

CHAPTER 5.

HELPING THE HELPERS: TIPS TO AVOID BURNOUT REACTIONS AND TO REMAIN PROFESSIONALLY EFFECTIVE

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5.1 GOAL

The aim of this chapter is to prevent professional burnout outcomes and allow staff to continue performing their duties with trafficked persons, a very challenging population.

5.2 LEARNING OBJECTIVES

At the end of this chapter the reader will be able to

- recognize how stress can affect each of us;
- identify how to assess the effects of stress on oneself and colleagues;
- share ideas on how to manage psychosocial teams and provide resources and psychological support for the helpers themselves to enhance services to the beneficiaries, i.e. the trafficked persons.

“If you are motivated by a wish to help on the basis of kindness, compassion, and respect, then you can carry on any kind of work, in any field, and function more effectively with less fear or worry, not being afraid of what others think or whether you ultimately will be successful in reaching your goal. Even if you fail to achieve your goal, you can feel good about having made the effort.” (Dalai Lama & Cutler, 1998, p. 272).

5.3 A BRIEF INTRODUCTION

Humanitarian workers and psychosocial professionals working with challenging and unusual populations have in common that they tend to be highly motivated individuals, often somewhat idealistic and ready to work in stressful environments. This has been recognized by many international humanitarian organizations, first by the International Committee of the Red Cross (ICRC) and later on by other organizations such as the United Nations High Commissioner for Refugees (UNHCR)¹ and more recently by the International Organization for Migration (IOM). The same recognition relates to domestic humanitarian action, indeed psychosocial professionals working in unusual and stressful situations and/or with challenging populations. Their strong desire to help others often masks their own needs. Frequently, although they are technically proficient in various specialized skills, they are unaware of stress as a phenomenon that can affect work ability and performance and impinge on their professional satisfaction. Unhappiness or even intense dysphoria, physical symptoms, burnout and many other manifestations may lead, in worse case scenarios, the otherwise healthy and previously motivated staff to leave their jobs with a sense of personal failure.

¹See for example the July 2001 UNHCR handout *Managing the Stress of Humanitarian Emergencies* and in the July 2001 International Committee of the Red Cross' handout *Humanitarian action & armed conflict. Coping with stress*

Humanitarian workers and psychosocial professionals are not exempted from pathological effects of stress and are not immune from psychiatric disorder. As Allen (2001) states (referring to therapists):

“We [...] are subject to all the risk factors that pertain to our clients, including genetic vulnerabilities (e.g., to anxiety, depression, alcohol abuse), family history of psychiatric disorder, and our own individual history of behavioural, emotional, and physical disorders. Fortunately, just as we are not excluded from risk factors, we are not excluded from protective factors, among the most important of which is a history of supportive and secure attachments.

Like everyone else, we who grew up to become therapists, were at significant risk for childhood trauma”.

In fact, the same author reports that, in comparing mental health professionals with other professional groups and with the general population, research has consistently found higher levels of childhood adversity among mental health professionals, including physical abuse, sexual molestation, parental alcoholism, hospitalisation of a parent for mental illness, and death of a parent or sibling. Their family environment also seems to be more dysfunctional. However, it is worth wondering if mental health professionals actually experience higher prevalence rates or if they are just better trained at identifying and reporting occurrence.

5.4 SOME HISTORY ON THE NOTION OF STRESS

It has been known since the late 1900s that traumatic events can induce symptoms in otherwise seemingly healthy individuals. Charcot and Freud, to cite just these two famous clinicians, wrote extensively about hysterical symptoms emerging in the aftermath of real and/or fantasized trauma. Since about the same time, it is also known that the extreme conditions of military combat can adversely affect the mental health of soldiers to the point of causing severe psychiatric symptomatology, some of which, depending on the constellation of individual and social factors, can be chronically debilitating.

Throughout the 20th century, as military medicine and psychosocial programs became gradually aware of this type of psychopathology, great efforts were put into the selection of more resistant recruits and into training improvements to prepare soldiers to the reality of war. Despite some success, scores of seemingly healthy soldiers broke down psychologically and many carried long term symptoms.

Recognition of these phenomena became particularly acute in the United States of America (USA) after the unpopular Vietnam war and the description of various “veteran syndromes”. Eventually, the study and treatment of USA veterans led to the introduction of novel ways of conceptualising its pathological manifestations and to the introduction of diagnostic categories such as Post Traumatic Stress Disorder (PTSD) or Acute Stress Reaction (ASR). At the same time, it was becoming obvious to many clinicians that many

other categories of patients exhibited symptoms similar to those of Vietnam vets. Early research for example made striking comparisons between PTSD patients and borderline syndromes, leading rather rapidly to the realization that many female borderline patients hospitalised in psychiatric settings reported having suffered traumatic physical and sexual abuse during childhood.

From then on, with a gradual receding of psychoanalytic theory, the impact of traumatic or quasi-traumatic events on the psychological functioning of individuals has skyrocketed. Whether the trauma be the result of accidents, war and violence of any type, natural catastrophes, or just being exposed to disturbing images, researchers and psychologists have followed a larger social movement that one author has claimed is the “age of victimisation”, whereby we are all by and large victims of some traumatic event and hence need some professional guidance to deal with its psychological impact.

What are traumatic events? There are several definitions. Generally:

- A **Type I** traumatic situation refers to a single event of very high intensity which a person is unable to withstand psychologically. Examples would be a violent assault or an earthquake.
- A **Type II** traumatic situation can produce the same consequences but refers to the repetition of highly disturbing situations. For example, repeated child sexual abuse or lengthy exposure to situations of physical insecurity such as those civilians may experience in a war zone

Obviously, the consensus exists that the most victimized and therefore the most traumatized individuals are the ones caught up in humanitarian catastrophes. There is ample literature supporting the need for psychological interventions with the victims of major natural disaster as well as the mostly female and child victims of war torn regions. There have been large scale programs seeking to facilitate trauma recovery for entire communities. Mental health professionals from all disciplines (medicine, social work, nursing, psychology, etc.) have developed considerable know how in the delivery of these services and benefits seem, by and large, to demonstrate the need for these programs. Post conflict zones have become important sites for psychological interventions... it must be said with mixed results! For example, Rwanda, Bosnia Herzegovina, etc.

It is becoming increasingly obvious that the larger professional group of humanitarian workers and psychosocial professionals, that is working in the field in war or natural catastrophe zones or domestically in emergency situations or with difficult populations (abused children, battered women, tortured persons, etc.), clearly benefits from psychological interventions as well. Even in peaceful countries, it is becoming increasingly routine for personnel of emergency services, firemen, police, ambulance staff, etc., to benefit from psychological attention when their interventions put them at risk for trauma. This has created a vast market for so-called psychological debriefings and support interventions by specialized mental health staff.

Sometimes the interventions are with unusual professional staff.

Example: Over the past two years Swiss television editing staff confronted on a daily basis to footage of unspeakable human suffering have been receiving professional counselling to find ways to reduce the traumatic effect of their professional tasks.

These interventions can be preparatory, ongoing, reactive and reintegrative. Thus, they apply to preparing humanitarian workers and psychosocial professionals to prop up their resources to confront difficult situations and to manage their mental hygiene over difficult and trying missions. They answer the needs of humanitarian workers in case of unexpected traumatic events or lengthy exposure to trying situations.

5.5 DEFINITIONS OF STRESS AND BURNOUT

First and foremost, it has been clearly demonstrated that even moderate amounts of stress can be a good ingredient in the work environment. In 1936, Hans Seyle used the term “stress” in a novel way to describe the general adaptation pattern individuals present when they are facing threats or aggression. Stressful reactions are first and foremost normal and adaptive physiological and psychological responses that allow a person to:

- Focus his/her attention on the dangerous situation;
- Mobilize the necessary mental energy to assess the situation and take decisions;
- Prepare for action of various types (generally fight or flight, but at times the freeze position or physical paralysis can also be a useful response);

To play with words, stress is a neutral state as long as it does not breed distress either immediate or delayed. Generally, negative stress is broken down into four categories:

- **Basic day to day stress** which is what most motivated people have to contend with in challenging situations;
- **Cumulative stress** which is the accumulation of low grade stress over stretches of time. Even low levels of stress can grow day after day if work conditions are not adequate or if the person does not have a healthy lifestyle;
- **Critical event stress** refers to acute emotional and physiological reactions to violent and potentially traumatizing stress;
- **Acute stress reactions** and **Post traumatic stress disorder** are the dysfunctional syndromes that can appear if the adequate care is not provided to the person who has either accumulated too much stress over long periods of time or if s/he has not received sufficient attention following a critical event.

Pines (1993) differentiates between stress reactions and burnout in that the later refers to the effects on highly motivated professional with strong ideals. Indeed, historically the term “burnout” was proposed by Freudenberger (1974, 1980) to describe how volunteers in social services gradually withered and lost their enthusiasm to perform their duties.

