supervisor. In addition to case supervision, one can also provide individual coaching as a support for work stress related to the organisation and personal professional development.

Case group supervision

Group supervision is best for caregivers who work independently from each other, e.g. doctors, psychologist, nurses, social workers, who work with different clients and come from different organisations. The ideal size of a group is 4-7 caregivers. An advantage of group supervision is mutual support of supervisees as a peer group, which makes them less dependent on a supervisor. It also allows for the application of multifunctional techniques such as role plays and mirroring. One can also apply this kind of supervision in a team.

Team supervision

In team supervision, the supervisor consults in one institution with a team of caregivers who want to work on problems of communication, cooperation, tensions and conflicts in the team. The focus is less on discussing cases but rather on interpersonal relationships between team members, work climate, hierarchies, competition, alliances, turf and faction fighting. Team supervision can help to develop a culture of creative and productive conflict resolution.

Organisational consultation

In this case the leader of an organisation hires a consultant to work with the team and management on issues concerning structure and culture, aims and strategies as well as corporate identity. Focus is on clarifying and improving division of labour, assigning tasks and competence, operating procedures, decision and communication lines, clear definition of hierarchies, what is the authority of the director, who is accountable to whom. Problems which arise in individual, group or team supervision are often related to structural shortcomings and can partly be solved by organisational transformation with the help of a specialised consultant.

Basic rules of supervision, coaching and consultation

The supervisor must be an independent external specialist, who has no personal connection to the supervisees and is in no way dependent on the organisation e.g. as a permanent employee. Only from the position of an impartial outsider can he professionally judge and monitor the arising problems and processes in supervision. A

director or a staff member cannot simultaneously be a supervisor of his colleagues, with whom he is closely related, both personally and professionally.

All issues shared in supervision are strictly confidential, because they may touch upon sensitive medical and psychological data of clients as well as personal problems of caregivers. Supervision requires mutual trust and acceptance of supervisees and supervisor. Therefore, in the beginning some probationary sessions should be held, in which both sides can freely decide whether they match and want to work with each other.

Supervisees and supervisor shall treat each other respectfully and attentively with mutual appreciation of their work. Suggestions and critique are not expressed in a derogatory or punishing way, there is no absolute "right" or "wrong", and the aim is a shared reflection and learning.

Agreement upon the rules of the frequency and duration of supervision, the supervisor's mandate, and the honorarium for the supervisor, should be set out in a contract between the hiring organisation, the supervisor and the supervisees(19,20).

Part II - Work related Stress in Trauma Centres

1. Introduction

Working with torture survivors is a very challenging task and carries some risks for caregivers. There are numerous studies showing a high degree of burnout and work related stress among caregivers in organisations working in the field of trauma(21-25). In the early years of the IRCT network this was officially ignored or seen as a marginal problem, although it was obvious how it was affecting staff performance and the quality of the work. IRCT council members June Lopez, Elizabeth Marcelino et al. talked for the first time in 1994 about countertransference issues and care for caregivers at an International Consultation Workshop on Therapy and Research Issues in the Care of Torture Survivors held in Tagaytay City in the Philippines.(26) At the IRCT's VIIIth International Symposium in New Delhi, India in 1999, in a session on care for caregivers, several speakers reported breakdowns, depression, withdrawal and anxiety among staff members in their centres as the result of the extreme load they bear. As means of prevention they recommended regular mental care and supervision for caregivers.(27) Since then there has been a growing awareness that something had to be done, and during the IRCT's IXth International Symposium in Berlin 2006, secondary trauma, care for caregivers and clinical supervision were among the key topics.(28) Since then some IRCT centres have sought regular supervision and organisational consultation for their teams, resulting in better conflict resolution, reduction of stress, improvement of the working climate, job satisfaction, and better output.(29)

