**Journal El-Baheth in Human and Social Sciences**
ISSN 2170-0370/E-ISSN 8127-2710
Vol 14 -N° 02 / June 2023 /PP 57 – 69

# The splitting in healthcare teams and the lack of compassion in the relationship between caregivers and patients

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**Received:** 03/02/2023 ; **Accepted:** 07/06/2023 ; **publication:** 14/06/2023

## Abstract

This contribution aims at shedding light on some results, coming out from academic research, whose initial objective is studying the psychic mechanisms underlying a «cold» attitude and lack of compassion among nurses in some Algerian healthcare establishments. These attitudes are perceived by patients' families as “inhuman” and lead to violent responses. Beyond the significant psychological suffering detected in our caregivers, the mobilized «split» seems to impact the internal organization of the care teams, as well as the relationship between its members, hence increasing the experienced suffering. If taking care involves the use of the caregiver’s technical competencies, it requires communication, availability and compassion towards the patient; among the interviewed caregivers, this benevolence seems psychically costly and care is replaced by the care of the “biological body”. Thus, the psychic suffering in relation to a disturbance of sense, pushes these professionals to more «technicity» to the disadvantage of compassion, which could impact the quality of the provided care

**Keywords** : Caregivers; Psychic suffering; Bond disturbance; Splitting; Lack of compassion

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## I- Introduction :

*“A good nurse is expected to combine technicity and empathy, cure and care” (Molinier, 2009).*

In the psychoanalytic conception, the individual is placed in a double movement: subjective, through a will and own choices, on the one hand, and social, involving the relationship between the subject and his environment and with the other, on the other hand. Our present contribution deals with the intrapsychic experience of caregivers, their intersubjective relationship with other members of the team, as well as the characteristics of their relationship with the patients under their responsibility; these aspects are intimately linked in the care profession and cannot be grasped separately in the analysis of the addressed problem.

Care involves attention, service and responsibility towards others (Mebtoul, 1998, as cited by Olive, 2010), but also implies a set of individual tasks that are part of a collective work. The care relationship is “an encounter between a person being taken care of and caregivers who will accompany him/her on the particular path of his life” (Furstenberg, 2011, p.78); this encounter would be likely to mobilize the emotional and affective part of the caregiver. (Valabrega, 1962; Jeammet, Reynaud & Consoli, 1996), which could have a deleterious effect on his psychic health and well-being.

Our research results have highlighted a significant suffering among the majority of caregivers, perceived through a somatic symptomatology (exhaustion, headaches, gastric problems, hormonal and allergic problems...etc.), or psychic (depressive or anxious symptoms, aggressivity, sleep and eating behavior disorders…etc.). These caregivers highlight the lack of recognition of their effort and work, but also a devaluation of their role as nurses. Also, the majority of caregivers have relationships that are marked by a lack of trust, conflict, or even a complete lack of relationship with other members of their team. The relationship of care is marked by technicity, with a lack of compassion and interest of the caregivers towards their patients; the attitude of nurses is qualified as «inhuman» and «lack of mercy», creating anger among patient's accompanying persons, who use violence against caregivers.

Through this contribution, we will try to analyze this lack of compassion, through a cross-reading of the collected data, to provide an in-depth explanation of things, and not only as they appear in our perception (Freud, 1938).

### I.1. Procedure and Participants

We are going to present some results of our Doctorate research whose initial objective is searching for an understanding of the psychic mechanisms underlying a relationship of care, perceived as distant or even «cold» among some nurses. The research concerned three hospitals in the province (wilaya) of Oran - Algeria, and 82 caregivers in several departments. The choice of the research population is carried out on purpose, among the caregivers in the selected departments, who have agreed to participate in the research.

Our research population, n= 82 is as follows: 22% Males and 78% females; 57.3% are under 30 years old, 20.7% are between 30 and 40 years old, and 22% are over 40 years old. 78% of these nurses are health-care technicians and 22% are health-care assistants. Concerning professional experience, 51.2% have less than 5 years in the profession, 24.4% have between 5 and 10 years, and 24.4% have been practicing for more than 10 years. As for the nature taking care, 25.6% of caregivers are assigned to «emergency»[1] care services, 30.5% are in services requiring a long healthcare with relative possibilities of healing[2], and 43.9% work in long-term care services with minimal possibilities of healing[3]. The nature of healthcare is an important parameter given the characteristics of the received population and the required investment for taking the latter in charge.

