CULTURAL COMPETENCE AND TRAUMA IN THE ORGANISATIONS: SOURCES AND PREVENTION OF STRESS AND DYSFUNCTION

Christian Pross

Abstract

This article addresses the impact of psychological trauma on organisations. The paper was informed by a study conducted with 13 organizations dealing with victims of extreme trauma such as torture, political, ethnic and religious persecution, domestic violence, and sexual abuse. 72 members of staff were interviewed to address repetitive patterns and clusters within their organisations. Interview analyses were combined with observations of team dynamics identifying informal structures of organisations that highlight the discrepancies between the outside appearance and the inside life of organizations.

Key words: trauma, cultural competence, organisations, burnout, vicarious traumatization, work related stress

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1. Introduction

Psychotrauma is a fairly new field. In the past 30 years many trauma centres have emerged all over the world. They were mostly built outside traditional structures of health care as grass roots organizations and in the founding years all the participants rolled up their sleeves to start building the organization with a lot of idealism. After a couple of years the enthusiasm of the “honeymoon”-period of the organization usually comes to an end when the team cohesion crumbles and conflicts arise about pay, increasing caseload, uneven distribution of workload, competition, power, leadership, decision making, funding, profile in public, politics. These conflicts often escalate dramatically into splitting, faction fighting and people resigning abruptly.

A report from a co-founder of the early years of a trauma center may highlight this: Working hours were extended into evenings, nights and weekends. Overtime and leave days were left to expire. Transitory periods of euphoric hyperactivity were followed by breakdowns of a ‘hysterical’ nature. Feelings of powerlessness and despair were ventilated by hostile exchanges and accusations. This kind of staff behavior generated anxiety in young interns of becoming mentally ill. Funding cuts resulted in colleagues ‘disappearing’ overnight while remaining staff was haunted by phantasies of war and persecution within the organization (Gurris 2002).

The leading question for this study was to identify the causes of these phenomena, whether they are personality bound, inherent in trauma work or due to organizational shortcomings.

McCann and Pearlman (1990) were among the first to describe how the client’s “contagious” traumatic experience can be transmitted to the therapist and called this phenomenon vicarious traumatization. Most subsequent studies have also examined vicarious traumatization at the individual level of the dynamics between client and therapist (Danielli 1988, Chresman 1995, Figley 1995, Stamm 1999) but have excluded, or only peripherally touched upon, environmental factors such as the structure and culture of the organization, team dynamics, and the relationship between the organization and the outside world. In a critical analysis of studies of vicarious traumatization (VT), Sabin-Farell and Turpin (2003) maintain that evidence of VT in trauma therapists is meager and question the validity of the term vicarious traumatization. They state that the distinction is blurred between VT and burnout and that the terms compassion fatigue (Figley 1995), secondary traumatic stress (Stamm 1999), and vicarious traumatization (McCann and Pearlman 1990) are tautological and overlapping.

The data from this study provide ample evidence that the after effects of work-related stress manifest themselves in trauma-like phenomena. However, it may be questioned whether this can be termed a disorder, similar to PTSD, or whether it is an inevitable contagious effect of working with trauma clients, considering that caregivers in well structured institutions report considerably fewer symptoms. The approaches developed by McCann and Pearlman, Figley and Stamm were very useful in formulating the initial hypotheses of our study that vicarious traumatization can affect entire teams and organizations. We suspected causing factors in structural deficiencies of organizations such as lack of professional management and leadership and diffusion of roles and competence. The process of collecting and analyzing our data made us discover a wide variety of structural problems and so took us beyond the concept of vicarious traumatization.

2. Methodology

The notions of this paper are derived from the author’s research and his experience as caregiver,
director of a trauma centre, clinical supervisor and organizational consultant. A key part is based on a qualitative analysis of 13 organizations dealing with victims of extreme trauma such as torture, political, ethnic and religious persecution, domestic violence, and sexual abuse. Eighty-two members of these organizations were contacted for interviews, the 72 of whom agreed to be interviewed. 47 were caregivers with direct client contact, 10 were supervisors, 7 were experts in trauma, and 8 were people working in advocacy for victims. The participants were between 33 and 75 years of age; 52.8% were women, 47.2% men. The average age was 53; that is, these were predominantly people with long-term professional experience. The professions involved were physicians (45.8%), psychologists (23.6%), social workers (12.5%), nurses, and teachers. Of the 47 interviewees with client contact, 48.9% were in leadership functions; 66.6% had been trained in psychotherapy, and one third (33.3%) had no therapeutic training. Fifty-seven of those interviewed were from Western countries and 15 from non-Western countries in transition from dictatorship to democracy. Further data were collected from the authors' own observations in numerous trauma clinics and networks; from annual reports, publications, and organigrams; and from organizational analyses and capacity assessments carried out by external consultants hired by donors or legal bodies to monitor the organizations' performance and efficiency (Press 2009, Press and Schweitzer 2010).