The above mentioned studies focus mainly on the person to person level, the dynamics between caregiver and patient. Some describe how "contagious" traumatic material can be transmitted to the therapist and call it "vicarious traumatization"(22), "compassion fatigue"(21) or "secondary traumatic stress"(25). Lilla Hárdi from Cordelia Foundation states: "listening is the most important characteristic of empathy, and through the thread of this empathy, the trauma intrudes into the caregiver's unconscious. Thus, we survive the trauma 'instead of the client.' We can often detect the milder symptoms of the posttraumatic stress disorder in ourselves: anxiety, depression, helplessness, flashbacks, alienation from 'normal' life, dissociative episodes, paranoid thoughts, cynicism, pessimism, extended helper's role, over-identification with the victim's rage/mourning, identification with the aggressor, feelings of guilt, hyper vigilance, social dysfunction, mistrust, existential panic."(30)

Recent studies show that the socio-political environment, as well as structural and organisational shortcomings, are also an important source of work related stress(31-33) and they suggest how organisational transformation can improve motivation and performance of caregivers.

The Human Rights Foundation of Turkey (HRFT) reports a whole range of environmental factors causing work related stress: the worsening condition of survivors during treatment due to the threat of being detained again, poor living conditions of the survivor, survivor developing expectations beyond what can be provided by caregiver, social isolation of survivor and caregiver, physical assault and intimidation of caregivers by state authorities. As a result, caregivers suffer from fatigue, loneliness, lack of

confidence, loss of motivation, alienation, feelings of guilt, inadequacy, uselessness, powerlessness and anger which accelerate a process of burnout(17).

Gurris in his study on centres for refugee trauma in Germany found as sources of work related stress: the extreme traumatic experiences of clients, the traumatising living conditions of refugees, conflicts with team and management, little treatment success with clients.

He designed a model in which treatment success is the basic factor. Caregivers who believe that trauma processing is important but achieve no or minimal results, are significantly vulnerable to work-related stress and are sensitive to destructive and frustrating team processes. He also notes that a personal experience of trauma on the part of the therapists may have a positive and negative effect on treatment. Caregivers who did not finish their psychotherapeutic training are quite vulnerable to negative effects (see also chapter 3 "Caregiver trauma…")(34,35).

2. Culture of trauma centres and structural problems

In the past 25 years the centres for the treatment of torture victims in the IRCT network were mostly founded by groups of highly dedicated human rights activists and professionals. The founders tended to be very strong charismatic personalities, pioneers in a new field with entrepreneurial skills and a missionary sense, which enabled them to build and defend their organisations against reluctant bureaucracies and the prevailing attitude of denial and indifference in society. Without their passion, zeal, enthusiasm and endurance, these centres would never have succeeded. The founders did not care much about traditional and passed-down rules and formalities regarding how to run an organisation in their societies. On the contrary, as dissidents and rebels they rejected these and invented new models. The pioneer, grass roots culture they shaped, the idealism and enthusiasm they spread in order to inspire their staff, created a particular "honeymoon" atmosphere: a friendly, buddy-like work climate, informal relationships and little focus on monitoring and accountability. This phenomenon of "honeymoon" can last several years and function fairly well, as long as the organisation keeps its original small size and program(33). Sociologists have found in their studies on non-profit organisations that organisational growth and a diversity of tasks require at some point more division of labour and management skills in an organisation. This inevitable transition from pioneer culture to professional management culture is usually very painful and is accompanied by crises(36,37).

The above mentioned charismatic founders' qualities which were essential in the creation of the organisation can turn into obstacles because they consider management issues a nuisance. For them, these issues belong to the evil world of established – repressive and alienating – institutions and state bureaucracies. Raised in a fight against state repression, they reject any hierarchy and create a dichotomy between a culture of "cold management" in the external world, and a culture of "the bleeding heart" in the inner world of the human rights movement. Rules and standard procedures mean, for them, coercion and a loss of autonomy. For these reasons, they often obstruct transforming their organisation into a professionally managed health care institution.