## I. 2. Tools

In the framework of this research, we used the quantitative descriptive method and the analytical qualitative method, through the semi-directive clinical interview of research and the Symptom Check-List/SCL-90R of Derogatis. In the research interviews, we discussed several axes, including the representations of the profession, the experiences of work, but also the relationship within the work teams, which we will develop in this contribution. Once the interview was completed, we had passed the SCL-90-R and finally the Thematic Apperception Test/TAT (which was passed to a dozen caregivers, but we will not present it as part of this contribution).

The purpose of the analysis of the research interviews was to derive meaning from what the caregiver “says” during the interviews in two stages, namely the descriptive analysis of content (through the identification of keywords and their repetition in other interviews), and the clinical analysis (in reference to the psychoanalytical theory that allowed us to identify the processes referring to defense mechanisms). The analysis of the content consisted of three essential steps, first, we carried out a pre-analysis work, through the categorization and fragmentation of the text where each «significant» fragment becomes a unit of analysis. monitoring the exploitation and coding work through the categorization of each unit of analysis into one of the defined categories (Bardin, 2013), with reference to the initial hypotheses, to arrive to the treatment of statistical analysis and interpretation (the analysis was done with SPSS/ Statistical

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Package for the Social Sciences). A work of qualitative analysis and inference was also used in the analysis of the interview, especially concerning certain situations and events carrying very strong meaning, which exceed the «manifest» content of the discourse of the subject.

The Symptom Check List SCL-90R was used to evaluate the manifestations of suffering in paramedical professionals, through the collection of symptomatology presented by paramedical professionals according to nine dimensions: Somatization- Obsession/compulsion- Interpersonal sensitivity- Depression- Anxiety- Hostility- Phobic anxiety- Paranoid ideation- psychoticism; it is a self-assessment questionnaire which allows to have a «reflection of the current psychological state» of the subject, according to Derogatis (as cited in Gosselin & Bergeron, 1993). This tool was originally implemented by Derogatis & Cleary in 1977, and the French version was adapted in Quebec by Fortin & Coutu-Wakulczyk in 1985. Dozens of studies suggest that the scale has satisfactory psychometric qualities (good internal consistency- good fidelity test/ retest) for both English and Quebec versions (Holli, 2003). It should also be noted that the nine dimensions are strongly correlated with the depression and anxiety scales, which makes the Check-list a tool for measuring overall distress (Gosselin & Bergeron, 1993). The Arabic version was adapted to the Palestinian population by Abu Hin in 1992; in addition to its use in Palestine, the questionnaire was used by the Association for Psychological Aid, Research and Training (SARP- Algeria), as part of an epidemiological survey on psychological trauma in Algeria between 1999 and 2000 (El Masri et al., 2001). Another application of this tool was made in a research conducted as part of studying the effectiveness of psychological take in charge among 30 adolescents who benefited of management during the latency phase (Saadouni, 2011).

The analysis of the Check-List was carried out in two stages: a quantitative treatment of the Check- List through SPSS (Statistical Package for the Social Sciences) as a first step, in order to calculate the general index of suffering, as well as the scores of positive symptoms (the scores were established by Derogatis, (1977), based on gender). Second, we carried out a psychodynamic analysis of the scores obtained at the different dimensions in relation to the mobilized defense mechanisms.

## II- Results and discussion :

### II.1. Results

### II.1.1 Caregiver Experiences and Splitting

The data of the Symptom Check-List/SCL-90R allowed us to identify a mental suffering affecting 84.1% of the interviewed caregivers, which could strongly impact the quality of the provided treatment, especially the care, since the quality of care is intimately linked to the quality of caregivers' life (Laly,2020).