Interviews were conducted on the basis of “problem-centered interviews” (Witzel 2000). In this type of interview, the interviewer continuously develops new hypotheses and proofs or revises them in response to the ongoing dialogue. The interviews were transcribed and analyzed, together with the other sources, using qualitative data analysis in accordance with “grounded theory” (Strauss and Corbin 1998) with the help of ATLAS-ti, a computer-based data analysis program (Muhur and Friese 2001). By comparing interviews with other interviews and with data from other sources, we were able to identify repetitive patterns and clusters and subsume them under specifying codes. The steps of coding—open, axial, and selective—eventually led to the formulation of progressively higher levels of abstraction, culminating in a theory explaining the observed phenomena.

The data collected from all these sources enabled us to compare formal with informal organigrams of the 13 organizations during different phases of organizational development. Formal organigrams show the official surface structure of an organization as it presents itself to the outside world. Informal organigrams show the subsurface, the deep structure that reveals the real dynamics of the institution: personal alliances, hidden agendas, and informal power holders (Malik 1989). By combining the data from interviews with leaders and staff and from observations of team dynamics, we were able to identify the informal structures and show the discrepancies between the outside appearance and the inside life of organizations.

3. Models of group development

The phenomena we found in trauma teams are reflected in theories about the formation of groups, such as Bion’s model of “dependency, fight/flight and advocacy for victims” (Bion 1970) and Tuckman’s model of “forming-storming-norming-performing” in group development (Tuckman 1965). In the early pioneer or honeymoon phase of trauma centers, the teams resemble the dependency or the forming group. The group feels unified in a common feeling of insecurity and depends on the leader to protect it from the hostile outside world (dependency group, Bion). This is a period of getting to know each other, a feeling of togetherness, agreeing on goals and tasks, and forging a minimum consensus (forming group, Tuckman). Later, team members begin to discover the differences between them and to compete and fight over differing ideas and aims (storming group, Tuckman). The group exhibits regressive behavior and splits into competing factions, with some siding with the leader and others attacking him or escaping from the group (fight/flight group, Bion). This phase can be very unpleasant, painful, and destructive. Yet it is a necessary part of group formation. It is followed by a period of adjusting to each other and agreeing on rules, values, professional standards, working tools, and methods (norming group, Tuckman). The dangers of the fight or flight conflict culture make the group seek an integrative leadership figure—often a male–female pair of leaders—who secure the survival of the group, which is a sign of maturation (pairing group, Bion).

Tuckman adds a fourth stage: performing. The team is able to function effectively as a unit; members are interdependent, motivated, and knowledgeable. Dissent is expected and allowed as long as it is channeled in acceptable ways. The teams we examined all more or less went through these stages. Some became bogged down in the storming or flight or flight stages. Some were blocked in an overly rigid norming culture, which hampered individual creativity and created “groupthink”. Some groups went through these stages over and over again, while in others, elements of forming, storming, and norming overlapped and occurred simultaneously.

4. Case example

The organizational chart in slide 1 shows the formal organigram of a national alliance of trauma centers with staff from different nationalities and cultures. Each center elects a representative into the alliance assembly which is the policy making body. The alliance assembly elects an alliance board who appoints and controls the director of the bureau. The latter and his staff are in charge of the daily management in funding, advocacy and center support issues. The bureau also channels funds to individual centers by assisting in application procedures and lobbying with various donors. There are two important bodies at the fringe of the formal organigram: the main donor, who officially does not interfere in the policy and the management of the organization and there are the founders of the network who officially only play a honorary and representative role.