Although they carry democracy and equality on their banners, some of the charismatic founders have problems with dissent. They are fighters, utterly convinced of themselves and their mission, and possessing a degree of self-importance and a sense of uniqueness which makes them show little tolerance for doubts or critique from within their own ranks.

This highlights a specific problem which is typical for human rights organisations. One of the bonding patterns of founders of human rights organisations and trauma centres is the fight against hierarchy originating from the struggle against despotism and dictatorship. Thus, in their perception, any kind of hierarchy, exertion of power, and leadership itself, is something dangerous, bearing the stain of abuse and repression. Yet what was, and is, a natural and positive driving force in the political struggle may not be appropriate in a health care and therapeutic environment. In each group of human beings hierarchies emerge: older ones versus younger ones, professionally more trained and experienced ones versus beginners, academics versus non-academics, etc. After some time in the apparently free space of an egalitarian team, informal power holders inevitably emerge; for example, those being more eloquent, speaking louder and longer than the more silent and modest ones. Informal power emerging in a hierarchy-free environment carries a higher risk of abuse than formal power in a structured environment with a defined set of rules and roles. Informal power operates in the dark. It is untouchable, non-transparent, not embedded in a system of rules, and not accountable to independent bodies such as a board or a controlling agency. Therefore, abuse of informal power is much more difficult to detect and expose than abuse in an environment of publicly controlled formal power. The myth of an environment without hierarchy ignores the fact that a benign hierarchy has a protective function, in the sense of good parenting. Parents protect younger children against their older siblings, as a leader protects weaker or younger team members against dominant or older ones(33).

Another problem inherent to this field is a tension originating from the extreme polarisation between perpetrator and victim. In anti-torture work, one is dealing with an extremely vicious and powerful external enemy – the torturer. In every counselling and therapy session the shadow of the patient's torturer is more or less present. This can have a strong impact on teams and organisations. One the one hand, the external enemy is a strong bonding force within the organisation. However, it can foster a black and white view of the world, a tendency to see the external world as bad and hostile and idealise the internal world of the team as harmonious and good ("them" versus "us"). In this setting, internal dissent is easily targeted as a threat and betrayal. This may be a reflection of the caregiver-patient relationship. The misery and suffering of a victim provoke strong feelings of empathy in a caregiver. These feelings are connected with high moral expectations in a caregiver to expect oneself to side with the victim (to be "good"). Selfish ("bad") impulses, like striving for a career, demanding a good salary, taking full vacation and avoiding working overtime, which go without saying in other fields, tend to be split off and suppressed. There is a strong pressure to identify with the victim and the cause. Yet victims/patients can be over-demanding, aggressive and exploitative towards caregivers. In transference and countertransference processes during therapy, the patient can shift into the position of a perpetrator and the caregiver into the position of a victim. This can be mirrored in a parallel process in a caregiver's

team at times when internal conflicts are dealt with and interpreted along the perpetrator/victim stereotype (for example: powerful, guilty ("bad") leader against helpless, innocent ("good") employee and vice versa). Accusing someone of behaving like a perpetrator in a team conflict – which does not happen rarely - can seriously harm and ostracise this person. Table 1 shows the most common structural shortcomings as sources of work related stress(33).

Table 1: Structural shortcomings in organisations with high stress and conflict level

Failure to maintain boundaries
Over-identification with clients, lack of professional distance
Lack of professional management and good leadership
Informal leaders involved in turf battles
Myth of egalitarian team
Awkward, lengthy decision making processes
Diffusion of roles and competence
"Ambulance chasing" or hectic, uncoordinated interventions and activities
Lack of professional quality standards
Insufficient or no therapeutic training
Lack of therapeutic concept
Clinical supervision non-existent or only sporadic
Re-enactment of the traumatic world of the clients
No coaching for leaders
Workaholism, self-sacrifice, self-care, insufficient or non-existent
No board, or amalgamation of board, management and staff, leading to conflict of interest

