Humanitarian aid workers are trying to make a difference in an increasingly dangerous world. *Psychosocial Support for Humanitarian Aid Workers: A Roadmap of Trauma and Critical Incident Care* highlights the risks of such work, educates professionals responsible for their duty of care, and brings together current thinking to promote collaborative working to support the carers of our world.

From the humanitarian aid worker trying to organise support amongst chaos, to the professional offering a safe place for recovery, all of these individuals are at risk of becoming traumatised. Therefore, it is vital that we recognise the psychological risks on these individuals, and that they recognise how they can support themselves, so they can continue to function in the work that they do. This book can be used as a trauma awareness guide for all staff whose work exposes them – directly or indirectly – to trauma, and therefore becomes a risk to their physical or mental wellbeing.

*Psychosocial Support for Humanitarian Aid Workers* will appeal to all those working in the field of humanitarian aid, counsellors and psychotherapists, emergency first responders, as well as those who are looking to support themselves after surviving trauma.

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‘Raising standards in psychosocial support for those working on humanitarian response to crises and disaster is only just being recognised by those organisations working in the field. This book is an essential and timely contribution to understanding the need for such support as well as providing a practical guide to establishing systems and approaches. I would urge all those responsible for humanitarian aid workers and indeed, for those responsible for staff or volunteers working in development organisations, to read this book as a matter of urgency and to take on board its recommendations.’

**Philip Goodwin, Chief Executive, VSO International**

‘As the lead in an organisation that works directly with the humanitarian aid sector and sees first-hand the needs of these organisations, this book is a must read.

*Psychosocial Support for Humanitarian Aid Workers* demonstrates that there is no doubt that self-care and resilience form an essential part of being prepared to undertake the very important work the humanitarian sector do in caring for others. At the other end, Fiona’s detailed analysis on the impact of trauma both on an individual and at an organisational level shows it must be treated as the highest of priorities.’

**Andrew Lewis, Nomad & TMB CEO**
I am dedicating this book to a friend of mine who died giving her life to humanitarian aid work. She wasn’t supported to ‘listen’ to her body when it was screaming at her to stop working, she couldn’t ‘internalise’ the voices of reason recommending that she needed to take time out. Her vision to change the world blinded her to her own self-care. And yet, her passion and work continues to make a difference and her legacy remains to help others. May she rest in peace.
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the Counselling and Trauma Service at TfL, and in private practice. She has generously dedicated her time and commitment to proofreading and editing my drafts. She is a fellow writer and is a sectional editor with the online journal *Contemporary Psychotherapy*. She has written for a number of further publications and has self-published several books under the name of Elizabeth.

Thank you to so many inspiring, motivating and passionate individuals working in the humanitarian sector and all of the wonderful encouragement presented to me whilst writing this book. ‘If you want to improve the world, start by making people feel safer’ (Porges, 2001). The work aid workers are invested in is clearly part of the solution to making a safer world.
Preface

*Psychosocial Support for Humanitarian Aid Workers* is a book that aims to psychologically prepare, strengthen and build resilience of aid workers by encouraging good psychosocial care practices for staff exposed to the humanitarian aid sector. Although the focus is on aid workers, this book will help anyone whose work involves direct or indirect contact with traumatic material, those living with or close to someone with post-traumatic stress disorder (PTSD), any individual who is suffering or has recovered from trauma, or anyone who has a general interest in trauma work. All the techniques referred to in this book are useful in supporting and managing symptoms of acute stress and trauma. As Bessel Van Der Kolk, a world-renowned trauma specialist psychotherapist states, ‘Trauma is now our most urgent public health issue’ (Van Der Kolk, 2014, p. 356). This book aims to enable individuals to recognise the symptoms of trauma, identify when a fellow colleague or loved one may be suffering, and create a resilience toolkit of coping strategies. It offers an educational journey to encourage organisations to review their duty of care policies, critical incident plans, and implement a ‘trauma management programme’ in supporting their staff, and for humanitarian donors to consider the funding allocations for staff welfare. The material can also be useful for psychotherapists or mental health practitioners who are interested in trauma, and working with emergency first responders or those in the humanitarian sector.