The organizational chart in slide 2 shows the informal organigram of the alliance with the de facto power structure, as it was extracted from the interviewees descriptions and several external consultant reports. The informal center of power is not the board or the director but the old boys network of the founders who interfere on all levels of the assembly. In the first couple of years the founders simultaneously were management executives and members of the controlling board. The bureau director was not only a board member but also married to an influential member of the board. In this nepotistic setting director and board had virtually unlimited power over the organization and nobody controlling them. Yet
there was a myth in the organization, that everybody was equal and all staff and alliance members were comrades fighting for a common cause. Fuelled by the external successes, public acknowledgement, generous funding, a high profile in the media and fast growth of the alliance the founders developpend a delusion of grandour, that they would be able to put an end to violence in mankind all together. They showed a kind of fanatic obsession about the topic of violence and abuse. In the early years one therapeutic strategy based on a crude interpretation of the Latin American model of “testimonio” was to “expose” patients, to make them talk about their traumatic experience as much as possible. If they didn’t talk they would be shown photographs and pictures of cruel, violent scenes to make them talk. The same strategy was applied in public relations work. In slide shows and videos violent scenes were shown with screaming victims. At one public event victims happened to be in the audience who suffered from acute flashbacks when seeing the slides and had to be carried out of the hall. The philosophy was: considering that there is so much evil, misery and suffering in the world, one had to relentlessly fight, not show any signs of exhaustion or doubt, sacrifice oneself for the cause and refrain from the trivial joys of life. The work ethic promoted by the founders put enormous pressure on staff and alliance members to dedicate their whole life to the mission of the organization.

The founders believed to be indispensable, they created an aura of infallibility around them and they seemed to be driven by an insatiable hunger for fame. They took a patronizing attitude in terms of “we know what is good for you” and showed very little sensitivity towards staff members and patients from other cultures.
The outside world would be depicted as hostile, other organizations were depicted as competitors instead of partners. Dissenters inside and outside the organization would be ostracized. Over the years several staff left the alliance, sometimes a complete team left and founded a new organization, which was then ardentely persecuted as renegades. Staff and alliance members were split into „bad“ and „good“ boys, „friends“ and „enemies“, the work climate in the alliance on all levels was characterized by extreme tension, suspicion, hostility, faction fighting and shifting coalitions. The daily working procedures were chaotic, there was no clear strategy, there were no clear definitions of tasks and responsibilities. Activities seemed to follow a day to day accidental and arbitrary agenda, decisions were made impulsively and not on the basis of long-term considerations and planning. The organization was paralyzed over long periods of time. Compared to the enormous resources of the organization the output and professional quality was fairly low.

Eventually the internal problems of the alliance became known to some donors, who hired an external consultant for an evaluation and organizational analysis. As sources of the problems the consultants identified:

- Some staff’s double roles of board members and employees
- Formation of the organization around the top management with lack of a departmental structure, which was described as a characteristic of first generation organizations headed by founding leaders
- Lack of evaluation of treatment outcome
- Insufficient documentation
- Lack of formalised guidelines for working procedures
- High turnover of staff and recruitment of young and inexperienced new staff which makes it difficult to retain experience

As a consequence the consultants recommended the following changes:

- Successful transition from from a first to a second generation organisation
- Members of the board should not be involved in in daily management and organisation and not be employed as staff members or consultants
- To improve relationship between management and staff a liaison committee should be established
- External evaluation of treatment models and research should be carried out
- All staff should have job descriptions
- Organisational structure should be changed so that the decision-making authority, control and responsibility are delegated more downwards in the organisation.