Burnout has been described as a gradual process of disillusionment which follows four often recurring stages:

- **Enthusiasm.** This initial stage is when the helper invests all his/her energy in the job and derives most if not all his/her gratification from work. Some helpers are more idealistic than others, have higher expectations, over-identify with their beneficiaries, etc., and, in essence, are not realistic about how to cope with discouraging conditions and challenging populations.
- **Stagnation.** This stage refers to the process of becoming stalled and losing one's hope and desire to make a difference. The job gradually loses its lustre and no longer makes up for the person's needs.
- **Frustration.** The helper is no longer helping and feels powerless. Some helpers complain and complain and complain. Others become angry and blame supervisors and, at times, the beneficiaries for their frustration. Most often, frustration leads to internalisation and withdrawal.
- **Apathy.** The final stage occurs when the helper becomes emotionally detached even in the face of frustration. S/he eventually stops caring!

5.6 COPING MECHANISMS AND REACTIONS TO STRESS THAT ARE UNHEALTHY

These reactions can be addressed in two ways: 1) as coping mechanisms or strategies to deal with a problem, and 2) as effects when the coping has not been particularly successful.

5.6.1 Coping mechanisms (Cohen, 2000)

Coping is behaviour that is designed to prevent, delay, avoid, or manage tension and stress. Coping is not unusual or rare behaviour. Coping is intertwined with one's social and emotional resources and one's emotional and psychological tools. Most individuals learn individualized ways of dealing with stress, but they usually follow a pattern of:

- Avoidance;
- Alteration;
- Management;
- Prevention; and
- Control of undue emotional expression.

Coping mechanisms may take three different forms:

1. The individual may attempt to change the source of strain or stress. This action presumes knowledge and perception of its causes. Attention is focused on changing the situation before strain or stress occurs.

2. The individual may attempt to redefine the situation so as to control the degree of stress and lessen or buffer its impact. Redefinition is a means of managing the significance and gravity of the problem situation. Cognition and perception are important in this process.
3. The individual may attempt to manage stress so s/he can continue to function as normally as possible. This includes denial, withdrawal, passive acceptance, undue optimism, avoidance, or even magical thinking.

POSITIVE COPING SKILLS

- Ability to orient oneself rapidly
- Planning of decisive action
- Mobilization of emergency problem-solving mechanisms
- Appropriate use of assistance resources
- Ability to deal simultaneously with the affective dimensions of the experience and the tasks that must be carried out
- Appropriate expression of painful emotions
- Acknowledgement of pain, without obsessing over troubled feelings
- Development of strategies to convert uncertainty into manageable risk
- Acknowledgement of increased dependency needs and seeking, receiving, and using assistance
- Tolerance of uncertainty without resorting to impulsive action
- Reaction to environmental challenges and recognition of their positive value for growth
- Use of non-destructive defences and modes of tension relief to cope with anxiety.

NEGATIVE COPING SKILLS

- Excessive denial, withdrawal, retreat, avoidance
- Frequent use of fantasy, poor reality testing
- Impulsive behaviour
- Venting rage on weaker individuals and creating scapegoats
- Over-dependent, clinging, counter-dependent behaviour
- Inability to evoke caring feelings from others
- Emotional suppression, leading to “hopeless-helpless-giving up” syndrome
- Use of hyperritualistic behaviour with no purpose
- Fatigue and poor regulation of rest-work cycle
- Addiction
- Inability to use support systems

5.6.2 When normal coping no longer works

Generally stress reactions (including burnout, acute stress reactions and posttraumatic stress disorder) are broken down in to five dimensions:

1. **Physical**
 - Sleep disturbance
 - Nightmares
 - Aches and pains
 - Appetite and digestive changes
 - Lowered resistance to colds and infection
 - Persistent fatigue

2. **Emotional**
 - Mood swings, feeling unstable
 - Anxiety, fear of recurrence
 - Depression, grief
 - Irritability, hostility
 - Self-blame, shame
 - Fragility, feeling vulnerable
 - Numbness, detachment
 - Fear of “contaminating” loved ones when sharing difficult experience
 - Irritability and lack of resistance to frustration

3. **Cognitive**
 - Intrusive memories
 - Reactivation of previous traumatic events
 - Preoccupation with the event
 - Increased rigidity, resistance to new ideas
 - Difficulty making decisions

4. **Behavioural**
 - Avoidance of reminders of the event
 - Social relationship disturbances
 - Difficulty connecting with “outsiders” and/or colleagues
 - Lowered activity level
 - Increased use of alcohol, drugs (self medication for depression, anxiety)
 - Loss of enthusiasm
 - Avoidance of work, frequently late, lower productivity

5. **Spiritual**
 - «Why me» struggle
 - Increased cynicism
 - Loss of self confidence
 - Loss of purpose
 - Renewed faith in higher being

- Profound existential questioning
- Loss of belief in cooperative spirit of mankind
- Disillusionment
- Loss of meaning
- Loss of life's objectives
- Feelings of alienation
- Changes in one's value system

As a personal exercise, please identify all the stress reactions you have experienced in the course of your professional activities. How many have you experienced? If you wish you may share this with the group and provide your own examples of what you experienced and its context.

Presentation of the **Secondary Traumatic Stress Scale**
(Bride, Robinson, Yegidis, & Figley, 2003)

All these reactions have obvious negative impact on ones professional duties.

5.7 PSYCHOLOGICAL AND SYSTEMIC CAUSES OF STRESS

Most authors consider that the most important contribution to professional burnout in high intensity clinical conditions relates to faulty narcissism and personal expectations that are too high. Beyond these psychological and/or cognitive reasons, the environment impacts in many ways to create synergies that can overwhelm all but the most functional helpers.

To be a helper is to receive gratification from helping others. Others become precious and this makes us precious in our own eyes. Szasz (1956, in Grosch & Olsen, 1994) elaborated on various categories of **psychological satisfaction** that define satisfaction of psychotherapists. These paraphrased categories that certainly fit most helping professions are:

- The pleasure of listening to patients' distress and complaints and our ability to make sense of their experience.
- The satisfaction procured by mastering our own anxieties through the attention we give the same concerns experienced by others. This is the classical notion that helpers are in the helping professions to help themselves.
- Curiosity is a great motivator. Each contact with a trafficked person is an adventure. Novel situations can be exciting and helpers must know how to hold back, suppress their voyeuristic tendencies and respect the trafficked person's intimacy.
- In the same vein, we access a very rich and diverse set of life stories and our work expands our horizons.
- There is great pleasure in diligently carrying out useful work. In fact, many helpers burn out because they derive all their satisfaction from work.

- We help because we enjoy the feeling that others need us. This gives clear goals in life. It is an inconvenient satisfaction when we experience failure helping others.
- A more clinical satisfaction derives from the pleasure of mastering human problems through verbalisation and mutual understanding.
- Pleasure is derived from the experience of never being alone and thus avoiding any hint of solitude.

The **helper's own trauma history** can be reawakened by the confrontation to traumatized beneficiaries and their narratives. Helpers must have a solid understanding of their life experience and their vulnerabilities. Sometimes it may be necessary to work through or re-examine some difficult and fragile personal zones in a therapeutic setting.

Our **environment**, the various systems we belong to, also contribute to our professional stress and can be major risk factors for professional fatigue and burnout.

- **Work conditions.** The workload can be at times overwhelming. Often everything must be done urgently and/ important decisions taken without enough time to consult colleagues.
- **Client pressure.** The trafficked person can be highly demanding and absorb a great deal of the helper's energy either because s/he mirrors back what a great helper we are or we experience the high of having people who are dependent on us.
- **Family pressure.** Helpers who have families sometimes realize that systems compete, work and home can both be very demanding and the more work is demanding the more family demands one's presence. There are at times dysfunctional cycles that develop: demand at work, creates expressed frustration from family, which in turn can push the helper back into the work environment to avoid frustration or anger at home.
- **Family of origin.** This refers to yet unresolved developmental ties with important parental figures. This can colour our relationships with colleagues and/or trafficked persons with who we reproduce family interactional patterns. Sometimes this influence is quite concrete with helpers who are often considered, indeed consider themselves, their own family therapists.
- **Bureaucracy.** For many of us, the real work is with people, not with administration. Unfortunately, we often discover that our job tends to be invaded by paperwork, administrative demands, and even demands from the "hierarchy".
- **Supervision.** This can be a huge benefit to helpers when supervisors are skilled and are able to provide empathic guidance to the supervisees. However, skilled supervisors are rare and many times supervision can be unpleasant, boring, persecutory, anxiety provoking, etc., and thus have the opposite effect of its intended benevolent process.
- **Personal sphere.** As if all this was not enough, it is notorious that helpers often tend to gather a great chunk of meaningful human interaction from work relations (clients and colleagues) and to be rather poorly endowed in the meaningful exchanges with family members and friends. There can sometimes be major confusion when clients merge into friends and helpers develop the illusion of symmetrical relationships.

5.8 IS WORKING WITH TRAFFICKED PERSONS STRESSFUL AND WHY?

Any psychosocial professional who has worked with physically and sexually abused populations recognizes that minimal empathy with trafficked persons can generate intense and painful reactions. Depending on the intensity and the reactions of the professional, this is generally referred to as vicarious stress or secondary trauma or professional burnout.