The introduction explores ‘the roadmap’ to trauma and critical incident care, highlighting the psychological risks to aid workers and exploring the changing face of the humanitarian sector. This is followed by a chapter on ‘the mechanics’ of trauma, exploring the physiology and neuroscience of trauma, including a clear explanation of how the body and mind are impacted by trauma exposure. Chapter 3 details two aid workers’ case studies, the first using Eye Movement Desensitisation Reprocessing (EMDR), and the second using Trauma-Focused Cognitive Behavioural Therapy (TF-CBT). This chapter gives a detailed insight into the therapy
work of treating PTSD, which I refer to as the ‘support vehicles for recovery’. Chapter 4 offers many resources and techniques for managing acute stress and trauma, with which I encourage the reader to develop their own resilience ‘first aid kit’ of coping strategies. Chapter 5 examines the psychological management of critical incidents; what I refer to as ‘the emergency route’. This chapter focuses on informing organisations how to develop a trauma management programme for staff, which should define support for every stage of a critical incident, from early intervention, trauma-specific treatments and follow-up, right through to recovery. In addition, it encourages humanitarian donors to acknowledge the indirect costs that front-line agencies incur by providing responsible staff psychosocial support services. The sixth chapter takes the reader on a journey through the complete package of care, from pre-, to during and post-deployment psychosocial support. I have referred to this journey as ‘the road most travelled’, as it is a process that needs to be embedded into the organisational culture. Chapter 8 explores the many facets of the cultural relevance of psychosocial services; the need to have knowledge of the ‘local roadmaps’, including access to culturally sensitive support and the development of local mental health services, and the consequent challenge of using western norms and staff, as well as the disparity of care between national and international staff. Finally, a list of references to sources of support is offered.

My aim is to balance theory, research and personal stories. This book is the voice of the aid workers, interweaved with personal case studies. As I gathered completed questionnaires and case studies, and as I interviewed aid workers, mental health workers and emergency first responders, I was repeatedly encouraged that this book is necessary. I have been overwhelmed with the level of support and encouragement from the humanitarian sector. In writing this, I hope to have done justice to the cause of highlighting the importance of caring for the carer, as this has been my passion and purpose. Carers deserve to be cared for, as they are the advocates for hope and healing in our world.

**Terminology**

*Psychosocial support*: ‘Any type of local or outside support that aims to protect or promote psychological wellbeing and/or prevent mental disorder’ (IASC, 2017, p. 4). I have used this term throughout the book to refer to any psychological support services.

*Staff*: full-time, part-time, contractors, volunteers, national, international, local, intern and office- or field-based. The term ‘staff’ does not take into
account the different contractual terms and conditions which apply and vary between, for example, a contractor and a volunteer.

_Aid worker:_ humanitarian workers, those working in development in humanitarian environments, emergency first responders, human rights workers, staff of development organisations, and rescue and relief workers.

_Humanitarian organisations:_ general term to cover all humanitarian organisations, including: community-based organisations, donor governments working in and on emergency settings, International Committee of the Red Cross and Red Crescent (ICRC), International Federation of the Red Cross and Red Crescent (IFRC), international non-government organisations (INGOs), national non-government organisations (NNGOs), national government authorities and United Nations agencies.

_Confidentiality/case studies:_ I have consent to use all the quotes and case studies included herein. If individuals wish to remain anonymous, I have disguised all identifying information and added a pseudonym after each reference (name, country). For material where individuals have given consent to be named, I have added their full name and job title. To protect privacy and confidentiality, all identifying client information has been altered or client consent has been obtained in line with BACP’s *Ethical Framework for the Counselling Professions* (BACP, 2016).

