The culture of organizations dealing with trauma: sources of work-related stress and conflict

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Abstract

In a comparative qualitative study of 13 organizations worldwide working with survivors of extreme trauma, the relationship between work-related stress and conflict and the structure of the organization is examined. Seventy-two caregivers, supervisors, and experts are interviewed and external organizational analyses and capacity assessments analyzed. The results show that organizations with high stress and conflict levels exhibit considerable structural deficiencies and an atmosphere shaped by a reenactment of the traumatic world of clients. This chaotic, unstructured, unpredictable environment parallels the total absence of structure that exists when a victim is at a perpetrator's disposal. Organizations with low stress and conflict levels, however, prove to have fairly clear organizational structures. The results of this study show that structural shortcomings are an important source of work-related stress and conflict in organizations dealing with extreme trauma. Furthermore, the study raises the question whether the stress symptoms experienced by caregivers amount to a diagnosis of "secondary" or "vicarious traumatization". Caregivers in organizations with structural deficiencies show symptoms described by others as secondary traumatization. However, these symptoms subside after organizational transformation and structural improvement. It is found that caregivers in well-structured organizations exhibit almost no such symptoms.

Keywords

Introduction

McCann and Pearlman in 1990 were among the first to describe how "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 (Danieli, 1988; Chrestman, 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 zation (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 hat the terms "compassion fatigue" (Figley, 1995), "secondary traumatic stress" (Stamm, 1999), and "vicarious traumatization" (McCann & 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 and Figley and Stamm were very useful in formulating the initial hypotheses of our study. However, the process of collecting and analyzing our data took us beyond these concepts.

Methodology

A total of 13 institutions were examined, organizations dealing with victims of extreme trauma such as torture, political, ethnic and religious persecution, domestic violence, and sexual abuse. Eighty-two people were contacted for interviews, the 72 of whom agreed to be interviewed. Forty-seven 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 longterm professional experience. The professions involved were physicians (45.8 %),[1] 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.

Interviews were conducted on the basis of "problem-centered interviews," as described by 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 & Corbin, 1998) with the help of ATLAS-ti, a computer-based data analysis program (Muhr & 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.

The study has some limitations. The participants could not be selected at random, but were contacted through networks familiar to the authors. This was necessary because there is considerable suspicion of outside researchers investigating organizations dealing with trauma and a degree of denial among caregivers regarding the issue of secondary traumatization. Self-reports by participants may in some cases be prone to exaggeration or minimized responses. It is in the nature of the study that it was carried out ex-post. The establishment of trauma clinics in the past 20 years with relatively limited prior knowledge and experience in the field has been an experiment in itself.

Results

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 pairing" groups (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 fight 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.

The Pioneer Phase of Trauma Centers—Forming

Most of the examined institutions were established by charismatic, visionary pioneers with entrepreneurial skills and a missionary sense, which enabled them to build and defend their organizations against reluctant bureaucracies and the prevailing attitude of denial and indifference in society. Because they tend to ignore and neglect structural issues and develop a sense of grandiosity, these types of leaders often obstruct the transformation of the organization into a professionally managed health care institution. The organization's culture in the pioneer phase resembles a "honeymoon"; it is shaped by a friendly, buddy-like work climate, enthusiasm, informal relationships, and no monitoring and accountability.

Table 1.

A. Structure in organizations with low stress and B. Structure in organizations with high stress and conflict level	B. Structure in organizations with high stress and conflict level
Maintaining boundaries	Failure to maintain boundaries
Balancing empathy with clients and professional distance	Overidentification with clients, lack of professional distance
Good leadership, delegating tasks and responsibilities, clear definition of roles and competence	Lack of professional management and good leadership; myth of egalitarian team; awkward, lengthy decision-making processes; diffusion of roles and competence; informal leaders involved in turf battles
Strategic concept, long term planning	"Ambulance chasing" or hectic uncoordinated interventions and activities
Selecting staff according to professional credentials and personality	Lack of professional quality standards
Therapeutic training including self-awareness, extensive ongoing professional training	Insufficient or no therapeutic training
Common treatment philosophy and therapeutic concept	Lack of therapeutic concept
External clinical supervision and collegial intervision	Clinical supervision nonexistent or only sporadic
Protected space for self-reflection to deal with destructive material	Reenactment of the traumatic world of the clients
Coaching for leaders	No coaching for leaders
Care for caregivers program	Workaholism, self-sacrifice, self-care insufficient or nonexistent
Functioning board consisting of independent experts	No board or amalgamation of board and management causing conflict of interest