A young psychotherapy intern describing during supervision the sexual abuse his new client had endured could not hold back his tears. This reaction was entirely appropriate and demonstrated his sensitivity to his patient's narrative and the emotional impact it had on him. The supervision allowed him to examine his emotional resonance, find the appropriate affective distance with his patient, and to build on this empathic capacity to help his patient work through her painful recollections.

Perhaps a ringing illustration comes from a clinician with substantial direct experience with trafficked persons:

“Being directly involved in the work to support women survivors of trafficking I have often been in touch with my own strong emotions such as despair, helplessness, sorrow, anger... Many times have I experienced the need to deny in my mind that there is such severe violence as trafficking in women and many times I have felt the need to do something, even beyond human capacity, to stop this crime. As a psychologist I am aware that these strong emotions are a sign of my client's suffering. I am also aware that most of these emotions have resulted from my clash with the limitations of reality – the impossibility to prevent the pain of so many women, to rescue all survivors or to cure all the severe psychological and physical consequences of trafficking. I believe that the only way to offer new opportunities in reality and to bear the suffering of another person without rejection or denial is by means of understanding” (This citation is from an unpublished article *Case studies on trafficking in women in Bulgaria* by Milena Stateva).

This testimonial contains most of the issues that helpers must be prepared to deal with to support efficaciously the trafficked persons. She isolates the most important of all “understanding”. Most mental health professionals would use the term empathy which refers to the very complex mental capacity to:

- decentre oneself from one's own viewpoint,
- enter the world from the trafficked person's perspective,
- let the other trafficked person's know that you can adopt his/her point of view without merging on an emotional level (which would flood the trafficked person),
- cognitively understand what s/he is experiencing,
- maintain your calm and reassuring professional stance, and
- provide comfort and meaningful advice and direction.

In research by Glick (1993), physicians designated as most empathic are those considered by colleagues to be more altruistic and to pursue less personal goals. In addition other characteristics stand out:

- Greater self confidence and less anxious than the norm.
- Less stereotypical attitudes regarding patients and a greater focus on psychosocial factors that can influence the consultation.
- Accent on selflessness, investing time and effort in one's profession rather than on status, salary, personal appearance, and self confidence.
- Frequently asks advice from colleagues and is not offended when patients seek more personal advice.
- Spends more time teaching and training others than trying to prop up his/her private practice.
- Satisfied with relations with colleagues and more trusting of the overall institution and their own ability to influence it.
- Greater dissatisfaction because of lack of time for family and work.

This complex mental operation is also very taxing as it requires great levels of concentration, but also the capacity to resonate with the pain, distress, anxieties, etc., of the trafficked person without oneself being affected by these states, i.e., being able to maintain sufficient psychological distance. Most people are able to be reasonably empathic with friends and loved ones in situations that occur within the normal realm of their experience. However, working with people who underwent any type of traumatic experience will confront the helper with a new range of experience and their associated emotions which can be rather destabilizing.

In examining the literature on stress reactions of humanitarian workers and psychosocial professionals with challenging populations, it is striking the extent to which vicarious dramatisation is a process in which the changes experienced by the helper parallel those experienced by the traumatized beneficiaries. According to Pearlman & Saakvitne (1995), vicarious traumatisation is the transformation of one's inner experience resulting from empathic engagement with client's traumatic material.

As Allen (2001) writes:

“Consider what goes on in your mind when you bear witness as your client talks about traumatic experience. Owing to your brain's gift for vivid imagery, you are likely to picture what your client went through. Like your client, you may later be haunted by these images, during the daytime or during your sleep. Owing to your empathy and penchant for emotional contagion, you will experience some degree of distress, potentially sharing in the full range of emotions –fear, anger, despair, and the rest. Like your client, you may feel guilty about

your emotional and physiological responses (e., feeling guilty for your vengeful fantasies or sexual arousal). Like your client, your cognitive assumptions may be shattered. Like your client, you may become sensitised, more reactive rather than less reactive to subsequent stressors. Just as it is for your client, the therapeutic work you are doing may constitute a reminder of your past trauma” (p. 376-377).

A few years ago, I debriefed a staff person working for a large humanitarian governmental organization who had been abducted in the Caucasus and freed after almost one year of living in particularly difficult material and emotional circumstances. We spent several days talking about what he went through and at times it was almost unbearable to remain seated and to listen to him describe aspects of his ordeal. His pain was becoming my pain. While I was able to remain fully functional for his benefit, in the evenings when recounting the narratives with the supervisor that was on hand to help, I developed several somatic symptoms (stomach and head aches mainly) and insomnia.

In addition to the confrontation with a new range of emotional experience, most helpers are not taking care of single cases. Quite the contrary, in shelters and in rehabilitation centres they are involved with many trafficked persons who rotate in and out of the institution creating the impression that work is never over, trafficked persons keep streaming in! Without proper precautions for the helper’s own physical and psychological well-being, the repetition and the need to be involved with many trafficked persons can lead to the experience of cumulative stress and even in some cases to what is referred to as compassion fatigue, secondary traumatic stress, vicarious traumatization or burnout.

5.9 SPECIFIC REACTIONS OF HELPERS: A MIRROR IMAGE OF THE TRAFFICKED PERSON?

If vicarious traumatization is the transformation one’s inner experience resulting from empathic engagement with client’s traumatic material, it is a normal reaction that results from working with traumatized beneficiaries and that the trafficked persons are NOT to be blamed for traumatizing the helpers. In fact, Rosenbloom, Pratt and Pearlman (1996) consider vicarious traumatization as an inevitable occupational hazard which may be mitigated.

They consider that working with victims of trauma:

a) **alters the helpers’ frame of reference** which includes his/her:

- **Worldview**, i.e., our beliefs about other people and the world, as well as beliefs about causality. Humanitarian workers and psychosocial professionals may lose their sense of hope, optimism and connection with others as their basic assumptions collapse. As a result of the narratives we hear, the psychological distress and the physical marks we witness, we may begin to see other people and the world as dangerous and threatening, malevolent and evil, untrustworthy and unreliable, exploitative and controlling, and/or disconnected and alienating.

- **Spirituality**, i.e., the sense of meaning and purpose in life.
 - **Identity**, i.e., as a person, a professional, a man, a woman, what can we really do for the traumatized person? For some, the shift brings along fears of identifying with the aggressor.
- b) **impacts our own areas of psychological needs** and chief among these:
- **Safety** – The need to feel safe, both for oneself and for important others. Behaviours are sometimes changed, concerns for loved ones increased.
 - **Trust** – Trust of others may be disrupted by the narratives of the trafficked person. After all, s/he was often manipulated by trusted acquaintances. But also, the helper's trust in his/her own judgement can be diminished. Some of the narratives may seem *incredible*, and some trafficked persons are not dependable on some aspects of their stories. What trust to put in the beneficiary's willingness to participate in a rehabilitation program? After all, many trafficked person's fail to follow the helper's best advice and may fail the return process into the community or, worse still, become vulnerable to being trafficked once again.
 - **Esteem** – Self-esteem is a crucial ingredient of feeling good about one's work. The narratives of many trafficked persons and the problems that must be solved can seem so overwhelming that one's own competency to perform may be in doubt and suffer. To esteem others is also an important motivation for the ideals of the helping professions. At times, it is discouraging to realize how bad and cruel other people can be. And as the esteem of fellow human beings ebbs, the helper's sense of cynicism, doubt, and self-protectiveness may increase.
 - **Intimacy** – The cumulated effect of working with a challenging population may lead the helper to no longer feel comfortable or enjoying his/herself when alone. This can bring an increase in digressive behaviours, self-medicating, promiscuity, compulsive exercising, excessive work, etc. Intimacy with loved ones can be subjected to great pressures. Helpers may increase distance with significant others, feel that they are not understood, connect only to pathos, etc.
 - **Control** – This need can be challenged in work with traumatized persons, in that the sense of helplessness increases in parallel with the trafficked person's experience. The helper may come to doubt his/her own reactions in the face of adverse situations and his/her ability to control events. Sometimes the helper may gradually drift into less demanding areas of his/her duties. Or, just the opposite, s/he may become more controlling and directive in work and family situations to recapture some sense of control.

Another common reaction often observed with vicariously traumatized helpers is a tendency to “blame the victim”, that is to project one's own feelings of helplessness, rage, etc., on

the trafficked person. These attitudes can lead to major cognitive distortions, the helper adopting viewpoints that are similar to popular myths about trafficking. For example, after all the trafficked person could have avoided his/her predicament, could have escaped, should not have cooperated with the traffickers, lied to the helper's and is in reality a knowing prostitute, etc. Anger at the mostly male demand side of trafficking can contaminate personal relations with male colleagues and friends who do not express sufficient sensitivity. Or, the government is responsible for the trafficking because it does not undertake enough to prevent it. Even the helper's own organization can become the focus of anger and disillusionment for not being supportive enough of the specific program s/he works in.