Some of these findings are echoed by Lilla Hárdi in her paper on care for caregivers: "Becoming traumatized by the client's trauma history, the caregiver mobilises his primitive or immature defence mechanisms as the result of regression. Denial results in mistrust, projection might result in the distorted image of 'the government as the enemy.' If the caregiver over-identifies either with the victim or with the aggressor, he might split the surrounding world into 'helpers' and 'enemies'. Recognising and elaborating our regressive behaviour with mature defences are the best 'psychological tools' to handle the process in a healthy manner, sublimation (productive or creative activity) and humour being the best boundary or border guards in such a situation.... Belonging to a team is a great help, with its support and criticism. It has a container function, sharing the load of traumata. Colleagues are the best 'boundary/border guards'."(30).

3. Caregiver trauma – resource and risk

Thirty-one percent of the interviewed caregivers in the Pross & Schweitzer study(33) reported a history of trauma. Similar figures were found in other studies on caregivers working in the field of trauma(23,34,38). These therapists may be more empathetic than the "unaffected" ones (see Part I, chapter 1). Yet these hypotheses have not been proven empirically(39) and the opposite can be argued: that affected therapists risk getting enmeshed and over-identified with clients, losing professional objectivity and transmitting their own trauma on clients and colleagues. Several studies show that an unresolved caregiver trauma can be a great risk factor for team conflicts and work related stress unless it has been worked through and resolved in some kind of self-awareness process while in therapeutic training(33-35,40). The Human Rights Foundation of Turkey notes that a caregiver who has experienced a similar trauma to that of the torture survivor can find himself identifying with the survivor, which can trigger post-traumatic symptoms in the caregiver(17).

4. Re-enactment of trauma

The atmosphere in organisations with the above mentioned structural shortcomings is shaped by a re-enactment of the traumatic world of the clients, creating a general atmosphere of fear and persecution, fantasies about the presence of the secret service, perpetrator-victim relationships, and obsession with violence and splitting behaviour (ex. categorising colleagues in terms of good and bad, friends and enemies). Moreover, an atmosphere of intolerance and dogmatism resembling a sectarian culture can be found, along with abusive relationships with denigration, slander, victimisation, scapegoating and expulsion of dissidents. A chaotic, unstructured, unpredictable environment in the organisation reflects the traumatic world of clients with a total absence of structure and control, resembling the one that exists when a victim is at a perpetrator's mercy(33).

5. Prevention of work related stress

Although some of the above mentioned sources of stress are an intrinsic element of anti-torture work there are ways of containing them and coping with them, in order to reduce stress levels. Caregivers name a whole range of resources and rewarding activities that enable them to cope with the challenges of this work.

The following resources and coping strategies are often mentioned by therapists: personal history of trauma (worked through in therapeutic training), empathy with clients, struggle against injustice, political activism, advocacy, media work, fundraising, job satisfaction in client work, peer support and exchange, continuing professional training, research, publishing, teaching, realistic aims, pragmatic approach, no dogmas, freedom from moral pressure.

As specific self-care strategies, they mention amongst others reducing commitment to a part time job, rotating into other professional fields, "mental health days" and preserving a sense of humour as an antidote to the intrinsically (see Table 2) dark content of this work.

In low stress and conflict level institutions, leaders support and encourage these self-protective strategies(33). Saakvitne et al. have created training modules for self-care strategies based on many of the same resources(41). Similar concepts were developed by Reddemann(42).

Table 2 shows resources and means of prevention of work related stress caregivers have developed to cope with the challenges in their work(14,30,35,41,43,44).