Such a pioneer organization can function fairly well in this setup, as long as it keeps its original small size and program. Some quotes from the interviews may highlight this aspect:

"There was no comparable institution in our country at that time and this pioneer situation shaped our start very much; we were somewhat euphoric, inspired by our mission."
"We were a staunchly committed community. We celebrated together, work and private life were never separated. . . this was something very pleasant; we were glad to have found each other."
"In the first couple of years we were very naïve; all (clients') stories touched us very deeply."
"We hoped that we could convince the establishment in the medical world and psychology that this is a new field and that it is very important to enlighten doctors and psychologists about the aftereffects of trauma."

However, when the organization's staff, budget, and variety of tasks grows, the necessary differentiation of this "community of friends" into a more professionally managed organization, with division of labor and a certain hierarchy of decision-making bodies, becomes inevitable. Organizations that successfully managed to go through a painful transformation ultimately functioned quite well and established a healthy climate and good working relationships. However, in institutions in which the pioneers proved unable to let go and clung to the dysfunctional structure of the honeymoon phase, problems arose.

Organizations With Low Stress Levels—Constructive Norming

Three fairly well-functioning organizations with low stress and conflict levels were examined. It turns out that they succeeded in passing unharmed through the storming phase and overcoming the structural shortcomings of the pioneer phase, undergoing a process of transformation into more professionally managed organizations with clear definitions of roles and tasks. Subsequently, the stress and conflict levels of the storming phase diminished. Table 1. A. lists structural characteristics we found in these organizations.

Key Preconditions for Successful Functioning

Key conditions for the successful functioning of an organization are an independent board, a clearly entitled leadership following, as one interview partner put it, "the good parenting principle," and a clear definition of roles, authority, responsibility, and accountability of staff members.

A leader who took over and stabilized the organization after a long crisis:

"In the old days, the board consisted of victims, affected people, who were not neutral, and this caused a lot of problems . . . now a board has been formed that is completely independent, with an entrepreneur, a parliamentarian, etc. . . . As a leader I need such a rational board, which guides me, because I can get enmeshed in the emotions of the team. I need a body like this that corrects me."

A supervisor:

"There must be a transparent and good form of leadership embedded in the team. It can be an authoritarian leader or a very democratic leader, a man or a woman, it doesn't matter, but it must be clearly defined leadership."

"Caregivers in these organizations tend to have less idealistic and more realistic attitudes and to put more emphasis on professionalism than politics: The challenge is to have goals that are reachable in order not to loose hope . . . otherwise people stop believing."

"From the beginning it was much more idealism, maybe they needed it, because there was much more "guerilla" work. But as the team has developed, maybe the culture is not so affected by people who are so idealistic."

"If you are not professional you are not taken seriously. You can be political, but that doesn't last in the end. If you establish yourself as a serious professional person, you are not pushed aside as easily as if you are only there as a political activist."
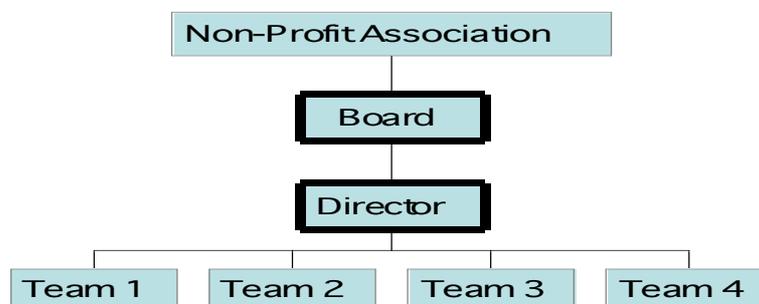
Clinical case supervision and intervision is a vital tool to deal with the destructive material inherent in this work (Lansen, 1996; Lansen & Haans, 2004). As there is a strong drive for identification with the victim or the perpetrator, one needs a protected space for self-reflection from a bird's eye view. A leader provides an example of a colleague in his team:

"He withdrew, he was very bitter and isolated himself . . . this was a case of over-engagement, where you are not distanced any more and completely lose yourself in the pain of the patient and have this narcissistic belief that you can save them. . . . Every trauma therapist experiences one or the other extreme . . . whether it is disengagement or overengagement in treatment. But you can always succeed through intervision in creating that helicopter view, and the person in question is actually able to correct himself."