Formally the founders stepped back into non-executive positions as consultants, fund-raisers and external representatives. A new bureau director was appointed, who hired a supervisor for the bureau team to better cope with the heavy work related stress. He also called the board for implementing all the recommendations of the consultant report concerning the restructuring of the organization. However the founders after initially cooperating with the new director started sabotaging his efforts to a degree that he left in frustration and anger. This pattern repeated itself over and over again. Every time a new director was hired by the board he initially was praised by the old boys. But as soon as he developed his own ideas and started to implement changes they started sabotaging his work. Informally the old boys continued to pull the strings in subtle but very effective ways. They thwarted decisions by the board and the director, they influenced elections by denigrating dissenters to get a majority of allies in the assembly and the board. They undermined their authority through informal communication channels to bureau staff and to individual centers. Their most effective tool of power were their close personal ties to the main donor, who funds about 40% of the alliance’s budget. Slide 2 shows the informal organigram of the alliance during the term of the 4th generation director at the height of a chaos of mobbing and intrigues. At this point a conflict resolution consultant was hired, who tried his best but failed. He detected a lot of anxiety, confusion and disorientation among staff and management. Some staff felt drawn into very old conflicts by the old boys, which were not theirs. The battles seemed to go on forever after the warriors left, and rearise with new actors, as if they were „hidden in the walls“ of the institution. Rumours and paranoid phantasies circulated, who was intriguing against who, people suspected that their phones were tapped, their mails checked, they would lock their doors so that nobody could overhear their conversations. Staff revealed to the consultant, that they felt like they were watched and controlled by the “secret police”. Some staff suffered from psychosomatic complaints and nervous break-downs and were absent on sick leave for long periods of time. At this stage to an outside observer the organization made the impression of a severely traumatic place in which the traumatic world of the clients seemed to be reenacted in the workplace.

It finally came to an end when a concerned strong faction within the assembly of centers and the remaining independent members in the board hired a strong experienced new director who in a long strainful process restructured, reshaped and restaffed the organisation. One factor for this change was that the most influential of the old boys managed to bite the bullet and decided to back the new leader. This marked the turning point of a long lasting agony of internal conflict, permanent crises with a high wearout of leaders and competent staff along with an erosion and decline of the quality of work. According to the categories of group development this organization got bogged down in the pioneer “storming” period for a very long time (see chapter 3. and 5.2.). This case example demonstrates the importance of strictly separating the roles of board, management and staff, i.e. of having a board of independent external experts who are in no way personally, institutionally or financially involved and thus have no conflict of interest in performing their mandate of monitoring the organization and its leadership (Pross 2009, Pross and Schweitzer 2010).

5. Work related stress in trauma centres

5.1. Studies on environmental and organizational factors

Our study on trauma centers show that the sociopolitical environment, as well as structural and organizational shortcomings, are an important source of work related stress (Pross 2009, Pross and Schweitzer 2010) and they suggest that organizational transformation can improve motivation and performance of caregivers. It is echoed by Smith et al. who identified organizational factors as one source of work-related stress, yet they do not specify them. In a comparative study of trauma therapists and therapists
in other fields, they found no difference in the level of work related stress. Therapists do in fact experience the effects of the confrontation with interpersonal violence that their patients went through. Yet these effects seem to be normal assimilative and accommodative reactions rather than destructive processes (Smith et al. 2000). In a survey of 129 trauma therapists Smith et al. found a high degree of emotional stress related to anxiety levels and severity of PTSD symptoms in patients. However, burnout seems to be related more to organizational factors than client related ones that is, emotional stress is particularly related to feelings of anxiety and ambiguity, to vagueness in connection with tasks and responsibilities. The authors see little evidence that work-related stress leads to secondary traumatic stress or vicarious traumatization. They conclude that preventive measures should be aimed at a reduction of anxiety in difficult situations, an increase in team support, and more clarity of tasks and responsibilities (Smith et al. 2001). In a more recent study Smith found a high degree of (over)identification in trauma therapists, as we did in our study. She found that work with traumatized refugees evoked a combination of high involvement and overwhelmed and negative feelings, whereas borderline patients evoked distancing (Smith 2009).

5.2. Culture of trauma centers and structural problems

Therapists in the Netherlands working with traumatized refugees and asylum seekers with therapists working with victims of the World War II. She found a higher level of emotional stress in the former than in the latter. In a survey of 25 caregivers, Birck (2001) found that the most stress-producing factors were not the exposure to contents of the patients' traumatic material, but the permanent burden stemming from the asylum situation, including the threat of deportation and conflict-ridden team dynamics. Munroe (2006) and Walkup (2002) have identified structural flaws in large humanitarian organizations as a source of secondary traumatization, which they label "organizational PTSD" or "self-deceiving organizations". This highlights a specific problem which is typical for human rights organizations. One of the bonding patterns of founders of human rights organizations 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 formal rules and 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" and a culture of "the bleeding heart" in the external world, and a culture of "the benign hierarchy" in their own ranks. They carry democracy and equality on their banners. Although they possess a specific problem which is typical for humanitarian organizations, the founders have problems with altruism and organizational issues. One of the bonding patterns of founders of human rights organizations 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 formal rules and 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" and a culture of "the bleeding heart" in the external world, and a culture of "the benign hierarchy" in the internal world of the human rights movement. Rules and standard procedures mean, for them, coercion and a loss of power. For these reasons, they often obstruct transforming their organization into a professionally managed health care institution (Pross 2009, Pross and Schweitzer 2010).