_Self-care:_ as with any trauma material the information in this book may be triggering. Please do bear this in mind when reading this book and take a break if necessary. Chapter 4 offers many techniques that can help you if you do begin to feel triggered in any way.

The material in this book has been taken from my own personal and professional experiences by sharing my journey of working in the field of trauma, through supporting emergency first responders – the police, fire fighters, veterans, ambulance personnel and humanitarian aid workers – and supporting clients through issues such as terrorist attacks, kidnapping and hostage-taking, civil unrest and war, assault, sexual violent crime, transport accidents, human trafficking, adoption, traumatic bereavement, childhood abuse and domestic violence.
1 Introduction
The roadmap of psychological risk

As a journalist turned aid worker I thought I was used to dealing with difficult and sometimes traumatising news stories. I’ve spent years sitting in newsrooms sifting through uncut footage from bomb blasts in Iraq, Afghanistan or Syria. As an editor it was also my job to watch the uncut versions of hostage videos sent from Islamic State or Al Qaeda and decide where that footage should be edited, or indeed if it was too gruesome to go to air at all. I’d also spent time in the field before, travelling to Liberia during the Ebola outbreak and also east Africa to cover stories on poverty, child marriage and malnutrition. I thought I was battle-hardened and could deal with almost anything, so when I was given the opportunity to travel to Sierra Leone following the Ebola outbreak I was keen to go. When I returned I would find myself bursting into tears or be overcome with anger at the slightest thing. I felt constantly on edge, had difficulty sleeping and had awful vivid memories of specific events that would haunt me. It wasn’t until several months after I returned home that I admitted to myself I needed help.

(Bianca, UK)

Aid work: the curse of the strong

Working within the field of trauma is deeply moving. I have been doing so for over 17 years, and in my view it is completely unacceptable to continue to hear stories of individuals who have fallen through the net of trauma care. The neuroscience and research of trauma has developed at a great pace over the last two decades. Stories of individuals suffering with trauma symptoms for years make headlines in the western world; and in developing countries research highlights significant numbers of people impacted by trauma as the prevalence of war and natural disasters continue to rise. How can we inform individuals of the impact of trauma, to enable them to be better prepared and able to recognise the signs and symptoms of trauma, and to develop skills to strengthen themselves while supporting
Introduction

their colleagues, family or friends if they are suffering? And if experiencing trauma to some degree is unavoidable, how can we make recovery a right for everyone? My hope is that this book will go some way to offering that. Trauma can lock us into a prison within ourselves, sometimes referred to as ‘the enemy within’. This book aims to break the silence of trauma, help to normalise trauma, and provide the reader with the confidence to be trauma-informed. It demonstrates trauma specialist treatments with detailed case studies and provides practical coping strategies and resources for those that are suffering from trauma and acute stress. I also hope this book offers comfort, on the darkest days, for anyone suffering from trauma. It is a book that will support anyone who has experienced trauma, anxiety, stress, burnout, compassion fatigue or vicarious trauma, as it gives an in-depth insight into the world of mental health through the lens of trauma.

As I was speaking to a group of security managers at a humanitarian forum, I became aware that trauma awareness training seemed to be a luxury, due to ‘lack of resources’. This book can be used as a trauma awareness guide for all staff whose work exposes them – directly or indirectly – to trauma, and therefore becomes a risk to their physical or mental wellbeing. I suffered from Post-Traumatic Stress Disorder (PTSD) over 20 years ago. At that time, there was very little understanding of the impact of trauma and there was no trauma specialist therapy available to me, but not understanding my symptoms was the most disturbing ailment. I often experience clients feeling the same way:

not knowing anything about trauma symptoms or PTSD, I thought I was having a nervous breakdown and this was a major mental health collapse. I couldn’t see how this would get better, that this was something that could be recovered from, I just thought, this is finally it; I’m losing it for good.

(Omar, Jordan)

Most people recover from trauma naturally, although they can still experience frightening symptoms for several weeks, and therefore to gain an understanding that these symptoms are OK and normal can make such a difference in those early stages. I want this book to offer that knowledge and reassurance, and I strongly believe everyone, with the right specialist help, can recover from trauma.