Another tool of protection and stress prevention is research and teaching, which also give space for distancing oneself from daily casework, while reflecting on and analyzing it. One interview partner names as his guideline "reframing instead of containing":

"If you just do not do anything, you get traumatized. But if you turn around, take your experience, reframe it, take it into education, teaching, counseling as examples . . . . Hearing about torture as such is bad, but if you can use the bad things as examples to make other people do better things, then it loses its negative power inside me."

Figure I. Organization A: Formal organigram

Caregivers' Protective Resources and Self-Care

The participants name a whole range of resources and rewarding activities that enable them to cope with the challenges of this work, such as a personal history of trauma (worked through in therapeutic training), empathy with clients, the 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, and 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 humor 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. Saakvitne, Gamble, Pearlman, and Lev have created training modules for self-care strategies based on many of the same resources (Saakvitne et al., 2000). Similar concepts were developed by Reddemann (2003).

Organizations With High Stress Levels—Permanent Storming

Organizations with permanently high stress and conflict levels never progressed beyond the pioneer phase; they became bogged down in permanent destructive storming. They failed to go through a process of organizational transformation, and so the structures of the pioneer phase become dysfunctional. Table 1. B. shows the structural characteristics that we found in these organizations.

  One typical example is the structure we found in organization type "A." Figure 1 shows its official formal organigram.

  It contains the official bodies: the legal governing body, a nonprofit association, whose members elect a board, which in turn appoints and controls the director, who is in charge of the various treatment teams that do the client work. The membership assembly in nonprofit associations is meant to consist of independent personalities from various professions and representatives of society, and the assembly takes place once a year. The board, elected by the assembly, thus consists of independent personalities who meet up to 6 times a year. They work on a voluntary pro bono basis and are supposed to have no stake in the company and not to be involved in the daily business of the organization. Their job is to control the budget, define the general policy of the organization, and appoint and control the director. The staff is divided into several teams of caregivers who are accountable to the director. At first glance, this structure—which is presented to the outside world and to donors—entirely reflects the way an ordinary health care or social service organization would be shaped.
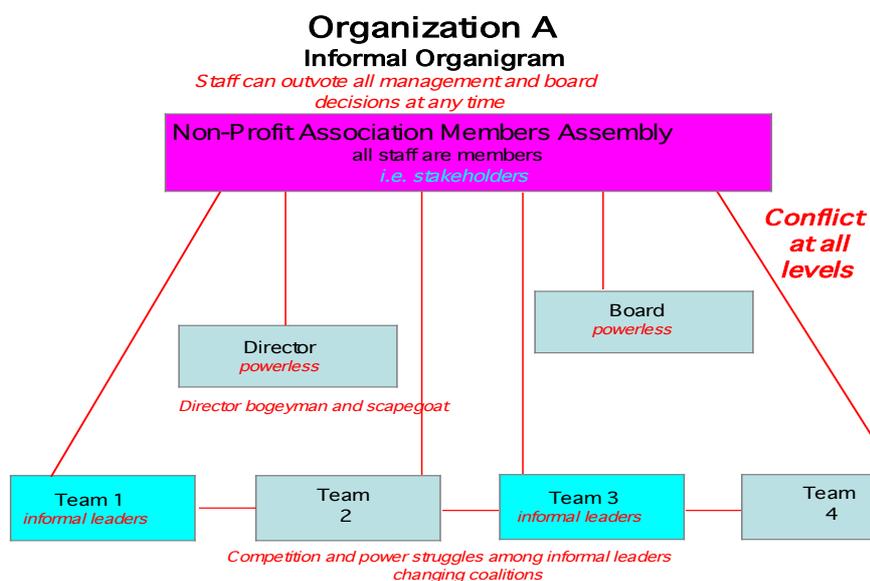