This suffering takes various forms, the most dominant of which are obsession-compulsion (obsessive thoughts and compulsive behaviors) in 74.4%, paranoid Ideation (projection of ideas, doubt, aggression, and self-idealization) in 68.3% and Hostility (behaviors, thoughts, aggression-bearing affects, irritability, resentment) in 64.6%. Psychoticism (refers to a continuum from withdrawal of the subject, to psychotic manifestations in the form of hallucinations or projections) which is seen in 59.8%, Somatization (disorders of the organs and body usual functioning, including respiratory symptoms, cardiovascular, muscular...etc.) in 58.5%, Anxiety (refers to the psychic and behavioral tension, manifested by the subject and expressed through trembling or other somatic symptoms) in 50%, and Depression (all the organic or psychic symptoms that refer to a decrease in the performance of the subject, through sadness and despair, withdrawal and disinterest in activities, decrease in energy and self-devaluation) in 47.6%; as for Interpersonal Sensitivity (implies self-depreciation and discomfort when interacting, with negative anticipation) it is present in 46.3%, and phobic Anxiety (manifestations of irrational and disproportionate fear of places, situations, objects, people...etc.) in 36.6% of the interviewed population.

Regarding the mobilized defensive mechanisms, we noted that 52.4% of caregivers used either the divide or isolation, and 36.6% used both mechanisms at the same time. These two mechanisms allow a «separation» of «not developed» psychic contents, since on one hand, the divide refers to the action of separation and division (of the ego or the object), allowing to tolerate the divided parts without possible compromise (Ionescu, Jacquet & Lhote, 2005); it also allows the work of structuring, discrimination, attention, and of organization of affects and thoughts, which would have a protective role for the psyche against any psychically «intolerable, unavoidable event» (Bayle, 1998). As for isolation, it allows the disruption of link between thoughts or between representations and affects (Laplanche & Pontalis, 1967), which allows caregivers to «cool» the affects related to patient care.

The clinical interviews allowed us to note a strong mobilization of the «divide» which is seen across all aspects of the work: divide of the care: biological body/ subject body, or sharing of the care of the patient; divide of the team: young/ less young-good/bad…etc. ; individual divide: caregiver life/ subject's life.

The division of care is done by sharing patients' rooms- patients sharing- care sharing (health checks - constant monitoring- treatment...etc.), and this in the absence of collective work on the same patient “*everyone has his tasks, so, there will be no problems between us*” the caregivers say, thus, the patient is limited to certain tasks performed on his body, without regard for the dimension of “subject to suffering” in its totality, which requires benevolence and compassion. This means the dominance of technical work that needs to be done, since focusing on the technical care of the body or "technicize" allows nurses to remain effective, on one hand, and to protect their mental health on the other (Molinier, 2009). Another aspect of the division of care is the ignorance of the "subject body" to be able to perform the care of the biological body, "*if I look at the patient I can't perform the care, so I look at the part to be cared for to be able to do my job*." (Safia, 15 years in the Medical-Surgical Emergencies profession); *Conscious patients exhaust me and drain my energy, I prefer unconscious patients, because I am not obliged to listen to them* (Aicha, 5 years in the Medical Resuscitation profession). These caregivers avoid looking and communicating, which are essential elements of the relationship with the patient, allowing to accompany him in his illness or even his suffering. These forms of division seem to allow caregivers to protect themselves from the affects that can destabilize them and thus continue to perform their work.

The division between work and personal life manifests itself through the separation between life in the hospital and life after leaving it: "*I am in a hurry to get out of here, when I take off my gown, I forget everything and another life begins*"; "*when I leave, I forget that I work here and I don't even answer my colleagues' calls*"; "*at home I'm another person, I'm not talking about what's going on there*". It should be noted, however, that this defensive mode is not mobilized by all caregivers since some of them have their personal time contaminated by professional time: "*I keep thinking about what happened during the day, and I talk about it around me*"; "*work broke me*; *I'm so demoralized when I finish work that I don't even stand my own daughter's cry*"; similar observations were also collected by Pascale Molinier among nurses (2009).