Aid workers are mostly driven by the belief that the humanitarian imperative comes first and the right to receive humanitarian assistance is a fundamental humanitarian principle, which should be enjoyed by all citizens of all countries. The prime motivation of responses to disaster is to
alleviate human suffering amongst those least able to withstand the stress caused by disaster. When humanitarians give aid it is not a partisan or political act but as humanitarian responses have become more prolific and protracted, and humanitarian and development agendas have become more closely linked, aid workers have also started to advocate for equality, justice and empowerment. It is considered that this type of work becomes more than a job:

This job is not a job. It is so much more than that. It is my life. This job requests every part of me. The aid worker in me has to be strong. This side of me has to manage and make important decisions, which could lead to the life or death of my team members.

(Eileen, Cameroon)

Humanitarian work is inherently stressful, with long working hours, away from family and friends, frequent transitions, security constraints, managing emergencies and making life-saving decisions. Other stressors include: working in warzones and areas of natural disasters, being exposed to suffering and death, witnessing the inhumane treatment of those who are disadvantaged or disempowered, and observing the best and the worst of humanity. Humanitarian aid aims to provide food, clean water, shelter, sanitation, agricultural and livelihood support, education and medical care. Aid workers advocate for justice, speak out against sexual violence and gender inequality, alleviate suffering, manage emergencies, build schools and reduce poverty. Steve Ryan, a security consultant, describes the reasons he experienced cumulative stress:

years of travelling, often at short notice, to dangerous places; the unforgettable smell of a mass grave in a Lebanese summer; constantly juggling social and work life; hearing the crack of a bullet overhead in Yemen; talking about risk across grand tables in HQ, or plastic picnic tables in the field; a close call in Syria, and guilt-inducing missed calls on my ever-present work phone had all taken its toll.

The case studies shared in this book include individuals who have been attacked, shot at, kidnapped and survived sexual violence. Additionally, and just as importantly, they include stories of individuals who have suffered the effects of cumulative stress and trauma. Trauma can just as easily be the result of cumulative stress, for example from harassment and poor management from organisations: ‘I cannot say how much the shock of the explosion had on my stress, but the main stressor which caused what was later diagnosed as PTSD from gradual build-up of stress, was caused by constant
harassment from my boss’ (William, Australia). All of these experiences were compounded by the lack of support individuals received from their organisations at the time. Self-care, resilience and mindfulness are some of the buzzwords referring to wellbeing and well mental health. This book aims to strengthen our own self-care and resilience, and that of the organisation. A resilient organisation encourages resilient staff, and vice versa.

Aid workers have often said to me that they feel guilty asking for support and instead reach out to unhealthy coping mechanisms to drown out the uncomfortable feelings, such as alcohol, caffeine, nicotine or recreational drugs. They can often overlook their own self-care, in the name of the greater cause. ‘I felt guilty if I informed anyone I was suffering. How could I complain, when I was faced with such despair in my work, and others were suffering from so much more?’ (John, Norway). Ben Porter, the founder of the Recreation Project, Uganda, and a staff care and psycho-social consultant, refers to a break-down truck to highlight the importance of self-care:

Whilst jogging down a red-dirt road in the Ugandan countryside, I came across a stranded tow-truck (a breakdown as they call them). My friend looked at me and laughed. What happens when the breakdown breaks down? Double trouble, I replied. The situation just got much worse.

Ben notes that ‘staff who are employed to assist those in need can end up breaking down and requiring assistance’. If we don’t take care of ourselves first and foremost, we will not be strong or resilient enough to care for others.