Figure 2. Organization A: Informal organigram

Figure 2 shows the informal organigram as it was extracted from the interviewees' descriptions and from organizational analyses and external expert evaluations. It shows the real dynamics, relationships, and power structure. In reality, all staff members are simultaneously members of the nonprofit association, which means each one has a dual role as employer and employee, that is, that each one has a stake in the company. This results in a conflict of interest. In practice, staff members have on numerous occasions overturned "unpopular" decisions by the director and the board concerning salaries, rules for working procedures, codes of conduct, and the like by calling an extraordinary membership assembly. On some occasions, shortly before the assembly, new members have been recruited in order to create a majority. As the membership assembly is the highest legal body, it can overrule the board and the director.

As a result, the board and the director are powerless. Instead, informal leaders emerge in the various teams who compete with one another. There are shifting coalitions and continuous turf battles over who has a say in what. Decisionmaking processes are blurred and nontransparent; there is a myth that all decisions are made collectively in the team and that everybody has a say in everything. This is impossible to achieve and completely dysfunctional in an organization of this size (a staff of more than 30). So either decisions are not made and problems postponed indefinitely, or decisions are made by informal leaders but may be overruled at any time by new alliances or populist currents in the various teams. The director is made the scapegoat for everything that goes wrong.

The result is chaos and a general atmosphere of hostility, suspicion, and mistrust. Factions of the team bully the director and individual team members. The teams are fragmented into "friends and enemies." There are few rules, and the rules that exist are not followed. There is no common therapeutic concept; each caregiver has his own little kingdom, which he anxiously defends against any outside interference or control. Record keeping is fragmentary and of low quality. Boundaries are crossed by, for example, extending therapy sessions, doing all kinds of unnecessary extra services for clients in managing their everyday affairs, overworking, and engaging in political activities that are not part of the organization's mandate. Caregivers do not maintain appropriate professional distance from clients and frequently overidentify with them. In some cases, intimate relationships with clients have occurred or staff members have drawn clients into their work-related conflicts with management.

Because of the conflict-ridden and tense environment, there is a high rate of staff turnover and frequent changes of directors. This in turn results in a lack of continuity and institutional memory.

Typical Culture of Trauma Centers

Specific trauma-related features may be found in the culture of trauma centers, which may be a source of permanent conflict and friction if the center finds itself stuck in the storming phase and fails to go through organizational transformation. However, these features do not need to become elements of destruction if they are contained and mastered through a functional structure and healthy work environment.

Martyr complex, self-sacrifice, and overidentification.
The issue of violence and victimization provokes strong feelings of empathy connected with high moral expectations toward oneself: to side with the victims, to sacrifice oneself. Selfish impulses like striving for a career and the demand for a good salary, which go without saying in other fields, tend to be split off and suppressed.

> "You develop a martyr complex. The whole world rests on your shoulders. Every day I feel overworked, that I haven't done enough."

> "I have to be a good man and I am a good man, because I side with the victim. To a large degree, I have to strongly suppress my own destructive tendencies, being selfish, my desire for money."

> "All people working in this field are highly dedicated people with high demands on themselves. And therefore they are very strict with themselves and others."

> "There was a person who would never cry in any situation. And he staunchly defended this attitude."

> "I have to tolerate this tension originating from the extreme positions of victims and perpetrator . . . there is strong pressure to identify with the victims, which I cannot escape."

"We all overidentified with the clients, we pampered them."

Narcissism, grandiosity
Pioneers and caregivers in trauma work show a degree of self-importance and a type of religious missionary sense, a sense of uniqueness.

"We (trauma people) are special. Nobody else faces such challenges."

"We were more narcissistic than the average, and were somewhat damaged people . . . with low self-esteem."

"We are a kind of elite of good men . . . (with) a sense of grandiosity of a compensatory nature along with the helplessness, about which we rarely speak. I have been that way, like an enlightened guru with a feeling of pride."

"Perhaps he found that through working for this cause he could become something very fantastic like Mother Theresa, the world's good Samaritan, the world's savior."

Caregiver trauma—resource and risk
Of the interviewed caregivers, 31.1% reported a history of trauma. For many, it was the driving motivation to enter this field and a resource for understanding and empathizing with their clients.