What is crucial to remember is that working with traumatized beneficiaries is very taxing to one's psychological defences, after all the helper keeps seeing a steady stream of trafficked persons, each one of them carrying his/her tragic narrative, and the helper must remain professional and available to the beneficiaries.

Under the most extreme conditions, helpers may be at risk for professional burnout.

5.10 WHAT CAN BE DONE TO AVOID VICARIOUS TRAUMATISATION, BURN OUT, ETC. ...?

Fortunately, much can be done to deal with professional stress before it produces too many negative effects. The protective factors and countermeasures are usually generated by the helper him/herself in combination with what should be provided by the employing organization. But the fundamental strategy to combating stressful working conditions is to self-reflect, self-observe and recognize the effects of stress upon oneself and its sources (both personal and organizational), and to look out for signs of the effects of stress on others and help them deal with its sources (both personal and organizational).

Personal protective factors are much more effective than what most professionals think. Some people are also remarkably resilient and are able to function for long periods in very adverse conditions without showing signs of strain. Under stressful working conditions, such as being confronted to traumatized persons, most helpers self-adjust and find ways to cope with what may be at times overwhelming stress of various sorts. Personal styles and character may become more effective (even unconsciously at times) and helpers will find ways to disengage responsibly from their workload (manage the treatment frame adequately), talk about their feelings with their supervisors, colleagues and friends (maintain a social support network), take time off from work, find ways to distract from painful aspects of work, etc. Other more specific strategies may be to check with a trusted person how you are feeling, take part in recovery or supervision or therapy, reconnect with social and spiritual support, etc.

Caring for oneself should be first and foremost each helper's responsibility. This begins with leading a healthy lifestyle which includes adequate:

- **EXERCISE** – Physical and mental fitness often go hand in hand.
- **NUTRITION**
- **REST AND SLEEP**
- **RELAXATION AND HEALTHY PLEASURES**
- **BALANCE OF OFFICIAL AND PRIVATE LIFE...**

Generally speaking, the following **organizational protective factors** are the necessary ingredients to combating stress and the risk for professional burnout:

- Recognize that professional stress and burnout are REAL problems that can affect all helpers.
- Identify stress and burnout symptoms.
- Assess the causes of stress and burnout.
- Take steps to eradicate stress factors and burnout.
- Evaluate the effectiveness of these actions.

Stress responds to responsible leadership styles and management that creates a supportive work climate with an:

- Attitude of open communication
- Availability
- Awareness of reactions
- Acknowledgement of loss
- Appreciation of efforts

The leadership style and management can also provide professional psychological support for all the staff as a group or small groups or, still yet, for individual staff that seems more at risk of burnout.

The most common approach is to set up peer support groups in which staff members can share and ventilate their feelings and seek solutions. The group approach has the advantage of building a team spirit even when facing difficult conditions and providing collective support for those who may be more vulnerable at any given moment. It is recognized that when support groups function well:

- The stressors are accepted as real and legitimate.
- The problem is viewed as a problem for the entire group and not as a problem that is limited to the individual.

- The general approach to the problem is to seek solutions, not to assign blame.
- There is a high level of tolerance for individual disturbance.
- Support is expressed clearly, directly and abundantly in the form of praise, commitment and affection.
- Communication is open and effective; there are few sanctions against what can be said. The quality of communication is good and messages are clear and direct.
- There is a high degree of cohesion.
- There is considerable flexibility of roles and individuals are not rigidly restricted from assuming different roles. Resources -material, social, and institutional- are utilized efficiently.
- There is no subculture of violence (emotional outbursts are not a form of violence).
- There is no substance abuse.

It is also advised that helpers working with traumatized persons benefit from regular **professional supervision**. In this context, supervision is conceived as an opportunity for the helper (or the manager) or small group of helpers to meet confidentially with a mental health specialist with training as a clinical supervisor. His/her work is to create conditions of respect and safety for the helper to explore the difficult issues evoked in him/herself by the traumatized beneficiaries.

Finally, one of the best measure to combat stress and vicarious traumatisation is to provide for diverse work experience and opportunities to learn new skills. In this sense, **staff development** and training is an essential tool to keep helpers involved, appreciated and aware of their value. Beyond this psychosocial function, knowledge provides a conceptual framework that helps bring coherence to experience, including secondary traumatic experience. Also, gaining more specialized information generally increases one's sense of self-efficacy and may contribute to regulate the optimal level of detachment that one needs to work with traumatized beneficiaries. Continued training also implicitly acknowledges that our expectations are informed, that goals we set must be realistic... and that we must tolerate failure.

As Pearlman and Saakvitne (1995) ironically state:

“Probably the most important recommendation we make to our colleagues about their personal lives is to have one” (p. 393).

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APPENDIX I

TRAUMATIC STRESS INSTITUTE (STI) BELIEF SCALE

(available from: TSI, 22 Morgan Farms Drive, South Windsor, CT 06074)

What it measures?

The TSI Belief Scale is intended to measure disruptions in beliefs about self and others which arise from psychological trauma or from vicarious exposure to trauma material through psychotherapy or other helping relationships. The scale is intended to provide a quick (15 minute) screening instrument for clinicians questioning the possibility of a trauma history in their clients, as well as indicating specific psychological need areas requiring attention in the psychotherapy process (McCann & Pearlman, 1990a). It is also intended, in conjunction with other measures, to diagnose the existence of vicarious trauma (McCann & Pearlman, 1990b; Pearlman & Saakvitue) in helpers.

TSI Belief Scale Sample Items

Self-Safety: the need to feel one is reasonably invulnerable to harm inflicted by self or others.

- Item: 1. I generally feel safe from danger.
4. I find myself worrying a lot about myself.
15. I believe I can protect myself if my thoughts become self-destructive.

Other Safety: the need to feel that valued others are reasonably protected from harm inflicted--by oneself or others.

- Item: 9. I'm reasonably comfortable about the safety of those I care about.
19. Sometimes I think I'm more concerned about the safety of others than they are.
40. I worry a lot about the safety of loved ones.

Self-Trust: The belief that one can trust one's judgments

- Item: 44. I feel uncertain about my ability to make decisions.
70. I have sound judgment.
74. I feel confident in my decision-making ability.

Other Trust: the belief that one can rely upon others.

- Item: 47. I can depend on my friends to be there when I need them.
64. Most people don't keep the promises they make.
66. Trusting other people is generally not very smart.

Self-esteem: The belief that one is valuable and worthy of respect.

- Item: 27. I deserve to have good things happen to me.
32. I am basically a good person.
34. Bad things happen to me because I'm bad.

Other-esteem: the belief that others are valuable and worthy of respect.

- Item: 31. This world is filled with emotionally disturbed people.
50. Most people are basically good at heart.
56. I don't have a lot of respect for the people closest to me.

Self-intimacy: the belief that time spent alone is enjoyable. Item:

- Item: 35. Some of my happiest experiences involve other people.
36. There are many people to whom I feel close and connected.
39. I often feel cut off and distant from other people.

Self-control: the need to be in charge of one's own feelings and behaviours.

- Item: 65. Strong people don't need to ask for others' help.
68. I feel bad about myself when I need others' help.
80. When someone suggests I relax, I feel anxious.

Other-control: The need to manage interpersonal situations.

- Item: 24. I don't have much control in relationships.
25. I am often involved in conflicts with other people.
55. I often feel helpless in my relationships with others.

APPENDIX II

FROM THE TRAINING MANUAL FOR MENTAL HEALTH AND HUMAN SERVICE WORKERS IN MAJOR DISASTERS (CENTER FOR MENTAL HEALTH SERVICES, 1994; available at www.mentalhealth.samhsa.gov/).

Organizational Context

Having an organizational structure and plan that builds in stress prevention can mitigate potential stress overload for staff. While these efforts may be time-consuming on the front end, the long-term benefits of reduced employee turnover and avoidance of thorny personnel issues, as well as increased productivity and program cohesion are well worth the efforts. The following five dimensions reflect necessary areas to address when designing a strong program that prioritizes organizational health:

- Effective management structure and leadership
- Clear purposes and goals
- Functionally defined roles
- Team support
- Plan for stress management

Individual Context

Psychologically healthy and well-balanced individuals are best equipped to implement and maintain an effective disaster mental health recovery program. Programs can build in supports and interventions to ensure that the majority of their staff will be functioning in the "healthy and balanced" range. As community needs change over time, so will workers' stress management intervention needs. Listed below are four skill building areas to address when designing the staff stress management component of a program:

- Management of workload
- Balanced lifestyle
- Strategies for stress reduction
- Self awareness

Stress Prevention and Management Methods

The following charts present suggestions for organizational and individual stress prevention for immediate and long-term response time frames. Suggestions for the immediate response phase may be applicable for the long-term response phase as well. Approaches for eliminating and minimizing stressors and stress reactions are included. Since each disaster and mental health response has different elements, program planners will need to tailor the following to their own locale, resources, and disaster.