I repeatedly hear from aid workers that stigma is one of the main reasons why individuals do not reach out for support. Individuals suffering mental health issues often worry that they will be perceived as ‘weak’ and, in fact, psychiatrist Tim Cantopher, who wrote the book *Depressive Illness: The Curse of the Strong* (Cantopher, 2012), describes individuals suffering from cumulative stress as resilient and strong. It is the very fact that they are conscientious, dedicated and hard-working that puts them at risk of becoming ill. The aid workers who shared their stories with me were not weak; I met strong, passionate, inspiring and resilient individuals. They also represent the ‘change makers’ who, at times, are willing to be the lone courageous voice advocating for colleagues who are also struggling, sometimes confronted with a wall of denial and a risk of being scapegoated. These individuals should be embraced as an asset to any organisation and not shamed into resignation, as has happened to some of the individuals whose stories are in this book.
Organisational duty of care

Organisations have made big strides in implementing and improving staff care policies over the last decade, but there is still a great deal to be done to prevent harm to staff faced with working in diverse and risk-fuelled environments, particularly national and local staff. Organisations have an ethical, moral and legal obligation to physically and psychologically take care of their staff, including employees, contractors and volunteers: ‘the provision of support to mitigate the possible psychosocial consequences within crisis situations is a moral obligation and a responsibility of organisations exposing staff to extremes’ (IASC, 2007, p. 21). A well-implemented organisational response to critical incidents, including an ongoing programme of psychosocial support, is essential. Peer support programmes help to build an internal culture of care and healing based on the humanitarian principles of humanity, neutrality, impartiality and independence (International Red Cross and Red Crescent Movement, 1965).

At the time of writing this book, InterHealth Worldwide, a holistic support service that supported over 500 NGOs, mission and government organisations, and 20,000 individuals, ceased operating. Report the Abuse, a charity formed to support aid workers that had experienced sexual violence, ceased operating. One of the main factors in both instances was lack of funding. I was involved in supporting fire fighters after the Grenfell Tower fire on 14 June 2017, in London, UK, in which 71 people died. The London Fire Service had drastically cut its in-house counselling team, and was desperately requesting pro bono therapists. I watched in horror as many therapists, who were not trauma specialists, volunteered and carried out assessments un-vetted. Research showed that the number of fire fighters on long-term mental health leave has increased by 30 per cent over the last six years (Greenwood & Harmes, 2017). These experiences demonstrate that although trauma is talked about more, there is still a significant underfunding and undervaluing of psychosocial services.

In writing this book, I developed a questionnaire to gather data and get a clearer picture of what psychosocial support was available to aid workers from their organisations. I received 30 completed questionnaires covering 18 organisations. Additionally, I gathered 12 detailed case studies, conducted 40 interviews and spoke to hundreds of aid workers over the last two years. I asked aid workers to recommend what psychosocial support they felt would be necessary and beneficial to both support them in their work, and to support them to maintain a healthy lifestyle.

The data collected highlighted that only 20 per cent of aid workers interviewed felt that their organisation offered sufficient psychosocial support. Ninety per cent felt pre-assignment consultations would be helpful
and every single individual requested post-assignment consultations, which unfortunately were not routinely offered, even to individuals deployed to high-risk environments. Additionally, many felt unprepared before deployment, and underlined that this was due to a lack of training. Stigma was named as a problem for 85 per cent of aid workers who completed the questionnaire, whether it was stigma of being seen as ‘weak’ or ‘losing out on career development’. Many requested the need for a change in culture, to enable staff to access psychosocial services through the workplace without feeling that they will be negatively judged. This book informs organisations of best-practice psychosocial support for staff. It helps to normalise symptoms of trauma; identify trauma as a workplace risk factor; challenge organisational culture and stigma; and create a holistic and community based approach to recovery.

If organisations do not invest and prioritise psychosocial support for staff, the consequences are vast:

workers suffering from the effects of stress are likely to be less efficient and less effective in carrying out their assigned tasks. They become poor decision makers and they may behave in ways that place themselves or other members of the team at risk or disrupt the effective functioning of the team. They are more likely to have accidents or to become ill. A consequence for humanitarian agencies is that staff stress and burnout may impede recruitment and retention of qualified staff, increase health care costs, compromise safety and security of staff and create legal liabilities.