### II.1.2. Team Organization and Quality of Care

The relational dynamic within the work teams is built on separation between young nurses and older nurses, and around specific representations where the young ones are considered by the elders as "*lacking in seriousness and commitment, and not having interest in the patient*". Elder nurses are seen as "*persecutors*" and "*problem-makers*" by younger nurses. This has contributed to the emergence of important relational conflicts, ranging from the lack of support among colleagues, to violence in all its forms. On the other hand, team division has fostered a sense of threat and persecution, especially in the cases of professional error or the failure of care "*I prefer to work alone because I don't trust others*"; "*when there is success in care it is thanks to the doctor, and when there is failure in care or error it is the nurse's fault*"; "*there is a distinction between doctors and nurses*"; "*we nurses are discriminated against and devaluated*". This division of teams does not help caregivers to understand, accept and develop the deaths of patients and failures of care that require the participation of all members: "*When a patient dies, I ask myself the question: why? Did I do my job wrong? Why am I here? There's too much death, so what's my role here*?" Thus, the care team who is supposed to share the responsibility on the patient, and allow giving sense to the experienced situations, is dislocated, especially in moments of crisis, through the constant search for a «responsible» for this failure.

As noted above, and based on the organization of the services and teams, paramedical caregivers performed the same tasks, as the distribution of care was done according to the number of patients and the care to be administered; in other services, the dispatching of work was by rank of nurses and caregivers' assistants. The various interviews allowed us to note that the distinction of ranks was badly experienced by caregivers' assistants, because it was perceived as a devaluation of their role, hence the devalued representation of their function: "*Being assigned to the patient's toilet, calls into question all the training I have received, since I am able to do more in the area of care*," according to the declarations of caregivers. On the other hand, the distribution of duties without rank distinction is not well-perceived by health technicians, who report that they are "*overwhelmed by the patients' toilet, which does not fall under my rank, and that I would be more effective if I were assigned exclusively to care*", according to the statements of health technicians.

The clinical research interviews revealed satisfactory reports to the work teams in over 31.7% of the caregivers, in which they found "assistance and support", which they assimilated to a "*second family*." The relationships were described as "*work-only and task-sharing*" among nearly 58.5% of caregivers, and discussions and meetings are primarily about the patient with "*a lack of trust between the members of the same team*" according to their statements, and 9.8% of the interviewed caregivers complained of conflicts between the members of the work team, who said that they were "*persecuted by their colleagues*", or simply mentioned "*a lack of relationship, discussion or meeting*".

Research data revealed a statistically significant correlation between the quality of the team relationship and the following dimensions of suffering: interpersonal sensitivity, paranoid ideation, anxiety, depression ($p < 0.05$) and hostility. ($p < 0.01$). In other words, the more conflictual the relationship with co-workers is, the more psychic suffering is manifested among caregivers, through the mentioned dimensions, correspondingly, the more the working group is containing and based on support, the less suffering is among paramedical professional. We note in passing that, caregivers found that they became more aggressive and emotional with their co-workers but also with their families because of work-related difficulties.

## II.2. Discussion:

## II.2.1. Suffering, Splitting and Lack of Care

*«We understand that medicine needs an objective pathology, but a research that makes its object disappear is not objective» Georges Canguilhem.*

Man is in a perpetual search for the "meaning" of his history which is marked by continuous conflicts between his desires and reality, whether it concerns his personal or professional life. According to work psychodynamics, work is linked very closely to one's subjectivity, because it allows him/her either to elaborate his/her suffering from his/her personal history, or to experience its pathogenic effect. This work of elaboration is done according to the needs of the workers' psychic economy, who will seek a compromise between their desires and reality, through the mobilization of psychic processes (Molinier, 2010); as for the relationship of care, it involves the use of the caregiver's psychic apparatus, which has consequences on the functioning of this apparatus. Considering the constraints experienced by the caregiver, including the lack of satisfaction of his/her desires, he will try everything to escape the psychic cost due to this lack. One of the most common ways of "disengagement" among caregivers is the choice of purely "technical" work, by using separation mechanisms, including cleavage division and isolation, by defending oneself against any kind of benevolence towards the patient, and by avoiding any relational investment that could generate emotional involvement with patients (Molinier, 2009). But is this a real disengagement, since these caregivers know that an important aspect of their work is missing and that they are not satisfied with.