Effective management structure & leadership

- Clear chain of command and reporting relationships
- Available and accessible clinical supervisor
- Disaster orientation provided for all workers
- Shifts no longer than twelve hours with twelve hours off
- Briefings provided at beginning of shifts as workers exit and enter the operation
- Necessary supplies available (e.g., paper, forms, pens, educational materials)
- Communication tools available (e.g., cell phones, radios)
- Full-time disaster-trained supervisors and program director with demonstrated management and supervisory skills
- Clear and functional organizational structure
- Program direction and accomplishments reviewed and modified as needed

Clear purpose & goals

- Clearly defined intervention goals and strategies appropriate to assignment setting (e.g., crisis intervention, debriefing)
- Community needs, focus and scope of program defined
- Periodic assessment of organizational health and service targets and strategies
- Community Mental Health Services Program Guidance guidelines integrated into service priorities
- Staff trained and supervised to define limits, make referrals
- Feedback provided to staff on program accomplishments, numbers of contacts etc.

Functionally defined roles

- Staff oriented and trained with written role descriptions for each assignment setting
- When setting is under the jurisdiction of another agency (e.g., Red Cross, Federal •0 Emergency Management Agency), staff informed of their role, contact people, and expectations
- Job descriptions and expectations for all positions
- Participating disaster recovery agencies' roles understood and working relationships with key agency contacts maintained

Team support

- Buddy system for support and monitoring stress reactions
- Positive atmosphere of support and tolerance with "good job" said often

- Team approach that avoids a program design with isolated workers from separate agencies
- Informal case consultation, problem solving and resource sharing
- Regular, effective meetings with productive agendas, personal sharing, and creative program development
- Clinical consultation and supervision
- In-service training appropriate to current recovery issues provided

Plan for stress management

- Workers' functioning assessed regularly
- Workers rotated between low, mid, and high stress tasks
- Breaks and time away from assignment encouraged
- Education about signs and symptoms of worker stress and coping strategies
- Individual and group defusing and debriefing provided
- Exit plan for workers leaving the operation: debriefing, re-entry information, opportunity to critique, and formal recognition for service
- Education about long-term stresses of disaster work and the importance of ongoing stress management
- Program checklist including organizational and individual approaches and implementation plan
- Plan for regular stress interventions at work and meetings (no chart?)
- Extensive program phase down plan: timelines, debriefing, critique, formal recognition, celebration, and assistance with job searches

Management of workload

- Task priority levels set with a realistic work plan
- Existing workload delegated so workers not attempting disaster response do usual job
- Planning, time management, and avoidance of work overload (e.g., "work smarter, not harder")
- Periodic review of program goals and activities to meet stated goals
- Periodic review to determine feasibility of program scope with human resources

Balanced lifestyle

- Physical exercise and muscle stretching when possible
- Nutritional eating, avoiding excessive junk food, caffeine, alcohol, or tobacco

- Adequate sleep and rest, especially on longer assignments
- Contact and connection maintained with primary social supports
- Family and social connections maintained away from program
- Exercise, recreational activities, hobbies, or spiritual pursuits maintained (or begun)
- Healthy nutritional habits pursued
- Overinvestment in work discouraged

Stress reduction strategies

- Reducing physical tension by taking deep breaths, calming self through meditation, walking mindfully
- Using time off for exercise, reading, listening to music, taking a bath, talking to family, getting a special meal to recharge batteries
- Talking about emotions and reactions with co-workers during appropriate times
- Cognitive strategies (e.g., constructive self talk, restructuring distortions)
- Relaxation techniques (e.g., yoga, meditation, guided imagery)
- Pacing self between low and high stress activities, and between providing services alone and with support
- Talking with co-workers, friends, family, pastor, or counsellor about emotions and reactions

Self-awareness

- Early warning signs for stress reactions recognized and heeded (see following section)
- Acceptance that one may not be able to self-assess problematic stress reactions
- Over identification with survivors' grief and trauma may result in avoiding discussing painful material
- Vicarious traumatization or compassion fatigue may result from repeated empathic engagement (Figley, 1995; Pearlman, 1995)
- Exploration of motivations for helping (e.g., personal gratification, knowing when "helping" is not being helpful)
- Understanding differences between professional helping relationships and friendships
- Examination of personal prejudices and cultural stereotypes
- Recognition of discomfort with despair, hopelessness, and excessive anxiety that interfere with capacity to "be" with clients
- Recognition of over identification with survivors' frustration, anger, and hopelessness resulting in loss of perspective and role

- Recognition of when own disaster experience or losses interfere with effectiveness
- Involvement in opportunities for self exploration and addressing emotions evoked by disaster work

Signs and Symptoms of Worker Stress

Thus far, the focus of this section has been to describe methods for preventing and mitigating staff distress in a disaster mental health recovery program. The signs and symptoms of worker stress are also important to discuss, as early recognition and intervention are optimal. Educating supervisors and staff about signs of stress enables them to be on the lookout and to take appropriate steps. When programs emphasize stress recognition and reduction, norms are established that validate early intervention rather than reinforcing the more common (even though we know better) "worker distress is a sign of weakness" perspective.

Common Disaster Worker Stress Reactions:

Psychological and Emotional

- Feeling heroic, invulnerable, euphoric
- Denial
- Anxiety and fear
- Worry about safety of self and others
- Anger
- Irritability
- Restlessness
- Sadness, grief, depression, moodiness
- Distressing dreams
- Guilt or "survivor guilt"
- Feeling overwhelmed, hopeless
- Feeling isolated, lost, or abandoned
- Apathy
- Identification with survivors

Cognitive

- Memory problems
- Disorientation
- Confusion

- Slowness of thinking and comprehension
- Difficulty calculating, setting priorities, making decisions
- Poor concentration
- Limited attention span
- Loss of objectivity
- Unable to stop thinking about the disaster
- Blaming

Behavioural

- Change in activity
- Decreased efficiency and effectiveness
- Difficulty communicating
- Increased sense of humour
- Outbursts of anger, frequent arguments
- Inability to rest or "letdown"
- Change in eating habits
- Change in sleeping patterns
- Change in patterns of intimacy, sexuality
- Change in job performance
- Periods of crying
- Increased use of alcohol, tobacco, or drugs
- Social withdrawal, silence
- Vigilance about safety or environment
- Avoidance of activities or places that trigger memories
- Proneness to accidents

Physical

- Increased heartbeat, respiration
- Increased blood pressure
- Upset stomach, nausea, diarrhoea
- Change in appetite, weight loss or gain
- Sweating or chills

- Tremors (hands, lips)
- Muscle twitching
- "Muffled" hearing
- Tunnel vision
- Feeling uncoordinated
- Headaches
- Soreness in muscles
- Lower back pain
- Feeling a "lump in the throat"
- Exaggerated startle reaction
- Fatigue
- Menstrual cycle changes
- Change in sexual desire
- Decreased resistance to infection
- Flare-up of allergies and arthritis
- Hair loss

APPENDIX III

ANNOTATED BIBLIOGRAPHY ON VICARIOUS TRAUMATISATION AND
FORMS OF TRAUMATIC STRESS IN THE WORKPLACE OF PSYCHIATRIC
NURSES (CLEMENTS, K., ROBINSON, R., & PANTELUK, 1998).

From a Poster Session on Vicarious Traumatization presented at
RPNAM and available at www.crpnm.mb.ca/vt.html

1. Burnout

Burnout refers to a complex of psychological responses to the stressors of constant interaction with people in need. For instance, burnout can occur when nurses struggle to maintain high levels of empathy & caring in work situations where there is likely to be unrealized, unrealistic expectations. (Blair & Romones, 1996:24)

Factors contributing to burnout are:

- little observable clinical success
- high rates of recidivism among the people in need/clients (I suppose?)
- lack of supervision & consultation
- nonreciprocal giving
- work context where expectations of caring & success cannot be met.

The symptoms of burnout include:

- energy loss
- exhaustion
- depression
- boredom
- loss of empathy
- pessimism
- cynicism
- anxiety
- antisocial attitude
- feelings of impotence
- substance abuse

2. Critical incident stress

A critical incident is defined as a traumatic event of sufficient magnitude to overwhelm usually effective coping skills of health care or emergency services personnel. Critical incidents are typically sudden, powerful events which fit outside the range of normal human experience.

Critical stress reactions are normal reactions of normal people to abnormal events. These stress reactions are characterized by a wide range of cognitive, physical, emotional, & behavioural signs & symptoms which one would expect in traumatized people. By virtue of belonging to a high risk profession, psychiatric nurses may at times become victims of stress & trauma. Exposure to various critical incidents over time can contribute to the phenomenon of vicarious traumatization. Psychiatric nurses might be 'victims' themselves or vicariously traumatized by their role of witness as members of critical incident stress management teams. (Mitchell & Everly, 1996)

Critical incident stress management "(CISM) represents an integrated 'system' of interventions which are designed to prevent &/or mitigate the adverse psychological reactions that so often accompany emergency services, public safety, & disaster response functions" (Mitchell & Everly, 1996:3)

3. Countertransference

Countertransference has traditionally referred to the activation of the therapist's unresolved or unconscious conflicts through the process of interpersonal engagement with the client's issues and patterns of interpersonal interaction (e.g. re-enactment of abusive relationships).