Table 2 - Caregivers resources and framework for self-care

Avoid overwork
Limit caseload
Keep a balance between empathy and professional distance
Not carry on work at home
Regular time off, "mental health days"
Share work related problems with colleagues, a supervisor or a coach
Team retreats where new projects and long term strategies can be discussed
Realistic aims, pragmatism - less idealism and grandiose „saviour of the world" fantasies
Advocacy and political work
Priority of professionalism over politics
Continuing professional education
Opportunities for research and training sabbaticals
Learn how to protect oneself against being misled by malingerers
Time for hobbies, leisure
Time for family and friends
Music, art, literature, movies, theatre
Preserve sense of humour
Sports, Nature
Playing games
Meditation, relaxation techniques
Spiritual and philosophical perspectives
Beware of drugs - alcohol, caffeine, smoking
Team culture, parties, joint cooking, weekend trips
Protection and care by leaders with good parenting
Social recognition by society, support by "celebrities" such as artists and opinion makers

6. Standards for structure

Summarising all the above mentioned notions, the following standards for organisational structure can serve as a guideline (see Table 3).

Table 3 - Standards for structure of a trauma centre(33)

Clearly entitled good leadership according to the good parenting principle
Delegation of tasks and responsibilities
Clear definition of roles and competence
Transparent lines of decision-making and accountability
Staff participation according to professional competence
Regular case conferences
Fixed working hours, service schedule, time management
Fixed channels for exchange of information, internal communication system
Statutes and internal rules of procedure, job descriptions
Regular management appraisals of staff
Maintaining boundaries
Balance between empathy with clients and professional distance
Clear intake procedures
Limitation of case-load
Explaining possibilities and limits to the client – working with transparency and with informed consent reduces the frustration caused by too high expectations
Careful selection of new staff and leaders (considering character and professional credentials)
"Affectedness" i.e. personal history of trauma is not a qualification by itself
Therapeutic training for caregivers including self-awareness
Extensive ongoing professional training (learning new methods)
Common treatment philosophy, therapeutic concept
External clinical supervision
Coaching and management training for leaders
Care for caregivers program
Board monitoring the organisation and the leader, consisting of independent experts who have no conflict of interest

7. Concluding remarks

Many of the above mentioned difficulties in teams and organisations dealing with torture rehabilitation are inherent to this work. These difficulties tend to emerge suddenly and unexpectedly upon a happy and rewarding euphoric pioneer period. This causes feelings of shock, anxiety, setback and disillusionment. The transition from the informal, family-like, pioneer culture to a more professionally managed institution is usually accompanied by friction and turbulence and does not necessarily lead to the decline and breakup of the organisation. It is a necessary and inevitable part of organisation building and development. Every crisis offers an opportunity. Keeping this in mind may reduce anxieties and enhance one's stress resistance and patience. Team- and case-supervision, as well as organisational consultation, and training by external consultants can help in solving these problems, get the organisation back on track and make work more rewarding and satisfactory.

Trauma centres are supposed to be places of refuge, safe havens for clients who have undergone horror and destruction and seen the total disruption of their familiar environments. Victims of human atrocities, such as torture and sexual violence, often have lost their basic trust in mankind. For them, there is no longer anything benign in the world. Being at a perpetrator's mercy, they have experienced extreme arbitrariness, the complete absence of structure, and the total impossibility of controlling or predicting what would happen to them, leading to insecurity, anxiety and disorientation. The individual therapist cannot repair all the damage within the client-therapist relationship alone. He needs the support of a team of empathetic colleagues, and protection and support from a competent and experienced leader and an external clinical supervisor. A certain amount of re-enactment of trauma by caregivers and teams is inevitable and can be a valuable source for understanding patients' problems. Of equal importance, the organisation as a whole must provide a healing atmosphere of support, safety and protection for its clients. It must give them the chance to regain control over their lives. This is why the stability and clarity of the structure of a trauma centre are of vital importance for the well-being of both patients and caregivers. Lack of structure and a chaotic environment, however, foster stress and conflict in teams, and disrupt an organisation. Moreover, they impair the helping capacity of caregivers, which is ultimately detrimental to the tortured clients(33).

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