(Antares, 2012, p. 7)

If something goes wrong the cost can be substantial. A prime example of this is the Steven Patrick Dennis versus the Norwegian Refugee Council (NRC) case. In June 2012 Dennis, a Canadian, was kidnapped and shot in the thigh in Dadaab refugee camp, Kenya. Three other NRC staff were also kidnapped and the driver was killed. They were held for four days, after which they were rescued by Kenyan authorities and a local militia. Dennis’ case of negligence to his duty of care against the NRC was successful, and resulted in a substantial compensation payout. Dennis was awarded damages for both psychological and physical injury. This momentous case has been described as a ‘wake-up call’ for the humanitarian sector.

There is no excuse for organisations not to have clear duty of care policies in order, as there are several psychosocial support guidelines that are widely available, including: the Antares Framework (2012); IASC MHPSS Guidelines (2007); and the Sphere Guidebook (2011).
published *Approaches to Staff Care in International NGOs* (People in Aid & InterHealth, 2009), where 20 NGOs were interviewed about their staff care policies. The survey found that practices were inconsistent at best, and only one-third of organisations had a specific staff care policy. The inconsistent staff care in the humanitarian sector was reflected in the data and comments that I gathered from my own research:

“I’ve worked in the humanitarian sector for 15 years now and I’ve never worked for an organisation that offered appropriate access to psychosocial support. I’ve always had to seek care on my own.

(Samad, Bangladesh)

We have an employee assistance programme (EAP), which has worked well when it has been used, although take up has been low. Since changing the referral system, the take up has been better.

(Lukas, Austria)

My organisation launched a program to detect early signs of burn out and trauma among their humanitarian workers. This has been really helpful.

(Aamir, Yemen)

The Inter-Agency Standing Committee (IASC, 2007) states six key actions in preventing and managing problems in mental health and psychosocial wellbeing among staff and volunteers: ensure the availability of a concrete plan to protect and promote staff wellbeing for specific emergencies; prepare staff for their jobs and for the emergency context; facilitate a healthy working environment; address potential work-related stressors; ensure access to health care and psychosocial support for staff; provide support to staff who have experienced or witnessed extreme events (critical incidents, potentially traumatic events).

**Ripple effect of trauma**

I have attended too many meetings where individuals become statistics, and where these statistics become minimalised and perceived as one-dimensional. Most people recover naturally from trauma exposure after a few weeks, although for some the symptoms continue and the employee could develop mental health problems including post-traumatic stress, anxiety, depression and compassion fatigue (Huddlestone, Paton & Stephens, 2006). Statistics focus on the individual who is suffering, but the reality of affected numbers is far greater. Trauma has a ripple effect; it
does not just impact the individual, but also their families, friends, teams, colleagues, the project and quality of work, and the organisation.

I believe one factor for organisations to remain resilient to shock is strong leadership; being able to sit with the discomfort of really listening to someone’s experiences, however distressing. As Ramalingham noted, in his book *Aid on the Edge of Chaos*, good leadership calls for a focus on strength rather than power (Ramalingham, 2013). Aideen Lucey, an organisational consultant, shared with me the idea of ‘emotion as intelligence’ rather than ‘emotional intelligence’. She noted that:

> the expression of emotions in organisations can be a source of intelligence about the work. Difficult emotions and experiences are thought about as having a meaning connected to the purpose of the organisation. Seen this way, stress, and its particular manifestations, become a communication about the work rather than a symptom of pathology in the individual worker.  