As noted above, the splitting has a structuring and protective role for the psyche (Ionescu, Jacquet & Lhote, 2005), which allows a relief of the unbearable tension according to Freud (1938); this «functional» division could disappear once the elaboration work is done or could manifest itself in the form of violence. At worst, it can freeze in the form of «structural division» and generate chaos in the psyche (Bayle, 1998). On the other hand, isolation is assimilated to a kind of «division» allowing to break the associative connection and the linking of thoughts and affects (Laplanche & Pontalis, 1967); It is considered by many authors as a useful mechanism for guiding the work of thought, concentration and abstraction (Jeammet, cited by Ionescu, Jacquet & Lhote, 2005), which seems to allow caregivers to continue to do their job, at least on the technical level without difficulties. Nevertheless, the prolonged suppression of the affect could have unfortunate consequences on the equilibrium of the subject.

It is thus clear that isolation and division - although they seem adaptive and useful for caregivers - are mechanisms of impulsive delineation, which can generate imbalances that can take the form of various somatic, intellectual and psychic symptomatologies, which has been noted by our caregivers. According to the psychoanalytic theory, symptoms originate in the conflict that opposes the Id and Superego, and can serve as a means for the Id to escape danger, or to represent a substitute for the impulsive process. During a defect of elaboration and psychic symbolization of the libido in the subject, the symptom evokes a splitting between the psychic and the somatic (Barus-Michel, 2004), and the libido would be maintained on the somatic level through the appearance of symptoms (Laplanche & Pontalis, 1967). According to Christophe Dejours, the adaptation of the subject to his work can be done in the form of somatic decompensation, but also psychiatric through delusions, depressive episodes, violence crises...etc. (Dejours, 2012).

In the care relationship, illness and death are common objects to both the caregiver and the patient, making the proximity between them very important (Valabrega, 1962). In the beginning of their careers, the caregiving relationship was marked by caregivers' identification of patients' suffering, allowing them to provide the "desired care for themselves or their families". These caregivers expressed their satisfaction with the quality of the provided care, where they stand "*close, motivated by the desire to help patients and listening to their needs*" according to their statement, but not without emotional spillovers for these professionals. Little by little, these "challenging" identifications have given way to professional identifications, by allowing caregivers to adhere to the "normative" image of the good caregiver, namely "*the one who does his/her job without becoming emotionally involved*", which was possible through the mechanisms of isolation and splitting. These defensive modes seem to allow the caregivers to tolerate the relationship of care, without being overwhelmed by reactive affects. Nevertheless, they have not prevented the manifestation of symptoms referring to a psychic suffering. Also, they describe the relationship with patients, that is limited to technical care, with a lack of benevolence. Thus, this relationship "without compassion", which ignores the part of the "suffering subject", described by the parents of patients as "*an absence of humanity on the part of caregivers*", would be the result of a psychic suffering related to the profession. But how can we put ourselves in a "good distance" that allows to take care of the patient without suffering emotionally?

### II.2.2. The Bond Between care Teams and the Relationship with Patients

*"... The subject cannot be conceived without the other, without the others..."Barus-Michel.*

We found out in our research that relational conflicts represented an aggravating factor in the suffering of many caregivers, according to the psychoanalytical literature. "Relationships with others" constitute one of the three forms of suffering threat (along with those of the body and forces of nature) (Freud, 1929), and the ability to overcome relational difficulties is related to the defenses operating in the subject, since "good defenses make good relationships" (Braconnier, 2010, p.34).

The group has an important role on the adaptive capacities of the subject to reality, since it represents a scaffolding of the Ego, so that it can regain an appropriate functioning, promoting the work of psychic elaboration (Kaës, 2000). It also sets the stage for social recognition and validation of practices (Lhuilier, 2006), which is essential for any professional. On the other hand, the relationship of the subject to the group was developed by Pierra Aulagnier, through the concept of "narcissistic contract", representing the place assigned to the subject within the group, and contributes to the construction of his identity through secondary socio-cultural identification (Castoriadis-Aulagnier, 1975). The problem of this specific bond is approached in relation to subjectivity, but also in relation to the institutions which the subject belongs to, since the institution «constitutes the foundation of the psyche, a primary data of identity and psychic economy» (Kaës, 2012, p.52). According to the same author, the institutional framework "supports the definition of specific roles, statutes, and tasks. It assigns to each one his/her place, which will be invested according to singular modalities. The quantity and quality of investments are a driving force behind the overall fabric of relationships" (Ibid, p. 53).