In vicarious traumatization, countertransference includes normal reactions to the painful feelings, images and thoughts accompanying exposure to clients' trauma material (e.g. rage, fear, revenge, horror, grief, vulnerability, guilt, shame).

"Experiencing disrupted beliefs and intrusive imagery as a result of the clinical material is both inevitable and normal." (Pearlman & Saakvittne, 1995:287)

Vicarious traumatization is unavoidable in trauma therapy. It does not just occur as a result of the therapist's own unresolved issues.

4. Vicarious traumatization

The theory of vicarious traumatization posits that accumulative exposure to client stories of trauma & abuse affects therapists in particular ways. Vicarious exposure to trauma can produce post traumatic stress symptoms in the therapist & changes in how she views herself & her world.

Vicarious Traumatization (VT) is defined as

"a transformation that occurs within the therapist (or other trauma worker) as a result of empathetic engagement with client's trauma experiences and their sequelae." (Pearlman & MacIan, 1995:558)

Vicarious Traumatization

- accumulates over time & across clients.
- is different from effect of therapy work in general
- produces symptoms of Post Traumatic Stress
- changes view of oneself & the world

The concept of vicarious traumatization can help explain how dramatic and/or accumulative exposure to the trauma stories of clients can negatively affect psychiatric nurses.

Vicarious traumatization can produce PTSD like symptoms in the therapist:

- generalized anxiety
- numbing
- overwhelmed
- poor coping
- anger
- intrusive thoughts
- nightmares
- irrational fears
- addictions
- sleep disturbances
- dissociative reactions
- intrusive images

Vicarious traumatization can produce changes in belief systems:

- loss of trust
- loss of sense of safety
- loss of connection with others
- despair
- cynicism
- disillusionment
- incapacity for intimacy

- poor self-esteem
- loss of sense of control

The consequences of accumulated vicarious traumatization in the workplace can be:

- negativity
- blaming
- victimhood
- feelings of powerlessness.

5. Are you at risk ?

Burnout, critical incidence stress, countertransference & VT interact & potentiate each other to produce occupational stress for nurses. These conceptual phenomenon interact with the characteristics of the particular nurse, the nature of the clients problems, & the circumstances of the work context.

How many of these contributing factors to occupational traumatic stress do you experience?

- Bear witness to client stories of trauma and abuse.
- Work with clients who re-enact pathological relationships in therapy.
- Empathize with clients experiences of severe pain in their lives.
- Witness traumatic critical incidences such as suicide.
- Work without adequate supervision & consultation.
- Work with clients & within a work context where concrete signs of success are few.
- Feel that you are unable to adequately care for clients or feel you are not able to meet your own expectations of quality work.

6. Prevention and solutions: Combating VT & Other Types of Occupational Traumatic Stress Symptoms (from Pearlman & Saakvitne, 1995: 383-399)

Strategies within Therapeutic Work

- recognize VT as an occupational hazard of trauma work.
- accept your reactions as normal responses to specialized work.
- limit exposure to trauma material (e.g. in books, conferences, discussions, movies),
- develop a supportive environment for discussing own reactions to work.
- balance your work load as to types of client problems.

- focus your empathy on strengths & resources of the adult survivor.
- maintain awareness of client re-enactment of pathological relationships.
- set & maintain clear limits on therapeutic relationships (protect self).
- build a network of professional connections.
- develop a balance of professional skills (e.g. trauma & non-trauma work).
- work within a supportive organizational context.

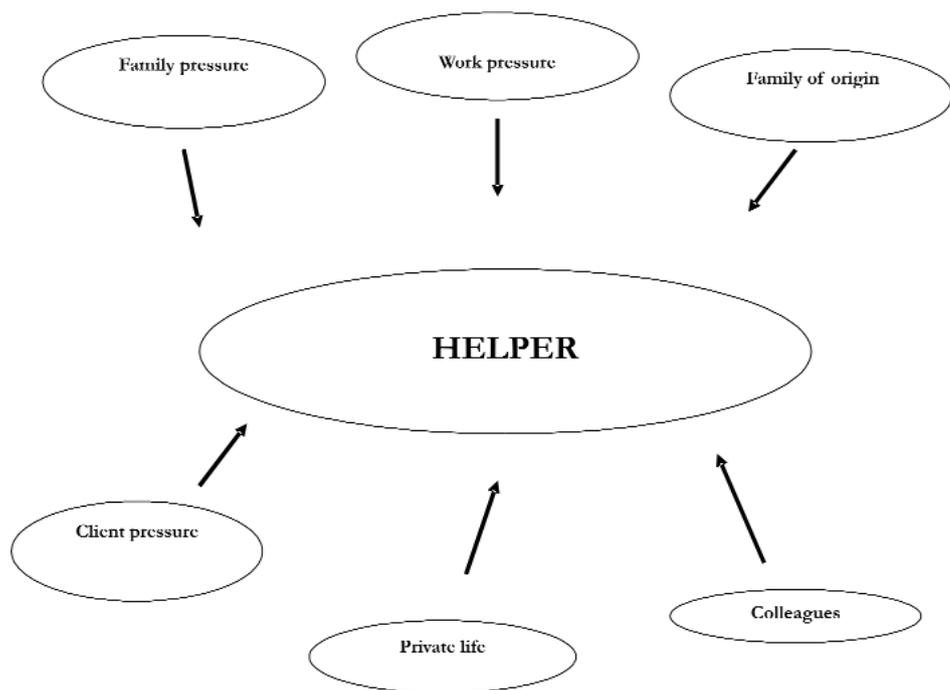
Personal Strategies

***** Not luxuries. Necessities *****

- take time to laugh, have fun, socialize with co-workers (but not about work)
- seek spiritual renewal in your life however you define that.
- emphasize self-care & self-nurturing activities
- consider personal counselling to work through issues.
- take sabbaticals from trauma work.
- take mental health breaks purposefully.
- develop hobbies, sports, creative interests.
- develop restful, meditative activities (yoga, music, reading, gardening).
- nurture supportive relationships & roles for self outside work.
- use nature as a healing force in your life.
- guard against addictive behaviours.
- be rested, fit, eat well.
- nurture sense of joy, grace, beauty, love & connection in your life>
- connect with community, friends.
- seek out experiences which instil comfort & hope.
- set clear boundaries between home & work (use clothing, rituals to mark change from work to leisure.)

Organizational Strategies

- safe, private, confidential work space.
- adequate pay & benefits as resources for dealing with stress.
- support for continuing education.
- supervision & consultation.
- working environment of respect toward clients.
- adequate vacation, sick time & personal leave time.
- access to or time to develop professional networks.
- join in community social action to combat problems of abuse.
- provide access to critical incident stress management teams

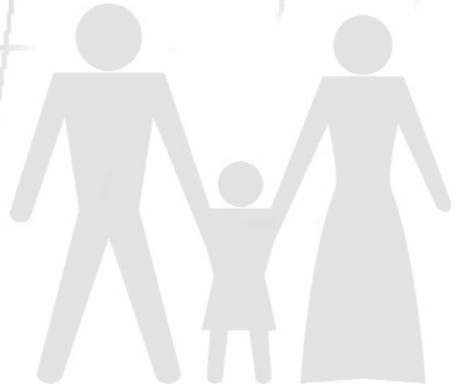




GLOSSARY

ABBREVIATIONS

CONTRIBUTORS



GLOSSARY

AIDS: “Acquired Immune Deficiency Syndrome” – essentially a Sexually Transmitted Disease (STD), either homosexually or heterosexually. The two other main routes of spread are via infected blood or blood products and by the maternofetal route. The syndrome was identified first in Los Angeles in 1981; a description of the causative virus (HIV) was available in 1983. The virus destroys a subgroup of lymphocytes, the helper T-cells (or CD4 lymphocytes), resulting in suppression of the body’s immune response. Until recently, AIDS has been considered to be universally fatal, although the type and length of illness preceding death varies considerably. (*Oxford Concise Medical Dictionary, 1998*)

Assessment: In general, assessment is a process of fact finding, problem finding and understanding the cause-effect relationships between events that can be rank-ordered on a definite time-scale of occurrence (diagnosing). In practice, it is a process to help the helper (social worker, mental health professional, nurse, volunteers etc.) to understand the person’s system of physical, mental and social functioning, and her interaction with former and/or current social environment in order to be able to make decisions for intervention, and to predict the most probable course of further functioning in different (expected) social environment(s).

Burnout: Burnout is a gradual process of disillusionment which follows four often recurring stages:

- **Enthusiasm.** This initial stage is when the helper invests all his/her energy in the job and derives most if not all his/her gratification from work. Some helpers are more idealistic than others, have higher expectations, overidentify with their beneficiaries, etc., and, in essence, are not realistic about how to cope with discouraging conditions and challenging populations.
- **Stagnation.** This stage refers to the process of becoming stalled and losing one’s hope and desire to make a difference. The job gradually loses its lustre and no longer makes up for the person’s needs.
- **Frustration.** The helper is no longer helping and feels powerless. Some helpers complain and complain and complain. Others become angry and blame supervisors and, at times, the beneficiaries for their frustration. Most often, frustration leads to internalisation and withdrawal.
- **Apathy.** The final stage occurs when the helper becomes emotionally detached even in the face of frustration. S/he eventually stops caring!