"I have experienced torture myself . . . and this for me personally means that working in such an organization was simultaneously a rehabilitation from my own history."

"About two colleagues, I know it (caregiver trauma) explicitly . . . I see it as a resource. . . . They have integrated their history well enough to be able to do good work."

"However, it is a risk factor when this experience has not been worked through in some kind of self-awareness in therapeutic training."

"Most colleagues have not undergone good trauma therapy . . . and this is the reason why they do not dare to expose themselves to the trauma of their clients . . . because in the moment of exposure their own trauma comes up and then they can no longer keep a distance."

One of the interviewed supervisors notes:

"You can see in people who have been tortured themselves and have then become therapists for torture victims, that there is a kind of fixation, that they no longer have the flexibility to process these new experiences . . . they are often very suspicious . . . so that they cannot provide enough confidence."

Reenactment of Trauma

The atmosphere in organizations with high conflict and stress levels is shaped by a reenactment of the traumatic world of the clients, with a general atmosphere of fear and persecution, fantasies about the presence of the secret service, perpetrator–victim relationships, obsession with violence and splitting behavior—categorizing colleagues in terms of good and bad and friends and enemies. The chaotic, unstructured, unpredictable environment reflects the total absence of structure that exists when a victim is at a perpetrator's disposal.

Obsession with violence
Caregivers report extensively and in great detail about the cruelty experienced by clients. Public relations photo presentations show mutilations and cruel scenes in the torture chamber, including rape. Film clips show prisoners being beaten with clubs, underlined with the sound of screaming and horrifying music.

"When we had a glass of wine together after a long working day, a colleague would not stop talking about the work. Finally I asked him, 'Tell me, do you actually have a hobby?' Another colleague answered in his place: 'Yes, torture!' "

Perpetrator–victim relationships

"When somebody criticized something, (the other one) would say: 'Now you are acting like a perpetrator.' . . . Immediately everybody spoke in terms of 'Who is the perpetrator and who is the victim.'

You will be influenced on both sides, in roles of both perpetrator and victim . . . you internalize it if you don't have some recreative sphere inside the center and outside in your private life. "

Enemy figures

"The organization had a tendency to look for an enemy to put the blame on, and then, when that person left, a new enemy appeared within a short time."

"He (the leader) has a pathological ability to see enemies and project them on other people. Which is useful externally, because he can fascinate an audience by saying, "Look, these are the perpetrators!" But internally it's dangerous. That could be part of the explanation for the poisonous climate we have here."

"We do not have these kinds of clear enemy figures in this country.2 One has a kind of general suspicion directed against the law-making bodies, who somehow discriminate against migrants . . . like the police, the immigration authorities, who actually are considered very evil people, little torturers."

Splitting behavior

"It is very difficult to tolerate this tension (between victim and perpetrator) if you do not have any selfawareness or education in terms of self-awareness. This tension needs to be vented somewhere. And then suddenly the person who identifies with my opponent during a conversation is my enemy."

(The trauma center) "has a tendency towards a borderline structure, where you have this very archaic defense mechanism of splitting . . . this total separation into good and evil. There is no integration and nothing unifying—no ability to see a person's good parts as well as his bad parts, this act of integration is impossible."

"He has a strong tendency towards splitting. I really believe that he was abused. I see a hurt child in him."

"I think that half of the colleagues are good at splitting . . . and I think splitting is something pathological. I find it difficult for clients when they are dealing with a therapist who is splitting and does not know what he is splitting."

Feeling persecuted

One caregiver accuses another in a team meeting of working for the secret service of a repressive regime:

"He frequently said that (the trauma center) is a place where the secret service would try to get hold of intelligence information."

"Rumors were spread that (management) was tapping phones and monitoring e-mails."

"This colleague tried to convince me that somebody followed him and let the air out of his tires in the car. Every week they were without air. I believed it when he said it, but I never saw it. It was a fantasy."

At the perpetrator's disposal

A caregiver recalls a special exposure treatment approach in his organization that colleagues satirically called the "bulldozer method":

"It is a method of getting the victim to talk about the violence. If the victims do not want to say anything about the experienced violence, then the therapist had pictures of violent scenes in the drawer . . . first he showed them a lighter scene, put it on the desk in front of the victim and said: 'Does that remind you of something?' And if the victims didn't react or break down, confess, the therapist showed them a picture of a worse scene."