According to the comments of the caregivers, the institution as an organization does not provide concrete solutions to the identified mode of operation: the feelings of caregivers concerning discrimination, injustice and lack of recognition, conflicting reports and lack of team cohesion, in addition to complaints from patients' parents of "*inhuman behavior towards the patients*", far from the social representation describing caregivers as "*angels of mercy*", result in violence as a response to the intolerable behavior of caregivers. This violence is badly lived, thus, creating a feeling of insecurity among the caregivers who incriminate the patients' parents "*they behave like bullies… they are narrow-minded…. they don't understand our job*…". This discomfort due to several factors affecting the quality of caregivers' life in the workplace, can only contribute to the "disengagement" of caregivers, which would be detrimental to the quality of care provided to patients.

On the other hand, the functioning of these teams falls far from corresponding to the definition of caregivers' teams, involving several professional categories, with collective actions that work together (Beaucourt & Louart, 2011), and where "Attitudes, cognitions and behaviors are inter-related and contribute to the dynamic processes of the activity" (Hackman, 1990, p.3). This way of acting together in a specific context is called collective care, which refers to interacting and group care to act in the best interests of patients (Beaucourt & Louart, 2011). Starting from the moment when the caregivers work in a group, it is possible for them to act at best only by being connected: by acting jointly on the patient's situation, the actions are discussed, debated or validated and their relationship will be close and empathic. Nevertheless, the breaking of the "bond" seems to cut off caregivers from a part of themselves by neglecting the "concern for the other", which can be observed through this lack of compassion and benevolence.

## III- Conclusion:

According to the psychoanalytic theory, suffering produces a deep disorganization of psychic functions and prevents any form of desire (Kaës, 2012). Concerning the absence of desire and motivation at work, it could manifest itself in the absence of commitment in what the worker does, and which could strongly impact the sense of work. In the absence of optimal conditions for the preservation of the well-being of caregivers, the quality of the provided care could not be meet appropriately the patient's needs. On the other hand, caregivers feel a sense of guilt related to their thoughts or the accomplished work: being "*relieved by the death of the patient*" or "*not being involved with the patient as before, and as he needs*". How can he continue to do his work when desire is missing? without having worked on his guilt? and without peer support or team support?

To re-establish the work of team caregivers in a functional and effective way, which integrates technicity and compassion, it would be necessary to take care of professionals and their well-being, through updating their technical knowledge and skills, developing their interpersonal and social competences, training to address their shortcomings.…etc.; teams should also be federated to work together and support each other. But above all, we should act on the organization that is the source of suffering for individuals and groups (Kaës, 2012), which could not be done without treating the institution (Tosquelles,2003).

## Referrals and references:

1. MEBTOUL, M. (1998). **Le soin sociomorphose- épistémologie d´une relation**. In J-L, Olive & M, Mebtoul. (Ed). (2010). *Le soin sociomorphose*. Collection Etudes. Presses Universitaires de Perpignan.
2. FURSTENBERG, C (2011). **La clé des soins relationnels: la sollicitude en chemin au domicile**; *in Recherche en soins infirmiers*, 107 : pp 76 – 82. doi 10.3917/rsi.107.0076
3. VALABREGA, J-P. (1962). **La relation thérapeutique. Malade et médecin**. Flammarion.
4. JEAMMET, PH., REYNAUD, M & CONSOLI, S.M. (1996). **Psychologie médicale**. Masson.
5. FREUD,, S. (1938). **Le clivage du moi dans le processus de défense** ; *in Résultats, idées, problèmes*. Tome II : 1921-1938. Col: Bibliothèque de psychanalyse.