Case management: A combination of crisis counselling, education, communication skills training, and mental health promotion of persons or groups in lasting crisis, who need immediate psychosocial support and guidance to regain trust and confidence in self and others, even if they would not ask for help. In short, case management is a process of empowerment for recovery from the impact of traumatic life events.

Child Abuse: The recurrent infliction of physical or emotional injury on a dependent minor, through intentional beatings, uncontrolled corporal punishment, persistent ridicule and degradation, or sexual abuse, usually committed by parents or guardians. (*National Association of Social Workers, 1994*)

Child: Persons under the age of 18 years unless, under the law applicable to the child, majority is attained earlier. (*United Nations Convention on the Rights of the Child, 1989: Article 1*)

Child Sexual Abuse (*United Nations*): Sexual abuse of children can be defined as contacts or interactions between a child and an older or more knowledgeable child or adult (a stranger, sibling or person in a position of authority, such as a parent or caretaker) when the child is being used as an object of gratification for an older child's or adult's sexual needs. These contacts or interactions are carried out against the child using force, trickery, bribes, threats or pressure. Sexual abuse can be physical, verbal or emotional and includes:

- Touching and fondling of the sexual portions of the child's body (genitals and anus) or touching the breasts of pubescent females, or the child's touching the sexual portions of a partner's body;
- Sexual kissing;
- Penetration, which includes penile, digital, and object penetration of the vagina, mouth or anus;
- Exposing children to adult sexual activity or pornographic movies and photographs;
- Making lewd comments about the child's body;
- Having children pose, undress or perform in a sexual fashion on film or in person (exhibitionism);
- "Peeping" into bathrooms or bedrooms to spy on a child (voyeurism).

Commercial Sexual Exploitation of Children: The sexual exploitation of children entirely, or at least primarily, for financial or other economic reasons. The use of a child for sexual purposes in exchange for cash or in-kind favours between the customer, intermediary or agent and others who profit from the trade in children for these purposes (parent, family member, procurer, teacher). There are three forms of commercial sexual exploitation of children, as defined by the United Nations, namely child prostitution, trafficking and sale of children across borders and within countries for sexual purposes, and pornography. (*The Declaration of the World Congress against Commercial Sexual Exploitation of Children*)

Communicable diseases (contagious disease, infectious disease): Any disease that can be transmitted from one person to another. This may occur by direct physical contact, by common handling of an object that has picked up infective microorganisms (SEE FOMES), through a disease carrier, or by spread of infected droplets coughed or exhaled into the air. (*Oxford Concise Medical Dictionary, 1998*)

Coping: Coping is behaviour that is designed to prevent, delay, avoid, or manage tension and stress. Coping is not unusual or rare behaviour. Coping is intertwined with one's social and emotional resources and one's emotional and psychological tools. Most individuals learn individualized ways of dealing with stress, but they usually follow a pattern of: avoidance, alteration, management, prevention, and control of undue emotional expression.

Crisis: Crisis means a decisive period of sudden, unexpected systems change that may last from a few days to months (active crisis) or for years (chronic crisis). Crisis is an extraordinary, highly threatened state of bodily, mental and social functioning, and a struggle for survival. Active crisis occurs, when an individual (or family, group, or community) is subjected to periods of highly increased internal and external stresses that disturb the customary state of equilibrium with the surrounding environment. Such episodes of active crisis are typically initiated by some hazardous event that may be a finite external blow, or by a less bounded internal pressure that has built up over time. Such hazardous event (precipitating factor) may be a single catastrophic occurrence or a series of lesser mishaps that have a cumulative effect. In contrast to stress, acute or situational crisis is a self-limiting state, usually lasting from 1 to 6 weeks. One can usually observe an identifiable beginning, middle, and end to crisis.

Empathy: Empathy is one's personal capability and willingness to put herself/himself in another person's inner self (stream of thoughts and feelings) on the base of understanding, and just observing from "outside". Being empathetic is not a request for practitioners to be perfect in "techniques" of communication. Rather, it is a request to present herself/himself as a real human being, reliable and consistent in contact with the services users, capable of conveying interest, warmth, trust, respect.

Evaluation: An ongoing process through case work (fifth step in the nursing-caring process), during which the extent of goal achievement is determined. The purpose of evaluation is to identify factors that enhanced or hindered progress, and if necessary and appropriate, to identify necessary changes in the goal setting of the intervention plan or terminate the case work, as indicated.

Exploitation: Exploitation includes, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs. (*UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children supplementing the UN Convention Against Transnational Organised Crime, 2000*)

Health education: Comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health. Health education is not only concerned with the communication of information, but also with fostering the motivation, skills and confidence (self-efficacy) necessary to take action to improve health. Health education includes the communication of information concerning the underlying social, economic and environmental conditions impacting on health, as well as individual risk factors and risk behaviours, and use of the health care system. Thus, health education may involve the communication of information, and development of skills which demonstrates the political feasibility and organizational possibilities of various forms of action to address social, economic and environmental determinants of health. (*WHO Glossary*)

HIV: Human immuno-deficiency virus, which is a retrovirus responsible for AIDS. There are two main types of the virus: HIV-1, which is responsible for the world wide pandemic of AIDS, and HIV-2, which can also cause AIDS and occurs mainly in West Africa. (*Oxford Concise Medical Dictionary, 1998*)

Intervention: From a mental health perspective, intervention is a carefully and responsibly planned process of comprehensive care to help the person in need to understand his/her own situation and interaction with his/her former and current social environment. The ultimate goal of any intervention should be to prepare the person for predictable and acceptable changes in his/her life and/or current environment that would promote his/her health in a creative and meaningful way.

Interview: Interviewing is an interpersonal process intertwined with informational content about diagnosis, treatment, and health promotion. Process and content cannot be separated. Master clinicians, if asked to choose the single most valuable tool at their disposal, agree that it is the personal interview.

Irregular migrants: Foreigners who have already found protection in a country, and because of uncertain situation in which they find themselves, feel impelled to move to the territory of another state in an irregular manner, without the prior consent of the national authorities or without an entry visa and proper documentation. (*UNHCR EXCOM Conclusions No. 58, 1989*)

Maternofetal transmission of HIV infection: The HIV virus may be transmitted from an infected mother to the child in the uterus or it may be acquired from maternal blood during parturition; it may also be transmitted in breast milk. (*Oxford Concise Medical Dictionary, 1998*)

Medical treatment plan: The plan used by physicians (MDs) to treat diseases and/or functional disorders in focusing upon pathology or injury to specific organs or bodily systems.

Mental health treatment: Variety of plans used by mental health professionals (psychiatrists, psychotherapists, psychologists, qualified nurses and social workers) to examine and treat maladaptive or harmful patterns of behaviour in a person's (or a family's) systems functioning, whereas the "causes" of a particular dysfunction cannot be attributed to any pathological state or injury (or hereditary handicap) to specific organs or bodily systems.

Mental health: The importance of mental health as been recognized by the World Health Organization (WHO) since its origin, and is reflected by the definition of health in the WHO constitution as 'not merely the absence of disease or infirmity' but rather, 'a state of complete physical, mental and social well being'. Advances in biological and behavioural sciences have broadened the understanding of mental functioning and the profound relationship between mental, physical and social health. Mental health has been defined variously by scholars from different cultures. Concepts of mental health include subjective perceptions of well being, self efficiency, autonomy, competence, intergenerational dependence, and self-actualisation of a person's intellectual, and emotional potential. From a cultural perspective, it is nearly impossible to define mental health comprehensively. It is however agreed that mental health is broader than 'a lack of mental disorders'. Mental health is fundamentally interconnected with physical and social functioning and health outcomes.