A caregiver experienced the uncertainty and unpredictability of the conflict-ridden culture in his organization as a parallel to what his clients had gone through:

"There were new alliances in the various teams all the time, people were constantly fighting with each other, and I, the boss, got all the blame. I sat in my office petrified, because I did not know from where and from whom the next blow would come. It echoed in some way the experience of our clients, who often told me that the worst periods were not those in the interrogation room but the periods in between, when you were waiting in your cell and did not know what would happen to you next."

Myth of an Environment Without Hierarchy—Informal Power

One of the bonding patterns of founders of trauma centers is the common belief that hierarchy, power, and leadership themselves are something dangerous and that it bears the stain of abuse and repression.

"Fighting against hierarchy may be part of why one gets recruited to work in a humanitarian organization."

"We were a team of plagued, well meaning and also competent people, who had been treated badly in traditional power structures. . . . we are kind of outlaws in this field."

"The fighting is a kind of parallel process . . . that we were against everything that symbolizes some kind of authority, in the same way our patients were against the authorities."

"We no longer wanted to experience anything that controls us. We wanted to control everything ourselves, decide ourselves. . . . We are somehow the watchful guardians of society and therefore we must not do anything that is generally accepted by the mainstream. We must be different and nonmainstream."

Yet below the surface of an apparently egalitarian team, informal power holders emerge, and this informal power proves to be quite abusive.

"In every institution there is a hierarchy of knowledge, experience, age. . . . But this is an unregulated, not formally defined hierarchy, which carries its own risks, risks of conflicts, competition."

"Mixing personal and political issues where it is no longer clear where the personal interests are . . . on this level there are parallel processes. The question is how to recognize and interpret them. And this process in our organization was always very violent and secret, never transparent."

"The system carries extremely abusive structures . . . there are taboos, secrets and alliances."

"Some colleagues in this field I find are clearly violating boundaries and abusing power."

It is striking that those who most ardently advocate an antihierarchical structure and grass roots democracy are themselves the biggest users of informal power. They conceal their personal and material interests, their desire for fame and power, beneath the role of advocate for the disadvantaged.

Thus, 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, nontransparent, 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. Just as parents protect younger children against their older siblings, a leader protects weaker or younger team members against dominant or older ones.

Myth of the Egalitarian Team

Another bonding pattern is the common belief that everybody is equal and that all decisions should be made by consensus in the team. This may work for a small pioneer group in the organization's honeymoon phase. However, it turns out to be dysfunctional when the organization grows and becomes more diverse in terms of tasks, aims, and manpower.

Interview partners report that team meetings last very long, in some institutions up to six hours a week:

> "I have the feeling that there is a lot of talking. Time is wasted . . . and then under the surface there is a mix of this, that and the other, and in the end nobody actually knows who is responsible, and most of the time nothing is ever done."

> "It takes a lot of time and energy. These team meetings always kill me. For me, this is the worst day in the organization."

> "If you always have to fight for trivial everyday issues, then you start feeling like Sisyphus."

> "It is really like fighting windmills. I run like a hamster on a wheel. I go on and on and on. I drain myself in any direction."

In some of the examined organizations, this concept went as far as demanding that clients become part of the decisionmaking bodies. Clients, that is, patients should be given the opportunity to become therapists and staff members in the organization: "This option of formal equal rights expresses an attitude carried by the perspective of an abolition of all power structures."

We found that the absence of formal hierarchy, which is supposed to prevent the abuse of power, actually fosters abuse in an environment of informal, uncontrolled hierarchy.

Organizational Analyses of Nonprofit Organizations

Organizational analyses by Heimerl-Wagner and Meyer (1999), Zauner and Simsa (1999), and Eckardstein and Simsa (1999) show that the above described structural characteristics are a typical phenomenon of nonprofit organizations (NPOs) in general. According to the authors NPOs are marked by the need to deal with unending tasks, such as social problems, poverty, and environmental protection. Thus, the workload always exceeds human and financial resources. There is a dependency on public funding, and thinking in economic categories is rejected by the NPO culture. NPOs are founded by charismatic, visionary leaders who tend to neglect organizational issues.