The above mentioned charismatic qualities which were essential in the creation of the organization 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" and a culture of "the bleeding heart" in the external world, and a culture of "the benign hierarchy" in the internal world of the human rights movement. Rules and standard procedures mean, for them, coercion and a loss of power. For these reasons, they often obstruct transforming their organization into a professionally managed health care institution (Pross 2009, Pross and Schweitzer 2010). Although they carry democracy and equality on their banners, some of the charismatic founders have problems with altruism and organizational issues. One of the bonding patterns of founders of human rights organizations 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 formal rules and 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" and a culture of "the bleeding heart" in the external world, and a culture of "the benign hierarchy" in the internal world of the human rights movement. Rules and standard procedures mean, for them, coercion and a loss of power. For these reasons, they often obstruct transforming their organization into a professionally managed health care institution (Pross 2009, Pross and Schweitzer 2010).
Another problem inherent to this field is a tension originating from the extreme polarization between perpetrator and victim. In trauma work, one is dealing with an extremely vicious and powerful external enemy – the perpetrator. In every counselling and therapy session the shadow of the perpetrator is more or less present. This can have a strong impact on teams and organizations. One the one hand, the external enemy is a strong bonding force within the organization. However, it can foster a black and white view of the world, a tendency to see the external world as bad and hostile and idealize 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 ostracize this person. Table 1 shows the most common structural shortcomings as sources of work related stress (Pross 2009, Pross and Schweitzer 2010).

Table 1. Structural shortcomings in organizations with high stress and conflict level

<table>
<thead>
<tr>
<th>Failure to maintain boundaries</th>
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<td>Over-identification with clients, lack of professional distance</td>
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<tr>
<td>Lack of professional management and good leadership</td>
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<td>Informal leaders involved in turf battles</td>
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<td>Myth of egalitarian team</td>
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<td>Diffusion of roles and competence</td>
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<tr>
<td>“Ambulance chasing” or hectic, uncoordinated interventions and activities</td>
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<tr>
<td>Lack of professional quality standards</td>
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<tr>
<td>Insufficient or no therapeutic training</td>
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<tr>
<td>Lack of therapeutic concept</td>
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<tr>
<td>Clinical supervision non-existent or only sporadic</td>
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<tr>
<td>Re-enactment of the traumatic world of the clients</td>
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<tr>
<td>No coaching for leaders</td>
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<tr>
<td>Workaholism, self-sacrifice, self-care, insufficient or non-existent</td>
</tr>
<tr>
<td>No board, or amalgamation of board, management and staff, leading to conflict of interest</td>
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Munroe (1995) argues that these hypotheses have not been proven empirically 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. A valuable insight into the patient–caregiver dynamic is provided by Wilson and Lindy (1994), who see the source of dysfunction in countertransference reactions by therapists, who exhibit either too much empathy or lose distance by enmeshing themselves in confluent and overprotective behavior with the patient, resulting in mutual dependence. Hafkenscheid (2005) does not see the source primarily in the destructive material transmitted by the patient and critically discusses the empirical evidence and clinical utility of the concept of event countertransference and vicarious traumatization. He suggests that therapists may too eagerly embrace these perspectives as a cover-up for their own failures. In overidentifying with the patient, therapists fail to provide meta-communicative feedback to patients about their dysfunctional interpersonal communication patterns stemming from war and persecution. Instead, they enter into an alliance with the patient in a “we are all victims of your trauma” myth. These enactments in centres with high stress and conflict levels described in our study can in fact be explained as countertransference reactions or enactments by caregivers of their own unresolved conflicts, as well as enactments induced by patients who project their experience of abuse onto the therapist, who then acts in the same pathological fashion as the patient, a pattern described by Gabbard (2001). Holloway (1995) observed similar countertransference phenomena in supervisor–supervisee relationships and terms them parallel processes. They occur when the central dynamic process of the counselling relationship is unconsciously acted out by the trainee in the supervision relationship. These enactments are inevitable and a valuable source for understanding the patient’s problems. Caregivers or the organization must find a middle ground in tolerating partial enactment while simultaneously preserving the capacity for reflective thought—in clinical supervision, for example, so that the interaction can be explored (Gabbard 2001) (see chapter 6.6).