- Monitoring:** Monitoring is the recording of actions and important events that occur in the flow of case management. The recording may take different forms and techniques, ranging from hand-written notes to electronic recording.
- Nursing assessment:** The first step of the nursing process, during which data are gathered and examined in preparation of the second step – diagnosis.
- Nursing diagnosis:** The second step in the nursing process, during which data are gathered and pulled together for the purpose of identifying and describing health status (strength, and actual or potential health problems).
- Nursing intervention:** An action performed by a qualified helper (e.g. a nurse or social worker) to prevent illness (or its complications) and to promote, maintain, and restore health.
- Nursing process:** An organised, systematic method of providing individualised nursing (and social) care that focuses on identifying and treating unique responses of individuals or groups to actual or potential alterations in physical and/or mental well-being (health).
- Opportunistic disease/ infection:** A disease that occurs when the patient's immune system is impaired. The infecting organism which is also described as opportunistic, rarely causes the disease in healthy persons. Opportunistic infections are common in patients with AIDS. (Oxford Concise Medical Dictionary, 1998.)
- Organized Crime:** A non-ideological enterprise involving a number of persons in close social interaction, organized on a [structured] basis with [different] levels/ranks, for the purpose of securing profit and power by engaging in illegal and legal activities. (*Abadinsky, 1994:8 as cited in Schloenhardt, 1999:9 and Graycar, 1999:7-8*).
- Primary health care:** Essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable. (*Alma Ata Declaration, WHO, Geneva, 1978*). As a set of activities, primary health care should include at the very least health education for individuals and the whole community on the size and nature of health problems, and on methods of preventing and controlling these problems. Other essential activities include the promotion of adequate supplies of food and proper nutrition; sufficient safe water and basic sanitation; maternal and child health care, including family planning; immunization; appropriate treatment of common diseases and injuries; and the provision of essential drugs. (*WHO Glossary*)
- Programme implementation:** A combination of assessment, planning, intervening, control and evaluation (monitoring) throughout the full process of case management, with a special emphasis on advocacy and mediation of a person's (or group's) basic needs and perspectives for change. In short, program implementation is a process of enabling a person (or a group) for responsible decision making to initiate, maintain and reinforce change in own life, including creation of new and/or mobilisation of available resources for chosen change.
- Prostitution:** The act of engaging in sexual intercourse or performing other sex acts in exchange for money or other considerations (e.g., food, clothing shelter, affection, etc.). (World Health Organization, 1996).

Public Health: Public health is a social and political concept aimed at the improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention. (*WHO Glossary*)

Rapport: Rapport is a close, mutually trustful and caring interpersonal relationship between a helper and her/his client. Establishing rapport involves creating a climate where the client can begin to gain confidence in her helper's personal and professional integrity. This is important because it creates the favourable conditions necessary for people to be able to discuss and reveal problems or difficulties, successes or failures, and strengths and weaknesses in ways that aid understanding and allow for a realistic plan of action to be created.

Rehabilitation Centres: The IOM-operated Centres are typically health rehabilitation centres, where trafficked persons are provided medical diagnostics and treatment, as well as psychological and psychosocial assistance under one roof. Enrolment into an IOM rehabilitation centre is on voluntary basis. The usual length of stay is 2-3 weeks. Rehabilitation centres are available to all repatriated and returned trafficked persons. After the initial rehabilitation period, the trafficked person can return home or continue to stay in a shelter, where s/he can obtain longer-term assistance (e.g. psychosocial counselling, vocational/job training, and educational reinsertion).

Reintegration Centres and Half-Way Houses: These facilities are operated by IOM in association with local NGOs. They provide an adequate, safe and secure temporary living environment for trafficked persons for a minimum of 3 months until the reintegration process with the family/peers and the community is arranged. Its main operating characteristics include: Beneficiaries should be involved in the management of the shelter; The shelter should serve as a step/transition period toward a) stabilisation and b) independent living; Reintegration Centres typically provide, directly or via different referral mechanism (NGO, governmental institutions) a rather wide range of services and support-activities.

Second-stage housing: These are semi-independent living structures aiming to prepare the trafficked person for their exit from the assistance scheme. Trafficked persons in such housing should be introduced to community programs (e.g. economic empowerment programs, life skills and vocational skills development, etc.). Case managers from the previous stages of assistance should maintain contact with the trafficked person for monitoring and assistance on a need basis.

Separated children: Children under 18 years of age that are outside their country of origin and separated from both parents or their previous legal/customary care giver. Some are totally alone while others may be living with extended family members. All are entitled to international protection under a broad range of international and regional instruments. (*Separated Children in Europe Programme*)

Sex Tourism: Sex tourism can be defined as trips organized from within the tourism sector, or from outside this sector but using its structures and networks, with the primary purpose of effecting a commercial sexual relationship by the tourist with residents at the destination. (*WTO Resolution A/RES/338(XI)*)

Sexual Assault: Any sexual act directed against a person forcibly and/or against that person's will; or not forcibly or against the person's will where the victim is incapable of giving consent because of his/her temporary or permanent mental or physical incapacity. (*National Incident-Based Reporting System [NIBRS] as cited in Snyder 2000:13*).

Sexual exploitation: A practice by which a person achieves sexual gratification, financial gain or advancement through the abuse or exploitation of a person's sexuality by abrogating that person's human right to dignity, equality, autonomy, and physical and mental well-being; i.e. trafficking, prostitution, prostitution tourism, mail-order-bride trade, pornography, stripping. (*Prof. Estes, Richard J., and Weiner, Neil A., The Commercial Sexual Exploitation of Children in the US, Canada and Mexico, University of Pennsylvania School of Social Work, Philadelphia, 2001.*)

Sexually Transmitted Diseases (STD): Any disease transmitted by sexual intercourse, formerly known as venereal disease. (*Oxford Concise Medical Dictionary, 1998*)

Smuggling: Procuring the illegal entry of a person into a state of which the person is not a national or permanent resident, in order to obtain a financial or other material benefit. Smuggling is distinguished from trafficking in that alien smuggling involves the provision of a service, albeit illegal, to people who knowingly buy the service in order to get into a foreign country. (*Article 3 of the Protocol against the Smuggling of Migrants by Land, Sea and Air, UN Convention against Transnational Organised Crime*)

Stress: Stress is the general adaptation pattern individuals present when they are facing threats or aggression (Seyle). Stressful reactions are first and foremost normal and adaptive physiological and psychological responses that allow a person to focus his/her attention on the dangerous situation; mobilize the necessary mental energy to assess the situation and take decisions; prepare for action of various types (generally fight or flight, but at times the freeze position or physical paralysis can also be a useful response).

- **Basic day to day stress** which is what most motivated people have to contend with in challenging situations;
- **Cumulative stress** which is the accumulation of low grade stress over stretches of time. Even low levels of stress can grow day after day if work conditions are not adequate or if the person does not have a healthy lifestyle;
- **Critical event stress** refers to acute emotional and physiological reactions to violent and potentially traumatizing stress;
- **Acute stress reactions** and **Post traumatic stress disorder** are the dysfunctional syndromes that can appear if the adequate care is not provided to the person who has either accumulated too much stress over long periods of time or if s/he has not received sufficient attention following a critical event.

Trafficking in children: Trafficking and sale of children across borders and within countries for sexual purposes is the transfer of a child from one party to another for whatever purpose in exchange for financial consideration or other rewards. Sexual trafficking is the profitable business of transporting children for commercial sexual purposes. It can be across borders or within countries, across state lines, from city to city, or from rural to urban centres. (*United Nations Economic Commission for Asia and the Pacific: Commercial Sexual Exploitation and Sexual Abuse of Children*)

Trafficking in persons: The recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation includes, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs. The consent of the victim of trafficking in persons...is irrelevant where any of the [previously mentioned] means...have been used. (*UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children supplementing the UN Convention Against Transnational Organised Crime, 2000*)

Transit centres/shelters: These facilities „typically” provide temporary accommodations to trafficked persons and are part of either a formal (e.g. governmental) or an informal (e.g. humanitarian) structure. They provide shelter for a certain period of time (1-6 months) in the country of destination/transit, usually until the trafficked person’s legal identification procedure is closed and his/her documents for return to the country of origin are issued.

Transnational Crime: The crossing of a border by people, things or criminal will, together with the international recognition of the crime at both national and international levels. (*Secretary-General of INTERPOL as cited by Graycar, 1999:2*). To be considered “international,” a crime must be a criminal offence in at least two nation states, thereby bringing into effect international conventions, extradition treaties or concordant national laws. (*Bossard, 1990:5 as cited in McFarlane, 1999:2 and Graycar, 1999:2-3*).

Traumatic events: A **Type I** traumatic situation refers to a single event of very high intensity which a person is unable to withstand psychologically. Examples would be a violent assault or an earthquake. A **Type II** traumatic situation can produce the same consequences but refers to the repetition of highly disturbing situations. For example, repeated child sexual abuse or lengthy exposure to situations of physical insecurity such as those civilians may experience in a war zone.

Unaccompanied child: A person under 18 years of age (unless under the law applicable to the child, majority is attained earlier) who is separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so. (*UNHCR Guidelines on Policies and Procedures in Dealing with Unaccompanied Children Seeking Asylum*)

ABBREVIATIONS

AID	Adolescent Diagnostic Interview
AIDS	Acquired Immune Deficiency Syndrome
APA	American Psychological Association
ASR	Acute Stress Reaction
CEE	Central and Eastern Europe
CPS	Creative problem solving
CTHDB	Counter-Trafficking Health Database
DSM	Diagnostic and Statistical Manual of Mental Disorders
GP	General practice
HIV	Human immuno-deficiency virus
ICD	International Codification of Diseases
ICRC	International Committee of the Red Cross
IO	International organizations
IOM	International Organization for Migration
NGO	Non-governmental organizations
PTSD	Post-traumatic stress disorders
RCP	Regional Clearing Point
SEE	South Eastern Europe
STI	Sexually Transmitted Infections
UNHCR	United Nations High Commissioner for Refugees ()
UNICEF	United Nations Children Fund
WHO	World Health Organization

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