In the pioneer phase, the structure is marked by:

- Family-like, direct interpersonal communication;

- Ad hoc work style without planning and improvisation;

- Friendly, buddy-like work climate;

- Expectation of mutual trust among staff, instead of monitoring and control;

- Inevitable need for monitoring and accountability is performed informally;

- Conflict resolution in informal ways by compromise;

- Conflicts resulting from this tend to be avoided and kept burning under the surface;

- Formal/official organizational structure of NPO tends to be resistant to change;

Echoing in some ways Tuckman's model of group development, the growth of the organization in NPOs generates crises with virtually the same phenomena we found in trauma centers:

- Power struggles;

- Low motivation, burnout;

- Fear of team and staff losing their autonomy;

- Reluctance to grant executive management more power and responsibility;

- As a result, lack of discipline, nobody accountable for task performance;

- Making necessary (tough) decisions tends to be postponed or avoided;

- Factual, professional issues/problems become personalized;

- Use of "killer" labels in conflicts: "unsocial," "inhuman," "undemocratic";

- Unclear criteria for output, unclear aims produce lack of orientation and insecurity;

- As a result, great need for continuous discussion on all issues by everybody;

- Too many people participate in decision making;

Taking these notions from sociological studies on NPOs into account may mitigate conflicts and reduce anxieties in trauma centers. It may enhance one's stress resistance when one knows that the transition from the pioneer phase to professionalization is usually accompanied by friction and turbulence and is a necessary and inevitable part of organizational transformation and development.

Discussion

The role of structure has hardly been examined in previous studies. Smith et al. (Smith, Kleijn, & Stevens, 2000, 2001; Smith, Kleijn, Trijsburg, & Hutschemaekers, 2007) 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). 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).

In a quantitative survey of caregivers in clinics for traumatized refugees (N = 101), Gurris (2005; see also Deighton, Gurris, & Traue, 2007) identified the main source of burnout and vicarious traumatization to be the limitations of a successful trauma therapy, due to both the fragile status of clients who were mainly asylum seekers and the high level of team conflict in most clinics. Having to struggle for asylum for their clients and the therapists' failure to work through traumatic events with their clients was related to high symptomatology. Therapists with this combination showed more compassion fatigue, burnout, and distress. This is confirmed by Smith (2009), who compared 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."

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 distance and lack of empathy, or lose distance by enmeshing themselves in confluent and overprotective behavior

with the patient, resulting in mutual dependence. Hafkenscheid (2003, 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 metacommunicative 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.

The phenomena in centers 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 (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 counseling 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).

As to the significance of caregiver trauma as a source of stress and dysfunction in organizations, Wilson and Thomas (2004) found in a survey of 345 therapists that 54% had a personal history of trauma. Of these, 88.5% were treating the same types of abuse and trauma as the therapists had endured. According to the authors, these data are open to many interesting interpretations. For example, therapists may have a conscious or unconscious desire to "work through" their own personal trauma by involvement with patients suffering similar traumas. Kassam-Adams (1999) found that 60% of therapists (n = 100) in centers for victims of sexual abuse had a history of childhood trauma and 66% a history of adult trauma. They found a correlation between childhood trauma and PTSD symptoms in therapists. Our data suggest that an unresolved caregiver trauma carries a high risk of producing stress and dysfunction. However, if it has been worked through in therapeutic training, it can be an important resource.

The above-cited studies provide valuable insights into the dynamics of the caregiver–client relationship. They confirm and supplement some of our hypotheses, while most of them only marginally focus on structural and organizational aspects.

Conclusion

The results of this study clearly show that structural shortcomings are an important source of work-related stress and conflict in institutions dealing with extreme trauma. Organizations with high stress and conflict levels exhibit considerable deficiencies related to structural dysfunction, such as failure to maintain boundaries, overidentification with clients, lack of professional distance, lack of a therapeutic and strategic concept, diffusion of roles and competence, lack of professional management and good leadership, the myth of an egalitarian team, awkward and lengthy decision-making processes, informal leaders involved in turf battles, nonexistent or sporadic clinical supervision, "ambulance chasing" or hectic and uncoordinated interventions, workaholism, selfsacrifice, insufficient or nonexistent self-care, lack of professional quality standards, and no board or amalgamation of board and management, causing conflicts of interest. The atmosphere is shaped by a reenactment of the traumatic world of clients, represented by a general atmosphere of fear and persecution, fantasies about the presence of the secret service, perpetrator–victim relationships, an obsession with violence, a martyr complex marked by feelings of grandiosity as the savior of the world, and splitting behavior involving categorization of colleagues in terms of good and bad, and friends and enemies.