*(Lucey, 2017)*

The fact is that aid workers are at significant risk of psychological ill-health, as shown by the research discussed below. The effects of cumulative stress and other less ‘quantifiable’ outcomes of trauma are not as clearly researched or documented. The more accessible statistics make for difficult reading:

- The *Aid Worker Security Report* highlighted that in 2016, 158 major attacks against aid operations occurred, in which 101 aid workers were killed, 98 wounded and 89 kidnapped (Stoddard, Harmer & Czwarno, 2017, p. 1).
- Since 2006, kidnapping of aid workers has increased by 350 per cent (Stoddard, Harmer & DiDomenico, 2009) and is considered to be the most used form of violence against aid workers (Schreter & Harmer, 2013).
- Between 55 and 78 per cent of aid workers experience at least one seriously frightening or disturbing incident during the course of their work and between 19 and 33 per cent of humanitarian workers report feeling that their life is in danger (Connorton, Perry, Hemenway & Miller, 2011).
- There is a significant body of evidence to demonstrate that workers directly exposed to traumatic events, including transportation disasters, physical attack, shootings, harassment and accidents, during the course of their work have an increased risk of developing PTSD, major depression, anxiety and/or drug dependency (Breslau, 1998).
Introduction

A study that examined the mental health of national humanitarian aid workers in northern Uganda concluded that over 50 per cent of workers experienced five or more categories of traumatic events. Additionally, respondents reported symptom levels associated with high risk for depression (68 per cent), anxiety disorders (53 per cent) and PTSD (26 per cent), and between one-quarter and one-half of respondents reported symptom levels associated with burnout (Ager et al., 2012).

A recent longitudinal study indicated humanitarians are at increased risk for depression, anxiety and burnout during deployment and after returning; aid workers also had lower levels of life satisfaction compared with pre-deployment levels, even months after returning from the field (Cardozo et al., 2012).

These figures are likely to be greater, particularly for national staff, where legal procedures and the cultural implications of discussing mental ill-health can make reporting more difficult.

Despite its ubiquitous presence, whether in crisis zones such as Syria, Yemen or the Congo, or day-to-day existence in both the developing and industrialised worlds, trauma often remains largely unrecognised and untreated. It is the same in the humanitarian sector. As a psychologist working for 30 years in the aid and humanitarian sectors, I have observed my own vulnerability – and that of others.

(O’Donnell, 2017)

A survey of 113 aid workers across five humanitarian organisations concluded that approximately 30 per cent of staff reported significant symptoms of PTSD (Eriksson, Kemp, Gorsuch, Hoke & Foy, 2012). In comparison, the National Comorbidity Survey Replication (NCS-R), conducted between February 2001 and April 2003, comprised interviews of a nationally representative sample of 9,282 Americans aged 18 years and older. PTSD was assessed among 5,692 participants, using DSM-IV criteria. The NCS-R estimated the lifetime prevalence of PTSD among adult Americans to be 6.8 per cent (Adshed & Ferris, 2007). Therefore, aid workers are experiencing trauma levels much greater than the national average, and more aligned with individuals exposed to war: about 30 per cent of the men and women who have spent time in more recent war zones experience PTSD (Iribarren, Prolo, Neagos & Chiappelli, 2005), and to individuals exposed to terrorist attacks, for example in the 9/11 US terrorist attack on the twin towers in New York, the prevalence of PTSD for those actually in the building, or injured, equated to 30 per cent (Hamblen & Slone, 2016).
The changing face of aid work

Humanitarian aid is changing, and there are many reasons why this is so. Due to changes in global conflict patterns aid workers are becoming more entangled with foreign and military policy, which can create a perception that aid workers are no longer neutral entities:

unfortunately, a priori decisions to react and harden against attack create humanitarian fortresses that further separate aid workers from the populations they assist and help to create a situation in which fear threatens to eclipse the humanitarian imagination. These mechanisms may save lives, but at what cost?

(Fast, 2014, p. 26)

Humanitarian aid is a growing industry and there is an ever-increasing demand for a greater number of people to be deployed to volatile and dangerous environments. Protracted conflicts causing forced displacement and adding to global migration movements are set to continue. There has also been an increase in the rise of terrorist attacks and natural disasters affecting a greater number of people (Stoddard et al., 2009). In turn,

striking at aid operations can be a means to destabilise and delegitimise the current order, punish or exact local populations, raise [perpetrators] visibility and political profile, or simply obtain economic assets in the form of goods, cash, vehicles or ransoms.