6. BARDIN, L. (2013). **L'analyse de contenu**. PUF.
7. GOSSELIN, M & BERGERON, J. (1993). **Evaluation des qualités psychométriques du questionnaire de santé mentale SCL-90-R. Québec** : *Recherche et Intervention sur les Substances Psychoactives*/ RISQ.
8. HOLLI, M.(2003). **Assessment of psychiatric symptoms using the SCL-90**. Thèse de Doctorat , Université d’Helsinki.

9. -المصري، م.، بوعطة، ش.، عرعار، ف.، بوقاف، م، طاجين، س.، غربي، ح.(2001) . **بحث ابيديميولوجي في**
**انتشار الصدمات النفسية والاضطرابات النفسية في المجتمع** الجزائري Elmasri,M., Bouatta, C., Arar, F.,
Boukaf,M., Tadjine, S.,/ Gherbi, H.(2001). Recherche épidémiologique sur la prévalence
In Revue de /.des traumatismes psychologiques dans la population Algérienne
psychologie, SARP, Alger, N09

10. -سعدوني غديري، م. (2011)، **مصير الأطفال المصدومين من جراء العنف: ماذا بعد التكفل النفسي؟** عين مليلة،
دار الهدى للطباعة والنشر والتوزيع Sadouni, M. (2011). Le devenir des enfants traumatisés par
la violence: et après la prise en charge/ psychologique? Dar El Houda

11. DEROGATIS, L.R. (1977). **Confirmation of the dimensional structure of the SCL-90: a study in construct**, *Journal of Clinical Psychology*, vol.12, issue3.
12. LALY, P. (2020). **Qualité des soins : la HAS intègre la qualité de vie au travail dans le référentiel de certification**. Accompagnement des professionnels pour une meilleure qualité de vie au travail, n° 110 mars 2020, pp29-32.
13. IONESCU, S., JAQUET, M-M., LHOTE, C. (2012). **Les mécanismes de défense-Théorie et clinique**. Armand Colin.
14. BAYLE, G. (1998). **Epitre aux insensés**. PUF.
15. LAPLANCHE, J & PONTALIS, J. B. (1967). **Vocabulaire de la psychanalyse**. P.U.F.
16. MOLINIER, P. (2010). **Souffrance, défenses, reconnaissance. Le point de vue du travail**. Érès: *Nouvelle revue de psychosociologie*. 2010/2 n° 10 | pages 99 à 110. doi 10.3917/nrp.010.0099
17. MOLINIER, P. (2009). **Temps professionnel et temps personnel des travailleuses du care : perméabilité ou clivage ? Les aléas de la « bonne distance »**. *in Temporalités*, 9/2009. http://temporalites.revues.org/index988.html
18. BARUS-MICHEL, J. (2004). **Souffrance, sens et croyance - l’effet thérapeutique**. Érès
19. DEJOURS, C. (2012). **Organisation du travail-clivage et aliénation**. In. *Travailler-Dossier les ambigüités du care.* N°28. (pp.149-158). doi 10.3917/trav.028.0149
20. FREUD, S. (1929/2002). **Malaise dans la culture**. PUF.
21. BRACONNIER, A. (2010). **Protéger son soi: pour vivre pleinement** . Odile Jacob.
22. KAES, R (S/D). (2000). **L´appareil psychique groupal**. Dunod.
23. LHUILIER, D. (2005). **Le « sale boulot »**. *Travailler*, 14, 73-98. doi.org/10.3917/trav.014.0073
24. CASTORIADIS-AULAGNIER, P. (1975). **La violence de l'interprétation. Du pictogramme à l´énoncé**. PUF.

25. BEAUCOURT, C., LOUART P. (2011). **Le besoin de santé organisationnelle dans les établissements de soin : l'impact du care collectif** ; *Management & Avenir*, vol. 9, n°49, p. 114-132. doi 10.3917/mav.049.0114
26. HACKMAN, J.R. (1990), **Work teams in organizations: An orienting framework**, in Hackman J.R. (ed.), *Group that work (and those that don't)*, Jossey-Bass, San Francisco, p. 1-14.
27. TOSQUELLES, F. (2003). **De la personne au groupe- à propos des équipes de soin**. Érès.