5.4. Re-enactment of trauma, intercultural conflict

The trauma center was in the pioneer phase with an egalitarian culture as described in chapter 5.2. The director’s and the staff’s roles and responsibilities were not clearly defined. They all were rather unexperienced in treating severely traumatized patients and had little intercultural communication skills. Client A had been member of the secret police torturing dissidents (B) in jail. After his country was invaded the dissidents (B) gained power, put him in jail and tortured him. A escaped to a safe country where he was treated in a center for refugee trauma by therapists T1 (Slide 3). In the course of the treatment T1 felt confused and threatened by A’s violent behaviour, double identity as perpetrator and victim and he had difficulties dealing with A’s cultural codes of honour and patriarchal family values. In an effort to protect T1 his colleague therapist T3 who was from the same cultural background as client A urged T1 to refer his client to another institution. T1 did not accept T3’s advice as an act of support. Instead he felt deeply devalued in his professional competence by T3 and accused him during a team supervision of collaborating with the secret service of A’s country of origin (Slide 4). For T3, who was himself a political refugee from A’s home country, T1’s accusation was a fundamental attack on his personal integrity. The conflict split the team in two irreconcilable factions with therapists T2 and T5 siding with T1 and therapist T4 and the director L siding with T3 (Slide 4). The conflicted risked to totally disrupt and destroy the center, it escalated to a point where L, the director, saw no other choice than firing T1 to protect the team and the organization from breaking apart. The team supervisor who also had no experience with intercultural teams and trauma work resigned. A period of relative peace and stability followed. Yet from the outside T1 kept fighting by involving a vulnerable patient of his into the conflict and spreading the message that his dismissal was an act of torture. He made intimidating phone calls to team members threatening that the center would “explode.” He approached the main donor, journalists and influential public figures of the center’s support network with denigrating allegations against the director. At the end of a long legal dispute he refused to accept a compromise settlement and enforced his re-employment. His comeback caused a lot of anxiety and instability in the team. The resurfacing conflict then haunted the center for several more years. The dynamics between the players followed a constant shifting of roles between perpetrator, victim and saviour. These dynamics can be highlighted by Karpman’s drama triangle (1968). When client A started treatment in the center he was in the position of the victim of the rulers in his home country (B) with therapist T1 as his saviour (slide 5). In the course of treatment the roles shifted, T1 felt threatened by A, i.e. T1 was in the role of the victim and A in the role of the perpetrator, whereas T3 took the role of the saviour by trying to protect T1 (Slide 6). When T1 violated T3’s personal integrity during the team supervision he shifted to the role of the perpetrator, T3 found himself in the role of the victim and the director L in the position of T3’s saviour by firing T1 (Slide 7). After this action L found himself in the position of the perpetrator, victimizing T1 while his colleagues T2 and T5 were in the position of his savours by siding with him in the split between the two team factions (Slide 8). The story finally came to an end when a highly respected and influential member of the board persuaded T1 to leave the center voluntarily.

One of the sources of this conflict lay in the fact that both T1 and T3 and some of their colleagues had an unresolved personal history of trauma which they
Client A had been member of the secret police torturing dissidents (B) in jail. After his country was invaded the dissidents (B) gained power, put him in jail and tortured him. A escaped to a safe country where he was treated in a center for refugee trauma.

Therapist T1 while treating client A felt confused and threatened by A’s double identity as perpetrator and victim. Therapist T3 in an effort to protect T1 urged him to refer client A to another institution. T1 felt devalued in his professional competence by T3 and accused him of collaborating with the secret service of A’s country of origin. The conflict split the team and escalated to a point where L, the director, fired T1 to protect the organization.
projected on clients and colleagues. They had no or no sufficient psychotherapeutic training with self-awareness, they had very little introspection, were unable to keep a professional distance and reflect upon their behaviour from a bird’s eye view in case conferences and supervision. All players including the director and the team supervisor didn’t have enough skills and experience in handling such a difficult situation. They were overwhelmed by the violent irreconcilable nature of this clash of cultures. On top of that the structural weaknesses of the center did not provide the necessary stable framework and healing environment to contain the destructive dynamics of the conflict (Pross 2009).