(Fast, 2014)

All of the above factors are contributing to aid work becoming more volatile and unpredictable.

Christoph Hensch shared with me his personal account of a direct attack on aid workers at an International Committee of the Red Cross (ICRC) surgical hospital in Novye Atagi, Chechnya on 17 December 1996. Only a few months earlier, the ICRC had opened a hospital in order to care for those who were wounded by the Chechen conflict. Christoph was the appointed Head of Office at the time. Six international staff were murdered and, even though Christoph was shot, he survived.

It was an unprecedented and unprovoked act of violence against the organisation and its workers…. My journey and that of the organisation seemed to move on parallel lines, and as in a true parallel, the lines did not touch except at certain specific events…. Very little time was spent walking next to each other, supporting each other. Individuals have to live their journey by themselves.
Christoph went on to describe how he felt the organisation resisted hearing his voice: ‘like an invisible barrier going up … as if people do not want to look at this side of the humanitarian action coin’. He felt a great deal of anger towards the organisation, which unfortunately led him to hand in his resignation (Hensch, 2016).

Hensch felt that ‘the biggest failure that occurred along the way was the inability to establish a fruitful process where both the individual and the community co-created a healing journey’. He proposes an integrated approach to recovering from trauma and stress, made up of four components:

1. objective support: access to professional services;
2. systemic environment: organisations need comprehensive policies, procedures and operating standards that reflect the duty of care for staff;
3. organisational culture: the ethos and values of an organisation to incorporate psychosocial and peer support;
4. subjective experience: identifying and acting upon the personal needs of the staff member.

The invisible costs that individual humanitarian workers are paying can be immense: working in insecure environments and experiencing and witnessing acts of violence and the suffering they cause can have adverse and devastating impacts…. It took many years to make sense of what happened to me and my colleagues on that fateful day twenty years ago, and to overcome the effects of PTSD. From my perspective, the initial experience of being shot was a trigger to a much longer experience of recovery, which was much more prolonged and painful than it needed to be.

(Hensch, 2016)

The scars of wisdom

My experience of suffering PTSD was over 20 years ago. Alongside Christoph Hensch (ICRC) and Jon Barden (a contractor working for DFID), all three of our stories are shared within this book. Not only do we share the scars of PTSD, but we also feel passionate about sharing our stories, so that individuals and organisations can co-create a protective, supportive and healing community. In a world where humanitarian principles are becoming increasingly harder to hold on to, we need to offer ourselves, our staff and our organisations, the humanitarian principles of humanity, neutrality, impartiality and independence.
Introduction

No one should fall through the net of psychosocial support, and no one should suffer with PTSD for years. It is accepted that trauma is a psychological risk hazard to aid work, and research is highlighting that this risk is increasing, therefore it is imperative organisations implement a trauma management programme into their duty of care policies, and that there is a clear pathway of psychosocial support for all staff throughout their employment.

As Report the Abuse enabled survivors of sexual violence to step forward and have a voice, we need to continue to break the silence of trauma injuries, create a safe container for people to speak out, normalise the impact of trauma, implement best-practice processes and enable individuals to recover well and in a timely manner. Having worked in the public, private and charity sector, the charity sector is lagging behind in offering psychosocial support services to staff, which goes against the grain of its values and ethos. Therefore, individuals and organisations need to have a greater awareness and knowledge of how to protect ‘the carers’ of our world, so they can remain resilient and continue to carry out the great work that they do.

Trauma and psychological distress become part of the ebb and flow of life. We can recover from acute stress and trauma injury, with the appropriate help and support. It may leave scars, but if processed those scars become engraved with understanding and wisdom. That wisdom can be used to help others in their recovery. The whisper of that wisdom comes across in every personal story shared in this book.
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