Organizations with low stress and conflict levels, however, prove to have a fairly clear and much less dysfunctional structure, which includes maintaining boundaries, balancing empathy with clients and professional distance, good leadership, delegating tasks and responsibilities, clear definition of roles and competence, selecting staff according to professional credentials and personality, extensive ongoing professional training, a common treatment philosophy and therapeutic concept, external clinical supervision and collegial intervision, coaching for leaders, a care for caregivers program, and a functioning board consisting of independent experts who offer support for leaders and staff and serve as moderators in conflicts.

The study raises the question whether the stress symptoms experienced by caregivers amount to a diagnosis of "secondary PTSD." In our study, caregivers in organizations with structural deficiencies showed

symptoms described by others as secondary traumatization. However, these symptoms subside after structural reforms, and caregivers in well-structured organizations show almost no such symptoms. Secondary trauma is obviously not an inevitable side effect of working with victims. Thus, in accordance with other critical comments (Hafkenscheid, 2003, 2005; Sabin-Farell & Turpin, 2003), the contagion model of McCann and Pearlman's (1990) concept of vicarious traumatization as well as Figley's concept of compassion fatigue (1995) should be reconsidered.

Trauma centers are supposed to be places of refuge, safe havens for clients who have gone through horror and destruction and seen the total disruption of their familiar environments. Victims of man-made disasters such as torture and sexual violence have lost their basic trust in mankind. For them, there is no longer anything benign in the world. At the perpetrator's disposal they experienced extreme arbitrariness, the complete absence of structure, the total impossibility of controlling or predicting what would happen to them. They lacked any ability to determine events. All this causes insecurity, anxiety, and disorientation. The individual therapist cannot repair all this destruction by him or herself within the client–therapist relationship. He needs the support of a team of empathetic colleagues, and protection and support from a competent and experienced leader. A certain amount of reenactment 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 clients. It must give them the chance to regain control over their lives. Lack of structure and a chaotic environment, however, foster stress and conflict in teams and disrupt the organization; this is experienced as a reenactment of trauma. They impair the helping capacity of caregivers, which is ultimately detrimental to the clients.

Recommendations

First of all, trauma centers need a clear structure with authorized leadership. The grass roots model can function well in the pioneer phase, but it becomes dysfunctional in the course of growth and professionalization. Donors and supervisors should be aware that charismatic founders are often the motor in the early pioneer phase of an organization but may have to be replaced when they fail to accept necessary organizational transformation and development. This is one key argument for the necessity of a board. Trauma centers, like all professionally managed organizations, need independent bodies of supervisors and moderators who are able to monitor and foster organizational development, support the organization in times of crisis, and help with conflict resolution. One key factor in unresolved tensions and ongoing chronic conflicts in organizations is a missing or malfunctioning board. Another must for trauma centers is regular clinical supervision and a work atmosphere that allows shared reflection on the work and the dynamics between client and therapist from a bird's eye view. Accordingly, caregivers must participate in ongoing professional training, and those with therapeutic and counseling functions must receive psychotherapeutic training that includes self-awareness.

Organizations and their leaders should place great emphasis on self-care, meaning limitation of caseload, avoidance of overwork, the opportunity to rotate into non–trauma-related work, time or sabbaticals for research and teaching, and a culture of sociability in the team that may include team parties, joint cooking, leisure activities, and retreats. Caregivers should cultivate a life outside the workplace that includes family, friends, travelling, and hobbies and should take good care of themselves, listen to their bodies and souls, and do anything that reduces tension and stress, such as meditation and relaxation techniques.

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Declaration of Conflicting Interests

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Notes

1. Of these (n = 33), 58% were psychiatrists.
2. A Western democracy.

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