### Table 2. Caregivers resources and framework for self-care

- 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
- 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

### 6. Prevention of work related stress – Recommendations

#### 6.1. Caregiver resources

Although some of the above mentioned sources of stress are an intrinsic element of trauma 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, fund raising, 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 reducing commitment to a part time job, rotating into other professional fields, “mental health days,” sabbaticals, shielding private life from work related issues, spending time with family, children and friends, leaving space to foster hobbies such as literature, theatre, movies, music, art, dancing, nature, sports, or cooking, and preserving a sense of humour as an antidote to the intrinsically dark content of this work.

In low stress and conflict level institutions, leaders support and encourage these self-protective strategies. **Table 2** shows resources and means of prevention of work related stress caregivers have developed to cope with the challenges in their work (Pross 2009, Pross and Schweitzer 2010). Saakvitne et al. (2000) have created training modules for self-care strategies based on many of the same resources. Similar concepts were developed by Reddemann (2003).

### Table 3. Standards for structure of a trauma centre

- 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
and easy-to-learn methods of psychotherapy that are not psychologically trained. Yet there are simple methods in Mozambique (Boia 2007). Above all group therapy approaches have proven to be effective (Curling 2005, Drozdek and Wilson 2004, Manneschmidt and Griese 2009). 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. 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 his or her position because he or she is the cousin 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. In the hypothetical case of this cousin’s malfunctioning, the director’s hands will be tied and he or she will be placed in an awkward position of dual loyalty (Pross 2009, Pross and Schweitzer 2010).

### Table 3. (Continued)

- 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 organization and the leader, consisting of independent experts who have no conflict of interest

### 6.3. Qualification of caregivers

Another tool of prevention of work related stress is a careful procedure of recruiting staff. It is difficult – if not impossible – to find out whether an applicant for this work is qualified and suitable in one interview. The best credentials, training certificates, an exemplary 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/her character and professional credentials) awareness
- Consent reduces the frustration caused by too high expectations
- Careful selection of new staff and leaders
- “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 organization and the leader, consisting of independent experts who have no conflict of interest

### 6.4. Qualification of leaders

An equally important element of prevention which we found in our study is good leadership. 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 organizational 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 or her role without blurring functional hierarchy, is prepared to endure “bad-boss” projections and carry through unpopular decisions. At the same time, he or she must encourage creative ideas and initiatives from staff, let others grow and blossom instead of seeing them as competitors, not abuse his or her 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 or she should work with them, appreciate 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 (Pross 2009, Pross and Schweitzer 2010).

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 or her anger will spread fear and intimidation instead of containing it. A workaholic self-sacrificing leader who does not take good care of him or herself will not encourage care for other leaders and regular coaching by an independent external leadership coach (Pross 2009, Pross and Schweitzer 2010).

The leader must also serve as conflict resolution moderator. If he or she is part of the problem, the board or an external mediator must take this role (Kets de Vries 1993).

6.5. Board, patron

Our study shows as demonstrated in the case example that the failure to overcome dysfunction, tension and conflict is often due to a missing or a malfunctioning board. A trauma centre should have a board that represents the legal body of the organization, be it a foundation, a charity or 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 conflict resolution moderator. In this case the leader of an organization 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

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 or her case, and a problem he or she 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 organization 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 organizations. 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.

Organizational consultation

In this case the leader of an organization 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 organizational transformation with the help of a specialized 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 organization e.g. as a permanent employee. Only from the position of an impartial outsider can he or she professionally judge and monitor the arising problems and processes in supervision. A director or a staff member cannot simultaneously be a supervisor of his or her colleagues, with whom he or she 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 (Holloway 1995, Lansen and Haans 2004).

7. Concluding remarks

Many of the above mentioned difficulties in teams and organizations dealing with trauma 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 organization. It is a necessary and inevitable part of organization 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 organizational consultation, and training by external consultants can help in solving these problems, get the organization 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/she 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 organization 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 organization. Moreover, they impair the helping capacity of caregivers, which is ultimately detrimental to the clients.

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